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**Disorders of Learning and Achievement: An IPA Exploration of the  
Lived Experience of Diagnosis and the Role of Growth and Fixed  
Mindsets**

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### **Abstract**

People with disorders of learning and achievement such as Specific Learning Disorder and Attention Deficit Hyperactivity Disorder experience consequences that extend to many areas of life. The purpose of this study was to explore the experience of being diagnosed with such a disorder, and investigate what role growth and fixed mindsets play in that experience, aiming to identify factors that had been positively contributory. Interviews from four participants living in small-town New Zealand were analysed using Interpretative Phenomenological Analysis. Diagnosis was viewed as beneficial for the access it granted to intervention, and detrimental for its capacity to elicit stigma, and become such a dominant presence as to inhibit individuality. Identity development centred around diagnosis and the ways participants either accepted or pushed against ‘labels.’ Negative consequences included withdrawal from learning environments and negative peer influence which was particularly salient during adolescence. Developmental stage affected the way symptoms were experienced and the success of interventions which needed to be implemented early and targeted appropriately to be maximally successful. Participants viewed their difficulties as fixed and immovable but employed growth mindsets in the development of strategies and perseverance to work around their difficulties, taking responsibility and control of their learning as they matured. Maturity also brought conceptualisation of the self as different but capable/worthy and in some cases, better for the challenge learning difficulties had contributed to their lives. They believed support people (e.g. educators) could be most helpful when they adopted growth mindsets toward learning, appreciating individuality and flexibility, tailoring their teaching and support to the individual needs of their students.

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## 1. Introduction

### Overview

Learning is a fundamental component of human life; in order for our species to persist and evolve, ancestors have had to learn the skills necessary for survival. They taught their children to hunt to ensure the success of the next generation; today, people teach their children to read and write, to understand the function of numbers, and to engage in an ever-changing technological world with the problem-solving ability to master whatever may be required in the future. But what of those people who struggle to learn? Outcomes tend to not be favourable; for example Able, Haynes, and Hong (2014) found that adults who had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) at an earlier time in their lives were less likely to be employed than their counterparts.

Health professionals have developed a process of diagnosis that aims to identify difficulties so that help can be made available, and those who struggle are not simply left behind (American Psychiatric Association, 2013). Diagnosis is no simple thing; though it may bring with it understanding and the ability to access interventions (American Psychiatric Association, 2013), it may also lead to negativity and stigma (Hamilton et al., 2014). When a diagnosis relates to one's ability to achieve academically or vocationally, beliefs about what that means may limit a person's potential beyond the direct effects of the disorder itself. For example, learned helplessness, one's belief that an aversive event (e.g. failure) is out of their control (Dweck, 1975), was found more frequently in students who were labelled learning disabled than those whose achievement was similarly low but who had not been given a label (Valas, 2001).

Protective factors can improve the outcome of those faced with the diagnosis of a disorder that affects learning and achievement – one possibility being a growth mindset.

Fixed mindsets (strong beliefs that capacity is set and unchangeable), may work to further entrench self-defeating beliefs and limit potential (Dweck, 2012b). However, growth mindsets (awareness that ability is changeable and that effort is the key to achievement), have the potential to improve outcomes and minimise the boundaries people impose on themselves and others (Dweck, 2012b). An exciting finding is that growth mindsets can easily be taught (Dweck, 2012b), giving the potential to improve the lives and outcomes of countless people who might otherwise be further limited by the belief that their disorder is an insurmountable limitation. The interplay of mindsets and the lived experience of learning difficulties is the focus of this thesis.

### **The Researcher**

My interest in growth and fixed mindsets led me to this research topic. As I first read about the goal attainment made possible with an adaptive growth mindset, I recognised the significance for people who are faced with challenges. I began to draw parallels between fixed mindsets, those which assert abilities to be stable and innate (Dweck, 2012a), and the tenets of labelling theory, where diagnoses are given added weight through internalisation. My prior education in Psychology had involved significant coverage of the advantages of diagnosis, but had also candidly addressed the limitations. I began to wonder if there was a way that growth mindsets might complement the diagnostic process, allowing clinicians and researchers to continue their work developing and implementing interventions, while minimising the negative effects for those who are categorised. Disorders that affect the ability to learn seemed a promising area of investigation, due to the focus of mindset research in issues of learning and achievement.

I bring to this study a particular interpretative lens, shaped by my experiences and unique to me, but I aim to be transparent in my bias. I am a middle-class, Caucasian female

who has very little personal experience of prejudice such as that which may be experienced by people with diagnoses of disorders of learning and achievement. I believe the reason that mindset research has resonated with me is that I have experienced the limitations of a fixed mindset, getting through the early years of school with little effort on the presumption of being ‘clever’ and then being unprepared when work became challenging enough to require effort. The more I have learned about the growth mindset, the more I have recognised it as the mindset I adopted, albeit unknowingly, to reach postgraduate level study.

### **The Research Setting and Participants**

Participants of this research were recruited from a small South Island town on New Zealand’s West Coast. The town had undergone an economic shift over the previous four to five years with the severe decline of its main industry. This was relevant for issues of employment that may have arisen for participants. These socioeconomic conditions may have also shaped the participant pool due to changing unemployment rates and migration from the area. The use of participants from a small town will itself be influential to findings as there will be aspects of life that are exclusive to the area. This study makes no claim to generalise findings, rather aims to capture and interpret the experience of this specific set of individuals, and highlight areas of importance that beg to be explored further and in different settings.

### **Thesis Structure**

Following on from this Introduction, the literature review chapter will give an overview of key topics including definition of terms, consequences of disorders that affect learning and achievement, factors that improve outcomes, and mindsets and their implications for those who struggle with learning. The methodology chapter will then present an argument for, and outline of, Interpretative Phenomenological Analysis and the

process of recruitment, data collection, and analysis. Each Results and Analysis chapter will present and evaluate an overarching theme of importance that emerged from participants' accounts. Those chapters will finish with a dedicated exploration of the influence/interaction of growth and fixed mindsets in relation to the theme. Conclusions, limitations and recommendations for further research will follow.

## **2. Literature Review**

The literature reviewed in this chapter was chosen for its relevance to learning and those who struggle. Due to a sparsity of research involving Specific Learning Disorders (SLDs) which is a relatively new term in the literature, research including learning disabilities which may at times more closely resemble Intellectual Disability, has been included. Where differing terms are used, distinctions will be made. Though the experience of those with differing diagnoses will of course vary, similarities are likely to be present due to the shared experience of struggling academically and/or vocationally.

This chapter will firstly clarify current definitions of SLDs and Attention Deficit Hyperactivity Disorder (ADHD), and will then argue why ADHD fits alongside SLDs within disorders of learning and achievement. The consequences of these disorders will then be discussed, followed by factors that complicate outcomes for those with a disorder affecting their ability to learn and achieve and those factors that may improve outcomes. Mindset research relating to learning and achievement will then be explored and its relevance for disorders of learning and achievement discussed. Finally, an argument will be made for the current study which aims to firstly explore the unique experience of these disorders and secondly attempt to understand the role that mindset may play.

### **Definition of Terms**

#### **Specific Learning Disorders.**

The diagnosis of learning disorders has undergone a recent overhaul. The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) has grouped what have traditionally been known as separate disorders (e.g. Dyslexia and Dyscalculia) under the umbrella of Specific Learning Disorder (SLD; American Psychiatric Association, 2013). The way those disorders are experienced remain the same, it is simply the way they

are categorised that has changed. Specification of areas of deficit (e.g. reading) are still made, resulting in something that closely resembles the previous, more recognisable terms.

The DSM-5 asserts that an SLD involves difficulties in at least one of the academic areas of reading or understanding words, spelling, writing, understanding numbers, or mathematical reasoning (American Psychiatric Association, 2013). The difficulties must begin during the schooling years and be present for a minimum of six months despite attempted intervention; someone must reasonably attempt to teach the skill to the child before it is deemed that they struggle to learn. The skill level must be definitively below what would be expected for age, and have a clear impact on daily living and functioning (American Psychiatric Association, 2013).

It is crucial to point out that individuals with SLDs are not deficient in intelligence, rather, they have difficulty learning in certain areas of skill, which is the main differentiation between SLDs and other disorders such as Intellectual Disability and Global Developmental Delay (American Psychiatric Association, 2013). SLDs do differ in severity however, ranging from mild (with difficulties in one or two domains and the ability to compensate), to severe difficulties in several domains requiring intensive interventions (American Psychiatric Association, 2013).

SLDs are neurodevelopmental disorders that emerge early in the developmental period but usually only become apparent when children enter school as that may be the first opportunity for comparisons to be made between them and their peers (Scanlon, 2013). SLDs are therefore very context specific and are considered a problem in terms of the barrier they pose to academic and vocational achievement (Scanlon, 2013). People who live with these disorders may view it differently though, feeling the effects in numerous other areas of their lives (e.g. peer relationships, mood, anxiety and self-esteem), which is not

surprising considering the various life domains that are dependent on learning (Scanlon, 2013).

Because SLDs have wide ranging effects, assessment must be suitably thorough. It remains heavily reliant on standardised tests due to their success in identifying specific areas of deficit in comparison to other areas of achievement, often focusing on discrepancy between overall IQ and significantly lower scores in specific domains (Eisenmajer, Ross, & Pratt, 2005). It is also necessary to perform a more holistic assessment that takes into account family and developmental history, home life and the family situation among many other things, and to be mindful of the effect that emotional states such as anxiety may have on test results (American Psychiatric Association, 2013). A comprehensive assessment is dually important as it provides the information for development of a holistic intervention, utilising strengths and targeting the difficulties of individual experiences, in order to optimise their outcome (Eisenmajer et al., 2005).

### **Attention Deficit Hyperactivity Disorder.**

Attention Deficit Hyperactivity Disorder (ADHD) is a disorder of executive functioning that similarly impacts the ability to learn and achieve academically (Birchwood & Daley, 2012). ADHD can be of the inattention or hyperactivity subtypes or may consist of a mixture of symptoms from both categories (American Psychiatric Association, 2013). The DSM-5 requires that several inattentive symptoms (e.g. distraction, carelessness, forgetfulness, organisational difficulties) and/or hyperactive symptoms (e.g. fidgeting, inappropriate behaviour, frequent interrupting, difficulty waiting turn) be present prior to age twelve (American Psychiatric Association, 2013).

The DSM-5 sets out that symptoms must significantly interfere with functioning or development, be present in more than one setting, and not be attributed to another cause

such as a Psychotic Disorder or Substance Abuse (American Psychiatric Association, 2013). ADHD can also range in severity from mild, with the minimum required symptoms and minor impairment, to severe with marked impairment caused by many symptoms in excess to those required for diagnosis (American Psychiatric Association, 2013). Some interesting gender differences appear to exist, with the disorder more prevalently diagnosed in males, and females more likely to present with the inattentive type (American Psychiatric Association, 2013), though these findings are controversial and relatively unexplained.

#### **ADHD as a Disorder of Learning and Achievement.**

ADHD is comparable to SLD in the way symptoms may interfere with the ability to learn and achieve academically. Children with ADHD are more likely to be held back a class, to be assigned to special education classes, and to do worse on achievement tests than their peers (Barkley, DuPaul, & McMurray, 1990; Birchwood & Daley, 2012). The behavioural aspects of the disorder may deflect attention away from academic difficulties, something that may be particularly true for those with the hyperactivity subtype (Barkley et al., 1990). Birchwood and Daley (2012) explored the relationship between academic achievement and the symptoms of ADHD, assessing 324 students (aged 15 and 16) on measures of ADHD symptoms, depression, anxiety, cognitive ability, and motivation. Accessing the students grades six months later, they found that of all three clinical dimensions, ADHD symptoms had the most significant impact on grades, with the non-clinical factors of motivation and cognitive ability having only a slightly larger influence. It is noted that this study used a community sample and self-report measures meaning findings may not necessarily be transferable to a clinical population (Birchwood & Daley, 2012).

When Barkley et al. (1990) compared children with the hyperactivity type of ADHD (n=42) to those with the inattention type (n=48), the hyperactivity group were two to three times as likely to display oppositional, antisocial, and conduct related behaviours. Interesting differences were also found between relatives of the groups, with those of the hyperactive type more likely to also have ADHD hyperactive type, substance abuse, and aggression, while those of the inattentive type had higher rates of learning problems and anxiety. Greatly significant was the finding that children with ADHD and behavioural problems were more likely to be engaged in programs that targeted their behaviour than ones that targeted their learning (Barkley et al., 1990), supporting the notion that disruptive behaviour may distract from other issues.

Neither SLD nor ADHD are disorders of intellect, rather sets of symptoms that may interfere with one's ability to learn new material and apply that learning in sustained ways that are needed to consolidate it (Quinn, 2013). ADHD is also comparable to SLD in the way that it may persist throughout life and the impact it may have on a person's employment trajectory. Able et al. (2014) challenged the prevailing misconception that effects of ADHD are limited to childhood, establishing that they may stretch far into adulthood. Those with ADHD were more likely to be impaired in their ability to work and be productive than non-diagnosed counterparts (Able et al., 2014). A lack of time management skills and ability to persist with their work were found to be huge barriers to achievement for a group of University students with ADHD, leading to confusion, self-doubt and depression, which was further complicated by a lack of experience in asking for help (Quinn, 2013). Though these young people had high levels of intelligence allowing them to progress in higher education, their symptoms still interfered with their ability to achieve.

## **Consequences of Disorders of Learning and Achievement**

### **Attribution and Helplessness.**

Some consequences of disorders of learning and achievement may be unique to the underlying diagnosis, or the individual, while others may be experienced similarly by many. When someone believes that they have no control over an outcome they may see little point in expending effort (Dweck, 1975). Children who struggle to learn may be more likely to make attributions to external factors (such as luck) than internal ones (such as effort), and may subsequently display higher rates of learned helplessness (Pasta, Mendola, Longobardi, Prino, & Gastaldi, 2013; Valas, 2001; Yeager & Dweck, 2012). A study by Valas (2001) compared three groups of children (total n=1833), learning disabled, low achieving, and typically achieving, and found that the learning disabled and low achieving groups displayed higher levels of learned helplessness. These two groups also had less belief in their academic abilities and lower self-esteem than their typically achieving peers (Valas, 2001). A more recent study by Pasta et al. (2013) supported the belief that children with SLDs place more emphasis on external factors such as luck.

Dweck, in her 1975 study of learned helplessness implemented a training program teaching children to take responsibility for their failures, making the connection between effort and success in reversing the effects of learned helplessness. Twelve children deemed helpless (by deterioration of performance when failure was likely) and 10 deemed persistent in the face of failure, were randomly assigned to either the retraining program or a treatment that only increased experiences of success, in line with the widely held belief that this was key to increasing motivation. An Effort versus Ability Failure Attribution Scale was delivered afterwards and indicated that those in the treatment group better appreciated the role of effort in preventing failure although they did not measure whether

this would transfer the classroom (Dweck, 1975). Heyman, Dweck, and Cain (1992) undertook a study exploring children's feelings of motivational helplessness (argued to be a similar if not synonymous construct to learned helplessness) and found that it may be so oppressing a force as to negatively influence children's self-beliefs about how 'good' they are, a significant overarching concept of worth. Persistent learning struggles may lead children to view themselves critically, inhibiting their motivation to persevere; the negative views of others can be just as influential, and the adverse consequences of stigma are increasingly recognised.

### **Stigma.**

One of the most vocal arguments against diagnosis comes from labelling theory, the belief that people will begin to internalise their diagnoses and see them as a dominant part of their self-concept. When a person has grown to believe that they are in some way 'deviant' they may shape their entire life around that position (Petrunik, 1980). An identity and social circle that is based on deviance may serve to perpetually reinforce their status as just that (Petrunik, 1980). Labelling does not stop at the individual, with the wider population often altering their views of the individual in accordance, leading to stigma and a change in expectation of what that person is capable of (Osterholm, Nash, & Kritsonis, 2007).

Young people with SLDs and ADHD are at risk of stigma, and those with ADHD may be particularly identifiable to their peers who may go so far as to blame them for their disorders. Swords, Hennessy, and Heary (2011) found that adolescents were readily able to discern which of their fictional peers (using vignettes) were displaying ADHD and depressive symptoms, with older youths able to distinguish between the two. A study by Coleman, Walker, Lee, Friesen, and Squire (2009) discovered that children not only

identified and stigmatised fictional peers with ADHD (and those with depression) but 25-35% believed lack of effort to get better was the cause of their disorders. Children with ADHD possibly receive more negative attention than those with depression or Intellectual Disability due to the externalising, disruptive nature of symptoms (Bellanca & Pote, 2013). Bellanca and Pote (2013) found that younger children held more positive beliefs toward 'disordered' fictional peers, indicating a need for anti-stigma interventions to begin early and be targeted appropriately to developmental stage. This is supported by findings that stigma may emerge in children as young as three (Corrigan & Watson, 2007).

The attitudes that teachers hold toward their students may be highly dependent on the effort they believe those students expend on their learning, with ability level and disability status less important. The apparent lack of stigma by teachers is promising given that they have great potential to impact the schooling experience of their students. Woodcock (2014) surveyed 181 Canadian trainee teachers to determine their attitudes toward students with learning disabilities (LD), providing fictional vignettes of children (describing ability level, typical effort, and presence of LD) and assessing teachers' sympathy, frustration, and expectations of each child. The students who received the most sympathy, least frustration, and most favourable feedback from the teachers were those who were of low ability (both LD and non-LD) but expended the most effort. Those students of high ability who expended little effort were given the least sympathy, most frustration, and most negative feedback. It appears that when teachers attribute failure to within the students control they have higher expectations and are more critical, and that they value effort above achievement (Woodcock, 2014).

### **Psychosocial Impact.**

Self-concept (sometimes referred to as self-perception) has a great deal of relevance to disorders of learning and achievement as it deals with the way people perceive themselves, something which may affect their behaviour. There is conflicting research about differences in the ways students with learning disabilities perceive themselves, ranging from findings that they have lower self-beliefs to those that claim they are actually more likely to have an overinflated sense of their abilities, as will be addressed in the section 'Factors that Improve Outcomes' below. Studies by Tabassam and Grainger (2002) and Baird, Scott, Dearing, and Hamill (2009) found school children with disorders of learning and achievement displayed lower levels of academic self-concept and self-efficacy. A longitudinal study of Swedish students however, found that once the direct impact of ADHD symptoms, as well as history of academic achievement were taken into account, self-perception of academic competence had no significant impact on academic outcome (Scholtens, Rydell, & Yang-Wallentin, 2013).

The study by Baird et al. (2009), though impressive in size (n=1518) was flawed in two significant areas. Firstly, the scales used to measure children's beliefs were low in internal reliability. Secondly, one of the scales was used in a way it was not originally intended (Baird et al., 2009). The Swedish study used a sample drawn from a high socio-economic population and the authors also acknowledge that the sample size may not have been sufficient for the number of variables that were explored (Scholtens et al., 2013). Scholtens et al. (2013) findings may not actually conflict with those of Tabassam and Grainger (2002) and Baird et al. (2009) but may simply indicate that low academic self-concept does not necessarily diminish the achievement of these students.

Studies have purported some distinct personality features that negatively characterise those with ADHD. A study exploring personality variables of College students with ADHD identified high rates of extraversion in those with the hyperactivity sub-type (believed to be compensation for low arousal), as well as higher rates of neuroticism and lower agreeableness (J. D. A. Parker, Majeski, & Collin, 2004). They also found evidence of lowered conscientiousness of those with the inattentive type of ADHD, though it could be argued that a lack of ability to apply oneself might be better explained by deficits in the executive functioning skills that are required to do so and which also characterise ADHD (Gudjonsson, Sigurdsson, Guomundsdóttir, Sigurjónsdóttir, & Smari, 2010; J. D. A. Parker, Majeski, et al., 2004). Gudjonsson et al. (2010) found deficits in self-control (both behavioural and emotion regulation), as well as goal-setting and planning, but likewise attributed these factors to dimensions of personality (responsibility and social concordance), rather than symptoms of the disorder itself.

People with SLD and ADHD are at increased risk of developing disorders such as depression (Mattison, 2015; Valas, 2001), and the relationship between mental health and achievement is complex (Able et al., 2014). Adults with ADHD were found to be three times more likely than comparable peers to report comorbid diagnosis of a disorder such as depression, anxiety, or insomnia, and were less likely to be employed (Able et al., 2014). They were also less likely to be married, indicating that symptoms may affect the ability to build or maintain healthy relationships (Able et al., 2014). Mattison (2015) asserts that the high comorbidity of ADHD and other mental disorders requires a more specialised and thorough system of assessment and intervention which again highlights that the nature of ADHD symptoms may negatively affect an individual's ability to get comprehensive help, with attention deficits and behaviour often taking precedence.

Disorders of learning and achievement differ from many mental disorders in two very significant ways: the early age at which they are usually diagnosed and the endurance of their effects. More transient disorders such as depression may result in severe lack of motivation which may cause problems at work to the point the individual may not even be able to attend; however, a diagnosis of depression in adulthood is far less likely to lead to internalisation of a label to the same extent as a diagnosis of a disorder of learning and achievement that is given early in the developmental period and carried throughout development and life (Able et al., 2014).

Being able to seek and receive the support of others may positively enhance the experience of those with disorders of learning and achievement but they may find it difficult to do so. The repercussions of disappointing experiences (in which support was inconsistent, inappropriate, or not forthcoming) can be long-lasting and destructive. In a study by Trainin and Swanson (2005), College students with learning disabilities (LD) who struggled to ask for help received lower grades than their LD peers who were effective at seeking support. This pattern did not exist between help-seeking and non-help-seeking students without LDs (who could still have benefited from support), indicating that the effects of suitable support may be greater for students with LDs (Trainin & Swanson, 2005). Deane and Young (2014) found that adolescent girls with ADHD and conduct disorders were less likely to seek support because they had trouble trusting others. This led to more destructive coping methods such as running away (avoidance) and substance abuse. The lack of trust that these girls felt toward the adults in their lives stemmed from histories of social ostracism, victimisation, maladaptive internalising and externalising behaviours, and a deficit of positive supportive experiences (Deane & Young, 2014). In terms of

support, getting it right the first time may be crucial for the chances of recipients seeking future support to be optimised.

### **Incompatibility with Environment.**

It is crucial to remember that findings from students in one country may not be transferable to another; culture exerts a strong influence over all areas of life. Research has identified distinct learning styles that cover a range of different ways that people are best able to absorb and understand information; appreciation of learning styles has been put forward as a way to maximise learning and motivation (Harfield, Panko, Davies, & Kenley, 2007). Culture provides one context in which learning styles are developed, with some cultures more prepared for the textbook and standardised test style of instruction that dominates the Western world.

Students who find themselves studying in a learning environment where the culture is significantly different to their own may struggle with the way education is provided. A study of East Asian international students at a New Zealand University combining quantitative (survey of n=117) and qualitative (interview of n=21) methods refuted the widely held belief that language difficulties were the biggest barrier to success (Lee, Farruggia, & Brown, 2013). They found that student's difficulties lay predominantly in incompatibility of learning and teaching styles and understanding the academic content (Lee et al., 2013). These are not only issues for students travelling to New Zealand from other countries; the individualistic nature of the European school system which values achievement and competition is in direct opposition to Māori values of collectivism and reciprocity which obligate everyone to work toward the good of the whole, for the benefit of all within (McCarthy, 1997).

Extra care must be taken when using European derived labels such as SLD and ADHD with other cultures, as argued by Gold and Richards (2012) when addressing the risks of labelling African American students as learning disabled. They believe that for the African American population which has already suffered much oppression, the 'label' of learning disability has a more powerful, detrimental impact than when used with other groups who have not lived for centuries dominated by others. They also believe it has the potential to serve as a tipping point to someone already over-burdened by labels and discrimination. They argue that the term learning disability itself has the power to convince teachers that there is nothing to be done for the student, encouraging a deficit mode of thinking (Gold & Richards, 2012), a point that may be relevant to students from all cultural backgrounds.

### **Factors that Improve Outcomes**

#### **Individual Factors.**

While reduction of negative consequences of disorders of learning and achievement is a viable focus for research and intervention, so too are protective factors which have the potential to positively contribute to experience. Emotional intelligence and having what is deemed an 'easy temperament' are two protective factors for those with disorders of learning and achievement but development and maturity may also play a role. A study exploring the transition of high school students to University (non-specific to learning disorders) found that emotional intelligence in the forms of stress management, being adaptive, and having strong interpersonal skills, were critical for a smooth transition (J. D. A. Parker, Summerfeldt, Hogan, & Majeski, 2004). A longitudinal study by Werner (1993) tracked 698 Hawaiian children from birth and was able to discern very different outcomes from the smaller group of children within the sample who had learning disabilities (n=22).

The learning disability group had more encounters with the law and mental health problems than their peers but the differences had largely disappeared by age thirty-two. Having an 'easy temperament' (being adaptable and predominantly positive and happy) was credited as a major protective factor but the reduction of differences with age may indicate that time and developmental maturity is particularly significant for this group (Werner, 1993).

Those who struggle to learn value control over their learning and lives which involves selecting and applying effective learning strategies. The ability to reframe learning difficulties as positive experiences that contribute to self-awareness (including a focus on strengths) is also valued (Gerber, Ginsberg, & Reiff, 1992; Reiff, Gerber, & Ginsberg, 1994). Studies of successfully employed adults and students with learning disabilities credit goal orientation, having a plan and working through it, dedicating extra time, and utilising metacognitive strategies for that success, indicating awareness of limitations and the compensations needed to succeed (Gerber et al., 1992; Reiff et al., 1994; Trainin & Swanson, 2005). Anctil, Ishikawa, and Scott (2008) found that persistence was key to feelings of competence in high achieving College students with learning disabilities, expressed as both an internal drive and the external act of reaching for help. This indicates that control need not be confined to what can be mustered from within, and that knowing when you need help and asking for it is simply another way to exert that control (Anctil et al., 2008; Trainin & Swanson, 2005).

One possible protective influence that has ironically received negative attention is positive illusory bias, the overestimation of academic, social, and behavioural abilities (Hoza, Pelham, Dobbs, Owens, & Pillow, 2002). Positive illusory bias may stem from experiences of failure and a need to protect oneself from feelings of inadequacy, and studies by Heath and Glen (2005) and Hoza et al. (2002) purport that children with

disorders of learning and achievement may be more likely than their peers to overestimate their abilities. Positive illusory bias seems to be in direct opposition to findings like those of Tabassam and Grainger (2002) and Baird et al. (2009), who reported lower levels of academic self-concept and self-efficacy respectively. Each study has its flaws, such as small sample sizes of each group in the studies by Tabassam and Grainger (2002) and Heath and Glen (2005); additionally, Hoza et al. (2002) used only male participants. There are also questions around the reliability of measures used by Baird et al. (2009) but it remains unclear whether any one study is superior to the others. The most logical explanation for such vast differences is that although the concepts seem to be similar, the studies are simply measuring different elements of self-perception.

#### **Teachers and Peers.**

Teachers have a great deal of control over the experience of children in their class and have the responsibility of ensuring that the classroom environment is one in which all children feel safe, welcome and valued. Osterholm et al. (2007) discovered that teachers had lower expectations of children with learning disabilities described in vignettes but those expectations did not necessarily translate into unfair treatment in the classroom. Brooks (2004) has argued that while the adults in any child's life have a significant influence over their attitudes and behaviours, the relationship is even more salient for those with learning disorders due to their struggles to achieve. He believes the vulnerability this group feels at school can be somewhat compensated for by teachers creating an inviting learning environment, and the key to motivation is lessening fear of failure which will subsequently increase feelings of competence (Brooks, 2004), a belief prevalent throughout fixed and growth mindset research.

Werner (1993) identified positive social interactions as a protective factor for those with learning disabilities, something that may be complicated by the presence of stigma. An Interpretative Phenomenological Analysis by C. Smith and Forrester-Jones (2014) analysed the reflective journals of 62 students who were researching people with mild to moderate disabilities. One of the most significant findings was that positive attitudes to individuals with learning disabilities grew after the students had spent face-to-face time with them. The same pattern was found by Bellanca and Pote (2013) and Osterholm et al. (2007) with those children who were given more detailed descriptions of the vignette children, or who could imagine that they knew them, softening their attitudes toward them. These studies offer support to the protective function of exposure as a tool to reduce stigma and promote understanding, but also highlight vignettes as an imperfect method of research which may not adequately assess views toward real people (Osterholm et al., 2007).

### **Positive Learning Environments.**

For children with ADHD to succeed academically, teachers need to address specific academic skills (e.g. reading and math) as well as working to develop ‘academic enablers’ (behaviours and attitudes that enhance achievement), a broad definition that includes such things as organisational skills and completion of homework (DuPaul et al., 2004). In a study by DuPaul et al. (2004), the grades of students with ADHD were predicted by both teacher ratings of skill level (reading) and academic enablers, while the grades of control children were only linked to teacher ratings, indicating the specific importance of academic enablers to the achievement of those with ADHD.

For a learning environment to be suitable for people who struggle to learn, it must be targeted toward their individual needs. Qualitative studies of adults with learning disabilities who were successfully employed found that learning situations which matched

their learning styles were credited as vital to achievement (Gerber et al., 1992; Reiff et al., 1994). Some culturally based models of learning suitably incorporate elements that are important for students who struggle to learn, such as individualised and supported learning in which control is shared between teacher and student. The Poutama is a Māori human development model based on the image of lattice-weaved steps (Royal-Tangaere, 1997). The rises in steps represent the climb toward knowledge, while plateaus depict the time required for the task to be fully mastered through practice and review. There is great emphasis on whanau (family) members assisting learners to climb the steps, with this bridging of knowledge in line with Lev Vygotsky's Zone of Proximal Development (Royal-Tangaere, 1997).

Another Māori model of teaching and learning is Tuakana/Teina in which these roles are fluid and there is much value placed on the absorption of knowledge through meaningful interactions with elders (Royal-Tangaere, 1997). These models provide reminders that there may be no single method of teaching or learning environment that can provide optimal outcomes for all students, and that relationships between teacher and student are a valuable tool.

### **Effective Support.**

Thus, for young people with disorders of learning and achievement, having relationships with supportive adults in their lives is crucial. Werner (1993) cited the supportive influence of stable adults as a significant protective factor for young people with learning disorders and credited them with instilling a sense of competence and self-esteem in those young people. This finding illustrates how external protective factors can facilitate the development of internal ones, bolstering individual strengths and belief that challenges can be overcome (Werner, 1993). Self-determination can be taught and expanded upon

through teaching strategies which serve as the positive counterpart of learned helplessness, helping to foster achievement and the awareness that effort is the key to successful outcomes, not inborn ability (Dweck, 1975; Wehmeyer, Field, Doren, Jones, & Mason, 2004).

Higher education support programs for those with disorders of learning and achievement can be successful when they are practical, targeted, and help to increase students' awareness of their limitations and strengths. Adults in support roles have the responsibility of imparting knowledge of the impacts of disorders so that students may know what to expect; students have credited this knowledge as key to developing effective compensations (Quinn, 2013; Skinner, 2004). Qualitative studies exploring the academic success of College students with disorders of learning and achievement found that support programs could provide help through practical accommodations, information about disability law, executive function focused coaching, and goal setting and time management support (Farmer, Allsopp, & Ferron, 2015; D. R. Parker, Hoffman, Sawilowsky, & Rolands, 2011; Skinner, 2004). Successful programs may help students maintain positivity and deal with increasing demands as semesters progress (Farmer et al., 2015).

When people with disorders of learning and achievement succeed academically and vocationally, the benefits may extend to other areas of their lives. The review of an occupational therapy program providing supported education and employment services for adults (some of whom were students) with diagnoses of various mental disorders (not specific to SLD and ADHD) highlighted the positive ways people viewed themselves at times they were in employment, and the satisfaction that came from being a 'good worker' (Schindler & Sauerwald, 2013). It appears that supporting people with disorders of learning and achievement so that they can successfully study and work helps not only with their

educational and vocational outcomes but the building of positive self-concept. One way to positively increase self-concept may be encouraging the adaptation of growth mindsets toward learning and achievement.

### **Mindsets: Implications for Disorders of Learning and Achievement**

#### **How Growth Mindset May Help.**

Growth mindsets are characterised by a core belief that personal attributes such as intelligence, creativity, and sporting ability can be developed and enhanced, while fixed mindsets are the belief that they are stable qualities that are largely inborn and static (Dweck, 2012a). At the most basic level, mindsets are significant because a person who believes they can change and improve is more likely to be motivated to work toward that, while someone who believes their ability or achievement is out of their control is far less likely to be driven to do anything about it (Dweck, 2012a). If a child carries a diagnosis and a fixed mindset through life, they may believe they are destined to fail and that no amount of effort will change that (Dweck, 2008). If a child carries a diagnosis through life with a growth mindset, they may be more likely to believe that they can overcome or find ways around their limitations and work towards a better outcome (Dweck, 2008).

It is believed that the growth mindset fosters resilience, the opposite of learned helplessness (Dweck, 2012b). Resilience in the face of a challenge is a prerequisite of academic success and when a student has a fixed mindset and believes that their intelligence cannot be changed, they may become self-restricting (Yeager & Dweck, 2012). While there is still a prevailing belief among parents and teachers that bolstering self-esteem through the use of praise will bring the most benefit to children, it is more important to instil a mindset that encourages patience and perseverance, and helps children to view failure as something that can be dealt with and overcome (Yeager & Dweck, 2012). Dweck

(2012a) goes so far as to claim that praise of children (e.g. “you’re so smart!”) is detrimental because it is a concrete statement which delivers the message that their ability level is inborn and stable; hence, there is not much they can do about it. Dweck’s (2012a) research consistently returns to the message that the foundation of success is effort (growth mindset), and that through hard work people can exert control over their outcomes.

Children who are focused on the act of learning will be more open to challenges and overcome more barriers to achievement than those who are predominantly concerned with ‘getting it right’. Performance goals are a focus on doing well, while learning goals are a desire to learn and grow, and the ability to see challenge and exertion as positive and rewarding (Diener & Dweck, 1980). Those with learning goals are mastery oriented while those who have performance goals are particularly averse to failure which can be extremely restricting (Elliott & Dweck, 1988). A study by Diener and Dweck (1980) found that mastery oriented children (challenge embracing and learning focused) were bolstered by success and relatively undaunted by failure, keeping prior successes in mind as a motivating force; those deemed helpless viewed any failure as predictive of future failure making them reluctant to try again. Elliott and Dweck (1988) manipulated goals (learning and performance) and beliefs about ability (through difficulty of the task) of fifth grade children (57 girls, 44 boys). Both low-ability and high-ability learning goal children were driven toward achievement and actually preferred challenges that involved the possibility of making mistakes, allowing them to develop more sophisticated problem-solving skills (Elliott & Dweck, 1988).

When mastery oriented people experience failure they are less likely to take it as a sign of personal shortcomings and rather see it as a failing of the strategy employed, leaving them confident and free to try another, without fear, until the successful strategy is

found (Dweck & Leggett, 1988). The helpless children in the study by Diener and Dweck (1980) were not only daunted by failure, they were more likely to discount or minimise prior successes and more pessimistic about their ability even before they had experienced negative outcomes (Diener & Dweck, 1980). This indicates that the helpless children took the things they could not immediately do correctly as proof of stable insufficiencies (Diener & Dweck, 1980).

Internalisation of a growth mindset has the potential to benefit all students, struggling, average and gifted alike (Esparza, Shumow, & Schmidt, 2014), and students with learning disorders may actually have higher rates of growth mindsets. Matheson (2015) investigated the mindsets (relating solely to intelligence) of 230 Canadian school students, searching for differences between genders, achievement, class stream and learning disability status. The group of 38 students with learning disabilities were more likely than their non-LD peers to hold an incremental theory of intelligence (synonymous with growth mindset), while no differences were found between any other variables (Matheson, 2015).

#### **How Others Can Influence Mindset.**

Mindsets are teachable, with parents and teachers having great influence over the mindsets that children develop. In a study by Dweck (2012b), the mindsets of some young participants were manipulated through an intervention that taught them how the brain works, the interaction of peoples' thoughts and behaviour, and that these things all have the potential to be changed. The youths were then engaged in a computer game that involved the opportunity to punish (by dishing out hot sauce) a person who had socially excluded them. The youths receiving the growth mindset treatment administered 40% less hot sauce than their peers, apparently recognising that though the person had been unkind to them, that did not mean they were innately bad; their behaviour in one situation was not the sole

determinant of who they were as a person (Dweck, 2012b). Dweck applied the same principals to a study of racism and conflict between Palestinian's and Israeli's and discovered that even within that well entrenched conflict, attitudes about supposed enemies could be changed for the better with a growth mindset.

The school system itself may run counter to the promotion of growth mindsets, with those students who receive lower grades disadvantaged in making the connection between effort and success (Masters, 2014). A classroom represents a range of abilities but when a child is achieving consistently low grades through the years they may conclude that they have a stable inability to learn (Masters, 2014). What grades cannot express though is that the student who receives 'C's for three successive years is making just as much learning progress as one who receives 'A's (Masters, 2014). If either student was not learning, or learning at a lower rate, their grade would decline. A higher level of achievement is required each progressive year to achieve the same grade and grades merely show where students fall within their year level (Masters, 2014).

Masters (2014) recommends that in order to motivate all children to exert effort, school assessment should involve personalised goal setting that expands children's learning and tracks their progress over time, consistent with a growth mindset (Dweck, 2012b). This would be a shift from comparisons between children to recognition of the individual's learning journey, an approach that would allow those at the bottom of the class to still experience reward and a sense of achievement for the effort they put in, while also preventing those at the top from resting on their laurels (Masters, 2014).

### **Criticism of Mindsets.**

Though it is clear that mindsets are a promising avenue of enquiry, it is unlikely that the answer to encouraging adaptive learning is as simple as this factor alone. Critics of

mindsets believe that the hypothesised relationship between mindset and achievement tells only part of the story, and that it is heavily influenced by how contingent the individuals self-worth is on their academic success (Niiya, Brook, & Crocker, 2010). A group of undergraduate students were assessed for entity theories (fixed mindsets) and incremental theories (growth mindsets) and how contingent their self-worth was on achievement. They were given an opportunity to self-handicap through choosing either a piece of music to listen to that they knew would be distracting (self-handicapping), or one that would not. The students with incremental theories (growth mindsets) whose self-worth was highly contingent on achievement were more likely to self-handicap than all other groups, even the entity theory/high contingency students; within this study, growth mindset seemed to negatively impact achievement (Niiya et al., 2010).

A second and third experiment by the same authors found the incremental theory (growth mindset), high contingency students were also less likely to practice before a task, and more likely to make internal attribution of failure than all the other groups (Niiya et al., 2010). The experiments by Niiya et al. (2010) were characterised by some significant limitations. The authors did not manipulate the mindsets (theories) of their participants so it is impossible to say that the handicapping was the result of students' mindsets rather than some other, unknown variable. The sample sizes were also small enough that the statistical significance of findings were weak (Niiya et al., 2010).

A study conducted in the early days of mindset research also raises a question about the benefit of growth versus fixed mindsets, with a group of mastery oriented children (those deemed more adaptive at learning), found to be more likely to attribute their success to stable, innate qualities (Diener & Dweck, 1980). Considering ability to be stable and innate is a major characteristic of a fixed mindset, yet these children were deemed to be

successful and contrasted to those in the ‘helpless’ group (Diener & Dweck, 1980). These studies do provide some evidence to challenge the assertion that growth mindsets facilitate maximum productivity and achievement in students. Thus, it may be important not to assign too much weight to mindsets as the major determinant of motivation, and there are likely to be other contributing factors that must be explored in order to optimise achievement (Niiya et al., 2010).

### **Positioning the Current Study**

The ability to learn new skills is important, society demands it. Children and young people who struggle to learn may feel weighed down with feelings of incompetence, hopelessness and negative self-perception (Brooks, 2001). Some may be driven to withdraw from the environment in which those feelings are most keenly felt, the classroom (Brooks, 2001). Stigma can be experienced by those with disorders of learning and achievement, but that can be reduced through increased understanding that comes from getting to know a person as more than their diagnosis. Understanding is arguably what is needed in order to help those who struggle to learn and it should not be limited to assessment of deficits, given that appreciation of strengths is a vital tool for intervention and optimisation of outcome (Brooks, 2001). The support that people with disorders of learning and achievement receive has the potential to positively influence their experience and should be individually targeted, practical, and delivered from a young age. For support to be effective it is important to study the population concerned in a way that is meaningful and thorough, and allows individuals to determine just which elements of their experience are the ones we should be taking notice of.

An Interpretative Phenomenological Analysis by Kenyon, Beail, and Jackson (2013), provides insight into meaningful protective factors that are valued by adults with

learning disabilities, and provides a close match to the aims of the current study. Eight adults from northern England (all Caucasian) with mild learning disabilities (mostly diagnosed while still at school) were interviewed about what their diagnoses meant to them, their beliefs about why they had been diagnosed, and the impact it had had on their lives (Kenyon et al., 2013). Themes of importance were development of an awareness of being different, relationships with non-disabled others, and living with impairment. Crucial stages of life were significant in terms of developing an awareness of differences such as the teenage years, in which those feelings were heightened. The issue of labelling emerged within the theme of relationships with non-disabled others and encompassed the ways participants felt they were viewed by the world and the need for understanding and positive change. Negative feelings toward professionals also arose when participants felt that they had been ineffective sources of help (Kenyon et al., 2013).

The fear of failure is one of the biggest hurdles to learning for those with a fixed mindset and people with disorders of learning and achievement may experience more than their fair share of failure (Brooks, 2001). Though research by Matheson (2015) has raised the possibility that children who struggle to learn may actually possess lower rates of fixed mindsets, those who do may still be at a disadvantage. When mastery oriented people with growth mindsets make mistakes, they do not take them as personal failures they simply see the need to try a different strategy. The participants of the study by Kenyon et al. (2013) highlighted the need for overcoming challenges and seeing difficulties as something to be mastered. If we can increase the confidence with which people take risks, they are more likely to embrace challenges and persevere until they succeed, something that can be fostered by the empathetic and effective support of others (Brooks, 2001).

There is a vast history of research of disorders that affect learning and achievement but the majority are quantitative, focused on statistical comparisons between individuals and groups. This does not capture the holistic experience of the disorder however, leaving a significant gap in the literature. The lived experience of a disorder of learning and achievement is a phenomenological construct and so deserves exploration with a phenomenological methodology that can capture a holistic understanding. This study will extend upon and incorporate elements of the research discussed in this chapter. It will differ from that of Kenyon et al. (2013) which uses a definition of learning disability that more closely resembles the DSM-V definition of Intellectual Disability. The current study also aims to expand upon the concept of support, exploring what was helpful and what was not so that potential applications may be taken from findings, and to explore the interaction and influence of mindsets.

The people who can provide the best insight into the ways to optimise the experience of those with disorders of learning and achievement are those who have themselves struggled with these disorders, so an important aim of the study is to explore that which holds importance for participants. While their individual experience may be unique to them, it is rich and meaningful and has the potential to shed light on any number of valuable insights that could illuminate the path of those to follow.

### **Research Questions**

Based on the aims of the study and the methodology chosen, a first and second order research question were developed:

- 1) To explore the individual experience and meaning making of being diagnosed with a disorder of learning and achievement.

2) To explore the influence of growth and fixed mindsets on the experience and meaning making of being diagnosed with a disorder of learning and achievement.

### **3. Methodology**

#### **Study Aims**

The central goal of this research was to explore the experience of being diagnosed with a disorder of learning and achievement, and to uncover the parts of that experience that held the most significance for a small group of individuals for whom it has been a reality. A further aim of this research was to explore the influence of mindsets on that lived experience. The focus was very much on depth and individual meaning making with comparisons having less importance, therefore a qualitative methodology was required. For the research to uncover what was truly important to participants, it was necessary to conduct it in such a way that they had the power to lead it in any direction that felt natural to them (Bryman, 1984). My desire was not to confirm any preconceptions (though it would be naïve to claim I had none) but to allow my participants to inform me and expand my understanding of their experience.

#### **Interpretative Phenomenological Analysis**

Interpretative Phenomenological Analysis (IPA) is a methodology that aims to explore lived experience as individuals have conceptualised it rather than trying to fit that experience into a framework that has already been developed by the researcher, giving it a strong phenomenological focus (J. A. Smith, Flowers, & Larkin, 2009). While the theoretical underpinnings of IPA assert the importance of the research participants meaning making of their experience, the role of the analyst in the interpretation and presentation of that experience is dually valued, making it hermeneutic as well (J. A. Smith, 2004). To summarise, IPA requires the analyst to provide an interpretation that is solidly grounded in the participant's account, but which goes beyond it as well (J. A. Smith et al., 2009).

IPA is idiographic and has a commitment to depth and detail, as well as an appreciation for individuality and context (J. A. Smith et al., 2009). IPA is therefore best suited to individuals or small samples that have been carefully chosen for their similarities to one another, with no need to acquire groups that are large enough to represent a population (J. A. Smith et al., 2009). IPA allows for flexibility, giving researchers the opportunity to be open to follow the path of findings they did not anticipate. For example, an IPA (and Foucauldian discourse) study by Johnson, Burrows, and Williamson (2004) on the experience of bodily changes in pregnancy found the experience to be far more complex than the satisfaction/dissatisfaction divide that quantitative methods had been able to uncover thus far. The methodology allowed them to explore those aspects of experience in more detail and to follow avenues of interest that they did not anticipate and prepare for.

Comparisons and similarities are of far less importance to IPA than positivist research approaches which are nomothetic and predominantly concerned with formulating statements that apply to large groups of people (Bryman, 1984; J. A. Smith et al., 2009). IPA does allow for generalisations to be made though, albeit cautiously (J. A. Smith et al., 2009), with Hefferon and Gil-Rodriguez (2011) asserting that transferability is a more realistic definition. Single cases are first explored in great depth, then drawn together by threads of similarity in experience and meaning making in the form of analytic induction (J. A. Smith et al., 2009). An example of transferability emerged from an IPA study exploring parents communication with children who have cancer by Young, Dixon-Woods, Windridge, and Heney (2003). They discovered that the majority of parents performed an executive-like filtering of information that their children received about their diagnoses which lead them to theorise that it would be a common pattern within that community (Young et al., 2003).

This process of generalisation from individual experience parallels the hermeneutic circle that is present within the interpretation of experience itself in IPA. To understand the full experience as lived by a participant, it is necessary to examine the smaller components of the whole, be they smaller experiences or single words (J. A. Smith et al., 2009). In order to fully appreciate those parts, it is necessary to view them in the context of the whole which may be anything from a sentence to an entire lifetime (J. A. Smith et al., 2009). Parents of children with Autism Spectrum Disorder in an IPA study by Finnegan, Trimble, and Egan (2014) placed great amounts of pressure on individual communications they had with their children about their diagnoses because they feared that what they said (specific instances) could lead their children to define themselves (all-encompassing) as disordered, an example of the part being viewed in context of the whole.

IPA researchers do not have direct access to the experiences they are trying to understand and must be honest about the limitations of the method; what they are really performing is research that is ‘experience close’ (J. A. Smith et al., 2009). Central to this limitation is the double hermeneutic, the divide that results from the researcher attempting to interpret (second order) the participant’s interpretation of a phenomenon (first order; J. A. Smith et al., 2009). IPA has also received criticism for its lack of guidance and structure in research process. However, there are positives to a method that is lacking in a prescribed, step-wise process as it gives the researcher the ability to work in a non-linear fashion, moving backwards and forwards through the data and analysis and acquiring a depth and understanding that may not otherwise be possible (J. A. Smith et al., 2009). The lack of prescription also contributes to subjectivity with no two researchers coming to the same conclusions, but IPA makes compensations for this by being transparent and honest about the lens with which the researcher has viewed the data, allowing for readers to judge

validity of findings for themselves and make differing interpretations of their own if required (Brocki & Wearden, 2006).

### **IPA Comparisons to Other Qualitative Methods**

For achieving the aims of this current research, IPA was superior to Discourse Analysis (and Foucauldian Discourse Analysis) as it was predominantly concerned with how diagnosis of disorders of learning and achievement were experienced by participants, rather than the influence and interaction of societal constructs on their experience. The main focus of Foucauldian Discourse Analysis is the context in which a phenomena has taken place, while IPA is concerned with the particular person in that particular context (J. A. Smith et al., 2009). Discourse Analysis also forgoes appreciation of cognition, something IPA embraces (meaning making would not be possible without it), and the key concept of this study's second order research question (mindsets) is grounded in cognition (Brocki & Wearden, 2006; J. A. Smith et al., 2009).

Grounded theory is another qualitative method that differs from IPA in both purpose and process, neither of which were adequate for the aims of the current study. Grounded theory is concerned with developing models and the main focus is generalisation to a wider population (Brocki & Wearden, 2006). Grounded theory uses purposive sampling to acquire a group that differs enough to represent that population, where IPA uses it to collect a homogenous group whose experiences are similar enough to build a comprehensive picture of the issue of interest (Brocki & Wearden, 2006). Sensitive issues that are only experienced by a small section of the population are perfect candidates for IPA, as demonstrated in the study by Kay and Kingston (2002) of women's attitudes toward having children when they knew they were genetic carriers of a serious X-linked condition. Sensitive topics such as termination of pregnancy were able to be explored in

depth within the study, something which the authors credit to the IPA methodology and the freedom and connection that it facilitates between researcher and participant (Kay & Kingston, 2002).

### **Research Preparation**

I undertook a review of literature in the areas of Learning Disorders (inclusive of a wide range of terms), ADHD, mindsets, and diagnoses, to clarify and hone my research topic. I was then granted approval for the research by the Massey University Ethics committee, which deemed it a low-risk study (see Appendix A). From that point, and with my supervisor's guidance I developed participant information, consent and transcript release forms in line with the requirements of the University ethics department (see Appendices B, C and D). The forms were all developed with participants in mind, a group of people who had been diagnosed with Learning Disorders or ADHD, meaning that extra care was required in ensuring that all information was clear and that easy to understand language was used at all times. These same principles were applied to the development of a questionnaire to assess growth or fixed mindset (See Appendix E).

The questionnaire was adapted from Dweck (2012a), using only questions relating to intelligence mindset as that was to be one of the research questions in the present study. Questions were reworded to be optimally comprehensible for participants and they were then tested on a small sample (n=7) of the general population. From seven questions, one was removed after it was found participants gave unanimous answers, thus making it redundant for differentiation. Another was removed because the wording was very like that of another, as were the answers given by the sample which indicated question repetition. Five questions remained which gave the added benefit of ensuring results would not be an even split. Though this questionnaire was only very lightly tested, this was acceptable as it

was not intended to be used as any means for making statistical comparisons. The questionnaire was only to be used during the intake screening phase to check that participants were not too similar in their intelligence mindsets so that there would be room for differences to be explored in the analysis phase. The questionnaire itself would not be drawn into the analysis in any way.

I began a reflexive diary recording both the process of my research and my thoughts, feelings, and experiences as it progressed. Researcher interpretation is a key component of IPA but the subjective nature makes it all the more necessary for transparency (J. A. Smith, 2011). A reflexive diary is a means of recording that interpretative process (which begins at the very beginning of topic engagement), while also encouraging the researcher to reflect upon and be conscious of influences, both external and internal (Biggerstaff & Thompson, 2008).

### **Participants**

Suitable participants were those people who had been diagnosed with a Learning Disorder (e.g. Dyslexia; SLD was not a term in use at time of their diagnoses) or ADHD in childhood or adolescence. It was not necessary for the diagnosis to be given by a Psychologist, it was only required that it be given by someone with appropriate professional standing and in a definitive sense, denoting a period before the diagnosis and after. Adult participants were chosen so that there would be sufficient passage of time between the point of diagnosis and interview so that changes and development in understanding could emerge. People with diagnoses of other significant mental disorders were deemed unsuitable for this study as they too can have a significant impact on educational/vocational achievement and outcome, among other variables of interest.

Participant recruitment was conducted with a flyer, briefly summarising the selection criteria and goals of the research. This flyer was distributed to a local adult learning institution, and posted on a community noticeboard Facebook Page, the latter being most successful at generating interest. Several other businesses/institutions were approached (including a Doctors clinic and an institution providing adult literacy classes) but no others responded to my enquiries.

Ten people contacted me by email expressing an interest in participating in the research. Two of them were putting forward children with SLD or ADHD and so did not meet the age criteria and one person was unable to be contacted by phone to answer the short series of screening questions determining suitability. One person believed themselves to have Dyslexia but had no form of diagnosis, meaning that key elements of the research question would not be able to be explored. One further person was deaf and offered to answer questions by writing but it was decided that this method differed too much from the semi-structured interviews that were to be used with the others.

Five people could be reached by phone and were screened with a short questionnaire that asked about their diagnoses, the age at which they were given, their current age and occupation, and the five questions designed to gauge fixed and growth mindset. All five met the criteria on most dimensions but almost all gave at least one answer that took some reflection on my part to determine their suitability. One had been diagnosed with Epilepsy as a child and I was concerned about the potential this had to influence both his educational experience and outcome. It was decided that because this was a medical condition, he need not be excluded. One person was originally from Canada so had possibly been through an education system that differed greatly to that of the other participants. I wondered if this might make any comparisons difficult but decided to include

them given that comparisons between participants were of less importance to the aims of the study than the unique experience of individuals.

One person did not receive a diagnosis in a formal setting but was given it by a family friend. This family friend did however work as a special education professional and so they were deemed a suitable participant. One person met the criteria fully but while they gave answers to my closed questions, they were not at all forthcoming with any information beyond that. I was worried that they may not be suited to IPA with its explorative, open, participant led interview style. I discussed this with my supervisor and she assured me that their input could still be valuable so I made the decision to include them in the study, however, I could not reach them again (after several attempts to call) to organise an interview.

I was left with four suitable participants though I had aimed for six, and after many more weeks of recruiting no further suitable candidates came forward. I believe that this was heavily influenced by the small population of the area (less than 10,000 urban, less than 14,000 in the wider district), as this affected not only the number of people available to meet my criteria but the number of suitable places at which I could recruit. After much discussion with my supervisor it was agreed that I go ahead with four participants, which would be somewhat compensated for by conducting a dual analysis of overall experience and the experience within the framework of fixed and growth mindsets. It is worth noting that some of the criticism of IPA conducted by students is a tendency to include too many participants, in line with the expectations of quantitative research that more is more (Hefferon & Gil-Rodriguez, 2011). This however may diminish a study's ability to achieve depth of analysis and contradict IPA's ideographic focus (Hefferon & Gil-Rodriguez,

2011). The first stage of appreciating ideography was getting to know participants as unique individuals.

### **Mini-Biographies.**

Zoe was in her mid-thirties, identified as Pākeha/NZ European and had received a diagnosis of Dyslexia late in her childhood (age 12) via a family friend who worked in the special education sector. She never felt comfortable in the mainstream schooling environment, eventually leaving to be home-schooled where she made considerable progress, and her highest level of education was a national diploma (degree level). At the time of interview, she managed the I.T. (information technology) sector of a local learning institution at which she had also had the opportunity to do some tutoring. Zoe was friendly and open about her learning experiences and keen to share them with the hope that the experiences of others could be improved.

Tim was in his early twenties, identified as Pākeha/NZ European, and had received diagnoses of Dyslexia and Dyspraxia early in his childhood (age 6 or 7). He had also been diagnosed with epilepsy which he continued to take medication to manage. Tim attended mainstream schools but dropped out at an early age and decided to try and gain his high school qualifications later in life. At the time of interview, he attended an alternative learning centre and was completing work toward his final high school qualification (level three NCEA). Tim had hopes to go on to University and study Geology, expressing an appreciation for the reward that came with achievement through learning, even though his early experiences had been fraught with difficulties.

Charlotte was in her late twenties, identified as Pākeha/NZ European, and had received diagnoses of Dyslexia and ADHD early in childhood (age 6). She had attended numerous schools in both mainstream classrooms and those dedicated to special education,

and accessed a variety of different support/intervention services. Charlotte gained a bachelor's degree (Psychology) at University and built a career that was centred around helping young people who struggled academically and socially. She had worked within the Youth Justice sector and was working as a learning facilitator in an alternative education setting when she was interviewed. She was extremely proud of the work she did with other young people whose struggles were similar to her own.

Penny was in her late-twenties, born and raised in Canada and had been living in New Zealand for a short time. She was diagnosed with ADHD as a teenager (age 14) and attended mainstream schools in both regular and special education classes, and utilised extra services available to support her. She then attended College (University), gaining two separate qualifications. Her highest level of education was a bachelor's degree and she was working as a midwife when interviewed. Penny continued to struggle with acceptance of her diagnosis, questioning whether her difficulties could better be explained by developmental period (adolescence). Penny was proud of her academic achievements and valued her work.

Though the answers participants gave to the short mindset questionnaire during screening did vary, all four final participants gave majority growth answers meaning that all four participants were deemed to hold predominantly growth mindsets toward intelligence by the questionnaire. While I had been aiming for variation, after some reflection I concluded that a short questionnaire was a far more rudimentary evaluation of growth and fixed mindsets than participants' interviews were likely to provide. For this reason, the mindset questionnaire was deemed superfluous to the research and the decision was made to focus solely on the expression of fixed and growth mindsets within participant accounts of their experiences.

## **Procedure**

Interviews were conducted in a semi-structured manner, with a template of question prompts that could be used where needed but the freedom for participants to discuss anything of personal importance (see Appendix F). The semi-structured interview method was advantageous as it allowed me to delve into areas that participants identified as important which I may not have been aware of or prepared for (Biggerstaff & Thompson, 2008; J. A. Smith et al., 2009). Prompts were themed around the diagnostic experience (e.g. How did you feel about having a 'name' for your difficulties?), life after diagnosis (e.g. How did other people treat you and how did you react to that?), and how they believed their diagnoses had affected their life outcomes (e.g. What are the ways you've learnt to live/deal with it; work around it?). Questions identified as having extra potential to explore mindsets were noted and given priority.

Upon meeting with each participant, I introduced myself and gave a brief overview of the research (as I had done on the phone), then presented them with a detailed information sheet and consent form (See Appendices B and C). After they had read these I verbally checked their understanding and gave them the opportunity to ask questions; when they gave consent to proceed we began the interview. Interviews were audio recorded (with approval of participants) and lasted for 35-55 minutes. At conclusion of each interview I thanked participants for their time and presented them with a twenty-dollar grocery or petrol voucher of their choice as recognition that the sharing of their experience was valued. I explained to each participant that their interviews would be transcribed and that they would then be given the opportunity to review them and give approval for me to continue. Each participant gave written approval for release of their transcript (see Appendix D), at which time the audio-recordings were deleted in line with Massey

University policy. It was also explained to the participants that their written transcripts would be kept for a period of five years by the University to which they consented.

### **Data Analysis**

A first reading of each transcript was performed and key thoughts were noted in the left-hand columns. On careful reading of each transcript I then singled out particular statements and passages (as determined by the making of a single or cohesive point) that indicated sub themes of significance. Key words were used to identify possible themes on first reading (recorded in the right-hand column of transcripts), which were then honed on subsequent readings, ensuring consistency between classification and grouping of statements. This was conducted by extracting all the key words and comments and organising them into categories of similar relevance, then assigning a sub-theme title that best encompassed the issue. I then went back to transcripts to check that the passages/statements did in fact fit within those sub-themes.

Many of the passages contained more than one sub-theme which reflected the interconnectedness of experience. Some passages/statements could be further segmented into individual sub-themes, others were assigned to the sub-theme within which they most closely fitted. Instances of each sub theme (counting all from each statement/passage) were then counted to gauge an indication of prevalence both within and between participant accounts. This method was by no means conclusive of the significance of each theme as the power of individual statements was equally, if not more relevant; it was merely the most logical method at hand, and the best way to measure predominance.

The tally of sub-themes within each participants' account provided data indicating the relevance of subthemes across participants, allowing me to determine trustworthiness. The subthemes discussed in the following two Results and Analysis chapters were present

in the accounts of at least half of participants, with the majority experienced by all four, meeting one measure of IPA trustworthiness set out by J. A. Smith (2011). In saying that, certain points at which one participants experience differs greatly from the others will also be discussed to highlight divergence (J. A. Smith, 2011). These instances are intended to address polarity within subthemes (e.g. acceptance and questioning of diagnosis) and capture complexity and range of experience.

The sub themes were then examined for their possible relation to one another and grouped together into categories of overarching meaning (superordinate themes). The grouping process was completely subjective and reliant on my interpretation of what participants were trying to convey in their comments; another researcher may have categorised those units of meaning quite differently. This grouping was a fluid process and went through several stages as my understanding of participant experience developed and deepened. I began with five overarching themes but with the added perspective of my supervisor, I further honed this process until I was left with two overarching themes of importance. This involved stepping back from the data and making interpretations that increased in depth until the core message became visible.

The second aim of this study was to explore the possible influence and/or interaction of growth and fixed mindsets on the experience of diagnosis of a disorder of learning and achievement. A second analysis was conducted within this framework, re-reading each transcript and searching for evidence of fixed and growth mindsets in both the participants' narratives and my own notes developed alongside them. I then followed a similar method to the theme analysis described above, grouping all mindset expressions that appeared linked by common factors (e.g. fixed descriptions of symptoms). It became apparent that expressions of fixed and growth mindsets were woven throughout the

accounts of all four participants. The ways in which they were expressed differed but there were also similarities and certain expressions were closely linked to both overarching themes and subthemes within. The influence and interaction of fixed and growth mindsets will be presented in the latter part of each Results and Analysis chapter in relation to the overarching theme.

### **Language Features Exclusion.**

It is common practice within IPA to examine the use of language features, searching for significance in things such as choice of words, hesitations and repetitions. I chose not to perform any analysis of this sort in the current study because it involved a population who struggle with expression as a part of their disorders. This would have made it impossible to tease apart symptom from significance and may have led to unfair interpretations and assumptions. The following two chapters' present findings from interviews with participants of this study in the form of direct excerpts and analysis conducted within the framework of IPA.

#### **4. Results and Analysis: Diagnosis and Identity**

Presented is a discussion of themes that arose as significant in the experiences of the participants of this study. Two overarching concepts of importance (superordinate themes) emerged across accounts, the first of which will be presented in this chapter, the second in the following chapter. The Results and Analysis chapters present my interpretation, sticking as closely as possible to participants' accounts in which they offered their own interpretations of their experience. When an analysis of the growth and fixed mindsets present within participant accounts was conducted it became clear that mindsets had contributed much to the lived experience of these individuals. The mindsets they held toward learning and intelligence emerged frequently as they discussed many issues of importance, as did the apparent mindsets of others and the ways that those impacted the participants lived experience.

This chapter focuses on the superordinate theme of diagnosis and identity. Diagnosis was a central focus of this study with many of the interview question prompts related to the topic, and a great deal of participant discussion of diagnosis was closely tied to identity. Identity develops partly through interaction with the environment, and for participants of this study, symptoms, barriers and labels appeared to directly impact that interaction. The family and school environments were significant contributors to identity development for participants from a young age; as they entered adolescence the influence of peers grew stronger. For some this meant identifying with others with learning and behavioural difficulties, for others this meant pushing against that, asserting their difference and rejecting that grouping. All participants came to their own, positive conceptualisations of self, with diagnosis taking its place to varying degrees within that. Some participants

who accepted their place within the group of those with disorders of learning and achievement could then turn their attentions outward to helping others within the group.

### **Identity Development in the Early Learning Environment**

#### **Craving Understanding.**

All participants struggled with the demands of the learning environment and for most, that included the struggle to be understood. Diagnosis was developed on the principle of creating understanding in order for help to be made available (American Psychiatric Association, 2013). When diagnosis and/or early, effective interventions are not forthcoming, the consequence may be not just academic (through lack of access to intervention), but also lead to considerable emotional turmoil. Tim and Zoe both felt frustration at being expected to explain themselves to teachers and other adults in their lives who demanded to know why they were struggling, while they were too young to understand themselves, let alone explain to others.

Zoe: So you know, it's an added thing in there and it's like, "Well why can't you?" and it's like, and I couldn't answer that because I didn't know why I couldn't...

By the time Zoe she received her diagnosis she had developed such anxiety about school, perpetuated by the fact that she left and was able to maintain avoidance of it, that she faced a seemingly insurmountable barrier to returning.

I: So what was the main thing that changed for you after the diagnosis? So you think it was probably that understanding from other people and from you, or...?

Zoe: A little bit. The actual diagnosis because it sort of happened... sort of, while I was, I was, I'd already started being home schooled, um... and then, from that I'd developed anxieties about school, so turning around and going back to school wasn't really possible for me.

Zoe viewed diagnosis as a way to gain understanding from others and felt frustration when diagnosis was not made readily available to her and that understanding was therefore restricted. Finally receiving confirmation of her Dyslexia came with relief and validated her struggles.

Zoe: Um, my parents' kind of took the attitude of okay you're in charge of your learning then, so that really was, what, you know, finally got me through. Um... it still took a few years [laughs] um... and it was like, a, um, a family friend who has worked with Dyslexic children and learning disabilities and things before who actually, finally did say, "Yes she's definitely Dyslexic."

Zoe, Tim and Charlotte all discussed the need for effective interventions to be implemented at the earliest stage possible. This of course was jeopardised when diagnosis was not forthcoming. Zoe's comment suggests that there is a critical timeframe.

Zoe: ... I think I was [hesitates slightly] seven when I was put into the reading recovery program. I think if I'd also been given extra help with writing, um, help through that time I think it would have made quite a big difference. I think, by the time I got the diagnosis, by the time I was later, and a teenager, it was probably too late.

In contrast, Tim did not feel that understanding was something afforded him by his diagnoses. He believed that the presence of diagnoses relieved people of the obligation to try and understand who he was as a person.

Tim: Um, well, mainly for me it's just been like, "What are your symptoms?"

I: Okay, yip.

Tim: And then, they're like, "Oh yeah you've, you know... you need help"

[laughs]. But they don't, really, study it they just go off the symptoms I suppose so far, that's what I've found anyway.

He continued: I still struggled [laughs].

I: Yeah. So it didn't change anything in your ability, it just was a, a word, or two?

Tim: Yeah, pretty much. Like it didn't change, yeah me personally. And, yeah I just, yeah just struggled pretty much.

I: Yeah.

Tim: Coz even the teachers freaked out when they were like, "Oh he's got Dyslexia and this and that."

He continued: It's like, getting put in the too hard basket pretty much.

When Tim discussed being "put in the too hard basket" it appears he was expressing the belief that people were not willing to accept the challenge of helping him. He seemed to feel that once his difficulties had 'labels' they took on a new quality, causing others to retreat and stop seeing him.

Tim: But then at the same time you get put into a box and people, don't really want anything to do with it.

Penny's feelings around her diagnosis differed to those of the other participants'. She did not experience the desire to have her difficulties understood in a diagnostic sense, rather, went along with others who felt it was important. She attributed the drive for diagnosis to her mother, claiming that a fourteen-year-old was not capable of making those decisions.

Penny: Yeah I took it [medication] because I got this diagnosis and it's like, oh maybe...

I: Mhmm.

Penny: I also, my mum probably cared more about the diagnosis than I've ever cared, and...

I: So in what ways?

Penny: So... well I mean she's the one that organised the... whole diagnosis thing, which asking a fourteen-year-old, "Do you wanna have that diagnosed?" I guess, I don't know the implications of that.

Though Tim and Penny's views of diagnosis differed greatly, the beliefs driving them were similar. They both held great concern about the potential for diagnosis to become a dominating feature of the individual, and awareness that when a person becomes defined by their diagnosis they may risk losing their individuality. They craved understanding as unique, multifaceted individuals, resisting what they felt was the desire of others to focus only on the shared elements of their disorders.

### **Individualisation versus Comparisons.**

All participants made comparisons between themselves and others which appeared to be a natural part of conceptualising their difficulties and differences. It may be difficult to determine and understand differences without others against which to compare oneself.

Charlotte: I think I was really struggling at school, keeping up with the class, my reading was really poor compared to kids the same age.

This subtheme was central to the concept of diagnosis, something that would not be possible without normative comparisons. Zoe, Tim and Charlotte all felt frustration toward teachers who grouped them with others at the expense of appreciating them as individuals: Comparisons could very much be detrimental to their experience.

Zoe: So, yeah, there was some help I mean there was a couple of teachers that were really good but there was a couple that were *not* helpful at all. And, so you know so I got things like from a teacher, coz my older sister had gone through a couple of years before me, and I got, literally got told once, “Ah, your sister can do it so I don’t understand why you can’t.” Which was really not helpful.

Zoe felt conflicted about her school and teachers, with some frustrating experiences of comparison and demands by teachers for her to explain her difficulties. She had other experiences though in which her interventions were adequately targeted and successful, indicating that those support people correctly determined her individual needs.

I: So the comparisons between you and your sister and just asking you why you can’t do it?

Zoe: Yeah, yip, and why? And I’m just like... [mumbled “I dunno”] how am I supposed to know? Um, yeah, I mean I, I, ah, I don’t wanna bag the school completely because there were good things as well, I mean they did actually put me into the reading recovery program, um, I did learn to read, um... you know that got me through, so... you know, that, that, definitely helped...

Tim could step back and take a very pragmatic view of his diagnoses and the loss of individualisation he believed to be the result. He felt that others defined him by his diagnoses, assigned him to a group of people who shared his learning struggles but nothing else. He could also appreciate the advantages of the diagnoses though, the way they provided him a means with which to access help.

I: Um, how did you feel about having, sort of a name for the difficulties? So you’d experienced those things all, you know up until that age and then all of a sudden you had sort of a label for them.

Tim: Um, sorta categorised.

I: Yeah?

Tim: I guess you could say.

I: In a negative way or a positive way? Or maybe a bit of both?

Tim: Um, probably a bit of both coz it's like, once you get like, you know this label, ya, sorta get put into a box but you can get help for it.

He could see the good intentions of diagnosis but believed that if people could be understood as individuals, through appreciation of their strengths and weaknesses, then their interventions and teaching could be targeted just as effectively. He felt that being categorised fell short as a system, and was somewhat contradictory to the ability to appreciate individual needs enough to target interventions appropriately.

Tim: See I think that's wrong too. Like how you have to be labelled... well what I call labelled, to um, like get the help.

I: Mhmm. What's your... do you have an alternative that you think would work really well, or, or just something that would be better suited to people or fairer?

Tim: Yeah just if ya didn't have to be labelled to get it, like it should be open to anybody, anyway. Like if you need like a little bit of help with this and that then that's cool, you should be able to get it like, you shouldn't... yeah have to have a label to be able to get it.

When questioned about his views on the way interventions should be provided, he identified appreciation of individualisation as key to thoroughness.

I: And what do you think would have been more helpful?

Tim: Probably a hands on approach.

I: Yeah?

Tim: Like actually working out where I needed help, and then going from there.

I: So sort of more of a thorough assessment do you think?

Tim: Yeah, yeah. Like, well if you're gonna do something properly you get, all the information don't you?

### **Barriers to Learning.**

Participants symptoms were direct learning barriers but they also described situations in which further barriers were imposed through ineffective support. The concept of learning itself became aversive for some, originating from the challenge and frustration it posed. Zoe identified the negative feelings she held toward learning and how that became something she needed to work through when she was finally provided with support that had the potential to help her.

Zoe: ... like she was the first person that really, sort of, could reach inside my head and actually get stuff out of me, so she was really good.

I: And probably the first person that had the understanding of how to do that.

Zoe: Understanding of how to do that, as well, yip. So that's, you know she really helped, and, I didn't, sort of realise it at the time because by then I had quite the barrier for learning, because it was like learning... ew.

Similarly, Charlotte felt that the way her support services were provided simply pushed her difficulties out into other areas of her learning and life, merely 'spreading them around.' It also made her feel singled out and different and meant some rewarding experiences were minimised.

Charlotte: At that age I don't think I really thought anything of it. I remember being annoyed that um, I was taken out of-, it was really bizarre I was taken out of maths class, to have English and reading catch up classes.

I: Oh okay.

Charlotte: And then I was taken out of maths class to have a- a- catch up maths class, which meant I missed out on my sports time which I really liked sports as a kid.

Charlotte's experiences with the children she supported in her Alternative Education class led her to believe that some services attached targets to those children, highlighting them as difficult and making them susceptible to blame. If children take on the blame for their learning difficulties, they may accept themselves as deficient or wrong which may be detrimental to their identity; one response may be to fight against this.

Charlotte: ... Um, I think that what happens-, what happens with the kids by the time they come to me and I'll- is they've had everyone pointing the finger at them. They're angry at the system; they're angry at the teachers; um, they're angry at the principal; they're angry at Mum and Dad. Um, they don't want anyone sitting there telling them anything anymore.

Her experience working with those children also gave her the understanding that parents, contrary to the supportive role they are in the position to undertake, can impose further barriers to children's learning. Intergenerational learning difficulties can shape parents' attitudes toward school, providing systemic complications for those charged with teaching and implementing interventions for those children. Parents may build an identity around devaluing education to protect themselves from negative feelings about their own learning difficulties. These identities may be passed down to the next generation through modelling and the home environment. Children are in particularly vulnerable positions as they have limited control over their lives and activities so these parental attitudes and behaviours can be very influential.

Charlotte: No, definitely not. I mean a prime example would be the boy I'm just speaking of. We did- we have to do education plans, where you sit down and make goals, and I said to the mum, "Oh you know, working on some really good maths would be a good thing ay?" and she goes, "Oh no, maths is for gay's, you're not doing math's are you [name removed]?" And this kids sitting next door to me I'm like, this is really helpful. And I'm like, "Well how about, we can do maths in other means it doesn't have to be worksheets," and she's like, "What do you mean?" Coz obviously Mum's the same, you know like Mum's had- walked the same...

I: Yes. She's struggled with it.

Charlotte: I'm like, "Oh we could do cooking," and she's like, "Cooking?" And I was like, "Yeah we can do maths in cooking," and then she was like, "Oh, you'd really like that wouldn't you [name removed]."

### **Educating Others.**

For support and interventions to be effective the people implementing them need to be suitably educated about disorders of learning and achievement. All four participants showed appreciation of this and Tim identified the extra importance this education took on when dealing with young children who were necessarily in positions of trust and reliance on others, and who assumed the adults educating them did so in an informed way.

I: Is there anything that you wish had happened or been done differently around that time [of diagnosis] that would have made it easier for you?

Tim: Um... Probably if the teachers, had more education about it maybe.

I: Mhmm.

Tim: Like that, that'd be a big one for me. Um, but then again coz I was so little and I didn't really know any different.

Charlotte felt that a lack of understanding contributed to unsuccessful interventions. She expressed regret in the way her interventions had been implemented, feeling that those around her did not understand what would have engaged her. This highlights the importance of taking a young person's developmental stage, learning and assistance needs into account when designing interventions. She gave an example of one educator who successfully tapped into her motivations and interests, using reinforcement to facilitate learning.

Charlotte: ... The best thing I can remember was, one of the ladies had a game, like a computer game.

I: Yip.

Charlotte: Which I quite liked. Um, which-, which was using I guess, probably exactly the same as what I'd been doing writing the word's again and again, but on a computer game so it's that whole token economy you're getting something from it.

Zoe and Tim both described educators who they believed did not have satisfactory understanding about disorders of learning and achievement. They believed this lack of knowledge jeopardised those educators' ability to teach them effectively.

Zoe: I've um... I dunno, I mean [significant pause] yeah I mean I guess it, it's easy to look back and say, "Why didn't this teacher do that?" I mean, but then I mean, even at, at Polytech even though I had some good teachers there was, there was one tutor that was just, "Oh you're probably not Dyslexic you just have writers block."

And I just kind of looked at him and went [noise indicating derision] "No" [laughs].

Zoe pushed against this claim because to question her diagnosis was to question her experience, her struggles, and the achievements she had made thus far. These were things

that Zoe valued greatly and, as will be discussed later, contributed to her development of a positive identity.

The misguided efforts of a high school educator were an issue for Tim, who did not define himself by his diagnoses and pushed against others who tried to do so. He lived with the concurrent diagnosis of Epilepsy and found it difficult when others tried to take control of his privacy, for his perceived benefit.

Tim: Oh well one tutor, ah not tutor, teacher, thought I should get up in assembly and tell everyone so then everyone knows. And then if I have a fit then everyone knows what to do.

He continued: And I was like, well, that's a bit dramatic like, I don't need to get up in front of, you know eight hundred people and tell them about my personal stuff [laughs].

What emerged from Tim's discussion of diagnoses was a strong belief that the current system was rigid and ineffective, contributing just as many negative consequences as positive. Tim was appreciative of the need for diagnosis and valued it for the simple fact that it allowed him to access help, demonstrating the complexity of feelings toward diagnosis.

## **Identity Development Through Time**

### **Developmental Stage.**

For participants of the current study, the relationship between diagnosis and identity development changed through time. The adolescent years are extremely significant for identity development and for Charlotte, Zoe and Penny, they were times of special significance for their disorders. They questioned just how much of the difficulties they experienced during that time were the consequence of disorder and how much could be

attributed to developmental stage. The relationship was multidirectional, not only did developmental stage influence the way their disorders were experienced, their disorders provided further challenges for an already complicated developmental period. Zoe seemed to consider the 'attitude problem' she experienced during that time to be inexplicably linked to adolescence.

Zoe: Yeah, I mean I guess, it was also... because when I went to sit School C [First high school qualification] I-, that was fifteen if I can remember, um, I hadn't done a lot of work, um, just because of, of, well actually I had an attitude problem, I was a teenage girl.

Charlotte discussed her incompatibility between her own learning abilities and her special education class, indicating that during this period at least, she was somewhat motivated to point out that she did not belong in that group. The comparisons she made helped her to decide where she belonged, where she positioned herself amongst her peers, and where she positioned herself within the range of learning abilities. Charlotte experienced a process of differentiation alongside identification that appears to have been heavily influenced by the social demands of adolescence.

Charlotte: I don't know if you remember them, yeah I was in the cabbage class [Special Education]. Um yeah, so, and I probably could have, if I'd actually been pushed I probably could have done the other classes just fine. Because the cabbage class was definitely very low level like I wasn't-, it wasn't through lack of um... not being able to do it I guess.

Developmental stage held the greatest significance for Penny and it emerged as influential to most aspects of the experience of her disorder and diagnosis. She presented her ADHD as being solely significant within her teenage years, indicating just how

influential developmental stage was for her. The additional complications of being a teenager such as identity development and the salient influence of peers may have provided just the right context for Penny's symptoms to impact her life. Penny's experience highlights the influence of context and the ways experience changes with time, place and perspective.

I: That it might have just been the teenage years?

Penny: Yeah. It was *relevant* as a teenage-er, not that it's only in my teens but it only ever had relevance as a teenager, it has no relevance to me now.

Penny compared her ability to learn and achieve as an adolescent with her learning accomplishments as an adult and speculated whether she had simply 'grown-out' of her ADHD, again, addressing the pivotal role that context and developmental stage played in the experience of her symptoms.

I: So you kind of alluded to, you don't know whether you believe you really have it or whether it's just you. Do you think it's possibly, I mean do you see it just as something that might have been your teenage years?

Penny: I don't- I dunno. I haven't ever read anything about it, whereas like I've had a different diagnosis that I went and researched and wanted to know everything about. This, that was also something in my adult years so, again probably why, just because you're an adult [laughs] you know like I...

I: Yes, and you have the ability to do those things.

Penny: Yeah. But as um, a teen I didn't do that and so I sometimes think like, oh is it something you grown out of? As I make quotation marks.

She not only questioned the existence of her disorder based on what she understood about the motivation and drive of teenagers, she also viewed her developmental stage as

something that absolved her of responsibility for seeking out and dealing with the diagnosis, as we saw earlier, when she described her mother's role.

Penny: ... I don't know how to study: I have no determination to study; I'm a teenager.

She struggled to see the relevance of her ADHD in her adult life because the negative effects had become manageable and therefore inconsequential, possibly indicating great success with the strategies she employed or simply a different perspective in the way she dealt with and conceptualised her difficulties, which influenced her experiences.

### **Peer Influence.**

During adolescence, the views of others, most notably peers, are particularly salient. Charlotte, Zoe and Penny may have been more motivated to attribute their difficulties during that period to the difficulties common among adolescents because it was more socially acceptable to align themselves with the adolescent group than those with disorders of learning and achievement. The heightened social pressures of that stage and desire to fit in may have given participants increased incentive to reject the 'learning disordered group' identity. Penny, however, found support in a peer group that she could be open with about her disorder and who were accepting of it.

Penny: ... Then I switched to an all girl's high school where I had lots of friends and was just really open with everyone about this diagnosis, and they, I can remember friends being like, "Oh you took your pill today," because I was just...

I: They noticed a difference?

Penny: Yeah. And I even can think it was like my body was there but my brain like was completely... dead.

Penny's experience also indicates the significant impact of medication, it led her to feel a separateness or detachment between her mind and body. The effects of her medication appeared to make Penny feel vulnerable but knowing that she had friends around her who knew what to expect and how to help her brought comfort.

For Charlotte, being assigned to a class of similarly struggling but also behaviourally challenged children, had significant negative repercussions. Her new peer group was a strong influence and she believed that they helped steer her toward delinquency. Her identity developed around those other troubled children as they became her most consistent influence. Her lack of opportunity to interact with the children in mainstream classes appeared to affect her identity development, limiting her positive peer influence. This highlights one way in which a child may come to feel defined by their diagnoses and lose sight of other aspects of self. It was not until Charlotte could recognise certain peers for their negative influence that she could make positive progress in her education and life.

I: No. So when you, I mean you obviously went from sort of struggling at school...

Charlotte: Yeah.

I: To being successful at University, what changed for you there, what...?

Charlotte: Um, people I was hanging out with I think, I just, different head space um...

She described this influence from the new perspective of educator, working with youth who shared many of the same struggles she experienced, but also from the perspective of an adult with increased maturity and understanding of the influences of peers.

I: So you think there should be services in the school so they can stay in the classroom and still be able to experience like normal kids?

Charlotte: Yeah, Yeah. Yip. I think it's um... coz come lunchtime the kids they hang out with are the youth guarantee kids course so that's the kids for, sixteen to kinda twenty-one-year-olds who don't have NCEA level one and two.

I: Oh yeah.

Charlotte: So instantly, I'm gonna try not to let them mix where possible- but instantly there's thirteen to fifteen, sixteen-year-old kids hanging out with these older kids, who've already dropped out of school. So it's kind of like their friendship, their world, um...

Charlottes point highlights the importance of the friend group during the adolescent stage (“...their friendship, their world...”). It also illuminates the necessity to consider factors beyond learning needs when developing interventions and learning environments for youth. Social influences can be powerful and have the potential to greatly impact all areas of a youth's life.

### **Stigma.**

The subtheme of stigma was significant more for its limited presence. Most of the participants did not feel particularly stigmatised by their peers as children, though they were certainly conscious of the possibility. For Zoe, the absence of stigma may have had more to do with her withdrawal from the context in which it would have been most likely; high school. This meant that for her, stigma was not absent it was simply less probable, as avoidance protected her somewhat from the negative attitudes of others. It also limited her ability to interact positively with peers, meaning the effects of withdrawal may have been similar to those of the experience of stigma itself.

Zoe: So yeah, it, it... I think [exhales] I hope the stereotyping of, of it is changing.

I: Good. When you were growing up did you encounter that a little bit, or?

Zoe: Um... a little bit. Um... I guess not so much I mean, I, because of my, my ah, because of my anxiety about school I, I became quite withdrawn anyways, so I did...

I: So you had less opportunity to encounter that?

Zoe: Yeah... became quite isolated and that was sort of by my choice, I was always the *loner*. Um, and I think, and I, I have every now and again you know I'll... somehow or another it'll come up in a conversation I'll say you know, "I'm Dyslexic," and things and I have had the, "Huh, you?" kinda comments, and it's like, "Yeah, me!" [laughs]. You know, so every now and again there is that, that kinda perception, but, I guess no one's blatantly been, "Oh, you're smart; you're not dumb," sorta thing, and, so, I haven't struck it too much...

Zoe's comments suggest that she had become adept at dealing with stigma as an adult and comfortable confronting it head on. It also showed that it was very much still present in her experience. The people she described may have a lack of knowledge about Dyslexia, making negative assumptions about those with learning disorders that they struggled to assimilate with the intelligent person standing before them.

Penny believed that she was at risk of stigma in her first high school but it is possible that negative views she herself may have held about those with disorders of learning and achievement influenced those feelings. She seemed keen to distance herself from those with disorders of learning and achievement with much of her narrative centred around questioning whether she warranted the diagnosis of ADHD. Penny's own beliefs about diagnosis and labels very much influenced her willingness to accept one for herself.

She may have been driven by a fear of similar stigmatising from others, were they to associate her with that group.

Penny: I spent, after I was diagnosed I had one more year in like a co-ed high school and, I would write my exams in this room but there was like other people in that room with really severe disabilities so it wasn't really something I wanted everyone to know about coz, um I felt like there'd be some stigma...

When Penny made comparisons between herself and others with 'severe disabilities' she may have been expressing beliefs that ADHD was only a mild concern. It is also possible that her efforts to distance herself were not due to overtly negative beliefs about the learning disordered group but simply a view of herself as more capable. She may have been pointing out the difference between some who are clearly 'disabled' and herself, whom she did not necessarily believe fitted within that category.

Her following excerpt indicates a belief that stigma was related to developmental stage, either in the sense that her peers would be less likely to stigmatise her as they got older, or that maturity made her less susceptible to the negative effects of it, tying in with the experiences described by Zoe. It is also possible that the more relaxed learning environment she moved to provided less social pressures (e.g. stigma) as well.

Penny: And so, I think when I was sent to the other school which seemed safer because it was a super lazy environment of, you're with those other girls, there was no dressing up, we always looked really sloppy because, it was just a different learning environment. Um, and I guess I was a little bit older... yeah I didn't feel stigma from anybody.

Zoe and Penny's views highlight the connection between stigma and identity and the struggle to accept a diagnosis that may be viewed negatively by others. They also

demonstrate that self-beliefs about disorders of learning and achievement may make people sensitive to and expectant of the negative beliefs of others.

### **Identity Resolution**

#### **Acceptance of the Diagnosis.**

While the perceptions and comparisons of others such as teachers and peers (outer experience) was important to participants, acceptance predominantly came from within (inner experience). It was derived partly from overcoming barriers and self-doubt, was influenced by the passage of time and developmental stage, and involved both accepting the diagnosis as valid and accepting it as part of the self. Acceptance was very much a dichotomy with some participants accepting their diagnoses, some questioning, and some shifting between those two positions, indicating that this was a topic of great significance. Tim was very accepting of his diagnoses as something he had just lucked (or un-lucked) into. He did not seem to spend time and energy wondering ‘why me?’

Tim: But, um... I don't know I guess it's... ah it comes from anything really doesn't it? Well not anything but like...

He also spoke about how the act itself of being given ‘label’s’ did not impact him negatively, though it has been evident that he believed the consequences of those diagnoses did, indicating some conflicting feelings toward his ‘label’s’ and the complexity of acceptance.

Tim: I guess so, yip. Coz it didn't really affect me so much, like it didn't... I wasn't devastated by it.

Charlotte questioned the validity of the concept of diagnosis itself due to her experience working in the fields of Youth Justice and Alternative Education. Her concerns,

which were largely around over-diagnosis and medication, filtered through to her family life.

Charlotte: Yeah. Yeah, like I've got um, two nephews who are both seven and they're both ADHD. Um, one that is much worse than the other but they're both on medication and I really struggle with the ways they've um – it's my partner's brother – um, talks to the kids about it. Like making excuses for-, "Oh, he's got ADHD though," it's the older brother. Or, "Oh he hasn't had his meds yet, that's why."

She continued: It's behavioural. Like I can really see what he's doing is behavioural and I think if you took him out of the environment...

Charlotte's questioning of her nephew's diagnosis revolved around the causes or origins of the disorder, behavioural versus biological. She appeared to believe that disorders reside within an individual (psychological/biological) but she attributed that particular child's behaviour to the context or environment therefore she could not accept that he had the disorder. While this could be resolved for her somewhat were she to reframe disorder as incompatibility between the child and their environment, that would identify a flaw in the concept of diagnosis itself: How fair is it to give the label to the child if the disorder does not reside within them? Charlotte seemed to believe that a great deal more progress could be made in situations like those if the environment (or incompatibility) was the thing labelled and identified as in need of intervention.

Penny fluctuated between the positions of accepting her diagnosis as part of herself and questioning it, holding it at a distance. Though it did not seem to sit well with her and how she viewed herself, she was reluctant to make a clear and definitive statement of doubt. She failed to see herself as disordered because she was confident in her abilities.

There appeared to be conflict between Penny's views of what ADHD was and how it affected people, and the way that she had experienced symptoms. There was an apparent incompatibility between the way Penny viewed ADHD (a deficit) and her identity as an intelligent and capable person.

Penny: Coz I mean I read books and stuff. I don't know if you read books if you're distractible [laughs].

The word treatment held connotations of deficiency for Penny and she did not view her ADHD in such a way. Her belief that her symptoms were merely idiosyncrasies was strongly held because even the medication (a clear medical treatment) she took for her ADHD was not enough to lead her to conceptualise the disorder as something to be treated. Though it is unclear what led her to make this separation it could have been influenced by a lack of definite onset of symptoms, as she may have experienced with other disorders/conditions. If she experienced her inattentive symptoms throughout her entire childhood, she may have come to accept them as simply part of who she was.

I: So you don't feel that anybody explained what part of the treatment that was, why that was necessary?

Penny: Yeah if your gonna tell me that was part of the treatment I'll be like, "Oh I didn't know that."

I: In what way?

Penny: Yeah like I didn't actually know that. And... I mean I didn't even know, now I have to think like, oh I was actually needing to be treated for something I thought I was just, needing to manage life with it.

Penny appears to differentiate between the concepts of 'cure' and 'manage' in terms of rationale and need for medication. The following excerpt shows Penny's oscillation

between the points of questioning her diagnosis and accepting it as something real. Her assertions that she did not care whether she had it or not may simply be the only position she could take which allowed that battle between questioning and acceptance to go on unresolved.

Penny: Um, or... yeah I'm kind of like yeah do you just grow out of it? And I don't want to say like, oh I don't believe I have the diagnosis, I don't, I don't care if I have the diagnosis that's how I feel about it I'm like, whatever, it's fine.

**Different not Disordered.**

Different not disordered was a theme strongly tied to identity that emerged from participants' accounts; a refusal to accept diagnoses as a statement that something was lacking or 'wrong.' In many ways, it encompassed the resolution of accepting a need for assistance but not necessarily accepting a diagnostic label in the way it was understood or imposed by others. It was both an internal process of acceptance of difficulties and a desire to reduce perceived negative views of others, due to awareness that they had great capacity to influence views of self. Zoe most strongly identified with this position ("I call them learning differences") and wished for other people to view her situation in that way.

Zoe: And for a, you know, just about everyone I've even spoken to about this it's that, it's not that we're dumb, it's just that we learn differently... and we haven't found the way yet to learn. So, if we're supported through finding the way to learn, for us, what works for us... that makes it, I think, a lot easier and I think that would help us in... being able to do that.

Charlotte showed appreciation of this concept in the way she taught her students, allowing them to do what worked for them and would facilitate their absorption of the

information, rather than judging them against the standards of other students and imposing ‘mainstream’ classroom rules.

Charlotte: ... I know a lot of my stuff in my classroom is, if kids wanna work on their laptop outside that’s fine, if they wanna be upside down I’ll just, whatever, I really don’t care as long as ya, kind of doing what ya doing.

Zoe did not view her diagnostic label as a statement of deficiency, rather proof of something that existed to make her differently abled. She believed that a diagnosis took the onus of responsibility and explanation away from the individual who was struggling; this highlights just one way in which diagnosis can be beneficial and contribute positively to identity. Naming and understanding her difficulties for what they were relieved Zoe of the view that she, as a person, was insufficient. Where Penny saw her diagnostic label as something that challenged her self-image, Zoe’s diagnosis strengthened hers.

Zoe: As I got older it’s been easier to have that, kinda, it’s like, you know, because it’s such a broad term really, and, and a lot of people don’t fully understand it, but... to actually be able to say “Yeah, I’m Dyslexic,” at least people have heard of that, and they kind of go, “Oh okay, well...” You know, and, for me as well, being able to actually understand that it’s not just that I’m weird or stupid, it is actually there’s something there, it’s just I learn differently, and to be able to say that and to... accept that there’s something, just different, um, actually really helped me...

For those beliefs to translate into understanding and acceptance by others she knew that those people would need to have sufficient education about Dyslexia, something that has already been presented as highly valued by participants. Her conceptualisation of Learning Disorders as ‘differences’ was an attempt to counteract the negative views of others toward that population; to provide them with that education.

I: Do you feel, do you feel as though people, from the outside that don't have any experience with it as well, don't understand that people with Learning Disorders are, you know, average to above average intelligence it's just a, a learning... you know it's an inability to learn?

Zoe: Yeah, that's what we are, we're just different. Um, I think some people understand it I think there is still a perception... um, because a lot of people with those kind of differences, ah, end up in lower jobs or, you know, un-skilled work, or, um, working for themselves and may seem like they don't necessarily have the *brains* [dramatic voice].

Once again comparisons with the learning disordered group and the awareness of negative judgements of others arose, as well as a need to defend their place as worthy contributors to society. Though Zoe was pragmatic in her acceptance of the ways her disorder restricted her ability to learn, she was in no way ready to accept it as a limitation of who she was as a person. Zoe believed that differences were a universal phenomenon and it was unfair to focus solely on the differences of certain groups (e.g. learning disordered).

Zoe: ... look at all the people throughout history who have Dyslexia, you know there's plenty of them out there, um... but, are still very successful. And even if someone is in a lower job, so what? If they're happy, healthy, and not... you know, contributing to society, so what?

She continued: Um, you know not everybody is suited to every... type of thing, and it's, you know... I guess for me it comes down to... you know, a shoe's not gonna fit everybody. Why should one way of learning fit everybody either? It's it, we're all different.

Zoe reflected on a journey of transformation from the shy, withdrawn child who avoided her peers and teachers (school avoidance) to protect herself from their negative attitudes, to a woman who actively engaged people in conversations, taking the responsibility upon herself to increase understanding and awareness; to improve the experiences of others in the position she had been. While the challenges she encountered were very real and daunting, the instances in which she managed to overcome them and achieve provided balance and reminded her that she was important, worthy and capable; she was more than her diagnosis alone. While this sub-theme predominantly fits within the overarching concept of diagnosis and identity, it also demonstrates a link between this overarching concept and that of the next chapter, 'The Journey to a Good Place.' For the participants of the current study, identity development was a journey in itself, the largely positive outcomes of which were influenced by those factors facilitating achievement to be explored in the following chapter.

### **The Self as Whole.**

This subtheme centred around the view that a disorder was neither separate, or defining of the whole person. Participants in many ways did not see it as a discrete 'thing;' rather, part of them that was being described or conceptualised in a certain way by outside forces. The relationship between disorder and self appears to be a complex one, with participants unwilling to allow their disorders to define their 'whole' person, but also unwilling to section that part of themselves off. This is as an example of the hermeneutic circle; the whole cannot be understood without all of its parts, and each part must be understood in the context of the whole (J. A. Smith et al., 2009).

Charlotte: I don't think that I really thought deeply about it, I think I just kind of-, it wasn't till I started working in Youth Justice that I kinda thought, actually... you

know, it's time to move on. And I- to be honest day-to-day I never think twice about it, don't even think about it. Um, it's something you live with rather than, like I don't th- as a title it's not a, it's not who I am.

Penny did not see any long-term impact of her ADHD. She was accepting of herself as a 'whole' person and struggled to identify a 'part' of herself as disordered. She refused to make apologies for difficulties arising from her ADHD because she believed that would have amounted to apologising for who she was as a person. Penny was defensive of her abilities and weaknesses, building strong self-worth from within. Her confidence and positive self-image led to a positive, if somewhat conflictual conceptualisation of her disorder and herself.

Penny: Oh and if it is any part of me it's like a really minute part where it's like, oh well, if you find it hard to communicate with me because I sometimes just go like, "Ah... what was I saying?" or, "Can you repeat the question?" well then that's... yeah. But because I'm not walking round with like a label on my head I don't think people, when talking to me, attach it to anything.

Penny described in detail the way her mother had questioned her about the possible impacts of her disorder and she replied:

Penny: "I have no idea, it's just there, and you always address it like it's this thing... and I just feel like I'm just, it's just me, I am me and this-, I don't know any different so I..."

Penny made many comments that indicated she did in fact doubt the presence of her disorder but was usually quick to follow those up with doubts of those doubts. This may have been for two reasons. Firstly, Penny had a very strong conceptualisation of herself as whole whereas she viewed diagnosis in much the same way as Zoe, a means to externalise

the attribution of responsibility. She struggled to take any aspect of herself, break it off, and set it aside as something that had a name and was out of her control. Secondly, Penny battled with opposing opinions of her mother. She saw her as the one driving the diagnosis which she did not readily accept, but also as a good mother (“...she’s like a really good mother, and very fair...”) who she trusted to do what was best for her.

Penny: But, yeah so um, I don’t know I think you’d probably have to ask her what she saw, because to me I don’t then or now see myself as having any...

I: So you just saw that as you, and that was just you?

Penny: Yeah, it’s just me and I don’t really, yeah, so. Um then we went through the diagnosis process and...

She continued: Yeah. But I never was really academic, until I reached University so. Um, and then I went through that, uh diagnosis and, yeah then I had ADHD which, [laughs] didn’t change very much except for now I have it, and, or no I had a label, I guess.

One of the most striking things about Penny’s statement was “... then I had ADHD...” indicating that she viewed it as something that was only ‘given’ to her by the diagnosis. In an excerpt already presented Penny did concede that if her disorder was any part of her it was “... like a really minute part...” appearing willing to section her disorder off and again, illustrating the fluidity with which she conceptualised and accepted her disorder.

### **Acceptance and Benefits of an Ingroup Identity**

#### **Personal Growth.**

All participants, but predominantly Zoe and Charlotte described positive outcomes that they attributed directly or indirectly to their diagnoses or disorders. Personal growth was an awareness that even though the symptoms of a disorder had made life challenging, it

had also been enriching. There was a strong connection between their disorders and positive identity development.

Zoe: Would I change being Dyslexic I mean sure it would be lovely to have everything easy but...

I: It's not really an option.

Zoe: It's not [laughs], you know, not yet, there's no *magic pill* [dramatic voice].

I: No.

Zoe: Um, and you know, in a lot of ways... it, it has made me who I am so...

I: So you feel you've got some positive things out of it too?

Zoe: Yeah, you know it's one of those weird things of, of... it has been... hellish sometimes, but it got me, you know I got through it and, yeah, didn't kill me [laughs].

Charlotte found a satisfying and rewarding career path as the result of her own struggles. She embraced in 'in-group' identity in some respects but was also able to differentiate between herself and those who were in far more serious situations, those 'at-risk' of more negative outcomes.

Charlotte: But, you know there was a number of things that happened that actually turned out to be a really good thing for me coz it meant that I realised my passion for at-risk kids' kind of like myself. And I was like, right I know what I'm going to do, so I went to Uni and did Psychology and then ended up working in Youth Justice residences with kind of like pretty similar kids to what I was.

I: Awesome.

Charlotte: So I wouldn't change it now like... yeah.

Zoe developed a conceptualisation of her difficulties as positively contributory, recognising that some of the hurdles she had overcome had endowed her with skills and awareness that others may never have the chance to develop.

Zoe: ... it is kinda that cliché of, well, somehow or other I got through it, so, you know. And it, yeah I mean god there were a lot of tears, there were a lot of arguments and there were, you know, um, yeah, but [significant pause] I mean who knows what I'd be like if I hadn't had it.

She discussed her Dyslexia in the past-tense which may reflect the lessening of severity of impact it has had on her adult life, again indicating the potential mediating and adaptive influence of maturity.

#### **The Ability to Relate to and Understand Others.**

Zoe felt that her experiences provided her with a privileged position within a group. She valued identification within the group of those with disorders of learning and achievement for how that allowed her to contribute positively to the experience of others within that group. This also demonstrates how grouping is not only done by those external to the experience but by those within.

Zoe: Um, so I've always tried to be open about that and talk to our learning support officers so that they can understand.

I: Mhmm.

Zoe: You know if they haven't had the problems themselves... Um and if, if they've needed me to talk to one, I haven't done too much but if, if, they wanted me to talk to classes I've said, look I'm more than helpful-, happy to. Anything that's gonna help them get through, you know, one on one or classes, whatever.

I: Yeah, that's really good.

Zoe: Just, ah yeah. I mean I think that probably would have helped me as well. You know.

Charlotte was aware that though she fit within the group, there were still limits to her appreciation of the struggles of others, recognising the unique individuality of experience even when diagnoses are shared. She very much asserted the belief that those external to the experience ('outsiders') were limited in how much they could appreciate and understand. This added value to the position of 'insider.'

Charlotte: Um, I think it's made me really good-, obviously I haven't walked their path, walked their journey but I can relate in different ways. Um, which I think is really helpful, coz I think lots of people, not saying this is you at all coz I don't know you, but I think might often go take the kids to the Counsellor or Psychologist or whatever, and they sit there and they talk to the kids and the kids come home and they're like, "They didn't get it." And I think that sometimes it helps to have experience in life, um that can help guide you, not that you're transferring the kid-, stuff to the kid but like, you can...

I: You've got a frame of reference maybe?

Charlotte: Yeah, yip, that's it [laughs].

Charlotte felt strongly that honesty was important and that her experience afforded her an advantage in that. She felt that it was important to build authentic relationships with youth and that the effectiveness of interventions hinged on them, which is supported by research on the benefits of the therapeutic alliance for youth treatment (Clark, 2013); a strong and trusting relationship provides a valuable foundation.

Charlotte: Um, I tend to form really, really good relationships with my clients. I don't know whether that's... I think- I've always thought that teenagers can kind of read who you are, so they can read if you're lying, they can read if you're...

I: They're pretty savvy.

Charlotte: ... talking absolute rubbish to you. So I think, that's kind of helped me that I haven't had to lie.

Charlotte's comments suggest that she believed others she had encountered either directly, or indirectly (through her students) had been dishonest in their attempts to help, possibly misrepresenting their own experiences or knowledge. The 'insider' identity that both Charlotte and Zoe adopted to varying extents allowed them to authentically interact with others within the group. What both women had achieved was taking their private experience and making it publicly available to others in the form of support.

### **Using Experience to Help others.**

Zoe and Charlotte were adept at recognising the ways they took their 'insider' experiences and perspectives and translated those into practical methods they felt had benefited other young people they had encountered in their work and personal lives.

Charlotte: Yeah, I definitely think that like having similarities or, saying to a kid, "Oh actually yeah no I get your struggle coz I'm Dyslexic and this is what-, these are the strategies that I've used to help myself."

Charlotte appeared to consider potential negative feelings that children who had struggled to learn might have toward certain learning terms so she utilised reframing of activities to keep motivation high.

Charlotte: Basic stuff that, I think- it puts kids off if I said to the kids, "Right we'll do times tables," they're all gonna go [noise indicating protest], and probably lie

down on the couches and put the dog on top of them. Um, whereas if I say to the kids, “Right we’re gonna play a game,” so we do bingo or something with times tables but they don’t even know what they’re doing.

Zoe used her own experience as an example to encourage persistence in others she had tutored. She too accepted that though others may be like her they would also be unique, and that while she could offer them encouragement, they would ultimately travel their own path. Thus, she recognised the heterogeneity of the ‘insider group.’

Zoe: Yeah. Yeah and even if it’s only that, someone to say, “It’s okay, you will get through it.”

I: Yeah?

Zoe: [Laughs] “Just keep trying, I know it’s hard, but... you’ll find a way. And it’s, a lot of its finding a way that works for you, and you know, everybody learns differently.” And that was something that *my* tutor, um helped me understand really... is that, it’s you know, the... chalk and talk, standing up in front of a room works for some people, doesn’t for others...

## **The Influence of Mindsets on Diagnosis and Identity**

### **The Fixed Mindsets of Others.**

Charlotte detailed experiences in which others appeared to hold fixed mindsets that had the potential to negatively impact learning. She discussed the fixed mindsets of others from her standpoint as a support person who was being restricted in her capacity to help struggling youth. She believed some adults were motivated to view diagnoses in fixed terms because attributing difficulties to something ‘within’ the child meaning that other people in that child’s life were relieved of responsibility.

Charlotte: Um, or people like teachers who might not have the full concept of what it is, quick to tell parents that their kids have got a behavioural problem or ADHD.

I: So you feel like the wrong people are making these calls and putting the idea's in parents' heads?

Charlotte: Yeah. Yip, and then the parents- some parents are thinking, "Oh right cool, they're poorly behaved at home I'll- this is a good, this is a good opt out for me."

I: This is something that I can put it all down to?

Charlotte: Yeah, and I think people like- some people, especially parents like to have labels or a reason. Um, coz obviously they've got other parents they talk to and, "Oh yeah well my child's ADHD that's why they do that." Actually, yeah...

The parents and teachers Charlotte described were taking a helpless, fixed view of the children's difficulties, giving them a name and not attempting any strategies or interventions (Dweck & Leggett, 1988). Charlotte felt that they were using diagnoses as proof that their children were acting in ways beyond anyone's control which meant that nothing pragmatic needed to be done to change their behaviour. This may be a response to parents' awareness of how their children's behaviour reflects on them; a form of self-protection from negative judgements of others.

She believed parents and teachers were using diagnosis in a counterproductive way and that responsibility should be shared for maximum gains to be made. Charlotte's comments indicate the belief that while children should learn to manage their own behaviour, parents should be aware of their contributions as well. Those counterproductive contributions may include reinforcing the fixed mindset belief that ability is stable and effort cannot alter that (Yeager & Dweck, 2012).

Charlotte: I've sat there and told parents before that, "Actually, you can make all the excuses in the world and say your kids got ADHD but what are you gonna do about it?" And they say, "Oh we'll put them on medication." "No, no, no sorry, what are *you* gonna do about it as a parent? What steps are you gonna put in place to-, to you know...?"

In Charlotte's experience, it appeared that ADHD had been used as an excuse for difficult behaviour, something which may have resonated with her as someone who has the disorder and eventually took responsibility for her own behaviour, proving that it was to some extent, within her control. She expressed the belief that most of the disorders experienced by the children she had worked with were situational, rather than centred within the child and immovable, as many others appeared to believe.

Charlotte: Yeah, yeah. Well that's my boys in my class and I've always said, "Hey actually... it's funny how in class all day I don't have a single problem with them but when you get home they're throwing a plate at the wall." So I mean you've gotta look at the context and the environment.

The negative effects of Tim's diagnoses left him wondering what could be done to improve the system. He was unwilling to accept that a few words, placing him with others who struggled in similar ways, was sufficient information for support people to be able to develop effective interventions. He believed the support to be ineffective due to its immovable focus on limitations within a person; a system derived within a fixed mindset framework (Dweck, 2012a; Matheson, 2015). He felt strongly that it was the responsibility of educators to determine what their students need.

Tim: ... yeah I guess if, yeah they were more educated about it all, and not so... like, closed min- would you say close minded?

Tim argued for a system that acknowledged incompatibility between a person's learning strategies and their learning environment, one in which responsibility for learning could be fairly distributed; a system built around the concepts of growth mindsets toward intelligence. Lack of understanding from others and effective intervention was part of participants' experience and some expressed the belief that educators needed to themselves be educated about the capacity for learning of those with disorders of learning and achievement, and the benefits of flexibility in teaching styles to maximise learning. This flexibility and openness to possibilities can be facilitated by a growth mindset toward learning, something that can be taught to educators as well (Dweck, 2012b).

#### **Fixed Mindset of the Self.**

Many of the comments made by participants when they described their symptoms resembled fixed statements of ability, indicating that they viewed their learning capacity as limited and stable (Dweck, 2012a; Matheson, 2015).

Zoe: ... and writing was just impossible. You know, I really couldn't do that... The reason for this may simply have been that symptoms were experienced as fixed and immovable, and given the early ages at which they first emerged, innate. No matter how hard participants tried, they could not alter the direct effects of their symptoms on their learning.

Charlotte: Yeah reading and writing I think was the, the- and spelling I've always been atrocious at spelling.

Though the narratives of all four participants around their experience of diagnosis contained a mixture of both fixed and growth mindsets, Penny held the most prominent fixed beliefs. At times, Penny expressed the belief that innate ability was a strong determinant of achievement (Dweck, 2012a).

Penny: Like and I, was *so* good at my multiplications but then it got into more difficult stuff and eventually got to a point where I'm like, this is hard, and I also don't really like math...

She credited other people's accomplishments with their innate ability, further evidence of a fixed mindset (Dweck, 2012a).

Penny: I don't know, she was super smart.

She also made comparisons between herself and others, using 'superior' ability to account for differences between, again expressing fixed beliefs about ability.

Penny: ... there's other people that just aren't strong, versus like I was in the University English, and then there's people taking University, or college level English who can't cope with the highest writing level I guess.

Penny: Yeah, um... well... I'm, compared to one friend who I know is a Midwife as well, who is like really quite um, she's really smart with very little effort and sciences are her thing, she's so good, she's really good at everything, but... she doesn't have any systems in place, well no that's not true, we have different- different systems in terms of information sharing.

Zoe saw school as something aversive, out of her control, and inflicted upon her by others, acutely aware of the barriers that prevented her from being successful. This emerged as she discussed topics that she found particularly difficult.

Zoe: Whereas at school it was always forced on me, and I think, because particularly on those days where my head just couldn't get around the idea of maths or the concepts of English or whatever it was, and still being forced to do it in that day, in that way, and it's just like, "I just, I can't get it."

Those learning barriers and experiences of not measuring up shaped her behaviour, causing her to avoid situations in which failure was a possibility. Her Dyslexia was contributory to her avoidance because it made failure a very real possibility in the majority of learning situations (Brooks, 2004).

Acceptance of limitations as relatively concrete may at first glance resemble a fixed mindset but for people with disorders of learning and achievement it may simply reflect the reality of the barriers they encounter on a daily basis (Brooks, 2004; Gerber et al., 1992). It may be a necessary part of accepting and understanding weaknesses in order to positively move on to finding ways to deal with them. Zoe saw her diagnosis as proof of a difference that existed within her; though stable, it was not a deficiency. This allowed her to confront her learning difficulties, reframe them in a way that allowed maintenance of a positive self-concept, and move on to the task of developing strategies to work around them, something that will be explored in the following chapter. She did not view Dyslexia as something that could be cured, but she was able to employ a growth mindset to adapt and deal with it (Dweck, 2012a).

### **Development of a Growth Mindset.**

Time and maturity may have a substantial influence on the development and application of a growth mindset toward learning. Zoe's ability to employ a growth mindset around her Dyslexia developed with time, maturing as she did and facilitated by experiences of achievement and success.

Zoe: Yeah. I've, I guess it's not the big thing that it used to be for me. You know it used to be the, the real block to everything.

As Charlotte matured she took responsibility for her behaviour and the effort she put into her learning, believing that she did have control over her outcome and the capacity to do much better (Dweck, 2008; Gerber et al., 1992).

Charlotte: ... and then I went to Uni and realised that actually, you know that wasn't an excuse for my behaviour just coz I couldn't read or write.

In an interesting contrast to Penny's comments indicating a fixed mindset toward intelligence, she also had great awareness of the role of effort in achievement. Though she appeared to believe in fixed abilities, she also expressed disapproval of her friend's lack of effort. She was also able to identify perseverance and strategies, factors that will be discussed in the following chapter, as the two most significant influences in her positive learning outcomes (Dweck & Leggett, 1988; Gerber et al., 1992).

Penny: Coz I also think I didn't, know how to study, coz no one... taught- you know there's lots of things that I'm like, I don't think it was the diagnosis or yeah, acknowledging this diagnosis that has really helped me because I'm like no I just, as an adult learned how to study and, had more determination to...

The above excerpt highlights two interesting points. Firstly, Penny's awareness of the role of effort in achievement contributed to her doubt in the validity of her diagnosis. She discovered that she did in fact have the capacity to apply herself and learn; therefore, her diagnosis, something she obviously considered to be a fixed statement of ability, needed to be questioned. Secondly, it is apparent that Penny's awareness of the necessity of effort, and her ability to create ways to apply that effort developed with time as she matured.

Tim discussed personal growth and the advantages of extra effort and/or being differently skilled. This reflects a growth mindset, appreciation for development and achievement that is possible through expenditure of great effort (Dweck, 2012a).

Tim: Yeah, like I've had to, like work harder than everyone else, and, but that's not a bad thing like that makes me a better person. Oh that didn't sound good did it?

He continued: Um, maybe not a better person but like, a stronger person. Like ya not, you have to work harder for things and, more appreciative I suppose.

Zoe's growth mindset helped her to overcome her fear of failure, allowing her to develop and test adaptive strategies to work around her learning barriers. It went far beyond that immediate, problem solving role and gave her freedom from a self-concept dominated by inability and comparisons with others.

Zoe: And you know, school's frustrating and it's hard, and... you know that, that put me off, but, looking back at it, I think it helped me, a lot more than I realised at the time. – 68

Viewing her learning difficulties as differences as opposed to deficiencies meant that trying different learning strategies was a viable option. Were someone to take the position that they were deficient and incapable, they may see little point in trying at all (Dweck, 2012a). She held a growth mindset of her ability to be successful and happy, and to be a valuable and equal member of society.

In summary, though participants could appreciate diagnosis as a means of access to support, a strong tension existed between this significant benefit and the risk of diagnosis becoming a dominant aspect of self, leading to the sacrifice of individuality. Participants believed that diagnosis can be helpful but it need not define someone. They struggled to incorporate their own and others views about the meaning of those labels. A key desire of

Zoe, Tim and Charlotte was to have a name for their struggles, without labelling who they were as a person. They believed positive learning experiences hinged on effective education of those who implement teaching and interventions which could be hindered by fixed mindsets toward learning.

For the participants of this study, the willingness to identify with the ‘disordered’ group changed with time and was particularly difficult during the adolescent period, possibly due to increased sensitivity to peer opinion and stigma during this time. Identity formation is a key feature of adolescence and young adulthood and a positive self-concept is built through acceptance of and overcoming challenges, gaining awareness of strengths in the process (Anctil et al., 2008). Maturity in both self-concept and management of learning difficulties may be highly influential to these changes.

With time, most participants accepted their diagnoses as both valid, and part of their identities to varying degrees. This involved rejection of stigma (perceived and real) and conceptualisation of difficulties as differences and the self as capable and worthy. Participants who accepted the ingroup identity turned their attention to helping others who were struggling through a similar experience of acceptance and identity. They came to accept that the expression of their symptoms was relatively fixed but this in no way prevented the development of a growth mindset in dealing with those difficulties. The following chapter will explore the ways in which participants transitioned from young people struggling to learn, to competent adults implementing successful learning tools, and the role that growth mindset played in facilitating that success.

## **5. Results and Analysis: The Journey to a Good Place**

This chapter explores the superordinate theme of the journey that all participants undertook which was largely from a challenging place to a good one. As discussed in Chapter Four, participants described their early schooling experiences and the difficulties they encountered but they also spoke of their achievements in life, their pride at having worked around their barriers, and the positive identities they had developed. It was clear that the journey from one position to the other was extremely significant and had contributed greatly to their lives. The examples they provided give insight into practical ways that others with similar learning difficulties could be supported to work around their barriers and achieve. The journey inherently involved a growth mindset toward learning, which developed and bore more fruit as maturity occurred. The distinct influence and interaction of the growth mindset will be explored toward the end of this chapter.

### **Generating Help from Within**

#### **Control and Choice.**

All participants cited control over their learning (and lives) as one of the most beneficial things to their ability to progress academically, be it through choice over learning content, developing strategies they could implement to work around difficulties and increase chances of success, or asking for help from others. Having control over the learning experience and choice of content allowed participants to engage with material that they found relevant and interesting, which in turn increased their motivation. Choice increased not only their engagement but their opportunities for success and it was naturally something that they were afforded more of with time, linking it to development and maturity.

Zoe: But yeah, you know, it's that kinda choice, I guess for me, made a big difference.

I: Mhmm.

Zoe: Um, I chose to go to this particular Polytech, I chose to go to this particular qualification. Um, and also you know by that time I was living on my own so I chose to go to school [laughs].

I: So that was something you were striving for by that point?

Zoe: Yeah, yeah...

I: Really, just needed to take it back?

Zoe: Yeah, so, first with the home schooling and then particularly by the time I got to Polytech being, you know, given the choice.

Penny also finally found connection with learning material once she got to the tertiary setting and could choose topics that were relevant and interesting to her. She connected this to her ability to both develop and persist in the application of tools required to study successfully, as will be discussed later.

I: Yip. Um, how much control do you feel you had over your learning and what kinds of control?

Penny: Um... probably not a lot of control in terms of like, I didn't have the tools to know how to study and... and until I just figured that or had more drive to do well, because in high school like I wasn't learning anything I was interested in.

I: Okay. So it was a relevance issue as well was it?

Penny: Yeah, coz since I've gone to College [University] Social Work was... and it's happened in both those programs in Social Work and Midwifery I, both those

times I'm like, "Oh these are the readings I'm meant to do?" And I'm actually sitting here reading them and gripped by what is being said...

Issues of relevance and motivation are not just important for the engagement and achievement of those with disorders of learning and achievement, but they are significant because they appear to facilitate learning for this group of people who persistently find the process challenging and aversive.

Charlotte's account was unique in comparison to the other participants' as she had experienced a pendulum swing of choice and control over her learning. This gave her valuable insight into the importance of choice in learning, but also caution around its use. Choice was a crucial component of academic achievement for Charlotte but she suggested it required a delicate balance. In the hands of someone who is not mature enough to responsibly manage it, it may be exploited and used to self-sabotage learning. Charlotte perceived she needed someone to take control and make positive learning choices for her because she was not yet equipped with the maturity to do so herself.

I: Um, how much control do you feel you had over your learning, and what kinds of control? So at school, Uni, anything...

Charlotte: Yeah. Um... I guess at school- Primary school probably none coz I was so young that everyone kind of did whatever for me. Um, intermediate... my parents actually sent me to, the first year of intermediate was actually a school which was um, self-directed learning [laughs].

I: Okay.

Charlotte: So basically you had the lesson plan set out but you got to pick whatever you wanted to do during the day, um.

I: And how did you find that?

Charlotte: Oh well, obviously for the ADHD combination and the- I never did the subjects I didn't want to do. I was only there for two terms, um, because I...

I: So they saw the error of their ways?

Charlotte: Yeah. Because I spend the whole time going, "Oh I'm going to do P.E.," and I'd do for a giant walk and wouldn't come back till three o'clock type of thing.

Charlotte believed diagnosis need not be something imposed upon the child and that they should be active participants in the process; they should have some control. The following excerpt reflects the need to give children a choice, though she was equally aware of the importance of maintaining control herself as the adult and support person. It was apparent from the participants' narratives and Charlotte's perception of the child she discussed that the necessity of diagnosis for accessing support is understood not just by professionals but by those who require it.

Charlotte: ... um... I know I've got a boy in my class currently who's about to be tested. Um.

I: So how old is he?

Charlotte: He's thirteen. So somehow it's... I think it's ridiculous but he's got to the age where he's finally come to me, got kicked out of high school and I'm like, looking at his writing and I'm like, this is not okay for a thirteen-year-old kid, you're writing like-, he's got the writing of a five-year-old basically.

She continued: Um, so for him, he'd been doing some writing and I said, "Oh, do you struggle with writing?" He's like, "Yeah, yeah I do." "Oh..." you know. And then they kind of come- they- we talk about that and you have a conversation you know they come up with different things, oh you know, "Do you have a book you like to read?" and they'll say, "I don't like reading, reading's for fag's." Um, and

then you might kind of try and sway the conversation to something like that. And he said the other day, “Oh I think I might like to be tested,” and he doesn’t know what he’s being tested for, but he likes the idea that there might be something he can be tested for to get him support.

I: So you would rather he come up with it himself though than be told, “You should get this done.”

Charlotte: Yeah. I mean at the end of the day I’ve already booked him in for the test before he even knew it was happening.

I: [Laughs].

Charlotte: Um, but I like the kids to come up with- then they have the pow- they feel like they’re in control, it’s their decision, um...

Charlotte herself found a positive balance of choice and control by the time she reached University, highlighting the important interaction of developmental stage with control students have over their learning. She could succeed at University and then apply her education to a career in which she became the one facilitating young people’s opportunities to take control and make choices relating to their learning and their lives.

### **Taking Responsibility.**

All participants recognised that gaining control over their learning and their lives involved taking responsibility for them. This subtheme was closely tied to development and maturation, indicating that as participants grew older they felt pressure to take responsibility for their own learning and outcomes. It was unclear whether this pressure came from society, close others, within, or a combination of all three. Charlotte came to the realisation that she needed to ‘turn her life around,’ that it was up to her and only her to make changes.

I: Yip. So What's helped you to reframe that?

Charlotte: I really don't know. I think, probably, once I'd left home, moved out of home um, realised it wasn't really an excuse.

She spoke about taking responsibility for her learning in the tertiary environment, about discovering that the power to take her learning seriously was something that came from within.

Charlotte: I just didn't give myself an out, like I didn't give myself an opportunity.

From a relatively early age, Zoe experienced the benefits of taking responsibility for her own learning. It allowed her the freedom to experiment and discover what worked for her, what was most likely to bring learning success.

Zoe: But you know, coz I had anxieties around going there, I couldn't actually end up going to school, so I stayed being home schooled. Um... and I think it was sort of after that that it... it, because I was sort of basically put in charge of my learning, and, um, what I realised is that, there were days that my brain would think 'Okay, maths is cool, I get that,' and other days it's like 'I have no idea what that means, I can't focus, I, I can't add two and two.' You know, whereas, and then there's days that, um, I'd never say English was easy, but I could, I could do it [laughs]...

As she put this into practice and began to succeed, her confidence in her abilities grew. By the time she reached tertiary education, responsibility and control meant owning her success.

Zoe: And that is an important thing, there's a, you know, um... you're responsible to be in class, you're responsible to get your assignments in, you're responsible for all that.

Penny detailed the ways in which she took responsibility for her learning. She was accepting of any accommodations afforded her by learning institutions but when they were not forthcoming, or did not give her the level of support she believed she needed, she took it upon herself to adapt in ways that were within her own control. She took responsibility for creating a learning environment in which her distractions would be minimised.

Penny: And then for my state exam for Midwifery I couldn't write it in a room alone, coz it's a national state exam, moderated by someone who's like hired to moderate them. She's not a Midwife, she has nothing to do with the council who puts the exams on, so she was this, you know other person. And you have to write it in the room but I just said, "Can I turn my desk to face the wall so I don't see anyone?" and I put earplugs in, and I wrote the state exam and...

I: And that worked?

Penny: I'm a Midwife so clearly I've, I did fine.

### **Strategies.**

This subtheme was of great significance for all four participants, who described the tools, 'tricks' and various methods they used to gain control over their learning. Discussion of these strategies indicated that for most participants they began as external compensations that then became internally driven with time, linking this concept with the importance of development and maturity. Tim recalled strategies that were put in place and which he found helpful from a very young age.

Tim: So I must have been like, six or seven.

I: Mhmm.

Tim: And I was just struggling at school really. And, um they used to give me this, like it was a Walkman, a CD Walkman with headphones and that, and then, coz I used to get distracted by everyone else.

I: Okay.

Tim: Then, if I had the headphones on then my work was sweet as.

In contrast, it was much later in her education that Charlotte found study strategies that worked for her. She saw strategies as learning opportunities that should be utilised for her benefit.

Charlotte: Um, if you were allowed a study sheet I was really good at cramming everything possible on it, and having a little magnifol- magnifying glass on the end of the pen, so...

When Penny developed learning strategies during tertiary education she took great pride in her resultant success, knowing that their development and implementation had been the result of her own hard work.

Penny: ... And studying, like, I would be stoked in University when I was like, I'm making these study sheets and I understand, and drawing pictures and... yeah just figured out a way to study.

She did however return to the belief that developmental stage and maturity played a role in her transition from struggling high school student to successful tertiary student ("Or learn to study, but, like a fourteen-year-old wouldn't wanna know that so"). It is possible to synthesise these beliefs by theorising that with time, she gained the maturity with which to develop and implement strategies that lead to her success.

Zoe found that using a computer broke down some of the barriers she experienced when writing on paper. The word processor became an external strategy that she relied

greatly upon, feeling discomfort when she had to revert to pen and paper. She developed a reliance on the 'spell-check' tool but given the technological world that we live in, inability to access it was rarely a problem for her.

Zoe: [Laughs] And there's no red squiggly lines to tell me that it's a [mumbled] with a suggestion, sort of thing, so [laughs] yeah.

Zoe described the ways that strategies she had developed to aide her learning had become helpful teaching tools in her hours spent tutoring, completing the circle, and showing how externally supported strategies that became internally driven can then become the external support for others.

Zoe: Um... partly time, just, just no longer having the pressure of ah having to go to school and stuff. Partly also, the time I spent teaching has helped. Um, being forced to communicate and forced, because I, I think... because I'm, I've always been used to putting things in a different way for myself to understand, you know with working around something, finding another way, that if somebody needed something explaining in a different way I was pretty good at actually being able to do that because I, I already in my mind have different ways of doing things.

### **Persistence.**

All participants took control of their learning in the tertiary or adult learning setting by putting effort in and showing great persistence. This involved being patient with themselves and served as a form of adaptability, allowing them to fit into, and function within their learning environments. Tim provided a contrasting example of a time in his life when he lacked persistence. He discussed this with regret and from the perspective of both hindsight and enhanced maturity.

Tim: Like, I just left because I was like, yay I can leave school. And bigger and better things, yeah. It didn't work out that way.

He may have been driven by his negative and unsuccessful learning experiences up until that time, but he did not anticipate that his desire to learn and progress academically would become stronger than his desire to distance himself from the learning environment.

Tim's experience re-entering a learning environment when he decided that qualifications were important to him was an example of responsibility as a prerequisite for persistence. Persistence was also closely tied to strategies, which could not be successfully developed and implemented without it.

I: Okay. So what sort of methods did you come up with to kind of work around it?

Did you have any sort of, special tactics or ways to kind of...?

Tim: Um, if it was something that I didn't really understand, then I'd work harder at it, and like go find like, jump on a computer or, get something to give me...

I: So you'd just get more information and just sort of build on it?

Tim: Yeah, yip.

Penny also described her persistence in the attainment of qualifications; though she appeared to apply persistence in bursts, she had developed a system that worked for her.

Penny: And then now I think, like I'm quite articulate, and do a good job, and get things done and, and even in University like, be um... I would put things off and put things off, but then I would just have like a six hour really dedicated session to writing a paper.

Zoe shared her experience with persistence in the hope it would inspire others to believe that achievement was possible. She viewed her experience as valuable because it had the potential to offer hope and motivation to those who might be tempted to give up.

Zoe: And it can take time. But, it's possible, you, you can get around what's in your head, and you can get through it, yeah. Whichever way it is that you need to do it. And, yeah I guess, it, it is really quite tricky to actually find what will work for you. Um, and some, some days it'll work perfectly and other days it won't. You know, and what can be also really frustrating is that they're no- never gonna be one answer, and it's not always gonna be the same answer [laughs].

Zoe believed that the best strategies and support in the world could not be effective without persistence because the target was continually shifting. She highlighted the way frustrations ebbed and flowed and what this meant for the ongoing experience of living with a disorder of learning and achievement. The ability to persevere in the face of ongoing challenges may be key to the outcome of those who encounter them.

### **Valued Help from Others**

#### **Asking for Help.**

Deciding whether to seek help from and rely on others was a significant part of the control participants could exert over their learning and lives. When a situation was challenging, they had two options: problem solve and find a way within themselves, or ask for external help. Concluding that a challenge could not be overcome on their own and deciding to ask for help was framed as an example of problem solving.

Zoe: Yeah, you know, it, it did help me because I knew that, yeah, I, well it was up to me how to work it through. Um, if I was having trouble it was up to me to either stand up and say, "I'm having trouble," or to find another way around it.

Participants could recognise the benefits of asking for help, though they were often still reluctant to rely on others due to histories of feeling let down by people who they felt should have provided help, and strong desires to achieve on their own knowing the sense of

satisfaction that came from it. This was evident as Tim discussed the prospect of attending University, something he hoped to do.

I: Do you think you would, sort of, seek out support services a little bit at the University, and things like that, or, do you feel you would be more just, just do it yourself?

Tim: Um, I could probably do it myself.

I: Yeah?

Tim: But if I started failing, and that, or noticed a pattern or if the tutors noticed a pattern, then that's when I'd probably go and get other help or get the tutor to help me or...

Participants felt that accepting help would diminish the sense of achievement that they could attribute to themselves, which sometimes caused reluctance. Charlotte pushed against reaching out to support services at University, predominantly because she greatly valued the sense of having achieved something on her own. Independence is often a highly-valued status of adolescence and adulthood in NZ European culture so this may be one more way developmental stage contributes to experience.

Charlotte: Yeah, though like now reflecting back on it I should have done it, coz it would have made sense. But um, I still managed to get through it on my own, I think I wanted a sense of actually achieving something without everyone else having input in it, coz I think all through my life I'd had, you know teacher aide's or someone sitting there with me, or someone saying, "Oh you need to do this; you need to do that," so I wanted to have a point of difference where I'd actually achieved something for myself and for no one else.

### **Positive Support/Advocacy.**

The value of effective support has already been established as highly important for participants through examples they gave of support and advocacy that they felt was not delivered in this way. All four participants appreciated the support of their parents of whom they had very different expectations to those of educators and support services. While practical support was desired from professionals, emotional support was sought from parents.

Tim: Like, even though like for instance like you know stuck in the, in a room [testing room], but knowing that Mum was there. Like if anything was to go wrong, and, her just being like you know, “Yes, it’s like this but you know, we can work through it.” And just all that like, emotional support I suppose.

The most important message Tim wanted to share was to encourage parents of those struggling with learning to help by providing reassurance and positive encouragement. His comments are a reminder that parents need not take on the role of educator to be effective support people, they need only be approachable and emotionally supportive.

Tim: Um [significant pause] I don’t know just [laughs], probably just tell the parents and that just to, I dunno, keep them close and let them know they’re there.

He continued: Like, coz it’s pretty scary.

I: So you think to enlist the support of their parents is an important thing to do?

Tim: Yeah, yip. And usually when you’re like that little if your parents are like, “Oh yeah you know it’s alright, it’s alright,” then, there’s a good chance it will be alright...

I: So you found a lot of support from your mum?

Tim: Mm, yeah.

I: So, what ways did she support you, so what practical ways, and...

Tim: Um... just being there really.

Teachers and other support people external to the family were expected to be practical in their provision of support. When Zoe spoke about the tutor she encountered at Polytechnic who facilitated such a positive learning experience, she identified appreciation of individuality as the key component of that person's success. As discussed in the previous chapter, appreciation of individuality was highly valued by participants in the development of positive identity. Zoe's comments address the practical ways appreciation of individuality can be used by professionals, tailoring learning and interventions accordingly.

Zoe: Um, she got that not everybody learns the same way.

She continued: Um, and was... very adaptive to how her students learnt. So, you know, in, she always made sure that she covered, um, the audial [sic] learners, the kinaesthetic learners and the visual learners. She made a really good, um, just a classroom environment that you felt comfortable in, um, as well as just being able to actually reach the students and be able to understand that, um, how it can be difficult, you know, to learn, sometimes, and, yeah, so she worked with me on that.

Tim's experience at the same institution was so similar to Zoe's he may have been describing the very same tutor. The way these tutors (or tutor) could adapt teaching styles to the individual needs of students made the presence or absence of diagnostic definitions unnecessary. Tim's experience was that all the students in his class were afforded the same individualised accommodations; he did not need to be singled out to get the learning support he needed.

Tim: Yeah, coz there was one tutor there [name removed], she, when we were in her class and, and like our first thing with her, she um done up a, like a, ways how you learn.

I: Aha. So learning styles?

Tim: Yeah, yeah and then, she, whatever, coz she had these tests and then whatever one you came out with was how she would teach it.

I: Okay, so she would adapt her teaching style to...?

Tim: Yeah, yeah.

I: Awesome.

Tim: And that was, I think I was a kinetic learner or something like real hands on.

He continued: Or if someone was like right into their books and stuff, then she'd teach them through books and, all that sort of stuff so, it worked both ways.

### **Flexibility of the Learning Environment.**

Teachers and support staff have a great deal of control over learning environments. Their attitudes and beliefs about learning can greatly shape the situations in which students find themselves and subsequently, their success. As Tim and Zoe addressed, the appreciation of learning differences was vital to their positive and successful learning experiences. Tim believed that earlier learning environments should be based first on the teaching and understanding of 'learning' before any content is taught.

Tim: ... Um, yeah, I, I don't know I think some of the tertiary stuff is actually, what we actually end up teaching I think should be taught in a, in a high school. Teach kids how they learn. I think that's more important than, teaching them how, you know facts and figures.

I: Content, yeah?

Tim: Yeah. First of all, teach them to learn... and then teach them the rest.

Zoe believed that lesson plans should be flexible, again showing appreciation for differences in the learning needs of students. She believed that rigidity in past lesson plans had been a direct barrier to her achievement, something she discovered when she experienced flexibility in the home schooling environment and the achievement that followed.

Zoe: ... So, being able to actually get you know, the class materials for, you know, an entire weeks' worth of lessons for maths could be done in a day and that would be cool coz that day I was in that mode. And then, you know, but if I wasn't in that mode I didn't have to do it then, I could switch subjects, because, it, it was still not in, within me to do that [laughs]. But it, it was easier, and it made me... actually... be able to get through [laughs]... scrape through.

Charlotte understood that for support to be effective for her, it needed to tap into her unique motivations, reflecting the importance of reinforcement in shaping the behaviour of children. Developmental stage may influence students' unique motivations and thus they should be considered and re-evaluated regularly.

Charlotte: I also remember [tutoring service] I quite liked coz you got [business name] sport vouchers, each time you moved up a level, and that was a bit of a bonus... Yeah, so I guess as a kid, you want something for doing something. And I was definitely, all the way through College (high school) I was definitely one of those kids, you know my parents had to bribe me...

When students reach a level of maturity that allows them to take responsibility for their learning (as discussed previously) that responsibility itself can be incorporated into the success of a learning environment.

Zoe: To a certain extent. I mean, I, I guess... because we were treated as adults, as well, basically... um, you know, the tutors had always said, you know, “We’ll put every effort into you as long as you’re putting the effort in too.”

What Zoe described was a mutual respect based on shared effort. Educators had respect for those students who were willing to apply themselves and work hard, while students respected educators for the control they were given over their own learning, the trust afforded them, and the knowledge that those educators were willing be flexible in the pursuit of student success.

### **The Influence of Mindsets on the Learning Journey**

#### **Growth Mindsets Facilitate Achievement.**

Zoe ascribed great importance to the act of going around her learning barriers. The hunt for and use of strategies is solution focused and representative of a growth mindset (Diener & Dweck, 1980; Gerber et al., 1992; Reiff et al., 1994).

Zoe: ... if I ever have the feeling or if I have that, that complete blank, I can open another document and it doesn’t matter if it’s anything at all to do with what it is that I need to write now, it’s got something on it so it’s a start.

She continued: ... it’s those kind of things that have just made me realise, yip, okay there are always ways around it...

In addition to finding ways to ‘avoid’ being hindered by symptoms, Penny could view a symptom of her ADHD as a strength, and use it to her advantage. This represents a growth mindset as well, rejecting societal beliefs about the negative effects of symptoms to focus on the ways in which they may be beneficial.

Penny: I think all, if it, if I, if my brain does like go faster than some peoples it’s to my advantage...

I: That's a great way to look at it.

Penny: ... because I can sit there and be like, I'm writing this email but I'm also loading that page because it's gonna mean I order like, the yarn I want and like just, all these things fly in and out of my head and when it's too much for I think, you're not gonna remember coz you're got more than like three things you want to do right now, I just write down lists.

For strategies to be successful, participants needed to persevere in their development and use. The benefit of adopting a growth mindset and viewing failures as the result of ineffective strategies (rather than ineffective selves) facilitates the drive to find a better way (Dweck, 2012a). Tim's experience was an example of this.

I: Okay. So what sort of methods did you come up with to kind of work around it?

Did you have any sort of, special tactics or ways to kind of...?

Tim: Um, if it was something that I didn't really understand, then I'd work harder at it, and like go find like, jump on a computer or, get something to give me...

I: So you'd just get more information and just sort of built on it?

Tim: Yeah, yip.

Tim's experience with achievement gave him great awareness of the relationship between effort and outcome, building upon his growth mindset toward learning (Diener & Dweck, 1980; Dweck, 2012a). He recognised that further learning he planned to do would be extremely challenging for him, his barriers still very much a reality, but he valued the end goal and achievement enough to embrace the challenge.

Tim: I wanna do the um, the Geology stuff. Go to, do Bachelor of Science in Geology.

I: Awesome.

Tim: So that should be pretty cool, hopefully I can, do that. But yeah that'll be hard.

The belief in the importance of perseverance in challenging situations is characteristic of resilience and a growth mindset (Yeager & Dweck, 2012). Those who hold a growth mindset are mastery-oriented, acknowledging that effort is the key to achievement and pushing through challenges is an expression of that (Dweck & Leggett, 1988). As discussed in the previous chapter many barriers imposed by disorders of learning and achievement were viewed in fixed terms by participants which represented the reality of symptoms. Their experiences demonstrate that this does not require the adoption of a fixed mindset though, rather it makes more pertinent the application of a growth mindset to develop and persevere in the application of strategies to work around difficulties. For the participants of the current study, development of growth mindsets toward learning and intelligence facilitated the implementation of successful strategies and responsibility over learning and lead to achievements and success.

### **Growth Mindsets Facilitate Positive Support.**

All participants had unique needs and expectations of support so 'getting it right' meant different things for each of them. This indicates the need for support that is flexible and responsive. Growth mindsets are developed with time and facilitated/supported by influential adults who give young people opportunities to practice and hone growth mindsets (Dweck, 2012b). This allows them to learn the connection between effort and achievement and removes the focus from the obstacles that are in their way. Thus, Tim argued he was more than his diagnoses. He positioned himself as a unique human being and believed that the other aspects of his self, not symptom related, deserved equal focus. Most importantly, Tim believed that he had the capacity to do better; he viewed his learning struggles with a growth mindset. His personal experience had proven that he had the

capacity to learn, it simply needed to be unlocked with the right strategies and support (Dweck & Leggett, 1988).

I: Do you feel that, like you talked about a good experience with a Polytech tutor, do you feel that these days' people do, the teachers do seem to be a little more educated?

Tim: Um, the Polytech ones to, yeah. I, I can't really compare them to anything else.

I: Okay.

Tim: But, yeah they seem to take the time and, actually get to know *you* and what makes *you* learn, and then try and amplify it I suppose.

That tutor could give Tim what he needed from a learning environment; she appreciated goodness of fit and shaped the learning environment to meet the needs of her pupils. While the methods of these educators show adaptability to unique needs, they also began from a point of similarity, with recognition of learning styles which are fundamentally based on similarities within and differences between groups. This shows that while individuality is vital, it is often still effective and even necessary to begin from a point of shared experience. Adaptive teaching is the epitome of the growth mindset, embracing the unique challenge of each student's needs, encouraging perseverance and increasing their opportunities to experience achievement through effort (Brooks, 2004; Dweck & Leggett, 1988).

Charlotte reflected this in her current role, working with children who struggled to learn in mainstream schooling environments. She acknowledged the necessity to appreciate the unique learning needs of the individual and conceptualised their difficulties as very much an issue of 'goodness of fit.' She believed there was an incompatibility between the

children and their learning environments, alleviating both of blame. She also believed that mainstream schools have a responsibility to consider and accommodate the unique needs of all.

I: So your current work role, so is it essentially teacher/Social Worker?

Charlotte: Um, it's not a teacher coz I'm definitely not a teacher. Um, they call me a coordinator [laughs], but basically I'm doing... so basically I've got- I can get up to ten kids, um, kids that have been stood-down, expelled um from school or don't fit into the mainstream schooling criteria, um so they come to me. Currently I've only got four boys, um, good kids, just haven't-, like schooling just doesn't work for them. You know, like, some kids you just can't sit them down at a desk and do work. Um, they're all- you know, one of them only lasted two days at the high school, before he was brought down to me type of thing.

She applied her growth mindset at work in creative ways, 'going around' the negative views of parents and others who could further hinder the children's learning; she employed a growth mindset to counteract the fixed mindset of others. Charlotte used reframing as a strategy to engage the children and parents and get them newly enthusiastic about learning, something they may have felt to be oppressive up until that point (Gerber et al., 1992).

Charlotte: Reframing it for parents, and reframing things for kids as well...

Charlotte's drive to find ways to help struggling children find satisfaction in learning was a rejection of the fixed mindset (Elliott & Dweck, 1988). She worked with youth who had several barriers to success: learning difficulties, lack of support at home, and often diagnoses of disorders that further complicated their journey and outcome.

Charlotte repeatedly embraced the challenge without fear of failure, regardless of the fact

that those children had been sent to her because others had already failed to help them (Dweck & Leggett, 1988).

Charlotte: ... I think it shaped who I am now. Um, it's made me really passionate about kids who are at risk or slipping through the system.

She credited her own struggles with her desire to do better for children like her and developed a growth mindset in her attitude toward education. The obstacles she faced and conquered in her own journey allowed her to repeatedly reinforce the knowledge that struggles can be overcome. Charlotte embraced challenge after challenge with confidence and fervour, demonstrating a strong mastery-orientation and growth mindset (Dweck & Leggett, 1988).

In summary, there is much that those with disorders of learning and achievement can do to support their own learning when they are given the opportunity to take control and responsibility. Growth mindsets have considerable power to facilitate and enhance the development of strategies and perseverance of their use, fostering the belief that challenges should be embraced and failure need not be feared. External support people can also contribute positively when they strive to be properly educated about the needs of this group, appreciate individuality, and are flexible and adaptive in the ways they provide teaching and support. In addition to this, they can support students in adopting growth mindsets toward learning. A growth mindset toward learning, held by parents, educators and participants themselves, played a crucial role in academic and life progress for participants of this study. The following chapter will discuss the implications of the conclusions drawn from both Results and Analysis chapters, including discussions of researcher reflexivity.

## **6. Conclusions and Recommendations**

This chapter will present conclusions from the Results and Analysis chapters of this research within the context of existing literature, focusing first on issues related to diagnosis, secondly on the connection between identity and diagnosis, and lastly on the journey participants underwent toward conceptualisations of themselves as capable and successful. Recommendations based on the findings of this study will then be presented, followed by limitations and then possible future directions for related research.

### **Diagnosis Requires Care**

Diagnosis was an issue of great importance to the lived experience of participants. Arguably, one of the simplest and most desired needs of young people with disorders of learning and achievement is understanding and participants felt that this was something that should be provided by diagnosis. Without an explanation in the form of diagnosis, Zoe felt pressure to explain her difficulties to teachers, though she lacked that understanding herself. This highlights the potential for diagnosis to contribute positively and provide the understanding that young people desire. However, when Tim received his diagnoses, he felt they caused people to retreat, which offers support to the notion that labelling an individual changes others' expectations of what they are capable of (Osterholm et al., 2007).

This can be conceptualised as a form of stigma, and though participants of the current study did not consider that to be a dominant part of their experience, it still impacted their lives to varying degrees at different stages. They described experiences in which other people were surprised to learn that they had disorders of learning and achievement, possibly indicating that those people held perceptions (possibly negative) of those disorders that did not match up with the competent people standing before them. This offers weight to findings that stigma can be reduced through exposure and interaction,

allowing others the chance to see the whole person rather than their label alone (Coleman et al., 2009; Gutshall, 2013; C. Smith & Forrester-Jones, 2014). They also held stigmatising ideas themselves at times, which affected how they positioned themselves.

Though participants appreciated that diagnosis provided a means with which to access help and support, Tim expressed a great deal of frustration at both the belief that this was a practical necessity, and the feeling that it left so much of the individual out of the process. He desired a system that assessed individuals needs and utilised their strengths, believing that would make diagnosis redundant and provide superior support and intervention for the those in need. This drive for recognition of the whole individual during diagnosis and intervention supports findings by Reiff et al. (1994) that individualised learning environments are highly valued by, and contribute to the success of those with disorders of learning and achievement. Most participants felt strongly that interventions needed to be implemented at the earliest stage possible and for those where this was not a reality, their early learning struggles were unnecessarily extended and/or amplified.

For support and interventions to be effective, those people providing them need to have suitable knowledge and understanding about disorders of learning and achievement. Participants described situations in which their learning was hindered by those who they believed were not sufficiently educated about these disorders, with Charlotte highlighting the risk of people viewing a diagnosis as a fixed deficiency (indicative of a fixed mindset) within the child that absolved all around them of any responsibility. Charlotte described a fixed mindset toward diagnosis which was counterproductive, as people (parents, teachers and the child) may be less motivated to attempt to alter the child's, and their own behaviour if they feel there is no capacity for change (Dweck, 2008; Elliott & Dweck, 1988).

### **Diagnosis and Identity are Intertwined**

Diagnosis greatly shaped the identity of participants, with early schooling experiences often providing the first clues that they were different to their peers. Participants made comparisons between themselves and fellow students to identify and understand their own differences. Participants symptoms were experienced as fixed and stable and they grew to understand that there was little they could do to eliminate those symptoms directly. The act of being singled out for support itself was in some cases experienced negatively, with participants resenting their identification as different or deficient, and feeling that this made them a target for the negative beliefs of others. Some participants utilised counterproductive ways of dealing with this such as withdrawing from the learning and school environment. Charlotte provided examples of the ways that intergenerational learning difficulties could contribute to the adoption of an identity passed from parent to child that devalued learning, something that is self-protective, placing the fault with learning itself rather than one's own difficulty in doing so.

Developmental stage was extremely influential to participants' experience and during adolescence, diagnostic labels, symptoms and differences to peers took on extra significance, as reported by Kenyon et al. (2013). Participants were aware that the teenage years are often characterised by a lack of motivation and some used this to explain away their symptoms as simply reflective of their developmental stage. Penny very strongly believed this to be the case, using her capabilities as an adult to further support this, but she also acknowledged it was possible it was her development and maturity that allowed her to progress, causing the effects of her disorder to become less prominent. Charlotte and Penny both distanced themselves somewhat from the 'disordered' identity (and others within that group) during the teenage years, preferring to align themselves more closely with the

teenage group than the subset with disorders of learning and achievement. While they accepted their differences to some extent, they positioned themselves low on the hierarchy of disorders in terms of severity, a further form of distancing themselves from those severely affected.

As is common, the peer group held particular significance during adolescence and for Charlotte, being placed within a class of students who struggled with learning and behavioural difficulties led to self-stigmatisation. She grew to believe that group was where she belonged and discovered that it was much easier to misbehave alongside them and be welcomed into the group, than to strive for educational achievement that she had thus far struggled with and felt would remain challenging or unattainable. Segmenting off groups of students leads to a 'shrinking' of their circles of influence and facilitates the development of an identity and peer group that is built upon and may perpetuate deviance in some groups (Petrunik, 1980). It is important that students have opportunities to interact with others who provide beneficial influence as Werner (1993) suggests, and this may be even more crucial when educational needs require placement within specially targeted classrooms.

The extent to which participants accepted their diagnoses greatly impacted their identity. Penny questioned her diagnosis because she could not consolidate her views of what the diagnosis meant to her (disordered, incapable etc.) and how she viewed herself, an accomplished individual. In contrast, Zoe accepted her diagnosis as proof of difference, evidence that she was not deficient, just differently abled. For her, the diagnosis was something worth fighting for as it relieved her of blame for her learning difficulties. She could accept her limitations but maintain a positive self-concept which allowed her to move past the fixed nature of her symptoms and who was to blame, to the task of finding ways around them. She rejected a fixed mindset conceptualisation of her difficulties as

insurmountable, adopting a growth mindset and the belief that progress could be made (Yeager & Dweck, 2012).

Participants did not wish for their disorders to define who they were as people but they were also relatively unable to separate them out as discrete sections of self. Participants viewed themselves as a whole which for some, meant that designating any part of themselves as separate/disordered/deficient was impossible. A direct conflict lay in the acceptance of the self as competent and the self as disordered. This may be what led Zoe to conceptualise her difficulties as ‘differences’ and Penny to resist the acceptance of the diagnosis itself. Participants also viewed aspects of their disorders as positively contributory, aware of strengths that were elicited through challenging times, and development of different skills and perseverance that they believed may not have emerged were it not for their learning difficulties. They felt that by overcoming challenges they had become stronger, more capable people. This supports findings by Anctil et al. (2008) that those who struggle with learning can very much begin to see the benefits of the extra work they must necessarily put in and strengths they develop as a result. Acceptance of diagnosis and identity resolution, which varied between individuals, appeared to free them up to address the difficulties they faced, and develop strategies to work around them.

Once diagnoses had been incorporated into a positive identity, some participants could turn their attentions to helping others who struggled in similar ways, eager to share what they had learnt and optimise the journey of others. The experience of living with a disorder of learning and achievement can afford people a privileged position and ‘in-group’ identity from which they can relate to and understand others. Charlotte and Zoe accepted their positions within the ‘group’ of those with disorders of learning and achievement, attempting to help others not only in practical ways (strategies etc.) but by facilitating the

development of growth mindsets, the confidence to embrace challenges with this belief, and the personal example that they can be overcome.

### **Achievement Requires Effort from Within and The Help of Others**

Though characteristics of fixed mindsets were present in the early participant experiences (e.g. avoidance of learning situations in which failure was likely), with time and maturity they recognised the adaptive functions of problem solving and perseverance. The ability to employ a growth mindset toward learning and appreciate learning goals over performance goals were things that developed with time and maturity (Elliott & Dweck, 1988; Yeager & Dweck, 2012), helping participants to work around their ‘fixed’ symptoms.

Control has long been identified as a crucial facilitator of learning for those who struggle (Anctil et al., 2008; Farmer et al., 2015; D. R. Parker et al., 2011; Reiff et al., 1994), a finding reinforced by the current study. Relevance and interest may be partly dependent on choice in learning material and subjects, and provide motivation for students for whom learning has previously been aversive. Increased choice over learning content is something that appears to be beneficial with development and maturity, as too much control, too early may have negative repercussions. Responsibility over one’s learning is needed for control and choice to have a positive impact. For the current participants, taking responsibility appeared to be a turning point in their learning journeys.

A key to developing control over learning may be a growth mindset, the belief that challenges can be overcome and should be embraced (Yeager & Dweck, 2012). The persistence that is required for students with disorders of learning and achievement to make learning gains is characteristic of a growth mindset (Anctil et al., 2008; Baird et al., 2009; Skinner, 2004). Persistence in the face of a challenge can build and strengthen the connection between effort and achievement (Diener & Dweck, 1980; Yeager & Dweck,

2012), and for the participants of this study, provided opportunities to experience the reward that comes with success.

With persistence, strategies could be developed to work around the barriers imposed by symptoms of disorders of learning and achievement. Strategies included practical tools and ‘tricks’ (e.g. having a bank of replacement words) but also reframing difficulties and tasks so that negative connotations (held by the self and others) may become less inhibiting (Gerber, Reiff, & Ginsberg, 1996). The valued use of strategies, persistence and responsibility by participants in the current study supports previous findings from research of successful adults with learning disabilities (Gerber et al., 1992; Reiff et al., 1994). The ability to recognise the need for help from others, and the readiness to ask for and accept it is yet another form of beneficial control. Participants were sometimes reluctant to seek out support when previous support had been ineffective or experienced negatively, or when the drive to achieve something alone and feel individual success was strong. Feelings of success were treasured by participants who valued autonomous achievement after so much time in which this did not seem attainable for them.

Participants spoke of support that they had experienced positively including that from their parents and families. Parents were valued for their emotional support and encouragement, in line with findings by Werner (1993) that supportive and stable adults were a significant protective factor for those with learning disorders. Participants had very different expectations of educators and other support people for whom the most praise went to those who appreciated goodness of fit between student and learning environment, tailoring teaching to the unique needs of their students. This supports findings by Reiff et al. (1994); Pasta et al. (2013); and D. R. Parker et al. (2011). Though people with disorders of learning and achievement may share common diagnoses their support should be targeted

to their unique needs (Reiff et al., 1994). The art of providing appropriate support may lie in taking the time to thoroughly identify those needs and adapt teaching and/or interventions accordingly.

Educators such as the ones praised by participants of this study appeared to exhibit a growth mindset, fostering confidence and achievement in their students (Elliott & Dweck, 1988). One very practical way to help people who struggle with learning may be to help them view the challenges that they so frequently encounter as opportunities to develop mastery (Elliott & Dweck, 1988; Kenyon et al., 2013). By reducing fear of failure and facilitating the development of skills and perseverance, the risks of embracing a challenge become less daunting, and the gains more accessible (Brooks, 2001; Elliott & Dweck, 1988). An effective educator leads by example and helps students to transform these lessons from external protective factors, to internally driven strategies, persistence and responsibility, previously discussed within this chapter and presented by Kenyon et al. (2013). Once those adaptive beliefs and skills have been internalised, those who once struggled to make learning gains are in a valuable position to support similar others to do the same.

In summary, the experience of being diagnosed and living with a disorder of learning and achievement is complex and personal but for participants of the current study there were significant shared factors. Firstly, diagnosis remained a contentious issue for participants who were acutely aware of what they considered both positive and negative outcomes. They valued diagnosis to access support and understanding, though this was often not afforded to the standard they believed it should have been. They were wary of diagnosis for its potential to elicit stigma and the risk that labels would become dominant, and individuality and other aspects of self be ignored and/or lost. Identity was shaped by

diagnosis to varying degrees and being placed in groups, by both others and the self was important to identity development. The adolescent years marked a period where feelings of difference were particularly strong, as they are a time of important identity development and one in which comparisons with peers are prominent.

Participants developed from children whose learning struggles were dominant to adults who recognised they had the capacity to learn and achieve, and they did this through individual factors and the support of others (Anctil et al., 2008). They developed growth mindsets toward learning, understanding that though it was difficult, they could still succeed with persistence and the development of effective strategies; they relished the control and responsibility this afforded them over their own learning. Growth mindsets of educators and other support people (e.g. parents) helped to instil the belief that with effort, achievement was possible, and though there may be barriers and failures along the way, this did not mean that they were incapable and/or deficient. The journey inherently involved a growth mindset toward learning which maturity brought to fruition. Growth mindsets provided the foundations on which the practical methods of success could be developed and were key to moving forward positively, highlighting the capacity they have for improving the learning experience of those with disorders of learning and achievement.

### **Limitations of the Current Study**

Though the participants shared many aspects of their experience of being diagnosed with disorders of learning and achievement, their differences were equally as pronounced. Penny's experience and meaning making differed most markedly from the others but there are important factors that may have contributed to this. Firstly, all other participants received diagnoses of Dyslexia (one with comorbid Dyspraxia and another with comorbid ADHD) while Penny received a diagnosis of ADHD. It is possible that the struggles of

those with ADHD alone and those with Dyslexia differ in ways that lead to very different conceptualisations of the experience. Secondly, Penny was born and raised in Canada while the other three participants grew up in New Zealand. Cultural differences may have existed in the parenting, home lives, schooling and social influences of Penny and the other participants.

The current study lacked cultural diversity, with all participants identifying as European/Pākeha. Given that this study was conducted in New Zealand, it would be valuable to replicate it with populations of different cultures, most importantly Māori. While the intentions of the study were always to be culturally inclusive, the demographics of the geographic area that participants lived in made that difficult. The age of participants was relatively similar as well (early twenties to mid-thirties) meaning that findings may only be applicable to one or two generations, and the schooling system of the mid-eighties, to early two-thousands. Again, this was a result of the participants who were available in that area at that point in time.

The small number of participants used was a further limitation of this study. An original aim of this study was to compare participants who held predominantly growth mindsets to those who held predominantly fixed mindsets. The limited number of participants available meant that all chosen held predominantly growth mindsets and comparisons therefore could not be made. For this reason, it is difficult to assert that positive outcomes of those with disorders of learning and achievement are in fact impacted by their growth mindsets. On reflection, this comparison would not have aligned well with the goals of IPA and a larger, quantitative study would be better suited to assess this. The fact that participants completed a questionnaire over the phone, before their interviews, which asked questions about mindsets related to intelligence, may also have led participants

to make assumptions about what the researcher was looking for. This may have altered the way they presented themselves during interviews, and led to 'favourable' depictions of their beliefs.

A limitation related to the IPA methodology was the fact that after transcription, sound recordings of participant interviews were deleted in line with University policy. Common practice in IPA is for the sound recordings to be listened to at various stages of analysis to ensure things such as inflection can be fully appreciated (J. A. Smith et al., 2009). It is possible that by working only from the written transcripts, important aspects of participant interviews were forgotten or not fully captured.

### **Researcher Reflexivity**

A significant aspect of my research experience that I frequently reflected upon was flexibility, which emerged in several ways. I originally aimed to compare fixed and growth mindsets through direct comparison of participants. I concluded that this did not fit well within the realms of IPA but I also discovered that mindsets were fluid and existed on numerous, immeasurable continuums, well suited to phenomenological exploration. I had to be flexible in development of my research plan, finding only four suitable participants but discovering an appreciation for depth of experience as a result, something I may not have been able to access to the same extent with a larger number. This depth of understanding came from increased familiarity and thorough testing of my own interpretations, searching participant accounts for evidence and confirmation.

There were many surprises along the way, one being the openness with which participants were willing to share their experiences with me. I had carefully considered ways to build rapport, and the possibility that early stages of interviews would not be as rich due to delay in the development of this. What I found was that rapport was built before

the interviews even began, based on participants' appreciation of my interest in their experience. This truly was the most valuable rapport-building tool of all. Something else I had not anticipated was the further development of my own growth mindset toward learning through my research journey. I quickly came to understand that success would be contingent on me embracing my role as student, letting go of control to the extent that I could value and accept my supervisor's input and not take critiques personally. I came to appreciate very early on that all critiques were being given, and should be accepted, for the good of this research.

### **Future Directions**

The theme of 'different not disordered' emerged in this study, which raises the issue of the applicability of the concept of disorder across cultures. Because disorder is measured against a norm, which must necessarily be culturally determined to some extent, the issue of fairness in diagnosis of people from other cultures (other than Western/European) has arisen (Gold & Richards, 2012; McDermott & Varenne, 1995). As mentioned above, an important continuation of this research would be to explore the effects of culture on the experience of disorders of learning and achievement (and mindsets). An aim may be to gain insight into the ways that experience is affected by being deemed disordered, when measured against criteria that some may argue are incompatible or unattainable by those from cultures other than that within which those criteria originate (McDermott & Varenne, 1995).

Two participants described behaviour that indicated they at times took 'advantage' of their diagnoses, stating they used them as 'excuses' to expend little effort and minimise the demands made of them by others. This was linked to developmental stage and both participants raised the possibility that adolescent lack of motivation facilitated this, but this

study was not equipped to explore this in depth. It would be interesting to see subsequent research explore the interaction of developmental stage and the symptoms of disorders of learning and achievement, looking into the ways that somewhat expected adolescent cognitions and behaviour might make symptoms seem more pronounced, and the ways that support people might be able to tease these aspects apart, to understand how best to help and motivate young people during this time.

The participants of this study discussed the diagnostic system and learning/intervention environment as being significant to their experiences. This study was not able to explore those topics in sufficient depth and a continuation of exploring these issues would be beneficial. Thorough conceptualisation of difficulties and strengths was highly valued and speaks to the tenets of ecological neuropsychological evaluation for development of interventions for those with disorders of learning and achievement (D'Amato, Crepeau-Hobson, Huang, & Geil, 2005). This system incorporates assessment of the systems with which the child interacts (not just the child) when assessing their needs (goodness of fit), and has a strong focus on utilising strengths (D'Amato et al., 2005).

Another alternative to the current diagnostic system is a response-to-instruction model that is essentially risk based, identifying difficulties (both academic and behavioural) at the very earliest time, rather than waiting until symptoms are clinically significant (Vaughn & Fuchs, 2003). Shifting from a deficit-model to a risk-model is in line with the desires of participants of the current study who did not want to be conceptualised as 'lacking' and craved a system that could help them without making sweeping statements of deficiencies. One major benefit of the response-to-instruction model is that rather than attributing a child's learning difficulties to some deficiency within them, the first line of investigation is the compatibility of the learning program and that particular child (Vaughn

& Fuchs, 2003); again, goodness of fit. This has the potential to relieve children of feelings of inadequacy, such as those experienced by participants in the current study.

### **Key Findings from Participants Lived Experiences**

- The experience of diagnosis may be optimised for young people with disorders and learning and achievement by including a comprehensive assessment of individual strengths as well as difficulties (Reiff et al., 1994). This can form the basis of interventions that target the unique needs of the individual and utilise and build upon their existing strengths. Highlighting strengths within the young person has the added benefit of increasing their confidence and feelings of capability (Anctil et al., 2008; Schindler & Sauerwald, 2013).
- It is beneficial to conduct diagnosis as early as possible and practical so that interventions can be implemented at the earliest time. This has the potential to minimise the length of time that children go without explanation for their difficulties and risk concluding that they are simply incapable of learning. The negative effects of an aversive learning environment can be long-lasting and efforts should be made to reduce them (Mattison, 2015). Early diagnosis and effective intervention are two ways to support this.
- Developmental stage should be considered when implementing interventions, and teachers and support people should be mindful of development, particularly during the adolescent years. It appears important to critically evaluate which aspects of the individual's experience and difficulties are expressions of disorders, and which reflect their developmental stage and may be time specific (Werner, 1993). Tapping

into development stage and interests can also heighten motivation. Support may be more beneficial when age appropriate.

- Positive social interactions and influences are arguably a protective factor for those with disorders of learning and achievement so facilitating positive interactions with peers and adults may be beneficial (Werner, 1993). This could be particularly true for those young people who are assigned to classrooms with high numbers of students with behavioural and/or social problems. Interactions with positively influential peers also have the potential to decrease experiences of stigma, allowing those with disorders to be appreciated as whole and valuable people, rather than by their 'labels' alone (Bellanca & Pote, 2013; Osterholm et al., 2007; C. Smith & Forrester-Jones, 2014).
- Parents have their own, unique role to play in the support of young people with disorders of learning and achievement, and the expectations placed upon them may differ from those placed upon professionals. They can support their children by providing stability, emotional support and encouragement, and by advocating for their child to ensure that professionals are meeting their needs.
- When parents, professionals and learning facilitators hold growth mindsets toward learning they can help to instil in the child beliefs that learning gains can be made (Dweck, 2012b). By modelling these mindsets, they increase the chances that young people will internalise them as well.
- The risk of failure can overshadow the learning of those with disorders of learning and achievement but if they learn that failure is not to be feared they may be more likely to embrace challenges (Dweck & Leggett, 1988; Yeager & Dweck, 2012).

When they hold a growth mindset and failure does occur, they understand that it was the strategy used which was not successful, and that by trying another they can still succeed (Dweck & Leggett, 1988). This takes the onus of failure away from the individual and has the potential to make learning itself a much less aversive experience (Diener & Dweck, 1980; Masters, 2014).

In conclusion, the diagnoses of disorders of learning and achievement are highly significant to identity development. Ineffective support and educators who lack education about these disorders can contribute negatively to the experience but appreciation of individuality (including strengths) and flexibility in lessons, interventions and learning environments can contribute positively to the learning experience. Fixed mindsets toward learning (of parents, educators, and youth) may hinder progress and achievement, though the immovable experience of symptoms may require a fixed conceptualisation given that they are experienced as such. This may allow for attention to be focused on development of a growth mindset to support responsibility, strategies and persistence in working around difficulties. The adoption of growth mindsets by parents and educators provides a positive model for youth and supports environments in which failure and challenges are not feared but viewed as means of progress.

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## Appendix A

### Human Ethics Notification - 4000015472

humanethics@massey.ac.nz

Fri 4/03/2016, 1:26 p.m.

A.Lindsay@massey.ac.nz;

Chloe.Duncan.1@uni.massey.ac.nz;

K.J.Ross@massey.ac.nz

Thesis LD MS

HoU Review Group

Ethics Notification Number: 4000015472

Title: IPA Exploration of Growing Up with a Disorder that Impacts Learning and Achievement: What Role Does Mindset Play?

Thank you for your notification which you have assessed as Low Risk.

Your project has been recorded in our system which is reported in the Annual Report of the Massey University Human Ethics Committee.

The low risk notification for this project is valid for a maximum of three years.

If situations subsequently occur which cause you to reconsider your ethical analysis, please log on to <http://rims.massey.ac.nz> and register the changes in order that they be assessed as safe to proceed.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:

"This project has been evaluated by peer review and judged to be low risk. Consequently it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Dr Brian Finch, Director (Research Ethics), email [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz). "

Please note that if a sponsoring organisation, funding authority or a journal in which you wish to publish require evidence of committee approval (with an approval number), you will have to complete the application form again answering yes to the publication question to provide more information to go before one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

You are reminded that staff researchers and supervisors are fully responsible for ensuring that the information in the low risk notification has met the requirements and guidelines for submission of a low risk notification.

If you wish to print an official copy of this letter, please login to the RIMS system, and under the Reporting section, View Reports you will find a link to run the LR Report.

Yours sincerely

Dr Brian Finch  
Chair, Human Ethics Chairs' Committee and  
Director (Research Ethics)

## **Appendix B**

### **Exploring the Experience of Growing up with a Learning Disorder or ADHD Diagnosis: What Role do Mindsets Play?**

#### INFORMATION SHEET

#### **Researcher Introduction – Chloe Duncan**

My name is Chloe and I am the researcher conducting this study as part of my Master's thesis project in order to complete my Master of Science in Psychology. I obtained a Bachelor of Applied Science majoring in Psychology through The Open Polytechnic of New Zealand at the end of 2013 and chose to continue my studies to become a registered Psychologist.

#### **Research Description and Invitation**

I would like to invite you to participate in this research which looks to explore your experiences and perceptions of growing up with a Learning Disorder or ADHD. We will explore the things that have been meaningful for you, and investigate whether different mindsets (ways of thinking) seem to have influenced experience.

To be suitable for this research you will be an adult, who has been diagnosed with a Learning Disorder (e.g. Dyslexia) or ADHD at an earlier time in your life, before finishing school or training. People with other difficulties that might affect their learning and achievement such as intellectual disability or significant mental health problems will unfortunately not be able to participate.

- I would like to meet with you and have a conversation together about this topic; I will ask you a series of short questions and then we will talk about your experiences. Our conversation will take approximately an hour and we will meet at the Greymouth town library in a quiet room.
- You will be interviewed in a way that allows you to talk about issues and experiences that have been important to you; I will have a set of questions to help with this process as well.
- I will ask if I can record and take some notes during our conversation.
- You are welcome to have whanau/family present during our conversation; they are welcome to contribute to our conversation. The research is about exploring your experiences and the things that have been meaningful to you.
- At the end of the conversation a \$20 voucher will be given as a token of appreciation for your time and for sharing your knowledge with me.

#### **After our conversation**

- I will type up our conversation and remove your name, any names you mention, the name of the school and any other information that may personally identify you. You can choose another name to be used in the research if you wish.
- I will talk to you about reviewing the typed copy of our conversation if you would like to. If there is any information you would like to add or remove, we can do this.

- The recordings and the transcribed conversation will be kept on my laptop which is password protected. The recording of your interview will be deleted once you have approved your written transcript.
- Your transcript will only be used by this researcher for this project. The researcher's supervisor may also have access to them but must abide the same, strict confidentiality principals as the researcher.
- After the research has finished, my supervisor, Dr Kirsty Ross, holds onto the information for a period of five years, after which it is destroyed.
- If you wish, I can provide you with a summary of the research and what it has discovered.

#### **Your rights as a participant**

- You are under no obligation to accept this invitation to take part in this research
- You do not have to answer any particular question
- You may withdraw from the study at any time up until the time when you have approved the typed conversation with me and your name has been removed
- You can ask questions about the study at any time during participation
- You will be given a summary of the project findings when the study has been completed
- You can ask for the recorder to be turned off at any time during the interview and ask to take a break at any time during the interview

#### **Project Contacts**

Please feel free to contact me and/or my supervisor if you have any questions about the project.

Researcher: **Chloe Duncan**      Email: **chloe.duncan@outlook.com**

Supervisor: **Dr Kirsty Ross**      Phone: **06 356 9099** exn: **84698**

Email: **K.J.Ross@massey.ac.nz**

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Dr Brian Finch, Director, Research Ethics, telephone 06 356 9099 x 86015, email [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz).

## Appendix C

### Exploring the Experience of Growing up with a Learning Disorder or ADHD Diagnosis: What Role do Mindsets Play?

#### PARTICIPANT CONSENT FORM – INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I **agree** to the interview being sound recorded.

I **agree** to have the transcript of my interview held for five years.

I **agree** to participate in this study under the conditions set out in the Information Sheet.

**Signature:**

**Date:**

.....

**Full Name - printed**

.....

## Appendix D

### Exploring the Experience of Growing up with a Learning Disorder or ADHD Diagnosis: What Role do Mindsets Play?

#### AUTHORITY FOR THE RELEASE OF TRANSCRIPT

I confirm that I have had the opportunity to read and change the transcript of the interview to my satisfaction.

I agree that the edited transcript and anonymized extracts from this may be used in reports and publications arising from the research. Anyone reading these extracts will not be able to identify me.

I understand that the voice recording of my interview will be deleted once I have approved my transcript.

**Signature:**

**Date:**

.....

**Full Name - printed**

.....

## Appendix E

### Intake Screening Questionnaire

[My Brief Explanation: **Purpose; selection; voucher; series of questions** – which people are **right** for this]

Verbal Consent

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Gender: M / F

Town: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Age at Diagnosis: \_\_\_\_\_

Made by: \_\_\_\_\_

Any others (incl. Mental health): \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_

Current Occupation: \_\_\_\_\_

### **Growth Mindset Questions**

Series of Statements, answer whether you **mostly agree** or **mostly disagree** (no need to be definite).

There is no right or wrong answer, it's just to get a sense of you. Best to answer as quickly as possible.

Clarify: *Intelligence* (how 'smart' you are); and *work* (School, training, work, any task completing).

Reminder: **Mostly agree** or **mostly disagree**

- |  |   |   |
|--|---|---|
| 1) You can learn new things but you can't really change how intelligent you are.     | A | D |
| 2) I like my work best when I can do it easily without too much effort.              | A | D |
| 3) I like work that I'll learn from, even if I make a lot of mistakes along the way. | A | D |
| 4) I like work best when it makes me think hard.                                     | A | D |
| 5) I like work best if I can do it right away without making mistakes.               | A | D |

## **Appendix F**

### Semi-structured Interview Questions – Learning Disorders and Mindset

#### **Tell me about being diagnosed with...**

*Prompts:* (questions marked with \* capacity to explore mindset)

What led to the diagnosis? What was life like before?

Can you describe to me what your symptoms were like?

How old were you (when diagnosed) and what was happening in your life at that time?

\*How did you feel about having a 'name' for your difficulties?

\*What changed for you after receiving the diagnosis?

\*How was life better? How was life worse?

Is there anything that you wish had happened/been done differently around that time?

#### **What was school/training/growing up like after that diagnosis?**

*Prompts:*

What kind of support did it bring for you?

How did other people treat you and how did you react to that?

\*What was most helpful for you during that time?

\*What was most unhelpful for you during that time?

\*How much control do you feel you had over your learning? What kinds of control?

Who did you get support from and how did that support/help you?

Who do you wish had supported you better or differently? In what ways?

#### **How do you feel your disorder/diagnosis has affected your life as it is today?**

*Prompts:*

How do you feel about how your life has turned out?

What has changed for you (in the way you feel about the diagnosis) over the years?

\*What are the ways you've learnt to live/deal with it; work around it?

\*Do you wish that you had done anything differently? (regrets?)

\*Do you have any thoughts or beliefs about why *you* ended up with...?

What would you say to another child/young person who was in a similar position?