

University of Southampton Research Repository ePrints Soton

Copyright © and Moral Rights for this thesis are retained by the author and/or other copyright owners. A copy can be downloaded for personal non-commercial research or study, without prior permission or charge. This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the copyright holder/s. The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the copyright holders.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given e.g.

AUTHOR (year of submission) "Full thesis title", University of Southampton, name of the University School or Department, PhD Thesis, pagination

UNIVERSITY OF SOUTHAMPTON

FACULTY OF MEDICINE, HEALTH & LIFE SCIENCES

School of Psychology

Children and Teachers' Perceptions of ADHD and Medication

by

Jess Bradley

Thesis for the degree of Doctorate in Educational Psychology

May 2009

Word Count 21,913

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF MEDICINE, HEALTH AND LIFE SCIENCES

Doctorate in Educational Psychology

CHILDREN AND TEACHERS' PERCEPTIONS OF ADHD AND MEDICATION

Jess Bradley

A detailed review of the literature revealed that children report mixed views towards ADHD and medication. They are also reported to experience a lack of control over their symptoms and in turn, report a reliance on medication to control behaviours. Research into children's sense of self is conflicting, where studies reveal poor self-image, but other work confirms an inflated sense of self. In addition, differences between adult and child perceptions of ADHD exist, and are explained by the Attribution Bias Context (ABC) model which describes the nature of informant discrepancies. Gaining a greater understanding of children's perceptions of ADHD is important in identifying and implementing effective interventions for children and their families.

This qualitative study explored 5 children's perceptions of ADHD through interview and drawing. Children's teachers were also interviewed in order to explore discrepancies. Analysis of the data revealed a grounded theory of internalisation of the ADHD label for children, and difference for teachers. Children were found to experience ADHD emotionally, in on/off conditions, as a medical disorder, with external locus of control and as part of their self/identity. Medication was felt to control their behaviour. Teachers described children's ADHD using a medical discourse and strengths were identified as attributes which are present in the absence of ADHD symptoms.

Results are discussed in terms of similarities and differences between adult and child perspectives, and only some of the data supports the predictions of the ABC model. Implications of the findings are discussed in terms of academic and applied settings, and future research directions are considered with particular reference to exploration of the process of internalisation of the ADHD label.

List of Contents

Section 1. Literature Review	6
1.1 Abstract.....	7
1.2 The Nature of Attention Deficit/Hyperactivity Disorder.....	8
1.3 Adult and Peer perceptions of ADHD	20
1.4 Children's perceptions of ADHD.....	32
1.5 Theoretical Framework.....	44
1.6 Conclusion.....	50
Section 2. Empirical Paper	53
2.1 Abstract.....	54
2.2 Introduction.....	55
2.3 Method.....	71
2.4 Results.....	77
2.5 Discussion.....	106
Appendix A: Interviews	119
Appendix B: Ethical Approval	123
Appendix C: Consent forms and Information Sheets	125
Appendix D: Interview Transcripts and Drawings	135
Appendix E: Codes, Concepts and Categories Tables.....	185
References	191

List of Tables

Table 1 Participants age and school.....	72
Table 2 Participant's scores provided by CTRS: RS.....	77

List of Figures

Figure 1 ABC model (de los Reyes & Kazdin, 2005 p. 496).....	466
Figure 2 Examples of children's drawings of a person 'I would not like to be like'	81
Figure 3 Examples of children's drawings of a person 'I would like to be like' ..	81
Figure 4 Drawing the ideal self - child c.....	Error! Bookmark not defined.
Figure 5 The person I would not like to be like - child b.....	90
Figure 6 A conceptual model of the process of Internalisation of the ADHD Label	92
Figure 7 A conceptual model of Difference	1055

DECLARATION OF AUTHORSHIP

I, Jess Bradley

declare that the thesis entitled

Children and Teachers' Perceptions of ADHD and medication

and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

- this work was done wholly or mainly while in candidature for a research degree at this University;
- where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- where I have consulted the published work of others, this is always clearly attributed;
- where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- none of this work has been published before submission.

Signed:

Date: 26 October 2009

Acknowledgements

I wish to thank my main supervisor Göran Söderlund for all his support in writing this thesis. I also wish to thank Julie Hadwin for her support in developing this research and Felicity Bishop in her supervision on the qualitative aspects of this study.

I am extremely grateful to the participants in this study for taking the time to share their stories with me, and to their parents for contacting me to express their interest in my study. I would also like to thank the schools who participated in my study for their help and cooperation.

Finally, I would like to thank my husband, David and parents, Judith and David Simpson for supporting me through this process.

Section 1.Literature Review

An exploration of children's and adults' perceptions of ADHD

1.1 Abstract

This review explores the literature around ADHD and perceptions of it. The nature of the disorder is discussed outlining key ADHD theories and controversy associated with the validity of the disorder.

Adult perceptions were explored and in the case of parents, biological causes of ADHD were supported. Parents were also found to rate medication as effective, more so than children. Fewer studies have shown the perceptions of teachers, although one study revealed that similarly to parents, teachers believe behaviours to be out of the child's control.

Children with ADHD have been found to show mixed views about their diagnosis and medication. Research concludes that children view their label negatively in terms of stigmatisation, but positively in terms of things getting better. Similarly, ambivalent views about medication are reported where it is thought of positively in helping with negative behaviours, but negatively in having side-effects and affecting spontaneity.

Research into children's perceptions of ADHD highlights a theme of control, whereby children experience medication as a controlling factor and a reliance on medication in order to behave appropriately.

The Attribution Bias Context Model is used as the theoretical framework for the study and provides an understanding of informant discrepancies in childhood psychopathology. It predicts that adults will attribute a problem to the child and perceive it as warranting treatment whereas the child will attribute the problem to the environment and not perceive it as warranting treatment.

Research is discussed in terms of informant discrepancies between adults and children and the implications for treatment effectiveness are considered.

1.2 The Nature of Attention Deficit/Hyperactivity Disorder

The aim of this section is to explore the nature of ADHD, causes, outcomes and efficacy of treatments. Examining these areas provides a context for further sections of the literature review which consider how adults and children view and experience ADHD.

1.2.1 Prevalence and diagnosis

Attention deficit/hyperactivity disorder (ADHD) affects 3-7% of the childhood population (Barkley, 1997) in a male to female ratio of 3:1 (American Psychiatric Association, 1987). It is characterised by inattention, hyperactivity and impulsivity and the most recent revision of the DSM (Diagnostic and statistical manual of mental disorders) (DSM-IVR; APA, 2000) identifies three subtypes; predominantly inattentive (ADHD-I); predominantly hyperactive-impulsive (ADHD-H); combined (ADHD-C). The combined subtype accounts for 50-75% of all children with ADHD, 20-30% have a diagnosis of ADHD-I and less than 15% are diagnosed ADHD-H (Morgan, Hynd, Riccio & Hall, 1996).

Secondary symptoms of ADHD include: low frustration tolerance; shifting activities frequently; difficulty organising; and daydreaming (Spencer, Biederman & Mick 2007). Children and adults with ADHD-I are less likely to experience emotional and behavioural problems than other subtypes. Those with ADHD-H have less difficulty with academic requirements, and those with ADHD-C have higher rates of

comorbidity with other psychiatric disorders and greater impairments overall (Spencer et al, 2007).

Historically, children presenting ADHD-type symptoms may have been diagnosed with oppositional defiant disorder (ODD) and conduct disorder (CD), which are now viewed separately to ADHD. ODD is characterised by negative, hostile and defiant behaviour and CD is more severe including rule violations, destruction, stealing or truancy (DSM-IVR; APA, 2000). Biederman, Newcorn & Sprich (1991) identified that 30-50% of children with ADHD present ODD or CD. There is also evidence to suggest that mood disorders are comorbid with ADHD (10-20%) (Goldman, Genel, Bezman & Slantez, 1998) with rates increasing into adolescence (Spencer et al, 2007) and 20-60% have emotional and behavioural difficulties (Dietz & Montagne, 2006). In addition there is evidence to suggest that the symptoms of ADHD decline throughout adolescence but still remain into adulthood (Spencer et al, 2007).

1.2.2 Aetiology

A number of researchers have considered the genetic basis of ADHD in an attempt to gain a greater understanding of the nature of the disorder. Barkley (2005) concludes that ADHD is a highly hereditary trait rather than a chromosomal defect. However, it continues to be a controversial area of research and some writers (e.g. Joseph, 2000) caution against identifying a genetic basis as it may limit further exploration of psychological causes, individuals may be stigmatised and drug treatment warranted.

Biederman & Faraone's (2005) summary of twin studies concludes that ADHD is heritable to 75% and Epstein, Conners, Erdhardt, Arnold, Hetchman & Hinshaw et al (2000) found that parents of children with ADHD experienced more difficulty with inattention and cognitive problems, hyperactivity, impulsivity and more problems with self-concept than control parents. In the same study however, no difference was reported in symptoms between biological and non-biological (adoptive) parents of children with ADHD (Epstein et al, 2000). This evidence supports the concept of familial aggregation, whereby ADHD 'runs in the family' due to the environment and social learning.

Biological risk-factors have been identified in ADHD, for example food additives, lead contamination and cigarette and alcohol exposure (Spencer et al, 2007). There is also evidence for neurobiological explanations, including abnormalities in dopamine transmission, whereby a genetic link is explored (Kirley, Hawi, Daly, McCaron, Mullins & Miller et al, 2002). The evidence for neurobiological explanations are criticised for their lack of longitudinal data (Spencer, 2007).

Psychosocial factors are also evidenced in the aetiology of ADHD, including low socioeconomic status, large family size, maternal mental disorder and foster care placement (Spencer et al, 2007). However, only small gene-environment interactions are identified (Swanson, Kinsbourne, Nigg, Lanphear, Stefanotis &

Volkow et al, 2007) and the current belief that a number of risk factors contribute to ADHD is upheld (NICE, 2009).

1.2.3 Models of ADHD

Barkley's (1997) model hypothesises neurological differences in children with ADHD; a deficit in response inhibition. The deficit leads to impairments in executive functions; working memory, self-regulation; internalisation of speech; and planning. Finally, the impairments result in decreased control of motor behaviour (Barkley, 1997).

The model is criticised on three points. It theorises a chain of reactions which stem from a deficit in response inhibition, however, the strength of the relationship between the primary and secondary impairments and lack of behavioural control are unknown (Barkley, 1997). In addition, it is unclear whether the executive functions exist in their own hierarchy or whether each individual with ADHD experiences impairments across all functions. Individual differences are not accounted for in the model, and the effects of culture, gender, and context etc. are unknown (Barkley, 1997).

Willcutt, Doyle, Nigg, Faraone & Pennington (2005) conducted a meta-analysis of research into executive functions which revealed significant differences between ADHD and control groups in all areas of executive function. The meta-analysis is

criticised for differences between research in methodology and sampling including the extent to which other factors were controlled for (comorbidity of other disorders, subtype of ADHD etc.) and the nature of participant recruitment (clinic or community samples), and the writers conclude that there is no support for the hypothesis that executive function deficits are the single cause of ADHD (Willcutt et al, 2005).

In contrast to Barkley's model, Sonuga-Barke (2002) describes a behavioural theory. The delay aversion model assumes that ADHD behaviours are functional expressions of an underlying motivational style; children with ADHD are motivated to escape or avoid delay. The model predicts that when faced with a choice between immediacy and delay, children will choose immediacy (Sonuga-Barke, 2002). Sonuga-Barke (2002) describes an evidence-base in support of the delay aversion model which has subsequently been interpreted as confirmatory for the deficient inhibitory control model. This highlights the subjective and complex nature of investigating 'causes' of ADHD and how research is subject to interpretation by different schools of thought.

Models of ADHD may provide useful conceptualisations of the disorder in medical research, however, they should be interpreted with caution and regarded as working hypotheses as evidence continues to be gathered to support and refute them.

1.2.4 Outcomes

Research has explored the academic, social and affective outcomes of ADHD, but it is worth noting some of the difficulties associated with measuring them as a pretext for the validity of the findings. Diagnosis is problematic; as a clinical label with no biological markers, diagnosis is applied to children on the basis of expert opinion and a collection of subjective reports about a child's symptoms (Nylund, 2000). Therefore, it is possible that some children are given the ADHD label and do not have it (Stein, 2007). In addition, the high level of comorbidity with other disorders gives rise to sampling dilemmas in research (Stein, 2007). If children with other disorders are included, the findings may not be attributable to ADHD and if they are excluded, then studies are not representative (Stein, 2007). Finally, there is little longitudinal research conducted on population-based samples making little generalisable information about outcomes (Stein, 2007).

The complicated issues associated with detangling inherent ADHD symptoms from those that occur as a result of interaction with the environment is viewed as an important step towards understanding the aetiology of the disorder and the nature of the different subtypes. The NICE (2009) guidelines outline research which suggests that distracting environments reduce on-task behaviour, and that children with ADHD find 'idle time' more difficult to manage. Nylund (2000) also highlights the importance of considering environmental factors such as teaching and learning styles, class size and stress in the assessment of children's behaviour and criticises the DSM-IV criteria for failing to invite clinicians in exploring multiple causes. This

work is by no means complete, and in the meantime, remains a limitation to conducting robust research into ADHD.

Loe & Feldman (2007) describe the educational and academic difficulties which children and young people with ADHD experience. Full-scale IQ has been found to be lower than controls, but on average, within the normal range (there is not space here to discuss the use of cognitive testing but it is worth noting that children with ADHD may behave differently to controls during such tests). In addition, children with ADHD score significantly lower on reading and arithmetic achievement tests than controls. Children with ADHD also have a higher use of support services and placement in special education classes, and are more likely to be excluded (Loe & Feldman, 2007). In an academic persistence task, normally achieving boys with ADHD performed worse than controls and were measured as being less effortful and co-operative (Hoza, Pelham, Waschbusch, Kipp & Owens, 2001).

Outcome studies give little reference to individual variability among children with ADHD, apart from noting sub-types as a variable. Nylund (2001) discusses the need to explore variability among children and their differing reactions to environmental factors in order to identify triggers for symptom presentation, this is viewed as more helpful than trying to discover biochemical differences and describe the “ADHD brain” (Nylund, 2001. p.22)

Social outcomes have been studied using school samples. Social difficulties among the ADHD population are extremely common (Hoza 2007a), and a study looking at peer status found that 80% of children with ADHD fell into the 'rejected' category and less than 1% were of 'popular' status (Hoza, Mrug, Gerdes, Hinshaw, Bokowski, Gold et al, 2005). In the same study, children viewed themselves as more socially effective than their peers did (Hoza et al, 2005). Despite the large sample used in the study, the control group was only matched on gender and age and did not account for other learning or social difficulties.

Treuting & Hinshaw (2001) noted that some children with ADHD present aggressive behaviour, which is likely to impact on their experiences of peer relations. In addition, boys with ADHD, sub typed aggressive, reported more depressive symptoms than their non-ADHD peers. The study also examined self-esteem among boys with ADHD and found that aggressive subtype boys reported lower self-esteem than non-aggressive ADHD boys. (Treuting & Hinshaw, 2001). Children and young people's experiences of ADHD and self-esteem will be discussed in more detail in a later section.

1.2.5 Treatments for ADHD

NICE (2009) recommend that drug-treatment is used for children with severe ADHD, and that it should not be a first-line treatment for those with moderate impairment. In addition, NICE (2009) recommend parent training/education programmes and individual psychological interventions for older adolescents.

Recommendations are also made on environmental adaptations to school and home, including reducing distractions and providing stimulation for 'idle times'.

Methylphenidate (Ritalin) accounts for more than 90% of the stimulant treatment for ADHD in the US (Goldman et al, 1998) and has been found to be effective in reducing core symptoms of ADHD. Functional improvements in classroom behaviour and academic performance have been noted, in addition to reductions in oppositional and aggressive behaviours and increased social skills and participation (Goldman et al, 1998).

The Multimodal Treatment Study (MTA, 1999) was a randomised clinical trial establishing the effects of medication, behavioural management, combined treatment and community care over 14 months in the US. Results showed that combined treatment and medication were more effective than behavioural interventions and community care in reducing symptoms. However, the combined treatment did not produce significantly greater benefits than medication alone (MTA, 1999). There were few significant differences between treatments in functional skills such as oppositional/aggressive behaviours, internalising symptoms, social skills, child-parent relations and academic achievements (MTA, 1999).

Limitations of the study included a failure to detail community care treatment (medication doses and intensity of behavioural programmes are likely to have

differed) and comorbidities were not controlled for (MTA, 1999). Hinshaw (2007) suggests that comorbidities with anxiety disorders predicts a preferential response to behavioural treatment. Furthermore, there is evidence to suggest that children whose parents show depressive symptoms and children with low IQ scores are less likely to have excellent responses to treatment (Hinshaw, 2007).

In an analysis of the findings from the MTA study, socioeconomic status (SES) was found to effect treatment outcomes (MTA, 2002). In the combined treatment group, children from more educated families showed greater reduction in ADHD symptoms. Children from lower SES benefited most from the combined programme on oppositional/aggressive symptoms, whereas children from higher SES households showed no differential treatment response.

Hoza, Kaiser & Hurt (2007b) outlined the difficulties associated with evaluating the effectiveness of multimodal treatments: 1) sequencing of dosage and treatments being combined and compared; 2) drawing valid conclusions about individual components of treatment when packages are employed; 3) use of measurement tools for assessing outcomes; 4) reaching a summary conclusion when multiple outcome measures yielding conflicting results are used.

The core symptoms and secondary effects of ADHD are measured to inform the planning and evaluation of treatments but Cunningham (2007) proposes that

greater attention should be paid to parenting and family factors. In a review of studies, Cunningham (2007) identifies factors which are measurable, associated with ADHD and determine long-term outcomes for children and their families: daily living; participation; social relationships; parental knowledge; attributions for behaviour; and readiness for change. This view is supported by Hoza et al (2007b), who propose measuring functional problems and returning to functional behaviour analysis. This notion suggests an acknowledgement of the complex and contextually sensitive nature of ADHD which indicates a shift away from a purely biological basis and recognises numerous factors which key stakeholders would view as important in measuring outcomes for children.

Common side-effects of medication are insomnia, decreased appetite, stomach-ache, headache and jitteriness (Goldman et al, 1998). However, these were reported by less than half the children in one study, where the mean severity was in the mild range (Barkley, Murray, Edelbrock & Robbins, 1990).

A more severe concern than immediate side-effects (which can be addressed by adjusting dosage and type of medication (Goldman et al, 1998)) is the risk of drug-abuse based on the idea that psychostimulants may induce changes in the brain that could predispose individuals to drug-abuse (Barkley, Cook, Dulcan, Campbell, Prior & Atkins et al, 2002). However, the evidence is unclear and researchers hypothesise that problems with drug-abuse are due to conduct disorder rather than

ADHD (Barkley, Fischer, Smallish & Fletcher, 2003; Volkow & Insel, 2003).

Furthermore, evidence has focused on cocaine use and does not make conclusions about nicotine or alcohol (Volkow & Insel, 2003).

There is considerably less research into treatment efficacy in Britain. Orford (1998) argues that ADHD is over-diagnosed and as a result, treatments to address the underlying causes of ADHD will not benefit the child. In contrast however, Kewley (1998) states that in 1995, 6000 children in Britain were being treated with psychostimulants which was 0.03% of school children, a fraction of those affected by ADHD, but this figure is reported to have risen to 208,000 in 2002 (Radcliffe & Timimi, 2004). The controversial nature of ADHD and medication continues to be debated in academia and in the media. This is important to consider when focusing on how children and parents experience treatment.

1.3 Adult and Peer perceptions of ADHD

The aim of this section is to explore the ways in which adults (parents and professionals) and peers experience ADHD in children. It is important to consider the attributions (mechanisms through which individuals judge the causality of behaviours) and perceptions of these groups in order to begin to understand how ADHD is viewed and what impact those views may have on children with ADHD, and the treatments they receive.

1.3.1 Attributions of causes of ADHD, behaviour and medication

Parental and child attributions of behaviour and causes of ADHD have been studied in order to gain a greater understanding of how the disorder is viewed and the responses which parents may have towards negative and positive behaviours. Reimers, Wacker, Derby & Cooper (1995) note that considering how children and their families understand their behaviour and its causes is crucial in developing effective strategies for managing those behaviours. Furthermore, the causal explanations parents make about their children's behaviour impact upon their own emotional and behavioural response to the child, influencing long-term family relationships (Miller, 1995).

Saltmarsh, McDougall & Downey (2005) compared the parental attributions and emotional responses to different types of child behaviours to parents of children with ADHD and a control group of parents with children with emotional and behavioural difficulties (EBD). They found that both groups of parents attributed

the main causal factor of positive and negative behaviours to the child themselves. In addition, both groups viewed their child as in control of their positive behaviour. Interestingly however, in contrast to control parents, parents of children with ADHD viewed their child's oppositional-defiant behaviour as unintentional and symptomatic of ADHD (Saltmarsh et al, 2005).

A study exploring parental attributions of behaviour when children were on and off medication found that mothers perceived the cause of positive social behaviour as being more internal to the child, more stable and more global than when the child was not medicated (Johnston, Fine, Weiss, Weiss, Weiss & Freeman, 2000). In contrast, mothers viewed the causality of negative behaviours as less internal to the child, less global and less stable when the child was medicated compared to not medicated. Negative behaviours were viewed as more controllable by the child when they were medicated and this may lead to parents reacting more harshly to negative behaviours when the child is on medication compared to when they are off medication (Johnston et al, 2000). In the same study, children gave attributions for their own behaviours in medicated and non-medicated conditions and reported fewer differences than their parents but viewed their compliance as more controllable when medicated.

Johnston et al's (2000) study used a variety of measures to elicit the attributions of children and parents although the method used to identify real-life situations relied

on the mothers recalling events. There are limitations to the method as it requires accurate recall of appropriate events to measure, and when parents know the dimensions against which they will rate the incident, it may bias the event they choose to report (Johnston et al, 2000). In addition, the study did not account for an expectancy effect (Johnston et al, 2000). There is concern among some writers that pharmacological treatment gives children with ADHD a cognitive schema in which they make 'pill attributions' rather than effort attributions for success (e.g. Henker & Whalen, 1989). This may therefore lead to children's lack of persistence in difficult situations and a reliance on medication to complete tasks or behave appropriately (Pelham, Hoza, Kipp, Gnagy & Trane 1997).

Two studies of expectancy effects of children with ADHD showed that medication expectancy has no effect on academic performance or behaviour (Pelham, Hoza, Pillow, Gnagy, Kipp & Greiner et al, 2002; Pelham et al, 1997). Children were found to make internal attributions for success on an academic task and external attributions for failure and all participants reported the same initial inflated optimism about the task and their abilities (Pelham et al, 1997). Limitations of the earlier study of small sample size and lack of acknowledgement of individual differences were addressed in the later study and results were replicated.

In response to the concern about a reliance on medication for success, Pelham et al (2002) conclude that children perform better when on medication, but continue to

maintain a positive illusory style which causes them to take the credit for treatment-induced success. They suggest that this may result in adolescents believing that they do not need medication for continued success and stop taking it resulting in negative outcomes (this will be discussed in the next section).

The evidence shows that interactions between parents, teachers and children are likely to be affected by the attributions they place on academic performance and behaviour in children with ADHD and are of up most importance when considering the dialogue between those groups about how to best manage and reduce symptoms of ADHD.

1.3.2 Parents' perceptions of ADHD

Studies exploring parental perceptions of ADHD have been conducted in the US, Canada, Australia and Britain (to a lesser extent) in an attempt to explore the social context around ADHD and how they may impact on children's treatment (Johnston, Siepp, Hommerson, Hoza & Fine, 2005). One study found that primary treatments (behaviour management and medication) were rated as above average in effectiveness. Half of the parents sampled in the survey reported using alternate treatments (diet and vitamins) and a quarter used child/family psychotherapy and rated them below average in effectiveness (Johnston et al, 2005). In addition, parents gave the strongest endorsement to behaviour management and parent training but low levels of endorsement to beliefs that ADHD is caused by psychological factors. However, parents opting for less empirically-based

treatments were more likely to view ADHD as dispositional to the child (Johnston et al, 2005). This view was echoed by Harbourne, Wolpert & Clare (2004) who found that it resulted in parents feeling blamed and experiencing emotional distress.

Johnston et al's (2005) study is informative in developing an understanding of the relationship between parental knowledge and attitudes about ADHD and their chosen treatments. However, the sample was self-selecting and may therefore not reflect typical views of all parents. Furthermore, the direction of the relationship between attitudes and treatment choice cannot be inferred as parents already had experience of different treatments prior to completion of the survey.

A similar survey-based study elicited parental perceptions and satisfaction with medication, and compared the views between white and non-white parents in the US. Non-white parents were less likely to recommend medication and were less satisfied with it overall (Dosreis, Zito, Safer, Soeken, Mitchell & Ellwood, 2003). They also believed that sugar influences hyperactive behaviour, medication leads to drug abuse and medication has bad side-effects more than white parents. In the same study, most parents, regardless of race/ethnicity believed that the long-term benefits of medication had been established. Two-thirds of parents in the study reported satisfaction with the improvement in their child's self-esteem, but a quarter gave neutral responses with regard to improvement in social relations with family and peers (Dosreis et al, 2003).

Dosreis et al's (2003) study clearly has implications for clinicians, parents and children from different racial/ethnic backgrounds as well as demonstrating a number of parental misconceptions about stimulant use. However, it is important to note that the attitudes and beliefs of parents from different countries may differ significantly to those in Britain and therefore, generalising the findings of such studies should be done with considerable caution. Further limitations of the study reflect typical methodological issues in this area in terms of using a self-selecting sample recruited on a voluntary basis. The authors also note a potential recall bias as the survey relied on parents recalling accurate information about their child's treatment. They also caution against a social desirability bias influencing reports towards more positive responses (Dosreis et al, 2003). Finally, the study is a reflection of parental satisfaction with medication at one point in time which highlights the need for more long-term investigation to be carried out.

Charach, Skyba, Cook & Antle (2006) explored the complexities of issues around medication. Parents reported initial confusion and guilt about their child's behavioural problems and needed time to adjust to the diagnosis and possible medication. Charach et al (2006) suggest that the confusion experienced by parents results from multiple conflicting messages from family, educators, medics and the media. In addition, parental concerns around stigmatisation contribute to a reluctance to accept the diagnosis and treatment. However, all parents reported the desire to do what is best for their child balancing adverse effects of medication with the benefits.

Segal (2001) interviewed mothers of children with ADHD and found that they fell into two categories, no-delay mothers who sought diagnosis and assistance early on and long-delay mothers who were given unhelpful labels (typically 'hyperactive') from professionals who did not know/understand them, leaving mothers feeling bewildered and unable to access support (Segal, 2001). Both groups experienced stresses and griefs associated with parenting their children and the idea of professional parenting was identified (skilled parenting to manage behaviour) (Segal, 2001). As a result of her findings, Segal (2001) highlights the importance of early diagnosis and help-seeking for parent's to be able to manage their children.

Some studies have compared parental perceptions of ADHD with child perceptions (e.g. Efron, Jarman & Barker, 1998; Gerdes, Hoza & Pelham, 2003; McNeal, Roberts & Barone, 2000). Efron et al (1998) found that there was poor agreement between parents' and children's perceptions of medication effects, whereby parents rated the child as a 'responder' and the child rated themselves as a 'nonresponder'.

McNeal et al (2000) also used questionnaires with mothers and children and found that mothers viewed medication as more beneficial than their children. Mothers were also found to be more knowledgeable about medication than their children.

Gerdes et al (2003) explored perceptions of family relations and found that parents of boys with ADHD viewed their relationships more negatively than parents of control boys and boys with ADHD viewed their relationship with their parents more positively than their parents did. The differences in perception between parents

and children are important in terms of seeking diagnosis and treatment and will be discussed in terms of informant discrepancies in a later section.

1.3.3 Peer perceptions of ADHD

The issue around labelling was explored among non-ADHD children who were asked to rate their attitudes and behavioural intentions towards a fictional peer presenting symptoms of ADHD (Law, Sinclair & Fraser, 2007). The study investigated whether the addition of the ADHD label made any difference to peer perceptions. Results showed that the majority of the children perceived the fictional child as male and that he was described negatively (careless, lonely, crazy and stupid). The addition of the ADHD label was found to have no effect on children's attitudes or behavioural intentions, suggesting that they responded only to the externalising behaviours, or that they were not familiar with the term (Law et al, 2007).

Law et al's (2007) study is criticised on the methodology in terms of providing a measure of children's reported intentions towards a fictional child rather than actual behaviour towards a real peer. In addition, the researchers note that the vignettes used did not contain any positive characteristics about the child.

Therefore, it is possible that the children in the sample would more readily endorse the negative qualities of the child and report a lower level of engagement. The study does, however, support the findings of Hoza et al (2005) who used real-life situations and found children with ADHD to be rated as 'rejected' by their peers.

The research into peer perceptions of ADHD demonstrates that children respond to externalising symptoms of the condition and think about how a child displaying ADHD-type behaviours will impact on them rather than the label of ADHD. However, it is not possible to separate the diagnostic label from the behaviours, which may result in children associating the term 'ADHD' with someone they would not wish to be friends with at school.

1.3.4 The Discourse Concept – a critical view of the ADHD concept

In exploring ADHD as a phenomenon and considering the ways in which people perceive and talk about it, it is important to consider the notion of discourse to offer a way of understanding concepts. Gee (1996) defines a discourse as:

[a] socially accepted association among ways of using language, other symbolic expressions, and “artefacts” of thinking, feeling, believing, valuing and acting that can be used to identify oneself as a member of a socially meaningful group or “social network” or to signal (that one is playing) a socially meaningful role (pp.131)

This definition of discourse assumes that language use produces group and individual identities and that it is reflective of human consciousness (Danforth & Navarro, 2001). Gee (1996) also identifies the concept of a “dominant discourse” referring to language and conceptualisations which are granted importance in a culture above alternative frameworks (Danforth & Navarro, 2001).

It is helpful within the context of the current study to consider the discourses which have been used in reference to ADHD previously and more recently in order to gain

an understanding of where children's and adults' perceptions of ADHD have come from, how they are maintained and how they possibly affect treatment of children in school and at home.

Current psychiatric practice seeks to identify disorders in individuals presenting difficulties and uses diagnostic criteria in order to apply a label. Once 'labelled', the individual can then undergo the prescribed treatment deemed most appropriate for a person with that diagnosis. Because of this approach to 'mental illness' (ADHD included) the dominant discourse which has surrounded ADHD is the medical discourse. This means that ADHD, along with other psychiatric diagnoses is viewed as a medical disorder, with a biological or genetic basis and therefore treatable (Bentall, 2009).

The construction of ADHD has changed over the last century since it was first described by George Still in 1902 as a 'defect in moral control'. This indicates an emphasis on moral development, and perhaps social factors we viewed as causal. Later on, a medical discourse was dominant, but the Diagnostic Manual of Mental Disorders (DSM-II, APA, 1968) attempted to move away from thinking about the symptoms as a result of brain damage towards a behavioural perspective, using the term 'hyperkinetic reaction of childhood' (Barkley, 2005). In the 1980s, the third revision of the DSM (DSM-III, APA, 1980) emphasised a cognitive and developmental nature of the disorder (Barkley, 2005) and ADHD was used as a diagnostic term. The

most recent revision of the DSM (DSM-IVR; APA, 2000) identifies three subtypes of ADHD; predominantly inattentive; predominantly hyperactive-impulsive; combined. This position reflects the medical discourse as dominant and research into the aetiology of the disorder is thought to support this position.

Children's perceptions of ADHD have not been studied in depth over this period of time, so it is difficult to make note of how they have changed or developed. However, research carried out in 1982 revealed that children diagnosed as 'hyperactive' presented low self-esteem and external locus of control (as a result of stimulant medication) (Linn & Hodge, 1982). Moreover, in the same year, a sample of hyperactive children who had been medicated expressed a dislike for their stimulant medication (Sleator, Ullmann & Neumann, 1982). These studies reflect the pervasive medical discourse which has been dominant for some decades.

More recently, there has been an attempt to challenge the medical discourse with the belief that ADHD is not a valid diagnosis, but rather a social or cultural construct (e.g. Radcliffe & Timimi, 2004). Challengers to the medical discourse argue that the diagnostic process is subjective with the absence of biological marker to identify the condition (Radcliffe & Timimi, 2004). Moreover, Nylund (2000) refutes the biological evidence on the basis of misleading media coverage and a lack of publication of contrary findings. Maras, Redmayne, Hall, Braithwaite and Prior (1997) researched the perceptions of ADHD among a group of educational professionals (including

teachers, governors and EPs) and reported that some held the view that ADHD is not a valid concept and that the label has been used to medicalise behaviours.

Bentall (2009) argues against the validity and utility of psychiatric diagnosis more broadly. He states that the medical model is based on the assumption of 'disease of the brain' and it therefore limits the approaches and interventions which maybe used for individuals. Similarly, McDermott (1996) argues for viewing children and young people within their contexts and for resistance to allowing labelling to take over and destroy their lives.

For the purposes of reviewing the literature, perceptions of ADHD are explored as a phenomenon. The discussion around ADHD as a valid label or socially constructed concept is raised again in the empirical paper when considering the results of the current study and implications to the research field and EP practice.

1.4 Children's perceptions of ADHD

Having considered the nature of ADHD and the way in which it is perceived by adults and peers, the child's view of their own ADHD can be explored. From diagnosis to treatment, children are examined and their behaviour analysed by family members, teachers and medical professionals to determine the nature of their condition. The way in which children experience this process is vital to consider in planning effective procedures and treatments (Reimers et al, 1995).

The aim of this section is to review the studies which demonstrate how children experience life with ADHD and treatments. In addition, there is a consideration of how diagnosis and treatment impact on children's self-concept. This is relevant to parents and professionals in order to ensure that children can develop and maintain appropriate and positive self-images and view themselves as valuable members of learning communities and social worlds who have a positive contribution to make.

1.4.1 Diagnosis

Research into children's perceptions of their ADHD began in 1998 with Cooper & Shea's qualitative study where 16 young people (11-16yrs) were interviewed about perceptions of their behaviour, understanding of the nature of ADHD and attitudes towards intervention. An overall theme expressed by participants was 'harmful dysfunction' in terms of behaviour. More specifically, the young people described the following: being disruptive (having difficulty controlling verbal loudness and feelings of anger and frustration); impulsive oppositionality (behavioural outbursts

described as involuntary reactions to internal stressors); dangerousness; concentration problems; and academic issues (literacy difficulties, a sense of failure but also some creative benefits) (Cooper & Shea, 1998).

Young people responded negatively towards their diagnosis particularly towards the perceived stigmatising effect. (Cooper & Shea, 1998). However, one young person identified it as less stigmatising than the lay label given to her by her peers (mad), resulting in a feeling that there was an explanatory factor to her presenting symptoms (Cooper & Shea, 1998).

Further studies have addressed children's experiences of ADHD, many of which (similarly to Cooper & Shea, 1998) have been carried out in Britain (e.g. Arora & Mackey, 2004; Hughes, 2007; Travell & Visser, 2006). Arora & Mackey interviewed (using a variety of activities) participants aged 8-15 years old about their ADHD. They found a strong biological basis for ADHD was reported; describing 'brain disorder, injury to the head, heart murmur, something in the blood and disease' (Arora & Mackey, 2004). A biological cause of ADHD was also found by Travell & Visser (2006).

Participants in Arora & Mackey's study reported negative behaviours from mild to severe. However, children did not report that the diagnosis had an impact on experiences at school or home – they expressed feeling stigmatised by the

behavioural difficulties, and experienced lay terms 'mad, angry, bad, naughty and hyper' (Arora & Mackey, 2004). This reflects the findings of Law et al (2007) that children respond to externalising behaviours more than the label.

The ADHD diagnosis is viewed as unhelpful by some writers (e.g. Nylund, 2000) who raise concern that it will inhibit the child and family from feeling able to manage their symptoms. The research into this area shows mixed views from children about their diagnosis and it is therefore important for practitioners to recognise positive and negative views in the diagnostic process.

1.4.2 Treatment

Studies exploring children's perceptions and attitudes towards treatment only investigate the use of medication. This is likely to be because other treatments such as environmental adjustments and behaviour management strategies are used with a child, perhaps without them having an awareness of being 'treated'. The use of medication requires compliance from the child and they are likely to have an awareness (broadly speaking) about the function of it.

Ascertaining children's views about their treatment is important because it helps to contextualise the issues around how children's needs can be best met by the decision-making professionals (Arora & Mackey, 2004). In their qualitative study, Travell & Visser (2006) elicited views about medication and found that participants

reported ambivalent feelings. There were some feelings of relief that behaviour and school work were improved, but also worry about taking tablets and stigmatisation. Cooper & Shea (1998) identified the mixed feelings about medication as a 'trade-off' between formal (educational) and personal goals. Medication was viewed positively because it enabled young people to succeed in areas where they had previously failed, but, the success involved making personal changes that sometimes led to feelings of discomfort. Participants reported concern that medication affected their spontaneity (Cooper & Shea, 1998).

Children in Arora & Mackey's (2004) study were found to have more neutral attitudes towards their medication, but reported that they would be happier if they did not have to take it. Singh (2007a) found among 8-12-year-olds that children presented a happy/sad binary on and off medication (where 'on medication' would be happy).

Using questionnaires to elicit perceptions, Efron et al (1998) found that a majority of children viewed medication effects favourably. However, the study compared attitudes towards two types of medication (methylphenidate and dexamphetamine) and found that there was a relatively large number of children who reported negative feelings towards them – 13% and 19% respectively. The study identified side-effects as the main reason for adverse responses. Children

reported problems getting to sleep, headaches and ‘feeling funny’ as the side-effects (Efron et al, 1998).

Further use of questionnaire measures has identified a positive correlation between children’s perceptions of their medication and their level of ‘illness concern’ (worry about the disorder, measured by items such as *“I worry that I will not listen very well if I don’t take my medication”*) (McNeal et al, 2000). The authors suggest however, that this effect may not be sustainable over longer periods of time and children may view their medication as less beneficial the longer they are on it. In addition, 51% of the children sampled in the study did not view their disorder as an illness, and thus, not requiring medication.

Children describe the function of medication as having the power to alter ‘naughty’, ‘bad’, ‘angry’, ‘moody’ and ‘noisy’ behaviour, (Arora & Mackey, 2004) make them feel more calm and increase concentration (Arora & Mackey, 2004; Cooper & Shea, 1998). In a study including younger children’s perspectives, children reported being able to ‘play nicely’, focus and listen to what was being asked of them whilst on medication. They reported fighting, getting into trouble, breaking things and scribbling outside the lines when off medication (Singh, 2007a). In Arora & Mackey’s study, children were asked what would happen if they didn’t take their tablet; levels of dependency were commonly reported in terms of ‘needing’ it. The level of understanding of how the medication worked appeared to be limited, though children reported a controlling effect.

The theme of control appears in a number of the qualitative studies. Travell & Visser (2006) report an attitude that medication controls behaviour: *"tablets are taking over me...the tablets are in control of me"* (p.211). This was also found in responses from Cooper & Shea's study whereby medication was viewed as having a controlling effect on behaviour, but that whilst some participants welcomed it others rejected or resisted it in an attempt to maintain their own control (Cooper & Shea, 1998). The notion of control was less clear-cut in the findings of Singh's (2007a) study. There was a view from children that their brains need medication to control their behaviour. However, they also expressed other reasons for their lack of control in a moral dimension of not wanting to control it. This perspective offers a more complex insight into children's experiences of control and their desire to maintain it.

The idea that children experience their medication as controlling may impact on their self-efficacy. When asked about the future, some young people thought that they would always have ADHD, and would always have to take medication (Travell & Visser, 2006). This view raises questions around the function of treatment and how well-equipped it leaves people to draw upon their own resources to solve problems (Travell & Visser, 2006). Arora & Mackey (2004) found however, that a majority of the children they interviewed thought that they would not need medication in adulthood due to some natural maturing process, including having more control over their behaviour.

Travell & Visser (2006) draw attention to the idea of a 'window of opportunity' whereby medication enhances a child's attention and concentration so that work can be done with the child to increase their skills in managing their own behaviour for when they are not medicated. However, the qualitative research outlined does not indicate that children feel a sense of the medication giving the opportunity for building their capacity to cope with future situations without it. It is interesting to note that any attempts to elicit children's views about their treatment have focused on medication. There has not been any research into how children experience other treatments. This may be reflection of children having less awareness of behavioural and parenting interventions being used. It would be important however, to explore whether children are aware of other treatments which they are receiving, or could have access to.

1.4.3 ADHD and self-concept

Singh (2007a) explored children's sense of self with particular reference to their medication within an ethical context. The concern being that medication may in some way mask or alter the character of a child. When talking to children about a sense of being good or bad, Singh identifies a tension which children experience when doing something bad but feeling good about it – an 'off-medication' experience. However, these feelings were recognised by the children as being inappropriate, and they may then feel bad about themselves.

Singh (2007a) explores 'authentic self' as the innate dimension to a person, or natural character, whilst acknowledging gene-environment interactions. She found that children's self-evaluations appeared to be structured by their ADHD diagnosis and the on/off conditions of medication. A majority of children in this study felt that at their core, there was a consistent 'badness', which medication could overcome to a degree. The findings of the study conclude that stimulant medication for ADHD does not mask the authentic self. However, when a child maintains a sense of self which is bad there are more complex ethical considerations about how far they should be encouraged to value and maintain it.

Hester (2007) questions the decision to interview children whilst they were on medication and what their responses may be if they were off medication at the time of interview. Singh (2007b) states that medication aids children's capacity to communicate more effectively for longer periods of time, which aided her own interviews. She also suggests that deeper self-understanding would not shift as a result of medication and so the view is that children would essentially have the same thoughts about their own selves (Singh, 2007b).

The binaries which children in Singh's (2007a) study identified within themselves fit with the idea of personal construct psychology (PCP) as a theory of personality whereby people construe the world in terms of opposites. Kelly's (1955) Fundamental Postulate is the main idea of his theory and states 'a person's

processes are psychologically channelised by the ways in which he anticipates events' (p.42). This describes human desire for personal meaning, which is achieved by perceiving similarities and themes in events, making predictions about those events and fostering anticipations about the future. The eleven corollaries set out in Kelly's (1955) theory detail the implications of humans as anticipating to make sense of their world. The application of personal construct theory offers an insight into understanding how a child understands or makes sense of their actions and self-concepts and PCP techniques can be used to elicit those constructs.

Cooper & Shea (1998) identify a theme around personal identity, though it is explored to a lesser extent. They note that students identify their un-medicated selves as their 'authentic selves' and that when on medication they are a new and different self. These findings suggest that individuals' experiences of medication are that they perceive it to alter their authentic self which is only presented in non-medicated conditions. These studies highlight an important discrepancy in the research given the ethical implications with medicating young people for symptoms of ADHD.

Cooper & Shea's (1998) study is criticised on being a small-scale study with difficulties in generalisability to a wider population. In addition, the lack of a standardised interview allows for a more subjective experience on the part of the interviewer and responses between participants cannot be directly compared.

However, qualitative studies are able to address the complexities of individuals' self-concepts and offer children the opportunity to talk more freely about their experiences.

The findings of Singh's (2007a) research that children report a negative self-image is in contrast to quantitative studies carried out as part of the MTA study which identifies a positive illusory bias among boys (i.e. overly optimistic self-perceptions) (Hoza, Waschbusch, Pelham, Molina & Milich, 2000).

Hoza, Pelham, Dobbs, Owens & Pillow (2002) measured children's self-perceptions of academic competence, social acceptance, athletic competence, physical appearance, behavioural conduct and global self-worth. Boys with ADHD were compared to control boys and teacher report data was also gathered to provide a baseline with which to compare boy's scores (criterion rater). Results from the study showed that boys with ADHD overestimated their self-perceptions more than controls did in academic, social and behavioural domains. In addition, they overestimated their competence in the areas in which they had greatest difficulty. The study also identified boys with ADHD experiencing depressive symptoms and found that they had lower domain-specific self-perceptions and global self-worth than control boys. Those without depressive symptoms did not differ significantly to control boys (Hoza et al, 2002).

The study supports the hypothesis of a positive illusory bias as a self-protecting function for boys with ADHD, allowing them to cope despite their experiences of failure. Even boys presenting depressive symptoms were found to inflate their perceptions of behavioural conduct – a primary area of deficit in ADHD. The researchers note that the measurement of children's self-concept remains complex and it is still unclear whether the inflated self-perceptions represent an attempt to present themselves favourably to others or if they are inaccurate perceptions. Of course, the latter suggestion is a subjective viewpoint as the 'inaccuracies' are measured against the perception of one criterion rater viewed as a more accurate source of information. A later study found also identified a positive illusory bias among girls (Hoza et al, 2004).

Hoza et al (2002) identify the need for longitudinal research to fully explore self-perceptions and identify where and when inflated perceptions may arise. In terms of sampling in quantitative research, comorbidity of depression, aggression and other disorders needs to be controlled for to be able to identify the effects of ADHD.

The exploration of self-concept among children with ADHD is vital in thinking about how they view their own abilities, strengths and weaknesses, and in considering how they are affected by the attributions they hold about their ADHD. By trying to understand how children with ADHD view themselves, it is hoped that a greater

insight into how diagnosis and treatment are viewed will be achieved. The beliefs which children have about the causes of their ADHD will have (as demonstrated by Singh, 2007a) an enormous bearing on their self-efficacy in managing their symptoms. This is important in being able to support children to maintain appropriate and positive views about themselves and in relation to their diagnosis and treatment.

1.5 Theoretical Framework

The aim of this section is to outline the theoretical framework which underpins the current study. As already discussed in previous sections, there are considerable differences in the perceptions of parents, professionals and children with ADHD. The theoretical framework is used to offer a model to understand why the differences exist, the relevance of acknowledging them and the implications on treatment outcomes.

1.5.1 Informant discrepancies

De los Reyes & Kazdin (2005) developed the Attribution Bias Context (ABC) model to theorise the nature of informant discrepancies and demonstrate the consequences of taking each perspective into account on assessment, classification and treatment of childhood psychopathology. There is no gold standard measure for ADHD and as a result, multiple informants are needed in the assessment of children. However, there are often discrepancies between reports which cause problems in identifying prevalence rates and classification of disorders, but also at an individual level, difficulties in identifying problems to target and planning of effective treatment (de los Reyes & Kazdin, 2005).

Discrepancies between adult and child perceptions and attributions have already been identified and discussed in previous sections (e.g. Efron et al, 1998; McNeal et al, 2000) and Hughes (2007) comments on the difficulties experienced when perspectives differ, similarly to those identified by de los Reyes & Kazdin (2005). In

addition however, she highlights a cautionary point about the impact that adults' conflicting perspectives may have on a child in terms of being confused and anxious. Hughes (2007) suggests that a lack of consensus among stakeholders results in a failure to identify and implement constructive and coherent intervention strategies, which in turn results in an over-reliance on medication. There clearly needs to be a greater understanding of the reasons for discrepancies in order to consider fully the impact they have on outcomes for the child.

The ABC model states that adults are more likely to attribute cause to the child's disposition and the child is more likely to attribute cause to the context or environment (de los Reyes & Kazdin, 2005). The model predicts that attributions of adult (observer) informants are similar to each other and discrepant to the child's (see Figure 1).

The ABC model also accounts for discrepant perspectives, whereby observer informants are more likely to view the child's problem as warranting treatment. In turn, this may cause observer informants to be more likely to access information of negative aspects of the child's behaviour from memory. The child is more likely to have the perspective that the environment needs to change. The ABC model therefore predicts that discrepancies in attribution and perspectives may lead to differences in the information about the child's behaviour that informants access

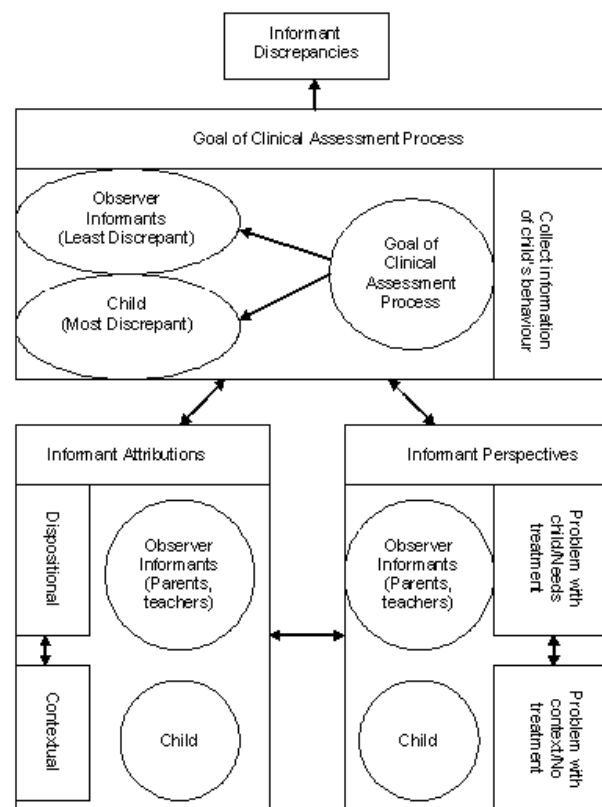


Figure 1 Conceptualisation of the ABC model. de los Reyes & Kazdin (2005, p. 496)

from memory and ultimately use to rate the child's levels of behavioural and emotional problems (de los Reyes & Kazdin, 2005).

The third component of the ABC model is the goal of the clinical assessment process. The purpose of clinical assessment is to gather information about the negative aspects of the child's behaviour in order to gauge whether treatment is warranted and then to plan it. The model posits that observer informants who view the problem as within-child and warranting treatment are more likely to report negative information and support the goal of the clinical assessment process than

the child. Finally, the ABC model predicts interactions between the three components to result in discrepant ratings of child psychopathology (de los Reyes & Kazdin, 2005).

Smith (2007) recommends that rater, method and child effects should be considered when making sense of multiple informants' perceptions. Rater effects, of parents and teachers include time spent with the child, feelings about the child and rater psychopathology. Smith (2007) highlights a number of studies which show a strong association between maternal depression and ratings of significant behaviour problems in children. He goes on to suggest that clinicians do consider rater effects, although the extent to which they are 'controlled' for is not stated.

Method effects also need to be considered in using multiple perspectives about childhood psychopathology. There are likely to be discrepancies when different measures are used to elicit information e.g. parent/teacher ratings and self-ratings for children (Smith, 2007). Clinicians are then met with a dilemma about which ratings to use.

Smith (2007) identifies three factors to be considered when addressing child effects; age, problem type and setting. The evidence to show the effect of age is not conclusive, with some research that children younger than 12 years do not add any further information than parental reports (Smith, 2007). More recently, however,

Karver (2006) found that parent-child agreement did not differ as a function of age. The evidence for problem-type (internalising or externalising) and setting (inpatient or outpatient) is considered difficult to differentiate, and is therefore reviewed together by Smith (2007). In summary, he reports that in non-referred samples, children report more internalising and externalising symptoms than their parents do, but in a clinical sample, children report more internalising symptoms and less externalising symptoms than their parents. There are issues around child motivation and what children are willing to report, given the situation they are in (i.e. they may report fewer externalising behaviours if it is felt it would have implications on increased length of detention, for example Smith, 2007). The evidence suggests therefore, that teachers and parents may be better placed to assess a child's behaviour, but that children will give more accurate reports of their own internalising symptoms (Smith, 2007).

The ABC model and the effects described by Smith (2007) offer a useful framework for considering the discrepancies among children, parents and teachers in perceptions of ADHD. They can be used to offer some insight into interpreting the different perspectives which are reported between and among observer informants and children. In addition, the model can be used to examine relationships between informant characteristics (e.g. child's age, type of problem, parental stress) and informant discrepancies. The purpose of researching children's experiences of ADHD has to be to inform the clinical process behind diagnosis and treatment. The ABC model, similarly to views shared by Hughes (2007) states that the discrepancies

in attribution, perspectives and the goal of the clinical process will ultimately hinder the effective planning of treatment in tackling a shared understanding of a target problem (de los Reyes & Kazdin, 2005). It is therefore vital to consider child perspectives in addition to those of parents and teachers in order to become aware of the discrepancies before steps can be taken to converge the perspectives to encourage greater success in all kinds of treatments.

1.6 Conclusion

The literature reviewed here outlines some of the many ongoing debates and concerns in ADHD research. There is considerable data evidencing core and secondary symptoms and numerous possibilities for aetiology. The research would appear to conclude that ADHD is a bio-psychosocial disorder with a number of factors contributing differently to each individual. Barkley's (1997) model concludes that response inhibition is the primary deficit in ADHD, and the date is upheld by some researchers as a valid explanation for ADHD and the model presented by Sonuga-Barke (2002) has a behavioural basis and there is a struggle to come up with endophenotypes (e.g. Castellanos & Tannock, 2002). Conversely, there is also a school of thought who questions the validity of ADHD (e.g. Nylund, 2002) in an attempt to challenge the medical model of diagnosing and treating such a 'disorder'.

The exploration of adult and child perspectives, attitudes and beliefs about ADHD reveals the many stories people hold about the disorder. It is perceived negatively with regard to the impact it has on children and parents' lives, it is also perceived as dispositional to the child and reactions to behaviour confirm this. Children with ADHD experience the symptoms as having a direct effect on their social relationships and academic performance.

One primary treatment to alleviate ADHD is medication, and the views towards it are varied between groups. Having an evidence-base to demonstrate its efficacy,

albeit short-term appears to have contributed to parental satisfaction with the use of it. Children present mixed feelings towards their medication in feeling that they are able to cope better when on it, but that they do not quite feel themselves. The narrative which surrounds a child in terms of taking medication and the effects of it are largely unexplored in the research.

The differences in opinion and perspective demonstrated by adults and children in the literature are discussed in terms of the ABC model as a framework for understanding informant discrepancies in childhood psychopathology. This framework provides the rationale for further investigation into children's perspectives of the ADHD: discrepancies in attributions and perspectives need to be identified in order to better understand the difficulties faced by clinical practitioners in planning and evaluating treatment. NICE (2009) highlight the importance of obtaining the child perspective in order to ensure a complete picture of the effects of treatment. Efron et al (1998) point out that children often find it difficult to verbalise their feelings and that to elicit such perspective requires considerable skill. The current study will endeavour to elicit child perspective by using a drawing technique in addition to interviewing in order to increase the quality of data obtained from child participants. The research will therefore demonstrate the effectiveness of using such drawing techniques with children, which could be of use in an applied setting for EPs and other adults working with children with ADHD.

The diagnosis and treatment of ADHD has a considerable and complex impact upon a child in terms of setting them apart from peers, which should be considered when evaluating views about treatment. The evidence for the impact of ADHD on self-concept is contrasting and negative self-concepts are reported alongside positive (but inflated) ones. Hester (2007) suggests that children should be encouraged to speak about their life experiences in terms of on and off medication and many of the studies reviewed have made attempts to report those views. The following study is an attempt to address some of the key concerns and questions around this area in the hope to contribute further understanding of children's experiences of ADHD and medication.

Section 2. Empirical Paper

Children and Teachers' perceptions of ADHD and medication: A qualitative study

2.1 Abstract

The purpose of this study is to explore children and teachers' perceptions of ADHD and medication, in order to contribute to a greater understanding of experiences and development of effective intervention strategies.

Perceptions of the children's teachers were explored and differences and similarities with child experiences were identified. The Attribution Bias Context model was used as the theoretical framework for the study. It makes predictions about adults' and children's attributions and perceptions of childhood psychopathology.

In this qualitative study, 5 children with ADHD were interviewed using respondent-style interviews and a drawing activity. The children's teachers were also interviewed. All data was analysed using techniques from grounded theory methodology.

Analysis of the children's data revealed a grounded theory of 'internalisation of the ADHD label', whereby children appeared to take on the diagnosis as a medical disorder and part of their identity. They experienced an external locus of control for their behaviours, which occurred in on/off conditions and were closely linked to emotional experiences.

Teacher interviews revealed a grounded theory of 'difference' and a medical discourse was used in their descriptions of the child's ADHD. The children's strengths were identified as attributes which were present in the absence of ADHD symptoms.

Results provide insight into children's and teachers' perceptions of ADHD and implications for further research and applied settings are discussed.

2.2 Introduction

The aim of this study is to explore children's and teachers' perceptions of ADHD and use methods from grounded theory to develop theory from the data. Gaining views of children and teachers is crucial for educational psychologists in an applied setting and the methodologies employed in this research fit closely with information gathering techniques an EP may use when working with children and teachers in school. The current study therefore makes an important contribution to the research field in illuminating the perceptions of children and teachers and applying findings to address implications for EP practice and approaches used by schools and teachers in supporting children with ADHD to manage their schooling and behaviour more effectively.

2.2.1 The Nature of ADHD

Attention Deficit Hyperactivity Disorder (ADHD) is characterised by inattention, hyperactivity and impulsivity (NICE, 2009). It affects 3-7% of the childhood population (Barkley, 1997), in a male to female ratio of 3:1 (American Psychiatric Association, 2000). The current guidance presented by the National Institute of Clinical Excellence (NICE) emphasises individual difference with ADHD whereby not every person presents all three core characteristics, and symptoms vary in severity. The DSM-IVR (APA, 2000) identifies three subtypes: predominantly inattentive; predominantly hyperactive-impulsive; and combined.

There is evidence to suggest that children diagnosed with ADHD also present comorbid disorders such as oppositional-defiant disorder or conduct disorder (30-

50%) (Biederman, Newcorn, Sprich & Slantez 1991); mood disorders (10-20%) (Goldman, Genel, Bezman & Slantez, 1998) and emotional and behavioural difficulties (EBD) (20-60%) (Dietz & Montagne, 2006). Outcomes of ADHD include educational and academic difficulties (Loe & Feldman, 2007) and social difficulties (Hoza, 2007a; Treuting & Hinshaw, 2001). Diagnosis of ADHD is made by psychiatrists basing their decision on judgements about accounts and observations of the child's behaviour. This raises questions about the validity of using such a label and highlights the social construction of the disorder. Rafalovich (2001) suggests that the ADHD child is constructed as a "disordered" mind against the backdrop of the "ordered" mind, which also supports Nylund's (2000) notion that descriptions of such 'disorders' are deficit saturated.

Research has endeavoured to locate a genetic basis of ADHD establishing it as heritable (75%) (Biederman & Faraone, 2005) and further investigation has focused on the biological basis of ADHD (Spencer, 2007) and neurobiological explanations (e.g. abnormalities in dopamine transmission) (Kirley, Hawi, Daly, McCaron, Mullins & Miller et al, 2002). Swanson, Kinsbourne, Nigg, Lanphear, Stefanotis & Volkow et al (2007) conclude that gene-environment interactions have been identified but the effects are minimal. However, Joseph (2000) raises caution about exploring genetic links of ADHD with the concern that further exploration of the disorder would be limited (Joseph, 2000). In addition, Bentall (2009) argues against the reliability and validity of biological and genetic evidence for psychiatric diagnoses and refutes the utility of such labels suggesting that they are of no use to the individual.

Nylund (2000) also challenges the view that ADHD has a biological root, and highlights difficulties in diagnosis (i.e. subjective diagnostic procedures, environmental factors, cultural bias, social and political pressures). Moreover, Stein (2007) concludes that some children may be diagnosed with ADHD who do not have it. The use of drug treatment upholds a biological cause of symptoms and is therefore questioned both in the evidence base and from an ethical position by those who challenge ADHD as a diagnosable disorder (e.g. Nylund, 2000).

2.2.2 Treatment of ADHD

NICE (2009) recommend pharmacological treatment for children with 'severe impairment' in addition to parenting programmes (NICE, 2009). There is some evidence to show that medication is effective in reducing ADHD symptoms and improving classroom behaviour and academic performance (Goldman et al, 1998). In addition to medication however, it is also important for adults to work with children on managing their behaviour in school in order for progress (social and academic) to be made (NICE, 2009).

EPs are well-placed to consult with teachers and teaching assistants on behaviour management techniques and to address needs which a functional analysis of a child's behaviour would reveal. For example a child may respond to having instructions broken down into small steps, or by using a visual timetable to support

them in understanding the structure of the day's activities. Learning breaks may be helpful as well the use of positive reinforcement techniques to maintain the child's engagement with tasks. By working to adapt the child's learning environment, adults are able to consider the contextual factors which may be impacting on the child's behaviour, thus reinforcing the idea that medication is not the single most important treatment available.

2.2.3 Perceptions of ADHD

Parents of children with ADHD have been found to attribute positive and negative behaviours to the child themselves however, oppositional-defiant behaviours are viewed as unintentional (Saltmarsh, McDougall & Downey, 2005). A study which included medication as a variable, found that parents viewed negative behaviours more harshly when the child was on medication than when they were off it (Johnston, Fine, Weiss, Weiss, Weiss & Freeman, 2000). This study relied on parents selecting and recalling appropriate events for analysis, and could be criticised on a potential selection bias.

Segal (2001) explored mother's experiences of parenting children with ADHD and highlighted difficulties experienced by mothers as stresses and griefs. She also demonstrated the importance of early diagnosis in order to offer support for parents and their children (Segal, 2001). The analysis carried out by Segal (2001) is, by its nature qualitative and therefore interpretative, as a result, the findings

reported in the study will reflect the preconceptions and experiences held by the researcher.

Using a grounded theory methodology, similarly to Segal (2001), Harbourne, Wolpert & Clare (2004) explored a concern voiced by parents where they maintained a biological basis for ADHD but felt that other adults considered the disorder to be related to psychological and social factors. This caused them to experience blame for their child's difficulties and resulted in emotional distress.

In a study exploring professional's (teachers, school governors, managers & administrators and educational psychologists) perceptions of ADHD, Maras, Redmayne, Hall, Braithwaite and Prior (1997) found that most respondents held the belief that children with ADHD have little control over their behaviour, and that there is a biological cause of ADHD. Some educational psychologists in the sample reported a belief that family, home and social factors are also causal (Maras et al, 1997). Maras et al (1997) used questionnaires to elicit responses from their participants. This may be problematic in terms of providing participants with a formal structure to follow in order to communicate their views; in this study there was no opportunity to discuss with participants or to further explore their views in order to provide a richer data of perceptions in contrast to the present study.

Studies eliciting parental views about medication found that parents believe that the long-term benefits of medication have been established (Dosreis, Zito, Safer, Soeken, Mitchell & Ellwood, 2002). A qualitative study explored the complex issues around decisions to medicate among parents, and found that parents reported confusion and guilt, as well as expressing a desire to make the best decision for their child (Charach, Skyba, Cook & Antle, 2006) and Johnston et al (2005) found that parents rated medication as above average in effectiveness. These studies focussing on parental attitudes towards medication make important contributions to the research providing both qualitative and quantitative data. However, they are criticised on their self-selecting samples and the possibility that the attitudes reported are not typical of all parents of children with ADHD. The recruitment difficulty applies to many research studies in the area and it remains important to consider whose views may not be accounted for in such research.

Cooper & Shea (1998) conducted a qualitative study of children's perceptions of ADHD in the UK. An overall theme of 'harmful dysfunction' was expressed by participants relating to the attentional and behavioural difficulties they experienced (Cooper & Shea, 1998). Furthermore, participants reported feelings about their diagnosis negatively, with reference to the perceived stigmatising effect of the label (Cooper & Shea, 1998). This finding was replicated by Arora & Mackey (2004), but positive views were reported where children express a sense of relief at things getting better as a result of a diagnosis (Travell & Visser, 2006). Children also report a strong biological basis for ADHD (Arora & Mackey, 2004; Travell & Visser, 2006) and Cooper & Shea (1998) identified a 'trade-off' which children reported where

medication was viewed positively in terms of helping improve socially and academically, but negatively when it was felt to affect individuals' spontaneity.

There continues to be a dearth in qualitative research into perceptions of ADHD, although the studies carried out to date offer important findings to the field. As pieces of qualitative work they are characterised by small samples and data gathering techniques which may not be standardised. As such these studies could be criticised on lack of generalisability, in particular ones that show the interpretations of the researchers alone. However, this is also the strength of such research as detailed in-depth information is gathered and researchers are able to use their analytical skills in interpreting the stories and experiences of participants in order to better inform the field and identify further ways forward to develop the research. Furthermore, they are able to evaluate how far the perceptions they gather correspond with the current dominant ADHD discourse.

Results of a questionnaire study showed that children viewed their medication positively, although there remained a large number who reported negative feelings due to side-effects (Efron, Jarman & Barker, 1998). Another questionnaire study concluded that compared to parents, children know less about their medication and report fewer benefits (McNeal, Roberts & Barone, 2000). These studies are, however, limited by the measures they use in obtaining views about medication, and possibly suffer from social desirability biases. Efron et al (1998) acknowledge

that children in their study may have given socially appropriate answers, or echo their parent's observations of their behaviour (i.e. reproducing a ADHD discourse). In addition, they also recognise the difficulties that some children in the study have with language, and therefore question the understanding participants had of the questionnaire items. This raises an important methodological point and supports the use of multiple techniques whereby the researcher is able to explore ideas with participants to ensure that their views are accurately reflected.

Children report that medication alters negative behaviour (Arora & Mackey, 2004), makes them feel calm and increases concentration (Arora & Mackey, 2004; Cooper & Shea, 1998) and negative behaviours increase when off medication (Singh, 2007a). Children were also shown to present a reliance on their medication (Arora & Mackey, 2004) and report a controlling effect (Arora & Mackey, 2004; Cooper & Shea, 1998; Travell & Visser, 2006). Again, the findings from these qualitative studies may be open to participants wishing to give socially desirable responses and thus reproducing the dominant ADHD discourse.

The 'control' theme is evident in many qualitative studies conducted in this area and was closely examined by Singh (2007a). The idea of medication as a controlling factor was thought to be more complex as children reported their brains needing medication in order to control behaviour, but that they also expressed a moral dimension of not always wanting to control their behaviour (Singh, 2007a). In the same study, Singh (2007a) found, that children considered themselves to maintain a core 'badness' which medication could only overcome to a degree. In contrast to

Singh's (2007a) findings that children maintain negative self-concepts, Hoza, Pelham, Dobbs, Owens and Pillow (2002) find support for a positive illusory bias among boys with ADHD, as a self-protecting function. Discrepancies in the research highlight the complex nature of eliciting views about the self, and differences in methodologies employed to do so.

2.2.3 Theoretical Framework

The theoretical framework for the current study provides a rationale for further exploration of children's perceptions. The Attribution Bias Context (ABC) model (de los Reyes & Kazdin, 2005) is used in the current study to offer an understanding of discrepancies between adults' and children's perspectives and the implications for treatment outcomes. The model states that adults are more likely to attribute the cause of the problem internally to the child and the child is more likely to attribute it to the environment (de los Reyes & Kazdin, 2005). The model makes predictions about perceptions; adults are more likely to perceive the problem warranting treatment, which makes them more likely to recall negative information about the child's behaviour. In contrast, the child is more likely to have the perception that the environment should change (de los Reyes & Kazdin, 2005).

The model identifies the goal of the clinical assessment process as gathering information and gauging whether the problem warrants treatment. Therefore, adults are more likely to report negative information than the child and support the goal of the clinical assessment process. The model predicts that an interaction from the three components (attributions, perspectives, goal of assessment process) can

result in discrepant ratings of child psychopathology (de los Reyes & Kazdin, 2005).

It provides a helpful framework for the current study as it emphasises the importance of discrepancies between reports and the possible implications for interventions.

2.2.4 Methodological Issues

Obtaining the child's story is not always given up most importance. Children may be viewed as "unreliable historians" (Nylund, 2000, p. 29). Darbyshire, Macdougall and Schiller (2005) note that institutions and professions often have an entrenched tradition of doing things 'to' children and their perspectives may not be taken seriously, or they would not be viewed as good research respondents. However, the NICE (2009) guidelines advise professionals to respect the knowledge and experience of ADHD that children have. The guidelines suggest that while standardised measures are helpful in the assessment process, they should not be used solely to determine a diagnosis (NICE, 2009). In addition, the criteria for diagnosing ADHD states that behaviours should be present in two settings (home and school), therefore highlighting the importance of gaining teacher's views in addition to the child's. Whilst the present study is not concerned with assessing for or diagnosing ADHD, it remains relevant to follow the same philosophies of current good practice in exploring the stories of children with ADHD and their teachers to gain rich pictures of their experiences, attitudes and perceptions in relation to diagnosis and medication in order to improve treatment effectiveness, and to

inform EP practice in supporting schools in managing behaviour and academic progress more positively.

The current study used multiple methods in eliciting children's views and perspectives on their ADHD. Darbyshire et al (2005) discuss the use of multiple methods and conclude that interviews, drawings and photographs can provide complimentary data. Similarly, Bradding & Horstman (1999) report on the success of using a drawing technique in conjunction with interviewing in order to provide rich data.

Arora and Mackey (2004) employed a range of activities to engage their child participants. In addition to talking they used a lifeline exercise, an exercise to elicit personal constructs (like me, not like me activity) and photographs to prompt discussions (Arora & Mackey, 2004). Arora and Mackey (2004) acknowledge that the battery of activities was helpful in engaging children who have short attention spans. Other research in this area has employed multiple methods including taking photographs, making lists and use of toys (e.g. Singh, 2007a).

Powney & Watts (1987) discuss the importance of using interviews as a tool to finding out about people. They suggest that interviews can be used to identify people's attitudes and can also contribute towards data collected from a number of sources in an attempt to describe a culture (Powney & Watts, 1987). Hughes (2007)

used the cognitive interview in order to enhance retrieval of events and describe situations from a variety of perspectives (Hughes, 2007). Semi-structured interviews employ an interview schedule and have also been used effectively in qualitative studies (e.g. Travell & Visser, 1996).

Powney and Watts (1987) categorise interviews into respondent and informant approaches. The primary difference between them is the level of control. In respondent interviews, the interviewer maintains control throughout the process and the purpose is to cover a set of questions determined by the interviewer (Powney & Watts, 1987). In contrast, the purpose of informant interviews is to gain some insight into the perceptions of an individual within a situation (Powney & Watts, 1987). The interviewee has the opportunity to explore certain issues in collaboration with the interviewer and it is 'unstructured' from the interviewer's point of view (Powney & Watts, 1987).

Cooper (1993) discusses the importance of eliciting 'authentic' responses from children. He suggests that informant interviews (Powney & Watts, 1987) are an effective way to elicit an authentic response and are achieved by using open ended questions, allowing the interviewee to shape the interview and avoiding interruptions or forcing the pace (Cooper, 1993). Cooper and Shea (1998) used informant style interviews and Segal (2001) used a narrative style of interview which started with one general question and no other planned structure. The use of

open questioning and a more exploratory approach of interviewing is therefore regarded as effective in eliciting authentic responses from participants.

In their research into children's views of hospitals Bradding and Horstman (1999) developed and evaluated the Draw and Write Technique as a methodology for qualitative data collection. Children are asked to draw a picture of a given topic and write about it if they wish. The technique is described as child friendly, non-threatening and facilitating the expression of child's views, preventing the adult from becoming continuously involved (Bradding & Horstman, 1999). In their critical appraisal of the technique, Backett-Milburn & McKie (1999) raise concern that data elicited from Draw and Write reflects the variety of context, setting and perceived demands, rather than absolute 'truths'. They also note caution against using projective techniques in analysis (whereby the child is assumed to have revealed their subconscious) (Backett-Milburn & McKie, 1999).

Moran (2001) developed 'Drawing the ideal self' as a technique based on the principles of personal construct psychology (PCP) (i.e. a theory of personality where individuals try to make sense of their world through dichotomies (Kelly, 1955)) to improve understanding of children's views in a therapist/client situation. The activity is used as an assessment tool and as a joint exploration of the child's attitudes and perceptions, as well as their views about their 'selves'. This approach is underpinned by the principle that the client is the expert of their own 'self' (Kelly,

1955). Other PCP-based activities have been used in research into children's views about themselves (e.g. Arora & Mackey, 2004; Singh, 2007) and drawing the ideal self was selected as an effective technique in the current study. The drawing technique is used alongside interviewing children in order to explore how the ADHD discourse is presented among the different methods and to avoid generation of standardised responses.

The current study uses grounded theory, a methodology developed for the purpose of building theory from data (Corbin & Strauss, 2008). Components of grounded theory practice include: simultaneous involvement in data collection and analysis; constructing inductive codes (concepts derived and developed from the data); using comparative methods at each stage of analysis; advancing theory development at each stage of analysis; memo-writing for defining categories, specifying purpose and identifying gaps; sampling for theory construction, not population representativeness; and conducting literature reviews after developing independent analysis (Charmaz, 2006). Leech & Onwuegbuzie (2008) cite grounded theory methods as appropriate in analysing interviews and drawings. Grounded theory methods are therefore appropriate for use in the current study as they can be used with both methods of data collection and allow theory to be developed from the data.

Charmaz (2008) describes grounded theory methods as flexible analytic guidelines which allow the researcher to focus data collection and build theories through successive levels of data analysis and conceptual development. She highlights the advantages of grounded theory methods as providing tools for the analytic process and allowing the researcher to stay close to the data in order to develop theoretical concepts (Charmaz, 2008). Corbin & Strauss (2008) describe a number of analytic tools used to facilitate the coding process (i.e. raising raw data to a conceptual level), including the use of questioning, making comparisons and looking at language etc. This therefore fits with the aim of the current study in exploring children's perceptions through interviews.

Grounded theory methods are used in order to explore rich data, but are criticised on small sample sizes and lack of generalisability (e.g. Harbourne et al, 2004). Further critique of grounded theory methods includes issues of subjectivity. Charmaz (2006) acknowledges this concern and discusses sensitising concepts as the contact a researcher has with the area of interest or context prior to starting investigation. Indeed, in their discussion of grounded theory methods, Harry, Sturges & Klingner (2005) recognise that such methods are inductive and therefore open to interpretation. They suggest, in the case of educational research that researchers will always hold views and insights about the context in which they are researching and that these grounded insights are part of the analytic process (Harry et al, 2005). In their critique of using grounded theory methods, Harry et al (2005) also recognise the process as time consuming, and recommend a smaller sample

size in order to complete quality analysis rather than having too much data to process which fits with the practical considerations and aims of the current study.

The present study utilises a grounded theory methodology and explores the following research question:

What are children's perceptions of their ADHD and medication?

What are teacher's perceptions of ADHD and medication?

2.3 Method

2.3.1 Design

The present research is an exploratory study of children's perceptions of their ADHD and medication using grounded theory methods. Five children were interviewed using informant-style interviews and a drawing activity. Each child's teacher was also interviewed about their perceptions of the child's ADHD and medication.

2.3.2 Participants

The original criteria for children to take part in the study were: attending mainstream school in key stage 2 (10 & 11 years old) with a diagnosis of ADHD; and taking medication for ADHD. Recruitment of children within mainstream schools in key stage 2 was problematic and the criteria was broadened to include children in key stage 3, and attending a special school for children with emotional and behavioural difficulties (EBD). Although the selection criteria for participants included girls, only boys were recruited, this reflects the representation of boys with ADHD diagnoses.

5 child participants were recruited for the study (see Table 1). In addition, all 5 children's teachers were recruited. A total of 10 participants took part in the study.

Child	Age (yrs)	Key Stage	School Type
A	10	2	Mainstream
B	12	3	EBD school
C	13	3	EBD school
D	11	2	EBD school
E	10	2	Mainstream

Table 1 Participants age and school

2.3.3 Measures

2.3.3.1 Interviews

Informant interviewing (Powney & Watts, 1987) was carried out with each child and teacher participant (see appendix A). The researcher explored issues with the child relating to their views about their ADHD and medication. Participants were encouraged to provide examples of events and to expand on ideas where the researcher sought for clarification. Interviews lasted approximately 30 minutes.

2.3.3.2 Drawing the ideal self

Each child participant completed the 'Drawing the Ideal Self' (Moran, 2001) activity (see Appendix A). The activity involves asking the child to draw two pictures on separate sheets of paper, one of a person they would not like to be like, and one of a person they would like to be like. Following the drawing, the researcher places another sheet of paper in between the two drawings and draws a line across the middle, marking the centre point. The researcher then asks the participant to mark

on the line where they think they are when on medication, off medication and where they would like to be.

2.3.3.4 Conners' rating scale

The Conners' Teacher Rating Scale – Short Form (Revised) (CTRS: RS) was completed by teachers in order to identify the ADHD sub-type of the child (results shown in Table 1). The CTRS: RS has 28 items which the teacher rates on a scale of 0 (not true at all) to 3 (very much true). Teachers are asked to think about the child's behaviour over the last four weeks. Items fall into four categories: oppositional (e.g. *defiant, spiteful or vindictive*); cognitive problems/inattentive (e.g. *forgets things s/he has already learned, short attention span*); hyperactivity (e.g. *restless in the "squirmy" sense, excitable, impulsive*); and ADHD Index (e.g. *disturbs other children, temper outbursts*). The scale is reported to have excellent reliability and internal consistency coefficients range from .75 to .90 (Conners, 2001). Factorial validity revealed that there are three distinct dimensions. Convergent and divergent validity was supported and discriminant validity strongly supported (Conners, 2001).

2.3.4 Procedure

Ethical approval for the present study was obtained from the ethics committee of the School of Psychology at Southampton University, also approval from research governance was sought who act under the British Psychological Society Code of Practice (BPS, 2006) (see Appendix B for letter of approval).

Special Educational Needs Coordinators (SENCo) of schools in Portsmouth and Hampshire were approached for the study. They were asked to identify participants and then supplied with a letter for parents to send out. Parents had the opportunity to opt in to the study by returning a reply slip to the school – this provided consent to be contacted directly by the researcher. Following a telephone conversation with the parent, the researcher sent them a consent form to be returned and information sheet. Child assent forms were completed with child participants prior to the interview. Teacher consent forms were also completed prior to interview and information sheets provided (see Appendix C).

The researcher carried out individual interviews with each child participant which lasted for approximately 30 minutes. The interviews took place in the child's school and were recorded using a Dictaphone. Following the interview, each child participant completed the 'Drawing the Ideal Self' (Moran, 2001) activity which took approximately 20 minutes (see Appendix D).

The teacher interviews were also conducted in the child's school and were recorded using a Dictaphone. They lasted for approximately 30 minutes (see Appendix D). Following interviews, teachers completed the Conners' Teacher Rating Scale – Short Form (Revised) (CTRS: RS).

Interviews were analysed using techniques from grounded theory methodology (Corbin & Strauss, 2008). Initially each interview was read through in order for the researcher to familiarise herself with the manuscripts and drawings and to begin to understand what the participant was experiencing (Corbin & Strauss, 2008). The researcher was aware at this stage of preconceptions she may have regarding the discourses used in the data, and such sensitising concepts (Charmaz, 2006) were recognised. Analysis of the data was therefore comprised of the researcher's interpretations of the interviews. Following the read through, coding began. Natural breaks in the manuscripts, as determined by the researcher were used as cut-off points for individual pieces of data (Corbin & Strauss, 2008) which were analysed. The drawings were also regarded as pieces of data. Each piece of data was analysed and presented as a memo i.e. a title and thoughts about what the data showed.

The titles of the memos were recorded as codes and then grouped together where commonalities were identified among them (Corbin & Strauss, 2008). The researcher took each group of codes in turn and labelled them as concepts whilst recording further thoughts about what they demonstrated about the participants' experiences. Further comparison of the concepts was undertaken in order to identify common themes/categories (known as axial coding) (Corbin & Strauss, 2008) i.e. commonalities were identified among 'responsibility' and 'controlling impulse' to create a category of 'control'. Five categories for children and teacher interviews were found.

Following identification of the categories, manuscripts were re-read and the researcher considered each participant and their story individually in order to integrate the categories to develop a core category used to represent the main theme of the research (known as selective coding) (Corbin & Strauss, 2008). The core categories were then represented as grounded theories of the data.

2.4 Results

2.4.1 Description of Participants

Table 2 shows the results obtained from the CTRS: RS. Scores are reported in percentiles which express the percentage of children in the normative group who scored lower than the respondent (Conners, 2001). A score above 95 indicates a significant problem, 86-94 shows a possible significant problem and 74-85 indicates a borderline score which should raise concern (Conners, 2001). Children a, b, c and d were all rated highly on the ADHD index score which indicates 'at-risk' of ADHD. Children a and d show greatest difficulty with hyperactivity and oppositional behaviour (ADHD predominantly hyperactive) and children b and c have difficulties in all areas (ADHD combined). Child e has greatest difficulty with inattention (ADHD-Inattentive).

Child	Oppositional (percentile)	Cognitive Problems/Inattentive (percentile)	Hyperactivity (percentile)	ADHD Index (percentile)
A	82	46	98	95
B	100	89	97	93
C	82	98	97	96
D	69	46	100	100
E	31	95	38	66

Table 2 Participant's scores provided by Conners' Teacher Rating Scale (CTRS: RS)

2.4.2 Child Interviews

Child interviews were analysed using the methods described in the previous section. See appendix E for a summary of the codes, concepts and categories. A grounded theory of internalisation of the ADHD label was identified.

2.4.2.1 Emotional ADHD

Three participants talked about anger in relation to their ADHD. They described ADHD as causing anger in them, leading to aggressive behaviours such as fighting and swearing. Two participants (both attending the EBD school) used the word 'angry' when describing their ADHD:

I found out that it [ADHD] also makes you have anger...its part of it, just makes you have outbursts of anger sometimes. (child c)

I think I get when I get a bit emotional I start being angry...if it's a really bad day you see the angry B of me, and I'm like really angry. I just go at anyone who gets on my nerves. (child b)

One participant also described the physiological experience of getting angry:

When I get angry, 'cos, my ADHD starts to kick in. It starts to get me a bit angrier it makes me had adrenaline...it helps me, it just, it just goes. I can't talk to anyone, if anyone like just says anything bad to me or something it'll speak to me and I'll just go and hit 'em or something. (child b)

In this instance, there appears to be a trigger which leads to ADHD 'kicking in' when the child experiences a 'fight or flight' reaction to the situation. He has labelled this

reaction as his ADHD and makes a clear link between the label and his emotional experiences.

In the case of child c, he describes feeling anger and getting into fights as part of his ADHD. The idea of attributing those emotions and behaviour to ADHD is reinforced by being told that his medication would be increased:

They said, we'll have to put you on a higher dose, to help you with your aggression and that, so they put me on a couple more to help me control it. (child c)

In another case, the word 'mad' is used to describe an emotional experience of having ADHD – it is inferred from the data that the use of the word mad in this case is in the context of 'anger', rather than referring to mental health connotations:

When people get me annoyed they make me go mad. (child a)

The angry emotion was depicted and labelled in three of the young people's drawings of a 'person you would not like to be like', shown as a perpetrator character harming others (see Figure 2). Child c showed a bully beating someone up, child d's drawing is of the devil whipping people and child e is a person who is going to kill people.

In contrast to their descriptions of the emotions associated with ADHD, the young people describe the effects of treatment as producing feelings of calm. This is largely in response to their medication:

It [medication] makes me calm down a bit more. (child a)

It helps me, um, get calm a little bit...it helps me relax for the whole entire day. (child b)

It makes me calm down. It makes you calm down.
(child d)

The young people also described other treatments or interventions they use to induce a calming effect such as having time out (of the classroom) talking to an adult and letting their anger out on a punch bag.



child a



child d



child e

Figure 2. Examples of children's drawings of a person 'I would not like to be like'



child d



child b



child c

Figure 3. Examples of children's drawings of a person 'I would like to be like'

In the case of the drawings however, the emotion depicted as opposite to angry in the 'person you would like to be like' drawings was happy (see Figure 3). This was either depicted as a character performing a heroic act (child d) or simply as a person who does not have ADHD (child b and child c).

2.4.2.2 Locus of control

The idea of self-efficacy, as the degree to which the young people feel in control of their own behaviour and symptoms of ADHD is a strong theme throughout the interviews. The young people expressed their ADHD in terms of behaviours against their will such as swearing or doing things they didn't mean to. This appears to have a disempowering effect on them as they view the manifestation of the ADHD as out of their control, but also the effect of their medication as well.

In one case, the child verbalises the distance he experiences between his ADHD and his own will or ability to control his own behaviour:

Child b: *If I hurt someone it won't wouldn't be my fault 'cos it'd be my ADHD that'd be kicking in and it would just hurt 'em.*

JB: *Your ADHD would be hurting people?*

Child b: *Yeah. Because when I go into um, if like, I hurt 'em really bad the other day and I sometimes be told off for it and I says to 'em 'it ain't my fault 'cos I got*

ADHD and it's a disorder that I can't handle and it's not my fault that I was born with it.' And they understand.

By expressing that it would not be his choice to hurt someone, but that the ADHD had done it, the child is relieving himself of the responsibility of his actions.

The idea of acting against their moral code of what is good and bad presents as a strong part of the locus of control category. By demonstrating to the interviewer that they were aware of the behaviours as negative or inappropriate but that they knew that this was the case, the young people were able to communicate that they were innately 'good' despite 'bad' behaviour:

I start saying things that I shouldn't be. (child b)

ADHD is when you're hyper and can't control yourself, they do stuff they don't mean. It just pops out. (child d)

When talking about their medication, all of the young people could describe the effects it had on them, generally termed 'calm'. The language used in these instances was around how medication 'makes me' calm as an external locus of control rather than the medication allowing an internal change to be made:

Sometimes I don't have my tablet, um, it makes me like shout out a bit more and things. And when I do have it it makes me calm down a bit more. (child a)

The young people described instances where they had not been on their medication and had done 'bad' things. The events appear to provide them with evidence that they need to take medication in order to avoid behaving badly. The evidence they provided confirmed the idea that the medication was the controlling influence for their behaviour, and thus reducing their internal locus of control for managing their ADHD:

JB: *What things are you really good at?*

child a: *I'm good at riding motorbikes, um, I don't really know. Can I tell you what I'm getting better at? I'm getting better at like putting my hand up and listening and stuff...and I'm getting better at not hitting my mum, 'cos I used to hit my mum. I hardly don't no more.*

JB: *How have you managed to get better?*

child a: *I think. I don't know. It may be the tablets I don't know.*

JB: *Tell me about your medication.*

child c: *I started off on Ritalin but that was bad because I was thinking of things what kids shouldn't really think of when they're that age. And then, I was also on a different one and then I had this voice in my head, telling me what to do, controlling me. Then I go the one I'm on now, it controls me.*

If I didn't have it [medication] then I'd behave really bad. (child b)

They [tablets] made me be a bit good. (child d)

As part of the 'Drawing the Ideal Self' (Moran, 2001) activity, the young people indicated on the scale that they were closer to the person they would like to be like on medication than they were off medication. This provides further evidence for the young people that their medication has a substantial influence on their behaviour and confirms the perception that taking medication enables them to be close to the positive images they depicted (see Figure 4).

In the study, only one participant (the oldest, child c) took some responsibility for having control over his ADHD, expressing that he felt he was more in control of it than when he was younger. This was not a consistent message however, as he also described the medication as a having a controlling effect.

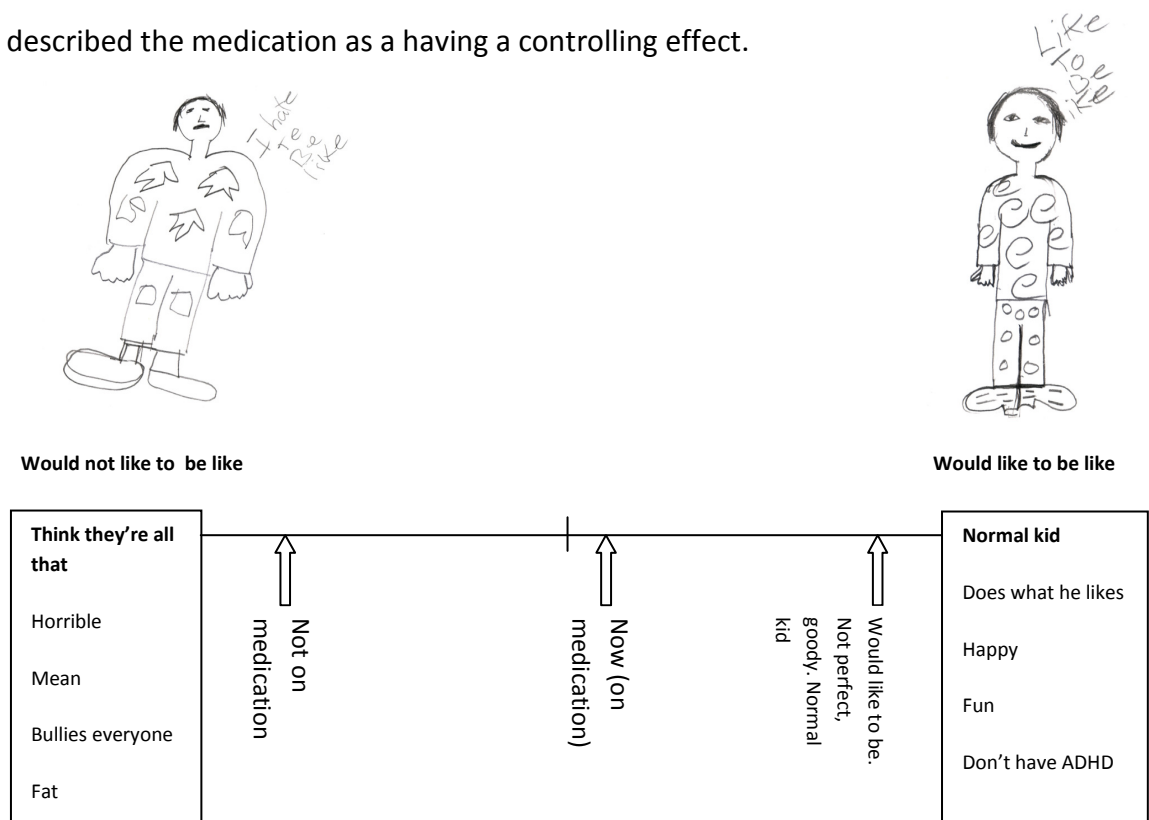


Figure 2 Drawing the ideal self - child c

The stories of the young people's ADHD demonstrate a strong theme of internal and external loci of control, responsibility and self-efficacy in managing symptoms of ADHD.

2.4.2.3 On/off conditions

When talking about their ADHD, the participants in the study share their perceptions of the disorder as something they 'have', as a permanent condition in their biology as something that dissolves around the body or something they were born with it. The biological model used to describe ADHD indicates that the children feel their ADHD is part of their personality. In addition however, to the permanent state of ADHD are the more temporary experiences of presentation of symptoms:

Just makes you have outbursts of anger sometimes. (child c)

I just get silly, burst out with mentalness (child d)

My ADHD kicks in (child b)

The participants describe the on/off condition of ADHD symptoms as directly related to being off and on medication. They also experience medication wearing off, which would also indicate a time when symptoms would be worse:

They [tablets] make me be a bit good and then they wear off I just go schizophrenic. (child d)

In one case, the child describes the on and off conditions of ADHD as dependent on the environment, in particular getting into a fight:

*Then I'll just get angry for some reason and it just starts to kick in.
It'll [tablet] only um, wears off in like four hours or three hours,
but now its worn off already because I've had a fight already.
(child b)*

This instance is particular to child b and no other participants describe their on and off conditions as being affected directly by an environmental factor.

2.4.2.4 Medical disorder

The ADHD label was familiar to the participants and they all appeared to experience it as a medical label or disorder. In addition, the idea of having medication also reinforces the medicalisation of the behaviours and perhaps influences the lack of internal locus of control experienced by the children.

One participant communicated negative feelings about ADHD as he felt singled out, and bullied as a result of it:

JB: *Can you tell me what it's like having ADHD?*

child a: *Bit annoyed 'cos some people they used to take the mick out of me...'cos they like push me over and things for no reason. And they just wind me up.*

Maintaining a different perception of his ADHD, another participant recognised that although he is not happy about having ADHD, he knows that other people have it, and appears to gain some comfort from that. This participant (child c) attends the EBD school in contrast to child a who attends a mainstream school and feelings of being different may be experienced to a greater degree in the latter.

Language commonly associated with mental health issues is used by child d in particular, who describes his ADHD and behaviour as *'burst out with mentalness'*, *'schizophrenic'*, *'mental'*. The use of language demonstrates the understanding the child has of his own behaviours, and possibly how other people have shared their perceptions with him.

2.4.2.5 Self/identity

When asked what they are good at and what they find difficult the participants express some elements of their selves not connected to the diagnosis. They all chose to talk about actions they were good at in terms of describing strengths, e.g. playing computer games, riding bikes and motorbikes, making things, sports. When talking about weaknesses however, the participants identified some specific actions such as writing, playing with Lego but also behaviours more closely linked to ADHD such as listening (in class) (inattention) and not being patient and shouting out (impulsivity).

I'm good at riding motorbikes....um... I don't really know. Can I tell you what I'm getting better at? I'm getting better at like putting

my hand up and listening and stuff...and I'm getting better at not hitting my mum, 'cos I used to hit my mum. (child a)

I'm good at more physical stuff, like mechanical and rugby, stuff that I can do with my hands. (child c)

I'm rubbish at writing, stuff like that. (child c)

Ok at art but I get some help to do the outlines for me and then I just colour it in...and stuff like that. (child b)

Listening's very hard for me 'cos I...I sometimes when they're talking I listens to other people than them...but ...I still, getting, try to. (child b)

One participant identified some strengths which were a result of his ADHD; running, being stronger and persevering at tasks:

It makes me better at running, and it builds up my muscles, it makes me stronger. (child c)

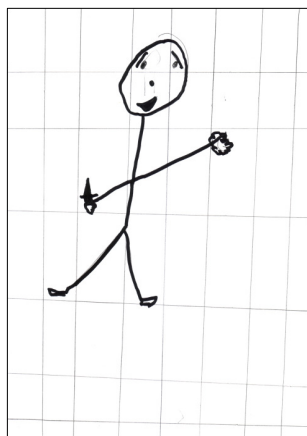


Figure 3 The person I would not like to be like - child b

The idea of ADHD appears to heavily influence the participants' view of their selves, but more negatively than positively. This point can also be inferred from the drawings where the young people identified 'ADHD-type' characteristics in the negative images, showing characters as perpetrators, doing 'bad' things and experiencing negative emotions. Child b's drawing shows someone in prison, they have killed someone and are described as having ADHD (see Figure 5). Other actions depicted show bullying behaviour and fighting (see Figure 2).

2.4.2.6 Internalisation of the ADHD Label

As explained in the methods section, the five categories were integrated to develop a core category representing the main theme of the data. This was identified as internalisation of the ADHD label and creates the grounded theory of the child data.

By being diagnosed with ADHD and prescribed medication for the disorder, children experience a process whereby the label is internalised to become part of their identity and therefore an explanation for 'bad' behaviour. It can also explain the external locus of control the young people appear to experience. Children describe disordered behaviour and link medication, and other treatments (although to a lesser degree) to reducing the symptoms. The process of experiencing treatment and its effects serve as a self-fulfilling prophecy for the idea that they have a disorder. For example 'If treatment makes me better, I must have a disorder which warrants treatment'. This perception held by children with ADHD is consistent with the medical model previously discussed whereby the child views their ADHD as a disorder which is treatable. The participants have therefore adopted the seemingly dominant discourse around ADHD and it is constructed as a medical disorder for them (taking on the 'disease of the brain' stance).

The participants in the study describe ADHD as inextricably linked to their behaviour, personalities and locus of control. However, the degree to which participants appear to internalise their ADHD label may differ in terms of their developmental level – the oldest participant was the only one who showed some distance between his 'self' and his ADHD whereas other participants talked about their ADHD as much more closely linked to them, this supports the notion that internalisation of the ADHD label is a process. This conclusion and potential implications will be discussed in more detail in the next section.

The figure below shows a representation of the theory in a hierarchical model whereby internalisation of the ADHD label is ultimately seen in the 'self/identity'. 'Locus of control' and 'medical disorder' impact on 'self/identity' and affect each other. Prior to that, 'emotional ADHD' and 'on/off conditions' provide more descriptive accounts of the ADHD experience. The arrows show bi-directional links between the categories as they are felt to influence each other.

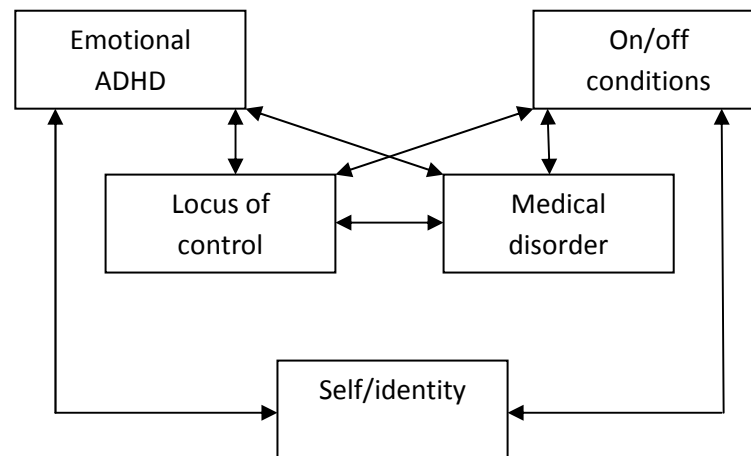


Figure 4 A conceptual model of the process of Internalisation of the ADHD Label

2.4.3 Teacher Interviews

Teacher interviews were analysed using the methods described in the previous section. See appendix E for a summary of the codes, concepts and categories. A grounded theory of difference was identified.

2.4.3.1 Medical disorder

Teachers spoke about the children's ADHD in terms of presenting symptoms, outcomes and attributions of symptoms. Symptoms were described as hyperactive, talkative, restless, distractible, impulsive and disruptive and outcomes were described in terms of poor social interactions and academic achievements.

In thinking about the children's ADHD, teachers spoke about the medicalisation of behaviours with mixed views. In one instance, teacher a described the child's medication as 'vitamins' used as a code word to ensure other children would not realise that the child was on medication:

...to start with I was like A, have you had your vitamins and I was keeping it, I didn't shout about the fact that he's got ADHD and he's on Ritalin and everything else. I didn't feel it was appropriate for children to know but he will openly tell them 'I've got ADHD I take Ritalin' he's just done that. (teacher a)

Language associated with mental health problems was also used by one teacher in their descriptions of the child's behaviour:

he ended up going loopy, he ripped his, eating his work, he ripped it up (teacher c)

Teacher b experiences the child using the label but does not accept the degree to which the child claims to be affected by it:

Teacher b: *He, um, does tend to play on what he looks at on as his disabilities, if you like, he has said that word that's why I'm using it. And he does tend to play on those which I don't think are as severe as he makes out.*

JB: *So, does he mean ADHD by his disabilities?*

Teacher b: *Yes, that's what he means 'I've got a disability I've got ADHD' and he does tend to look upon it as a disability and he tends to try and take advantage of that fact.*

Two teachers spoke about the child's ADHD as a limiting factor in their academic potential:

He's not calm enough to finish a piece of work with consistency all the way through. It isn't, he hasn't got the self regulation to put the quality in the work all the way throughout. (teacher d)

He's a bright boy as well but due to his ADHD that hasn't yet you know necessarily shone through over the last two years. (teacher a)

Interestingly, four of the teachers attempt to normalise the children's behaviour by comparing them to other boys or teenagers:

He's like a normal little boy really. (teacher b)

Everything about him is just exasperated and exaggerated behaviour that you'll see in normal sort of you know young adolescents. And with D, everything's just a lot bigger a lot louder faster and just unregulated. (teacher d)

As a say I think he's just a normal teenager as far as I'm concerned. (teacher c)

Children tend to get a little bit more fidgety towards the end of lessons anyway...but I wouldn't know whether that's because its just before the time he takes a tablet or whether it's just him being a typical boy. (teacher e)

There was one exception to the medical disorder theme, where fighting behaviours were not viewed as part of ADHD, but attributed to social learning in the home:

JB: So do you think that's [fighting] his ADHD?

Teacher a: No, it's his upbringing

JB: So there's other factors.

Teacher a: There are other factors, yes...he thinks its socially acceptable to behave um the way he does when he's on and off Ritalin. He doesn't see that the way he's behaving isn't um socially acceptable, because that is the behaviour that is demonstrated to him on a regular basis.

Other factors viewed as causing 'ADHD-type' behaviours were identified by teacher c as problems at home and diet.

The outcomes of ADHD, according to teachers were difficulty in developing friendships and poor social skills:

He hasn't got a particularly close circle of friends. He's got children who will accept him into their games and accept him as their friends, but nobody particularly close. (teacher a)

He tends to keep himself to himself...it could be just the case that he's familiar with boys that he might have been friends with in year 5 and he gets to see them out in the playground. (teacher e)

Other social skills described as difficult by teachers were eye contact (teacher c), recognition of appropriate social boundaries i.e. when it is appropriate to hug someone in school (teacher d) and being vulnerable to bullying:

He's easily a target for getting the other children to bully or to actually get him to do things that are inappropriate because he cannot say no. (teacher d)

The medical disorder category appears to provide an over-arching theme for the teacher interviews, and could be conceptualised as a medical discourse (as a language for describing ADHD). The teachers use a number of concepts and labels in their descriptions of the child's ADHD including lay terms (fidgety, lack of focus, distractible) and terms used in diagnosis (hyperactive, impulsive disruptive). By labelling ADHD in these ways, the teachers maintain the medical discourse and it provides a language for talking about ADHD.

2.4.3.2 Control

Control was a strong theme in the teacher interviews which links in with the notion of a medical disorder i.e. if a child has a disorder then they must not be in control of the symptoms:

I find that he can be, he's a lovely lad you know there's nothing deliberate about his behaviour. (teacher d)

He does find it difficult to settle himself and manage himself and he cannot control himself if the situation means we need excitement. (teacher d)

What's more of a concerns is that he doesn't know how to manage his own feelings he doesn't know how to be in control of his own feelings. (teacher d)

In describing the effects of medication, teachers also infer that there is a controlling effect of the tablets. This in itself then becomes a disempowering statement of the child's internal locus of control as the regulating factor is viewed as medication.

Um, but its two different, completely two different sides of the coin whether he's had it [medication] or not. (teacher a)

Sometimes he tends to get a little bit fidgety towards lunchtime when he's due to take his medication. (teacher e)

In contrast, teacher b believes that the child is in control of his behaviour and decides when to behave badly:

If he's decided, and it's almost like you can see a switch being switched on you can see in his eye 'I'm going to kick'. (teacher b)

It's very difficult because the behaviour which he presents I think is chosen behaviour. He presents behaviour that he thinks is ADHD by remembering what he's like when he's not on medication...he's completely in control but he pretends that he's not. (teacher b)

This description of b's behaviour highlights an alternative perspective on ADHD that it is a social construction i.e. the teacher believes that the child is presenting expected behaviours which fit with the ADHD label.

2.4.3.3 Emotional ADHD

Emotional experiences of ADHD that teachers describe are in terms of temper outbursts, frustration and worry:

C's behaviour just deteriorated because he just doesn't like change and he was so worried. (teacher c)

If he gets into any sort of urm, an argument with another pupil he will immediately fly off the handle. (teacher b)

He can still, he gets very frustrated very easily. Um, and even if he has had his medication there is a possibility especially on the playground that he will get frustrated. (teacher a)

Teacher e however, talks about the difference in emotions the child experiences between being on the playground and in the classroom:

I see him as happiest when he's in the playground...you wouldn't see that if you were to come and see him in my class. (teacher e)

The teachers do not appear to have a direct involvement in the children's emotional states and reactions. They are described as internal to the child, but with no reference about how the teacher is able to support them in reducing or managing negative emotions. The final extract used is interesting because the teacher appears resigned to the fact that e will never be as happy in the classroom as he is in the playground. The emotions appear to be expected and accepted by

the teachers with little challenge. This supports the medical discourse as teachers and children are helpless in improving the situation.

2.4.3.4 Managing symptoms

The management of ADHD was described in terms of teacher's perceptions of the effects of medication and non-medication treatments. Three teachers spoke about the effect of medication on the children's symptoms (the two teachers who did not talk about the effect of medication had not seen the child off-medication and therefore did not have a comparison between on and off medication). Teacher e described it as alleviating fidgety behaviour which was apparent prior to taking it. Two other teachers described the effects of medication as more significant, identifying marked differences between on and off medication:

I've seen, since he started taking Ritalin I have seen an improvement in his work. He is focused on his learning. He is keen to please. He is keen to achieve...when he has had it, he is very subdued he is a different child completely...when he hasn't had Ritalin he might as well not be here. (teacher a)

The effects of his medication. They calm him down, he's a very pleasant little boy when he when he's reacting to his medication. Urm...very pleasant very polite, urm and he'll sit and he'll try and do his work and he's patient. (teacher b)

I think the way he, he reacts when he's looking for attention or a reaction I think is a very uh, a minor example of what he could be

like without the medication... I think he would be a very dangerous little boy without the medication. (teacher b)

All of the teachers identified other ways in which they manage the child's ADHD symptoms in school and promote on-task behaviour. The use of positive feedback is identified as important for reinforcing good behaviours (teachers b and d). Teacher a recognised the need to keep the child occupied in order to maintain motivation and gave him 'jobs' to do, she also had a system in school whereby the child could talk to a teaching assistant at the beginning of the day if he had any issues. Teacher c described the importance of preparing the child for changes. In addition to proactive strategies used to prevent problematic behaviours in the classroom, teacher b described reactive strategies such as time-out and use of humour to diffuse situations.

Teacher a described the use of the school behaviour system and the times when it applies to the child:

I do follow the school behaviour system with A now I didn't when he first came to my year group. To start with I didn't break him in gently but I made allowances. There are still if he hasn't had his Ritalin like yesterday I still made allowances. (teacher a)

The teacher notes a difference to the way in which child a's behaviour is managed, dependent on taking medication i.e. the medication puts the child in the same

category as everyone else, but being off medication singles them out for different treatment.

One teacher described her difficulty in managing the child's behaviour, and the correlation between his mood/behaviour and the severity of her approach:

He's just extremely wearing because it's constant, constant talking, and on a Friday he's as high as a kite and we have to really come down really severely with him. (teacher d)

In general, the teachers appear to value the behaviour management strategies they employ; however, the ADHD is like a caveat to the strategies being effective. This highlights the idea that teachers need to make attempts at managing inappropriate classroom behaviour, but if it fails to be effective, then the ADHD or lack of medication is the reason.

2.4.3.5 Strengths

In addition to describing the children's difficulties in terms of their ADHD, teachers also talked about the children's strengths. These were described as personality qualities, such as helpful, polite, supportive and loyal. Engagement with learning was also identified and included concentration, enthusiasm and willing to try. Some children were described by their teachers as academically able, and others as more able at practical tasks:

He is, quite low level his reading age is seven years three months, but the good thing with C is he will try and if you know he's got the support he'll be alright. I think he's really bright in other ways, electronics, science, things like that, good with his hands. (teacher c)

He's got a friendly character and he's got a caring character as well which is nice, he's quite happy to develop his ideas and he's got some fantastic ideas, um, and it's just getting it down onto paper and being able to show what he can do. I think he struggles with that probably the most. (teacher e)

When describing positive attributes of the children, two teachers used the term 'can be' to indicate that the qualities would only be seen some of the time, and perhaps when the child decides to present himself in that way:

He is a lovely lovely boy. He can be extremely helpful. He can be extremely loyal. (teacher a)

He can be extremely helpful. Urm, he can be very polite, urm. He can be supportive...supportive when he chooses. (teacher b)

Similarly to the negative behaviours seen in the children, strengths are attributed internally, although are perhaps viewed as occurring if the medical disorder is

overcome. There is a hint here of the children's 'self' as good, but the presence of ADHD is generally 'bad'.

2.4.3.6 Difference

As detailed previously, the five categories identified in teacher interviews were further analysed and integrated to develop a core category, This was identified as difference and creates the grounded theory of the teacher data.

The teachers described their experiences of a child with ADHD in terms of the diagnosis and medication. A strong medical discourse was present throughout the interviews as issues around labelling and treatment were explored. Four of the five teachers spoke about normal behaviours in relation to the child in an apparent attempt to balance out the medical model they use. The grounded theory of difference indicates that teachers viewed the children as different to others in their class and demonstrated this with the evidence they gave about each child.

Figure 7 shows a representation of the theory, with medical disorder as an overriding theme effecting 'emotional ADHD', 'control' and 'managing symptoms'. 'Strengths' is shown as an opposite state of medical disorder to reflect the notion that they are prevalent when ADHD is overcome.

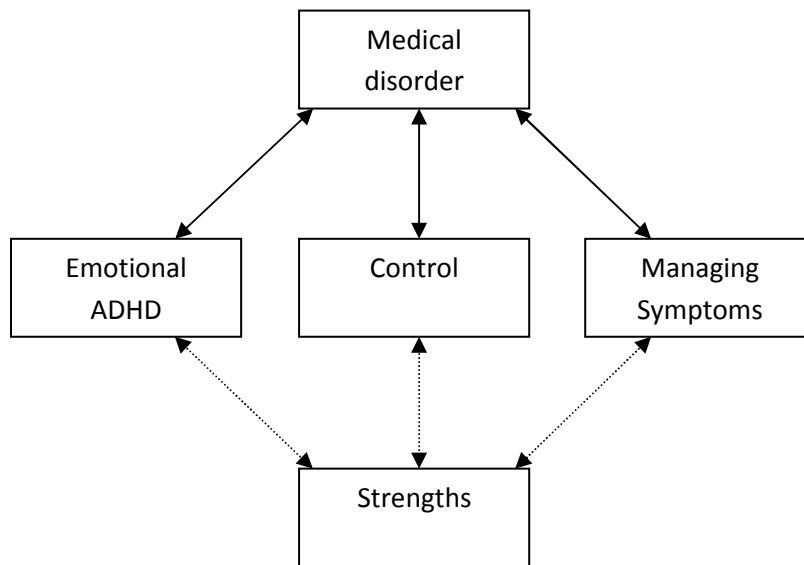


Figure 5 A conceptual model of Difference

2.5 Discussion

The aim of this study was to explore children's and teachers' perceptions of ADHD and medication. Analysis of the child data revealed a grounded theory of internalisation of the ADHD label. The children in the study were found to have internalised the label which accounted for their perceptions of the disorder and the medication treatment they received. The study therefore concludes that in order to increase children's self-efficacy in managing their own behaviour and maintaining an internal locus of control the work with them (as an EP practitioner) should focus on externalising the label in order to view their behaviours as within their control and not necessarily part of their identity. This conclusion also supports the notion that ADHD is a socially constructed concept whereby the validity and utility of a medical label is challenged in order to make way for more helpful moves towards exploring the meaning of behaviours and context in which those behaviours occur. By viewing behaviour in this way, the notion of ADHD as a disorder and part of an individual's biological or genetic make-up can be dispelled, thus increasing both the child's and adults' resources in managing the difficulties in the context they experience them.

Children described a close link between anger and their ADHD, and experienced feelings of calm linked to taking medication. Feeling different was experienced by some children along with negative feelings towards having ADHD, and this appeared to be affected by the school setting. Children perceived an external locus of control for their behaviour which was compounded by taking medication. Symptoms were viewed as what the ADHD 'made' them do.

ADHD was experienced as a permanent condition with temporary outbursts, sometimes connected with being off medication, or medication wearing off. The children experienced their ADHD as a medical disorder and as something which medication alleviated. This also impacted on the children's sense of self and identity and ADHD was viewed as a limiting factor to being able to behave well in school and at home.

Teachers described the children's ADHD using a deficit model associated with a 'medical disorder' perspective. Behaviours were primarily attributed to the child although social and environmental factors were also identified to a lesser degree. Four teachers used normalising statements about the children which contrasted to the majority of discourse used and may be linked to the setting i.e. all of the teachers from the EBD school used the term 'normal' whereas only one of the teachers from mainstream did.

Generally, children were viewed by teachers as not being in control of their behaviour which was compounded by the perceived effects of medication. In contrast however, one teacher felt that the child was in control sometimes despite 'claiming ADHD behaviours'. Non-medication strategies were described in terms of behaviour management and were not described as having the same effects as medication. In addition, the effectiveness of management strategies was

sometimes dependent on the child having taken their medication, compounding the control effect.

Teachers described children's emotional experiences of ADHD to a lesser degree than the children, but identified temper outbursts, frustration and worry. Children's positive attributes were described in terms of personality qualities, but only present in the absence of ADHD symptoms i.e. a 'good' self but overshadowed by ADHD.

The core category of difference is perhaps unsurprising given that the teachers were asked to talk about a child in the context of their ADHD. The medical discourse used in the interviews impacted on how teachers described the children and so talking about a child as different to his peers was perhaps inevitable. The data elicited from teachers is important in the current study as it highlights the perceptions they have about the children they teach and perhaps says something about the expectations they may have about those students and the degree to which they feel they are able to influence or manage the child's behaviour. By adopting the medical disorder perspective, teachers view children's behaviour as out of their control, and may in turn regard their own resources as inadequate in supporting the child to manage their own behaviour. This is vital information for EP practice in gaining an understanding of how teachers view ADHD and therefore next steps in working with them to develop their own sense of self-efficacy in managing social and academic behaviour among those children with ADHD. By

supporting teachers, and other adults to view ADHD as a socially constructed concept, it may be possible to move their thinking on to regard the presenting behaviours as manageable and changeable.

The purpose of interviewing teachers in this study was to identify discrepancies with and similarities to children's perceptions in line with the ABC model. The categories identified among the two data sets were very similar, both having categories entitled medical disorder and emotional ADHD, and both exploring ideas around control and self. The content of the categories differed in some instances and is worth discussing. In both their interviews and drawings, the children identified the anger - calm dichotomy and linked it to on/off conditions (of ADHD and medication). Teachers on the other hand, described ADHD more in terms of presenting behaviours and symptoms with comparatively little reference to the emotional experience of ADHD, and they noted increased engagement with learning as an effect of medication. This is likely to indicate that the children were more aware of their emotional experiences than the teachers, and that the drawing activity was useful in eliciting them. In addition, the children appeared to be more aware of medication wearing off than their teachers.

Children expressed a lack of internal locus of control for managing symptoms and this was mirrored to some degree by the teachers. Only one teacher maintained that the child remained in control of his behaviour despite acting 'out of control'.

Both children and teachers perceived medication as alleviating symptoms, rather than facilitating the child's ability to manage himself more effectively, compounding the perception of an external locus of control and children and teachers viewed non-medication treatment as adult-imposed and as strategies 'done to' the children rather than identifying changes that the child was able to make.

Teachers were able to identify personal qualities in the children, however, these were felt to only be present in the absence of ADHD symptoms. Children found it harder to identify their own strengths and tended to talk about abilities rather than qualities.

A grounded theory of internalisation of the ADHD label was identified for the children's data, and therefore contradicts the predictions of the ABC model (de los Reyes & Kazdin, 2005). Children in the current study attributed their difficulties internally and perceived them to warrant treatment. In general, teachers, as predicted by the model attributed problems internally to the child, although they also identified some social and environmental risk factors. The teachers also identified the benefits of treatments and therefore perceived the problem as warranting treatment.

The ABC model predicts discrepancies among informants which were not evident in the current study. The children interviewed were diagnosed with ADHD and

prescribed medication and as, identified by the analysis, internalised the label. It would appear therefore, that as the children had experienced the clinical assessment process where the end result was to be medicated, they had come to attribute their difficulties internally and selected evidence that medication was warranted.

Nylund (2000) describes internalising discourses as deficit saturated, with the concern that pathological labels locate the problem within the child. He predicts that such internalising discourses are true of children as well as adults around them, which supports the finding of the current study. It would therefore be interesting to explore perceptions of ADHD with children who were at the beginning of the clinical assessment process, or recently diagnosed.

Internalisation of ADHD was identified by Nylund (2000) as problematic for children and their families in being able to manage or cope with symptoms of ADHD. The current study therefore fits in closely with these assertions and concerns about the degree to which the label is internalised and inhibits self-efficacy in managing symptoms are shared. Nylund (2000) describes externalising the problem as an important process as a way of increasing the individual's internal locus of control for managing their behaviours. This also concurs with Bentall's (2009) assertions on the utility of psychiatric diagnoses, which he views as unhelpful to the individual and disregarding of important contextual factors. In line with current EP practice,

the notion of exploring the meaning behind 'symptoms' and the contexts in which they occur is viewed as far more helpful than the application of a diagnostic label and the prescribed treatment that goes with it.

Cooper & Shea (1998) identified the theme of 'harmful dysfunction' which was present in both the child and teacher interviews of the current study in describing the effects of ADHD. Children have been previously found to view their label negatively in terms of a stigmatising effect (Arora & Mackey, 2004; Cooper & Shea, 1998; Travell & Visser, 2006) and this view was identified in the current study (with differences noted between school settings). Views towards medication have previously been found to be mixed (Cooper & Shea, 1998; Travell & Visser, 2006) and this finding was also replicated in the current study. When asked, children said they would prefer not to be on medication, but all children in the study identified positive effects of medication and evidenced 'bad' behaviour when off medication as justification.

The theme of control was identified in previous research in relation to medication as having a controlling effect (Arora & Mackey, 2004; Cooper & Shea, 1998; Travell & Visser, 2006; Singh, 2007a) which was supported by the current study. Moreover, children reported a desire to do the right thing which was sometimes overruled by ADHD.

Singh (2007a) also explored authentic self and found that children reported a core badness, which medication could overcome to a degree. The drawings completed by the children in the current study support this finding where medication was reported to bring them closer to their 'ideal self' and further away from the person they would not like to be like. It is worth noting however, that the activity may to some degree, force the child's thinking into discreet categories as it focuses on opposites.

Previous research into adult perceptions of ADHD is supported by the current study to some degree whereby adults hold the belief that children with ADHD have little control over their behaviour (Maras et al, 1997) and that there is a biological basis to ADHD, although other (social and diet) factors are considered.

More recently, research into the perceived effectiveness of treatment has been with parents, whereby medication is endorsed (Johnston et al, 2005). The current study demonstrated that teachers also perceive medication to be effective in the cases where they could identify on and off medication differences. Those teachers who only experienced the child on medication had little to say about its effects.

The current study is not without its limitations. Grounded theory methods were selected as appropriate tools to analyse the qualitative data gathered in interviews, but such an interpretive approach is acknowledged as a limitation. The nature of

the study meant that some aspects of grounded theory methods were not followed, for example, Corbin & Strauss (2008) state that a review of the literature should take place after the analytic process, but the university model of conducting a doctoral thesis requires the literature review to be completed prior to data collection. However, Charmaz (2006) and Harry et al (2005) recognise the role of prior knowledge in such research and by being aware of sensitising concepts the researcher can acknowledge experience and insights they may already hold. Time constraints and recruitment issues in the study also made it difficult to follow Corbin & Strauss' (2008) methodology of analysing each interview prior to conducting the next one.

The sample used in the study was small, and with qualitative methods of this nature, difficult to generalise. However, Harry et al (2005) emphasise the importance of recruiting a small sample in order to complete quality analysis. A further point to consider with the sample is comorbidity of other diagnoses. Children were recruited due to their diagnosis of ADHD, however, other diagnoses were not recorded. Three of the participants attended the EBD special school, and could therefore be considered as having an 'EBD label'. Previous research shows high levels of comorbidity with other disorders and therefore research of this nature is likely to recruit children who have a range of difficulties.

The two school settings are also important to consider in the current study. There appeared to be some discrepancies with the level of 'difference' experienced by children and teachers i.e. those from the special school experienced less difference than those from mainstream. The analysis highlighted the discrepancies where appropriate, but it may be an area to explore in further research, particularly in relation to the degree of internalisation of the ADHD label.

In terms of the chosen methods of data collection, informant-style interviews (Powney & Watts, 1987) were an appropriate way of gathering rich data and allowing children and teachers the opportunity and space to explore their experiences with the researcher. Prior to starting the interviews, the researcher briefed each participant on the purpose of the session stating the specific aims. This involved using the term ADHD and introducing it to the interview early on. It is worth noting that this may have impacted on the information which interviewees gave, and could have, to some degree, introduced the medical discourse. Given the nature of the interviews and the fact that children had already been diagnosed, and medicated, it was felt that they had been exposed to talking about their ADHD previously, and ethically needed to be fully informed about the aims of the study.

A further consideration about the child interviews was that they were taking medication at the time. Hester (2007) questions the authenticity of responses in interviewing children when they are on medication but Singh (2007b) justifies the

decision by stating that children may be more attentive in the interview when on medication. As the current study used the school as the interview location it was likely that children would be on medication at the time of interview.

The interpretive approach of the current study and process of conducting a review of the literature prior to data collection raises issues about the researcher's preconceptions of ADHD and the effect they may have on the analytical process and results obtained. The hermeneutic circle is the process by which understanding of the whole is derived by referencing individual parts, and understanding of each part is established with reference to the whole (Geanellos, 1999), in addition it accounts for the relationship between the interpreter and the interpretation (Geanellos, 1999). In the current study, the researcher was aware not only of previous research, but also of previous experience in working with children with ADHD and adults in teaching and parenting roles as a Trainee EP.

It is likely that the researcher was more sensitive to some of the discourses revealed in the analysis as those representative of discourses experienced previously (in particular the theme of control, and the medical discourse used by adults). As a result therefore, the current study is felt to give an accurate reflection of the experiences of children and teachers in this area and provides a helpful interpretation of data in both academic and applied settings.

The current study makes an important contribution to EP practice. EPs have a role in working with children, families and schools in bringing about change and supporting individuals and groups in managing difficulties associated with ADHD more effectively in order to improve children's experiences of school both academically and socially. By having an understanding of how children and teachers perceive and experience ADHD as a set of behaviours and as a label, EPs are able to challenge views associated with the medical model, and promote the notion of ADHD as a socially constructed concept, thus empowering all individuals involved in using their own resources to manage the problem. This may involve working with adults in making environmental adaptations for a child (e.g. access to quieter work areas, use of visual timetables etc to promote clear expectations and structure) and in developing their own behaviour management approaches (e.g. in gaining the child's attention and giving clear, direct instructions, use of positive instant feedback etc).

EPs endeavour to identify presenting needs and work with schools to address them, which is in contrast to responding to diagnostic labels and following prescriptive recommendations. The findings of the current study show that the sample experienced ADHD as a diagnostic label and as a within-child problem. In addition, the study found children to feel little control over their 'condition' thus supporting the notion that in order to increase self-efficacy in managing behaviours, the ADHD label needs to be externalised from the child and a more helpful discourse of presenting needs should be employed. EPs are therefore well-

placed to work with children and adults on recognising and developing the personal resources they have rather than having a reliance on medication.

By using the findings of this study to work towards externalising the ADHD label and describing behaviours and needs instead of symptoms, EPs can work towards promoting the idea of ADHD as a social construction and therefore empowering those involved to address the needs of a child without medical intervention.

In terms of methodology, the present study also highlights the importance and effectiveness of using techniques with children and adults which allow them to explore and share their views accurately. Informant-style interviews (Powney & Watts, 1987) and Drawing the Ideal Self (Moran, 2001) elicited rich data from participants with relevance to current EP practice for use in future research and applied settings.

Appendix A: Interviews

Children's perceptions of their ADHD and self-concept

Interview with Child Participants

The researcher will use an informant style interview with children and the following techniques will be employed:

- Use of open-ended questions
- Allowing the shape of the interview to be dictated by the range of concerns raised by the participant, advancing the interview through requests of clarification, exemplification and development of ideas
- Use of participant vocabulary and techniques of paraphrase and reflection
- Indicating interest, empathy and positive regard
- Avoiding interruption and forcing the pace
- Ending the interview with warmth and communicating appreciation

Within the framework of informant style interviews, the following areas will be covered:

- The experiences of having ADHD
 - Does ADHD affect behaviour in school? (specific events)
 - Does your ADHD affect behaviour at home? (specific events)
- The management of ADHD symptoms
 - What do adults do, what does the child do to manage symptoms?
 - Times or places when it is easier to manage behaviour.
- The function of the medication
 - Is it positive or negative?
 - What would happen if the medication was not there?
 - Does the medication control behaviour?
- Child's strengths and weaknesses (self-concept)
 - With and without medication

Children's perceptions of their ADHD and self-concept

Drawing the Ideal Self (Moran, 2001)

The 'drawing the ideal self' activity (Moran, 2001) involves drawing a number of items. The present study will use the first drawing of the person only, given the time taken to complete the activity in full.

Instructions

1. Think about the kind of person you would not like to be like. This is not a real person. Make a quick sketch of this person in the middle of the page.

How would you describe this person? What kind of a person are they? Tell me three things about what he/she is like? (Researcher writes the labels)

2. Draw the kind of person you would like to be like.

How would you describe this person? What kind of a person are they? Tell me three things about what he/she is like? (Researcher writes the labels)

3. Place the two drawings on the table with the first on the left. Place a piece of paper in a landscape position on the table in between the two drawings and draw a horizontal line the length of the page. Mark the mid-point on the line.

Map where the child would rate himself and label each point. – in this step, the researcher will ask the child to rate themselves on each scale both 'with' and 'without' medication

Children's perceptions of their ADHD and self-concept

Interview with teacher

The researcher will use an informant style interview with teachers and the following techniques will be employed:

- Use of open-ended questions
- Allowing the shape of the interview to be dictated by the range of concerns raised by the participant, advancing the interview through requests of clarification, exemplification, development of ideas
- Use of participant vocabulary and techniques of paraphrase and reflection
- Indicating interest, empathy and positive regard
- Avoiding interruption and forcing the pace
- Ending the interview with warmth and communicating appreciation

Within the framework of informant style interviews, the following areas will be covered:

- The effect of ADHD on the child
- The management of symptoms
 - How the teacher/school help to manage the child's behaviour
- The function of the medication
 - Is it positive or negative?
 - What would happen if the medication was not there?
 - Does the medication control behaviour?
- Child's strengths and weaknesses
 - With and without medication

Appendix B: Ethical Approval

Your Ethics Form approval

Psychology.Ethics.Forms@ps1.psy.soton.ac.uk
[Psychology.Ethics.Forms@ps1.psy.soton.ac.uk]

Sent: Friday, September 12, 2008 3:43 PM

To: [Bradley J.A.](#)

This email is to confirm that your ethics form submission for "Children's Perceptions of their ADHD and medication" has been approved by the ethics committee This email is to confirm that your ethics form submission for "Children's Perceptions of their ADHD and medication" has been approved by the ethics committee

Project Title: Children's Perceptions of their ADHD and medication.
Study ID : 631
Approved Date : 2008-09-12 15:43:47

Appendix C: Consent forms and Information Sheets

Children's perceptions of their ADHD and self-concept

CONSENT FORM

Parent

Researcher name: Jess Bradley

Ethics reference:631

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet

and have had the opportunity to ask questions about the study

☐

I agree for my child to take part in this research project and agree for their data

to be used for the purpose of this study

☐

I understand my child's participation is voluntary and I or my child may withdraw

at any time without my legal rights being affected

☐

Name of Parent (print name).....

Signature of Parent.....

Date.....

Children's perceptions of their ADHD and self-concept

ASSENT FORM

Child

Researcher name: Jess Bradley

Ethics reference: 631

Please initial the box(es) if you agree with the statement(s):

I have been told about the project and know I can ask questions about it

☐

I understand that I don't have to take part in the study and can ask not to do it

☐

Name of participant (print name).....

Signature of participant.....

Date.....

Children's perceptions of their ADHD and self-concept

CONSENT FORM

Teacher

Researcher name: Jess Bradley

Ethics reference: 631

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet
and have had the opportunity to ask questions about the study

☐

I agree to take part in this research project and agree for my data to
be used for the purpose of this study

☐

I understand my participation is voluntary and I may withdraw
at any time without my legal rights being affected

☐

Name of participant (print name).....

Signature of participant.....

Date.....

Children's perceptions of their ADHD and self-concept

Parent Information Sheet

Researcher: Jess Bradley Ethics number: 631

Please read this information carefully before deciding to take part in this research. If you are happy for your child to participate you will be asked to sign a consent form.

What is the research about?

I am a third year doctorate student in educational psychology from the University of Southampton. I am interested in finding out about how children experience and perceive their ADHD and the medication they take. I will be asking your child about how it feels to have ADHD and what it is like to take medication. I will also be asking them to describe themselves, through drawing to try and understand how they view themselves. It is important to try and understand children's perspectives in relation to ADHD so that more effective treatments can be planned.

I will also be talking to your child's teacher about how they manage their behaviour and what things help, this will also be in relation to their medication.

Why has my child been chosen?

After receiving a letter from school about this study, you agreed to be contacted to take part. Your child has been selected to take part because he/she has a diagnosis of ADHD and is taking medication.

What will happen to my child if I take part?

I will visit your child in school to introduce myself and explain the study to them. I will visit them again in school (a week or so later) to carry out an interview with them which I will record on a Dictaphone. I expect the interview to take about an hour and during that time I will talk to your child and we will also complete a drawing activity. After meeting with your child I will meet with their class teacher. This may be on the same day, or it could be at a different time.

Are there any benefits to my child in taking part?

Your child will have the opportunity to talk to me about their ADHD, which they may find helpful. The information your child tells me about themselves will be important and will contribute to further research knowledge in this area.

Are there any risks involved?

I don't anticipate there to be any risk to your child during or after the interview.

Will my child's participation be confidential?

All the information your child gives me will be kept confidential in accordance with the Data Protection Act and University policy. The transcript of your child's interview will use a code to ensure anonymity, and the information will be stored on a password protected computer which only I will have access to.

What happens if I change my mind?

You and your child have the right to withdraw from the study at any time you wish. Your legal rights are not affected by this decision.

What happens if something goes wrong?

In the unlikely case of concern or complaint you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: (023) 8059 5578

Where can I get more information?

If you have any further questions, please contact my research supervisor at Southampton University - Julie Hadwin on (023) 8059 5000.

Children's perceptions of their ADHD and self-concept

Child Information Sheet

Researcher: Jess Bradley

Ethics number: 631

Please read this information carefully before deciding to take part in this project

What is the project about?

I am a psychology student from the University of Southampton. I am interested in finding out about your ADHD. I will be asking you about how it feels to have ADHD and what it is like to take medication. I will also ask you to describe yourself and do some drawing. It is important to try and understand your experiences so that your ADHD can be managed.

I will also be talking to your teacher about ADHD and what things help in school.

Why have I been chosen?

Your parents received a letter from me telling them about my project my project and decided that they would like you to take part.

What will happen to me if I take part?

I will meet with you in school once to introduce myself, then I will come back on another day to talk to you. We will have a quiet room to talk in and I will record what we say on a Dictaphone. I will also ask you to do a drawing activity.

Why should I take part?

You might enjoy having the chance to talk to someone about your ADHD. Also, the information you tell me will be really helpful for other research in this area.

Are there any risks involved?

I don't expect there to be any risk to you during or after the interview.

Will my participation be confidential?

All the information you give me will be kept confidential in accordance with the Data Protection Act and University policy. This means that only I will see the information and I will give you a code name so that no one will know what you said. I won't tell your parents or teacher what you said. If you say anything to me that makes me think you are in danger or someone else is in danger, I will have to tell someone about it.

What happens if I change my mind?

You have the right to withdraw from the project at any time you wish

What happens if something goes wrong?

If anything goes wrong you can ask your parents or teacher to contact the university

Where can I get more information?

If you have any further questions, please ask your parents or teacher to contact the university.

Children's perceptions of their ADHD and self-concept

Teacher Information Sheet

Researcher: Jess Bradley

Ethics number: 631

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

I am a third year doctorate student in educational psychology from the University of Southampton. I am interested in finding out about how children experience and perceive their ADHD and the medication they take. I will be asking the child in your class about how it feels to have ADHD and what it is like to take medication. I will also be asking them to describe themselves, through drawing to try and understand how they view themselves. It is important to try and understand children's perspectives in relation to ADHD so that more effective treatments can be planned.

I will also be asking you about how they manage their behaviour and what things help; this will also be in relation to their medication.

Why have I been chosen?

After receiving a letter from school about this study, the child's parent agreed to be contacted to take part. The child in your class has been selected to take part because he/she has a diagnosis of ADHD and is taking medication. As his/her teacher, you have also been selected to participate in the study.

What will happen to me if I take part?

I will visit you and the child in school to introduce myself and explain the study. I will visit you again in school (a week or so later) to carry out an interview with the child, and separately with you which I will record on a Dictaphone. I expect the interview to take about half an hour and during that time I will talk to you. I will also ask you to complete an ADHD checklist.

Are there any benefits to me in taking part?

The information you give me about the child and your experiences of ADHD in your classroom will be important and will contribute to further research knowledge in this area.

Are there any risks involved?

I don't anticipate there to be any risk to you during or after the interview.

Will my participation be confidential?

All the information you give me will be kept confidential in accordance with the Data Protection Act and University policy. The transcript of your interview will use a code to ensure anonymity, and the information will be stored on a password protected computer which only I will have access to.

What happens if I change my mind?

You have the right to withdraw from the study at any time you wish. Your legal rights are not affected by this decision.

What happens if something goes wrong?

In the unlikely case of concern or complaint you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: (023 8059 5578)

Where can I get more information?

If you have any further questions, please contact my research supervisor at Southampton University - Julie Hadwin on (023) 8059 5000.

Appendix D: Interview Transcripts and Drawings Child A

JB: So D, maybe you could tell me a bit about what its like being at school.

Child a: It's fun 'cos I get to play with my friends and I get to learn more.

JB: What do you like playing with your friends?

Child a: Urm...football, tag....and like just running around everywhere.

JB: And what are your favourite lessons?

Child a: Urm..literacy, art and... maths

JB: What do you like about those ones?

Child a: 'cos literacy 'cos if like you get to like keep writing and if you like write and you do like 5 really bits of neat work you get like a pen.

JB: Oh wow

Child a: And in maths you get to learn more like so if when you're older and someone asks about maths and you have to help and in art so like you can create things and things like that

JB: That sounds really good. Is there anything that you find difficult in school?

Child a: mmm. [Pause]. Sometimes forgetting to put my hand up.

JB: Oh right. What happens if you forget to put your hand up?

Child a: I get a name on the b- on the bad side, for shouting out.

JB: For shouting out, oh right and what happens if you get your name put on the bad side?

Child a: If you get a name and another name and then another name you get 20 minutes, if you get another name and then three ticks you get rest of the day.

JB: You get the rest of the day, rest of the day doing what?

Child a: Urm in another class. But not with the whole of the day, the rest of the school day.

JB: Oh right. So why do you think you sometimes shout out?

Child a: Urm. 'cos sometimes I keep my hand up for ages and sometimes I'm not patient

JB: Oh, because you're not patient. Can you tell me what its like having ADHD?

Child a: Umm. Bit annoyed 'cos some people they used to take the mick out of me. And, when people get me annoyed they make me go mad. 'cos they like push me over

and things for no reason. And they just wind me up. No sometimes, they just wind me up.

JB: That's difficult isn't it?

Child a: And then I'll get in troubles...for hitting back.

JB: Ok. So sometimes it's fighting....Does it...does it affect you in any way in lessons?

Child a: [pause]. Sometimes 'cos sometimes I don't have my tablet...umm it makes me like shout out a bit more and things. And when I do have it it makes me calm down a bit more.

JB: Your tablet makes you calm down a bit more, ok. So how often do you take a tablet?

Child a: Um. Once in the morning and one after lunch.

JB: Mhm. And what does it do?

Child a: Um. It like calms me down and things.

JB: So it makes you feel calmer? Ok. So does that mean it stops you shouting out in class? [nods] Yeah? And does that mean it stops you getting into fights with friends as well?

Child a: mmm. 'cos it. 'cos it makes me just ignore 'em. And when I don't have it it don't make me.

JB: Oh ok. so, what would happen if you didn't have your tablet?

Child a: Um. I would have probably had 20 minutes by now, that's what happened the other day I had 20 minutes before 9 o'clock.

JB: Oh right. What does 20 minutes mean?

Child a: You get 20 m- you get 20 minutes staying in another class.

JB: Ok. So if you don't have your tablet you sometimes have to have 20 minutes because you've messed about in class.

Child a: mmm.

JB: so do you think that your medication helps you to be better then? [nods] Yes, you do, you're nodding. What do, um, what do adults in school do to help you cope with your ADHD?

Child a: They just Miss um she just says like 'cos she's really nice and she just says like just don't worry A just ignore 'em they're only gonna try and wind you up and get you in trouble.

JB: Right ok. So Miss helps you ignore the other children? [nods] Yes. Do your teachers or LSAs do anything else to help you in school?

Child a: Um. Like when I get like quite mad and things with other people when they wind me up and they do things wrong teacher goes and 'just go and sit down with misses class a little bit to calm down'

JB: Right. So they know that you sometimes need to calm down. Yes. Are there some times when it's easier to cope with ADHD?

Child a: Mmm don't know.

JB: You're not sure. Whats it like at home, having ADHD?

Child a: Well, my brother winds me up and things.

JB: What does he do that winds you up?

Child a: 'cos like when I'm asleep he gets he usually on top of my bed and jump on me and things and at night time like he like starts like at lunchtime when I have it and when I get home and there's like 6 o clock I wanna go all night and he plays his little leapster frog game and he asks me to do it for him all the time...

JB: He asks you to do what?

Child a: Play leapster frog and that all the time.

JB: Oh ok.

Child a: And like round my old way when I didn't have medication um this man thought I sweared at boxing but I didn't.

JB: Oh right, so what happened?

Child a: He said go home...and I went home and then my dad said why didn't you phone mum and he said 'cos you sweared and I said 'no I didn't'

JB: So, somebody thought you might have been swearing

Child a: Hmm

JB: But you weren't

Child a: 'cos I said 'stuff that', 'cos we have to do do um, 'cos we was like talking and some of us and um and we was getting bored and we didn't want to do press ups or nothing so we have to go outside and run, do like 10 runs jogging around this and then we have to do sprint and everything and then I went 'stuff that we've already done 10 rounds'

JB: So you got told off for swearing

Child a: Yeah, he thought I sweared but I didn't.

JB: What things are you really good at D?

Child a: Um. I'm good at riding motorbikes....um... I don't really know. Can I tell you what I'm getting better at? I'm getting better at like putting my hand up and listening and stuff...and I'm getting better at not hitting my mum, 'cos I used to hit my mum. I hardly don't no more.

JB: How have you managed to get better?

Child a: I think, I don't know. It may be the tablets I don't know.

JB: You must have worked really hard on it. You think it might be the tablets?

Child a: And sometimes they make me not like eat an' that. Thats why I don't have a lot of like lunch time things.

JB: You feel like you're not very hungry?

Child a: mmm. Even when I get home.

JB: Did the doctor say that that might happen?

Child a: I can't remember.

JB: Are there some things that you're not so good at? You told me some of the things you are good at like riding motorbikes and getting better at putting your hand up and listening. Is there anything that you're not so good at?

Child a: Umm. Sometimes playing the games at my mates that we do 'cos like I'm saying like come on shall we play this game and things and they go 'no' and I go 'but you said yesterday we could' and he said 'so'. And things like that 'cos like at school all my other friends are really good at football and that, and um, they always get all the best players and things. And I say 'come on lets make it fair teams, and we could put like choose captains and then you could pick one then the others pick one and then one again like that so its fair'.

JB: Sometimes you find it hard if people aren't being fair with you.

Child a: I find it hard when people like get all lairy with me and start hitting me to try and wind me up.

JB: Why do you think people want to wind you up?

Child a: I don't know.

JB: Do other people get wound up?

Child a: Someti-...I don't know actually. Like, like, I'm playing football and if one of my mates budge me and I fall in to someone else then he'll go up to me and go 'come on then, fight me' and I go 'all I was doing was playing football'. And like, when I was in year 4 this boy called G and everyone used to start on me.

JB: Thats difficult.

Child a: 'cos one night G, G and this boy called P that are in year 7 and they was round my mum's 'cos they was in and I....and they're two years older than me I think. When I was in year 4 they was in year 6 I think. And um. They's, they slept round mine and um G hit me with a pillow and pretended he was asleep and me and Paddy was half asleep and G came up to me and went 'boof' and um I said I lobbed one back at him then 'what did you do that for?' and he tried to run at my door and my dad went, my dad just went like that (put his arm out) 'come on G mate' just got his arm and just went 'come on G mate just come indoors and we can sort it out' and he told my dad to p-, the p- word.

JB: That sounds a bit tricky. Is there anything else you want to say about ADHD about what is like having it or having tablets for it?

Child a: I don't know what else to say.

Child B

JB: B, maybe you could tell me a bit about yourself.

Child b: Um, I'm a bit...ummm, bit, upset, I think I get when I get a bit emotional I start being angry. Um, I start saying things that I shouldn't be. Saying things and then, it just pops out and I'm a bit, I'm like...sometimes if it's like a really good day I haven't...you see the nice Ryan of me. If it's a really bad day you see the angry Ryan of me, and I'm like...really angry I just go at anyone who gets on my nerves just like that and that's it. So, plus I play rugby to...to take out my anger from...take my anger out on that... and it, a bit more better 'cos it's, my anger goes down bit more now, it's gone...right down, so that's it.

JB: So the rugby helps you.

Child b: Yes.

JB: So, the things that you said about being upset and getting angry, do you think that that's got anything to do with ADHD.

Child b: I think so, because...when I get angry...'cos... my ADHD starts to kick in. It starts to get me a bit angrier it makes me had adr- adrenanline, I can't say it.

JB: Adrenaline?

Child b: Yes that's it. And um it just helps me, it just, it just goes, I just can't talk to anyone, if anyone like just says anything bad to me or something it'll speak to me and I'll just go and hit 'em or something and I can't, I can't, I'm not allowed to do that...so I've got to do, I've got to ask if I can have time out for ten minutes or something and they'll let me.

JB: Ok. So does the time out help?

Child b: Yes.

JB: What do you do in time out?

Child b: Uh, do...play sort of like games that'll help me...anger games like that or I start, I sit down and read to someone and then I'll start...start talking to someone.

JB: And that helps things get calmer.

Child b: Yes.

JB: So, you said that sometimes your ADHD kicks in and that's when there's problems. Does that mean that sometimes you're not feeling the ADHD so much?

Child b: Yeah.

JB: What times?

Child b: It's like at school when people...when I'm, when I'm really happy and it's a good day...it could turn into a worse one because..if, if, anyone if anyone said something to me or stuff like that then I'll just get angry for some reason and it just starts to kick in. And plus I have...have to have um med...tablets. One of them is like a small one, I don't know what that is but it helps me..um, get calm a little bit. And then I've got to have a big tablet and then that'll, that'll be for the rest of the day.

JB: Ok

Child b: It'll only um, wears off in like four hours or three hours, but now it's worn off already because I've had a fight already. And it just worn off. I gets angry.

JB: So you have to take those tablets in the morning?

Child b: Yeah. I can't take them without a drink...it'll just taste disgusting and I can't handle that so I have to have a drink.

JB: what do those tablets do?

Child b: One of them, um...one of them let helps me talk much better because I've got like a little disorder that I can't... when I talk it's like I repeat myself a bit. And then my other, my big tablet it helps me relax for the whole entire day. It wears off in like four or five hours so...I've got enough...um, wearing off to do and I keeps calm. So that's it.

JB: Ok, so the tablets that you take for your ADHD help you feel more relaxed. Does that mean that it helps you behave in a way?

Child b: Yes, but if I didn't have it then I'd behave really bad and I just...like...try and like hurt someone and like try and kill or something, and I don't want to do that 'cos I'm...I have to take them. But when I run out of tablets yeah, and I can't take them... that means...I'd have a really bad day and I like...I'd have to, I'll be sent home and stuff like that so...

JB: When you go to rugby have you taken your tablets to go to rugby?

Child b: I have, I take my tablets in the morning so when I go to rugby and it's all relaxed and I can take all my anger out on that.

JB: So you wouldn't need a tablet, so it's worn off by then.

Child b: Yeah.

JB: You wouldn't need your tablet for rugby?

Child b: No. 'cos if I hurt someone it won't wouldn't be my fault 'cos it'd be my ADHD that'd be kicking in and it would just hurt 'em.

JB: Your ADHD would be hurting people.

Child b: Yeah. Because when I go in to um...if like... I hurt 'em really bad the other day and I sometimes be told off for it and I says to 'em "it ain't my fault 'cos I got ADHD and it's a disorder that I can't handle and it's not my fault that I was born with it" and then they understand.

JB: The people at rugby understand.

Child b: Yeah.

JB: Do people at school understand that?

Child b: No. Only the teachers do 'cos they actually listen to me really good...and I thought 'thank you very' I I said I keep....'cos I'm not religious I just prays some of the time saying 'thank you, thank you very much' and all that to them and everything you know I'm just like...I can handle it now but when I'm talking to someone else like a little kid, like another kid it just...puts me off because I can't handle it because I only like talking to teachers that are like...that I know very well and stuff like that...that can help me.

JB: Do you think that the other students in school don't listen that well?

Child b: Yeah, the teachers do.

JB: What about at home...does your ADHD affect you when you're at home?

Child b: Some of the time I snaps at my brother and my mum...especially my mum because I love my mum very much...but sometimes I just snaps at her for some reason or no reason at all...it's like...

JB: And you don't know why that is.

Child b: No.

JB: Is there anything else, or any other way that your ADHD affects you?

Child b: Um, swearing because when I'm angry when my ADHD kicks in it just starts I just start swearing out any word I can think of...even if it's horrible about their mums or something like that and I and I don't want to say that, it's a bit but it's hard for me to control it. So. That's it.

JB: Is it easier to control it if you've had your tablet, is that what you mean?

Child b: Yeah. I would rather take, two of, both of my tablets one in the afternoon and one at night and I think it would be much better because I can't...I have to take 'em in the morning so.

JB: Why do you want to be able to do that?

Child b: In the night so I don't get all...so I don't have to get up in the night and go to the toilet and stuff like that I can just relax and...so I don't have to snap at my brother and my mum.

JB: So in the night time...

Child b: Yeah, especially, no it's like especially at night. If I snapped at my dad then it'd be bit...it would it it's like no...he will slap me but not as hard, like as hard as he would usually do so...that's it.

JB: What things are you really good at?

Child b: Rugby of course. Rugby of course. 'Cos when I go in for a tackle it just, I just take them down really good.

JB: Is there anything in school that you're really good at?

Child b: Art. Ok at art but I get some help to do the outlines for me and then I just colour it in...and stuff like that.

JB: Do you like art?

Child b: I love it 'cos we've got an art teacher and she's my teacher as well now...but I had to move out of Anne-Marie's class 'cos of a problem.

JB: So you're going to be in a different class now. Is that going to be alright?

Child b: Yeah.

JB: Is there anything that you find difficult?

Child b: ...listening. Listening's very hard for me 'cos I...I sometimes when they're talking I listens to other people than them...but ...I still, getting, try to.

JB: So you've told me quite a lot about your ADHD and it sounds like you take your tablets in the morning and that it helps you not experience your ADHD so much?

Child b: Yeah.

JB: And then when the tablet wears off you might find that your ADHD kicks in. And it also sounds like that when something happens even when you're on medication your ADHD might kick in as well...and then that would be when you feel angry.

Child b: Yeah.

JB: Is there anything else you want to say about those things?

Child b: No.

Child C

JB: Could you start off by telling me a bit about school?

Child c: School's not that great.

JB: Ok

Child c: When you're in primary school its not as bad. I didn't know I had ADHD until I was like diagnosed with it

JB: Do you know when you were diagnosed with it, how old you were?

Child c: I was 3. But I had it before I was diagnosed with it. Right.

JB: Does that mean that you had to go...and see a doctor?

Child c: Yes

JB: And did anyone tell you what ADHD is?

Child c: No. They just told me that its something that just dissolves around your body. I found out that it also makes you have anger.

JB: So you were told that it was something that dissolves around your body.

Child c: Yeah, just like not go away, and make you feel anger.

JB: Did it affect your time at school do you think?

Child c: It used to when I was in primary school, not now because I've learnt to control it.

JB: In what way did it affect you in primary school?

Child c: Like just walking into school and getting into a fight with someone. My mum couldn't work because I had to go home every day.

JB: Was that to do with the anger you were just talking about?

Child c: Yeah and physically hurting people.

JB: How have you managed to be more in control of it now do you think?

Child c: I've been put on loads of different medication.

JB: Tell me about your medication.

Child c: I started off on Ritalin but that was bad because I was thinking of things what kids shouldn't really think of when they're that age. And then, I was also on a different one and then I had this voice in my head...telling me what to do...controlling me. Then I got the one that I'm on now...it controls me. But it has bad side effects.

JB: What are the side effects?

Child c: They can make me stop growing, and stuff like that...stop eating. Make all my bones seize up. They said 'we'll have to put you on a higher dose, to help you with your aggression and that'. So they put me on a couple more to help me control it.

JB: Do you know what that medication's called?

Child c: Risperidon.

JB: How often do you have to take it?

Child c: I take it every night and it lasts all through the day.

JB: So there isn't really a time when its worn off.

Child c: No. Because I used to be on one in the morning and one in the afternoon, but it didn't last through the day.

JB: Do you take it at the weekends as well?

Child c: Yeah, I take it all the time.

JB: And how do you feel about that?

Child c: If I don't take I...I broke my mum's fingers...and...I had to go to hospital when my (...) and I run, 'cos I cut my arm up here I had to have one of those tubes on, and I runned out the hospital, run down the main road and there was a (...) chasing me and he pushed me to the ground...

My mum said 'oh just sit down...'

JB: So that was a time when you weren't on medication

Child c: Another time where I forgot to take it....

JB: So do you think that the medication controls your ADHD?

Child c: Um, I have control of it myself but if I don't take it.... its not just the ADHD

JB: So what kinds of things have you learnt to do yourself?

Child c: Just try and ignore stuff.

JB: Ignore what?

Child c: Ignore people who are annoying me and just try and keep calm. Don't think of stuff what you could do to hurt people... When I want a fight I look like thoughts in my head, think sometimes about getting that person, and when I'm like calm I don't do that

JB: You kind of put those thoughts out of your head.

Child c: When I was younger I used to punch my head to try and stop the thoughts, I used to do it proper hard, smack my temple there [points to temple] to stop me thinking of horrible things.

JB: It sounds like you've learnt lots of ways of managing your own behaviour. Would you be able to do those things if the medication wasn't there?

Child c: Probably not. If like...at night if I forget to take it I sit in my bedroom and shout and scream otherwise me and my brother will be punching each other.

JB: Are there things that adults do in school that help you manage?

Child c: Yeah. It depends on what we're doing. If we're doing some kind of work I will...

JB: If you're doing work. Is there anything else they do that helps you behave better?

Child c: Just like, calming me down, letting me go out the classroom if I need to calm down.

JB: So they spot things in you as well.

Child c: Yes. N's been helping me at this school ever since I came here, so she knows what I go like when I lose it.

JB: So she can help you get out and calm down.

Child c: Yeah.

JB: What kinds of things are you good at?

Child c: I'm good at more physical stuff, like mechanical and rugby, stuff that I can do with my hands.

JB: Yeah...making things, fixing things.

Child c: Yeah, in school in DT, I can go and build stuff.

JB: So you're good at practical activity. Anything else?

Child c: Fishing.

JB: Where do you go fishing?

Child c: I go coarse fishing and deep sea fishing.

JB: Do you ever catch anything?

Child c: I caught a carp that was 23 pounds. It was as long as my arm.

JB: Do you think that your ADHD helps you with anything, makes you better at anything?

Child c: It makes me better at running, and it builds up my muscles, it makes me stronger.

JB: ADHD makes you stronger.

Child c: Yeah, 'cos it don't make you quit. I used to give up on everything...I can do it now.

JB: What do you think is different? You said that you've always had ADHD, so what's changed?

Child c: Most things really, like I'm not so aggressive anymore compared to how I used to be. I don't use all my muscles in my upper part for fighting, I use my legs.

JB: So you can put more energy into things like running than feeling angry.

Child c: Yeah. Last week when you saw us put the [punch]bag up, I was punching that

JB: So was that aggression.

Child c: Yeah, it calms you down, thats why they put the bag in the hall.

JB: So you find that if you have your time on the punch bag.

Child c: I let all my aggression out by punching something not someone, then I calm down.

JB: So, is part of ADHD having anger and aggression.

Child c: Its part of it, just makes you have outbursts of anger sometimes.

JB: Ok...How do you feel about having ADHD?

Child c: I don't feel happy about it...it does bring me down sometimes...there's loads of people with ADHD though.

JB: Thats true. And, how do you feel about taking your medication?

Child c: I don't really mind, I've been on it so long..I just shove it down

JB: So you don't always think very much about it now?

Child c: No I just take it.

JB: And you don't mind being on it.

Child c: No... But there's other kids with ADHD who don't have to have it. There's like the bad one, really horrible one where you have to take tablets, a medium one where you have to take tablets, and then there's just a normal one where you don't have to take tablets...and I'm on the highest one...and I've got autism.

JB: So you've got a diagnosis of that as well.

Child c: Yeah.

JB: How does that affect you do you think?

Child c: Its just like ADHD, it just gives me more aggression.

JB: Are there some things which you're not very good at, you've told me about some of the things which you are good at?

Child c: Like, I'm good at the stuff I've told you about

JB: Yeah, practical things.

Child c: I'm rubbish at writing, stuff like that

JB: You find writing difficult?

Child c: Yeah.

JB: Do you think you would notice a difference with how you got on in lessons if you didn't have your medication?

Child c: Only that it would be harder to concentrate. That's the thing with autism, it makes you have short...um...short focus...short thinking span.

JB: So the tablets help with your attention span as well, and let you concentrate on something for long enough to be able to do it.

Child c: Yeah.

JB: Anything else?

Child D

JB: D, first of all, could you tell me a little bit about what it's like being in school?

Child d: Boring.

JB: Yeah?

Child d: Fun when you get in the hostel, you get to play games.

JB: Is that in the evenings?

Child d: Yeah. Better.

JB: It's better in the hostel.

Child d: We get to go on the bikes.

JB: Do you? What sort of games do you play?

Child d: We play any age appropriate games.

JB: What sort of things are they?

Child d: Ratatouille.

JB: What's that?

Child d: Um,

JB: Is that one of your favourite things to do?

Child d: Don't forget playing on the bikes.

JB: Where do you go on the bikes?

Child d: On the main playground. We get to do anything we want but if we swear we get time.

JB: Time on what?

Child d: Bedtime. If we swear like the 'f' word we get five minutes, we have to go five minutes to bed early.

JB: Has that ever happened to you?

Child d: I had forty five minutes but I didn't get it all.

JB: Ok, you've done forty five minutes.

Child d: Yeah, cos I had an infection, I couldn't hold in the shower so I let wee.

JB: So you got forty five minutes for that. What about being in school D?

Child d: I don't like school 'cos Miss does my head in.

JB: Does she, how is that?

Child d: Boring, she gives us comprehension which, I ain't a good writer and she gives us lots of handwriting which I'm not good at. But I ain't good at my writing so she tells me to re-write it and it does my head in.

JB: What does that mean, does you head in?

Child d: She keeps telling me to re-write it if its not neat and stuff. Hope we can hurry up 'cos I'm going to be popping balloons soon.

JB: You're going to be doing what?

Child d: Popping balloons.

JB: Why?

Child d: 'Cos we're making around the world in eighty days.

JB: Oh I see you're learning about around the world in eighty days.

Child d: Yep.

JB: Can you tell me a bit about your ADD and ADHD?

Child d: ADHD is where you're hyper and can't control yourself, they do stuff they don't mean. Um, it just pops out and ADD I ain't got a clue about only ADHD.

JB: So is that what you've got then?

Child d: Yes.

JB: So what does it mean for you?

Child d: Ummmm, I just get silly, burst out with mentalness. Burst out with mentalness? Yeah, like getting the old bill called in.

JB: Getting the old what?

Child d: Bill.

JB: Oh I see.

Child d: We should call them pigs. 'old bill, old bill, they make me fucking ill'. That's what we sing for them. I've done it again then did you see that?...oh shit, I've done it again.

JB: Do you think that's your ADHD that makes you do silly things?

Child d: Yeah.

JB: And what helps you to not do silly things?

Child d: Um, take tablets, but when I had tablets they only work, they work for a little time here.

JB: What did they do?

Child d: They made me be a bit good and then they wear off I just go schizophrenic.

JB: What does that mean?

Child d: Mental [rolling eyes and making noises to show someone being 'mental']. I'm doing that.

JB: Do the tablets make you feel funny?

Child d: Yeah they make me sleepy one did. The Strattera makes me sleepified.

JB: Ok, you had Strattera?

Child d: It's umm, a ventalin I think. It makes me sleepy.

JB: Have you had any other tablets?

Child d: R....Ritalin.

JB: And what does that make you do, or feel like.

Child d: It makes me calm down. It makes you calm down.

JB: D, can you tell me things you're really good at, or the things you like doing?

Child d: PS2, piano.

JB: Playing the piano?

Child d: Yes. [shows playing the piano and sings along]

JB: Where do you play the piano?

Child d: Hostel. We get a teacher coming in and

JB: How often do you do that?

Child d: Sometimes. Plus we've got another brat called C.

JB: What have you learnt to play on the piano?

Child d: I'm learning in the hostel...walking in the air, wedding march, the Taliban song.

JB: You must have to concentrate really hard to learn to play the piano.

Child d: We've got one kid in there who's not in there but used to be in there he's really good at it and he can do all different songs.

JB: It sounds to me like you're quite good.

Child d: I'm trying to do James Bond.

JB: Do you find that when you're playing the piano you can sit still a bit better?

Child d: [looking at a Frisbee]

JB: Can you think of some other things that you're good at as well as PSP and piano

Child d: It's not PSP it's playstation. Nintendo, 'cos we've got a Nintendo DS, gameboy, lots of computers. And we've got sometimes S, who we normally call S because he acts like a girl, so I call him S, he brings his playstation 3 in.

JB: Are there some things D that you find more difficult then?

Child d: Yeah.

JB: Like what?

Child d: Lego.

JB: What's difficult about Lego?

Child d: It's hard 'cos you don't know what to do. I get silly sometimes but the other thing I'm doing next Sunday at the Labour Club is dressing up as the Blues Brothers. It's not fancy dress I just like it.

Child E

JB: Could you start of by telling me a little bit about yourself E?

Maybe you could tell me something you like doing.

Child e: Quadbiking

JB: Quadbiking, do you do that at the weekends?

Child e: Sometimes.

JB: Who do you do that with?

Child e: Dad.

JB: Where do you go?

Child e: In the garden.

JB: You do it in the garden. You must have a big garden.

Child e: Yes.

JB: Does anyone else do that or is it just you and your dad?

Child e: Some people yes, my brothers and sisters.

JB: Have you got your own quad bike?

Child e: Yes.

JB: That's exciting. What is it about quadbiking that you really like?

Child e: Driving.

JB: That sounds like fun. Is there anything else you like doing?

Child e: Playstation.

JB: Oh, you've got a playstation. What kind of games are you in to?

Child e: Fighting and driving.

JB: What's your favourite one at the moment?

Child e: Driver.

JB: Could you tell me a little bit about what it's like being in school?

Child e: Um, good.

JB: What things do you like in school?

Child e: Maths

JB: Why do you like maths?

Child e: Not sure.

JB: Are there some things that you don't like in school?

Is there anything that's a bit more difficult?

Child e: ...Writing.

JB: How do you manage with that, do you have some help?

Child e: Yes.

JB: Do you ask for help?

Child e: Yes.

JB: Could you tell me a little bit about your ADHD? What do you know about it?

Child e: Not sure.

JB: Do you know what it means?

Child e: Not sure.

JB: How about the tablets that you take...can you tell me a bit about that?...when do you have to take them?

Child e: At lunchtime and in the morning.

JB: One in the morning and one at lunchtime. What do they do?

Child e: Don't know.

JB: Do they make you feel any different?...If you didn't take them would you feel any different?

Child e: Yes.

JB: What would be different?

Child e: Not sure.

JB: How do you feel about taking them?

Child e: Alright.

JB: You feel alright about taking them?

Child e: Yeah.

JB: How do you remember to take them?...does somebody remind you or do you remember?

Child e: I remember.

JB: That's good. You know where you have to go to get it at lunchtime.

What about at home. Do you think your ADHD affects your behaviour at home?

Child e: No.

JB: When does your tablet wear off?

Child e: At night.

JB: You don't have a time when you're not on medication. Do you take it at the weekends?

Child e: No.

JB: What's it like at the weekend?...do you think you're any different?

Child e: A little bit different.

JB: A little bit different. How...in what ways are you a little bit different?

Child e: I concentrate less.

JB: You can't concentrate at the weekends? What kinds of things do you need to concentrate on?

Child e: Homework.

JB: Is that more difficult to do at the weekends than on a school night?

Child e: Yes.

JB: Is there anything you can do to help with that?...Is there anything that mum or dad can do to help you concentrate on homework.

Child e: Not sure.

JB: It sounds like you're getting on really well at school at the moment, you're a really hard worker. You're managing your behaviour really well and taking your tablets. Then at the weekends you have a break from you tablets and sometimes you notice its a bit harder to concentrate on something. What's that like when it's difficult to concentrate? What does that feel like?

Child e: Not sure.

JB: Can you tell me what things you're really good at?...you said maths, are you quite good at maths?

Child e: Yes.

JB: Something that your teacher told me that you are good at is being a very good friend, a very sociable boy in the playground, is that right? Do you think you're good at getting on with other people?

Child e: Yes.

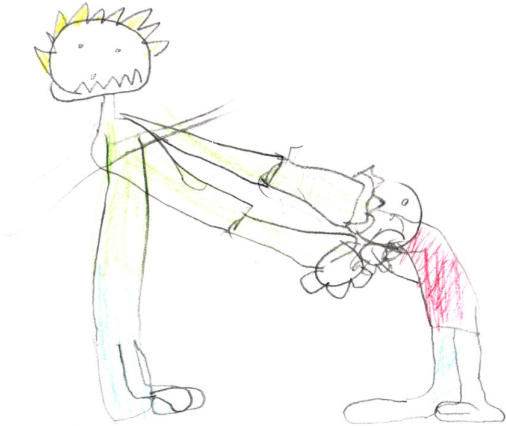
JB: Can you think of some things that you're not so good at?

Child e: English.

JB: Anything else?

Child e: No.

Child A



Would not like to be like

Bully beating someone up

Think they're strong

Bullies people smaller than him

Angry

I hit back

Haven't had tablet

Would like to be like

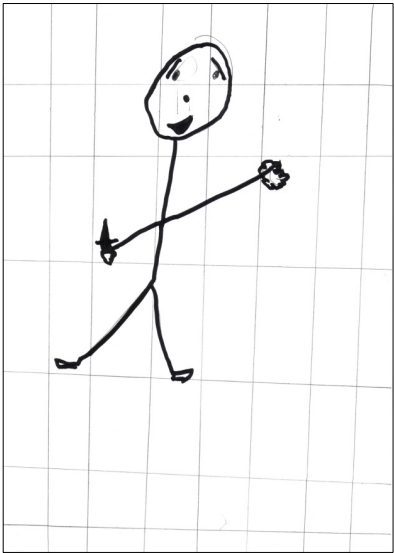
Me in Pompey scoring a goal

Kind, not stingy, loves football

Passing, shooting

Had tablet

Child B



Would not like to be like

In prison

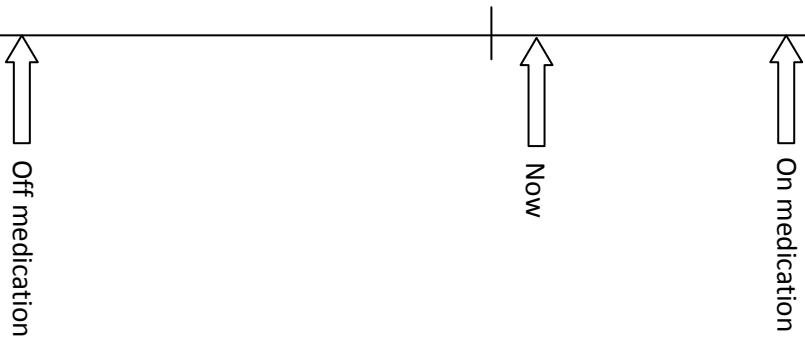
An ADHD person

Killed someone

He could handle it

It wasn't his fault

Sad



Would like to be like

At the beach

Happy

Enjoyable

Excited

He feels free

Child C



Would not like to be like

Think they're all that
Horrible
Mean
Bullies everyone
Fat

↑
No medication

↑
Now

Would like to be like

Normal kid
Does what he likes
Happy
Fun
Don't have ADHD

↑
Would like to be.
Not perfect, goody.
Normal kid

Child D



Would not like to be like

Devil
 He's got a whip
 to whack the
 dead people
 Angry

↑
Ritalin

↑
Where I am – half good
half bad

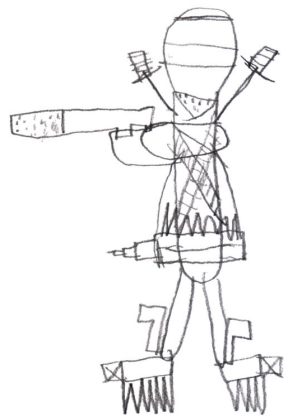
↑
Where I'd like to be

↑
Stratera

Would like to be like

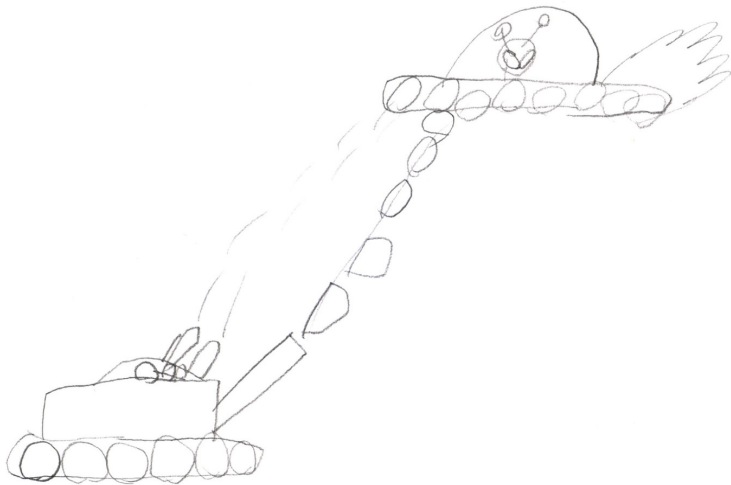
Superman
 Happy
 Saved people – good
 people

Child E



Would not like to be like

A man with some weapons
He kills people
Mad
Angry



Would like to be like

Tank destroying some aliens.
Aliens need to be destroyed so they don't take over the world
Doing a good thing

↑
Not on medication

↑
Now (on medication)

↑
Would like to be

Teacher A

JB: Maybe you could start off by telling me about how you think D's ADHD affects him in the classroom.

Teacher a: Um when he hasn't had his Ritalin umm I'm peeling him off the ceiling. He cannot focus on a task. He cannot settle to a task. He is disruptive. He is easily distracted. Umm, and to get him to pick up a pencil could take an hour...so when he hasn't had his Ritalin he might as well not be here. Umm, however when he has had it um, he is very subdued he is a different child completely. The... I've seen, since he started taking Ritalin I have seen an improvement in his um work. He is focused on his learning. He is um keen to please. He is keen to achieve. Um, but its two different, completely two different sides of the coin whether he's had it or not.

JB: And what things are in place in school that mean that adults can help him manage his behaviour.

Teacher a: Um. I do follow the school behaviour system with A now I didn't when he first came to my year group. This is my second year as A's class teacher. Umm to start with I didn't break him in gently but I made allowances. There are still if he hasn't had his Ritalin like yesterday I still made allowances. The objective of the day is for A to stay in the class and for me not to have to send him out to another teacher as per behaviour policy. Um so whether if he's had his Ritalin its a different set of criteria to if hes had his R- if he hasn't had his Ritalin. If he hasn't had his Ritalin he is on the same um behaviour um code as the rest of the children are on you know, two strikes and you're out type thing. Which if he's had his Ritalin happens very very rarely. Um so the things we've got in support here are the behaviour policy dependent on Ritalin or not. Um he has the opportunity if he wants to to grab 5 minutes to chat with teaching assistant um before lessons start, so if he's got any issues that are bothering him he can get them off his chest before he comes into class. Um. Quite often does little jobs for me...the tartan paint is a good one. Um. Just, ke-, not keeping him occupied but keeping him on board keeping him in a positive frame of mind.

JB: Thats important

Teacher a: mmm.

JB: You've kind of already spoken a bit about what its like if he hasn't had his medication and it sounds like it would be quite noticeable.

Teacher a: Very.

JB: So do you think that his medication controls his behaviour?

Teacher a: Yes and no. He has still got the potential to kick off if he hasn't had if he has had his medication. He can still, he, he gets very frustrated very easily. Um, and even if he has had his medication there is a possibility especially on the playground that he will get frustrated and he will take things into his own hands and um act inappropriately.

JB: So do you think that's his ADHD?

Teacher a: No. It's his upbringing.

JB: So there's other factors...

Teacher a: There are other factors yes.

JB: That's quite difficult to unpick it all then.

Teacher a: Not really I think, he thinks it's socially acceptable to behave um the way he does when he's on and off Ritalin. He doesn't see that the way he's behaving isn't um isn't socially acceptable, because that is the behaviour that is um demonstrated to him on a regular basis.

JB: What do you think his strengths are?

Teacher a: His personality. He is a lovely lovely boy. He can be extremely helpful. He can be extremely loyal. He can be extremely...how can I say, just he's a lovely lovely boy. Um. He's a bright boy as well but due to his ADHD that hasn't you know necessarily shone through over the last two years however, um his progress is you know, he is making more progress now. Um. He's very loyal to his friends and to his parents and to adults that he trusts. You've got to earn his trust.

JB: And his weaknesses?

Teacher a: His temper. Um, on and off Ritalin he's got a temper that um will suddenly go um...No, I think that's about it really weakness wise.

JB: Is there anything else you want to say about how his ADHD affects him?

Teacher a: He hasn't got a particularly close circle of friends. Um although the children in the whole year group in our school are very understanding of A and his problems um, he hasn't through his...he hasn't managed to um, gain himself a close circle of friends. He's got children who will accept him into their games and accept him as their friends, but nobody particularly close.

There is one girl who's in my class who he's grown closer to this year, um, and he's had a positive affect on her behaviour as well, because she feels she should model being the perfect child all the time. Last year she was a particularly wild child so you know, they've had a good effect on knock on effect on each other but he doesn't have a particularly close circle of friends. And he, he tries to gain friends by trying to impress them. You know, bringing things in from home, um, acting you know the big I am when you know he's actually one of the smallest children in the year group. But that does worry me...his lack of friends.

JB: Do you think that the other children have like a stigma attached to his ADHD, or is it just his behaviour?

Teacher a: I don't know whether its they don't want to be friends with him or he doesn't want to get close to other children. I don't know whether he doesn't want a particular close friend or whether children – children are wary of him but they are also very accepting of him. They know when he hasn't had his vitamins as we call them. Um, to start with I was like A have you had your vitamins and I was keeping it, I didn't shout about the fact that he's got ADHD and he's on Ritalin and everything else. I didn't feel it was appropriate for the children to know, but he will openly tell them 'I've got ADHD I take Ritalin' he's just done that um, but no the other children are very accepting of him. Um, but not accepting enough to want to be a close friend.

JB: Can I just ask about the vitamins bit is that come from a way of talking openly about his medication without having to say Ritalin?

Teacher a: Yes. Um, because every day at lunchtime when I go downstairs at lunchtime to pick them up my first question to anyone is 'A have you had your vitamins?' Because while we're out on the playground its easier for him to run round to the medical room to get them. Very rarely is there an opportunity for me to talk 1:1 privately with a child when I've got another 33 in my care at the same time. Its a bit of a code really, um he understands it and a lot of the children do now.

JB: Its just kind of stuck

Teacher a: It has it has but he's quite openly telling them its Ritalin and you know 'it stops me being naughty'

JB: Is that what he says?

Teacher a: Used to I think he does anymore.

Teacher B

JB: Could you start off by telling me a bit about B?

Teacher b: Um, B is a year 8 boy...he's um, not particularly...how can we say, he's not a very very able pupil but he's more able than he makes out. He um, does tend to play on what he looks at on as his disabilities if you like, he has said that word that's why I'm using it. And he does tend to play on those which I don't think are as severe as he makes out.

JB: So, does he mean his ADHD by disabilities?

Teacher b: Yes. That's what he means. "I've got a disability I've got ADHD" and he does look upon it as a disability and he tends to try and take advantage of that fact. He is taking his medication, I've had a word with his parents he is taking his medication. So any ADHD behaviour that he exhibit's tends to be through choice...he knows he's got the label he knows what the label entails and he does tend to use it. He's very manipulative little boy...very.

JB: What sort of behaviours do you think his ADHD cause him to present.

Teacher b: Um...well...it's very difficult because the behaviour which he presents I think is chosen behaviour. He presents behaviour that he thinks is ADHD by remembering what he's like when he's not on medication, if you get what I mean. So he will urm...if he gets into any sort of urm, an argument with another pupil he will immediately fly off the handle and urm, makes it very difficult to be, to hold him back, he's a very strong little boy, who is now doing rugby at weekends so he's getting very very muscular and he's getting very broad now so it's getting more difficult to hold him. He knows this and takes advantage of it...so he will...go for a kid, physically go for a kid and then say "well it's me ADHD". And he does, he doesn't realise it, well he does realise it but he refuses to acknowledge the fact that we can hear him making comments to other kids and winding them up... and then when, if they hit him depending on what kind of a mood he's in he will either let them hit him and go looking for a member of staff as a victim or he will use that excuse to go for them...and get the attention that way, and he may be sent home, which sometimes is what he wants. He will I have heard him do little asides to kids...quite nasty ones and then when that kid fires up – 'cos we're in a school for kids with behaviour development needs, urm... and he will deliberately wind kids up so that he can react and either get attention or get sent home.

JB: What do you think the effects of his medication are on him?

Teacher b: The effects of his medications, they calm him down, he's a very pleasant little boy when he's reacting to his medication. Urm... very pleasant very polite, urm, and he'll sit and he'll try and do his work and he's very patient. He's like a normal little boy really, except, when he feels like a bit of attention that's when his, he thinks that his ADHD will kick in. But even his mum and dad have said, you know he takes his medication.

JB: So you think that you would see a difference if he...

Teacher b: Oh definitely yes, def- if...if, I think the um, the way he, he reacts when he's looking for attention or a reaction I think is very uh...a minor example of what he could be like without the medication...do you see what I mean? It's what he thinks it should be, I think if that level is what he thinks it should be I think the level that he would be without his medication would be much higher. I think he would be a very dangerous little boy without the medication.

JB: So, do you think that the medication controls his behaviour?

Teacher b: Yes. To a certain extent because he, even though he's on the medication he still has that control over his behaviour while he's on the medication if you get what I mean. He can't, he can either go along with the medication and be quite...I don't want to use the word normal but like a normal child should be...urh, and he's fine until he wants attention, until he gets fed up doing something and he wants a way out...and then he controls, he's completely in control...but he pretends that he's not.

JB: So is it difficult to tell if he's in control or not or do you think you always know that he is in control?

Teacher b: No, I think that most of the time that I've seen him, in fact I can't think of an incident when I don't think he's been in control...because you can see it in his eyes and the expression on his face, it's that little grin. But sometimes he just can't hold back "I've won", especially when he's on his way home. And you can see...when I've had...I've been with children with ADHD where the medication is wearing off or they haven't taken it; they can't control it, whereas with B when he kicks he's watching all the time for a reaction and you can see his eyes... flicking over to see what you're doing or what, how someone else is reaction to what he's doing. An ADHD kid doesn't do that they're...they just see, you know, like tunnel vision "this is what I'm doing" and they don't see what's happening around them. They don't look to see "oh, is she going to deal with this". I've seen B kick off and then look before he says something to make sure there's a member of staff to intervene...so that if he's going to go for someone that's bigger than

him, or harder than him, he'll make sure there's a member of staff who'll get in, in time to save him. ADHD kids can't do that.

JB: Do you think that he's got ADHD?

Teacher b: I've never seen him without his medication. So if he has got ADHD, the medication's working and what he does when he kicks is choice. But surely if he didn't have ADHD the medication would have some sort of other effect on him? 'Cos they are like amphetamine aren't they? So I don't know. I've not seen him without his medication so I can't say.

JB: Are there other things that adults in school do or that B does himself to help him manage his behaviour?

Teacher b: Yeah, we tend to either remove him from the situation...sometimes we've had to remove the whole class from the situation and leave him on his own if he refuses to move, so we use that. Urm, I tend to use a lot of humour with B. He does, he's got a good sense of humour and he does react to humour. He also reacts to ur, he likes a cuddle. He does like a cuddle, I know we're not supposed to touch kids, but some of the'se kids, B's not one of them but a lot of the'se kids the only cuddle they're going to get all day is off the teacher, so when my kids come in they get a cuddle if they want one...and B does like a cuddle. He likes to come up...and one of the things he does do is if he has been naughty, he'll come in the following day and the first thing he does is is he comes up and he gives you a cuddle and says "sorry". You know, and then he kicks off again [laughs]. But he does like a cuddle.

JB: He responds to that nurturing

Teacher b: Yes, he does like the cuddle that's why a lot of the kids get sent to me, 'cos I'm the mum if you like, I'm the mum of the school. And my TA, you know we've both got seven or eight kids between us plus grandchildren so, we're the mums. That's what they get when they come to us, and B does respond to that.

JB: It sounds that he would choose that himself...to have that contact

Teacher b: Oh yeah, he will come to you for contact, but you know once he, you know when I first got him he didn't but once he realised that there were kids coming in and saying good morning and coming up for a cuddle, they come to me I don't go to them... then he started doing it then he would come up for a cuddle and that's when you know that when he's doing his work you can go along with him, instead of just looking at him you can put your arm

across his shoulder, you know say “you’re doing really well” and pat them on the back he likes that. He does like that.

JB: Could you think of his strengths?

Teacher b: Um, his strengths. He can be extremely helpful. Urm, he can be very polite, urm. He can be supportive...supportive when he chooses.

JB: Towards other people.

Teacher b: Towards other people towards his peers, towards staff he will help umm, yeah he is a very very supportive little boy. He can be very empathetic and sympathetic...he can do it...he can do it when he chooses. But...as I say if he’s decided...and it’s almost like you see a switch being switched on you can see in his eye “I’m going to kick”...you can almo- when you get to know the kids you can say that with your own children ‘he’s going to do that now...he’s going to do it’.

JB: Do you know why he would make that decision at that point?

Teacher b: It depends on the situation sometimes it’s a way of urm, he might have said something and he thought “I can’t backtrack, if I backtrack I’ve got to loose face” and so that’s when he will sort of either go for a kid and he’s quite happy to take the belt. He’s quite happy to take a smack from a kid in order to get the reaction that he wants. He’s very...compliant in that he will take the smack. But his dad has said when he’s at rugby he reacts completely differently. Totally different reaction at rugby.

JB: Why do you think that is?

Teacher b: I don’t know. I think he wants to do the rugby and I think in rugby he does not get the nurturing that he gets here. In rugby it’s sort of, I mean it’s...there was one boy who was having a go at B but you know...and they had a word with the coach, and the coach said, “right ok, in the next scrum or the next physical contact that you have show him how hard, you know how tough are, that you are a heavy little boy who’s got muscle. And you know when he tries to tackle you, go for it” and B did, and you know he didn’t hit the kid but he used physical force like you do in rugby to make a stand and he said he just made a stand well this kid tried to get him over and couldn’t...and this kid realised just how strong B is. And B did it in a very calm way and hasn’t had a problem with the kid since then. Whereas here...we can’t say to them “oh you’re being bullied, tell you what, let them know how hard you are”. We’ve got to go “oh you’re being bullied we must sort something out about that” and that’s when he gets all the nurturing and he likes it and that’s why, I think that’s why he does

it...because, he will get the attention and he'll get the sympathy and...that's why he does it. He wants that attention.

JB: So in terms of his weaknesses, is that kind of what you've spoken about in his choosing to...

Teacher b: Yeah, I think his main weakness is that he chooses to behave like that because as I say, the medication he's on...and I've seen him...if he just went I would think maybe the medication's worn off, or maybe it wasn't strong enough for him, whatever. But, when you get that little sidelong glance, to see if you're watching, to make sure that if he's going to kick he safe to kick, someone's going to step in. And, also, the little whispers...you know, little whispers and as he whispers to one of the kids – and the kids'll blow "he said this he said that" and B goes "no I didn't" He likes to play the victim. But that's one of his weaknesses I would say.

Teacher C

JB: Tell me about C

Teacher c: Right, I started working with him in year 7 when he moved down from F. Um, didn't start at the beginning of the year, started about November time...or a bit before. But he...very quiet, but fine actually because year 7 we had quite an established group there were seven in the group but he, he, I used to have a desk so of by, by the door and um he used to sort of like pull his desk right up to mine and sit by me...and that was fine you know as long as he was settled that was fine. But that became a sort of everyday he needed to be near me to do anything...and because he was quite low level he, I used to help him quite a lot with his work um, and we did we formed a good relationship and I feel he could come to me, and he was fairly settled. We had a few blips nothing major, his main problem was if you know I mean obviously he had to do certain work on his own I couldn't be there all the time then he sometimes used to flip his lid and walk out the classroom. He's quite a strong lad, in year 7 he was fairly strong and he used to punch the window, but he'd never do anything (I mean we have some real blighters you know, throwing tables chairs) but he wasn't ever...to that extreme. It was just a walk out you know, not even really swearing a lot, just punch a couple of windows "I'm not doing it".

Mum at the time was with her first husband I think it was but I think there were problems at home anyway. They weren't getting on. Um, but mum was very supportive, you know anytime we used to ring if there was a problem she was always supportive. But as I sat because there were obviously problems in the marriage I think that started to reflect on C's behaviour. And we did see a bit of a....um, again nothing major but it was, pretty sulky and things like that. Then I think the marriage broke down at the end of year 7, yeah, 'cos I still working with him and apparently dad was threatening to take the children...and....kill himself and the children, he had a lot going on at that period of time. Um, and we had sort of instructions not to, came to school that she doesn't want C to see him and all things like this. Obviously again, it had an effect on him...but...he was quite settled in that group and they were a nice group. We had sort of, I mean we've still got (other student) here (other student) is here and they were a nice group. But C's...he's always willing and he will try, but um, doesn't like change. And you can tell, C's behaviour just deteriorated because...he just doesn't like change and he was so worried, I know when you came in to the one to one, you have to say to him what's going on and who's this, and because he would just flip. He ended up going loopy, he ripped his, eating his work, he ripped it up because he was so worried that

this was, somebody had come in to see how he was behaving what he was doing and that was his reaction to that. Back on track, now K's back, he's now, he was also very unsure because they said he could most probably do the transition back to mainstream and, but he hadn't really heard anything. It was all sort of up in the air and um, until we did his one to one, when you came in and we did his annual review, nothing was sort of for sure nothing was for definite and he was very wary "when am I going, what's happening?" which is understandable . He's one of those children like everything black and white and "this is what's going to happen and this time you'll be doing this and then" he loves all of that he loves routine you know. But now he knows he's going to go, he goes he's been for a visit and he goes Tuesday all day. And then, after half term they'll ease him in gradually I think he's going two days a week. So...I'm really pleased for him...and he is, quite low level his reading age is seven years three months, but the good thing with C is he will try and if you know he's got the support he'll be alright. I think he's really bright in other ways, electronics, science things like that, good with his hands. He's a nice boy, I think he'll do alright.

Don't know much about his ADHD, um, when, in Year 7 he was on Ritalin, and we were administering it at lunchtime, obviously mum was giving him Ritalin first thing I think. He was having I can't remember if was one or two at lunchtime. But now he's on – he knows the name of it I've forgotten the name of it. But we don't have anything to do with that now, mum administers that so...but,

JB: Is he always on his medication?

Teacher c: I presume so, as I say, we're not sort of told much about it really. Um, she's very supportive and I think she would...if there was any change she'd let us know. I know he goes to the ed psych, just before Christmas. I think he had his sort of annual appointment or whatever it is. So, we haven't been told anything so I presume he's been on medication.

JB: So, does that mean that you wouldn't necessarily know if he was off it or if he hadn't taken it?

Teacher c: Yes, I presume so, because um, I think if there'd been a problem you know if he's come off it or he refused to take it or she forgot- I think she would let us know, she's supportive that way. But as far as I know, I mean, Dougie would know better than me, I mean it's not something we talk about his medication but um, I presume he's still on it, I think so.

JB: So, do you think that you know how his ADHD affects him then?

Teacher c: Um, he is quite a character, he will openly admit, you know “I can’t have chocolate, I can’t have too much fizzy drink, I can’t have this”. And you can definitely see a change in him...ur, the day we broke up for Christmas, obviously you give them treats and K brought them some, a tube of Skittles [laughs] he went, and they had a selection pack. And I brought cloudy lemonade in and you could see a change definitely in C. When he has things like that...

JB: What was he like?

Teacher c: Just hyper, really hyper and he said “I get really hot, really hot”. And another thing he often mentions is itchy legs. If he’s sat still – cooking is the main one when we’re in the HE room, and he’s got to stand up obviously you’re preparing like your veg or whatever, he’ll say “I’ve got me itchy legs” and he thinks it’s when he’s standing still too long, I don’t know. But he’s uh, when, a couple of months ago he mentioned it and he said “it’s when I peel potatoes” and it’s obviously something – I – when he’s standing up for any length of time, still. But I don’t know [laughs].

JB: Does he need to do something to...?

Teacher c: He seems to forget about it pretty quickly. He’ll sort of mention it – he did on Tuesday “oh, I’ve got me itchy legs” and then we go and we just laugh and it’s forgotten and he doesn’t sort of carp on about it or anything like that.

Can’t say...as I say I think he’s just a normal teenager as far as I’m concerned and that is why I think they sort of um, got him back to mainstream. Yes, he’s quite low level but I don’t think that’s anything to do with his ADHD. But, I mean I’ve always had a great relationship with him and I think most people in the school have a good relationship, there are a couple of people obviously he don’t get on with but I think that’s life isn’t it? There’s a couple of, he was with a teacher last year – I was over the other building last year so I didn’t have a lot to do with C, but he, the teacher he was with, I know there was a few sort of dodgy moments and C said “I wanna move class” and things like that. But, like any teacher I think clash of personalities you know things like that. I don’t think it was anything major.

JB: Relationships are important aren’t they.

Teacher c: Yeah, I mean you look through C’s file we do, I don’t know if you’ve seen we do incident sheets if there’s a particular incident that obviously needs recording you have to an incident sheet. But you look through C’s file there

might be two but that'd be to do with play time and fighting. But he's not a fighter as such but he will stick up for himself. But he's...he's a nice lad.

JB: It sounds like he just presents as a regular teenager and you can't see anything that's particularly um, any particular affects of his ADHD on his behaviour.

Teacher c: Not really, no. I'd say with the problem during year 7 with mum and dad, I mean I think affects any child do you know what I mean? And going through that I think he heard a lot that he shouldn't have been hearing um, but it wasn't like, he was still coming to school every – he's a brilliant attender. He might say he hates school but he's a brilliant attender and when he's here he's fine. I think he may have got sent home a couple of time last year, um mum perhaps had to be called to come and collect him and things like that. Nothing major, you know nothing out of the ordinary if you like.

JB: But when things are more difficult at home, changes in the routines, that's what he found more difficult.

Teacher c: Yeah, but this, Mr, you met him on the 1;1, um, he's fine. They seem to get on really well. I mean at one point when we first sort of September time when we came back, I went to the wedding with an LSA in August, and um...there was a bit you know I think C is very close to his mum. He was like walked her down the aisle, gave her away. At one point he came and spoke to the LSA and I at the reception, and said "I don't really like him" but I think that was just just bravado and they went on the honeymoon. I think it's quite a good family, he's got a brother and a sister and I think they're alright, but as I say typical teenage things. Yesterday he come "I hate my brother" you know, but nothing. I'm hoping, I'm really hoping he manages at mainstream. I think being in the environment he's in at the moment which is such small groups that'll be the only thing he'll find difficult.

JB: It's going to be a big change.

Teacher c: Yeah, I think they're quite supportive up there so he'll support if he needs it. So , yeah, he's a good lad.

JB: You obviously like him.

Teacher c: I do yeah, we have days when we get on each other's nerves you know "oh Doug, just be quiet for 5 minutes" oh he is, when you speak to him you'll see, hyper and he wants to say, talks a lot and I don't know if that's part of his ADHD or teenager. The only other thing I'd say is he finds it very difficult

with eye contact. He'll sort of look off around the room and carry but talking to you and then occasionally he'll just look at you when he looks- but eye contact is quite difficult for him.

JB: Do you know why that would be?

Teacher c: I don't know. He has, um he wears glasses. But I don't know. I wouldn't say that it's because he doesn't know people but he does it to me. He won't you know you'll try and have a sort of one to one with him and he'll look off round the room and he'll look back at you quick and then he'll look away again. Well you'll notice when you speak to him.

JB: Is he still listening when he's doing that?

Teacher c: Um, that's a good – actually sometimes you do have to repeat things, and, 1:1 you're telling him something and then "what did I say?" "I don't know" you know and he'll go like that. You do have to repeat things.

JB: Sometimes he loses concentration.

Teacher c: He's alright [laughs]. I'll miss him anyway

Teacher D

JB: Tell me about D

Teacher d: D is a year 7 pupil who has been with the school for some years now, um, and also, he's got ADD, um and that's the reason why he's here. He has a hostel placement here as well because mum needs respite from him because his needs are so demanding. So he's actually on site hostel from Monday evening to Thursday evening, then he's home holidays and weekends...Part of Friday's problem is because he's going home he's so excited on a Friday so...and he loves going home, that, then he ends up having warnings and opportunities very very quickly and early on in the day...he cannot cope and moderate his behaviour. That's the reason why he's out of school and in with us but we're not ideally the best place for him because we're not fully able to meet his needs but there are no, there's nowhere else for him to go, so we have him. Now in terms of academically, no problem at all he's roughly where he should be maybe a few months adrift on some things. What's more of a concern is that he doesn't know how to manage his own feelings he doesn't know how to be in control of his own feelings, um, nor what he says [laughs] and he finds ignoring bad behaviour extremely difficult so if there's something going on he has to be party to it as well even if you can ration through with him that it's not the best choice that the consequences he cannot stop himself. Um likewise with comments you might have managed to get the class stopped in terms of saying inappropriate comments urr but he will carry it on. The next day he will say 'i'm not going to say that racist comment, you know the one I said [do excuse for the tape] you know Paki. He'll make that inappropriate comment 'I won't use that, you know that comment you know that racist one, I'm not allowed to say anything about tits 'cos that's sexist.' And i just look at him [laughs] because you know he's a lovely boy there's no malice in him and so it's very easy to teach him. I find that he can be, he's a lovely lad you know there's nothing deliberate about his behaviour. He's just extremely wearing because it's constant...constant talking, and on a Friday he's as high as a kite and we have to really come down really severely with him um, which is a lot harder than we would do normally just to get the message through. So today we, warning 2 was given by quarter past nine so we phoned home and he's not having his PSP for the whole weekend complete change of behaviour now. And it's about, well, we'll phone home again, have something else taken away 'ooohoooh' (doing an impression of D being upset)he's done that you know, he tries hard. In his own mind, but what he gives it can be completely illegible and you'll go 'go back and do it again', he comes back and it's fine but there often the need just to get the work done with no real interest of quality as such.

JB: Do you think that those behaviours that you have described are due to ADD?

Teacher d: Yes. Yeah...I...it's, he does find it difficult to listen, he finds it extremely difficult to read body language. He does find it difficult to settle himself and manage himself, and he cannot control himself if the situation means we need excitement. [laughs].

JB: Ok, that's really difficult for him.

Teacher d: Yeah. And it's, but he can't see that it's a problem either. If that makes sense.

JB: Yes, he hasn't got that level of self-awareness.

Teacher d: No. No self awareness.

JB: Right.

So you talked about that you would sometimes need to be quite firm with him in order to bring his behaviour down, are there any other things that adults do in the school which help him manage his behaviour?

Teacher d: Constant reaffirmation all the time. Making sure he's looking at you because when he talks to you his eyes are wandering and you know, he's jiggling around etcetera and you've actually got to manipulate the chin round sometimes and 'look at me' and so he gets direct eye contact and at least then [laughs] he's got blinkers on...blinkers would work wonderfully with D. Um and also it is just about looking at him and talking to him really close like face to face, so he is, all he can see is you so that external factors are really...I think if, in a room like this where there's perhaps nothing on the wall then it'd be easier because he's got less to focus on. I think he finds things in rooms which are lots happening, lots of people lots of noise and making it harder for him to focus and listen.

JB: He kind of hasn't got a filter.

Teacher d: Yes as I say blinkers. Yes.

JB: Are there any things which he does which um, which help him manage his own behaviour?

Teacher d: No.

JB: No.

Teacher d: He's not, he needs adult support in recognising where he's gone wrong. He does know but he needs that prompt. Um, I have it with all my pupils, if I'm talking 'oh K, K, K, K' 'what am I doing?' 'no, what am I doing?' 'talking' 'so you need to be...' listening or waiting is the answer I'm needing. But with D it can be... there are a few times when I have to ask 'what am I doing?' for him stop and then realise that 'oh I need to stand and wait' and he can do it but he needs that adult.

JB: Wouldn't be able to recognise that on his own.

Teacher d: No.

He's easily a target for getting the other children either to bully or to actually get him to do things that are inappropriate because he cannot say no.

JB: Right.

Teacher d: If that makes sense?

JB: Yes. So he can't say no to other children?

Teacher d: No. And I don't think he perceives risk at all. So if he saw somebody else perhaps he was with a group of children and he saw them by water he'd go and join in. If they said 'oh go on look the ball gone in go and get it' he probably would he wouldn't be able to think 'actually it's a bit dangerous'.

JB: And is that another way of him showing that he wants to interact with his peers?

Teacher d: I think theres not much wanting to interact, he hasn't got the idea about boundaries. Hugs are very important to him and he needs that constant affirmation again you know, that he is being valued he likes that. And he gets all that in the hostel but what of course we're trying to do in school is 'you've got to think about asking because not all of our members of staff want to be hugged'. And so it's about getting him to say 'can I have a hug' first. And um, which is working because he sort of [shows action of him about to hug someone], and you can see him 'cos I think it's something that's really important to him that he has a hug hes 'ooh can I, I've got to ask you first, can I have a hug' his arms are up in the air and he's ...bless him. So yeah, I mean he's he doesn't do it to all members of staff but there are certainly, and he does with me I'm with him all the time and I don't have a problem with hugging and if that means then that we have that quiet for a second where I've got his attention where he says nothing at all.

JB: So there's quite a lot of work going into his self-regualtion.

Teacher d: Yeah.

JB: That sounds like, it's sort of the main thing.

Teacher d: Self-regulation and it's also just about managing our feelings...or not so much managing just controlling. Actually being. In some ways he finds it very difficult to take responsibility for his own actions because he has them pointed out to him first of all.

JB: He wouldn't automatically know what he has done that is inappropriate.

Teacher d: No.

JB: Is there anything else you want to mention about him?

Teacher d: Not really, I mean he's...everything about him is just exasperated and exaggerated behaviour that you'll see in normal sort of you know young adolescents. And with D everything's just a lot bigger a lot louder faster and just unregulated.

JB: Let me just ask you about his strengths before we finish. What do you think his strengths are?

Teacher d: Enthusiasm. It doesn't matter how many time you knock him back, he's just coming back again. Again it's that almost he can't properly identify that perhaps he has been told off, if that makes sense. Yeah. But it is certainly something that you know there won't be any bad feeling it almost done and dusted forgotten, and he'll try and make amends, and off we go again with such, and he is, he's always enthusiastic until you pull him up about the fact that he needs to calm down or regulate himself etcetera. Very loving child very loving child. He, he has got a good brain in him and I don't think his full potential can be seen because of his other behaviours. You know he's not calm enough to finish a piece of work with consistency all the way through. It isn't, he hasn't got the self-regulation to put the quality in the work all the way throughout, um, he cannot sit still you know he needs to be on the move the whole time. Um, but he tries and he responds really well to adults tries to be friendly with everybody but doesn't know the boundaries of being appropriate and so can go over the top with other people. It's a hard one because he tries so hard in all the areas but his condition means that he finds it difficult to tick all those areas. He's lovely, I've got a lot of time for him and he's a wonderful young man, perhaps sometimes just in small doses [laughs].

One more thing about D is that um, there have been comments come home that he doesn't know how to respond to being with an animal he's actually

quite rough. Probably not due to any sort of malice, just more of a ...having a game with them he's an only child so he does.

JB: OK.

Teacher d: So it is praps trying to play with a ch- ur an animal like you would a child.

JB: Right.

Teacher d: But obviously rabbit's don't enjoy being shoved down toilets.

JB: Would he have um...do you mean that he hasn't got a very good understanding of how the animal, like the pain that it would experience.

Teacher d: Yes and the empathy.

JB: Yeah.

Teacher d: Exactly the same correlation as with people. Can't see how that would effect them.

JB: Wouldn't be able to see something from another person's perspective.

Teacher d: No. Well he does but it's in very basic and almost like learnt behaviour 'I know that if I hurt somebody they would be sad'. But it's no real deeper.

JB: No, it's quite simplistic understanding of things that people have taught him.

Teacher d: And certainly wouldn't be able to put it into practice.

JB: No.

Teacher d: And food.

JB: Yeah?

Teacher d: He has a preoccupation with food so if there's food it's got to be eaten really quickly. Um, mum has an awful lot of problems with food disappearing out of cupboards. It's just got to be eaten and it could be really inappropriate like um, uncooked chicken at breakfast time. Um and he, all the cupboards are locked at home and things because he tries to get in.

JB: Sounds like another sort of self-regulation thing.

Teacher d: Yes. When the hostel took them out for Christmas meal and he found that there was crackling available it was just beyond belief, the excitement that

having crackling on the table produced in D was just, he was just on the ceiling. 'Oh my, oh [excited noises] crackling!' and he could not get over the fact that he could eat the crackling and it was...funny [laughs].

JB: Ok, it's a really extreme overreaction

Teacher d: ...to something that we would take for granted.

JB: Thank you.

Teacher E

JB: Maybe you could start off by telling me a little bit about E.

Teacher e: Um. E. He's quite a quiet boy. Um, he tends to keep himself very much to himself. Um, I had him in year 5 and year 6. In year 5 he was very very quiet and I think in year 6 he had come out of his shell a little bit and out in the playground I've seen him playing around with the other boys and that sort of thing so that's a really good sign. Sometimes he tends to get a little bit fidgety towards lunchtime when he's due to take his medication. Um, that I noticed in year 5 because I had him for English in year 5. But overall, quiet boy keeps himself to himself but if you ask him questions he's quite happy to answer them.

JB: So you say he gets fidgety sometimes when its getting close to lunchtime.

Teacher e: Yes.

JB: So he has a tablet at lunchtime.

Teacher e: Yes

JB: So is he on Ritalin?

Teacher e: I'm pretty sure that is what he's on, you might need to double check that.

JB: Does that mean that you've noticed a difference between when he's on his when its perhaps wearing off or he's not it?

Teacher e: If that's, um it could be just because it's before lunch and he...children tend to get a little bit more fidgety towards the end of lessons anyway, um, but it tends to, his concentration tends to be um less strong just before just before lunch, but I wouldn't know whether that's because its just before the time he takes that tablet or whether it's just him being being a typical boy.

JB: Do you think that there are other aspects of his ADHD in school that you notice?

Teacher e: Um. How do you mean?

JB: In terms of being a bit more hyperactive, or finding it difficult to concentrate.

Teacher e: Um, he seems to al... Usually, if I give him a task he's quite happy to get his head down and work. Often I'll have to sort of, just reinforce that there are people there to help. Sometimes he'll sit there and you can see that he's

sometimes struggling with something or he's, he needs to get ideas and it'll take me to go over and say 'E, are you struggling with that do you want help?' and then we'll discuss it and go through some things together. He tends to be a lot more active out in the playground um, playing with the boys and that sort of thing. He's very quiet in lesson but when he's out on the playground he's not a boy who would sit by himself uh, on the steps or something like that. He'll be playing around with the other boys.

JB: So its kind of almost that he's a bit more sociable when he's outside.

Teacher e: Yeah Yeah. Yeah, he's got a couple of good friends that he plays with out in the playground. Um but yeah, he he will, he'll be set a task and he'll just try and get on with it to be honest. Um, and it its not really affected by distractions or anything like that. So yeah, he keeps himself to himself really.

JB: Do you know any reasons why that would be, why he, because you're describing somebody that's quite different in a social situation compared to in the classroom.

Teacher e: Um, it could be it could be the friends which surround him on the table. I mean I know that the boys that he plays out with on the playground don't sit on his table. It could be just the case that he's familiar with boys that he might have been friends with in year 5 and he gets to see them again out in the playground so, familiarisation I s'pose.

JB: So in terms of helping E managing his behaviour, it sounds from how you're describing him, it sounds like um the medication is probably something that helps him manage and you're not seeing many other sort of ADHD-type behaviours presenting in the classroom.

Teacher e: Um, the only thing that really comes, this is just coming from experience with working with ADHD children before – there's never been outbursts or anything like that, there's never been um, any aggressive behaviour or anything like that. He's very much kept himself to himself, the only thing which possibly comes through is the fidgeting just before lunchtime and he'll um, not be...he's just slightly more off task towards the end of that session. Um, but as I say that's, that's from coming from having him last year as well... just tends on the carpet he'll sort of urh, everybody else will be sort of cross-legged and he'll sort of stretch out and then he'll cross his legs again and then he'll sort of fidget this way and fidget that, and he'll just, you just seem to see a little bit more of the sort of frustration..Um, towards that end.

JB: So do you need to do anything differently with him at that point?

- Teacher e: Um, no, I tends to um give him sort of give him his independence really because he can he can do things I mean he's he's a lot better at joining in with conversations and things in year 6 which is really lovely um and he's doing particularly well this year which is really good. Um, obviously we encourage him to sort of put his hand up when he wants help and that sort of thing, but there's...or um if he's sat around lots of people he might just need a reminder that 'E, you need to sit still' um, but nothing...nothing which requires sort of um, sanctions to come into place or anything like that, it's just a quick reminder and he's usually fine after that, but no, no outburst or anything, anything to that degree at all.
- JB: Have you got any experience of E when he hasn't had any medication?
- Teacher e: Um, not that I know of [laughs]. Um, as far as I'm aware that he he takes medication at lunchtime...um, and in the mornings as well and apart from that I wouldn't, I wouldn't be aware, unless his mum decides to take him off and calls me in the near future, I wouldn't, I wouldn't know. I'm sure sh, I would think that he would just be a little bit more fidgety and things in lessons... um but as far as I'm aware he's on that medication.
- JB: What are his strengths?
- Teacher e: Um, his strengths. I would say um, concentration during the lessons...once he does get into an activity he does keep going and he has got the enthusiasm to give things a go. He won't sit there with a blank, blank page he will really you know 'ah...I really want to get...I really want to understand this I want to get going'.
- JB: He's quite motivated.
- Teacher e: Yeah. He's when you, when you speak, speak with him ...you get a little bit more of his true character come out um, and ...can't think what he um, if he usually draws or writes things....I know sometimes his writ- 'cos he's not one of the higher ability for the English um...so...he does struggle with his writing but I think he enjoys that as much as drawing images or anything like that. But the... I see him as happiest when he's in the playground. When he's with the other boys and having, and having fun. Um, but I would say that's probably one of his strengths...um, but it depends who he's with, you wouldn't see that if you were to come and see him in my class, he'd be a very different boy that you'd see compared with when he's with these other particular boys. It would be interesting for you to see him in the classroom and then see him in the playground um, to see the different personalities. He's got a friendly character and he's got a caring character as well which is nice.

- JB: Are there any things which he finds much more difficult, maybe weaknesses?
- Teacher e: Um...he does find writing an issue. Um, you can often see that he's got the ideas there he just, it's getting down onto paper that he struggles with and occasionally it takes an LSA working with him or myself to model something first...and, but take the ideas from him first and sort of question him 'oh what do you mean by that' or 'what would happen if...' and he will...he's quite happy to develop his ideas and he's got some fantastic ideas um, and it's just, getting it down onto paper and being able to show what, what he can do. I think he struggles with that probably the most.
- JB: Its quite a big barrier isn't it, for attainments if that how you assess?
- Teacher e: Yes. I mean he was I had him for – we've changed maths groups, but I had him for maths for a while he was doing really well with the maths, so I think maths is probably stronger than his English. Um, and he seemed to enjoy the maths session as well, and he would, that, that's when he was more um, verbal in the maths lessons than what I remember him being in year 5 when I had him for English...so it may be sort of a preference for subjects.
- JB: Is there anything else about E that you wanted to mention?
- Teacher e: Just compared with year 5 he's particularly working really hard in year 6. He's a lot more verbal...he's a lot more willing to get involved when we're all on the carpet and share his ideas, yet occa- he's not, he hasn't changed so much that he's 'ah I want to say something' and he's he's constantly talking. He's not that far at all but he's...you can tell that he's thinking about what we're talking about and wants to say something...occasionally if he... he won't often put his hand up but you can almost see on his face he's thought of an answer and when you say 'oh E do you want to share anything' he usually has something that he wants to share which is really good. That's probably the biggest change I've seen from year 5. Just being a little bit more verbal and things. Its good, he is doing well.

Appendix E: Codes, Concepts and Categories Tables

Codes, Concepts and Categories Table - Children

Code	Concept	Category
Adults can help manage ADHD	Managing ADHD Having understanding adults helps Anger management techniques help Removing or being removed from the situation is seen as helpful	Emotional ADHD
Self-treatment, cathartic effect of punching		
Teachers helping me manage ADHD		
Talking to people who understand helps me to handle ADHD		
Effect of medication - feeling calm	Calming Effect	
Not taking medication and shouting out	Medication reported to have a calming effect – a ‘cure’ for anger. Also a slowing effect – seen in talking better, ignoring distractions and having better attention.	
Medication for aggression		
Non-medication treatment - time out and talking	Non-medication treatment Only one child talked about additional ‘treatment’ for managing ADHD symptoms and identified time-out (reactive) and talking (proactive) in a structured session. the outcome of the strategies are to feel calmer.	
Anger as a symptom of ADHD	Anger ADHD is experienced as anger. The two labels could be used interchangeably which fits with the idea that the purpose of treatment is to calm.	Locus of control
Anger as ADHD		
Fighting as a symptom of ADHD		
Getting mad		
Culpability of harmful behaviour	Responsibility The ‘on’ condition of ADHD is closely linked with the idea of control and responsibility. If they can’t control an ‘ADHD outburst’ then it is likely that they would find it harder to accept responsibility for those actions. There is also a link between the medical label and the behaviour and how the young person understands and uses it.	
Medication and control		
Justifying taking medication		
Controlling behaviour		
Locus of control		
Control, is it possible to control the symptoms?	Controlling Impulse	
Getting into trouble when off medication	Difficulty in controlling impulsive behaviours are reported - including	

Control/medication	swearing, being impatient, breaking rules. There is a theme of knowing right from wrong but doing the wrong thing i.e. a desire to comply but an inability to do so.	
Swearing as a symptom		
Following class rules		
Medication makes me better at things		
Burst out with mentalness	A permanent state with occasional presence It is thought that the ADHD is always there but under control. Sometimes there is an outburst. The conditions in which ADHD 'kicks in' may be in or out of the child's control. This gives rise to 'on' and 'off' conditions.	On/Off Conditions
ADHD as a temporary condition		
ADHD as more permanent		
ADHD on and off conditions		
Medication only lasts for a short time	Awareness of medication wearing off Tablets wear off – in one case, naturally, but in another an event triggers this (fight). Is this a situation where there is a physiological change e.g. fight or flight and the medication is less effective or is there an element of choice? The child chooses to be involved in a fight and reports the tablets as having worn off. This is discrepant with the idea that the tablet is calming?	
Medication is dependent on the situation		
Severity of ADHD	Spectrum of ADHD ADHD presents to people differently and some are worse affected than others. The worst type of ADHD would warrant medication.	Medical Disorder
Effect on appetite	Side effects Side effects are viewed as part of taking medication.	
Being sleepy		
Growing, effect on bones.		
Negative feeling about having ADHD	Perceptions Negative perceptions focus of being different to others, including experiencing ADHD as in terms of mental illness. Positives on being strong and having energy.	
Being different		
Positives about ADHD		
Mental health		

Strengths in abilities	Self Concept Strengths are described in terms of abilities. In the drawings, children expressed positive and negative qualities (see drawings). Negative qualities were associated with having ADHD and positive qualities were associated with not having ADHD or being 'free' of ADHD. ADHD is seen as part of the children's identity.	Self/Identity
Negatives in qualities		

Codes, Concepts and Categories Table – Teachers

Code	Concept	Category
Easily led/lack of awareness of danger	ADHD Symptoms Manifestations of ADHD are described as inattention, hyperactivity and impulsivity	Medical Disorder
Impulsivity/distractibility		
Inability to moderate behaviour		
Restlessness		
Inattention/hyperactivity		
Hyperactive		
ADHD as limiting factor		
Socially acceptable, difference		
Social explanations	Attributions Some perceptions of causes of behaviour are given including social and dietary factors.	
Impact of diet		
Social factors		
Appropriate social interaction	Poor social skills Teachers describe children having a range of social skills difficulty impacting on their social experiences at school.	
Eye contact		
Social impact		
Withdrawn		
Outgoing		
Making friends		
Better learner	Medication as beneficial Medication is talked about positively in terms of alleviating symptoms of ADHD. Some teachers have evidence of children not being on medication and conclude that things are better when the child is on it. One teacher has evidence of bad behaviour when on medication but rationalises it with a belief that things would be worse without it.	
Reducing ADHD		
Positive medication		
Eradicating symptoms		
Stopping naughty behaviour		
Uneducable?		
On-medication condition		
Medication as good for you		
Reducing symptoms		
Medication wearing off		
Normal behaviour?	Medical Disorder Teachers describe the children as different to peers and their ADHD to be a label which describes their negative behaviours. One teacher also talks about disability in relation to the child. Normalising statements are given to explain some of the behaviours as normal or typical behaviours exhibited by other boys or	
Lack of ADHD symptoms		
Medical disorder		
Invisible ADHD		
Using the ADHD label		
Disability		
Uncomfortable labelling		
Mental health language		
Socially acceptable		
Low expectation		

	adolescents	
Responsibility	Control Teachers view children's behaviour as a result of their ADHD and something which they do not have control of. There is one teacher who thinks that the child does control his behaviour.	Control
Behaviours against the moral code		
Self-regulation/self-awareness		
Out of control		
ADHD in control		
Intentional behaviour		
Attention seeking		
Choosing 'ADHD on'		
On/off bad behaviour		
Going along with medication		
Locus of control		
Medication in control		
Hyperactivity linked to frustration	Emotional ADHD Teachers identify frustration in the children, often manifested as aggression, restlessness, poor social interactions and poor coping strategies in demanding situations.	Emotional ADHD
Happiness/unhappiness		
Temper outbursts		
Emotional responses outbursts		
Aggression		
Aggression		
Emotional reaction to difficult situation		
Reaction to demands		
Strategies to manage behaviour	Behaviour Management Teachers identify the effects of medication viewed as important factors in the child's behaviour management. Teachers also identify non-medication strategies they use to keep the children focused and motivated in their classrooms. Only one teacher talks about how difficult it is to manage the child's behaviour.	Managing Symptoms
Difficulty in managing symptoms		
Needing support		
Positive feedback		
Strategies for managing motivation		
Behaviour management		
Strategies for managing behaviour		
Strategies for managing symptoms		
Reducing fidgety behaviour		
Effect of medication		
Effect of medication on engagement	Personality – Strengths Teachers describe strengths in the children, both in skills and personality qualities. There is an element of strengths being seen despite ADHD using the term 'can be', implying that in the absence of ADHD, strengths may come through.	Strengths
Personality qualities		
The 'can be' effect		
Practical skills		
Private person		
Academic skills		

References

- American Psychiatric Association (2000) *Diagnostic and statistical manual of mental disorders*. 4th ed-revised. Washington, DC.
- American Psychiatric Association (1987) *Diagnostic and statistical manual of mental disorders*. 3rd ed-revised. Washington, DC.
- American Psychiatric Association (1968) *Diagnostic and statistical manual of mental disorders*. 2nd ed. Washington, DC.
- Arora, T. & Mackey, L. (2004) Talking and listening to children diagnosed with ADHD and taking psychostimulants. In *Children at the margins: supporting children, supporting schools*. Eds Billington, T. & Pomerantz, M. Stoke on Trent: Trentham Books.
- Backett-Milburn, K. & McKie, L. (1999) A critical appraisal of the draw and write technique. *Health Education Research*. 14(3), 387-398.
- Barkley, R. A. (2005) *ADHD and the nature of self-control*. New York: The Guilford press.
- Barkley, R. A., Fischer, M., Smallish, L. & Fletcher, K. (2003) Does the treatment of attention-deficit/hyperactivity disorder with stimulants contribute to drug use/abuse? A 13 year prospective study. *Paediatrics*. 111(1), 97-109.
- Barkley, R. A., Cook, E. H., Dulcan, M. Campbell, S., Prior, M., Atkins,

M. et al (2002) Consensus statement on ADHD. *European Child and Adolescent Psychiatry*. 11, 96-98.

Barkley, R. A. (1997) Behavioural inhibition, sustained attention, and executive functions: constructing a unifying theory of ADHD. *Psychological Bulletin*. 121(1), 65-94.

Barkley, R. A., McMurray, M. B., Edelbrock, C. S. & Robbins, K. (1990) Side effects of methylphenidate in children with attention deficit hyperactivity disorder: a systemic, placebo-controlled evaluation. *Pediatrics*. 86(2), 184-192.

Bentall, R. (2009) *Doctoring the Mind*. London: Allen Lane

Biederman, J. & Faraone, S. (2005) Attention-deficit hyperactivity disorder. *The Lancet*. 366, 237-248.

Biederman, J., Newcord, J. & Sprich, S. (1991) Comorbidity of attention deficit hyperactivity disorder with conduct, depressive, anxiety and other disorders. *American Journal of Psychiatry*. 148, 546-577.

Bradding, A. & Horstman, M. (1999) Using the write and draw technique with children. *European Journal of Oncology Nursing*. 3(3), 170-175.

Brandau, H. and Pretis, M. (2004) 'Early identification and systemic educational intervention for young children with attention-deficit/hyperactivity disorder (ADHD)'. *European Journal of Special Needs Education*, 19(1), 17-30.

British Psychological Society (2006) *Code of Ethics and Conduct*.

Castellanos & Tannock, (2002) Neuroscience of attention-deficit/hyperactivity disorder: the search for endophenotypes. *Nature* 3(8) 617-28.

Charmaz, K. (2008) Grounded theory in the 21st century: Applications for advancing social justice studies. In N. Denzin & Y. Lincoln (Eds.), *Strategies of qualitative inquiry*. London: Sage.

Charmaz, K. (2006) *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage.

Charach, A., Skyba, A., Cook, L. & Antle, B. J. (2006) Using stimulant medication for children with ADHD: what do parents say? A brief report. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*. 15(2), 75-83.

Conners, K. C. (2001) *Conners' rating scales – revised*. MHS: New York.

Cooper, P. & Shea, T. (1998) Pupils' perceptions of AD/HD. *Emotional and Behavioural Difficulties*. 3(3), 36-48.

Cooper, P. (1993) Learning from pupils' perspectives. *British Journal of Special Education*. 20(4), 129-133.

Corbin, J. & Strauss, A. (2008) *Basics of qualitative research* (3rd ed.): *Techniques and procedures for developing grounded theory*. London: Sage.

Cunningham, C. E. (2007) A family-centered approach to planning

and measuring the outcome of interventions for children with attention-deficit/hyperactivity disorder. *Journal of Pediatric Psychology*. 32(6), 676-694.

Danforth, S. & Navarro, V. (2001) Hyper Talk: sampling the social construction of ADHD in everyday language. *Anthropology and Education Quarterly*. 32(2), 167-190.

Darbyshire, P., MacDougall, C. & Schiller, W. (2005) Multiple methods in qualitative research with children: More insight or just more? *Qualitative Research*. 5(4), 417-436.

Dietz, S. & Montagne, M. (2006) Attention deficit hyperactivity disorder comorbid with emotional and behavioural disorders and learning disabilities in adolescents. *Exceptionality*. 14(1), 19-33.

De Los Reyes, A. & Kazdin, A. (2005) Informant discrepancies in the assessment of childhood psychopathology: a critical review, theoretical framework and recommendations for further study. *Psychological Bulletin*. 131(4) 483-509.

Dosreis, S., Zito, J. M., Safer, D. J., Soeken, K. L., Mitchell, J. W. & Ellwood, L. C. (2003) Parental perceptions and satisfaction with stimulant medication for attention-deficit hyperactivity disorder. *Developmental and behavioural Pediatrics*. 24(3), 155-162.

Efron, D., Jarman, F. C. & Barker, M. J. (1998) Child and parent perceptions of stimulant medication treatment in attention deficit hyperactivity disorder. *Journal of Pediatric Child Health*. 34, 288-292.

- Epstein, J. N., Conners, C. K., Erdhardt, D., Arnold, L. E., Hetchman, L., Hinshaw, S. P., et al. (2000) Familial aggregation of ADHD characteristics. *Journal of Abnormal Child Psychology*. 28(6), 585-594.
- Geanellos, R. (1999) Exploring Ricoeur's hermeneutic theory of interpretation as a method of analysing research texts. *Nursing Inquiry*. 7, 112-119.
- Gee, J. P. (1996) *The social mind: language, ideology and social practice*. New York: Bergin & Garvey.
- Gerdes, A. C., Hoza, B. & Pelham, W. E. (2003) Attention-deficit/hyperactivity disorder boys' relationships with their mothers and father: child, mother and father perceptions. *Development and Psychopathology*. 15, 363-382.
- Goldman, L. S., Genel, M., Bezman, R. J. & Slantetz, P. J. (1998) Diagnosis and treatment of attention-deficit/hyperactivity disorder in children and adolescents. *Journal of the American Medical Association*. 279(4), 1100-1107.
- Harbourne, A., Wolpert, M. & Clare, L. (2004) Making sense of ADHD: A battle for understanding parents' views of their children being diagnosed with ADHD. *Clinical Child Psychology and Psychiatry*. 9(3), 327-339.
- Harry, B., Sturges, K. & Klingner, J. (2005) Mapping the process: An exemplar of process and challenge in grounded theory analysis. *Educational Researcher*. 34(3), 3-13.

- Henker, B. & Whalen, C. (1989) Hyperactivity and attention deficits. *American Psychologist*. 44, 216-223.
- Hester, D. M. (2007) Whither authenticity: ADHD, medication, and striving for the 'good life' – a commentary on Singh. *Clinical Child Psychology and Psychiatry*. 12(2), 183-187.
- Hinshaw, S. P. (2007) Moderators and mediators of treatment outcome for youth with ADHD: understanding for whom and how interventions work. *Journal of Pediatric Psychology*. 32(6), 664-675.
- Hoza, B. (2007a) Peer functioning in children with ADHD. *Journal of Pediatric Psychology*. 32(6), 655-663.
- Hoza, B., Kaiser, N. & Hurt, E. (2007b) Multimodal treatments for childhood attention-deficit/hyperactivity disorder: interpreting outcomes in the context of study designs. *Clinical Child and Family Psychology Review*. 10, 318-334.
- Hoza, B., Mrug, S., Gerdes, A. C., Hinshaw, S. P., Bukowski, W. M., Gold, J. A., et al. (2005) What aspects of peer relationships are impaired in children with attention-deficit/hyperactivity disorder? *Journal of Consulting and Clinical Psychology*. 73(3), 411-423.
- Hoza, B., Gerdes, A. C., Hinshaw, S. P., Arnold, L. E., Pelham, W. E., Molina, B. S., et al. (2004) Self-perceptions of competence in children with ADHD and comparison children. *Journal of Consulting and Clinical Psychology*. 72(3), 382-391.
- Hoza, B., Pelham, W. E., Dobbs, J., Owens, J. S. & Pillow, D. R.

(2002) Do boys with attention-deficit/hyperactivity disorder have positive illusory self-concepts? *Journal of Abnormal Psychology*. 111(2), 268-278.

Hoza, B., Pelham, W. E., Waschbusch, D. A., Kipp, H. & Owens, J. S.

(2001) Academic task persistence of normally achieving ADHD and control boys: performance, self-evaluations, and attributions. *Journal of Consulting and Clinical Psychology*. 69(2), 271-283.

Hoza, B., Waschbusch, W., Pelham, W. E., Molina, B. S. & Milich, R.

(2000) Attention-deficit/hyperactivity disorder and control boys' responses to social success and failure. *Child Development*. 71(2), 432-446.

Hughes, L. (2007) The reality of living with AD/HD: children's concern about educational and medical support. *Emotional and Behavioural Difficulties*. 12(1), 69-80.

Johnston, C., Seipp, C., Hommerson, P., Hoza, B. & Fine, S. (2005)

Treatment choices and experiences in attention deficit hyperactivity disorder: relation to parents' beliefs and attributions. *Child: Care, Health and Development*. 31(6), 669-677.

Johnston, C., Fine, S., Weiss, M., Weiss, J., Weiss, G. & Freeman, W.

S. (2000) Effects of stimulant medication treatment on mothers' and children's attributions for the behaviour of children with attention deficit hyperactivity disorder. *Journal of Abnormal Child Psychology*. 28(4), 371-382.

Joseph, J. (2000) Not in their genes: a critical view of the genetics of attention-deficit hyperactivity disorder. *Developmental review*. 20, 539-567.

- Karver, M, S. (2005) Determinants of multiple informant agreement on child and adolescent behaviour. *Journal of Abnormal Child Psychology*. 34, 251-262.
- Kelly, G. (1955) *A theory of personality. The psychology of personal constructs*. New York: Norton.
- Kewley, G. D. (1998) Attention deficit hyperactivity disorder is undiagnosed and undertreated in Britain. *British Medical Journal*. 316, 1594-1595.
- Kirley, A., Hawi, Z., Daly, G., McCarron, M., Mullins, C., Millar, N., et al. (2002) Dopaminergic system genes in ADHD: toward a biological hypothesis. *Neuropsychopharmacology*. 27(4), 607-619.
- Law, U. G., Sinclair, S. & Fraser, N. (2007) Children's attitudes and behavioural intentions towards a peer with symptoms of ADHD: does the addition of a diagnostic label make a difference? *Journal of Child Health Care*. 11(2), 98-111.
- Leech, N. & Onwuegbuzie, A. (2008) Qualitative data analysis: a compendium of techniques and a framework for selection for school psychology research and beyond. *School Psychology Quarterly*. 23(4), 587-604.
- Linn, R. T. & Hodge, G. K. (1982) Locus of control in childhood hyperactivity. *Journal of Clinical Psychology*. 50(4), 592-3.

Loe, I. & Feldman, H. (2007) Academic and educational outcomes of children with ADHD. *Journal of Paediatric Psychology*. 36(6), 643-654.

Maras, P., Redmayne, T., Hall, C., Braithwaite, D. & Prior, P. (1997) 'Helicopter children' and 'butterfly brains'. ADHD: perceptions, issues and implications. *Educational and Child Psychology*. 14(1), 39-49.

McDermott, R.P. (1996) 'The acquisition of a child by a learning disability' in S.Chaiklin and J Lave (Eds), *Understanding Practice: Perspectives on activity and context*. Cambridge: Cambridge University Press.

McNeal, R. E., Roberts, M. C. & Barone, V. J. (2000) Mothers' and children's perceptions of medication for children with attention-deficit hyperactivity disorder. *Child Psychiatry and Human Development*. 30(3), 173-187.

Miller, S. (1995) Parents' attributions for their children's behaviour. *Child Development*. 66, 1557-1584.

Moran, H. (2001) Who do you think you are? Drawing the ideal self: A technique to explore a child's sense of self. *Clinical Child Psychology and Psychiatry*. 6(4), 599-604.

Morgan, A., Hynd, G. Riccio, C. & Hall, J. (1996) Validity of DSM-IV ADHD predominantly inattentive and combined types: relationships to previous DSM diagnoses/subtypes differences. *Journal of the American Academy of Child and Adolescent Psychiatry*. 35, 325-333.

MTA Cooperative Group. (2002) Socioeconomic status as a

moderator of ADHD treatment outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry*. 41(3), 269-277.

MTA Cooperative Group. (1999) A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. *Archives of General Psychiatry*. 56(12), 1073-1086.

NICE (2009) The NICE guideline on diagnosis and management of ADHD in children, young people and adults. NICE Clinical Guidelines 72.

Nylund, D. (2000) *Treating Huckleberry Finn: A new narrative approach to working with kids diagnosed with ADD/ADHD*. Jossey-Bass. San Francisco.

Orford, E. (1998) Diagnosis needs tightening. *British Medical Journal*. 316, 1595-1596.

Pelham, W. E., Hoza, B., Pillow, D. R., Gnagy, E. M., Kipp, H. L., Greiner, A. R., et al. (2002) Effects of methylphenidate and expectancy on children with ADHD: behaviour, academic performance, and attributions in a summer treatment program and regular classroom settings. *Journal of Consulting and Clinical Psychology*. 70(2), 320-335.

Pelham, W. E., Hoza, B., Kipp, H. L., Gnagy, E. M. & Trane, S. T. (1997) Effects of methylphenidate and expectancy on ADHD children's performance, self-evaluations, persistence, and attributions on a cognitive task. *Experimental and Clinical Psychopharmacology*. 5(1), 3-13.

- Powney, J. & Watts, M. (1987) *Interviewing in educational research*.
London: Routledge.
- Ravalovich, A. (2001) Disciplining domesticity: framing the ADHD parent and child. *The Sociological Quarterly*. 42(3), 373-393.
- Radcliffe, N. & Timimi, S. (2004) The rise and rise of ADHD. *Clinical Psychology*. 40, 8-13.
- Reimers, T. M., Wacker, D. P., Derby, K. M. & Cooper, L. J. (1995)
Relation between parental attributions and the acceptability of behavioural treatments for their child's behaviour problems. *Behavioural Disorders*. 20(3), 171-178.
- Saltmarsh, R., McDougall, S. & Downey, J. (2005) Attributions about child behaviour: comparing attributions made by parents of children diagnosed with ADHD and those made by parents of children with behavioural difficulties. *Educational and Child Psychology*. 22(4), 108-126.
- Segal, E. S. (2001) Learned mothering: Raising a child with ADHD. *Child and Adolescent Social Work*. 18(4), 263-279.
- Singh, I. (2007a) Clinical implications of ethical concepts: moral self-understandings in children taking methylphenidate for ADHD. *Clinical Child Psychology and Psychiatry*. 12(2), 167-182.
- Singh, I. (2007b) Authentic problematics of empirical ethics: response to D. Micah Hester. *Clinical Child Psychology and Psychiatry*. 12(2), 189-190.

Sleator, E., Ullmann, R. & Neumann, A. (1982) How do hyperactive children feel about taking stimulants and will they tell the doctor? *Clinical Pediatrics*. 21, 474-9.

Smith, S. R. (2007) Making sense of multiple informants in child and adolescent psychopathology: a guide for clinicians. *Journal of Psychoeducational Assessment*. 25(2), 139-149.

Sonuga-Barke, E. J. (2002) Psychological heterogeneity in AD/HD—a dual pathway model of behaviour and cognition. *Behavioural Brain Research*. 130, 29-36.

Spencer, T. J., Biederman, J. & Mick, E. (2007) Attention-deficit/hyperactivity disorder: diagnosis, lifespan, comorbidities and neurobiology. *Journal of Pediatric Psychology*. 32(6), 631-642.

Stein, R. E. (2007) Measurement of ADHD outcomes: implications for the future. *Journal of Pediatric Psychology*. 32(6), 728-731.

Still, G. (1902) Some abnormal psychical conditions in children. *Lancet*. 1, 1008-1012, 1077-1082, 1163-1168.

Swanson, J., Kinsbourne, M., Nigg, J., Lanphear, B., Stefanotis, G. & Volkow, N. et al (2007) Etiological subtypes of attention-deficit/hyperactivity disorder: Brain imaging, molecular genetic environmental factors and the dopamine hypothesis. *Neuropsychology Review*. 17, 39-59.

- Treuting, J. J. & Hinshaw, S. P. (2001) Depression and self-esteem in boys with attention-deficit/hyperactivity disorder: associations with comorbid aggression and explanatory attributional mechanisms. *Journal of Abnormal Child Psychology*. 29(1), 23-39.
- Travell, C. & Visser, J. (2006) 'ADHD does bad stuff to you': young people's and parents' experiences and perceptions of attention deficit hyperactivity disorder (ADHD). *Emotional and behavioural Difficulties*. 11(3), 205-216.
- Volkow, N. D. & Insel, T. R. (2003) What are the long-term effects of methylphenidate treatment? *Biological Psychiatry*. 54, 1307-1309.
- Willcutt, E. G., Doyle, A. E., Nigg, J. T., Faraone, S. V. & Pennington, B. F. (2005) Validity of the executive function theory of attention-deficit/hyperactivity disorder: a meta-analytic review. *Biological Psychiatry*. 57, 1336-1346.