**Figure 1: Diagrammatical representation of the Grounded Theory ‘Caught in the eye of the storm’**

*Eye of the storm*

*Amid the storm*

Parental ability to cope without ADHD medication

Worries about long-term medication effects

Prior non-adherence experiences

Parental ability to cope with the child

Teachers preconceptions and experiences

Parental worries about child’s lack of academic progress

Support from parents and doctors

Degree of adolescent autonomy

Adolescents’ beliefs

Keeping the wheel spinning round

Failing to meet behavioural expectations

Accepting the medication

Becoming a good child

# Figure 2: The paradigm model for the category ‘Becoming a good child’

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| **Context:** Entering school means having to conform to expected norms  *The mainstream school system, certainly in the United Kingdom, requires children to behave and conform in a certain way starting in primary school. Each school has its own policy for acceptable behavior and rules for the classroom which all school children are expected to adhere to. Children are generally expected to listen well, be polite, look after things, share with others, sit still, keep hands to self, obey and respect adults, be calm, not talk, and not fidget.* | | | | |
| Parental ability to cope with the child | Causal conditions | Actions/interactions | Consequences | Teachers preconceptions and experiences |
| Failing to confirm to social norms: At school (e.g. *high levels of continued hyperactivity, inattention, and impulsive behaviour, being noisy, unable to sit still, behaving without thinking, struggling academically*); teachers’ criticism of child’s behaviour and / or discussion of possibility of ADHD with parents  At home (e.g. *inability to listen, hyperactivity, uncooperative, irritating siblings, forgetful, sleepless, restless, no sense of danger, aggressive / angry behaviours*) | Parental pursuit of a medical solution  Receipt of the ADHD diagnosis  Prescriber decision to offer medication (dependent on e.g. *seeing typical ADHD symptoms, severity of symptons, impact on school performance, family distress, parents’ preferences, child age*)  Parental acceptance of the medication (dependent on e.g. *parents’ perceived levels of distress in the child, their own ability to cope, the level of distress in family life, irritation to siblings, positive expectations about medication*) | Meeting school expectations *(*e.g. *the child is calmer, less distracting, able to sit still, less noisy, more focused, joins in with classroom activities, improved academic performance)*  Pleasing teachers – good reports and even receipt of awards  Meeting home expectations *(*e.g. *quieter child, reduced impulsive behaviour and aggressive / angry outbursts, improved familty and social life, and increased ability to listen, hold a conversation, and do homework)*  Enhanced self-esteem  **Becoming a good child** |
| Parental worries about child’s lack of academic progress | | | | |

# Figure 3: Paradigm model for the category 'Keeping the wheel spinning round'

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| **Context:** Receiving medication means ‘becoming a good child’ by meeting expectations and improving own and others’ lives  *Parents worry about their child’s school attainments, they fear teachers’ rebuke, and they worry that their child won’t manage without the medication. In this context, parents can view the medication as necessary for accessing the school curriculum and receiving a good education.* | | | | |
| Parental ability to cope without ADHD medication | Causal conditions | Actions/interactions | Consequences | Worries about long-term medication effects |
| Experiencing medication side-effects (e.g. *sleep problems, loss of appetite, and changes in temperament, mood swings, and emotional disruption, changes in character and personality, and being blank*)  Dose increases to sustain drug benefits  Negative effects versus functional benefits  Parents’ forgetting how child behaved without the medication  Location of the child’s problematic behaviour (at home or at school)  Severity of symptoms and side-effects  Teachers worries about drug holidays:   * on the safety of children with ADHD and their peers * on their own ability to cope with the child’s behaviour without medication | CAMHS practitioners conceiving side-effects as manageable *(e.g. by reducing the dose of medication, switching to other medications, and/or planning drug holidays on non-school days)*  Parents tolerating medication side-effects against educational benefits.  Parent-initiated drug holidays at weekends and/or during school holidays.  Teachers emphasising medication should only be interrupted on non-school days  GPs expressing own concerns about stimulants:   * unknown long-term effects * economic cost * viewing trials without the medication an opportunity for cost savings | Following a ‘*school-time medication pattern*’ and giving medication during the school week only, not at weekends and other non-school days. Psychological and physiological side-effects managed. Longer drug holidays enable catch up with growth. The child might return to a lower medication dose after a longer break from medication.  Following an ‘*all-time medication pattern*’ giving children the medication every day, all the time.  **Keeping the wheel spinning round** |
| Prior non-adherence experiences | | | | |

# Figure 4: Paradigm model for the category 'Not playing the game anymore'

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| **Context:** Children on longterm medication become adolescents still on medication  *Adolescents start to assume responsibility for own health and start making own decisions independent of parents and doctors. There is a lack of ADHD adult services in the United Kingdom.* | | | | |
| Support from parents and doctors | Causal conditions | Actions/interactions | Consequences | Degree of adolescent autonomy |
| Adolescent awareness of medication side-effects (e.g. *feeling different on medication, losing inner energy, low mood, feeling angry and feeling flat*):   * Stigma * A desire for independence * Lack of perceived benefits * Increased autonomy, feeling mature * Feeling bored of medication taking * A desire to stop taking medication.   Parents’ fear of losing beneficial effects of medication.  CAMHS practitioners identifying reasons to support medication breaks (e.g*. risk of diversion with continued use, ability to use psychological interventions in older children, adolescents’ ability to make sense of withdrawing medication, possible development of executive functions)* | Parents and doctors diasagreement with adolescents’ decision to stop the treatment  CAMHS practitioners’ attempts to negotiate medication continuation:   * Stressing the importance of medication adherence * Discussing the pros and cons of medication. * Suggesting at least a break from medication before stopping it altogether * Allowing young people to assess for themselves their ability to manage without medication | The majority of adolescents wanting to drop out of treatment.  Some adolescents agreeing to a drug holiday.  Many deciding to stop taking the medication even perhaps against their parents’ and doctors’ advice.  **Not playing the game anymore** |
| Adolescents’ beliefs | | | | |