UNDERSTANDING THE EXPERIENCES OF STUDENTS AND TEACHERS OF STUDENTS DIAGNOSED WITH ADHD: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF THE ADHD LABEL IN SCHOOLS

By

Gemma Louise Hemming

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ABSTRACT

Attention Deficit Hyperactivity Disorder (ADHD) is the most prevalent, yet controversial diagnosis affecting children and young people. This study aims to inform educational practice and challenge the negative outcomes associated with ADHD by exploring the lived experience of young people and their teachers. I use Interpretative Phenomenological Analysis (IPA) making use of a paired design to explore how student-teacher dyads within a mainstream secondary school conceptualise and experience ADHD. Findings suggest participants' conceptualisations of ADHD and associated treatment (e.g. medication) were widely varied and influenced by their personal experiences. Consequently, I advocate a bio-psycho-social understanding of the condition as beneficial for both students and teachers. Students experienced stigma and isolation but benefitted from positive relationships with teachers. Teachers found it difficult to assess the need for a *different* approach when teaching students with ADHD, but also recognised positive relationships as factors to enable student's success. This study offers a unique contribution to the substantive topic, and original application of a multi-perspective IPA design. Implications for professional practice are discussed and I invite further research to build upon the current findings by addressing the experience of female students with ADHD, wider samples of secondary school teachers, and further multi-perspective designs.

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CONTENTS

INDEX OF APPENDICES

LIST OF FIGURES

LIST OF TABLES

ABBREVIATIONS

ADHD	Attention Deficit Hyperactivity Disorder
APA	American Psychiatric Association
BPS	British Psychological Society
CYP	Children and Young People
DCP	Division of Clinical Psychologists
DECP	Division of Educational and Child Psychologist
DFE	Department for Education
DSM	Diagnostic Statistical Manual
EP	Educational Psychology/Psychologist
HKD	Hyperkinetic Disorder
ICD	International Classification of Diseases
IPA	Interpretative Phenomenological Analysis
ITT	Initial Teacher Training
LA	Local Authority
NICE	National Institute of Clinical Excellence
RCP	Royal College of Psychiatrists
RQ	Research Question
SEN-D	Special Educational Needs and Disability
TEP	Trainee Educational Psychologist
WHO	World Health Organisation

CHAPTER ONE: INTRODUCTION

1.1 Background and Context

Attention Deficit Hyperactivity Disorder (ADHD) is the most frequently diagnosed and researched childhood condition worldwide (Barkley, 2013). In the UK, the number of children and young people (CYP) diagnosed with, and prescribed medication for ADHD, has steadily increased over the last decade (McCarthy et al., 2012). However, the condition's existence as a medical 'disorder' remains subject to controversial debate. Educational Psychologists (EPs) have contributed to this debate and as practitioners, regularly encounter CYP with ADHD within the school context. Evidence suggests that CYP with ADHD experience significantly poorer educational outcomes in comparison to their peers (Loe and Feldman, 2007; Daley and Birchwood, 2010; Kent et al., 2011). In my opinion, a central role of EPs is contributing towards improved outcomes for *all* CYP and EPs should, therefore, engage in this area of research and practice. Furthermore, the British Psychological Society (BPS) support the important role of EPs in the assessment and intervention for CYP with ADHD (BPS, 2000).

Their propensity to poor educational outcomes also highlights a need for teachers to understand ways to improve outcomes for CYP with ADHD. Indeed, UK guidelines suggest that The Department for Children, School and Families should educate teachers to support children with ADHD during initial teacher training (ITT) (National Institute of Clinical Excellence [NICE], 2009). However, the most recent review of ITT expressed concerns that the level of coverage given to Special Educational Needs and Disability (SEN-D) did not prepare teachers adequately (Carter, 2015).

1.2 Thesis Rationale

I have become increasingly interested in the topic of ADHD throughout my personal and professional experience prior to, and during, my Doctoral training in Educational Psychology. During a voluntary role caring for children on residential breaks I reflected on the impact of medication on the self-identity and behavioural attributions for children with ADHD. I learnt many were facing school exclusion, poor academic outcomes and difficulties at school with teachers and peers, which contrasted with their presentation within the residential context. Subsequently, during my professional training two pivotal cases challenged my understanding of how CYP with ADHD are supported within school contexts.

Lisa (pseudonym) was a Year 6 pupil in a mainstream primary school. She was diagnosed with ADHD; was significantly underachieving academically and experiencing social isolation. Lisa's diagnosis helped her mum to understand Lisa's needs and communicate them to others. In contrast, Lisa's teachers avoided attributing any understanding of Lisa's needs to the ADHD 'label', to prevent unnecessarily generalising qualities of ADHD to Lisa which she did not experience. They did not perceive ADHD to be a 'valid' condition and had not received any training about it. I reflected upon how teachers' conceptualisation of ADHD in this instance may have exacerbated a problematic situation, (e.g. tensions between home-school conceptualisations of ADHD resulting in teachers' reluctance to administer medication during a residential trip as this did not align with their own views).

Bradley (pseudonym) was a Year 8 student in a mainstream secondary school. He experienced difficulties with attention, impulsivity and behaviour, and thus, was

underachieving academically, disengaged with learning and showing signs of anxiety. Bradley's parents were reluctant to pursue medical exploration of whether these difficulties could be explained as ADHD and preferred for his needs to be met at school without diagnosis and/or medication. However, school staff were insistent that Bradley *required* an ADHD diagnosis for school staff to understand his needs and increase the likelihood of implementing EP recommendations. It seemed that teachers in this instance perceived pedagogical implications of the diagnosis itself. I also hypothesised that school staff might have perceived Bradley's behaviour might have improved following a diagnosis and subsequent medication for ADHD. Again, tensions between home-school conceptualisations may have exacerbated a problematic situation.

In addition, I have a personal interest in the topic of ADHD, influenced by listening to a family member's memories of school. Although not diagnosed with ADHD, this family member strongly identifies with those who meet diagnostic criteria. He recalls persistently struggling to focus, failing to meet deadlines, poor organisational skills and impulsive behaviour teachers did not tolerate. He developed a coping strategy of copying work from peers so that his difficulties went undetected. He felt several teachers did not understand him and throughout his entire secondary school experience recalls only one teacher with whom he had a positive relationship. This prompted me to reflect upon whether a diagnosis of ADHD in this instance, would have helped teachers to understand and meet his needs in the way he perceives it may have done.

Together these experiences culminated in my interest in the topic of ADHD, as I considered how as a Trainee Educational Psychologist (TEP) I could contribute

towards improving outcomes for this group of CYP. My reading of literature on the topic developed my interest in how ADHD could be conceptualised *so* differently and the potential impact of this for the CYP affected.

1.3 Methodological orientation

The current study explores the experiences of students diagnosed with ADHD and selected teachers within a mainstream secondary school in the UK. This is achieved through application of Interpretative Phenomenological Analysis (IPA) to reveal how students and teachers conceptualise and experience ADHD within their context. The study implements a paired design to explore multiple perspectives of the same phenomenon to consider shared and/or conflicting meanings between the pairs. I argue that understanding the lived experience of the phenomenon of ADHD, from the perspective of young people and their teachers will inform the development of school practices to challenge the negative outcomes associated with ADHD, and provide greater understanding of the how best to respond to ADHD within schools.

1.4 Definition of terms

ADHD is a relatively recent phenomenon, preceded by various terms including: minimal brain damage/dysfunction (1908 – 1980's); hyperkinetic reaction of childhood (Diagnostic Statistical Manual [DSM] 2; American Psychiatric Association [APA],1968); attention deficit disorder with or without hyperactivity (DSM 3; APA, 1980); before becoming known by its contemporary term in DSM 3 Revised (APA, 1987). Combined-type ADHD typically involves three behavioural characteristics: inattention; hyperactivity; impulsivity whereas some children may only experience

difficulties in inattention (inattentive type) or hyperactivity/impulsivity (hyperactive-impulsive type) (APA, 2013). The International Classification of Mental and Behaviour Disorders (ICD) 10 also uses the term Hyperkinetic Disorder (HKD) as a *severe* form of ADHD (World Health Organisation [WHO], 1992). The terminological complications and conceptual confusion around ADHD are critically examined in chapter two, but it is important to note here that the term 'ADHD' is used throughout the current study to refer to CYP with any type of this diagnosis. Hereafter, the term adolescent and/or student is used to reflect the age group of the CYP in the current study.

1.5 Overview of structure and content

The current chapter has provided a brief account of the context in which ADHD is situated; a broad rationale for my interest in the topic and my aspirations for this research. Chapter two reviews relevant existing literature to provide greater understanding of the context and controversy surrounding ADHD and an in-depth analysis of existing literature regarding adolescent and teacher experiences of ADHD. Chapter three outlines this study's research questions (RQ), rationale for the theoretical framework of IPA and the research design. In chapter four, I present and discuss the findings addressing each research question in turn with reference to extant literature. Finally, chapter five summarises the findings explicitly noting the original contribution of the current study and implications for practice. Limitations of the current study and suggestions for future research are also addressed in this final chapter.

CHAPTER TWO: LITERATURE REVIEW

2.1 Chapter overview

This chapter first outlines the search strategy used to identify previous literature into the topic of ADHD in schools. To contextualise issues surrounding the diagnostic label of ADHD, definitions and conceptualisations are reviewed before focusing on adolescent and teacher experiences of the phenomenon. The chapter concludes with a rationale for the unique contribution of the current study.

2.2 Search strategy

An initial search was conducted using the terms *'ADHD'* and *'UK'*, *'medical'/ 'educational'/ 'psychological definitions of'* in Google to obtain information pertinent to the UK health and educational context. Subsequently, an academic literature search was conducted using the term *'ADHD'* and *'secondary school', 'teacher', 'student', 'pupil', 'adolescent', 'experiences',* and *'IPA'* into Google Scholar and the University of Birmingham search platform, which provides access to a wide range of databases including PsychInfo, EBSCO and ProQuest. Searches were limited to material published since 2006 to identify contemporary sources. Abstracts were trawled for their relevance to the current study with a view to focus on empirical studies obtaining the views and experiences of students and teachers. This also highlighted articles relating to the conceptualisation of ADHD whereby sources were used iteratively to explore relevant materials from key authors. Articles exclusively focusing on parental experiences of ADHD, or of adult ADHD, were not included in the review.

2.3 Definitions of ADHD

2.3.1 Medical

From a medical viewpoint, ADHD is defined by *maladaptive* levels of inattention, hyperactivity and impulsivity (National Institute of Clinical Excellence [NICE], 2009). Diagnostic criteria in the UK are determined by two medical classification manuals: The Diagnostic and Statistical Manual 5 (DSM 5) published by the American Psychiatric Association (APA, 2013) but used across the world and The International Classification of Mental and Behaviour Disorders 10th revision (ICD 10) developed by the World Health Organisation (WHO, 1992) and used across Europe. The manuals adopt almost identical criteria for the presentation of symptoms, requiring evidence of symptom persistence and impairment across two or more settings (Appendix 1). However, ICD 10 refers to Hyperkinetic Disorder (HKD) which is defined as *severe* requiring a greater number of diagnostic criteria to be met in each domain (Lange et al., 2010). Furthermore, ICD 10 maintains the requirement for symptomatic onset before the age of 7, as featured in previous DSM criteria but revised to a less demanding criteria of onset before the age of 12 in DSM 5.

The global prevalence of ADHD is cited as 5.3% (Polanczyk et al., 2007), whilst estimates in the UK range between 3 - 9% (NICE, 2009) and 2 -5% (Royal College of Psychiatrists [RCP], 2016). This may in part be owing to differential definitions, e.g. prevalence of around 5% according to DSM 5 criteria, and 1.5% according to the more stringent ICD 10 criteria (O'Regan, 2007).

Though delineated as a medical disorder, ADHD remains defined by behavioural descriptors, demonstrated by the terms: “a heterogeneous behavioural syndrome” (NICE, 2009, p384); “a group of behavioural symptoms” (National Health Service, 2016) and “a behavioural disorder” (RCP, 2016). Furthermore, NICE guidelines acknowledge that *“ADHD symptoms are continuously distributed throughout the population with no natural threshold between affected and unaffected individuals”* (NICE, 2009, p27), although clinical samples show that boys are more commonly affected than girls at ratios as high as six to one (Cormier, 2008). Whilst there seems to be a shared understanding regarding the defining features of hyperactivity and attention difficulties, differing terminologies, reflected in the use of DSM 5’s Attention Deficit Disorder and ICD 10’s Hyperkinetic Disorder, can cause confusion for those working to support children who experience such problems (RCP, 2016).

2.3.2 Educational and Educational Psychology

Within the education system, ADHD is described under the Special Educational Need and Disability (SEN-D) category of social, emotional and mental health (Department for Education [DfE], 2015). This combines its status as a mental health disorder to recognise implications on learning, placing it firmly within statutory guidelines for SEN-D. Furthermore, this brings ADHD into the realm of Educational Psychologists (EPs) who are often involved in supporting schools to meet the needs of students with SEN-D (DfE, 2015). To date, the British Psychological Society (BPS) does not appear to have published a specified definition of what it considers ADHD to be. As contributors to NICE guidelines, one can assume that psychologists adopt this definition. However, members from the Division of Clinical Psychology (DCP) and Division of Educational

and Child Psychology (DECP) published a response to a review of NICE guidelines, expressing concerns regarding both the diagnostic validity and rigour of diagnostic criteria for ADHD, essentially critiquing the manualised definitions. Within this document, they develop an ethical argument that the new DSM 5 definition could be applied to a high proportion of children, potentially causing a surge in diagnosis and medication for an unnecessarily high number of children (BPS, 2011).

2.3.4 Section summary

Although a definition is an “exact meaning”, literature thus far has highlighted inter-disciplinary variation between medical, educational and psychological definitions, creating ambiguity around the phenomenon of ADHD. A conceptualisation differs from a definition in that it is an idea or explanation which has been formed through thinking. Trevis (2013) highlights how this acknowledges internal mental processes, leading to individual interpretation of meaning based on their world view and previous experiences.

2.4 Conceptualising ADHD

2.4.1 Medical

The first account of a phenomenon associated with attention deficit can be traced as early as 1775 (Barkley and Peters, 2012), although the scientific starting point for what is known today ADHD is commonly attributed to George Still, who in 1902 described a condition of abnormal defect of moral control (Barkley and Peters, 2012; Lange et al., 2010). His belief that the condition was caused by within-child factors received

further support following Charles Bradley's discovery in 1937 that stimulant medication could reduce levels of hyperactivity (O'Regan, 2007), seemingly attributing a biological cause. Throughout the twentieth century the concept has evolved but remains positioned within a medical framework as a psychiatric disorder within DSM 5 and ICD 10. However, the paradigm within which mental health is viewed can lead to varying conceptualisations.

The historical context of ADHD indicates its origin from a medical paradigm whereby difficulties are assumed to arise from innate or biological causes. Contemporary research within the fields of neuroimaging and genetics offer empirical support for biologically based theories of abnormalities in brain structure and/or neural function, imbalance of chemical neurotransmitters and the expression of particular genes (O'Regan, 2007; Selikowitz, 2009). Whilst some present these findings as irrefutable scientific evidence of a biological basis to ADHD (e.g. Barkley and 74 co-endorsers, 2002; Barkley et al., 2004), others have responded with criticism that studies are simply not robust enough to draw definitive conclusions (Visser and Jehan, 2009; Lange et al., 2010). Furthermore, Timimi et al. (2004) warns against inconsistent findings being presented as spurious truth, particularly where some proponents of this view have been exposed as having financial links to pharmaceutical companies, therefore benefitting from the view they promote. In addition, the search for biological causes may seek to reduce children's behaviour to over-simplistic explanations, ignoring the opportunity to appraise social factors (Visser and Jehan, 2009). Consequently, the 'truth' of ADHD as a primarily biological disorder continues to be challenged.

2.4.2 Socio-cultural

Timimi and Radcliffe (2005) argue ADHD is *best* understood as a socio-cultural construct. This is supported by considerable research into the presence of ADHD across varying social risk factors, for example: socio-economic deprivation; exposure to trauma; neglect; abuse or loss and parental mental illness (Galves and Walker, 2012; Richards, 2012; Harwood and Allan, 2014). Variation in cross-cultural prevalence rates from 0.5% - 26% also indicate how social values of a particular culture influence the extent to which behaviour is judged as *normal* or *disordered* (Timimi and Taylor, 2004). For example, Dwivedi and Banhatti (2005) report Chinese and Indonesian clinicians gave significantly higher scores for hyperactivity than other nations, suggesting a lower tolerance level for this type of behaviour than in other cultures. Furthermore, Liang and Gao (2016) explanation that Chinese cultural beliefs emphasise innate abilities as explanations for behaviour. This links to their finding that teachers in Hong Kong were more likely to regard students' behaviour as 'not trying hard enough' in comparison to Australian and Western counterparts. Taylor (in Timini and Taylor, 2004) also proposes hyperactivity may be perceived to have a greater impact in the Chinese environment, which places great emphasis on academic success. Polanczyk et al (2007) highlight significant variability in prevalence rates between North America, Middle Eastern and African nations, although conclude this is likely due to the disparity of studies conducted outside of the North America and Europe, as opposed to specific cultural differences. However, studies within such nations do highlight some specific cultural factors which may influence perceptions of behaviour. For example, Ghanizadeh et al (2006) highlight how in Iran students with ADHD are regularly rejected from education, which may be linked to a lack of formal

training for teachers around the topic. Moreover, how ADHD is conceptualised within the education system (i.e. whether diagnosis leads to allocation of additional resources etc) is likely to affect teachers' perceptions, experience and thus management of students with ADHD.

Although the previous examples are not exhaustive, prescription medication in Western nations continues to rise (McCarthy et al, 2012; Graham, 2008c). Opposing his co-author, Timimi argues that Western culture in particular seems to have developed a preference for simplistic biological explanations for children's behaviour, which has the potentially negative consequence of ameliorating responsibility of families and professionals in addressing contextual factors (Timimi and Taylor, 2004). Australian writer, Graham (2008a) also remarks how factors within societies, such as the demands of formal schooling, may actually *contribute* to the construction of ADHD through oppressive regimes where children are required to conform to unrealistic standards placed upon them (Graham, 2008a). Within this review, a broad range of international literature is considered, drawing attention to particular cultural differences acknowledged by the authors as they arise and focusing on UK studies where possible.

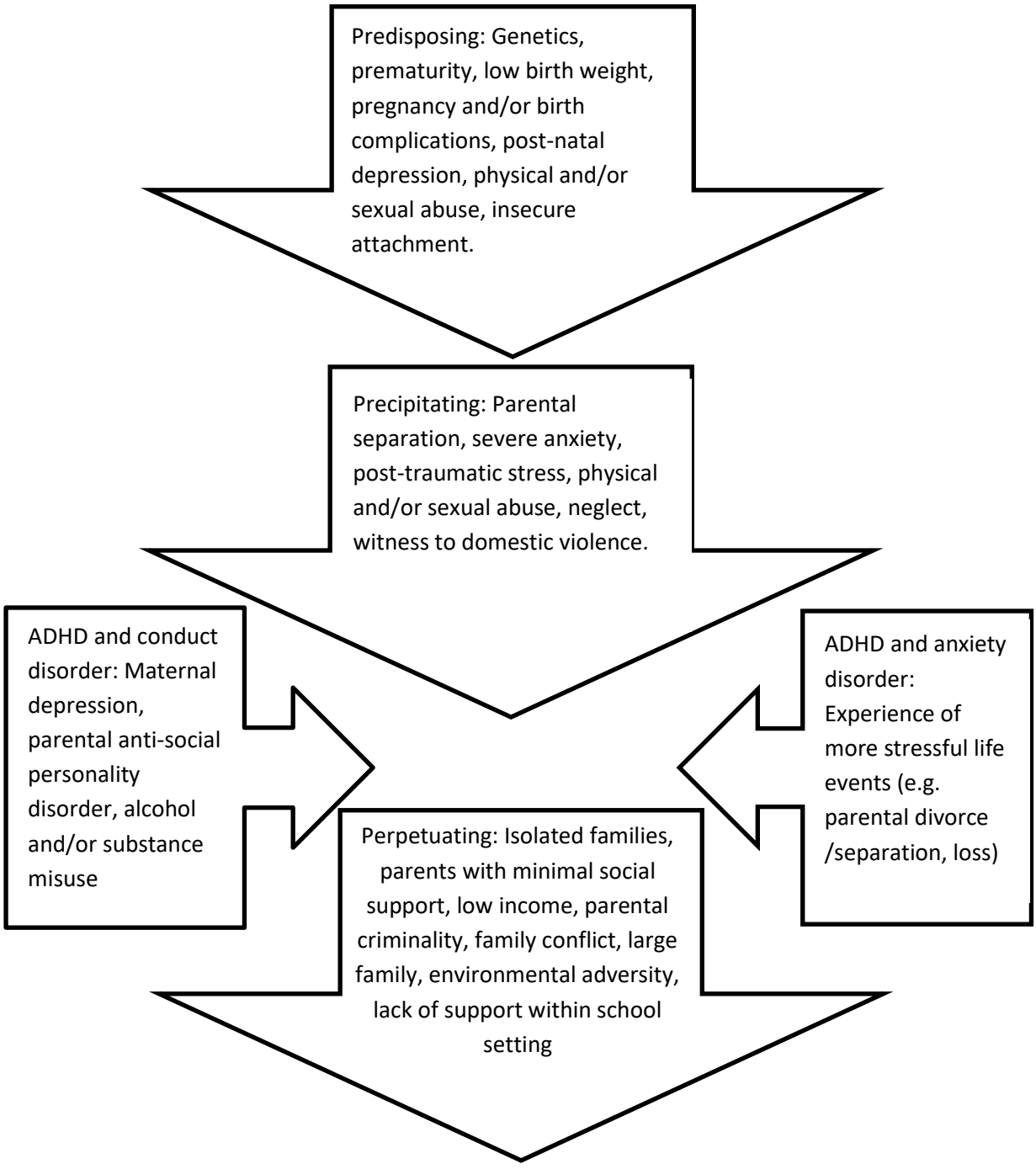
In summary, from a sociological paradigm ADHD does not exist as an objective 'disorder', but is created and reified through social means. This debate is far from over with articles as recent as 2016 questioning *"Is ADHD a real disorder?",* and concluding with calls for further research (Quinn and Lynch, 2016). However, Wheeler (2010) writes that even those who reject the notion of ADHD as a psychiatric diagnosis, can be in *"no doubt that approximately 5% of the school population display some features*

of inattention, hyperactivity and impulsivity". (p265). This echoes the view of Cooper (2008) who sees the extreme polarity between biological versus sociological explanations as unhelpful, creating barriers to effective support through contradicting one another.

2.4.3 Integrated model

An alternative paradigm strongly promoted in recent years attempts to make sense of both biological and sociological paradigms. Proponents of a bio-psycho-social approach advocate that the roles of biological and contextual factors need not be mutually exclusive, but can be integrated to understand how biological predisposition of individual differences can be exacerbated or reduced by social and environmental factors (Hughes and Cooper, 2007; Visser and Jehan, 2009; Colley, 2010; Bowden, 2014). In recent years, this has also recognised the bi-directional interplay between genetics and environment and the association with co-morbid diagnoses, as shown in Figure 1 (Richards, 2012). Richards (2012) concludes a considerable research evidence base for the link between ADHD symptoms and psycho-social factors, but acknowledges variation in the impact to a child depending on the mutual influence of biological factors over time. This systemic approach to conceptualising ADHD requires a multi-modal approach to intervention (Cooper, 2008).

Figure 1: Factors that should be considered as part of a bio-psycho-social formulation of presenting ADHD symptoms and co-morbid diagnoses – adapted from Richards (2012) p 497.



Despite being widely promoted as the current state of knowledge about ADHD, there remains concern that the biomedical paradigm retains dominance. Harwood and Allan (2014) caution, through a process of 'medicalisation' – where non-medical problems are defined and treated as medical - diagnosis can obscure other interpretations of behaviour and inevitably influence the way in which the child is understood. The associated consequence of a biomedical discourse is the increase in psychostimulant medication as treatment. Argument surrounding ADHD recognises the irony of a concept defined by subjective interpretation of *behaviour* being the most likely to elicit prescription medication, which for many is of grave concern. Coinciding with the publication of DSM 5, the BPS held a conference dedicated to challenging the medicalisation of childhood and potential long-term adverse effects of stimulant medications (Timimi, 2013; Moncrief, 2013). Furthermore, their efficacy in improving attention across typically developing subjects raises questions about the extent to which we are treating a *disorder* or drugging *diversity* (Timimi and Taylor, 2004). Graham (2008a; 2008b) goes further to say that even when ADHD is viewed within a bio-psycho-social paradigm, within-child interventions such a cognitive behavioural therapy seems to dominate in comparison to interventions addressing the social environment of schools, which she sees as integral to the construction of ADHD itself. She goes on to argue a lack of understanding about ADHD in schools is the biggest failing as a consequence of a dominant biomedical approach (Graham, 2008c).

2.4.4 Section summary

In summary, the literature reviewed highlights how ADHD is conceptualised differently depending on the paradigm to which one ascribes. I adopt the position of Prosser (2006) who states *"whatever one's view on the reality of ADHD, ADHD is real in its*

*consequences" (*p2). Regardless of whether one views ADHD from a biological, sociological or bio-psycho-social paradigm, for those diagnosed, ADHD becomes *their* reality through the label they are given to describe their behaviour. What then, is the value of a diagnosis in people's lives? As this paper seeks to focus on the lived experience within schools – what is the value of diagnosis in schools?

2.5 Adolescent experiences

2.5.1 Section introduction

This section reviews 16 qualitative studies exploring the lived experience of adolescents diagnosed with ADHD. Fourteen articles met the initial search parameters and a further two articles pre-2006 were accessed based on frequent citation and relevance. Within the review, adolescence refers to young people aged 11-16 years. However, some studies draw upon retrospective accounts of adults recalling their experiences at this age. The articles sourced indicate parallel research has been undertaken across professional disciplines (e.g. health, education and psychology), both in the UK and across developed countries (e.g. USA, Scandinavia, Australia and Israel). Despite variety in professional disciplines and methodological approaches (e.g. retrospective accounts, grounded theory, narrative, phenomenological, IPA, thematic analysis), several shared perspectives can be derived from participants' accounts.

2.5.2 Conceptualisation

Most studies found adolescents perceive ADHD as solely biological in origin (Cooper and Shea, 1998; Meaux et al., 2006; Travell and Visser, 2006; Gallichan and Curle, 2008; Prosser, 2008). Gallichan and Curle (2008) warn of the potential negative consequences of this view, whereby adolescents feel they were not in control of their behaviour although they strive to behave in ways they know are socially desirable. Both Cooper and Shea (1998) and Travell and Visser (2006) advocate adolescents would benefit from understanding ADHD as a bio-psycho-social phenomenon, given the heterogeneous symptoms they report. Only one of the reviewed studies found that children and young people (CYP) neither fully accepted or rejected the medical definition of ADHD, but actively tried to redefine the experience to make sense for them (Brady, 2014). Their motivation for doing so appeared to be related to a desire to maintain some sense of control over their lives.

2.5.3 Implications of medication

The experience of being prescribed medication for ADHD is also likely to perpetuate adolescents' views of ADHD as a biological phenomenon. Prosser (2008) found adolescents emphasised the role of medication in enabling them to think before making choices with generally positive effects within the school environment. Similarly, Meaux et al. (2006) report perceived benefits of medication within the school environment (e.g. talking less, paying attention in class, being more motivated), although this was also experienced alongside negative side effects (e.g. feeling numbed and less sociable). Although many adolescents reported negative side

effects, they continued to take medication feeling that this helped them to meet parent and teacher behavioural expectations (Meaux et al., 2006; Avisar and Lavie-Ajayi, 2014). This highlights how adolescents felt passive in their own lives, allowing others to make decisions for them (Dunne and Moore, 2011; Avisar and Lavie-Ajayi, 2014). In response, Meaux et al. (2006) found a minority of students stopped taking medication as they approached adolescence as they sought to exert more control over their lives. In addition, Gallichan and Curle (2008) warn how interventions aimed solely at changing the individual (e.g. medication alone) can lead to negative judgements about oneself and increased feelings of difference to others as they strive to meet others' expectations. This is supported by Meaux et al.'s (2006) and Singh et al.'s (2010) findings that despite its potential positive impact on behaviour, prescription medication appears to increase feelings of difference by making adolescents more *aware* of their difficulties in comparison to peers. Furthermore, adolescents expressed negative outlooks for their future which was perhaps influenced by their lack of feeling in control and internalised negative messages about themselves in comparison to others (Krueger and Kendall, 2001; Hallberg et al., 2010).

2.5.4 Feeling different to others

Adolescents' experiences of feeling different to others is prominent across numerous studies. This is eloquently captured by the title of Shattell et al.'s (2008) study – *"I have always felt different*" - which highlights the struggle to fit in with both classroom expectations and peers. However, Shattell's (2008) conclusions are drawn from retrospective accounts of predominantly female college students. The large female sample in Shattell's (2008) study is surprising given the known gender ratios, but could

represent females' increased likelihood of attending college and educational success in comparison to males. Interestingly, Krueger and Kendall (2001) found that females with ADHD tended to internalise negative thoughts resulting in a view of themselves as inadequate (e.g. "I try and do the right thing but I can't") whereas males tended to externalise resulting in the feelings of being misunderstood (e.g. "I'm alright but you're the problem").

Nonetheless, feelings of difference are echoed across several studies of both male only and mixed gender samples. Hallberg et al. (2010) highlight how this is likely to be particularly stark during adolescence as self-identity develops through a process of reflection in comparison to others. Within their study, feelings of difference were experienced to such an extent that participants attempted to conceal their diagnosis and medical treatment in the school environment, to feel *normal* among peers. Although this specific finding was only reported in Hallberg's (2010) study in a Scandinavian context, increased comparison to others during adolescence and associated shame about diagnosis and medication are seen cross-culturally (Krueger and Kendall, 2001; Kendall et al., 2003; Meaux et al., 2006; Travell and Visser, 2006; Dunne and Moore, 2011). Moreover, this perception appears to be supported by empirical data. De Boer and Pijl (2016) found that attitudes from socio-grams suggest students with ADHD were not only least accepted by peers, but also the most rejected, in comparison to other SEN groups such as ASC. O'Driscoll et al. (2012) also showed how intolerance is particularly prevalent in adolescence in comparison to younger children. This demonstrates the potential stigma attached to students with ADHD and the social exclusion children with the condition may face in schools.

2.5.5 School experience

Students also report experiences of stigma from teachers. Children felt that regardless of whether teachers perceived ADHD to be *real* or not, they provided limited support (Singh, 2011). Kendall (2016) found adolescents expressed largely negative views of teacher behaviour, displaying a common theme of feeling humiliated after being shouted at in front of peers. A case study undertaken by Dunne and Moore (2011) reports similar experiences of alienation and exclusion exacerbated by unsupportive teachers. Honkasilta et al. (2016) also shares similar findings in which adolescents evaluated teachers' behaviour as: disproportionate; traumatising; neglectful and unfair. Furthermore, adolescents saw their own behaviour as justified in response to how they were treated by teachers. However, Prosser (2008) maintains stigma is associated with displayed behaviour and *not* necessarily the label of ADHD. He found students felt they were treated fairly according to their behaviour, and that once teachers knew them as an individual the label ceased to be a problem. However, Travell and Visser (2006) found that approximately half of their total sample (n = 17) said they felt listened to and understood by most teachers, whilst the remainder felt unheard or misunderstood.

Previous research has highlighted how the experience of stigma and challenges for CYP with ADHD appear to be greater at secondary school in comparison to primary school (Dunne and Moore, 2011; Prosser, 2008). Using the analogy of fitting square pegs into round holes, Gallichan and Curle (2008) suggest adolescents saw medication as "trimming the edges of the peg", but required additional support from teachers to ensure the "peg" could fit into the hole. Adolescents highlighted a preference for teachers who showed high levels of encouragement, approval, belief

and validation (Gallichan and Curle, 2008). Relationships as a protective factor has been highlighted across several studies whereby students express a preference for teachers who show genuine care and take extra time to support them (Prosser, 2008; Shattell et al., 2008; Dunne and Moore, 2011). Rogers et al. (2015) also demonstrate how a self-reported close emotional bond with teachers was associated with increased academic motivation for students with ADHD. Therefore, Rogers et al. (2015) conclude teachers need strategies to foster emotionally strong and collaborative relationships with students with ADHD. CYP and their parents provided suggestions of how their school experience could be improved including: greater staff knowledge and training to understand ADHD; acknowledgement of individual needs and appropriate planning of interventions and support and improved working with parents (Travell and Visser, 2009). Indeed, the quality of parent-teacher relationship has been found to have a positive effect on student-teacher relationship (Gadaskaz and Rogers, 2014, cited in Rogers and Meek, 2015).

2.5.6 Section summary

This section has outlined how adolescents tend to conceptualise ADHD as a biologically based phenomenon. This could have negative effects on their perception of control and perceived *need* for medication to meet classroom expectations. Accounts from adolescents suggest individuals can feel isolated, unsupported and misunderstood within the school environment but highlights how teachers can shape their experience to be perceived as negative or positive.

2.6 Teacher experiences

2.6.1 Section introduction

I now consider research literature into teachers' experiences of ADHD. Focusing on qualitative studies yielded a limited number (n = 7). However, it is recognised that knowledge (the information one possesses) and attitudes (beliefs and feelings about ADHD) influence teacher behaviour (the way they respond), and thus not only affect the teacher's overall experience but the experience of the students they teach (Kos et al., 2006). For this reason and to extend the review, quantitative studies exploring teacher knowledge, attitudes and behaviour, were also included increasing the number to 30 studies.

2.6.2 Conceptualisation

Teacher knowledge about ADHD has most often been measured by responses to quantitative tools which adopt clearly defined correct and incorrect responses. In my opinion these are most aligned to a medical conceptualisation of ADHD. Therefore, knowledge as assessed in these studies may merely be a representation of the extent to which one agrees with medical conceptualisation. International literature suggests teacher knowledge varies widely, but highlights a consistent finding that teachers knowledge of ADHD *symptoms* is stronger than their knowledge about causation and/or treatment (Blotnicky-Gallant et al., 2014; Ward, 2014; Mulholland et al., 2015). I would interpret this to mean that teachers have a shared understanding of the *definition* of ADHD but their conceptualisations were of broader scope. Ghanizadeh et al. (2006) highlight how cultural differences may play a part. Their study of teachers in

Iran found a 50:50 split in teachers' conceptualisation of ADHD as caused by medical or social factors. Similarly, one study in Jordan found 75% of teachers identified both biological causes and parenting as explanations for ADHD (Al-Omari et al., 2015). In a South African study, 100% of teachers interviewed considered ADHD to be a physiological disorder of genetic or other biological causation. However, 80% also perceived environment to play a part (Kern and Seabi, 2008). Contrastingly, within Western nations, Glass and Wegar (2000) found 78% of teachers perceived ADHD to be biological in origin whereas only 11% identified environmental causes and 10% felt the behaviour was part of a normal spectrum. This seems to indicate a greater preference for biological explanations in Western nations in comparison to the Middle Eastern and African nations in the above studies. However, Glass and Wegar's (2000) findings could also be considered dated in comparison.

Many authors recognise how differences in methodologies can explain knowledge scores, whereby true/false response sets lead to inflated correct answers (e.g. 82% Bekle, 2004). By contrast, studies including a 'don't know' response option produce lower knowledge scores reflected by the greater number of don't know responses (e.g. 45% Youssef et al., 2015). This suggests that teachers are uncertain regarding their conceptualisation of ADHD and may feel confused about the concept. Although qualified teachers appear to have greater knowledge levels than pre-service teachers, there are mixed findings regarding the extent to which general teaching experience accounts for this (e.g. Bekle, 2004; Kos et al., 2004; Akram et al., 2009; Anderson et al., 2012;). However, specialist training and experience of teaching students with ADHD is an important predictor of knowledge (Kos et al., 2004; Kendall et al., 2011; Ward, 2014; Youssef et al., 2015). Finally, Youseff et al. (2015) reports that knowledge

was greater among primary school teachers compared to secondary school teachers, although this may only be representative of the population on Trinidad and Tobago. Only one study has explicitly used a sample of secondary school teachers, however the results are interpreted specifically in relation to Chinese culture and are therefore not transferable (Liang and Gao, 2016).

2.6.3 Views on medication

International literature indicates teachers hold positive views regarding the efficacy of medication in the treatment of ADHD (Curtis et al., 2006; Kern and Seabi; 2008; Kendall et al., 2011). Teachers in Kendall's study shared that when children with ADHD did not take medication they were perceived as disruptive and difficult to manage. They felt that medication was not only beneficial, but *necessary* to prevent academic difficulties. Furthermore, Kern and Seabi (2008) found that behaviour management, diet and home programmes were perceived as ineffective by South African teachers. In contrast, Glass and Wegar (2000) and Havey (2007) found an overwhelming preference for a combined approach of medication plus environmental management, regardless of teachers conceptualisation of ADHD. Surprisingly, even though 40 teachers perceived ADHD to be caused by environmental factors alone, only 11 felt that behaviour modification alone was a sufficient intervention (Glass and Wegar, 2000). Therefore, in some cases medication was perceived as preferential treatment even when teachers believed attention difficulties to be attributed to environmental factors. This may represent the scientific authority of the diagnostic process whereby even if teachers question the medical conceptualisation of the

‘problem’, they are willing to follow clinicians’ advice for medical treatment (McMahon, 2012).

Previous studies have highlighted the importance of the socio-cultural context when interpreting findings. Moldavsky et al. (2014) conducted a thematic analysis of comments written by English teachers in response to vignettes of children who met diagnostic criteria for ADHD. They found teachers were hesitant to recommend medication and expressed negative views about its use (e.g. that it should only be used if the problem was severe). However, this may be because the vignettes were not explicitly labelled as *diagnosed* with ADHD. Some teachers commented they were not qualified to provide an opinion about medication highlighting the perceived authority of medical professionals. Others were steadfastly against the use of medication and may have been influenced by recent professional debates highlighted in Section 2.3 and 2.4. Teachers presented an overwhelming preference and confidence for using within-school strategies to manage the children described in the vignettes, therefore differing from previous studies. This is the only study published in the UK to have explicitly explored teachers’ views of medication and reveals different findings from previous literature. This sample remains limited to primary school teachers and highlights the dearth of literature exploring secondary school teacher perceptions.

2.6.4 Emotional responses

Kewley and Latham (2008) highlight how teacher ethos is extremely important in communicating how they feel towards a student with ADHD. Previous literature has

concluded teachers tend to hold pessimistic views about teaching children with ADHD (Kos et al., 2006; Mulholland et al., 2015). Studies using vignettes to elicit teacher perceptions confirm teachers report greater negative emotions in relation to vignettes labelled as diagnosed with ADHD, in comparison to those not diagnosed with ADHD (Ohan et al., 2011). As the vignettes were identical descriptions of behaviour this suggests that stigma was attached to the *label* as opposed to the behaviour described. This contrasts with Prosser's (2008) conclusion that stigma was associated with behaviour rather than the label. However, it seemed the label elicited negative perceptions that the child's difficulties would have a more severe impact in the classroom. The presence of the ADHD label had some positive effect in that teachers were more willing to implement behavioural interventions. However, this was accompanied by lower confidence in their ability to manage behaviour (Ohan et al., 2008; Ohan et al., 2011). This may be affected by teachers' perception of their ability to manage the child's behaviour without medication for ADHD. Batzle (2010) found that teachers rated vignettes of children labelled as having ADHD less favourably than those labelled as having ADHD *and* taking prescribed medication. Both were rated less favourably than children with no label but identical behaviour. I interpret that this demonstrates how the ADHD label can result in lowered or negative expectations and how medication can ameliorate this effect to some extent. Eisenberg and Schnieder (2007) demonstrate how the stigma of the ADHD label can also lead teachers to underestimate the academic ability of children with ADHD. The use of vignette methodologies in these studies may be criticised for lacking ecological validity.

However, similar feelings of stress have been described in response to real-world experiences. Kendall et al. (2011) found participants shared feelings of exhaustion,

failure and disappointment in response to teaching children with ADHD. Similarly, Greene et al. (2002) found high stress levels in relation to teachers' interactions with children with ADHD but concluded this was highly individualised. For example, children who displayed associated oppositional /aggressive behaviour or severe social impairment were rated as significantly more stressful to teach. Teachers have been found to report less of an emotional connection with students with elevated levels of ADHD symptoms and found them more difficult to work with than students without symptoms of ADHD (Rogers et al., 2015). However, like Prosser (2008) they conclude this effect was in response to the core symptoms as opposed to the label. This contrasts with Ohan et al. (2011) who suggests negative emotions are evoked by the label itself. Others have investigated whether teaching experience improves feelings of tolerance and competence but found mixed results (Kos et al., 2006; Mulholland et al., 2015).

Kendall et al.'s (2011) teachers also reported positive emotions and a sense of accomplishment when supporting a child with ADHD. Blotnicky-Gallant et al. (2014) also found teachers held more positive than negative beliefs about ADHD and that positive attitudes were related to use of evidence-based classroom strategies. Therefore, teachers can find teaching children with ADHD rewarding, but this is often outweighed with negative emotions as the experience challenges their practice and feelings of competence.

2.6.5 Pedagogical responses

Although there appears to be a common belief among teachers that children with ADHD are challenging in the classroom, research is unclear regarding the extent to which teachers use specific pedagogical strategies for students with ADHD. For example, teachers acknowledged the importance of structure as beneficial for all children, not just those with ADHD (Nowacek and Mamlin, 2007). However, teachers have been found to modify their practice for students with ADHD in several ways including: providing greater structure and routine; preparing work in more detail; reducing task demands or length of time on task and drawing on others for academic support (Kos et al., 2006; Nowacek and Mamlin, 2007). Teachers also provide behavioural modifications such as prompting attention and allowing movement, but prefer less intensive strategies to highly individualised behaviour management (Nowacek and Mamlin, 2007; Martinussen et al., 2011). Furthermore, Kendall et al.'s (2011) participants reported finding it difficult to balance treating children equally, versus giving individualised attention to children with ADHD. They preferred generic classroom management practices such as effective planning, discipline and time management with the notable exception of intervening to facilitate peer relationships for children with ADHD. Similarly, teachers reported modelling acceptance among students as important (Nowacek and Mamlin, 2007). Nowacek and Mamlin (2007) recognise how the need for such strategies increases as children progress through school with middle grade teachers making more modifications than elementary school teachers. As yet, there does not seem to be any published material on the pedagogical strategies used by secondary school teachers.

International studies have found a large proportion of teachers believed children should be taught in specialist settings by specialist teachers with qualifications in ADHD (Ghanizadeh et al., 2006; Al Omari et al., 2015; Youseff et al., 2015). This has been interpreted as a lack of confidence in teachers' skills to address ADHD. This seems to be supported by Lopes et al. (2009) who found teachers in mainstream schools expressed a need to obtain information from fellow teaching colleagues or specialist support agencies to successfully support students with ADHD. Martinussen et al. (2011) supports the notion that training can change teacher behaviour by increasing their awareness of behaviour management strategies. However, participants in England expressed confidence in their skills to support children with ADHD and remained concerned that students should be managed within the mainstream school system (Moldavsky et al., 2014).

2.6.6 Section summary

Teachers tend to conceptualise ADHD as a bio-medical phenomenon but experience uncertainty regarding the influence of environmental factors. They appear to support the use of medication, although recent UK findings suggest many teachers are now questioning this. Accounts of teachers suggest that teaching children with ADHD can be both challenging and rewarding but that stress and negative emotions are commonly experienced. The extent to which students with ADHD require specific pedagogical responses remains under question.

2.7 Chapter summary

Multi-disciplinary definitions and opposing conceptualisations of ADHD can give rise to ambiguity surrounding the phenomenon of associated difficulties in schools. The potential positive effects of labels within education are discussed by Lauchlan and Boyle (2007) as reducing ambiguity, raising awareness, increasing social belonging and directing treatment/resources. As discussed in Section 2.4, the label of ADHD may be unlikely to reduce ambiguity given the uncertainty around how it is conceptualised. Consequently, failing to establish a shared understanding of the diagnosis and how to respond could contribute towards an environment which exacerbates the problem (Hughes and Cooper, 2007). The label may have positive implications in terms of triggering resources under the SEN-D Code of Practice (Department for Education [DfE], 2015), although the ownership of ADHD as a medical phenomenon may influence teachers to feel it is not within their remit, knowledge and skills to respond.

Although both adolescents and teachers broadly seem to conceptualise ADHD as a bio-medical construct, teachers appear to experience greater uncertainty and draw upon environmental explanations to some extent. Historically, teachers seem to support medication as treatment for ADHD but the UK context represents shifting views with teachers expressing a preference for pedagogical strategies. Meanwhile, many adolescents choose to continue medication to enable them to feel able to meet school expectations, despite negative side-effects. Accounts from adolescents suggest negative school experiences including isolation and feeling unsupported and misunderstood by teachers. This experience is echoed in teacher accounts who report

teaching students with ADHD to be stressful and frustrating. However, there are limited studies exploring teachers' in-depth experiences.

Despite evidence of adolescence as a particularly difficult time for students, there is a dearth of research into the experience of secondary school teachers supporting students with ADHD. As the student-teacher relationship has been found to be particularly influential in both student and teacher experiences, I sought to invest in the novel approach of exploring the experience of students paired with a teacher they themselves selected as someone who understood them. This adopts a strength-based approach to uncover how each participant experienced the other and to consider whether each individuals' conceptualisation of ADHD played a part in developing their relationship.

CHAPTER THREE: METHODOLOGY

3. 1 Chapter overview

This chapter is presented in two parts. After outlining the aims and research questions, part one considers the underpinning theoretical stance upon which the research is positioned. Part two presents how the research was carried out including an account of ethical considerations and researcher reflexivity.

3. 2 Aims and research questions

I aim, through this research to develop an in-depth understanding around the effect of the diagnostic label ADHD in relation to student and teacher experiences within mainstream secondary schools. I also aim to develop understanding around how both students and teachers make sense of the phenomenon ADHD. Furthermore, I adopt a multi-perspective design to consider whether students and teachers develop a shared meaning in their experiences.

Consequently, the following research questions are addressed:

- How do students with a diagnosis of ADHD conceptualise the term ADHD?
- How do teachers of students with a diagnosis of ADHD conceptualise the term ADHD?
- How do students with a diagnosis of ADHD experience their diagnosis within the school environment?
- How do teachers experience teaching a student with a diagnosis of ADHD?

- How do students and their teachers develop a shared understanding in their conceptualisation and experience of ADHD?

3.3 Part one: Theoretical underpinnings

3.3.1 Ontology and epistemology

Grix (2010) argues the social science researcher must fully understand and make their position explicit to demonstrate a logical approach to their work. Social research is concerned with understanding the world and this is informed by how we view the world (ontology), and thus how we come to understand it (epistemology) (Cohen et al., 2000). Through reflexivity I have come to understand my own position on what constitutes reality and how the social world should be understood. I consider my position to be congruent with a constructionist-interpretative viewpoint. Firstly, this is based on a constructionist ontology which states there is no *one* external reality, but that reality is created by, and in constant revision by social actors and their interactions (Bryman, 2012). Therefore, multiple realities are constructed and experienced differently by individuals. Thus, realities can legitimately be accessed via subjective accounts of participants, rather than seeking an objective 'truth'.

An interpretivist epistemology is logically aligned to constructionism in that if the social world is viewed as multiple realities, one must depart from trying to achieve objectivity and seek to develop ways of understanding each participant's individual reality. Therefore, I seek to understand a situation from the perspective of my participants, acknowledging that there will be variations in in their understanding of a complex construct (ADHD) and the way in which they experience it. I accept that their

experience is *their* reality, however I also bring my own reality upon hearing their story which is then interpreted by me as the researcher.

3.3.2 Interpretative Phenomenological Analysis

My constructionist-interpretative ontological and epistemological stance influenced me to select Interpretative Phenomenological Analysis (IPA) as my methodology. IPA is rooted in psychology and described as a *"qualitative research approach committed to the examination of how people make sense of their life experiences"* (Smith et al., 2009: 1). IPA was chosen in preference of other qualitative approaches (e.g. thematic analysis, grounded theory) due to its suitability of capturing detailed and nuanced accounts of individual participants *before* the development of group level themes. The underpinning philosophical assumption of phenomenology (i.e. that experience can be examined it its own right) is congruent with my epistemological stance, and compatible with eliciting the type of knowledge required to address the aims and research questions outlined in Section 3.2. However, the development of phenomenology to a more interpretative endeavour addressing hermeneutics matched my own views regarding the dual role of the researcher, therefore giving preference to IPA in comparison to other phenomenological approaches. To demonstrate compatibility, it is necessary to further examine the key philosophical assumptions of the approach: phenomenology; hermeneutics and idiography.

❖ Phenomenology

Phenomenology as a philosophical movement is attributed to Edmund Husserl (1859 -1938), who adopted the view that to study 'experience' was justified in its own right (Ashworth, 2008). Phenomenology brackets physical matter and suspends the notion of being able to separate reality from one's experiences, in preference of focusing on a participant's subjective experience and perception of the world as a valuable form of knowledge. Therefore, phenomenology seeks to examine a given phenomenon through investigation and analysis of lived examples of the phenomenon within a given context (Giorgi and Giorgi, 2008). Within the current research, ADHD was viewed as a phenomenon, which exists for individuals within their own subjective world.

The philosophy of phenomenology is concerned with how people make sense of the world around them, and it is the job of the researcher to access this from the first person perspective (Bryman, 2012). In doing so, Husserl recommends the researcher bracket their own knowledge of the phenomenon being researched. Whilst he accepted that it was impossible to make pre-existing knowledge unconscious, he believed it could be 'bracketed' so as not to influence the research process (Giorgi and Giorgi, 2008). As the philosophy advanced, later phenomenologists, such as Heidegger (1962), Merleau-Ponty (1962) and Sartre (1958) argue for a more interpretative phenomenology with a view of the person embedded within a world influenced by relationships, language and culture which inevitably influences their experiences (Smith et al., 2009). This also applies to the researcher who brings their own personal values, beliefs and knowledge to the process and is addressed by considering hermeneutics (discussed below).

❖ Hermeneutics

IPA adopts an interpretative stance influenced by hermeneutics – the theory of interpretation (Ashworth, 2008). This purports that all human-beings are sense-making creatures, and therefore participant accounts represent their attempt to make sense of their experience (Smith et al., 2009). Furthermore, understanding is developed through reflection in dialogue between the researcher and participant. The participant attempts to make sense of their own experience, whilst the researcher attempts to make sense of the participant's account, therefore co-constructing the data. Smith et al. (2009) refer to this as a "double hermeneutic" (p.35), capturing the dual role of the researcher. The hermeneutic aspect of this methodological framework therefore, recognises the presence of the researcher and the impact this can have upon the research. Within the interview process Smith et al. (2009) suggest that the researcher requires *"a spirit of openness"* (p.27), to *really* access the participant's viewpoint. It is accepted that the researcher's prior knowledge and pre-conceptions are inevitably present and can influence and be influenced by the research process. Consequently, on-going researcher reflexivity is an essential requirement in IPA and is addressed in Section 3.4.8.

❖ Idiography

Finally, IPA is an idiographic approach, committed to the detailed examination of a particular case, seeking to discover how a phenomenon is experienced for each individual person (Smith et al., 2009). This contrasts with nomothetic approaches

acknowledging that the individual is not simply *"the point of intersection of a number of quantitative variables"* as stated by Eysenck (reported by Allport, 1961: 8, cited in Ashworth, 2008). Rather, an idiographic approach emphasises the individual and particular factors that take specific form for *this* person, therefore seeking to understand how *this* individual experiences a given phenomenon in their own context (Smith et al., 2009). Whilst attention is primarily on single case analysis this can lead to exploration of similarities and differences between cases, applying a process of analytic induction to move beyond the single case towards shared themes across cases (Smith et al., 2009).

3. 4 Part two: Research design

3.4.1 Overview of design

The study utilises a paired design to draw on the perspectives of both students and teachers in relation to their experiences of the phenomenon of ADHD. This represents a *"bolder IPA design"* (Smith et al., 2009: p52), whereby the student-teacher dyads become the unit of analysis for the case study. For this reason, participants were drawn from three separate schools to ensure the school itself was not considered the unit of analysis. Considered to be in its infancy, Larkin et al. (2013) highlight how multi-perspective designs maintain the theoretical stance of IPA, but also build upon systemic psychology recognising the benefits of exploring participants' experiences of a shared phenomenon of which they may have very different views. Furthermore, analysis of dyads and/or across groups provides the opportunity to explore what happens *between* the individuals involved to uncover shared or conflicting meanings.

3.4.2 Data collection method

To acquire the type of knowledge required to address my research questions, in-depth semi-structured interviews were chosen. The research interview is defined by Cannell and Kahn (1968: 527) as:

> *"a two-person conversation initiated by the researcher for the specific purpose of obtaining research relevant information and focused on content specified by research objectives" (cited in Cohen et al., 2000: 269).*

The semi-structured approach can be viewed as a middle-ground between structured and unstructured approaches, where the interviewer begins with a schedule to address their defined purposes, but uses the schedule flexibly to facilitate discussion of relevant topics (Robson, 2011). The in-depth nature of interviewing within IPA is specifically concerned with enabling participants to speak freely and openly at length, in order to elicit rich and detailed accounts of their experiences (Smith et al., 2009). Both interviewer and interviewee are active within the interview process. The interview can be led by interviewee's interests or concerns, allowing for co-construction of knowledge. The design and implementation of my interviews was influenced by Kvale (1996) who proposes qualitative interviews should seek to centre on and interpret meaning of the participant's life world. He advises the interviewer must adopt a deliberate naiveté to be open to unexpected findings generated by their participants. Ambiguous and contradictory statements should be accepted as reflections of the complex social world the participants inhabit. Therefore, changes in description and meaning are seen as part of them constructing their social world. For example, the

interview process may elicit new insights and awareness for participants they had not previously thought about.

3.4.3 Data collection procedure

Interview schedules were drafted through a process of self-reflection and supervision to ensure the interview questions would elicit information required to address the research questions (Appendix 2). The schedule was trialled with a student already known to the researcher (via referral) and a teacher chosen by the student. These pilot interviews provided the opportunity to reflect with participants upon the question order, technique and skills of the interviewer, in order to improve the efficacy of the interview schedule as a preparatory step before data collection, as recommended by Robson (2011). During transcription of these interviews, I reflected upon the interview schedule, question wording and which questions elicited detailed responses in addition to evaluating my interviewing skills to guide successive interviews. Participant feedback resulted in few changes to the interview schedule but generated ideas for presenting topics more accessibly. Due to few changes being made, the pilot interviews were subsequently used as research data and included in data analysis.

Prior to each interview the information giving/consent procedure (Appendix 3 and 4) was used as an opportunity to build rapport; engaging in conversation unrelated to the research topic. Participants were invited to choose where their interview took place (e.g. at school, home or at the researcher's office) and all chose to meet at school. Each interview began with a question to elicit a descriptive account to establish rapport and put them at ease. Participants were made aware of the time commitments

involved and were reassured that I was interested in *them* and *their* experience; making it clear there were no right or wrong answers. I adopted a position of being open-minded, patient and empathetic when listening to participant responses, and used silence or gentle probes (e.g. repeating back part of what the interviewee said) as advised by Smith et al. (2009). All interviews were audio-recorded. The two pilot interviews were transcribed by the researcher and the remaining four transcribed by a professional transcription service provided through Disability Support Allowance. Following each transcription, I listened to the audio-recording alongside the written transcript. Reflections regarding my interviewing skills were noted in my research diary, which allowed me to evaluate and adjust accordingly to develop these skills throughout the research process (e.g. becoming comfortable with periods of silence longer than typically usual in conversation). I also noted immediate feedback regarding the interview content to produce a summary letter for each participant of their individual interview (Appendix 5).

3.4.4 Participants

Participants were recruited from across three mainstream secondary schools within the host Local Authority (LA). I contacted each school who met the inclusion criteria (Table 1) to approach key members of staff (typically a Special Educational Needs Coordinator (SENCO) and/or pastoral member of staff) via email with information about the project. Link EPs were also provided with a hard copy of the letter to distribute to school staff (Appendix 6). Twelve schools met the school inclusion criteria, of which: six did not respond; one responded but felt unable to participate due to being in 'requires improvement' Ofsted status; and two responded they did not have students who met the student inclusion criteria (Table 1).

In accordance with IPA the study adopted purposive sampling to obtain a small and *relatively* homogenous sample who could offer insights into the specific phenomenon of ADHD. This is suggested to facilitate the identification of convergence and divergence between participants, whilst maintaining an individual focus (Smith et al., 2009). Whilst homogeneity is recommended, Smith et al. (2009) also recognise the limitations of exactly *how* homogenous a sample can be. In the current study student inclusion criteria were adopted to aid homogeneity, accepting a certain level of diversity (e.g. ethnicity, free school meal status [an indicator of social deprivation], SEN-D) to obtain a sufficient sample size. Participating teachers were identified by the students, so it was not possible to regulate homogeneity in the teacher sample. Homogeneity is not claimed in terms of sample characteristics, but in terms of their shared experience of the phenomenon under investigation.

Table 1: Inclusion criteria for participation

Inclusion/Exclusion criteria	**Rationale**
Schools	
Must 'buy in' to LA Educational Psychology Service (EPS)	On the grounds of the research being provided as a 'free' opportunity to schools who already worked in partnership with the LA EPS.
Schools must not be in special measures	On the principle of avoiding harm by approaching school staff who were in particularly stressful circumstances.
Mainstream secondary schools	Secondary schools were chosen due to the dearth of research in this area in relation to teachers' experiences. The decision to focus on mainstream secondary schools was designed to address settings where there was not necessarily a specialism for supporting children with ADHD (e.g. specialist provision) and to seek theoretical transferability to

Inclusion/Exclusion criteria	Rationale
	contexts in which the majority of students with ADHD are taught.
Students	
Students must have a diagnosis of ADHD which has been in place for at least six months.	On the principle giving students time to process their diagnosis, and avoiding harm by discussing any new/raw emotions.
Students who are currently prescribed medication for ADHD.	This pertains to homogeneity of the group and allows the research to access the experiences of the phenomenon of ADHD and the use of medication.
Students must be in Key Stage 3	It was felt best to avoid approaching students in Key Stage 4 who may be facing particularly stressful circumstances of examinations and to aid homogeneity of the group in their secondary experience prior to GCSE's.
Students who do not have any co-morbid diagnoses, such as Autism Spectrum Condition or Conduct Disorder.	This facilitated homogeneity across participants in accordance with IPA methodology and allowed the interview to explore the phenomenon of ADHD in relative isolation.
Students must not be at risk of exclusion or known to Social Services.	On the principle of avoiding harm by engaging with participants who were experiencing potentially stressful circumstances in relation to the stability of their school placement and/or or living arrangements.

Student participants identified by schools as meeting the student inclusion criteria were approached by the researcher to give further details of the study. Teacher participants were identified by asking participating students to identify five teachers who "knew them well", who were approached in the order of student preference. As the research adopted a multi-perspective design, participants were recruited as pairs forming three student-teacher dyads. Pen-portraits of each student-teacher dyad is displayed in Table 2 (pseudonyms are used to protect confidentiality).

Table 2: Pen-portrait of participants

Pen-Portrait Student	Pen-Portrait Teacher
Max is a 14-year old male of dual heritage (White British and Indian) who is in Year 9. Max recalled he was diagnosed with ADHD around 10 years old and has taken prescribed medication of Concerta XL ever since. School records indicate Max was not identified as having SEN-D. Max's interview was carried out in the summer term of Year 9.	***Mr Tom Smith*** is a White British male who has 13 years teaching experience, of which 11 were at his current school. He is primarily a teacher of Art and Design which he has taught Max in Year 7 and Year 9. Mr Smith has also known Max as his form tutor for 3 years. Mr Smith's interview was also carried out during the summer term Max was in Year 9.
Josh is a 12-year old male of White British heritage who is in Year 8. Josh's mother reports he was diagnosed around age 5 and currently takes a combination of Concerta XL and Atomoxetine prescribed for ADHD. Josh is recorded as having SEN at the level of SEN Support stage. Josh's interview took place in the summer term of Year 8.	***Mrs Brenda Williams*** is a White British female with over 30 years teaching experience. She has taught at her current school for four years primarily teaching Geography and History. She first met Josh in Year 7 in her History class and also now teaches him in Year 8. Mrs Williams' interview was also carried out in the summer term when Josh was in Year 8.
Joe is a 12-year old male of dual heritage (White British and Black Caribbean) in Year 8. His diagnosis of ADHD had been made 6 months prior, following a long period of investigation and trials on different medication. At the time of the interview he was prescribed Concerta XL, but had previously taken Risperidone. On school records Joe's needs were indicated at SEN Support stage. Joe's interview was carried out in the Autumn term of Year 8.	***Miss Lynn Langstone*** is a White British female who has been teaching for over 30 years. Her relationship with Joe began before he joined the school due to her role as Head of Year 7 which included supporting transition from primary school. She subsequently chose to place Joe in her form tutor for Year 7. She had also begun teaching Joe for English during Year 8. Mrs Langstone's interview was also carried out during the Autumn term Joe was in Year 8.

3.4.5 Data analysis

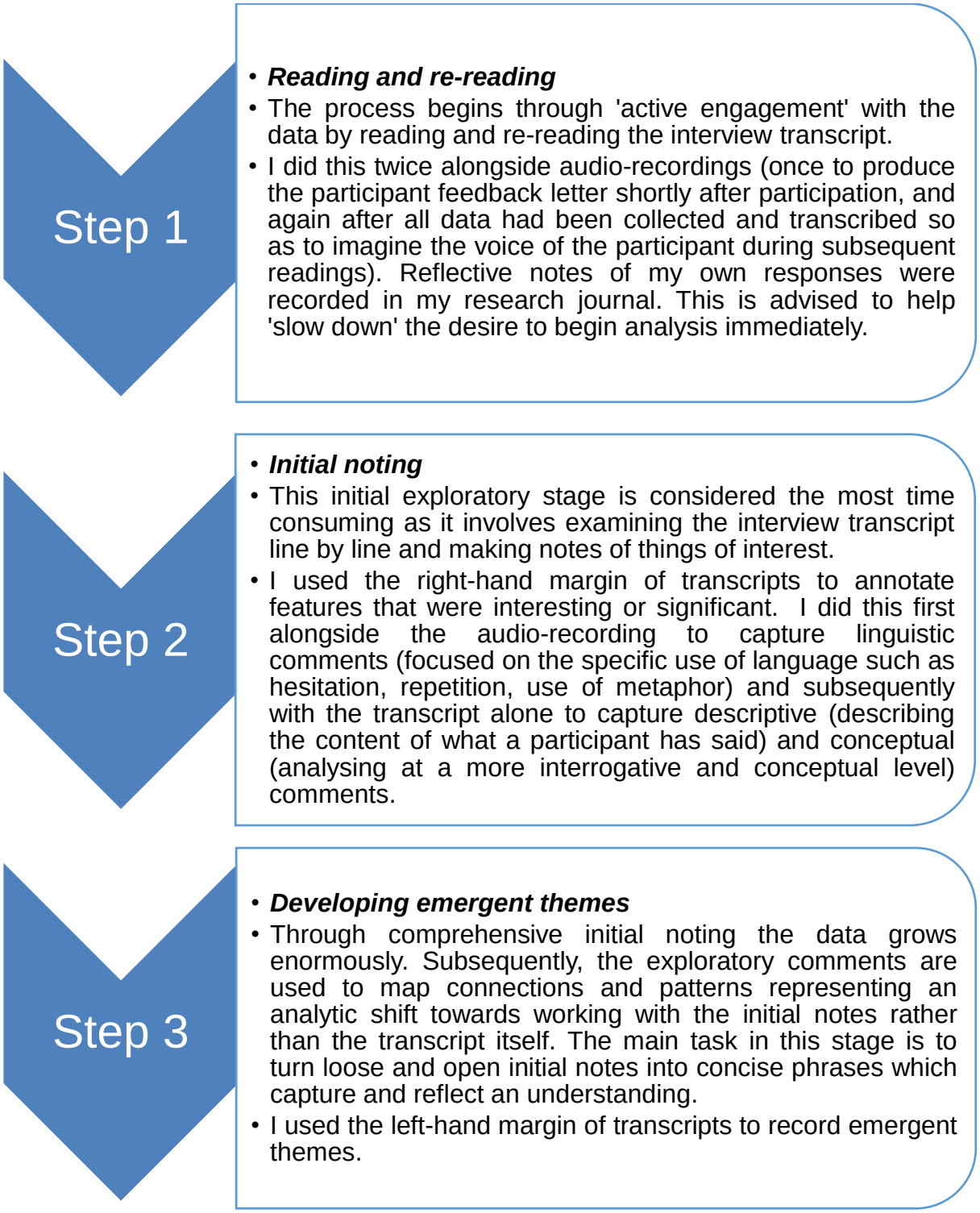
The essence of IPA analysis is for the researcher to attempt to make sense of the participants' attempts of making sense of their own experiences, thereby capturing the double hermeneutic process (Smith et al., 2009). This encompasses a balance between 'emic' and 'etic' positions: the former focused on hearing and prioritising the participant's view; and in the latter, the researcher's attempt to make sense of their participant's experience in a way to answer the research question (Reid et al., 2005). Therefore, the process becomes a reflective engagement whereby the analysis results in a joint product of how the analyst *thinks* the participants thinks.

Although there are many ways of conducting IPA analysis Smith et al. (2009) summarise the following strategies which I applied within my research:

- Close line by line analysis of each participant's account
- Identification of emerging patterns, usually within single cases and then subsequently across multiple cases
- A transparent approach, in which analysed data can be traced from initial comments to thematic development
- Reflection on my own perceptions throughout the process.

I chose to adopt a step-by-step method for analysis outlined by Smith et al. (2009) in Figure 2. Excerpts demonstrating this process are presented in Appendix 7.

Figure 2: Stages of IPA analysis (developed from Smith et al., 2009)



Step 4

- ***Searching for connections across themes***
- This stage involves mapping how emergent themes might fit together to develop themes.
- This was achieved by writing each emergent theme onto a post-it note and placing them on a large board and moving them around to explore how the themes might relate to one another. I used a range of techniques to search for connections including: abstraction (placing alike themes together to produce superordinate themes); subsumption (where emergent themes become superordinate as they help bring together other themes); polarisation (identifying oppositional themes); contextualisation (relate themes to life events) and numeration (identifying how often a theme is discussed).

Step 5

- ***Moving to the next case***
- The process of Step 1 - 4 is repeated with each individual case. As far as possible this means bracketing emerging ideas from the previous case so that each participant's account is analysed on its own terms, maintaining IPA's commitment to idiography.
- I continued with steps 1 – 4 of the process for each individual case beginning with the students, followed by the three teachers.

Step 6

- ***Looking for patterns across cases***
- This stage involves looking for connections across cases to consider shared meanings between participants.
- As a multi-perspective design this was undertaken in two stages. To compare themes across groups, the themes for each student were written onto different coloured post-it notes and placed on a large board moving them around to see how they related to one another. To aid this process pieces of paper were attached to the board and used to note where all 3 participants shared similarities, where there were similarities between two participants, and where all 3 differed. This process was then repeated across the group of teachers. The second stage involved comparing themes within the student-teacher dyads and was achieved through listing the similarities and differences between the pair.

3.4.6 Ethics

Researchers must consider a moral and ethical perspective on how they design and conduct research to ensure it respects participants and avoids harm (Denscombe, 2010). Before commencing recruitment and data collection, ethical issues were considered with reference to: the British Psychological Society (BPS) Code of Ethics and Conduct (BPS, 2009); the BPS Code of Human Research Ethics (BPS, 2010) and the British Educational Research Association's Ethical Guidelines for Educational Research (BERA, 2011). An application for ethical approval was made to the University of Birmingham Ethics Committee for Ethical Review, and approval was obtained on 13th June 2014 (Appendix 8). The salient ethical issues of the study and steps taken to address them are outlined in Table 3.

Table 3: Salient ethical issues of the current study and steps taken to address them.

Potential Ethical Issue	**Steps taken to address potential issue.**
Ensuring Informed Consent	• Participants were provided with an individual letter (schools) or information leaflet (students, parents and teachers) explaining the purpose of the study and commitment required. This was accompanied by oral explanation in a face-to-face meeting with the researcher with the opportunity to ask any questions before agreeing participation. • Participants were made aware of the key focus of the research, what to expect if they agreed to be interviewed and the time commitment this involved, the inclusion of verbatim extracts published in reports and their right to withdraw. Participants were also made aware that participation required both student and teacher to take part, therefore if one withdrew consent the other's data would not be reported. • The potential issue of teachers feeling coerced to take part because they had been chosen by students was handled sensitively by reassuring teachers that there were other teachers I could approach if they did not wish to take part. Students were required to identify five potential teachers who "knew them well", who were approached in the order of student preference.

Potential Ethical Issue	Steps taken to address potential issue.
	• All students, parents of students and teachers signed an informed consent form before data collection.
Ensuring Confidentiality	• Interviews were carried out in a private and confidential room at a location chosen by the participant. • Participants were aware that audio recordings would only be accessed by the researcher and a professional transcription service (where relevant) but that verbatim extracts of their interview may be reported. • Pseudonyms were used to protect participant identity and they were informed of potential identifying details which would be reported (e.g. gender, ethnicity). • I exercised transparency regarding the extent to which full confidentiality could be offered (e.g. explaining that due to participation in dyads the student-teacher pairs would likely recognise one another's identity and comments if they accessed the full report). Participants were also made aware of confidentiality clause regarding safeguarding. • Participants were informed about planned dissemination of the research and the potential for publication in academic journals before consenting to take part.
Ensuring the Right to Withdraw	• Participants' right to withdraw was stated on the information leaflet, consent form and orally by the researcher before interviews were carried out. • The right to withdraw could be exercised up until one week after the interview had taken place.
Avoiding Risk of Harm (including emotional discomfort and distress)	• Selection criteria exclude those who had received an ADHD diagnosis in the last six months so as to avoid engaging with participants who may not have had sufficient time to process their diagnosis, or may be experiencing new/raw emotions. • Students were reassured that I was interested in working with students with ADHD, to understand their experiences and support school practices. They were reassured they were not seeing me because they had done anything wrong in school and would not get into trouble for sharing their views with me. Ensuring confidentiality when reporting feedback to schools also supported this. • Teachers were also reassured that I was interested in their personal views and experiences to inform school practices. They were reassured I too was still developing my knowledge and skills in the topic of ADHD and I did not expect them to possess 'expert' knowledge. • My training as a Trainee Educational Psychologist (TEP) which incorporates counselling and therapeutic skills allowed me build

Potential Ethical Issue	Steps taken to address potential issue.
	rapport with participants and conduct the interviews sensitively, noticing any signs of discomfort or distress and handling them appropriately. Within some of the interviews participants expressed they felt they may need to "look up" ADHD to understand more about it. I responded to this with a genuine empathic response indicating that I myself was still developing my own views on the topic and that it was okay to feel that we didn't understand everything about it. Each participant had my professional contact details and were reassured that if they wanted to discuss anything further they could contact me. No participant exercised this following their interview.

3.4.7 Validity in IPA

There is an increasing recognition of the need to adopt different criteria when judging the value of qualitative research as it sets out to achieve different purposes to quantitative studies (Bryman, 2012). Within qualitative research, validity involves establishing how credible conclusions have been drawn from *real* accounts of the social world as experienced by the participants (Denscombe, 2010). Smith et al. (2009) suggest the following criteria by Yardley (2008) as appropriate to assess the validity of IPA studies. Yardley's (2008) principles are outlined below with examples of how they were enacted in the current study.

- Sensitivity to context

This involves the researcher's awareness of the contextual factors surrounding the study. For example, my engagement with existing research literature highlighted debate around the concept of ADHD as a contextual factor which may influence participants responses. Acknowledging this allowed me to approach interviews with

respect and insight into the different views participants may hold. I felt informed and able to show sensitivity in my responses to encourage participants to speak openly and honestly.

I also demonstrated sensitivity to the sociocultural environment of each participant. As a TEP I have experience of working with a diverse range of young people and teachers. Relevant protected characteristics of participants are presented to recognise factors which were not homogenous to the sample (Section 3.4.4, Table 2). This also adds contextual understanding for the reader to support theoretical transferability of the findings. Sensitivity to context was also demonstrated through the design and implementation of interview schedules to ensure a commitment to obtaining access to participants' lived experience. I sought to address any perceived power imbalance by putting participants at ease and recognising them as the experiential expert of a phenomenon I was interested in, approaching each interview with genuine curiosity about what I would find.

- Commitment and rigour

Commitment relates to being attentive to the participant both during data collection and analysis. I maintained a commitment that the participant's experiential claims remained central to each interview. Each analysis was carried out with respect for each individual account first, before group level themes were developed. Rigour refers to the thoroughness of data collection, analysis and reporting of findings. This was applied through obtaining a sample carefully matched to the research questions and inclusion/exclusion criteria, reflecting on the interview process to develop my skills as

a research interviewer and the systematic procedures applied to data analysis. Participant validation was *deliberately* not used as IPA recognises the findings are the researcher's interpretation of participant's subjective accounts, thereby acknowledging the double hermeneutic (Smith et al., 2009). A potential threat to rigour is the use of a professional transcription service for four of the interviews. This was addressed by checking the transcript alongside the audio to ensure accuracy which also enabled me to reconnect with the original data before engaging with analysis.

- Transparency and coherence.

This criterion relates to transparency and clarity of the researcher's presentation of the research process. I have presented my own ontological and epistemological views alongside the theoretical underpinnings of IPA which manifest throughout the study (Section 3.3.1). Of key importance is the recognition that readers of the study add a third layer of interpretation whereby *they* make sense of how *I* have made sense of participants' data. However, I have presented extracts demonstrating the analysis process to aid transparency (Appendix 7). Final themes are presented with supporting quotes from interview transcripts so the reader can see how conclusions have been drawn directly from participant data. I also kept detailed records of my decisions, thoughts and feelings throughout the research process in a research diary – described further in Section 3.4.8.

- ❖ Impact and importance.

Yardley (2008) suggests the real pursuit of valid qualitative research is whether it translates into something that is interesting, important or useful for others. When designing the current study, care was taken to target a gap in research with the aim of illuminating new insight into a previously studied topic. An original contribution of this study is its drawing together of student and teacher perspectives within the previously unstudied domain of mainstream UK secondary schools. The implications of findings are presented later in Section 5.2 and 5.3.

3.4.8 Reflexivity

Reflexivity is the acknowledgement that the researcher is not an objective outsider, but contributes to the construction of meaning throughout the research process. (Willig, 2008). This requires the researcher to reflect upon the ways in which their background, values, experiences and beliefs have influenced the research (Willig, 2008).

I am a female researcher of White British heritage. I therefore share some attributes with some participants but also differ in several significant ways. I myself am not diagnosed with ADHD, nor do I have any experience of close family and friends diagnosed with ADHD. However, as Smith et al. (2009) reassures, the IPA researcher does not need to be a cultural 'insider' to understand the experiential claims of participants, but does require cultural *competence* to understand participants' terms of reference. I believe my direct contact with students with ADHD via my professional

experience and extensive reading around the topic means I was in an informed position to undertake the research with student participants. I have also not been a teacher. However, my professional role regularly requires working with teachers to effect change for students, therefore bringing a certain level of cultural competence to understanding situations from teachers' perspective.

In chapter one I outline some of my own professional and personal experiences which influenced my decision to research within this topic. In chapter two I have also discussed some of the controversy surrounding the ADHD label, which I have engaged with at a professional level through discussion with colleagues and attending training and conferences. Therefore, it is important to declare experiences which have shaped the way in which I conceptualise ADHD.

Prior to my professional training, I assumed a medical conceptualisation of ADHD based on my knowledge of ADHD being primarily treated with medication. This was challenged when, during my employment as a LA officer supporting children with social, emotional and behavioural difficulties, I attended a training session about ADHD which refuted the medical conceptualisation in favour of socio-cultural critiques described in section 2.4.2. The trainer posed the conundrum that by accepting medication for children's behaviour we fail to locate behaviour within the environment – surely something EPs should promote. I identified with this view, wholeheartedly for some time accompanied by doubt about the validity of the condition. As outlined in chapter one, in my subsequent professional training I continued to encounter CYP diagnosed with ADHD, witnessing both potential negative and positive effects of the label and medical treatment. Having chosen the research topic and beginning to

engage with research literature I found myself even more confused by debates, although I consistently found myself most concerned with the consequence of a diagnosis and particularly what this meant in schools, leading to the research focus and questions. Throughout my experiences, I have retained a commitment of empathy towards CYP with ADHD and a genuine interest in their experiences. I believe the debate around ADHD can act as a barrier for effective support for students with ADHD, although I identify with teachers' confusion around the concept. Therefore, I believe EPs can make a valuable contribution in supporting both students with ADHD and their teachers to effect change in the environment, rather than difficulties being perceived as solely within-child. Due to my professional role, where my primary client remains the student, I envisage the students' voice and experience to be prominent within the research – seeking teachers' experience as a way of understanding how to support students.

To capture reflexivity throughout the research process, I kept detailed records of my decisions, thoughts and feelings in a research diary. Whilst I recognised that it was not possible to *exclude* my own values and beliefs completely, it was important to raise my awareness of my own interaction with the data to remain attentive to the process. As described in Section 3.4.3 this supported me to reflect on the value of the pilot interviews, my immediate responses after interviews and my initial response to hearing audio-recordings and reading the interview transcripts. Furthermore, this level of reflection helped to informed my approach to subsequent interviews. Extracts from my research diary are presented in Appendix 9.

As discussed in Section 3.4.7 I have followed Yardley's (2008) guidelines to maintain rigour and transparency of the research process. Within this section I have attempted to include readers in the reflexive process so that they are aware of my position as the researcher to consider how this might have influenced findings. Finally, reflexivity also involves thinking about how the research impacted upon the researcher (Willig, 2008). This is addressed later in a final reflective account (Section 5.6).

CHAPTER FOUR: FINDINGS AND DISCUSSION

4.1 Introduction to chapter

This chapter presents the findings of the current study addressing the conceptualisations and lived experiences of ADHD from the perspective of students diagnosed with ADHD and selected teachers. Empirical findings are discussed in relation to previous literature. Firstly, I present an overview of the superordinate themes developed for students from their individual themes. I then discuss how the superordinate themes address the research questions relating to students' conceptualisation of ADHD, and their experiences of ADHD within the school environment. Individual accounts that revealed a unique or in-depth perspective are presented as each superordinate theme is discussed. Secondly, I present an overview of the superordinate themes developed for teachers from their individual themes. The superordinate themes are discussed in relation to the research questions addressing teachers' conceptualisations of ADHD and their experiences of teaching a student with ADHD. Again, unique or in-depth perspectives are presented throughout. Finally, I present and discuss the findings in relation to each student-teacher dyad, drawing together the two individual accounts to explore shared and/or conflicting meanings in their conceptualisation and experience of ADHD. Quotations from individual transcripts (in quotation marks) are used throughout to privilege the voice of the participants and capture the idiographic nature of each participant's account. Some quotations contain underlined phrases to draw the reader's attention to salient features which are discussed.

4.2 Overview of student themes.

Table 4 presents an overview of how each students themes contributed towards superordinate themes at the group level.

Table 4: Overview of group level themes for students and how they were derived

Group Level Superordinate Themes	Themes (taken from individual theme)
1) Uncertain explanations of ADHD	• "I don't know what ADHD is" (Max) • Medical ambiguity (Max) • A part of me that I learn to manage (Josh) • ADHD as fixed (Joe) • ADHD as flexible (Joe)
2) Complexity and individual experience of ADHD	• Concentration, impulsivity and behaviour (Max) • ADHD as emotions to manage (Josh) • ADHD as behaviour (Joe) • Personal meaning (Max) • Separating ADHD from me (Josh) • Individuality of ADHD (Josh) • Impact of medication on behaviour (Joe) • Influence of others' views [toward medication] (Joe) • Impact of medication on behaviour (Joe)
3) Sense of isolation and being different	• No-one else knows (Max) • Misunderstood (Max) • Being different to others (Josh) • Emotional impact of ADHD (Josh) • Negative perception of ADHD (Joe) • Negative consequences of ADHD (Joe) • Dislike of taking medication (Joe) • Trying to be good (Joe)
4) Influence of Relationships	• Importance of relationship [with teacher] (Max) • Relationships as support (Josh) • Influence of parent-teacher relationship (Josh) • Influence of peers (Josh) • Teacher qualities (Joe) • Influence of others views [toward medication] (Joe)
5) Role of Teachers	• Teachers as helpers (Max) • Teacher's managing the environment (Josh) • Teacher actions (Joe)

4.3 RQ1: How do students with a diagnosis of ADHD conceptualise the term ADHD?

I interpreted two superordinate themes in relation to how students conceptualised ADHD; (i) uncertain explanations of ADHD and (ii) the complexity and individual experience of ADHD.

4.3.1 Student theme 1: Uncertain explanations of ADHD

Table 5: Shared and unique perspectives within the superordinate theme: uncertain explanations of ADHD.

Shared perspectives	**Unique perspectives**
• **Ambiguity** • Medical ambiguity (Max) • ADHD as fixed (Joe) • ADHD as flexible (Joe)	• "I don't know what ADHD is" (Max) • A part of me that I learn to manage (Josh)

The unifying feature for students' explanations of ADHD was in fact the uncertainty with which they presented their view. Max and Joe both contributed an aspect of their understanding of ADHD as biological in origin. For example, Joe explained:

Joe: "It's a problem that you are born with and it stops you from working properly – you fidget a lot, you scream and shout, you can't control your behaviour half of the time and it is a really bad thing, you can't get rid of it really. You can grow out of it but it won't ever go." (p4, 32–35)

Later in the interview he also likened ADHD to *"other illnesses or sicknesses"* (p12, 5) clearly positioning ADHD as a medical phenomenon. Gallichan and Curle (2008) suggest attributing biological causes of ADHD can mean students perceive they are

not in control of their behaviour. All students expressed this perception to some extent, perhaps indicating support for this previous finding.

For example, Max says:

Max: "Some teachers think we're being just loud, and just tell us off but it's not actually our fault like normally most of the time…*normally we do misbehave, but sometimes we can't help it sometimes". (p8, 20-22)*

However, both Max and Joe's statement that they were not in control "*half the time, most of the time or sometimes"* (underlined) suggest they do not ascribe to ADHD as a *solely* biological phenomenon over which they have *no* control. Instead, they are uncertain regarding the level of perceived control over their behaviour. This appears better aligned to Brady's (2014) findings whereby adolescents maintained some control over their lives by not *fully* accepting a biological origin of their ADHD but defining it so it made sense within their own lives. In contrast, Josh refers to feelings of control but presents this as something he has now learned to manage with help from teachers.

Josh: "Well I couldn't control myself in year 7 because I didn't think before I acted, I'd hit somebody and then think about what I'd done and I regretted it, but I think before I actually act now". (p5, 2-4).

Josh: "They've [teachers] given me strategies and methods for calming myself down, being able to walk away before anything major happens or just going and telling somebody." (p4, 11-12)

Although he recognises teachers could suggest strategies, Josh maintains a sense of personal responsibility to apply these methods to calm *himself* down. I interpreted this to mean Josh minimised biological explanations in preference of the ability to exert

control over his own behaviour. Although Josh was taking prescribed medication, he was the only student not to mention medication at all. In contrast, the perceived *need* for medication to conform to classroom expectations was evident for both Max and Joe, which could be viewed as perpetuating their understanding of ADHD as a *medical* phenomenon requiring *medical* treatment. However, students were similar in that their explanations of ADHD were ambiguous. This uncertainty is highlighted when Max says:

Max: "It's hard to say…[what] ADHD is…I don't really know what it is basically. I don't know much about it. I just know that I need help and…that's it" (p5, 23-24)

I believed this to be a genuine state of not knowing as opposed to being defensive or avoiding, but sadly highlights how despite being diagnosed with ADHD, Max did not fully understand what this meant. Previous research has highlighted how CYP are often passive actors in their diagnosis and subsequent understanding of ADHD (Avisar and Lavie-Ajayi, 2014). This may be a contributing factor to students' uncertainty around explanations of ADHD, in addition to the heterogeneity of the disorder discussed in more detail below.

4.3.2 Student theme 2: Complexity and individual experience of ADHD

Table 6: Shared and unique perspective within the superordinate theme: complexity and individual experience of ADHD.

Shared perspectives	**Unique perspectives**
• **Behavioural descriptors** • Concentration, impulsivity and behaviour (Max) • ADHD as behaviour (Joe)	• ADHD as emotions to manage (Josh) • Personal meaning (Max) • Separating ADHD from me (Josh) • Individuality of ADHD (Josh) • Influence of others views [toward medication] (Joe) • Impact of medication on behaviour (Joe)

Max and Joe shared in their perception of ADHD as behaviour difficulties incorporating poor concentration and impulsivity.

Max: "You just can't focus and you just keep shouting out…instead of putting your hand up" (p2, 15-16)

Joe: "You get distracted easily by other people and then when they have stopped, you don't know when to stop half of the time and then instead of them getting in trouble, you get in trouble, because they have stopped but you are carrying on with the same thing over and over." (p5, 26-29)

The underlined phrases demonstrate their perception of the persistence and cyclical nature of such difficulties. Again, there is a sense that for both participants they feel unable to control their behaviour even though they try to. This supports Gallichan and Curle's (2008) conclusion that even when adolescents attribute a biological cause to their behaviour they strive to behave to others' expectations. Josh also mentions difficulties with concentration but to a lesser extent as problematic in the classroom. In contrast, Josh used various emotional vocabulary (e.g. anger, frustrated, annoyed) attaching a meaning of ADHD as a difficulty in managing emotions, which neither Max nor Joe discuss.

Josh: "It limits you in a way because you can't really focus as much as others will be able to and yes you just react a lot more quickly. For me it is anger problems, I react quicker than anybody by lashing out." (p2, 1-3)

Although this seems a unique perspective among this participant group, Singh (2011) found many children in the UK talked about ADHD as 'anger and aggression', demonstrating the accompanying emotional difficulties they experienced. Josh's use of the phrase *"for me"* indicates his commitment to explaining *his* personal experience which he acknowledges may not necessarily be shared by others with the same diagnosis.

Josh: "One of my friends does have ADHD as well (p3, 12)…but he's quite different, he's actually quite a sensible one; he doesn't have anger problems or anything." (p3, 17-18)

It seems that each of the students attached a different personal meaning to their diagnosis based on their experiences. For example, Josh's experience of ADHD as 'emotions', whereas Max's personal meaning related to academic support such as help with spellings. Joe was the only student to disclose a period where he elected to cease medication, providing another unique perspective within the data set. Meaux et al. (2006) highlight how this is common during adolescence as young people begin to desire greater control and autonomy. However, for Joe this experience seems to have reinforced his perceived *need* for medication to conform to others' expectations.

Joe: "I really don't like taking it but again, I've seen a change in my behaviour and everyone else has too. They are proud of me taking it and they know it is helping". (p8, 35-37)

This is likely to have shaped Joe's conceptualisation of ADHD as biological in origin, reinforced by others who encouraged him to continue medication. Similar to previous research, Joe continued to take medication despite his own feelings that he did not like to take it (Meaux et al., 2006; Avisar and Lavie-Ajayi, 2014).

4.3.3 Summary

The students in the current study had largely varied conceptualisations of ADHD. Although they all recognised core traits of ADHD to some extent, they developed a personal meaning to their diagnosis which influenced their conceptualisation. This contrasts with previous research which suggests the majority of adolescents express a solely biological conceptualisation (e.g. Cooper and Shea, 1998; Meaux et al., 2006; Travell and Visser, 2006; Gallichan and Curle, 2008; Prosser, 2008). Whilst two students (Max and Joe) attributed biological causes to some extent, for both this was acknowledged alongside environmental factors, such as how they were supported within school and the influence of others' views. Furthermore, students' conceptualisation of the difficulties they faced associated with ADHD were heterogeneous in nature, ranging from difficulty controlling behaviour in the classroom, difficulty managing emotions and requiring academic support. This supports Travell and Visser's conclusion (2009) that the heterogeneous experience of ADHD requires a bio-psycho-social understanding in order to encompass all perspectives that may be experienced by young people.

4.4 RQ2: How do students with a diagnosis of ADHD experience their diagnosis within the school environment?

I interpreted three superordinate themes in relation to how students experience their diagnosis in the school environment: (i) isolation and difference; (ii) influence of relationships and (iii) role of teachers.

4.4.1 Student theme 3: Isolation and difference

Table 7: Shared and unique perspectives with the superordinate theme: isolation and difference.

Shared perspectives	**Unique perspectives**
• **Being different** • Misunderstood (Max) • Being different to others (Josh) • Negative perception of ADHD (Joe) • **Impact of being different = isolation** • No-one else knows (Max) • Emotional impact of ADHD (Josh) • Negative consequences of ADHD (Joe)	• Dislike of taking medication (Joe) • Trying to be good (Joe)

Consistent with previous literature (e.g. Shattell et al., 2008; Hallberg et al., 2010), all students in the current study shared their experience of isolation as a consequence of feeling different to others. For example, Josh explains:

Josh: "In a way you can't do some of the things that other people without ADHD can. Sometimes for me, I know it sounds weird but mentally, sometimes with ADHD you don't have the freedom to do a lot of things that people without it can do." (p11, 38-40)

Josh perceives he does not experience the same level of freedom and choice as his peers, thus making him *feel* different through this direct comparison. He goes on to

describe how this means other people often made decisions for him. His acceptance of his behaviour being monitored by others in this way is possibly another feature which increases feelings of difference to peers. Again, this also highlights the passivity with which a diagnosis of ADHD can be experienced as suggested by Avisar and Lavie-Ajayi (2014). Isolation was also experienced in other ways. For example, I interpreted Max's comment below as feeling his diagnosis is unimportant to other people.

Interviewer: "What do you think other people understand about ADHD?"

Max: "Not that much. They just, they just carry on with their life and that. They don't really know that much. (p6, 24-25)

In my interpretation, he feels that other people don't need to know much about ADHD because it doesn't affect them. To me, this created a sense of being separate from others and was also expressed in Max's theme of being misunderstood. This experience was also echoed within Joe's themes of the negative perception and consequences of ADHD. He explained:

Joe: "When you say ADHD people think aww misbehaviour, yeah misbehaviour bad vibes and trouble…that is how everyone sees ADHD and that is how I see it as well; as a bad thing." (p6, 15-16)

Joe was unwavering in his description of ADHD as *"a bad thing"* and concluded *"I really wouldn't like to have it" (p9, 36).* This was reinforced by Joe's experience of negative consequences of having ADHD such as getting into trouble at home and school, detentions and the effect of his behaviour on others' learning. This felt burdensome and was accompanied by Joe's continued efforts to 'be good' (like his peers). He was motivated by the school reward systems; wanting to obtain good

grades and a good job in the future; but was acutely aware how ADHD made this more challenging for him in comparison to his peers. Joe's theme of disliking medication was a unique perspective within the data set. In line with previous research, it is possible that his experience of taking medication is another factor which increased his feelings of difference to others (Meaux et al., 2006; Singh et al., 2010). Furthermore, his desire to be without medication could be seen not only as an attempt to exert more control over his life, but to avoid feelings of shame and difference and desire to be like others.

4.4.2 Student theme 4: Influence of relationships

Table 8: Shared and unique perspectives within the superordinate theme: influence of relationships

Shared perspectives	**Unique perspectives**
• **Relationship with the teacher** • Importance of relationship [with teacher] (Max) • Relationships as support (Josh) • Teacher qualities (Joe)	• Influence of parent-teacher relationship (Josh) • Influence of peers (Josh) • Influence of others views [toward medication] (Joe)

The importance of the student – teacher relationship has been highlighted by previous research as an important factor in shaping adolescents' experience, behaviour and academic motivation (Rogers et al., 2015; Honkasilta et al., 2016). In this study students were required to elect and talk about a teacher who "knew them well". This was purposefully designed to elicit factors that contribute to a perceived positive relationship. All students elicited themes suggestive of their emotional connection with the teachers concerned. For example, Joe says:

Joe: "Before I came into the school, she came into my primary school saying 'aww I hope Joe does well…I really hope he gets a space', and she was hoping that I did, and I did, and then since I come here she has been caring and really nice." (p3, 5-8)

Max's description also suggested longevity of his relationship with Mr Smith had been an important factor:

Max: "I've known him since Year 7 when I first started here all the way up to now. He's been my form tutor and Art teacher all the way." (p3, 3-4)

He often used the phrase *"he just knows"* when talking about his chosen teacher suggesting he perceived this teacher to have an implicit understanding of him as an individual. Similar to Prosser's (2008) findings, it appeared that in relation to the selected teachers - those whom students perceived to know them well as an individual - the stigma of the label ADHD was not experienced. However, Max's comments demonstrate how this was not necessarily universal and he continued to feel misunderstood by some teachers.

Max: "Some of them [teachers] just think "Oh they're just misbehaving" and they don't know the actual cause of it....They don't really help that much 'cos they don't really know what it is." (p4, 37-38)

In addition to talking about the subject teacher he had chosen to participate in the research, Josh also described the emotional connection and relationship he had developed with his Head of Year, Miss Buchanan.

Josh: "Sometimes I'm annoyed and I might just want to talk to Miss Buchanan about it and she'll understand (p9, 21-22)… Sometimes I might get into trouble and Miss Buchanan will…phone my mum and tell her what's happened and everything, so they know each other quite well. They are sort of friends". (p9, 34-36)

Joe's elected teacher, Miss Langstone had a dual role as his English teacher and Head of Year. The Head of Year role had a perceived benefit for both students. For Joe, it meant he had begun developing a relationship with Miss Langstone before he started at secondary school. For Josh, it was the perceived parent-teacher relationship, which previous research has found positively impact students (Gadaskaz and Rogers, 2014, cited in Rogers and Meek, 2015). Joe, on the other hand, did not overtly recognise the parent-teacher relationship, but his experience of how others' views shaped his choice to continue medication incorporated elements of pressure from both parent and teacher, so could be viewed as the two working together to influence his behaviour.

Josh and Joe also shared in their reference to the influence of peers in the classroom. They both recognised how seating plans could influence their behaviour positively or negatively, for example:

Josh: "The friend I mentioned earlier who also has ADHD…I sit by him in History…and that helps because he's sensible so when I'm not focussing Mrs Williams doesn't have to tell me to get my head down because my friend, he does, because he already has experience with it."(p8, 15-19)

Josh: [Referring to another subject seating plan] "I sit by a girl now…she's quite loud and makes a lot of noise and shouts a lot (p9, 1)…So when I want to focus because I need to focus, it just stops me because she's shouting halfway across the room…." (p9, 12-13)

This also adds a unique perspective relating to their conceptualisation of ADHD by recognising the influence of relationships on their behaviour, therefore acknowledging potential environmental factors which shape their behaviour.

4.4.3 Student theme 5: Role of teachers

Table 9: Shared and unique perspectives within the superordinate theme: role of teachers

Shared perspectives	Unique perspectives
• **Teacher's classroom management** • Teacher's managing the environment (Josh) • Teacher actions (Joe)	• Teachers as helpers (Max)

Josh and Joe shared in their awareness of how teachers' management of the environment could shape their own behaviour. As highlighted above, both acknowledged sitting near friends who helped them to concentrate (Josh and Joe) as a useful strategy. Joe also felt seating near the teacher was helpful whereas Josh felt the enthusiasm of his teacher helped him to stay more engaged in the lesson. However, all students expressed a need for teachers to know *more* about ADHD to effectively understand their challenges and ways to support them, consistent with Travell and Visser (2009). Joe presents the view that if teachers knew more about ADHD it could influence their actions by helping them to be more prepared for challenges.

Joe: I think they [teachers] need to know [about ADHD] so they can prevent the problem before it actually happens and they know what they are dealing with. (p9, 19-20)

However, Josh was less optimistic saying that:

Josh: "A lot of the teachers [do] understand ADHD but…they treat it the same as a person without ADHD." (p11, 23-24)

This suggests that from a student point of view, not only do teachers need to know

about ADHD but they need to know what to do differently to support them. However, students' perceptions of what this involved resulted in different interpretations based on their personal meaning of ADHD. For example, Josh who conceptualised ADHD as 'emotional difficulties' discussed: learning emotional management strategies; the opportunity to walk away/leave the classroom; and use of isolation as a quiet place to calm down. In contrast, Joe's conceptualisation of ADHD as 'behavioural difficulties' led him to perceive the role of teachers as preventers of 'misbehaviour' via distraction and pre-empting challenging behaviour before it occurred. Despite Max's similar conceptualisation of ADHD as 'behaviour' his expectations of teachers was far more focused on academic support (e.g. reading, spelling and correcting work). Although Max mentions concentration he was unable to elaborate on strategies teachers could use to support this, perhaps owing to his feelings that medication played a primary role in supporting his concentration.

4.4.4 Summary

Several perspectives on the experiences of an ADHD diagnosis within the school environment were shared by two or more students. Notably, and consistent with previous research (e.g. Shattell et al., 2008; Travell and Visser, 2009; Dunne and Moore, 2011; Hallberg et al., 2010), they experienced feelings of isolation in comparison to their peers. This appeared to be exacerbated for Joe in relation to his perception of how others viewed ADHD and his dislike of taking medication which increased feelings of difference (Meaux et al., 2006). Genuine and caring relationships with individual teachers proved to be an important feature contributing to positive student experiences, similar to previous research (e.g. Prosser, 2008; Shattell et al.,

2008; Dunne and Moore, 2011; Rogers et al., 2015). However, this study also contributes an understanding of the importance of pastoral staff in a secondary school context (e.g. Head of Year) in supporting these relationships. Students showed an awareness of how teachers could shape their school experience but this was open to varied interpretations based on the personal meanings of ADHD to each of the students.

4.5 Overview of teacher themes.

Table 10 presents an overview of how each teachers themes contributed towards superordinate themes at the group level.

Table 10: Overview of group level themes for teachers and how they were derived

Group Level Superordinate Themes	Themes (taken from individual theme)
1) Views on validity of ADHD	• Alternative explanations of behaviour (Mr Smith) • Immaturity (Mr Smith) • Difficulty meeting classroom expectations (Mr Smith) • Spectrum of ADHD (Mrs Williams) • When diagnosis "doesn't fit" (Mrs Williams) • Accepting difference (Mrs Williams) • "The missing girls" (Mrs Williams) • Label to aid understanding (Miss Langstone)
2) Views on medication	• Resisting the dominant view (Mr Smith) • Avoiding medication (Mrs Williams) • Acceptance of difference (Mrs Williams) • The need for medical intervention (Miss Langstone)
3) Weighing up the need for a different teaching approach: teaching for all	• Conflict whether to treat as the same Vs do things differently (Mr Smith) • Clear expectations (Mr Smith) • Planning for all (Mrs Williams) • Whole school ethos (Miss Langstone)
4) Weighing up the need for a different teaching approach: doing things differently	• Conflict whether to treat as the same Vs do things differently (Mr Smith) • Being alert (Mr Smith) • Matching strategies to presenting needs (Mrs Williams) • Feeling prepared (Miss Langstone) • Encouraging independence (Miss Langstone) • The need for support strategies (Miss Langstone)
5) Relationships	• Relationship (Mr Smith) • Getting to know the student (Mrs Williams) • Strength of our relationship (Miss Langstone) • Seeing Joe's strengths (Miss Langstone) • Working with parents (Miss Langstone) • Protecting Joe (Miss Langstone)

4.6 RQ3: How do teachers of students with a diagnosis of ADHD conceptualise the term ADHD?

I interpreted two superordinate themes in relation to how teachers conceptualised ADHD; (i) their view on the validity of ADHD and (ii) their view on medication.

4.6.1 Teacher theme 1: Views on the validity of ADHD

Table 11: Shared and unique perspectives within the superordinate theme: views on the validity of ADHD

Shared perspectives	**Unique perspectives**
• **Questioning validity?** • Alternative explanations of behaviour (Mr Smith) • When diagnosis "doesn't fit" (Mrs Williams) • Accepting difference (Mrs Williams)	• Immaturity (Mr Smith) • Difficulty meeting classroom expectations (Mr Smith) • Spectrum of ADHD (Mrs Williams) • "The missing girls" (Mrs Williams) • Label to aid understanding (Miss Langstone)

Previous research suggests that regardless of knowledge *level*, knowledge of ADHD symptoms by diagnostic criteria is the most consistent area of teachers' knowledge (Blotnicky-Gallant et al., 2014; Ward, 2014; Mulholland et al., 2015). In the current study, all teachers showed an understanding of the types of behaviour which could be considered 'typical' of students with ADHD (e.g. difficulty sustaining concentration, shouting out, poor organisational skills and time management). Despite their shared understanding of the *definition* of ADHD, the extent to which they conceptualised ADHD as a justifiably *medical* phenomenon differed. To some extent, Mr Smith and Mrs Williams shared in their scepticism of ADHD as a biological disorder and identification of environmental factors which could contribute to similar behavioural

presentation. Mr Smith held the strongest view in support of this explaining:

Mr Smith: "To me personally I think it's a modern…you know diagnosis of young people that erm…suggests that they can't sort of stay focused for very long. But personally, I mean I've said this to a few people, it's my personal view – I think it's…it's sometimes an excuse for poor behaviour." (p1, 27-30)

Mr Smith: "I personally don't think there's been enough research gone into it…I think with a lot more research they might actually find it's down to poor diet or poor parenting" (p7, 19-21)

Therefore, Mr Smith questions the validity of ADHD as biological in origin and is keen to consider alternative explanations for the types of behaviour currently attributed to ADHD. Previous research has also found many teachers attribute ADHD to dietary causes (Ohan et al., 2008; Kern and Seabi, 2008), although NICE guidelines indicate this is not an established causal factor but can exacerbate behaviour (NICE, 2009).

He also says:

Mr Smith: "It seems like whatever he was diagnosed with it seems to be not having such an effect in the lesson and form."

Interviewer: Ok, why is that?

Mr Smith: "It might be cos he's just growing up and he's getting bigger." (p4, 32-37)

This seems to indicate that there was a time when Max presented differently. Mr Smith's view that Max seems to manage better *because he has grown* indicates how his previous behaviour could have been interpreted as an immaturity. Family factors were also recognised as contributing factors, for example:

Mrs Williams: "I think that there are a few in this school who actually present like him and I don't know whether it's the primary school they've come from, whether it's home background or whether it's the way they're dealt with here [that helps]" (p5, 39-41)

However, like 10% of teachers in Glass and Wegar's (2000) study, to some extent Mrs Williams rejects the medical conceptualisation of ADHD in preference of seeing the behaviour as part of a normal spectrum of personality.

Mrs Williams: "I think…you know as I said before in the past we would have…and we have like just labelled these kids as you know, got ants in the pants, inattentive, daydreamers, whatever, all those sorts of things. And I don't know whether in a way that was just, it's just people's personalities are different, they learn in different ways and if they need to look out the window and have time out or if they need to wander round the class that just would have been dealt with." (p14, 27-33)

Therefore, she does not seem to dismiss that there are children who experience such difficulties but accepts this as *difference* not *disorder*. Miss Langstone was the only teacher who appeared to conceptualise ADHD as a medical condition, demonstrated by the underlined phrases.

Miss Langstone: "At that point it wasn't actually officially diagnosed so I couldn't say [to Joe] you've got ADHD and use that term, but he knows that I know the symptoms of what it was and what it probably is going to be diagnosed as, so he understands that I know why he does what he does" (p10, 6-10)

However, she did not see ADHD as an all-encompassing explanation, but as a helpful shortcut to *aid* understanding, whilst also recognising Joe's individuality. Drawing on their previous experience of multiple students, both Mrs Williams and Miss Langstone recognised ADHD as a collection of core traits which are expressed heterogeneously.

Miss Langstone: "I see that it is not the same in all students as well, you can't label everybody as having the same traits." (p12, 13-15)

Mrs Williams: "It's on a spectrum isn't it, it's totally on a spectrum for ADHD, some children are mildly and some children it's more noticeable" (p3, 20-21)

Mrs Williams shared her previous experience of running a SEN resource base where many children had a diagnosis of ADHD and displayed challenging behaviour. Therefore, she commented how perhaps her experience in mainstream school had been limited to what she perceived as 'mild' and easily manageable cases. However, she was unwavering in her view that Josh did *not* fit the diagnostic label of ADHD.

Mrs Williams: "He is not inattentive, he doesn't want to wander around the room, he isn't gazing out in space, he's proactive, he interacts, he puts his hand up, all the opposite of which I…you know the kids I've taught in the past that I've had experience of with ADHD are all the sort of like mirror opposites of those sort of thing." (p3, 15-19)

Her description of what Josh is *not*, allowed me to interpret her understanding of what ADHD *was* and she drew upon comparison with students she had taught previously to determine her view. However, she described Josh as fitting in with classroom expectations perfectly and could not identify aspects of his behaviour which she interpreted as ADHD. Interestingly, following my interview with Mrs Williams she was surprised to find out that Josh took prescribed medication for ADHD. Therefore, her view that his behaviour was not representative of ADHD may have be influenced by this.

Mrs Williams also provided a unique perspective as she became concerned about the skew towards male diagnoses. The interview prompted her to reflect on the absence of female diagnoses, which she attributed to society's expectations of gender norms.

Mrs Williams: "But yes all boys, all boys (whispers) are we not diagnosing the girls or something...(p6, 9-10) (full voice) Or is it that the girls…is it society, is it the girls are more aware of how they should behave and it's more acceptable for a boy to be chatty and looking out the window" (p6,18-20)

Again, this view seems aligned with the sociological critique of the dominant medical model acknowledging how social values can play a part in constructing how behaviour is judged as normal or disordered (Timimi and Taylor, 2004). The role of *schools* in constructing ADHD is also recognised by Graham (2008a) and seems to be echoed in Mr Smith's view that:

Mr Smith: "It's fine in break time and lunch time but in here it's a different environment. Again, it is a social skill again isn't it - that you understand that actually no you're not talking about irrelevant things and talking out of turn and coming up with, asking questions that's got nothing to do with what you're actually in here to learn." (p5, 25-27)

This suggests Max's difficulties are related to classroom expectations and also echoes the earlier theme of interpreting Max's needs as 'immaturity'.

4.6.2 Teacher theme 2: Views on medication

Table 12: Shared and unique perspectives within the superordinate theme: views on medication

Shared perspectives	**Unique perspectives**
• **Avoiding medication** • Resisting the dominant view (Mr Smith) • Avoiding medication (Mrs Williams)	• Acceptance of difference (Mrs Williams) • The need for medical intervention (Miss Langstone)

Similar to Moldavsky et al. (2014) two teachers in this study were hesitant to endorse prescription medication for ADHD. Both Mr Smith and Mrs Williams did not necessarily dispute the 'problem' of attention deficit but shared the view that there should be *other ways* around it which did not rely on medication. Both showed an awareness that this may be considered contrary to the dominant position advocated by medical professionals.

Mr Smith: "They [referring to professionals who have influenced his own view] don't think it's right to give…you know prescribe young people with drugs. There should be other ways around. You know what I mean, there's too many medicines being given to young people and I don't particularly - I side with the people who think that maybe there are others ways around it." (p2, 7-11)

Mrs Williams: "I mean I haven't researched enough about it and I don't know enough about it to know, but medicating just…I don't know young kids, rather than managing their behaviour and tasking them to do different things in different ways, channelling them in different ways that suit their personalities and things. Is it not our job to find something that fits them rather than making them be the same as everybody else via medication?" (p15, 2-7)

Similar to primary school teachers in Moldavsky's study, they expressed a preference for within-school strategies for the management of ADHD. Mr Smith's view had been

informed by professional debate and seemed to be influenced partly by his scepticism of the biological basis for ADHD (and therefore *need* for medication), in addition to an ethical argument. In contrast, Mrs Williams' view seemed most influenced by her moral responsibility to allow children to *be* children and accept their differences. I interpreted the last line of her quote as demonstrating her view that adults had a responsibility for protecting children and finding ways to meet these needs without the use of medication. Her view seems aligned with Timimi's argument regarding the extent to which, as a society, adults are restricting the diversity of childhood through medication (Timimi and Taylor, 2004).

Miss Langstone was the only teacher to share positive views about medication. This was a strong and recurrent theme incorporating both the assumed positive *internal* experience for Joe, and perceived positive impact on his behaviour.

Miss Langstone: It's the calmness really, far calmer…just the odd little outburst you'll get but generally he seems a lot more together, a lot more controlled and a lot more settled and calm basically. When he wasn't on it he seemed a lot more irritable and almost looking for a problem. (p11, 1-5)

Miss Langstone advocated the benefits observed for Joe in school and more widely for *any* student following diagnosis. This seemed to be influenced by her experience of previous students who she perceived had also benefitted from medication. She also brought a unique perspective as the only teacher to have experienced the relative student without medication. She explained:

Miss Langstone: He refused to take the medication and that is when, the old behaviour started to come back and things weren't good so, I explained to him that it is not you, the behaviours you are adopting, because you are not having your tablets; we still love you as much but we don't like your attitude and the things that you are doing because you are not having your tablet. They got him back to the [Medical Centre] and got him put back on the medication. (p5, 14-20)

This shares similarities with Kendall et al.'s (2011) findings that teachers perceived medication as necessary to prevent disruptive behaviour and academic difficulties. This captures Miss Langstone's role in encouraging Joe to continue with medication which also serves to communicate a medicalised view of ADHD to Joe. Despite the perceived need for medical intervention Miss Langstone acknowledges this is not a "cure-all" and recognises the need for within-school strategies as complementary. However, her unique experience of teaching Joe without medication reinforced her view of its perceived benefits. In contrast, Mrs Williams experience of Josh as meeting classroom expectations "perfectly", which to her knowledge was independent of medication means she may have 'overlooked' any potential benefit of medication for Josh.

4.6.3 Summary

As with previous research, all teachers recognised core traits of ADHD (Blotnicky-Gallant et al., 2014; Ward, 2014; Mulholland et al., 2015). However, their conceptualisations were wide-ranging encompassing medical, socio-cultural and integrated models outlined in Section 2.4. Mr Smith and Mrs Williams shared in their reluctance to endorse medication, similar to previous UK research by Moldavsky et al. (2014). However, there was also a distinction in their view whereby Mr Smith was actively sceptic of a biological explanation for behaviour, whereas Mrs Williams was uneasy at the prospect of behaviour being labelled as 'disorder' and sought to value diversity. As with students, each teacher's conceptualisation was personal to them and influenced by their own life experiences, in addition to their direct experience of the respective student and previous students. Whilst Miss Langstone was the only teacher

to endorse aspects of a biological conceptualisation this was in relation to her personal experience appraising the benefits of medication for individual students, including Joe who she had experienced both with and without medication. However, she did not attribute a solely biological cause and, also, recognised the role of the environment in shaping Joe's behaviour. Teachers' views of this are discussed in more detail in the subsequent sections.

4.7 RQ4: How do teachers experience teaching a student with a diagnosis of ADHD?

I interpreted three superordinate themes in relation to how teachers experience teaching a student with ADHD: (i) teaching for all; (ii) doing things differently and (iii) relationships.

4.7.1 Teacher theme 3: Weighing up the need for a different approach: teaching for all

Table 13: Shared and unique perspectives within the superordinate theme: teaching for all

Shared perspectives	**Unique perspectives**
• **Treating students equally** • Conflict whether to treat as the same Vs do things differently (Mr Smith) • Clear expectations (Mr Smith) • Planning for all (Mrs Williams)	• Whole school ethos (Miss Langstone)

There is no contemporary published material regarding the pedagogical strategies used by secondary school teachers for ADHD. Reports from primary school teachers suggest they utilise and prefer generic classroom management strategies before individualised strategies for children with ADHD (Nowacek and Mamlin, 2007; Kendall et al., 2011; Martinussen et al., 2011). Consistent with this, all teachers in this study referred to strategies which could be considered for the benefit of all and avoided singling out the student as 'different to others'. Mr Smith expressed:

Mr Smith: "I like to think that I treat him exactly the same as other pupils. I don't want to, because he's being diagnosed with something I'm not going to single him out or give him preferential treatment. He would be the same in my mind, he'd be exactly the same as each other pupil in the class – I wouldn't treat him any differently." (p4, 11-15)

Similar to previous research, he recognised clear expectations as a generic pedagogical approach which benefitted all students, not just Max (Nowacek and Mamlin, 2007). However, there was some tension as he later goes on to explain things he does differently for Max (discussed in section 4.7.2). Miss Langstone also shows a preference for Joe to be treated like everybody else.

Miss Langstone: "Yes, the form tutor … the teaching staff, everybody knew [about Joe's difficulties at primary school], but it wasn't addressed; he was treated like everybody else but people did know. T*he [Behaviour Support Team] team were there, a support network, Mr Sharp in particular was always there as a back-up and he would always have somewhere to go if there was a problem in another lesson."* *(p3, 40-41; p4, 1-3)*

This also seemed to reveal factors which were pertinent to a secondary school context (e.g. information sharing across whole school staff; ensuring Joe was a valued member of his form group; and the involvement of pastoral staff). I interpreted a real

sense of collective responsibility and whole school ethos that *all* children at *this* school were expected to achieve.

Effective planning has also been reported by teachers as a preferential generic classroom strategy (Nowacek and Mamlin, 2007). This was evident in Mrs Williams description of teaching:

Mrs Williams: "I mean I can't say that I make any huge big efforts…I sort of plan my lessons so they try and engage kids and we try and do activities all the time (p7, 10-12)…but you do that for the benefit of all and it just so happens if you are more collaborative in your learning and you're a bit more proactive, then that actually ticks a box with dealing with children who've got, you know short attention spans or need to get up and move round the room." (p7, 15-19)

She described strategies which made the subject topic interesting and fun, using activities and movement and chunking tasks as beneficial for several students – not just those diagnosed with ADHD.

4.7.2 Teacher theme 4: Weighing up the need for a different teaching approach: doing things differently

Table 14: Shared and unique perspectives within the superordinate theme: doing things differently

Shared perspectives	**Unique perspectives**
• **ADHD specific strategies** • Conflict whether to treat as the same Vs do things differently (Mr Smith) • Being alert (Mr Smith) • Feeling prepared (Miss Langstone) • The need for support strategies (Miss Langstone) • Encouraging independence (Miss Langstone)	• Matching strategies to presenting needs (Mrs Williams)

Despite teachers' preference for generic classroom management strategies they did all recognise some additional pedagogical strategies required to address specific challenges associated with ADHD. All mentioned seating arrangements which reduced distractions and pairing students with peers they were perceived to work well with as beneficial. They also all described ways in which they encouraged students to become more independent and self-manage their behaviour, which I interpreted to be unique to students with ADHD (e.g. teaching them to restrain impulsive noises and make choices about who they worked best with in class, Miss Langstone's role in encouraging Joe to continue with medication). Secondary school teachers encouraging independence is an original finding – within this study, and is particularly pertinent given adolescents' desire to exert more control as they get older (Meaux et al., 2006).

The extent to which the ADHD label prompted teachers to 'do things differently' was mixed. For example, Mr Smith expressed conflict between wanting to treat Max fairly, but also the same as everyone else.

Mr Smith: "I don't really like to give lee-way like I just said but, 'cos I like to treat them the same as other people. I don't see why they should actually be given a little bit of lee-way but you do, at the back of your mind it's there isn't it" (p7, 37-39)

Mr Smith: "Well the more you know about it you're more likely to kind of like be aware of things like that, like what I've said like you're always clocking where you've sat them (p6, 28-30)…You're more aware of it, because of that label, you're more aware of it in the lesson time" (p6, 36-37)

I think this conflict was experienced as a result of his conceptualisation of ADHD whereby he questioned its validity as a disorder, but also felt the label did have some pedagogical implications. For example, he also acknowledged how because Max was more *"hyper and energetic"* (p7, 17) than other students he did not always immediately follow traditional behavioural management systems, preferring to give verbal warnings and encourage Max to reflect on his behaviour before issuing consequences. I interpreted this to capture Mr Smith's recognition that in order to be *fair* this meant Max sometimes needed to be treated *differently*. Miss Langstone also shared how the 'attention deficit' label had pedagogical implications:

Miss Langstone: "I would say to somebody it is the attention deficit, it is someone who cannot sustain an attention span that perhaps other students in the class can sustain on some occasions. It's almost like you've got to provide short sharper activities rather than something long and drawn out because it is that lack of attention that will then lead to bad behaviour or whatever because the lack of focus has gone so it is constantly having to make sure that somebody is on track all of the time – that is how I see it, you monitor them in small chunks" (p6, 9-15)

In contrast, Mrs Williams' approach of planning for all meant she perceived little pedagogical use of the ADHD label. She commented:

Mrs Williams: "If a kid has got ADHD and they come into your class and they present then you'll look at your stuff afterwards and think, right okay that explains that, now I know where I am. If they don't then why not just move on in that way and wait till they do?" (p13, 28-31)

She viewed knowing a child had a diagnosis of ADHD in advance as not particularly useful, as she preferred to match strategies to presenting needs. As previously discussed, she did not feel Josh displayed such characteristics and did not require additional support strategies, although this is also complicated by the situation that she did not know he was taking prescribed medication for ADHD. She did describe occasions where she had developed strategies for other individuals with ADHD such as providing time out to leave the classroom and involving students in presenting to the class, but had developed these strategies through understanding their individual needs as opposed to influenced by their diagnosis of ADHD. Miss Langstone's theme of feeling prepared also seemed to be influenced by Joe's presenting needs as opposed to the ADHD label. A transition meeting with Joe's primary school played a significant role, but the fact that this occurred before Joe's 'official' diagnosis suggests any negative perception was related to his behaviour not the label. Miss Langstone comments:

Miss Langstone: "I put him deliberately into my form so I could keep an eye on him (p2, 9-10)…Kelly made notes and we shared that with staff too, so people knew sort of how to handle Joe before he actually stepped in the building." (p4, 20-21)

She described how feeling *"forearmed and forewarned*" (p12, 29) was helpful in planning support and interventions for Joe. Both Mrs Williams and Miss Langstone also commented how their previous experience of teaching students had helped them to feel prepared and develop confidence in their skills supporting future students with ADHD.

4.7.3 Teacher theme 5: Relationships

Table 15: Shared and unique perspectives within the superordinate theme: relationships

Shared perspectives	**Unique perspectives**
• **Relationship with the student** • Relationship (Mr Smith) • Getting to know the student (Mrs Williams) • Strength of our relationship (Miss Langstone) • Seeing student's strengths (Miss Langstone)	• Working with parents (Miss Langstone) • Protecting Joe (Miss Langstone)

All three teachers spoke about the need to develop a genuine relationship when dealing with students with ADHD. Previous research has recognised the need for teachers to foster strong and collaborative relationships with students with ADHD, but has not explicitly explored how this can be achieved (Rogers et al., 2015), which I attempt to address within this study. Mrs Williams' explanation was:

Mrs Williams: "Whereas I would say that probably my experience of other kids that have had ADHD would be to…I know it's…it's unfair or wrong, but almost get to know them better than the bulk of the rest of the class. So you almost feel…you don't feel guilty, but it is a way to go to make sure that you know them better than perhaps other individuals in the class." (p11, 13-17)

She went on to describe that this involved knowing the student's personal background (home and primary school); their interests within the subject and which peers the student worked with best. However, it was interesting to me that Mrs Williams positioned this as something which might make teachers feel guilty, suggesting that this may not be readily adopted by teachers as this perhaps goes against their preference for treating children equally.

Mr Smith and Miss Langstone both referred to the strength of their relationship with their respective student, showing a genuine positivity and recognition of their strengths as ways of developing this relationship. Miss Langstone also recognises the role of praise which appears to serve multiple purposes in terms of building relationships with students, both supporting students to see their own strengths and being able to maintain a positive outlook when supporting challenging students. Continuity in the relationship also appeared to be helpful as Mr Smith explained:

Mr Smith: "But I think, I think it's also that relationship between you know the two of us being we've known each other now for three years and I think that's good, I've got quite a good rapport with Max. So I think that's helpful." (p5, 37-39)

Mr Smith and Miss Langstone also discussed working with parents, a factor which has previously been found to positively influence student-teacher relationships (Gadaskaz and Rogers, 2014, cited in Rogers and Meek, 2015). This was more prominent in Miss Langstone's account due to her role as Head of Year which involved frequent contact with parents.

Miss Langstone: "Yes right from the start when I met the mum, to seeing mum after school … seeing her at open evenings … all the positive feedback and then the phone calls, making sure he was on track; we've permanently been in contact with each other." (p9, 24 -28)

Her reference to being permanently in contact was not presented as burdensome but as a shared responsibility – *"working together as a triangle"* (p8, 21) – to support Joe. It appeared to me that Miss Langstone positioned mum as the 'expert' within the triangle which I interpreted as a function of communicating respect and reducing the power imbalance between the teacher and parent. Miss Langstone showed a personal commitment to supporting Joe no matter what and forgiveness when he made mistakes which also contributed to their positive relationship.

Miss Langstone: "So it is a bit like a rollercoaster with him; it is three steps forward and one back, so as long as we are moving forward, that is the main thing." (p4, 31-33)

Her commitment to both Joe and his mother meant she had a good understanding of the context surrounding Joe. She was aware he had experienced stigma at his primary school (before diagnosis) and was keen to protect him from this and potential further negative effect since his diagnosis.

Miss Langstone: "Without any disrespect, they [primary school] did paint a very negative picture over there, they painted him as the child from hell really – he isn't at all, at all [emphasis]. That was a shame, we certainly didn't want him to come with that sort of label, as just being a naughty lad."

Interviewer: "That could have gone either way."

Miss Langstone: "Oh yes, our aim was to get him up and doing and giving him positions of responsibility straight away, trusting him to come to open evening and he excelled himself, he was amazing" (p12, 31-40)

This seems to agree with Prosser's (2008) finding that stigma is more often associated to *behaviour* than label but also shows Miss Langstone's awareness that the label could exacerbate this stigma and lead to further negative judgements from others. This

is particularly relevant given that the experience of stigma appears to be greater at secondary school (Dunne and Moore, 2011; Prosser, 2008; O'Driscoll et al., 2012). As a result, she actively intervened to ensure Joe was given opportunities to be viewed positively by others, recognising how this was likely to shape his behaviour.

4.7.4 Summary

Consistent with previous research (e.g. Kendall et al., 2011), teachers in this study shared in their struggle between the use of generic classroom management strategies versus tailored individual strategies for students with ADHD. All teachers expressed a preference for strategies that avoided singling out the student as different, but recognised pedagogical strategies required for specific challenges associated with ADHD (e.g. seating arrangements, encouraging self-management of behaviour, deviating from whole-school behaviour management systems, providing tasks in short sharp bursts). In contrast to previous research (e.g. Ohan et al., 2011; Mulholland et al., 2015) teachers in this study did *not* express stressful and pessimistic views about teaching students with ADHD. Consistent with UK research, they presented with confidence in their skills (Moldavsky et al., 2014). Furthermore, this study shows this in real-life practice as opposed to in response to vignettes used by Moldavsky et al. (2014). Two teachers also discussed their previous experience of supporting students with ADHD as helping them feel prepared and confident, supporting that exposure to teaching students with ADHD can aid confidence (Kos et al., 2004; Kendall et al., 2011).

The study revealed some original findings into the perspectives of teachers in the secondary school context which have not previously been researched (e.g. the perceived importance of: information sharing across whole school staff; students belonging to a form group; pastoral care; transition support and encouraging student independence).

Rogers et al. (2015) found teachers reported less of an emotional connection with students with ADHD symptoms. However, in this study all teachers recognised the importance of developing an emotional connection for students with ADHD and addressed ways this could be achieved (e.g. recognising the student's strengths, effective praise, continuity of the relationship, knowing their personal background and subject interests). A collaborative relationship with parents was also recognised as important, which has been previously suggested by adolescents and parents (Travell and Visser, 2009) and found to have a positive effect on the student-teacher relationship (Gadaskaz and Rogers, 2014, cited in Rogers and Meek, 2015).

4.8 RQ5: How do students and their teachers develop a shared understanding in their conceptualisation and experience of ADHD?

I will now present and discuss the findings of an original contribution made in this study by drawing together the perspectives of students and their teachers to explore shared and/or conflicting meanings in their conceptualisation and experience of ADHD.

4.8.1 Max and Mr Smith

Both Max and Mr Smith referred to behaviours Max displayed consistent with diagnostic criteria for ADHD. However, their conceptualisation of ADHD was very different. Max showed a greater acceptance of ADHD as a medical phenomenon and was largely positive about the effect of medication. In contrast, Mr Smith was more resistant to what he perceived as the dominant medical view of ADHD and questioned diagnostic validity in preference of alternative explanations for behaviour (e.g. dietary, parenting, immaturity). Consequently, Mr Smith expressed negative views regarding medication and a preference for interventions addressing environmental factors. To some extent Max also recognised that medication alone did not eradicate the difficulties he experienced and that there were factors in the classroom teachers could manage which could either help or hinder his learning.

Both Max and Mr Smith recognised this role of teachers, although Max perceived a need for academic support from teachers whereas the aspects Mr Smith described were more consistent with behaviour management strategies (e.g. seating position, verbal warnings, when to use the behaviour management system). Ironically, this is consistent with Max's description of his own needs as 'behaviour' but not the support he perceived he needed from teachers. Mr Smith did not reference the types of support Max perceived he needed (e.g. help with spellings), although this is likely due to his role as Max's Art teacher and form tutor which may not evoke the need for such support.

Both Max and Mr Smith recognised the importance of their relationship, particularly the element of continuity and rapport which had developed through knowing Max as

an individual. This is consistent with Prosser's (2008) conclusion that once teachers knew their student as an individual the label ceased to be a problem. However, Max highlighted this was not his experience with all teachers and shared feelings of being misunderstood by some teachers, echoing previous research (Travell and Visser, 2009).

4.8.2 Josh and Mrs Williams

Again, both Josh and Mrs Williams shared in their knowledge of behaviours consistent with diagnostic criteria for ADHD, although interestingly Mrs Williams did not perceive that these behaviours were typical for Josh. Similarly, although Josh did refer to difficulties with concentration, his primary conceptualisation of ADHD was in relation to difficulties managing emotions. It may have been that this was less evident in the classroom situation for Mrs Williams to observe or that this did not match with her conceptualisation of difficulties attributable to ADHD. Both recognised ADHD as a spectrum which affected individuals differently which I interpreted as recognition of psycho-social factors affecting how ADHD is expressed. In particular, Mrs Williams' view was aligned with sociological critiques of ADHD where she thought critically about the factors in society which contributed to how ADHD was perceived (e.g. society's expectations of gender and lack of acceptance of diversity), consistent with arguments presented by authors such as Timimi (in Timimi and Taylor, 2004), Timimi and Radcliffe (2005) and Graham (2008a). Consequently, she expressed a preference for teachers applying pedagogy to meet students' needs and avoiding medication – a similar view expressed by English primary school teachers in Moldavsky et al. (2014).

Similarly, Josh did not mention medication as a pedagogical tool and both referred to similar strategies which helped Josh to remain engaged within Mrs Williams' lessons (e.g. fun and active learning tasks, seating next to peers he worked well with). Although neither explicitly referred to the strength of their relationship with one another they did both recognise the importance of relationships in their experience of ADHD. Mrs Williams expressed a perceived need to build stronger relationships for students with ADHD, but I interpreted perhaps this had not actualised in her relationship with Josh as she did not perceive him to have additional needs within her class. Josh recognised his and his parent's relationship with his Head of Year as a supportive factor, consistent with previous research (e.g. Travel and Visser, 2009; Gadaskaz and Rogers, 2014, cited in Rogers and Meek, 2015) but also recognising the important role of pastoral staff within the secondary school context.

4.8.3 Joe and Miss Langstone

Joe and Miss Langstone shared in their description of behaviours consistent with diagnostic criteria and acceptance of a broadly medical conceptualisation of ADHD. This was perpetuated by their mutual recognition of medication as a pedagogical tool. However, this was not seen in isolation and both also recognised pedagogical practice as important in shaping behaviour. Therefore, ADHD was not seen as a *solely* biological 'disorder' which could *only* be treated through medication, but as complex condition which responded to medication but also required environmental changes. There was a conflict in experience of medication as Joe expressed a dislike for how it made him feel but perceived encouragement from his parents and teachers to

continue. Previous literature suggests this is not uncommon during adolescence and can be accompanied by adolescents electing to cease medication, as Joe did (Meaux et al., 2006). However, this experience seemed to reinforce Joe and Miss Langstone's view of the perceived *need* for medication. Furthermore, this may have exacerbated Joe's perception of being different to his peers and perceived lack of control over his own behaviour. Krueger and Kendall (2001) warn how this can lead adolescents to internalise negative messages about themselves and their future. This was certainly true for Joe. Despite his motivation for positive school experiences and future prospects, he was acutely aware of the perceived stigma and potential negative outcomes associated with ADHD. Miss Langstone shared in her awareness of this and actively intervened to protect Joe from potential negative experiences and outcomes. As with other student-teacher dyads both recognised the strength of student-teacher relationships as a protective factor, consistent with previous research (Rogers et al., 2015). In this pairing this relationship appeared to have grown particularly strong through Miss Langstone's role as Head of Year incorporating regular contact with Joe's parent, in addition to her personal qualities and teaching style which involved encouragement, approval, belief and validation as highlighted in previous research as preferred by students with ADHD (Gallichan and Curle, 2008).

4.8.4 Summary

Analysis of student-teacher dyads reveal how to some extent all shared in their understanding of ADHD as defined by diagnostic criteria, but held varying conceptualisations based on their personal life experiences. Whilst some student-

teacher pairs shared some aspects of their conceptualisation of ADHD, it was found that this was not necessary to develop a positive experience for the students, who all chose their respective teachers as someone who knew them well. Therefore, the way in which teachers conceptualised ADHD did not influence whether students felt their teacher knew them well, although this has previously been hypothesised as a barrier to support (Hughes and Cooper, 2007). However, it was notable that in this study all students and teachers shared in their recognition that responses to ADHD should include classroom management strategies implemented by teachers. Each student-teacher dyad revealed the same discrepancy in that students expressed a desire for teachers to know more about ADHD, whereas teachers experienced a conflict between their use of generic classroom management strategies and individualised strategies for ADHD. Each dyad also recognised the importance of relationships as a contributing factor to students' positive experiences in line with previous research (Rogers et al., 2015). What is most revealing from analysis of the student-teacher dyads is the way in which positive relationships developed which were not dependent on a shared conceptualisation of ADHD, but on factors such as continuity, rapport, teaching style and working with parents.

CHAPTER FIVE: CONCLUSION

5.1 Introduction to chapter

This chapter summarises findings in relation to each research question, highlighting the study's original contributions and implications for practice. I then summarise the implications for practice, before considering limitations of the current study and areas for future research.

5.2 Summary of findings and contribution to knowledge

5.2.1 How do students with a diagnosis of ADHD conceptualise the term ADHD?

This study found adolescent students developed varied conceptualisations of ADHD. This is similar to Brady's (2014) findings where adolescents were aware of the biological framework surrounding ADHD but used their personal experiences to make sense of ADHD for *them*. In this study, the idiographic focus of IPA allowed me to capture the heterogeneous nature of difficulties experienced. The heterogeneity of *experience,* in turn, shaped how each student conceptualised ADHD in line with Trevis' (2013) explanation that conceptualising complex phenomenon involves drawing on personal experiences to create meaning. Where students did attribute a biological cause this was accompanied by a perceived lack of control over their behaviour, as Gallichan and Curle (2008) warn. This led to a perceived *need* for medication and/or an overwhelming sense of personal responsibility to exert control over one's behaviour. Despite the seemingly medical conceptualisation adopted by two students (Max and Joe), all students acknowledged ways their school experiences could

promote or exacerbate their behaviour, therefore also acknowledging potential psycho-social influences.

Understanding how adolescent students conceptualised ADHD within this study contributes to knowledge by recognising how their conceptualisations are affected by personal experience and the potential negative implications if students view ADHD as a solely biological phenomenon over which they have no control. Therefore, like Travell and Visser (2009) I conclude introducing ADHD as a bio-psycho-social construct which can be influenced at all levels is more beneficial to student's sense of autonomy and optimism.

5.2.2 How do students with a diagnosis of ADHD experience their diagnosis within the school environment?

This study found adolescent students shared similar feelings of isolation and perceived difference to peers that has been recognised across previous research (Shattell et al., 2008; Travell and Visser, 2009; Hallberg et al., 2010). The students were acutely aware that their diagnosis made them different to peers and the potential negative consequences for their school and longer-term future experiences. A key distinction to previous research was the difference in students' evaluation of teachers' behaviour, although this is recognised as attributable to the methodological choice whereby students were asked to consider a teacher they had self-selected as someone who knew them well. Nonetheless, this novel design provided a useful insight into students' perceptions of what *made* a positive relationship with these particular teachers. This included feelings of an emotional connection to the teacher, continuity to the

relationship and the perception that these teachers understood them as an *individual.* However, students also reported feeling misunderstood by other teachers at times, comparable to previous research (Travell and Visser, 2009). Moreover, the students expressed a desire for teachers to know more about ADHD – to increase their understanding of issues faced by students with ADHD and how to support them. Each student contributed ideas about what this would involve, but again this was strongly associated with their individualised conceptualisations of ADHD, based on their personal experiences. Therefore, I conclude that teachers need to be knowledgeable, not only about the core symptoms of ADHD, but understanding how this can be expressed heterogeneously. It is, therefore, imperative to build an understanding of each student's circumstance to know how best to support them.

An original contribution of this study is that students not only referred to the relationships they experienced with *teaching* staff, but also pastoral staff, notably Heads of Year. This is a feature pertinent to the secondary school context which has not been recognised in previous research, but which has implications for planning support/provision for students with ADHD. Of interest, Max and Joe in the current study elected a teacher with a dual role as teacher and form tutor. Furthermore, Joe's teacher was also his Head of Year and Josh initially elected his Head of Year as the person who knew him best. This indicates the perceived importance of pastoral care for students with ADHD which included their emotional connection to pastoral staff and close relationships formed with parents.

5.2.3 How do teachers of students with a diagnosis of ADHD conceptualise the term ADHD?

Secondary school teachers' conceptualisations of ADHD in this study varied considerably. Again, the idiographic nature of IPA supported my understanding of each teacher's personal circumstance which influenced their view such as: their view of 'disorder' versus 'difference'; their engagement with academic research into the topic; their personal experiences *outside* of their teacher role; experiences with previous students and direct experience of the 'research' student. Similarly to students, teachers developed their own understandings of ADHD which was nuanced to their autobiographical experiences. Although teachers varied widely in their attribution of medical causes and perceived need for medical treatment, all teachers recognised environmental factors which could affect the presentation and management of ADHD. In contrast to previous research (Glass and Wegar, 2000; Havey, 2007) not all teachers in this study preferred a combined approach of medication and environmental management. Similar to Moldavsky et al.'s (2014) findings two teachers (Mr Smith and Mrs Williams) cautiously favoured avoiding medication, recognising this was contrary to contemporary medical advice and questioning their knowledge to make such judgement.

Understanding how teachers conceptualised ADHD within this study contributes to knowledge as irrespective of how they conceptualised ADHD, each teacher was chosen by the student as someone who knew them well. This suggests that how teachers conceptualised ADHD did not impair their relationship with respective students. I consider that this may be because all teachers recognised the role of the

environment, despite the extent to which they attributed biological causes. Therefore, similarly to Cooper (2008) I conclude that a solely biological conceptualisation may induce feelings of powerlessness for teachers to influence student behaviour. Conversely, a solely psycho-social conceptualisation did not impede the student-relationship in this particular study. On balance, I conclude similarly to students, teachers would benefit from understanding ADHD as a bio-psycho-social construct which can be influenced at all levels.

5.2.4 How do teachers experience teaching a student with a diagnosis of ADHD?

In this study teachers were not pessimistic or negative about teaching students with ADHD as prior research indicates (Greene et al., 2002; Kendall et al., 2011). However, previous research has focused on the experience of primary school teachers who teach the child daily. This difference could be attributed to the nature of student-teacher encounters in secondary school being dispersed throughout the week. In addition, methodological choices could have contributed to this difference. For example, Greene et al. (2002) found teacher stress was highest for those who taught students who displayed highly oppositional/aggressive behaviour. The sample of the current study is unlikely to include such students as I elected to avoid students at risk of exclusion and conducted the study in mainstream schools. Bell et al. (2011) comments that mainstream teachers' experiences of students with ADHD is likely to be limited to those whose symptoms are controlled enough for them to manage in a mainstream classroom, which may not elicit high stress levels. Furthermore, the fact that teachers were elected by the students as someone who knew them well is likely to indicate a perceived low stress relationship, although the intention of the research

was to focus on students' positive experiences. Consequently, teachers in the current study demonstrated confidence in managing students with ADHD. All teachers were experienced (13 years + teaching experience) and are therefore likely to have encountered several students with ADHD in their teaching career. Two teachers (Mrs Williams and Miss Langstone) explicitly referred to their prior experience of working with students with ADHD as influencing their knowledge of support strategies, reflecting that exposure to teaching students with ADHD can aid knowledge and confidence (Kos et al., 2004; Kendall et al., 2011). However, all teachers experienced difficulties balancing their preference for generic classroom management strategies against individualised strategies for students with ADHD. Although the teachers' emotional responses were largely more positive than in previous research, Miss Langstone's experience of Joe's behaviour as more difficult to manage when he stopped taking medication is reminiscent of previous research (Batzle, 2010).

The strategies teachers employed were individualised to student's specific needs, acknowledging the heterogeneity of ADHD. The study makes an original contribution by presenting factors which are germane to secondary school contexts. For example, teachers perceived a collective staff responsibility to create a positive support network for students with ADHD which included: their own emotional connection with the student; contact with parents; the role of form tutors and pastoral staff (e.g. Head of Year) and information sharing. For one teacher (Miss Langstone) this involved supporting the student's transition from primary to secondary school which was regarded as beneficial in forming a relationship. This again has implications for planning appropriate provision for students with ADHD in secondary schools which involves staff at all levels. The study also contributes by examining the positive

student-teacher relationship from the previously unstudied *teachers'* perspectives which revealed ways they perceived emotional connections could be formed.

5.2.5 How do students and their teachers develop a shared understanding in their conceptualisation and experience of ADHD?

This study analysed student-teacher dyads to explore how students and their teachers developed a shared understanding of ADHD and/or where they experienced conflicting meanings. Hughes and Cooper (2007) hypothesise that failing to establish a shared understanding of diagnosis and how to respond can contribute to an environment which exacerbates the problem. However, this study found that irrespective of whether the student and teacher shared their conceptualisation of ADHD the student perceived that the teacher knew/understood them well. Nonetheless, all student-teacher dyads agreed that the response to ADHD should include classroom management strategies. Therefore, based on Hughes and Cooper's (2007) comment, I would argue a shared understanding of *how to respond* as the more important of these two factors. Each student-teacher dyad revealed different ideas about how best to respond based on individual needs and/or influenced by their respective conceptualisations of the 'problem'. Therefore, an important implication for teachers is to understand ADHD as a heterogeneous condition which cannot be met with a "one size fits all" approach, but requires an understanding of student's individual experiences to plan appropriate support. Each student-teacher dyad also shared understanding of the importance of relationships. The unique design allowed for exploration of factors which fostered positive relationships from both student and previously un-researched teacher perspectives.

The present research also contributes to IPA as a research methodology. Although IPA's popularity has grown in recent years, Oxley (2016) reports there remains few IPA studies conducted within education and published EP literature. Moreover, it has previously been criticised for requiring participants to be articulate and reflexive, although this criticism comes from earlier studies focusing on adult participants (Smith, 2004). This study has shown IPA's potential to elicit rich and detailed accounts from young people about a phenomenon which is important to them. In this instance students were provided with 'fiddle items' during the interview to aid concentration, which I would recommend for future studies when interviewing young people with ADHD. The current study also contributes to IPA as a research methodology as the bolder design (using multiple perspectives) is still in its infancy (Larkin et al., 2013). This study demonstrates the value of such a design in drawing together the perspectives of children and adults to consider shared and/or conflicting meanings they develop relating to the phenomenon of ADHD. Moreover, the methodological choice to position young people as the primary participant who selected a teacher to participate was a purposeful choice to uphold the importance of examining the phenomenon from the position of the people whom it affects.

5.3 Implications for practice

This section summarises overall implications for practice arising from the current research findings.

Findings suggest that both students and teachers would benefit from being introduced to ADHD from the bio-psycho-social model. For students, ADHD should not be introduced as a *solely* biological phenomenon, as this can negatively impact on their self-appraisal and approach to learning. Instead, acknowledging psycho-social influences can serve as a protective factor and encourage students to develop some autonomy and acceptance of support from others to manage their behaviour in different contexts. However, previous research has highlighted CYP often feel passive in their diagnosis and subsequent understanding of ADHD (Avisar and Lavie-Ajayi, 2014). Therefore, this has implications for clinicians as to how a bio-psycho-social model is discussed with CYP and how to ensure the diagnostic process considers a broad range of bio-psycho-social factors when formulating an understanding of the 'problem'.

For teachers, understanding ADHD as a complex bio-psycho-social condition is important in order to appraise the role of multi-modal interventions. Whilst teachers may feel unable to influence decision making around medication, teachers do affect the learning environment. Therefore, understanding that environmental adaptations/psycho-social interventions can support students with ADHD is an important factor which may contribute to teachers' confidence, particularly when the CYP and/or parents have elected not to take (or cease taking) medication which is common in adolescence (Meaux et al., 2006). Therefore, clinicians should also consider how best to share information between medical and educational professionals to develop teachers' understanding about what ADHD *is* and how it can be managed through multi-modal intervention. EPs may be well placed as an intermediary between these professional groups due to their skills in sharing complex

psychological models, delivering training and understanding of the school context (Cameron, 2006).

Teacher training is an implication endorsed by young people in this and previous studies. However, as students' experiences of ADHD are heterogeneous, teachers need to recognise how it can be expressed differently and the need to understand each student's circumstance to best support them. Furthermore, training should draw upon teachers' existing skills and perceived effective strategies with reflection upon how particular strategies were matched to individual presenting needs. I recommend the inclusion of the voices of CYP with ADHD where possible, so that their views of the school environment are shared. This research offers preliminary ideas for this, such as which attributes young people found effective for creating positive relationships with teachers. Teachers also need to be aware of the stigma and isolation students with ADHD typically experience and recognise ways they can intervene to support emotional health, well-being and aspirations, in addition to the support they provide within the classroom. However, whilst training would be beneficial, it is also important to acknowledge the influence of teacher's autobiographical experiences on how they conceptualise ADHD. Therefore, EPs working with teachers need to recognise this and informally share psychological thinking, in addition to formal training opportunities.

Finally, the study reveals implications for secondary schools, particularly the important roles of form tutors, Heads of Year and/or other pastoral staff as key points of contact for students with ADHD and their families. In this study, the Head of Year role

supporting transition was particularly beneficial and indicates an area for the development of future good practice.

5.4 Strengths and limitations of IPA and the current research

Overall, the study has contributed to the extant literature on the topic of adolescent/student experiences of ADHD and demonstrated the value of exploring secondary school teachers' experiences alongside this. The following sections reflect upon the methodological choices and execution, evaluating their success in relation to the research questions and my own execution of the method. The evaluation will consider sampling issues, the interview process, data analysis and ethical challenges.

5.4.1 Sample issues

An obvious superficial criticism of the current study is the small sample size and therefore, potential lack of generalisability to the population of interest. As noted, although care was taken to select a sample with a shared experience of the phenomenon under investigation as advised by Smith et al. (2009), the study did not strive to achieve homogeneity in terms of sample characteristics. Consequently, the study does not seek to generalise to *all* students and teachers who share this experience. Generalisability is an assertion of positivism, whereas research within an interpretivist-constructionist orientation does not seek such claims. Instead, this study seeks theoretical generalisability – where the reader can assess the findings in relation to the sample characteristics, drawing on their professional and experiential knowledge to decide whether this is transferable to *their* context (Smith et al., 2009).

To enable readers to make these judgements, I provide pen-portraits of each participant. The use of participant quotes throughout the findings and attention paid to idiographic and *unique* perspectives within the data also contributes to an in-depth and contextualised understanding of each individual participant's circumstance. Oxley (2016) refers to this commitment within IPA as metaphorically shining a light on the *parts* to build an understanding of the whole.

5.4.2 The interview process and data analysis

Wagstaff et al. (2014) explore the experiences of eight researchers to evaluate IPA: a methodology still in its infancy. I agree with the researchers' conclusions that the strengths of IPA are apparent in the outcome of rich phenomenological data and social validity of findings (Section 5.3). However, upon reflection there are limitations of the current interview schedule (Appendix 2). Questions concerning participants' constructions of ADHD were initially highlighted as "difficult to answer" by both (student and teacher) pilot interviews. Following interviews, participants acknowledged that although such questions could be answered, this may be better addressed later in the interview. Upon listening back to the interviews alongside transcripts I considered it was important to introduce this question early in the interview, but revisit this throughout the interview with reassurance to participants that they were not expected to have fully formed answers at any point during the interview. This worked well and allowed subsequent participants to be aware of the interview's direction without feeling pressured to answer this question immediately. In hindsight, it may have been beneficial to communicate the research questions to participants at the start of the interview to convey my interest in their thoughts about ADHD, as well as their experiences. Participants may thus have felt better prepared for these questions.

Nonetheless, all participants produced adequate data which addressed this question. This highlights the potential for research to also challenge the interviewees thinking which was only achieved through rapport building during the information giving/consent stage and beginning of interviews.

Similar to researchers in Wagstaff et al.'s (2014) study, I too appreciated an approach which explicitly but respectfully incorporated the researcher's influence. However, Larkin et al. (2006) acknowledge this requires a careful balance between phenomenology (giving voice to participant concerns) and interpretation (contextualising and making sense of these concerns from a researcher perspective). Smith et al.'s (2009) description of initial noting was useful to address this as it incorporates both descriptive commenting (which I considered the phenomenological aspect) and conceptual commenting (which I considered incorporated more of my own interpretation). In addition, as quotes were chosen from the transcripts I reflected upon the distinction between the content as it was said and my own interpretations of participants' comments, therefore incorporating both the phenomenological and interpretative aspects of IPA.

Wagstaff et al. (2004) also highlight the challenge of moving between idiographic data and shared themes. I also found this difficult as whilst attempting to develop group themes I retained an in-depth knowledge and respect for each individual transcript which I did not wish to lose. However, I was reassured by the resolution of this issue for researchers in Wagstaff et al.'s (2004) study that it was possible for themes within IPA to contain variation whilst grouping a similar idea. This is evident in the resultant themes of the current research (e.g. students' complexity and individual experience of

IPA; teachers' views of medication) which address both shared and divergent aspects within the same theme. In addition, permission for the IPA researcher to be flexible and creative (Wagstaff et al., 2004), allowed me to develop my own method for presenting findings which incorporated both shared and unique perspectives in the data, therefore addressing both group level and idiographic themes. Furthermore, the small sample size meant all participants had a voice and a presence in the final presentation of findings.

5.4.3 Ethical challenges

Potential ethical issues and steps to address them were outlined in Section 3.4.6. Upon reflection, some potential ethical challenges could have limited the research findings. For example, the application of a bolder design required both student and teacher to partake for data to be included. This was unproblematic for the current study as both parties agreed to participate in all cases. However, had this not been the case this could have wasted time for both researcher and participant, who may also have been disappointed that their experience (and voice) was not included. In hindsight, I would change this procedure to offer inclusion of any data collected contributing towards RQ 1–4, as only RQ5 required both participants' views. This would offer greater equity in ensuring those who wished to share their experiences were represented without relying on joint participation.

A further ethical challenge, which could have influenced the data obtained, was that some participants' responses during the interviews suggested they felt they may need to "look up" ADHD to increase their understanding. Despite my attempts to reassure

participants and position them as the ‘expert’, it is possible that questioning about the concept of ADHD, may have elicited feelings of anxiety to provide the ‘correct’ response. At times during the interviews, I felt as if participants were seeking my validation. Whilst I attempted to maintain impartiality this may have been perceived as indifference towards participants’ views. However, as interviews progressed I became more confident at indicating a neutral stance such as stating “I’m not 100% sure what my views are on it at the moment”, but reassuring participants I was genuinely interested to hear their perceptions. No participants in the current study indicated that this was experienced as distressing, but does highlight how potential power imbalances may still have been present.

5.5 Suggestions for further research

Drawing on the findings and limitations of the current study, as well as areas highlighted within the literature review, there are several directions for future research.

5.5.1 Drawing on different sample populations

In the current study, all participants were male. Previous research has identified potential differences in the way male and female adolescents experience their diagnosis (Krueger and Kendall, 2001). Therefore, future research may seek to explore the way in which females conceptualise and experience ADHD. In relation to the theme of isolation and difference shared by males in the current research, this may be even more prominent among females. Krueger and Kendall’s (2001) findings suggest females are more likely to internalise negative thoughts resulting in feelings

of inadequacy, in comparison to males. However, Shattell et al.'s (2008) study suggests that females may be more resilient and likely to experience educational success compared to males.

5.5.2 Further application of IPA

The use of IPA within education research is still in its infancy (Oxley, 2016). In, addition, IPA has historically been used with adult samples (Smith, 2004). As noted, this study demonstrates the successful application of IPA with adolescent participants, using adaptations for the participant groups' SEN-D. Future research may wish to utilise similar methods of semi-structured interviews within an IPA framework with younger children with ADHD to elicit understanding about their experiences in primary school settings. This would be likely to require further adaptation, potentially incorporating more activities to aid discussion within the interview and/or incorporating movement breaks to support children's concentration.

The study also demonstrates the successful use of IPA to explore secondary school teachers' experiences. One finding of the current study is that secondary school teachers did not report the same emotional responses elicited by previous research, generating a potential hypothesis that this may be due to the nature of secondary schools in which student-teacher encounters are more dispersed than in primary schools. However, the finding may also be attributable to teachers' level of experience in the current study and/or the methodological choice that teachers were elected by respective students. Therefore, future research should seek to explore these hypotheses by speaking to a wider sample of secondary school teachers to elicit

shared and/or conflicting meanings across a broader sample. Exploration of secondary school teachers' conceptualisation and experience of supporting students with ADHD more generally would contribute significantly to a dearth of existing literature from this perspective.

5.5.3 Further application of multi-perspective designs

The current study contributed a multi-perspective design drawing together the perspectives of students and their teachers and demonstrating successful application of such design for future IPA projects. A study using a similar design of dyad participation suggests shared meanings were developed between the pairs through dialogue with one another (Visser and McDonald, 2007). This was observed to some extent in Joe and Miss Langstone's account of the dialogue which occurred regarding the period when Joe ceased medication, but not necessarily for the other pairs. However, Visser and McDonald (2007) used both individual and joint interviews which is likely to have increased the opportunity to reveal such findings. This could be potentially useful to employ in future research to consider how dialogue between students and teachers help them to develop shared meanings and address any conflicting views from within their individual accounts. However, this needs to be carefully considered from an ethical viewpoint to ensure participants did not experience distress or harm to their relationship by airing conflicting views.

Several participants in the current study referred to the parent-teacher relationship as important. In a similar study using multi-perspective design, Trevis (2013) explored the shared and/or conflicting meanings between parents of children with ADHD and their

primary school teachers. Due to the dearth of literature surrounding secondary school teachers exploring the parent-teacher relationship in this context would make further worthy research, particularly concentrating on the role of pastoral staff (e.g. Head of Year) who from this study seem to have most contact with parents. Finally, future research could seek to build on 'bolder' IPA designs by drawing together the perspectives of students, parents *and* teachers to further understand the interaction between the three parties in supporting students with ADHD.

5.6 Personal reflections and learning from the research process

In keeping with the epistemological and theoretical foundations of IPA, I feel it befitting to engage in personal reflection about how the research has impacted upon me, both personally and professionally.

On a personal basis, the process of research has imbued both challenge and reward at every stage. One of the most challenging aspects for me has been achieving the level of persistence required throughout an extended research project, particularly when facing obstacles (e.g. access to participants). I maintain that at these times stepping away from the research briefly and re-connecting with others about the reasons I elected the research topic helped enormously. As a result, I would advise any future doctoral researcher to select a topic they are passionate about to maintain interest throughout the research period. In achieving final submission, I have also learned first-hand that I am capable of much more than I thought possible, which I hope will be of reassurance for those about to embark on similar endeavours.

As a researcher, I have learned to trust more in my decision making. At each stage I experienced anxiety in making the 'right' choice, however, I have come to reflect that the choices I have made were only ever 'right' for my research journey. It is not only plausible, but *likely* others would have approached the topic differently. I experienced anxiety particularly during the analysis stage, where I began to wonder if other researchers would have generated similar themes. However, as the analysis procedure progressed and reassured by my supervisors, I began to accept and understand that my own knowledge and pre-conceptions shaped the analysis process, and to have confidence in the themes as they emerged for *me*.

The research process has inevitably impacted my own knowledge and understanding around the topic of ADHD. From my early assumptions of ADHD as a medical disorder, which were later challenged by learning about socio-cultural critiques, the current research has allowed me to engage with a topic of interest at a more interrogative level to develop my own knowledge of the 'disorder'. Both through my reading of literature and engagement with participants I have come to support an integrated model of ADHD which incorporates pre-disposing, precipitating and perpetuating bio-psycho-social factors. However, I remain cautious of medication being 'accepted' as a first-line response to ADHD diagnosis and believe more needs to be done to understand how parenting and pedagogical methods can support CYP's needs first. Furthermore, I believe *all* CYP diagnosed with ADHD would benefit from interventions which address factors within the environment which can shape behaviour, however recognise that guidance over intervention of this nature remains poor and under-researched. I do not accept that any child should be prescribed medication without also addressing factors within the environment and believe more

should be done to understand the potential longer-term consequence and risks associated with medication.

My increased understanding of the debate surrounding ADHD and of the experiences of students with ADHD and their teachers highlighted in this study, will undoubtedly influence my professional practice as I transition to a practising Educational Psychologist. What began as a topic of curiosity has now become an area which I feel compelled to develop further. I have already noticed changes in my own professional practice, whereby when working to support students with ADHD I will seek to discuss with school staff their views of diagnosis and how they understand ADHD affects *this* particular child. I have also begun to develop training packages incorporating suggestions made in Section 5.3. As a result of both the current research and additional project work undertaken within the LA (presented in Volume 2 of the thesis), I have also become involved in working alongside medical colleagues in Paediatric Services to develop improved assessment pathways for CYP referred for assessment of ADHD. In doing so, I hope this will lead to further opportunities such as the developing evidence based psycho-social interventions for CYP diagnosed with ADHD. As discussed in chapter one, I believe it is a professional duty of EPs to support positive outcomes for all CYP and develop better ways of working. Therefore, I hope to contribute towards this responsibility by sharing my understandings from this research with others in the hope they will also be able to utilise the findings to improve practice.

5.7 Chapter summary and concluding comments

This chapter has summarised key findings in relation to the current research questions. In doing so, it has revealed this study's original contribution both to the substantive topic and to methodological practice within IPA. As a researcher and EP practitioner one of my motivations for undertaking this research was to inform the development of educational practice. I believe the study's implications for practice provide initial steps to support this and suggestions for future research have been made reflecting on the limitations of the current study and remaining gaps in existing literature. Finally, and in keeping with the epistemological and theoretical foundations of IPA I offer a summary of personal reflections and learning.

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APPENDICES

Appendix 1: DSM 5 and ICD 10 criteria for the diagnosis of ADHD and HKD (respectively)

❖ DSM 5 criteria for ADHD

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterised by (1) and/or (2):

1. **Inattention**: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: **Note**: The symptoms are not solely a manifestation of oppositional behaviour, defiance, hostility, or failure to understand tasks or instructions.
   a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
   b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
   c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
   d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
   e. Often has difficulty organising tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganised work; has poor time management; fails to meet deadlines).
   f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
   g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
   h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
   i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

2. **Hyperactivity and impulsivity**: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

Note: The symptoms are not solely a manifestation of oppositional behaviour, defiance, hostility, or a failure to understand tasks or instructions.

a. Often fidgets with or taps hands or feet or squirms in seat.
b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
c. Often runs about or climbs in situations where it is inappropriate. (**Note**: In adolescents or adults, may be limited to feeling restless.)
d. Often unable to play or engage in leisure activities quietly.
e. Is often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
f. Often talks excessively.
g. Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).
h. Often has difficulty waiting his or her turn (e.g., while waiting in line).
i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

❖ **ICD 10 criteria for HKD**

1. **Inattention**: At least six symptoms of attention have persisted for at least 6 months, to a degree that is maladaptive and inconsistent with the developmental level of the child:

a. Often fails to give close attention to details, or makes careless errors in school work, work or other activities.
b. Often fails to sustain attention in tasks or play activities.
c. Often appears not to listen to what is being said to him or her.
d. Often fails to follow through on instructions or to finish schoolwork, chores or duties in the workplace (not because of oppositional behaviour or failure to understand instructions).

e. Is often impaired in organising tasks and activities.
f. Often avoids or strongly dislikes tasks, such as homework, that require sustained mental effort.
g. Often loses things necessary for certain tasks and activities, such as school assignments, pencils, books, toys or tools.
h. Is often easily distracted by external stimuli.
i. Is often forgetful in the course of daily activities.

2. **Hyperactivity**: At least three symptoms of hyperactivity have persisted for at least 6 months, to a degree that is maladaptive and inconsistent with the developmental level of the child:.
a. Often fidgets with hands or feet or squirms on seat.
b. Often leaves seat in classroom or in other situations in which remaining seated is expected.
c. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, only feelings of restlessness may be present)
d. Is often unduly noisy in playing or has difficulty in engaging quietly in leisure activities.
e. Often exhibits a persistent pattern of excessive motor activity that is not substantially modified by social context or demands.

3. **Impulsivity**: At least one of the following symptoms of impulsivity has persisted for at least 6 months, to a degree that is maladaptive and inconsistent with the developmental level of the child:
a. Often blurts out answers before questions have been completed.
b. Often fails to wait in lines or await turns in games or group situations.
c. Often interrupts or intrudes on others (for example, butts into others' conversations or games).
d. Often talks excessively without appropriate response to social constraints.

4. **Onset of the disorder** is no later than the age of 7 years.

5. **Pervasiveness**: The criteria should be met for more than a single situation, for example, the combination of inattention and hyperactivity should be present both at home and at school, or at both school and another setting where children are observed, such as a clinic, (evidence for cross-situationality will ordinarily require information from more than one source; parental reports about classroom behaviour, for instance, are unlikely to be sufficient.).

6. The symptoms in 1 and 3 cause clinically significant distress or impairment in social, academic or occupational functioning.

Appendix 2: Full interview schedules

STUDENT INTERVIEW SCHEDULE

Introductions and consent.

Thank-you for meeting with me. Check participant has read information sheet and fully understands. Explain expectations of the interview.

- Interview will last about 45 minutes – 60 minutes.
- I will ask some questions around the topics that I am interested in but the interview will also be shaped by what you say so it will be quite flexible.
- The main thing that I am interested in is hearing your experiences – so there are no right or wrong answers – it is just about your experience of being a student diagnosed with ADHD and what you understand by the term.
- Reiterate audio recording, confidentiality, right to withdraw.
- Participants to sign consent form if they agree.

Turn on recorder, rapport building, thanking for time and explain research context.

Interview Questions (* denotes questions added following reflections on pilot interview)

1. So that I can get to know a little bit about you tell me about your favourite thing to do? (can be hobby, favourite subject, highlight strengths)

As you know for this research project I am interested in your experience of ADHD and of being a *student* diagnosed with ADHD.

2. I wonder if we can start by thinking about what ADHD means. *What would you say ADHD is*? (e.g. if you were describing it to someone else)
3. How does having ADHD affect you in school?
4. What would you like teachers to understand about you?
5. ** Do you think it's important for teachers to know about ADHD?*
6. Tell me a little about the teacher you have chosen who teaches you well?
7. What does (she) understand about you?
8. **What sort of help do you think a teacher should give a student with ADHD?*
9. Is there anything that you would like to say to other teachers of other students diagnosed with ADHD?
10. **Imagine if you were to deliver an assembly or make a leaflet to tell them about ADHD – what would it say?*

I think we have covered all of the questions I wanted to ask now. Is there anything that we have not talked about that you feel is important and would like to tell me? Summarise the main points of discussion.

Do you have any other questions or comments?

Thank-you very much for taking the time to talk to me.

TEACHER INTERVIEW SCHEDULE

Introductions and consent.

Thank-you for meeting with me. Check participant has read information sheet and fully understands. Explain expectations of the interview.

- Interview will last about 45 minutes – 60 minutes.
- I will ask some questions around the topics that I am interested in but the interview will also be shaped by what you say so it will be quite flexible.
- The main thing that I am interested in is hearing your experiences – so there are no right or wrong answers – it is just about your experience of teaching a student with a diagnosis of ADHD and what you understand by the term.
- Reiterate audio recording, confidentiality, right to withdraw.
- Participants to sign consent form if they agree.

Turn on recorder, rapport building, thanking for time and explain research context.

Interview Questions

1. Can you tell me a little bit about your current role in school?
   (noting best things about their current role)

As you know, for this research project I am interested in your experiences of teaching (child's name), as a student with a diagnosis of ADHD.

2. I wonder if we can start by thinking about what ADHD means. Can you tell me about what you understand by the term ADHD?
3. Tell me a little bit more about (child's name)?

Moving on to think about your experience of teaching (child's name)

4. How has your understanding of the term ADHD helped you to understand (child's name) needs?
5. Can you tell me a little about how you find teaching (child's name)?
6. Are there any barriers/obstacles you have had to overcome?
7. What have you found successful?
8. Is there anything *(three things)* that would say to other teachers about your experience of teaching a student with a diagnosis of ADHD?

I think we have covered all of the questions I wanted to ask now. Is there anything that we have not talked about that you feel is important and would like to tell me? Summarise the main points of discussion.

Do you have any other questions or comments?

Thank-you very much for taking the time to talk to me.

Appendix 3: Participant information sheet (student version)

What will happen to the information that I give?

I will type up our interview and look at it closely to identify the things that are important to you and your experience. I will also look for connections between your experience and other people's experiences including your teacher.

All of your information will be stored confidentially so only I have access to it. I will remove your name and any other personal details from any documents so that people cannot identify you. I will give you a false name and change any other people's names or details you say during the interview.

I will be speaking to other students and teachers and will use information from all of the interviews I have carried out to summarise what students and teachers have said. You, your parent, your teacher and school will be able to see this summary.

A report will also be written, which will mainly be read by other researchers. I may want to use a quote of something you have said but people will not be able to know that it was you who said it.

What will the interview be like?

The interview will last no longer than an hour. I will ask you some questions around the topics I am interested in but the interview will also be shaped by what you say. The main thing I am interested in is hearing your experience – so there are no right or wrong answers.

You will be able to ask for breaks to move around during the interview and if you like you can bring an object to fiddle with whilst we talk. Most importantly, the interview should feel comfortable for you.

Who is carrying out this research?

I am a research student from the University of Birmingham. My contact details are

[redacted]

The research project is being supervised by Anita Soni who can be contacted at

[redacted]

ADHD

What's your experience?

What is this research about?

This research project aims to find out about people's experiences of ADHD.

We know that there are lots of children young people diagnosed with ADHD. But we don't know much about what school is like for them. We also don't know much about what it is like for teacher's who teach young people diagnosed with ADHD.

I am interested in hearing about the experiences of both young people diagnosed with ADHD and of teacher's who work with these students. I hope that by hearing these experiences this will help others to understand what it is like. It may also help us think about how schools can make things easier for students diagnosed with ADHD and their teachers.

Who can take part in the research?

I am looking for students in year 7, 8 or 9 at a secondary school in Wolverhampton who have a diagnosis of ADHD and take ADHD medication.

I am also looking for teachers who teach these students.

Understanding the experiences of students diagnosed with ADHD and their teachers.

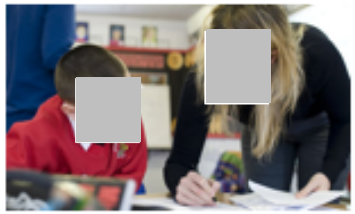
Do I have to take part?

It is up to you to decide whether you want to take part in this research project. If you do want to take part you will be asked to sign a form but will be allowed to change your mind without giving a reason. If you do take part you will have up to a week to change your mind about whether you would like the information you give to be used for this research project.

What will happen to me if I take part?

If you decide to take part we would meet for an interview which would last no longer than an hour. I would ask you around eight questions which would be about your understanding of the term ADHD and your experience of being a student diagnosed with ADHD. We will meet in a quiet room at your school or at my office at a time that is good for you. I will record the interview and listen to it later.

I will also ask you to choose five teachers who know you well. One of them will also be invited to take part in an interview asking questions about their understanding of the term ADHD and their experience of working with you. This means that both you and one teacher would need to be happy to take part before I interview you.



Appendix 4: Participant consent form (student version)

STUDENT CONSENT FORM

Understanding the experiences of students with ADHD and their teachers: An Interpretative Phenomenological Analysis of the ADHD label in schools.

Please read the following statements and tick the box if you agree with them.

I have read and understood the information sheet for the research project.	
I have had the chance to ask any questions and I am happy with the answers given.	
I am aware that the interview will last up to an hour.	
I am aware that one of the teachers I have chosen will also be interviewed for the research project.	
I understand that taking part in the study is up to me and I can stop at any time without having to give a reason up until a week after the interview has taken place.	
I understand that what I say will not be shared with anyone else. But if I say something about any child which makes the researcher think that they may be at risk of harm, then she would need to tell a senior teacher in school.	
I understand that what I say in the interview will be used in research reports, but that my name or personal information which could identify me will not be used.	
I agree to my interview being tape recorded.	
I agree to take part in the research project.	

Name: …….

School: ……..…….

Date: ……..……....

Participant Signature: …….

Researcher Signature: ……..….

<u>Data Protection</u>

I understand that my data will be held in accordance with the Data Protection Act (1998; 2003). The recording of my interview will be kept in a locked filing cabinet and will then be transcribed by the researcher or a professional transcription service. My name or other identifying details will not appear and any written notes will be stored in a filing cabinet. Data will be kept for 10 years, after which it will be destroyed.

Appendix 5: Example summary letter produced for participants (pseudonyms applied)

Dear Josh,

I would like to thank you for giving your time to participate in my research. I am confident that the information you gave in your interview will provide valuable insights into the experience of being a student diagnosed with ADHD. I have summarised some of the points you made below:

• You described ADHD as something which makes it hard to focus, and can make you react quickly to things by getting angry. We talked about how this was sometimes difficult in school (e.g. if you missed parts of a conversation with friends and getting told off in lessons for being distracted and making people laugh)

• You explained how since Year 7 teachers had helped you learn to control anger so that you no longer got into fights, and that there were teachers you could go to talk to.

• You described how you thought a lot of the teachers might understand ADHD but treat the person the same as a person without ADHD. We discussed that you would like teachers to know how ADHD can affect the way people act and specifically that it was hard for you to deal with feelings of stress and frustration which is why you sometimes lashed out in Year 7. You said that having 'time out' somewhere quiet to calm down was helpful.

• You chose to talk about Mrs Williams as a teacher who knows you well and explained how her enthusiasm in lessons helped you to understand better. You also said sitting next to a sensible friend and sometimes working in groups in her lessons helped you to focus and enjoy the lesson.

Thank-you so much for sharing your experience with me. I hope you have enjoyed reading this short summary.

I will keep in touch about the outcomes of my research and provide you with a summary of the overall findings once I have looked at all of the interviews I have carried out with other students and teachers. Once again, thank you for your time.

Yours Sincerely,

Gemma Hemming

Trainee Educational Psychologist.

Appendix 6: Invitation letter to schools

Dear Headteacher,

I am writing to invite your school to participate in an exciting Doctoral research project being carried out by a Trainee Educational Psychologist, on behalf of the *Service Location (omitted)* Educational Psychology Service and the University of Birmingham. **There will be no charge to the school for participation and time will not be taken from your Educational Psychology time allocation.**

What is the research about?

The research project aims to find out about people's experiences of ADHD. I hope to interview a small sample of students with a diagnosis of ADHD and teachers who work with these students to address the following questions:

- How do students with a diagnosis of ADHD conceptualise the term ADHD?
- How do teachers who teach students with a diagnosis of ADHD conceptualise the term ADHD?
- How do students with a diagnosis of ADHD experience *being* a student?
- How do teachers experience teaching a student with a diagnosis of ADHD?

What is required of participants?

Students and teachers participating in the research would be required to take part in an interview lasting up to an hour. The interview can take place at school or at the researcher's office at a time that is convenient for the school, student and teacher. This will be organised by the researcher.

What are the benefits of the research?

There is currently a lack of research into people's experience of the ADHD label in schools, both from the perspective of students and secondary school teachers. If we were to know more about this, it may provide an opportunity for schools, Educational Psychologist's and others' to reflect upon how we can support the inclusion of students' with ADHD and develop practice to support teachers in facilitating this inclusion.

It is hoped that for participants having the opportunity to share their views will be a positive experience which can be used to inform future practice. Each participant and the school will receive a summary of the outcomes of the research following its completion.

What next?

I will be looking to interview at least one student in Key Stage 3 who has a diagnosis of ADHD and take prescribed medication for their symptoms. I will also be looking to interview one teacher for each student identified in your school.

If you are interested in your school being part of this important research please contact me for further details.

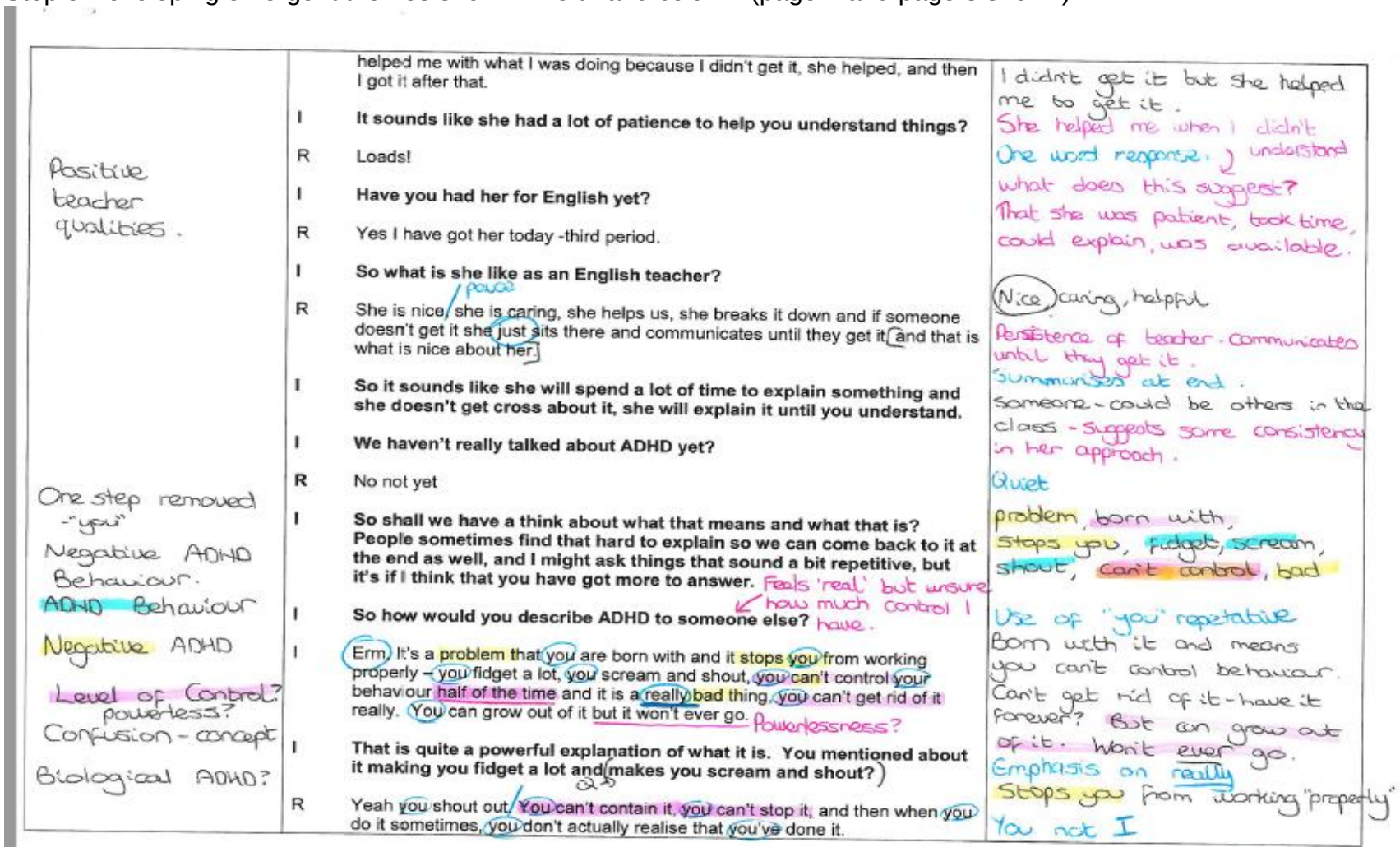
Yours sincerely,

Gemma Hemming

Trainee Educational Psychologist

Appendix 7: Excerpts demonstrating analysis procedure

- Step 2 Initial noting of Joe's transcript shown in right hand column.
- Step 3 Developing emergent themes shown in left hand column (page 4 and page 8 shown)

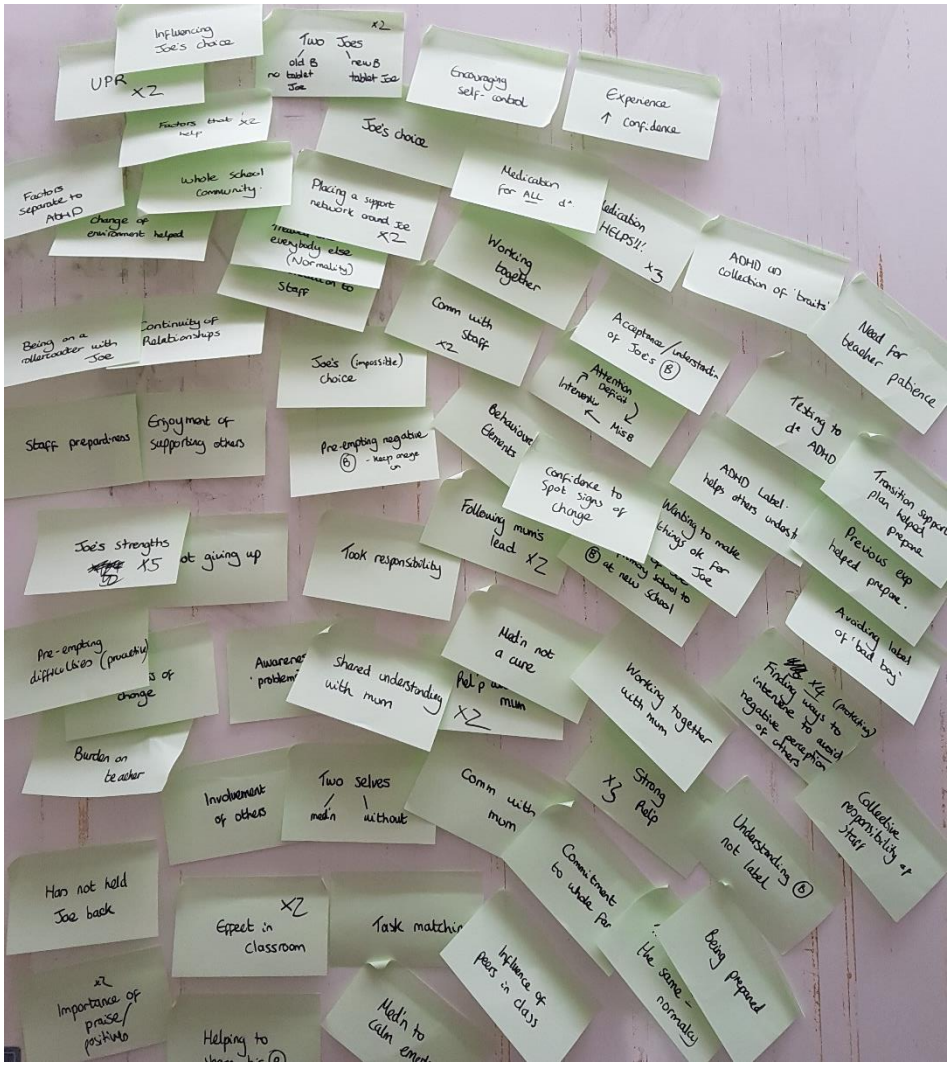


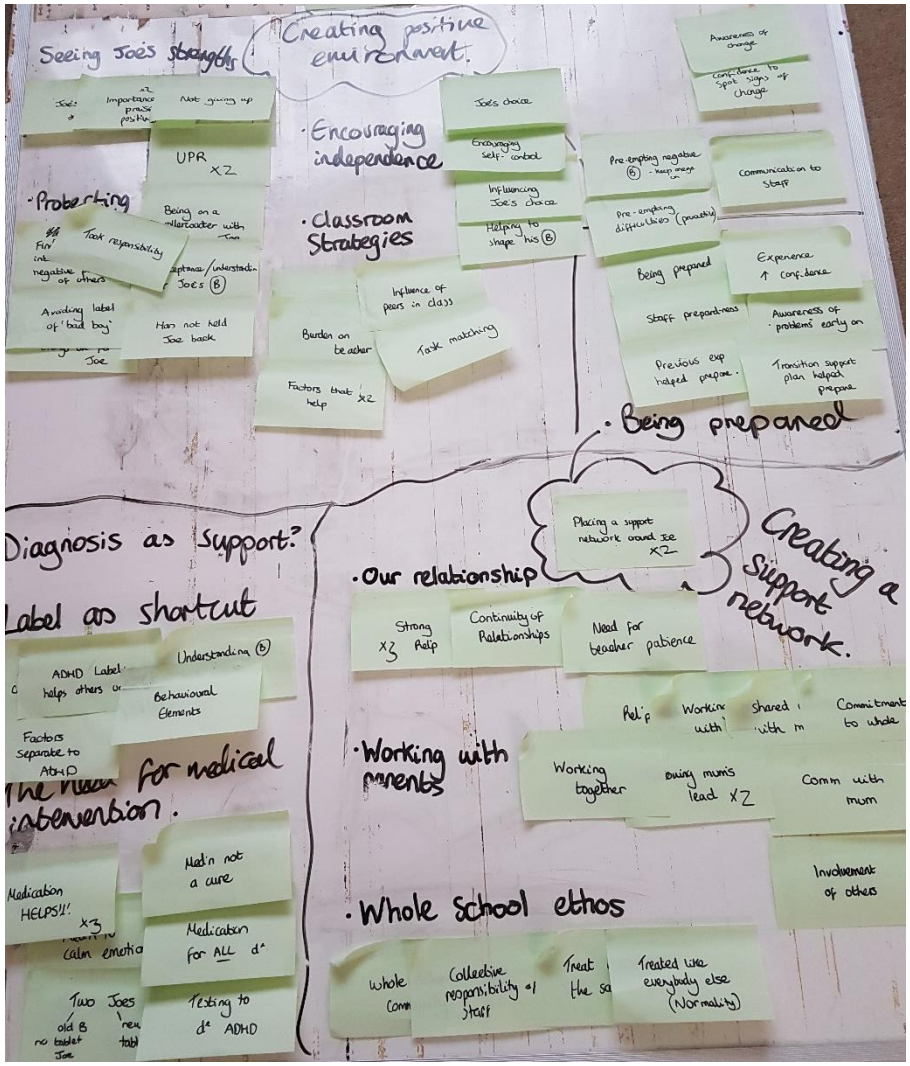
		helped me with what I was doing because I didn't get it, she helped, and then I got it after that.	I didn't get it but she helped me to get it. She helped me when I didn't understand. One word response. What does this suggest? That she was patient, took time, could explain, was available.
Positive teacher qualities.	I	**It sounds like she had a lot of patience to help you understand things?**	
	R	Loads!	
	I	**Have you had her for English yet?**	
	R	Yes I have got her today -third period.	
	I	**So what is she like as an English teacher?**	
	R	She is nice, she is caring, she helps us, she breaks it down and if someone doesn't get it she just sits there and communicates until they get it and that is what is nice about her. (pause)	Nice, caring, helpful. Persistence of teacher - communicates until they get it. 'Summarises' at end. Someone - could be others in the class - suggests some consistency in her approach.
	I	**So it sounds like she will spend a lot of time to explain something and she doesn't get cross about it, she will explain it until you understand.**	
	I	**We haven't really talked about ADHD yet?**	
	R	No not yet	Quiet
One step removed - "you"	I	**So shall we have a think about what that means and what that is? People sometimes find that hard to explain so we can come back to it at the end as well, and I might ask things that sound a bit repetitive, but it's if I think that you have got more to answer.**	problem, born with, stops you, fidget, scream, shout, can't control, bad. Feels 'real' but unsure how much control I have.
Negative ADHD Behaviour. ADHD Behaviour Negative ADHD	I	**So how would you describe ADHD to someone else?**	Use of "you" repetative. Born with it and means you can't control behaviour. Can't get rid of it - have it forever? But can grow out of it. Won't ever go.
Level of Control? powerless? Confusion - concept Biological ADHD?	I	Erm, It's a problem that you are born with and it stops you from working properly – you fidget a lot, you scream and shout, you can't control your behaviour half of the time and it is a really bad thing, you can't get rid of it really. You can grow out of it but it won't ever go.	Powerlessness? Emphasis on really. Stops you from working "properly"
	I	**That is quite a powerful explanation of what it is. You mentioned about it making you fidget a lot and makes you scream and shout?**	
	R	Yeah you shout out. You can't contain it, you can't stop it, and then when you do it sometimes, you don't actually realise that you've done it.	You not I

emphasis — don't like it, don't agree with it

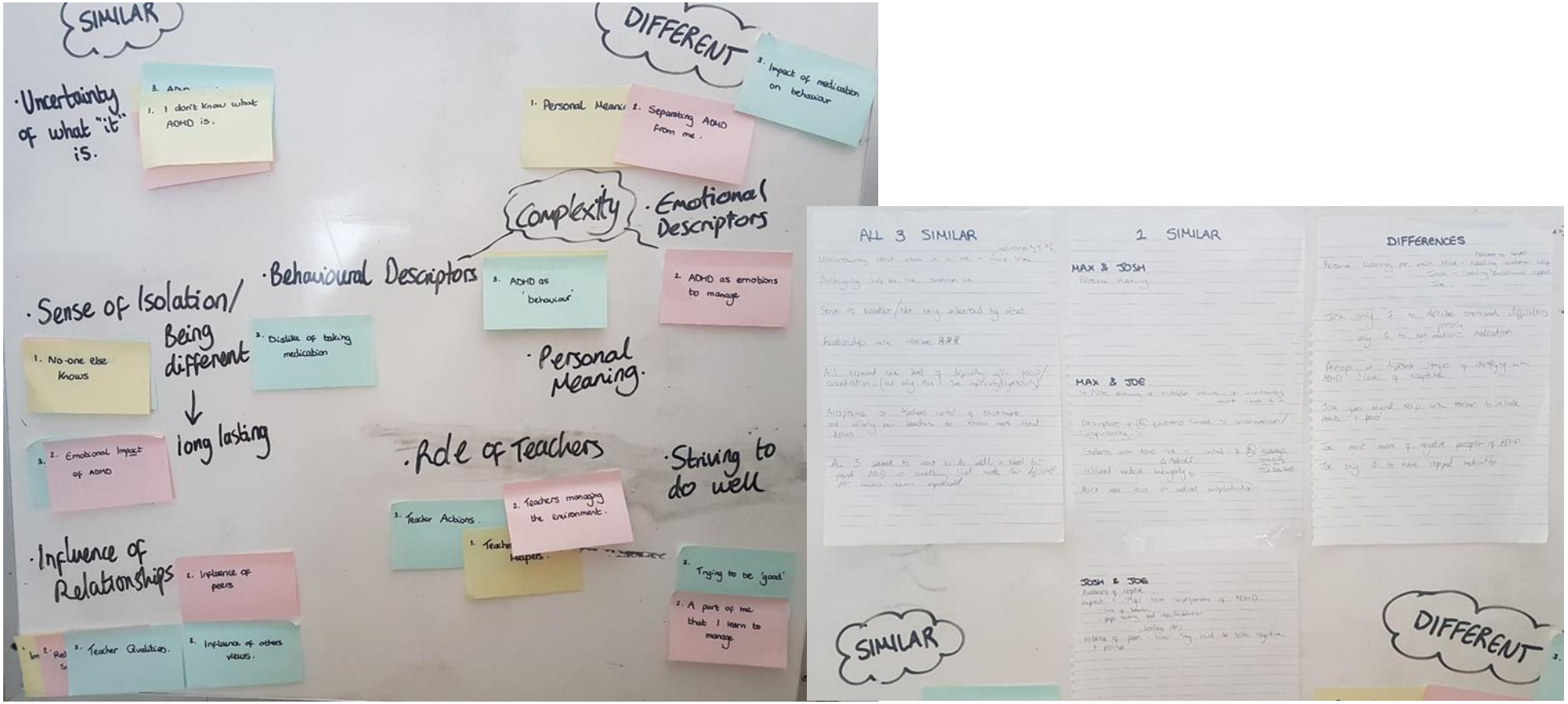
Negative Feelings about medication.	R	Yes lcads – even though I don't like it; I don't like taking it in the morning and I don't really agree with it, but it helps and I've noticed a change as well, because in Year 7 I was really good taking the mediation and then I stopped taking it for 3 or 4 months and then everyday my mum used to get phone calls from the school saying "Ahh Joe has been misbehaving today – you need to warn him about his behaviour or he won't be coming to school for the rest of the week". And then since I've been back on it I've had 'R's' which are reward points but despite being late I'm getting 'C's; I don't really get enough 'C's' anymore.	Don't agree with medication Don't like taking medication but know it helps. Concept of time change. Effect of (B) on others. And to self - loves praise/rewards. consequences. Being on medication gets rewards
Conflicting feelings about medication.	I	**That's good to hear. Why did you stop taking it?** (what are we communicating to young people with this message?)	
Medication changed me.	R	I didn't like taking it anymore, it was getting on my nerves, taking it every morning and evening and then getting forced to take it – I didn't want to take it anymore. (summarises)	frustration in voice - said quickly. Getting forced by others to take medication
Positives of medication	I	**Why was it getting on your nerves?**	
Other's expectations.	R	I just didn't like it, getting forced to take something I don't want.	Didn't want to take medication. getting on nerves.
Dislike of med'n	I	**Getting forced to?** (emphasis)	Getting forced to take - I don't want to.
Other's make me take med'n	R	Yes because I had to take it – I wasn't really getting forced but I kept getting erm, I kept getting told to take it and I didn't want to and it got really frustrating and I didn't take it anymore, I just stopped taking it.	Other people's expectations Vs My own wishes.
It's my body!	I	**So you felt frustrated about being told that you had to take it?**	Getting told to take it. I didn't want to. Frustrating. I just stopped.
Dislike of med'n	R	Yes.	Still don't like taking it, but I and others notice change.
positives of med'n	I	**But then when you did take it, you felt like it did help with your behaviour, but there was still a part of you that didn't really like having to take it?** (pause.)	Affects how other people feel about me = Affects how I feel about myself.
Changes me.	R	Yes. I really don't like taking it but again, I've seen a change in my behaviour and everyone else has too. They are proud of me taking it and they know it is helping. Erm yeah they are proud. They are happy to see me take it and it really helps me and other people.	Repeats idea of others being proud
Dislike of med'n	I	**How do you feel about it now?**	Really don't like taking it,

❖ Step 4 Searching for connections across emergent themes for Miss Langstone

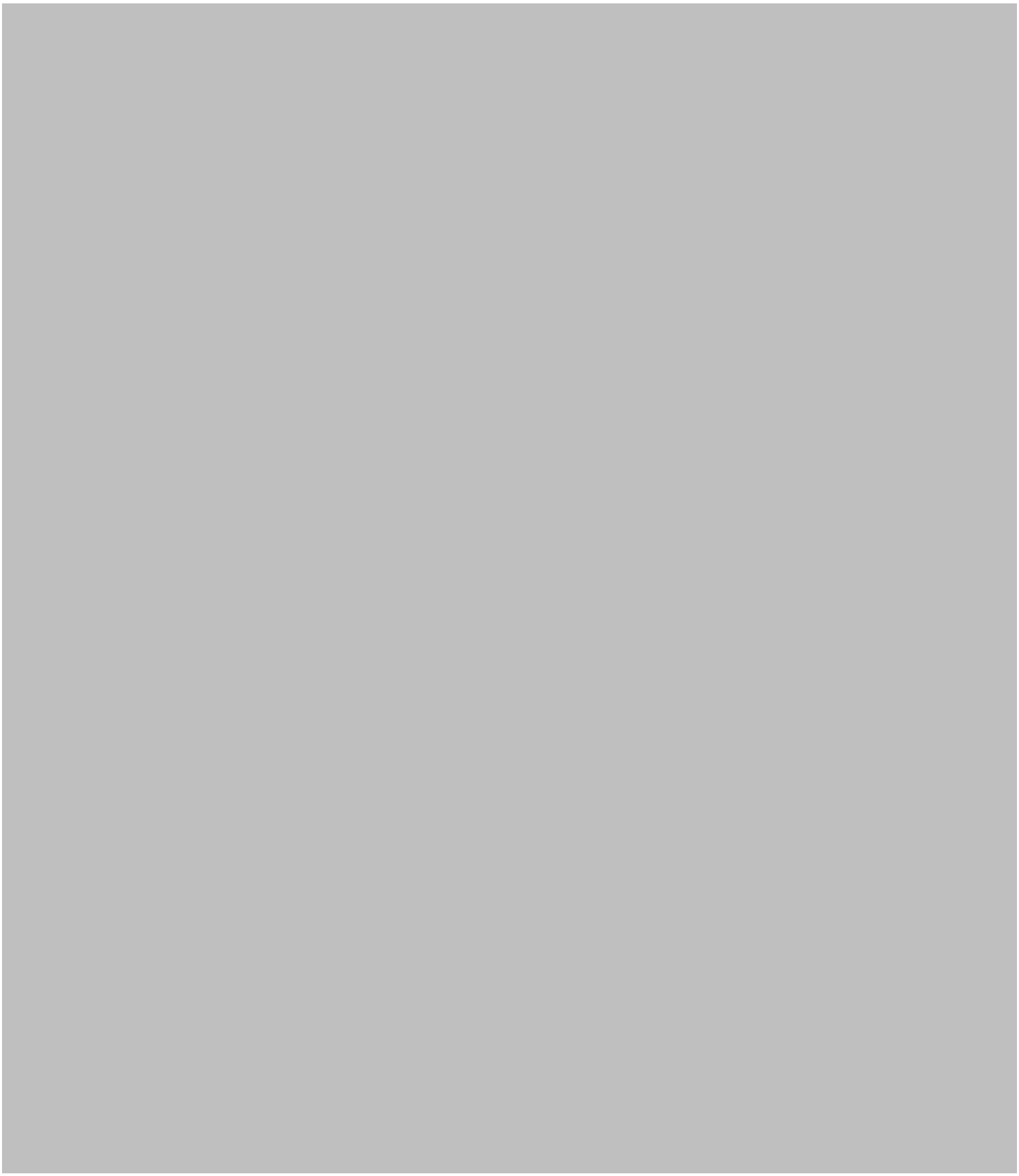


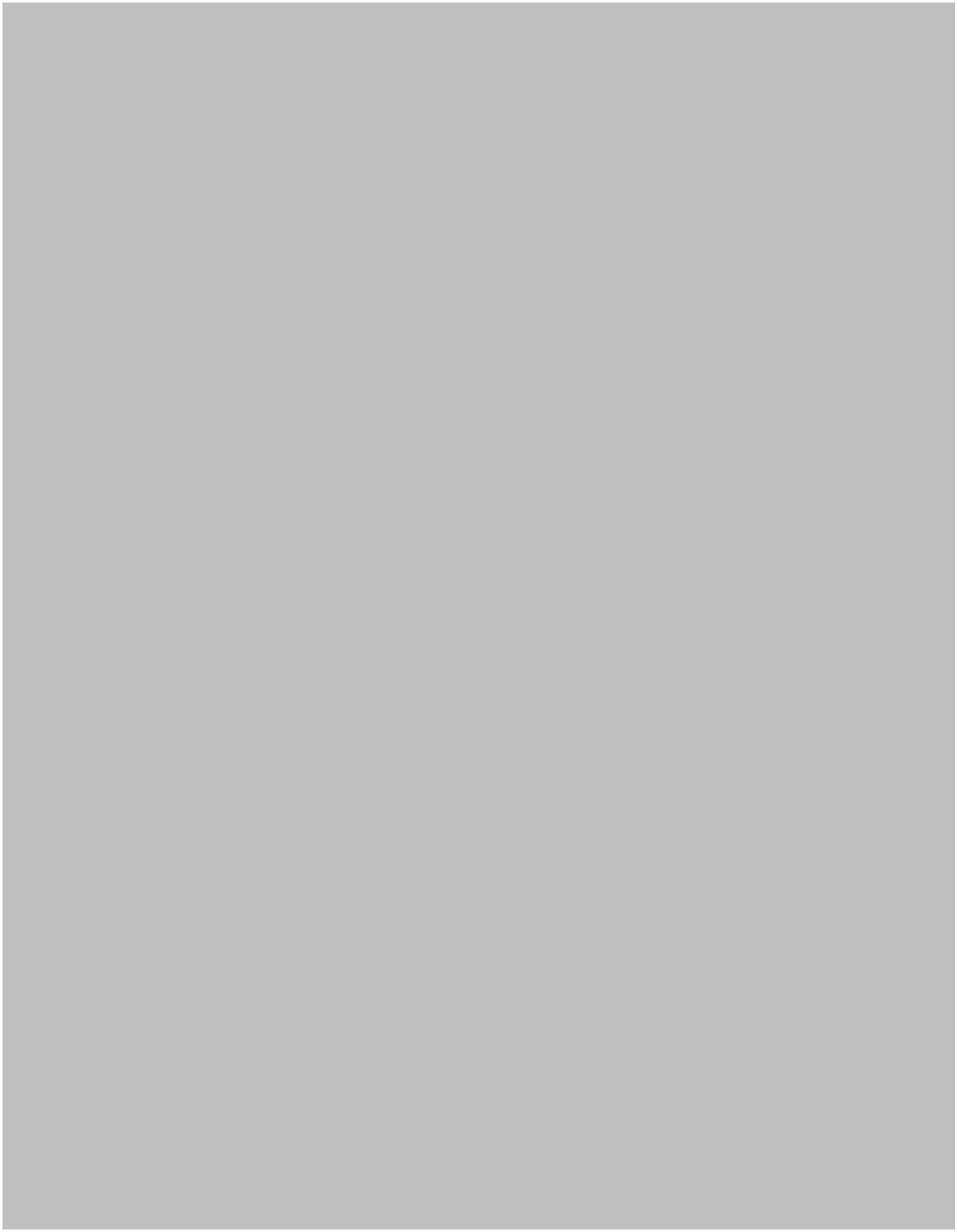


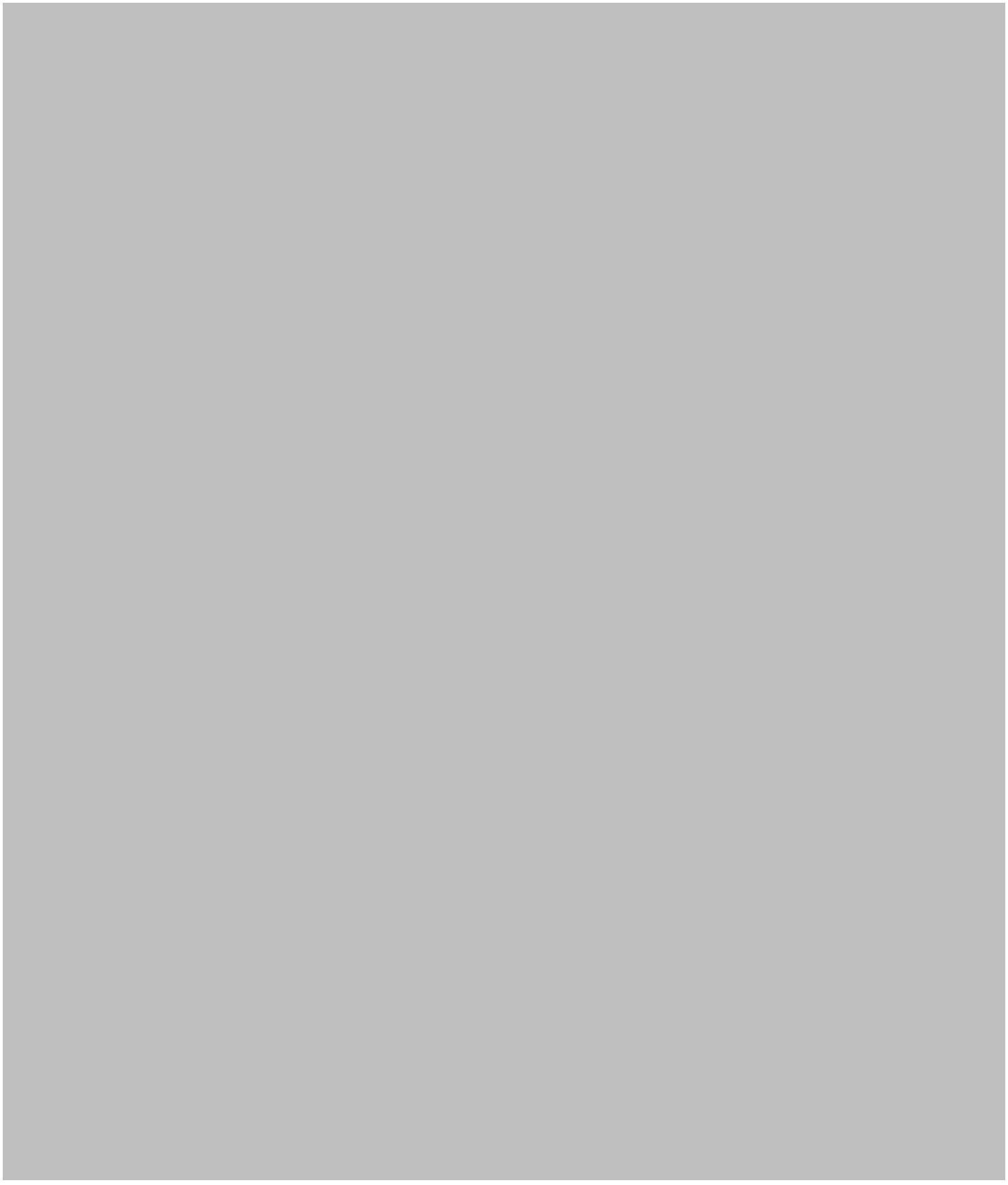
❖ Step 6: Looking for patterns across cases (developing group themes for students)

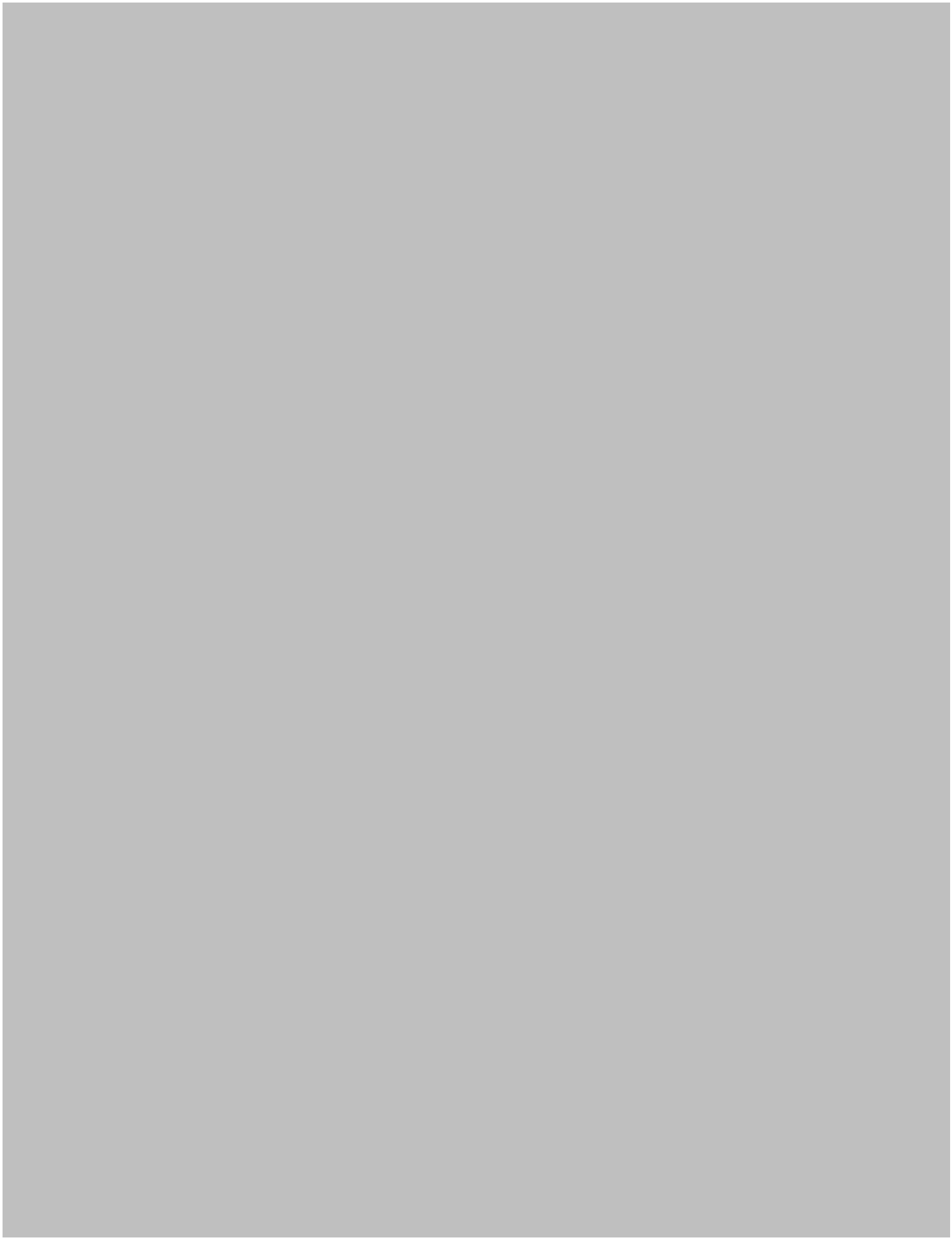


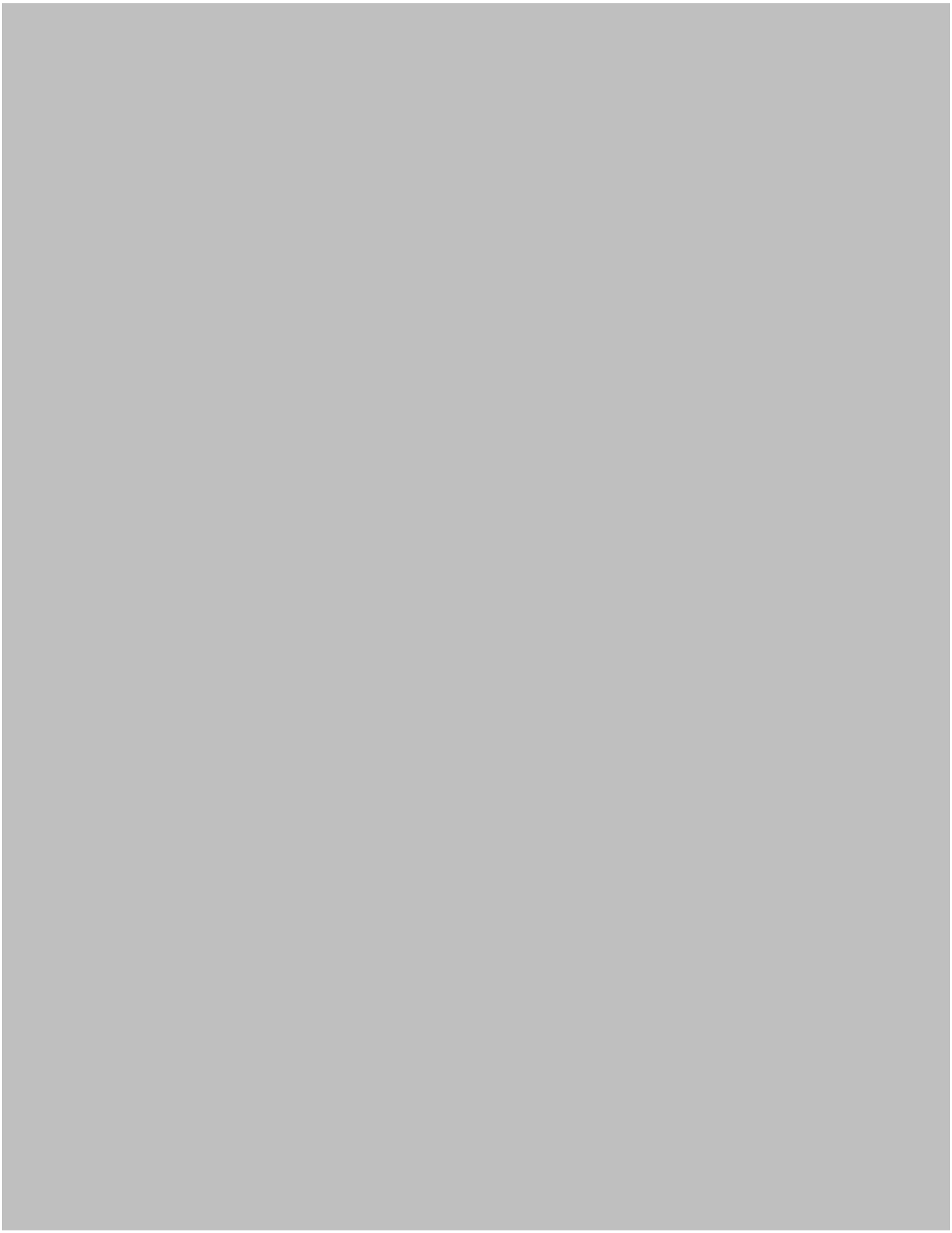
Appendix 8: Application for Ethical Review and confirmation of favourable ethical opinion from the University of Birmingham Research Ethics Committee (June 2014)

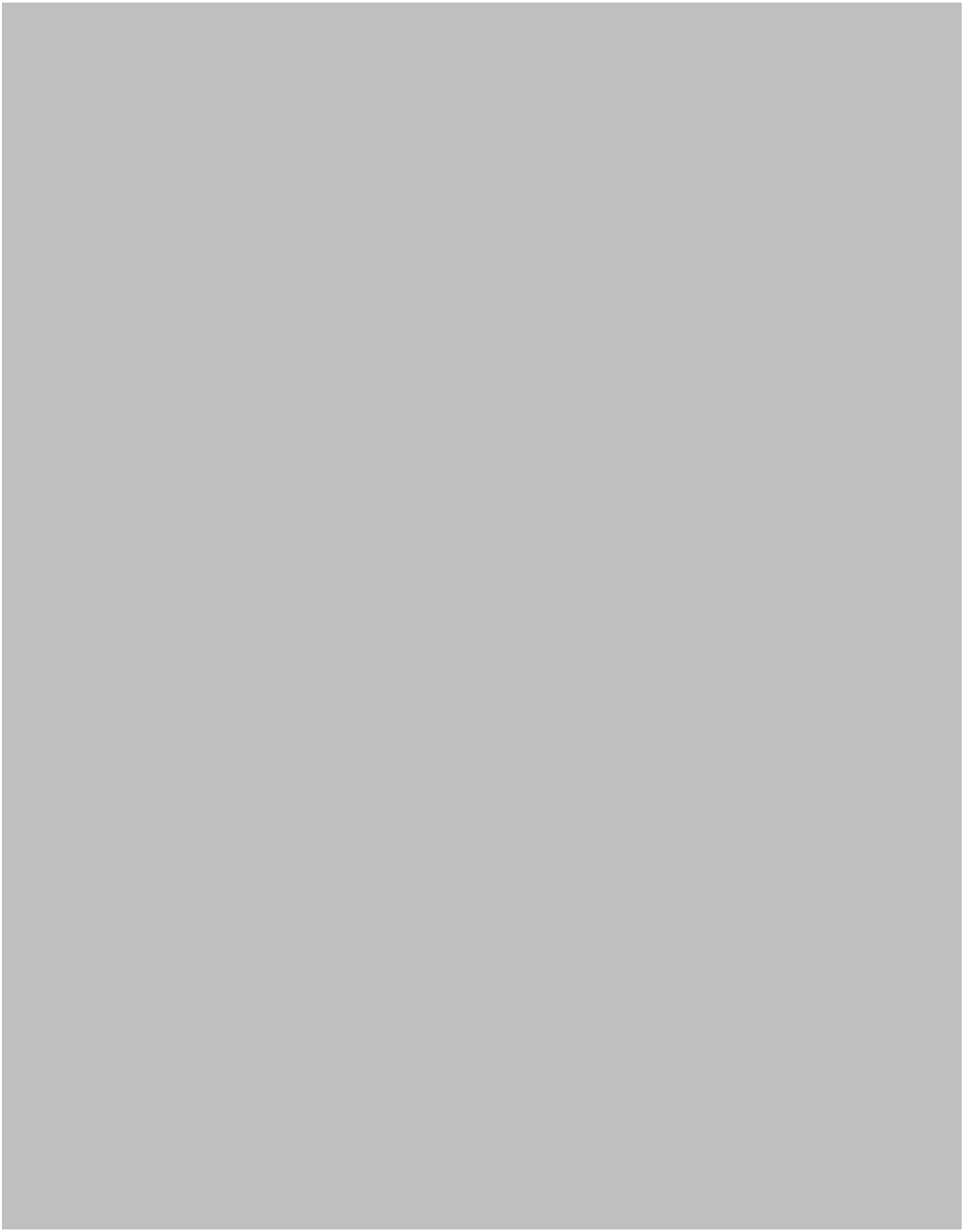


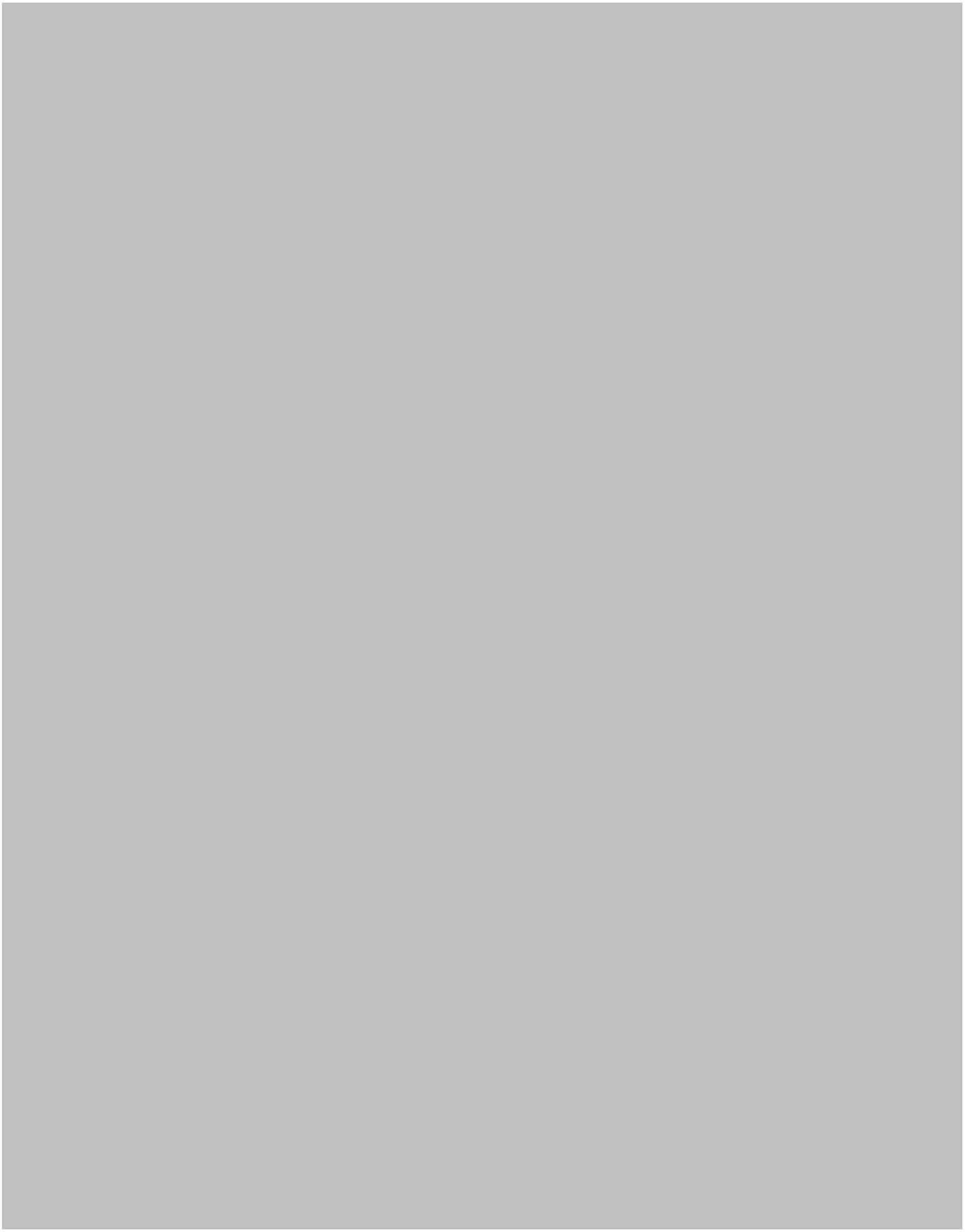


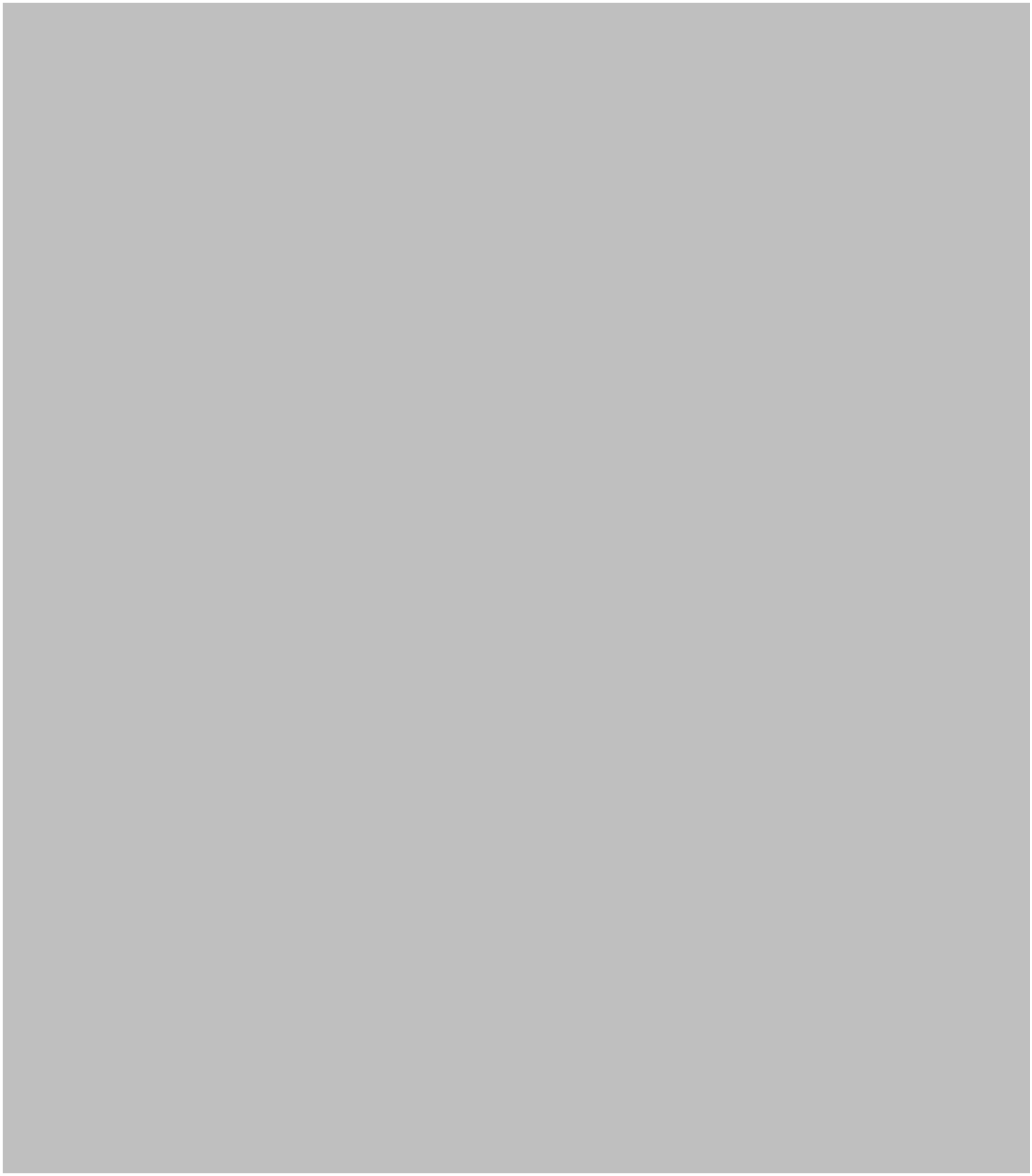


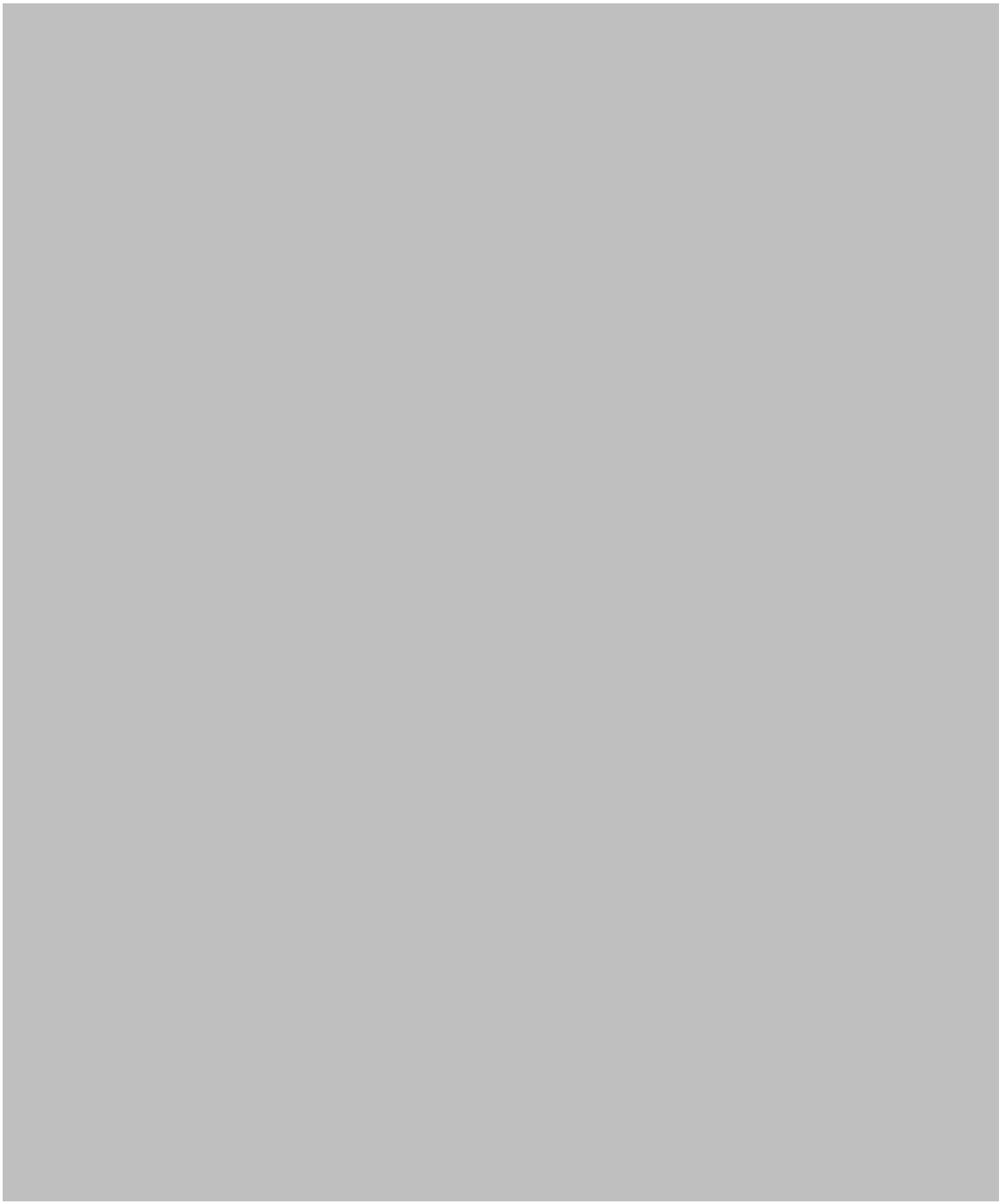


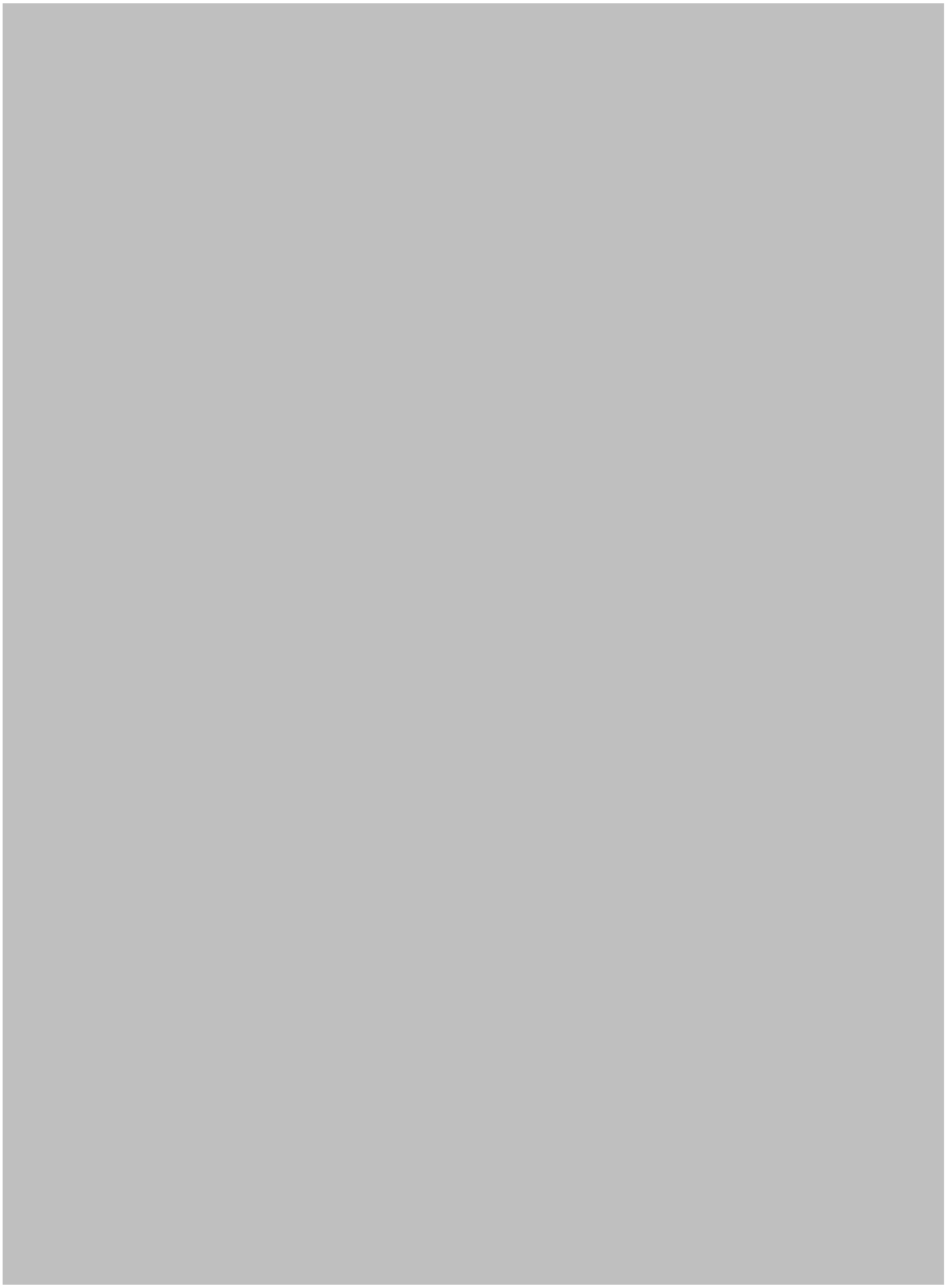


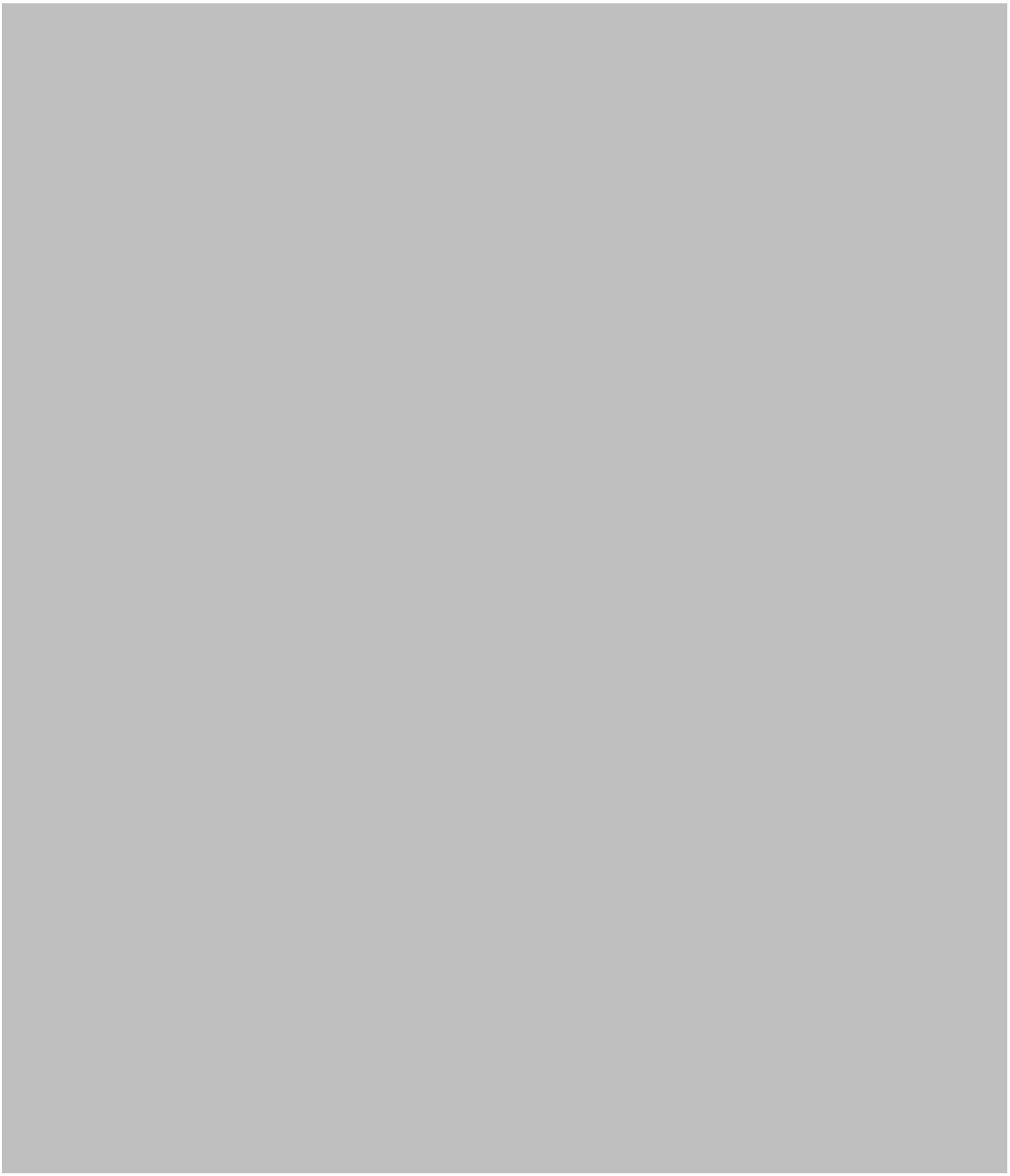




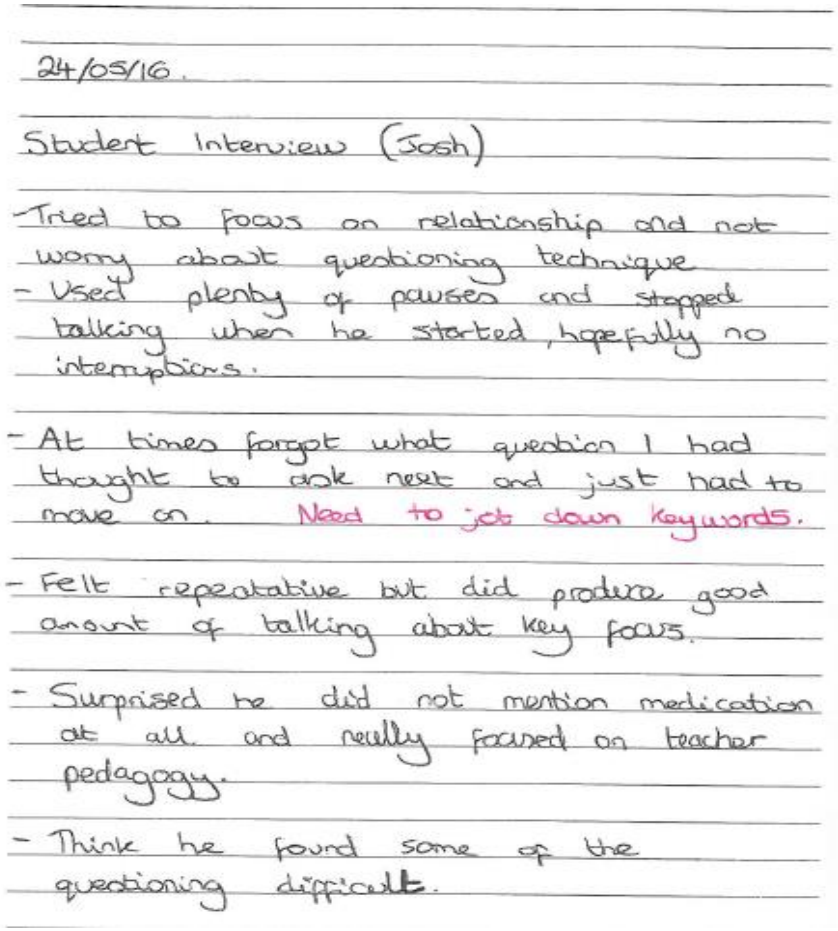








Appendix 9: Extracts from Research Diary



24/05/16.

Student Interview (Josh)

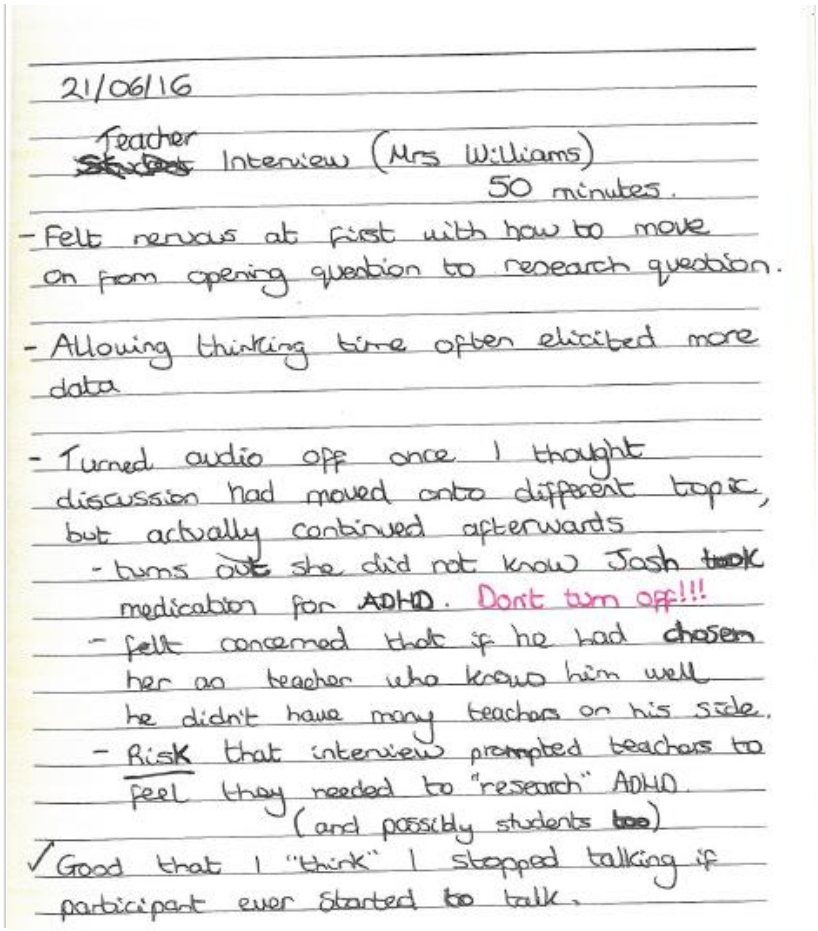
- Tried to focus on relationship and not worry about questioning technique
- Used plenty of pauses and stopped talking when he started, hopefully no interruptions.

- At times forgot what question I had thought to ask next and just had to move on. Need to jot down keywords.

- Felt repeatative but did produce good amount of talking about key focus.

- Surprised he did not mention medication at all and really focused on teacher pedagogy.

- Think he found some of the questioning difficult.



21/06/16

Teacher ~~Student~~ Interview (Mrs Williams)
50 minutes.

- Felt nervous at first with how to move on from opening question to research question.

- Allowing thinking time often elicited more data

- Turned audio off once I thought discussion had moved onto different topic, but actually continued afterwards
  - turns out she did not know Josh took medication for ADHD. Dont turn off!!!
  - felt concerned that if he had chosen her as teacher who knows him well he didn't have many teachers on his side.
  - Risk that interview prompted teachers to feel they needed to "research" ADHD (and possibly students too)

✓ Good that I "think" I stopped talking if participant ever started to talk.