

How do Young People Diagnosed with ADHD Perceive their Condition?: An Interpretative Phenomenological Analysis

Orla Kenny

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Professional Doctorate in Educational and Child Psychology.

April 2016

Abstract

Attention Deficit Hyperactivity Disorder (ADHD) is one the most prevalent of childhood diagnoses. There is limited research available from the perspective of the child or young person with ADHD. The current research explored how young people perceive ADHD. A secondary aim of the study was to explore to what extent they identify with ADHD. Five participants took part in this study. Their views were explored using semi-structured interviews guided by methods from Personal Construct Psychology. The data was analysed using Interpretative Phenomenological Analysis (IPA). Data analysis suggests that the young people's views of ADHD are complex and, at times, contradictory. Four super-ordinate themes were identified: What is ADHD?, The role and impact of others on the experience of ADHD, Identity conflict and My relationship with ADHD. The young people's contradictory views on ADHD are reflective of portrayals of ADHD in the media. A power imbalance was also identified where the young people perceive that they play a passive role in the management of their treatment. Finally, the young people's accounts revealed a variety of approaches taken to make sense of their condition.

Declaration

University of East London

School of Psychology

Doctorate in Educational and Child Psychology

Declaration

I declare that while registered as a research degree student at UEL, I have not been a registered or enrolled student for another award of this university or of any other academic or professional institution.

I declare that no material contained in the thesis has been used in any other submission for an academic award.

I declare that my research required ethical approval from the University Ethics Committee (UREC) and confirmation of approval is embedded within the thesis.

Signature:

Date: 21.4.16

A handwritten signature in cursive script that reads "Orla Kenny". The signature is written in dark ink on a white background.

Acknowledgements

Firstly, I would like to thank the young people who took part in this research for sharing their stories and experiences with me. Without them this research would not have been possible.

I would like to thank my academic supervisor, Helena, for her kind words of wisdom and guidance throughout my research journey. I would also like to thank my placement supervisor, Shirley, for her support and encouragement.

Finally, I would like to thank my family and friends for their understanding and support.

Table of Contents

Abstract	i
Declaration	ii
Acknowledgements	iii
List of Tables	ix
List of Figures	ix
Table of Abbreviations used	x
CHAPTER ONE: INTRODUCTION	1
1.1. Chapter Overview	1
1.2. PART ONE: History of ADHD	1
1.3. Theories of ADHD	6
1.3.1. Biological Discourses on ADHD	6
1.3.1.1. <i>The Executive Dysfunction Theory</i>	6
1.3.1.2. <i>The State Regulation Model</i>	7
1.3.1.3. <i>The Delay Aversion and Dual Pathways Theories</i>	7
1.3.1.4. <i>The Dynamic Developmental Theory of ADHD</i>	8
1.3.1.5. <i>Findings from genetic studies of ADHD</i>	8
1.3.2. Sociological Discourses on ADHD	9
1.3.3. A Bio-psycho-social Perspective on ADHD	10
1.4. Conclusion of Part One	10
1.5 Part Two: Context of the Research	11
1.5.1. National Context of the Research	11
1.5.2. Local Context of the Research	12
1.6. The Current Research	12
1.6.1. Researcher's Position	13
1.6.2. Relevance to Educational Psychology	14
1.7. Conclusion of Part Two	14
CHAPTER TWO: LITERATURE REVIEW	16
2.1. Chapter Overview	16
2.2. Methodology of the Systematic Literature Review	16
2.2.1. Stage one: Scoping the Literature	17
2.2.2. Stage two: Filtered Down Search	18
2.2.3. Stage three: Final Studies	19
2.3. Analysis of Body of Research	21
2.3.1. Quality of Life and ADHD	21
2.3.1.1. <i>Research on quality of life and ADHD</i>	22

3.5.3. Stage 3: Clustering of Themes.....	52
3.5.4. Stage 4: Final Super-ordinate Themes.....	53
3.5.5. Stage 5: Integration of Cases.....	53
3.5.6. Reflexivity	53
3.6. Quality Assurance with Qualitative Research	54
3.6.1. Credibility	54
3.6.2. Transferability	55
3.6.3. Dependability	55
3.6.4. Confirmability	55
3.7. Ethical Considerations of the Research	56
3.7.1. Informed Consent.....	56
3.7.2. Duty of Care and Impact of the Researcher	56
3.7.3. Anonymity.....	56
3.7.4. Data Protection	57
3.8. Conclusion of Chapter	57
CHAPTER 4: RESULTS	58
4.1. Overview of the Chapter	58
4.2. Analysis and Interpretation of Super-ordinate Themes	63
4.2.1. Theme One: What is ADHD?	64
4.2.1.1. <i>Something in their body</i>	64
4.2.1.2. <i>Summary of sub-theme</i>	68
4.2.1.3. <i>My actions are speaking louder than my words</i>	69
4.2.1.4. <i>Summary of sub-theme</i>	74
4.2.1.5. <i>Summary of super-ordinate theme</i>	74
4.2.2. Theme Two: The role and impact of others on the experience of ADHD.....	74
4.2.2.1. <i>Us vs Them</i>	75
4.2.2.2. <i>Summary of sub-theme</i>	78
4.2.2.3. <i>Understanding and Support</i>	78
4.2.2.4. <i>Summary of understanding and support</i>	83
4.2.2.5. <i>Summary of Super-ordinate theme</i>	83
4.2.3. Theme Three: Identity Conflict	83
4.2.3.1. <i>I don't feel like a normal kid</i>	84
4.2.3.2. <i>Summary of sub-theme</i>	86
4.2.3.3. <i>Multiple Selves</i>	86
4.2.3.4. <i>Summary of sub-theme</i>	94
4.2.3.5. <i>Summary of Super-ordinate theme</i>	94
4.2.4. Theme Four: My relationship with ADHD	94
4.2.4.1. <i>Just concentrating on the wrong thing</i>	95

4.2.4.2. Summary of sub-theme	96
4.2.4.3. Questioning	96
4.2.4.4. Summary of sub-theme	98
4.2.4.5. Distancing	98
4.2.4.6. Summary of sub-theme	100
4.2.4.7. Summary of Super-ordinate theme	100
4.3. Conclusion of Chapter	100
CHAPTER FIVE: DISCUSSION	101
5.1. Overview of the chapter	101
5.2. Discussion of Findings Related to the Research Aims	101
5.2.1. RQ1: How do young people diagnosed with ADHD perceive their	101
condition?	101
5.2.1.1. Links to current research and theory	102
5.2.2. RQ2: Do young people identify with their diagnosis?	106
5.2.2.1. Links to current research and theory	107
5.3.1. Summary of Chapter	111
CHAPTER SIX: CONCLUSION	112
6.1. Summary of the Main Findings	112
6.2. Strengths and Weaknesses of the Research	112
6.2.1. Sample Size and Characteristics	113
6.2.2. Power Imbalance	113
6.2.3. Language Demands	114
6.3. Future Research	114
6.4. Implications for Practice	114
6.5. Closing Reflections	116
7. References	120
Appendix 1: Search methodology details	133
Appendix 2: Study Characteristics	142
Appendix 3: Interview Schedule	152
Appendix 4a: Interview aids-Blob Tree	155
Appendix 4b: Interview Aids-School situation pictures	156
Appendix 5a: Research information sheet for schools	162
Appendix 5b: Consent form for schools	163
Appendix 6a: Research information sheet for parents and young people	164
Appendix 6b: Consent form for parents	165
Appendix 6c: Consent form for young people	166
Appendix 7: Example of analysis- Individual case	167

Appendix 8: Example of analysis-Group	198
Appendix 9: Young people’s drawings of ADHD.....	203
Appendix 10: Extract from research diary	204
Appendix 11: Contents of USB Stick.....	205
Appendix 12: Ethical Approval.....	206

List of Tables

CHAPTER	TABLE		PAGE
2	2.1	Inclusion and exclusion criteria for the initial scoping search	18
2	2.2	Inclusion and exclusion criteria for the final search	19
3	3.1	Summary of Research Framework	37
3	3.2	Participant information	50
4	4.1	Individual Super-ordinate and sub-ordinate themes	59-60
4	4.2	Summary of Group Super-ordinate themes	61-61
4	4.3	Transcription Key	63

List of Figures

CHAPTER	FIGURE		PAGE
2	2.1	Prisma flow chart	20
4	4.1	Super-ordinate theme one	64
4	4.2	Super-ordinate theme two	74
4	4.3	Super-ordinate theme three	84
4	4.4	Super-ordinate theme four	95
5	5.1	Super-ordinate themes one and two	102
5	5.2	Super-ordinate theme three	107
5	5.3	Super-ordinate theme four	109

Table of Abbreviations used

ADHD	Attention Deficit Hyperactivity Disorder
APA	American Psychiatric Association
BPS	British Psychological Society
DSM V	Diagnostic and Statistical Manual of Mental Disorders, 5 th edition
EP	Educational Psychologist
GP	General Practitioner
HKD	Hyperkinetic Disorder
ICD	International Classification of Mental Health and Behavioral Disorders, 10 th edition
IPA	Interpretative Phenomenological Analysis
NICE	National Institute of Clinical Excellence
PIB	Positive Illusory Bias
SDT	Self-Determination Theory
SEMH	Social, Emotional and Mental Health
TEP	Trainee Educational Psychologist
QoL	Quality of Life
WHO	World Health Organisation

CHAPTER ONE: INTRODUCTION

1.1. Chapter Overview

This chapter provides an introduction to the current research and it is divided into two parts. Part one examines ADHD as a concept. It begins by defining ADHD and continues to provide an overview of the history of ADHD and how this has shaped the conceptualisation of it. This includes a critical discussion of the controversial nature of the concept ADHD. Next, the researcher reviews ADHD from a variety of perspectives. Part one concludes with a summary.

Part two describes the current research. It begins with an outline of the national and local context of the research. The researcher then states her position on ADHD and how this may impact upon the research. Following this, there is an outline of the current research and its relevance to Educational Psychology. Part two concludes with a summary.

1.2. PART ONE: History of ADHD

The diagnosis and treatment practices for ADHD in England are informed by NICE guidelines which were published in 2008 and have since been updated in 2013 (to include information about ADHD in adults) and in 2016 (to include dietary advice). These guidelines recommend that ADHD should be diagnosed through the use of the tools such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) which is the American Psychiatric Association's (APA) classification manual of mental health conditions (APA, 2013).

The DSM-V defines ADHD as a neurodevelopmental disorder characterised by developmentally inappropriate levels of inattention, hyperactivity and impulsivity (APA, 2013). The symptoms must be present before the age of 12 years old and these symptoms must persist in multiple settings for a period longer than six months. The DSM-V (APA, 2013) specifies three distinct presentations

of ADHD: combined presentation: predominantly inattentive presentation; and predominantly hyperactive/impulsive presentation. The DSM-V (APA, 2013) defines ADHD as being mild, moderate or severe. Diagnostic criteria have been introduced for adults presenting with ADHD.

The International Classification of Mental Health and Behavioral Disorders (ICD-10) is the World Health Organisation's classification system for mental health conditions (WHO, 2010). The ICD-10 (WHO, 2010) uses the term Hyperkinetic Disorder (HKD) rather than ADHD. It does not classify the disorder into sub-groups rather it defines HKD as "as a persistent and severe impairment of psychological development, characterised by early onset; a combination of overactive, poorly modulated behaviour with marked inattention and lack of persistent task involvement; and pervasiveness, over situations and persistence over time of these behavioural characteristics" (WHO, 2010). The ICD-10 also acknowledges that symptoms can continue into adulthood.

However, the definition of ADHD provided above would must certainly be challenged. This will be discussed further in section 1.3.2. From the researcher's social constructionist position, it is important to reflect upon the history of ADHD as its conceptualisation has been influenced by social, cultural, economic, technological and political conditions (Smith, 2013). Rafalovich (2004) argues that although mental health disorders are often perceived as being medical problem, it is naïve to ignore the impact of social influences on mental health disorders.

Over time, a variety of terms have been employed to describe the collective symptoms of ADHD: hyperkinetic impulse disorder, organic brain syndrome, minimal brain damage, minimal brain dysfunction and Attention Deficit Disorder (Smith, 2013). In some form or another, ADHD has been recognised as a disorder in the by the APA since 1968 (APA, 1968). However, the earliest known recording of individuals presenting with what appears to be 'ADHD symptoms' dates back to documents from the 18th, 19th and early 20th century. For example, Alexander Crichton in 1798 is often cited as being the first

physician to record what appears to be a condition similar to ADHD (Crichton, 2008). Another often cited early depiction of ADHD comes from the children's story of 'Fidgety Philipp'. This is part of series of stories created by a German psychiatrist, Heinrich Hoffmann, in the late 19th century (Lange, Reichl, Lange, Tucha & Tucha, 2010). The story depicts a young boy who is struggling to sit still and listen whilst having dinner with his family. The story concludes with the boy falling off his chair and pulling the table cloth off the table together with its contents. Again, many of the descriptions of the boy correlate with the criteria for hyperactivity and inattention that are used to diagnose ADHD today. However, some have argued that Hoffman was not interpreting these behaviours as being a disorder rather he was telling a moral tale of a misbehaving child (for further details please see, Lange et al., 2010).

Sir George Frederick Still was the first Professor of Paediatrics in England at King's College Hospital in London (Farrow, 2006). He presented a series of lectures entitled 'On some abnormal psychical conditions in children' (Still, 1902) which many feel initiated the scientific study of ADHD as it is considered today. Still's (1902) descriptions of a group of children who presented with difficulties in self-regulation and sustaining attention share some characteristics associated with ADHD. Still (1902) felt that these children had a "defect of moral control...without general impairment of intellect and without physical disease" (p.1079). His contribution to the study ADHD was his separation of impulsive symptoms from general intellectual difficulties and physical diseases (Conners, 2000)

In the 1930s, two German physicians, Franz Kramer and Hans Pollnow began reporting a condition which they referred to as a "hyperkinetic disease of infancy" (Krammer & Pollnow, 1932, p.39). Kramer and Pollnow's list of symptoms share several similarities with ADHD, such as references to hyperactivity, inattentiveness, and impulsivity. They also discussed the impact that this could have upon the child's education. A significant stage in the transition towards the today's conceptualisation of ADHD stems from the worldwide encephalitis lethargica epidemic which spanned from 1917-1928 (Rafalovich, 2001). Ross and Ross (1976) stated that many of the children affected became "hyperactive, distractible, irritable, antisocial, destructive,

unruly, and unmanageable in school. They frequently disturbed the whole class and were regarded as quarrelsome and impulsive, often leaving the school building during class time without permission” (p.15). The descriptions of these children also share some characteristics with ADHD as it is conceptualised today. However, the importance of this work lies in the interest it created about hyperactivity in children (Lange et al., 2010). Linking hyperactivity to brain damage is significant as it marked the beginning of viewing hyperactivity as a medical condition requiring medical treatment (Rafalovich, 2004).

Smith (2013) argues that to truly understand fully how ADHD as a condition emerged, one must critically reflect upon the medicalisation of hyperactivity. Hyperactivity was first treated with a medical intervention in 1937. Bradley (1937) was working as a medical director in a hospital for children with neurological impairments. He was interested in studying brain structures. His neurological examinations often resulted in severe headaches for his young patients, which he treated using a stimulant drug (Lange et al., 2010). He noted an interesting side effect, a marked improvement in the behaviour of the children and their approach to learning. However, as argued by Brown (1998), Bradley’s work was not influential at the time as psychoanalysis was prominent and behavioural disorders were not generally seen as having an organic origin. However, in the 1950s, interest was growing in the use of stimulant drugs to treat behavioural disorders (Lange et al., 2010). In 1954, Ritalin, a now well-known drug was first marketed to treat hyperkinetic children (Lange et al., 2010).

As discussed earlier, linking hyperactivity to brain damage in the 1920s was a significant turning point as it led many to believe that any child who presented with behavioural difficulties had experienced some form of brain damage. This belief led to the conceptualisation of minimal brain disorder (Lange et al., 2010). The idea that hyperactivity and brain damage were linked gained momentum and credibility due to the work of Strauss and Lentinen (1947) and Strauss and Kephart (1955). These theorists believed that hyperactive behaviour alone was symptomatic of brain damage. However, by the 1960s this work was being challenged. In 1963, the Oxford International Study Group of Child Neurology (Bax & MacKeith, 1963) argued that brain damage cannot be inferred purely

from behavioural symptoms alone and that hyperactivity was the result of a functional disturbance rather than damage to the brain (Lange et al., 2010). The result of this debate was a change of terminology from minimal brain disorder to minimal brain dysfunction (Ross & Ross, 1976). The debate continued and a national task force was created with the aim of establishing a definition for minimal brain dysfunction (Lange et al., 2010). The resulting definition established the three core symptoms together in a disorder that are today referred to as ADHD. Minimal brain dysfunction was defined as follows:

“The term minimal brain dysfunction refers to children of near average, average or above average general intelligence with certain learning or behavioural disabilities ranging from mild to severe, which are associated with deviations of function of the central nervous system. These deviations may manifest themselves by various combinations of impairment in perception, conceptualisation, language, memory and control of attention, impulse or motor function” (Clements, 1966, p.9).

This definition also assumed a neurological basis for the disorder rather than the social and environmental factors suggested by psychoanalysts (Lange et al., 2010). However, the definition was criticised as it lacked an empirical base. Barkley (2006) argued that it was too general and that it actually represented a number of labels that are used today such as ‘dyslexia’, ‘language disorders’, and ‘hyperactivity’. However, the concept of hyperactivity as a disorder persisted and in 1968 it entered the DSM’s second edition (APA, 1968) under the label of ‘Hyperkinetic Reaction of Childhood’.

There have been multiple changes to the definition of ADHD since then. There was a shift in how this disorder was conceptualised and some began to argue that difficulty with attention not hyperactivity was the most pervasive feature (Douglas, 1972). In response to this development, the APA (1980) then renamed the disorder ‘Attention Deficit Disorder’ in its third edition. In response to further debate, the APA (1987) introduced the term ‘Attention Deficit Hyperactivity Disorder’ in 1987. ADHD has since then undergone more re-conceptualisations. The most recent changes to the definition of ADHD are

outlined in the fifth edition of the DSM–V (APA, 2013). Thus it can be seen that ADHD as a condition has emerged as a result of intense academic and social debates on hyperactivity and inattention. ADHD is a condition that divides opinion.

1.3. Theories of ADHD

1.3.1. Biological Discourses on ADHD

It is beyond the scope of this introduction to evaluate critically the immense number of neurobiological studies carried out in relation to ADHD. Rather, an overview will be briefly presented to provide the reader with an understanding of the most prominent theories in this area. Research appears to focus on the following: structure and function of the brain, brain size, neurochemicals and genetic studies.

There are a number of theories that argue for a neurobiological basis for ADHD. Johnson, Wiersema and Kuntsi (2009) provide a critical overview of four of the most prominent psychological theories of ADHD. The main points of these theories will be critically discussed below.

1.3.1.1. The Executive Dysfunction Theory

Findings from neuroimaging studies suggest that there are structural and functional differences in the brains of those with and without ADHD. In particular, differences have been noted in the frontal regions of the brain which is responsible for carrying out executive functions (for an overview please see Armstrong, 2010). The executive functions are “brain circuits that prioritise, integrate, and regulate other cognitive functions” (Brown, 2006 p. 36). The Executive Dysfunction Theory makes explicit links between ADHD and deficits in the frontal region of the brain (Barkley, 1997; Willcut, Doyle, Nigg, Faraone & Pennington, 2005). However, the relationship between ADHD and executive function is not fully understood and it continues to be debated (Brown, 2006). Researchers are not clear on whether these differences are due to brain abnormalities or a maturational lag. Longitudinal studies have shown that the brains of those with ADHD do follow normal patterns of development, however, their brains develop at a slower rate approximately two to three years behind

their non-ADHD peers (Shaw et al, 2007). Further support for the maturational lag theory comes from studies which found that ADHD children showed delayed development of executive functions (e.g. Barkley, 1997; Rubia, 2007). Johnson et al. (2009) conclude that the Executive Dysfunction Theory can account for inattention and impulsivity as seen in ADHD, but not hyperactivity.

1.3.1.2. The State Regulation Model

Sergeant and Van der Meere (1990) developed the State Regulation Model of ADHD by drawing upon the earlier works of two other researchers: Sander's Cognitive Energetic Model of Information Processing (1983) and Sternberg's Addictive Factors Model (1969). Sergeant and Van der Meere (1990) argue that there are three energetic pools involved in information processing (arousal, activation and effort). According to this theory, ADHD is not the result of a deficit in attention, rather, it is the result of a deficit in regulation of effort and/or activation. Those affected by ADHD struggle to maintain the optimal activation states needed to carry out everyday tasks. ADHD symptoms can either increase or decrease depending on the individual's state at the time. For example, an individual may become hyperactive or impulsive to increase stimulation. The State Regulation Model argues that if children with ADHD can achieve an optimal state then task performance between them and typically developing peers should show minimal differences. However, as pointed out by Johnson et al. (2009), it is difficult to test this theory and it is not possible to clearly define what an 'optimal state' would be as it is likely to vary according to individuals and be context and/or task dependent.

1.3.1.3. The Delay Aversion and Dual Pathways Theories

The Delay Aversion Theory of ADHD was first suggested by Sonuga Barke, Taylor, Sembi and Smith (1992). This began as a motivational explanation for ADHD. Delay aversion (rather than impulsivity) refers to the tendency to opt for smaller but immediate rewards rather than larger but delayed rewards. However, Songa Barke (2003) reconceptualised this theory to include cognitive explanations and developed the Dual Pathways Theory. According to this, ADHD can develop along two 'pathways'; a cognitive pathway, which references executive dysfunction and a motivational pathway, which references delay aversion. This theory proposes that 'impulsivity' is at the core of ADHD

whilst hyperactivity and inattentiveness function to reduce the subjective experience of delay when it cannot be avoided. This theory is largely based on a number of studies that compare the performance of ADHD participants and controls during inhibition and delay aversion tasks. The authors of this theory continue to work on this model and they have since suggested a triple pathway model to include deficits in temporal processing (Songa Barke, Bitsakou & Thompson, 2010). As acknowledged by the authors, more research is needed in this area and the findings require further replication.

1.3.1.4. The Dynamic Developmental Theory of ADHD

The Dynamic Developmental Theory of ADHD was suggested by Sagvolden and colleagues (Sagvolden, Johansen, Aase & Russell, 2005). This theory explains ADHD by considering a wide range of factors from neurotransmitters (dopamine) to societal factors. It finds its roots in behaviourism and it is based on animal studies. According to this theory, ADHD is caused by two behavioural principles: altered reinforcement and extinction processes, which result in the observable behaviours seen in ADHD. Children with ADHD have a reduced 'window of opportunity' for reinforcers to associate themselves with a behaviour. This means that socially desirable behaviours may not be reinforced in time. Extinction will occur when the reinforcer stops being delivered and the behaviour is no longer elicited. It is suggested that children with ADHD will experience faulty extinction processes due to lowered levels of dopamine. Johnston et al. (2009) appear to favour this theory of ADHD. They conclude that it provides a comprehensive theoretical framework for ADHD, although it needs to be extended to include experiments with humans.

1.3.1.5. Findings from genetic studies of ADHD

Some researchers argue that ADHD is a heritable disorder, however, current findings from genetic studies are inconsistent and inconclusive (for further reading see Li, Chang, Zhang, Gao & Wang, 2014). Thapar, Cooper, Eyre and Langley (2013) reviewed the research evidence for the causes of ADHD by critically examining the research base over a 15 year period. They conclude that no single risk factor can explain ADHD, rather, both inherited and non-inherited factors are involved. They also note that research in this area has shown an overlap between ADHD and other neurodevelopmental conditions such as

Autism Spectrum Disorders. They identified the following as possible risk factors associated with ADHD: having a biological relative with ADHD, some gene variants, extreme early adversity, prenatal and postnatal exposure to lead and low birth weight/prematurity.

1.3.2. Sociological Discourses on ADHD

As highlighted throughout this chapter, ADHD is a condition that divides opinion. Many theories and aetiologies have been put forward to explain ADHD (for a detailed discussion, please see above). However, some writers challenge its very existence and strongly contest the conceptualisation of ADHD as a medical condition.

Rafalovich (2004) has argued that ADHD evolved as a result of social forces coming together to create a medical condition. He considers ADHD from a sociological and genealogical perspective. The sociological perspective considers the medicalisation of deviant behaviour as an attempt to control and monitor individuals in society. Whilst the genealogical perspective considers the role of historical and contemporary discourses on how ADHD is perceived today (see Part one, section 1.2 for further details on how definitions of ADHD have been shaped through history).

In the past few decades, there has been an increase in the diagnosis and prescription of medication for childhood mental disorders (Timimi, 2010). Some view the increase as not stemming from our better informed practice but from a socio-political stance (Rafalovich, 2004; Timimi, 2010). Sami Timimi, a Consultant Child and Adolescent Psychiatrist in the UK, writes on mental health issues from a critical psychiatry perspective. Timimi (2004) argues that ADHD is best understood as a cultural construct and suggests that social, cultural and political contexts have changed how society perceives children and their emotions and behaviour (Timimi, 2010). Timimi (2010) argued that the use of medical practices to treat and manage children's emotional and behavioural problems has led to the "McDonaldization of children's mental health" (p.697). Timimi (2004) challenges ADHD on several grounds, such as the fact that there are no medical tests used to diagnosis it and the prevalence rates show great variability. In addition, those diagnosed with ADHD often have an additional

diagnosis which questions the specificity of the disorder (Timimi, 2004). Such sceptical views on ADHD have long been voiced. For example, Conrad (1976) argued that the medical treatment of ADHD is the result of three main factors; the pharmaceutical revolution, trends in the medical profession and the government. As early as 1976, Conrad strongly felt that the use medication to treat children who present with behavioural difficulties was a form of social control.

1.3.3. A Bio-psycho-social Perspective on ADHD

Cooper (2008) argued for a bio-psychosocial model of ADHD. This model encourages a more holistic view of ADHD rather than attempting to explain it through a single framework. ADHD is seen as arising from the inter-play between a biological predisposition to ADHD that is then influenced by psychological and social factors. This is the preferred model of the British Psychological Society (BPS, 2000) which states:

“A full understanding of AD/HD in a particular child requires consideration of biological factors (especially genetic influences and brain function), psychological factors (especially cognitive and emotional processes and the child’s internal world) and social factors (especially parental child rearing practices and classroom management)” (p. 10).

1.4. Conclusion of Part One

As can be seen from the discussion above, ADHD is a controversial condition and it continues to receive considerable research attention. Debates about ADHD range from its aetiology and diagnosis through to its treatment and prognosis. At the root of the debate on ADHD is how people construct it. Some view ADHD as a neurodevelopmental condition to be diagnosed (APA, 2013) whilst others view ADHD as being a social and cultural construct (Timimi, 2004). From each side, arguments are made to explain the concept of ADHD as we perceive it today.

1.5 Part Two: Context of the Research

1.5.1. National Context of the Research

Recognition of children's mental health in England is increasing. In the latest review of special educational needs, mental health was recognised as a category (Department of Education [DoE], 2014). Children with special educational needs are now classified according to four labels:

1. Communication and Interaction,
2. Cognition and Learning,
3. Social, Emotional and Mental Health,
4. Sensory and/or Physical.

The Social, Emotional and Mental Health (SEMH) category was previously labelled Behavioural, Emotional and Social Difficulties (BESD). The inclusion of mental health suggests that opinion is changing and there is now a growing recognition that there is a group of children and young people who experience mental health difficulties during their school life. ADHD comes under the SEMH category. In the UK, 3-9% of school age children are diagnosed with ADHD (NICE, 2013). As discussed earlier, the BPS views ADHD as stemming from an interplay of biological, psychological and social factors. As such the BPS supports a bio-psycho-social model of ADHD (BPS, 2000).

This research is interested in promoting the voice of the young person. In England, there has been an increase in interest on listening to children's perspectives on issues that matter to them. The Children and Families Act 2014 and the Code of Practice (DoE, 2014) emphasise the importance of collecting the views of children and young people themselves. The United Nations Convention on the Rights of the Child (UNCRC) (1990) states that;

“States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child” (Article 12).

This article defends children's right to have their voice heard and for it to be taken seriously.

1.5.2. Local Context of the Research

Whilst undertaking this research, the researcher worked as a trainee educational psychologist (TEP) in an outer London Borough. The research topic chosen followed the researcher's interests. The Educational Psychology Service, in which she worked, is part of a wider team of professionals such as specialist teachers, behaviour support teachers, Portage workers and a variety of professionals with skills and expertise in special educational needs. All secondary schools in the borough are run by Academy Trusts. Academies are publically funded independent schools in England. They receive funding directly by the government rather than through local authorities. In addition, some academies receive funds from businesses, universities, other schools, faith or voluntary groups.

The ADHD diagnostic process in the borough involves a core team of professionals; consultant community paediatrician, an educational psychologist and liaison with the local Child and Adolescent Mental Health Services (CAMHS). Referrals are generally made by general practitioners or schools. The team follow the DSM-V (APA, 2013) definition for diagnosing ADHD. Children and young people referred for an ADHD assessment are now also considered for an assessment for an Autism Spectrum Disorder.

1.6. The Current Research

The purpose of this study was to explore how young people diagnosed with ADHD perceive their diagnosis. A secondary aim of this study was to explore to what extent young people identify with their diagnosis. Thus, this research had the following purposes.

1. To explore how young people diagnosed with ADHD perceive their condition.

2. To explore to what extent young people diagnosed with ADHD identify with their diagnosis.

The researcher explored this from an Interpretative Phenomenological Analysis (IPA) perspective (Smith, Flowers & Larkin, 2009). IPA aims to gain an insider's perspective on the phenomenon of interest, in this case ADHD. Using this method allowed the research to assess the personal meanings that young people hold in relation to their ADHD diagnosis.

1.6.1. Researcher's Position

I am 30 year old Irish woman. I grew up in a village in the west of Ireland and I moved to the UK when I was 21 years old. At the time of carrying out the research, I was a TEP working and living in London.

My first encounter with the term ADHD came through the media. I rarely reflected upon ADHD until I began working in a school for young people with social, emotional and mental health needs. At this time, I noticed that many of the young people were diagnosed with ADHD. Further, there was a sense of confusion about what the label meant. For example, it was at times dismissed as an 'excuse' for misbehaviour yet at the same time it was perceived as a serious condition that required medical treatment.

As a TEP, I encountered a case of a young person diagnosed with ADHD. My role in this case was to deliver therapeutic sessions to this young person. I again reflected upon my understanding of ADHD. I began researching the condition through journals and books. I was struck by the vast amount of information and research that was available on the condition. Yet despite this, there was no consensus on what it was and it seemed to polarise opinions. It was at this point that I decided I would like to carry out research to understand more about this controversial condition. Furthermore, I was interested in exploring the condition from the perspective of young people.

Upon beginning my thesis research, I was aware that I too, was unclear on the meaning of ADHD. I have reflected upon this at length to uncover my underlying beliefs regarding ADHD. This research has supported me to shape my

understanding of ADHD. I believe that ADHD is a social construction. The label offers society a way to categorise people who deviate from expected behavioural norms. However, for the purposes of my research, I am not interested in debating whether ADHD is a valid condition or a social construction. I am interested in how young people who receive this label perceive the condition and if they identify with it. I aimed to engage with the lived experiences of the young people in this study.

1.6.2. Relevance to Educational Psychology

Educational psychologists (EPs) assess and support the educational, social and mental health needs of children and young people they work with. EPs may work with children and young people with ADHD pre-diagnosis or post-diagnosis. They may also be involved in the diagnostic process. They are in a privileged position to promote marginalised voices and bring them to an open forum. In England, EP practice is influenced by the Children and Families Act 2014 and the Special Educational Needs and Disabilities Code of Practice (DoE, 2014). The Children and Families Act 2014 emphasises that importance of collecting the views of children and young people themselves during assessments and when planning support. The Code of Practice (DoE, 2014) also has a strong focus on this. EPs may therefore in a position to introduce alternate ways of looking at ADHD. ADHD as discussed is controversial yet it is one of the most prevalent childhood diagnoses (Cooper, 2008). Amid the debates on its validity, 3-9% of school age children have received this label (NICE, 2013). It is thus imperative to improve understanding of the condition and the impact that it can have upon young people.

1.7. Conclusion of Part Two

This section reviewed the national and local context of the research. The researcher stated her position and outline the relevance of the research to Educational Psychology. As stated, this study aimed to explore ADHD by listening to the voices of young people diagnosed with the condition. It was hoped that exploring ADHD from this perspective, would provide insight to how

young people construct ADHD. The next chapter will provide a critical review of relevant literature on how ADHD is perceived.

CHAPTER TWO: LITERATURE REVIEW

2.1. Chapter Overview

The current researcher is interested in exploring how adolescents with ADHD perceive their condition. This chapter provides an overview of the relevant research in this area. A systematic search was carried using relevant search terms to establish what is currently known about this topic. The main body of the chapter critically assesses the identified research. This includes studies that explored how ADHD as a condition is perceived by both the public and by those diagnosed with the condition. It is argued that much of the research on perceptions of ADHD focuses on accounts from parents and teachers and the perceptions of the general public. However, research from the perspective of those diagnosed with ADHD tends to explore how they perceive some aspect of themselves rather than their condition specifically. For this reason, research on how adolescents with ADHD perceive themselves is also presented. Following on from this, the author discusses the gaps revealed by the above research and the relevance of the current research. The chapter concludes with a brief discussion of the theoretical underpinnings of the research.

2.2. Methodology of the Systematic Literature Review

This section outlines the methodology of the systematic literature search. The researcher followed Petticrew and Roberts' (2006) methodology. The review looks at the last ten years of research on perceptions of ADHD as a condition and how those with ADHD perceive themselves. The systematic search was carried out across four stages (presented below). When critiquing the identified literature, the author also addressed the following questions;

- What is the quality of the research?
- What methods have been employed to explore ADHD as a condition?

2.2.1. Stage one: Scoping the Literature

The primary purpose of this stage was to assess the types of studies that have been carried out exploring how ADHD as a condition is perceived. For this reason, initial searches were kept broad to allow a general picture to emerge from the literature. The electronic databases included: EBSCO (Academic Search Complete, CINAHL Plus, Education Research Complete, Psych Info, Psych Articles) and Scopus. They were selected as they are frequently used Psychology databases in the English language and were judged to identify the vast majority of relevant research on perceptions of ADHD.

The results of this initial scoping revealed a limited number of studies in this area. For this reason, the inclusion criteria were broadened, in order to allow for a larger number of papers to be reviewed. The search criteria were broadened to include papers on how those with ADHD perceive themselves, rather than focusing on the condition specifically. Perceptions of ADHD may vary based on cultural values and societal norms. The researcher included studies from outside the UK. Although some of this research may not necessarily be relatable to the UK context, it does provide a more comprehensive picture of how ADHD is perceived in other countries.

As discussed, the purpose of this initial search was to explore broadly the literature on perceptions of ADHD. The search was carried out using the following terms: *ADHD*, *perceive*, and *viewpoint*. Studies were examined by reading the title and abstract, and applying the following inclusion and exclusion criteria: (1) explored how ADHD as a condition is perceived; (2) explored how adolescents diagnosed with ADHD perceive some aspect of themselves in line with the DSM V criteria for a diagnosis of ADHD; (3) studies that explored self-perceptions of adolescents with ADHD; (4) papers between the years 2005-2015; (5) Worldwide and (6) studies were in a peer reviewed journal as an original article, a meta-analysis, a systemic review or a synthesis of previous research. Please see Table 2.1. below for an overview of the inclusion and exclusion criteria. (Please see Appendix 1: Table 1 for further details of this search).

Table 2.1: Inclusion and exclusion criteria for the initial scoping search

	Include	Exclude
Focus	<p>Explored how ADHD is perceived by those with and without ADHD.</p> <p>Explored how people with ADHD perceive aspects of themselves in relation to their diagnosis.</p>	<p>Did not explore some aspect of how ADHD is perceived.</p> <p>Explored experiences of those not diagnosed with ADHD.</p> <p>Explored experiences of ADHD services and schools.</p>
Publication Date	Papers between the years 2005-2015	Papers before 2005
Source type	Peer reviewed journals with original articles, meta-analyses, systematic reviews, or synthesis of previous research.	Books, magazines, dissertations, commentaries and opinion pieces.

2.2.2. Stage two: Filtered Down Search

For the second stage, the search was filtered down to identify literature relating to adolescents only. The researcher adopted the age range for adolescence (10-19 years) as given by the World Health Organisation (2016). The term 'child' was also included to allow research to be included within the 10-19 year age bracket. The following inclusion and exclusion criteria were applied: (1) participants diagnosed with ADHD within the age range of 10-19 years old; (2) studies collected the views and perception of young people of ADHD or some aspect of themselves related in line with the DSM criteria for a diagnosis of ADHD; (3) published between 2005-2015 and (4) in a peer reviewed journal as an original article of meta-analysis.

The searches were carried out using EBSCO and Scopus under the following terms: *ADHD*, *child perspective*, *adolescent perspective*, *ADHD in adolescents*, *perceptions or attitudes or opinion*, *ADHD in adolescents*, and *Interpretative Phenomenological Analysis*. While these search engines identified many relevant studies, most of the research was from outside the UK. To identify UK based studies, the researcher carried out additional searches based upon the most prominent research topics that were emerging from the searches in stage one and two. This was carried out using Google Scholar. The above inclusion and exclusion criteria were applied with various combinations of the following

terms: *UK, ADHD, Interpretative Phenomenological Analysis, adolescent, parent, GP, teacher perception, stigmatization, quality of life, and, self-perception*. The researcher searched through the first two pages of results from Google scholar (20 findings), as after this point relevant studies were not being identified. Please see Table 2.2., for an overview of the search criteria. (Please see Appendix 1: Tables 2 and 3 for further details).

Table 2.2: Inclusion and exclusion criteria for the final search.

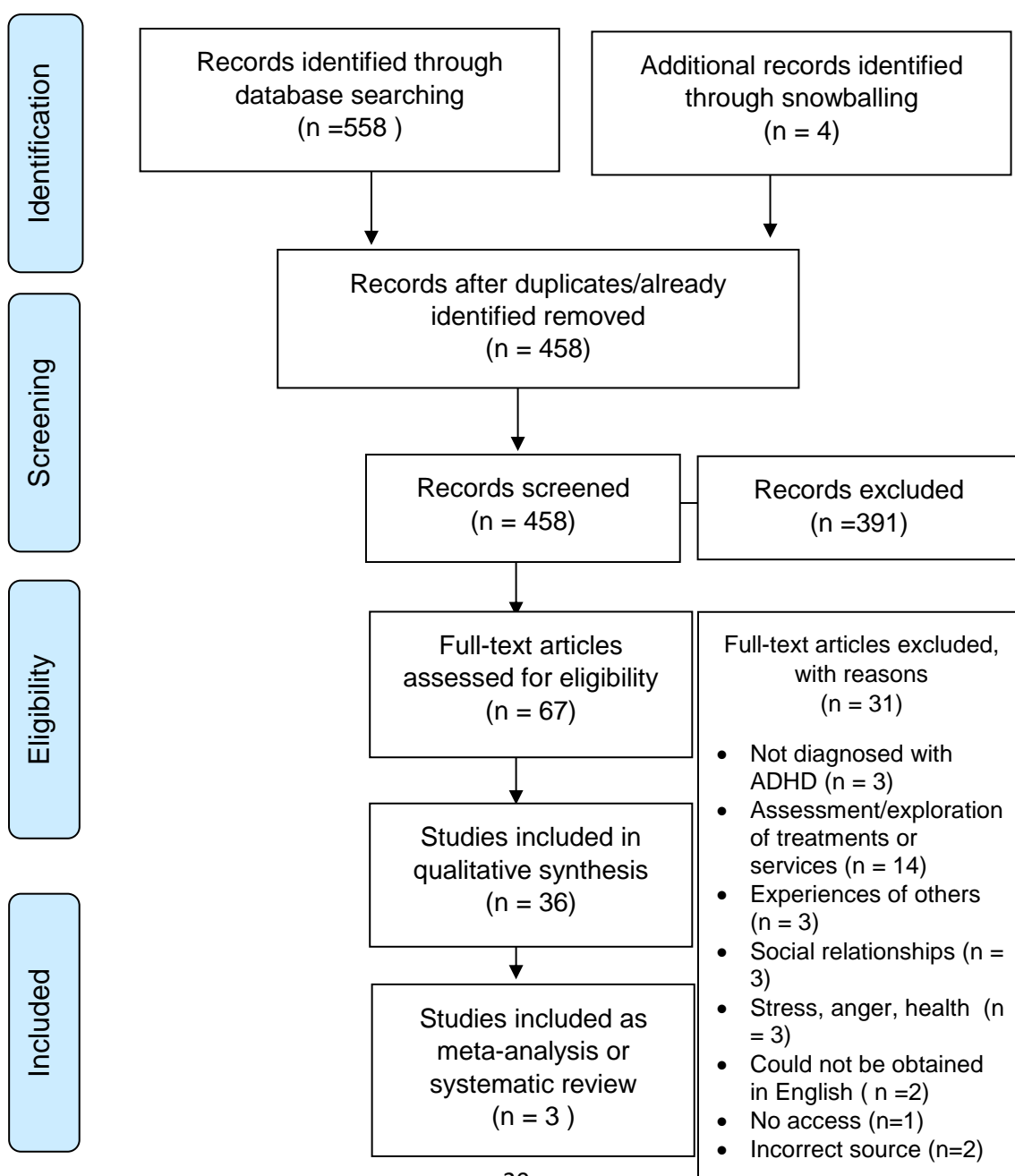
	Include	Exclude
Population	Diagnosed with ADHD Age range: 10-19 years	Not diagnosed with ADHD Outside the age range 10-19 years
Focus	Collected the views and perceptions of young people diagnosed with ADHD	Explored experiences of those not diagnosed with ADHD Explored experiences/evaluation of services and schools with no account of personal experiences
Publication Date	Papers between the years 2005-2015	Papers before 2005
Source type	Peer reviewed journals with original articles, meta-analyses, systematic reviews, or synthesis of previous research.	Books, magazines, dissertations, commentaries and opinion pieces

2.2.3. Stage three: Final Studies

558 articles were identified through the above searches and a further four were identified through snowballing. Snowballing is a technique whereby the researcher searches for additional articles, by examining the reference list of studies that have already been identified, for additional relevant articles. After duplicates were removed, 458 articles remained and these articles were assessed for suitability by reading the title and abstract. After the inclusion and exclusion were applied, 67 articles remained for full-text exploration. From this a further 31 articles were assessed as not meeting the inclusion criteria. Three studies were excluded as the participants were not diagnosed with ADHD or the majority of the sample was not diagnosed with ADHD. Two studies were

excluded as the text could not be obtained in English. A further two studies were excluded as the source of the paper did not meet the inclusion criteria. 14 studies were excluded as the main focus was on an evaluation of a treatment or service. A further three studies were excluded as they explored the experiences rather than perceptions of ADHD of those not diagnosed with the condition. Three more studies were excluded as the focus was on social relationships and a further three were excluded as they explored perceptions of stress and anger. One was excluded as full-text access could not be obtained. The search with 36 full text articles meet the inclusion criteria. Please see Figure 2.1. for details of the literature search.

Figure 2.1: Prisma flow chart



2.3. Analysis of Body of Research

The literature search yielded information that can be organised into five clusters. The clusters were created by arranging papers into ‘themes’ based upon similarity of topic. The five clusters are:

1. Quality of Life and ADHD,
2. Self-perceptions in adolescents with ADHD,
3. Attitudes towards ADHD,
4. Knowledge and Understanding of ADHD,
5. Perceptions and Experiences of young people diagnosed with ADHD.

The vast majority of the identified research was quantitative. A variety of methods were used to gather data such as surveys, questionnaires, and self-report measures. The qualitative studies mainly approached data collection using semi-structured interviews but also focus groups. Most of the studies were carried out in Europe or North America. Below is a critical review of this research presented according to the five clusters as listed above.

2.3.1. Quality of Life and ADHD

Research has found that the difficulties experienced by children and young people diagnosed with ADHD appear to extend beyond the challenges posed by the three core symptoms of hyperactivity, inattention and impulsivity (Nijmeijer et al., 2008; Wehmeir, Schacht & Barkley, 2010). Quality of Life (QoL) is increasingly being used as an outcome measure for children and young people with ADHD (Danckaerts et al., 2010). QoL is defined as an “individuals’ perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (WHO, 1997, p. 1). Much of this research comes from the US. QoL is most often assessed using self-report measures, such as questionnaires and rating scales with children. In addition, many of the studies include parental reports on the QoL that they feel their child has. The measures generally assess physical and psycho-social health (WHO, 1997).

Cortese (2010) argues this is an important area, as assessing the perceived QoL of children and young people with ADHD may provide a more contextualised understanding of ADHD and allow professionals to incorporate the child's perspective in treatment plans.

2.3.1.1. Research on quality of life and ADHD

From this research, a general trend has emerged of discrepancies between child rated QoL and parental ratings on the QoL that they feel their child has. Klassen, Miller and Fine (2006) explored agreement between parent and child ratings of QoL across nine domains. They were interested to see if agreement would be greater for physical rather than psychosocial domains. Indeed, the children did rate themselves significantly higher than their parents did for behaviour, self-esteem, mental health and family cohesion but they also rated themselves significantly poorer on physical function. However, discrepancies were noted between parent and child reports in the presence of a co-morbid disorder, psychosocial stressors and increased ADHD symptoms. These results are based on outcomes from the Child Health Questionnaire which has been validated with US population norms (Landgraf, Abetz, & Ware, 1996). The Child Health Questionnaire is a generic QoL instrument which measures fourteen physical and psychosocial concepts. This is problematic as many of the questions focus on physical health such as experiences of bodily pain and discomfort which are not symptoms of ADHD according to current diagnostic criteria.

Others have explored whether symptom severity is linked to perceived QoL. In the US, Limbers, Ripperger-Suhler, Boutton, Ransom and Varni (2011) assessed QoL for children diagnosed with ADHD who attended a general paediatric clinic or a psychiatric clinic with a control sample. They found that the parents of the children in the general paediatric clinic reported statistically significant higher QoL than the parents of children in the psychiatric clinic on all measured areas with the exception of school functioning. However, they did not find statistical differences in the children's reports. This suggests that children do not perceive their QoL in the same way that their parents do. This is problematic as much of the research on QoL and ADHD is based upon on parental perceptions of their child's QoL (Danckaerts et al., 2010).

Danckaerts et al. (2010) carried out a systematic review (36 studies included) of research in this area. They found that while the condition was viewed as impairing by both parents and children, parents perceived this impairment to be greater. However, of the 36 studies, only seven actually included reports from children and adolescents whilst 29 included parent reports only. This is problematic as research has demonstrated that there is a discrepancy between parent and child ratings of QoL.

Wehmeir et al. (2010) reviewed existing literature in this area to determine how the social and emotional difficulties associated with ADHD impact on the quality of life of children. Drawing together the research, they concluded that QoL for children with ADHD is affected by the challenges and additional stresses of impaired social and emotional development.

2.3.1.2 Conclusions from research on quality of life and ADHD

This is an interesting area of research and it could potentially provide improved insight into the impact that ADHD has on a young person's life. However, the research in this area is inconclusive. It has not been clearly demonstrated whether symptom severity or co-morbid conditions affect child ratings of QoL. That said, it is clear that ADHD is not viewed as having the same impact by children and parents. Some studies suggest that there is less agreement for more subjective domains (Klassen et al., 2006). There is a limited exploration of why QoL is affected for children with ADHD. In addition, studies often do not use the same measurement tools so this may account for some of the variability in findings. How a young person perceives their condition may impact upon how they see themselves and in turn impact their perceived QoL and self-concept.

2.3.2. Self-concept in Adolescents with ADHD

Self-concept refers to an individual's perceptions of who he or she is as a person (Harter, 1999). There is an established body of research that explores the self-concept of children and young people with ADHD. However, the literature is uncertain when it comes to defining the nature of the relationship between self-concept and ADHD. Some researchers argue that ADHD negatively impacts upon self-concept whilst others have found that children and

young people with ADHD have overly positive views of themselves and tend to under report problems, in comparison to teacher and parent ratings. This is referred to as the Positive Illusory Bias (PIB). Research has suggested that some level of PIB is normal or expected. However, children with ADHD present with higher than average PIB (see Owens, Goldfine, Evangelista, Hoza & Kaiser, 2007 for an extensive review). It has been argued the PIB can be either maladaptive or protective; adaptive in that it can act as a buffer to negative feedback or maladaptive in that receiving feedback and adjusting accordingly increases self-awareness and development (Owens et al., 2007). This topic is most often approached using self-report scales and questionnaires.

2.3.2.1. Research on self-concept in adolescents with ADHD

Whilst children and young people with ADHD may rate themselves more favourably than their teachers or parents do, this does not provide insight to how they see their condition. Wiener et al. (2012) investigated perceptions of children (9-14 years old) with ADHD of their symptoms and their attributions for problem behaviour. The children with ADHD showed PIB in relation to their ADHD symptoms. This was observed by noting the discrepancy between parent reports of the symptoms and the children's own reports of their symptoms. However, the children also reported that their problematic behaviours were stigmatizing. This suggests that, whilst children with ADHD may report overly positive views of themselves, they still perceive their condition to be stigmatizing.

In contrast to research showing PIB, others have found that ADHD negatively affects self-concept. Students who are gifted are typically believed to also have high self-esteem (Colangelo & Assouline, 1995; Roznowski, Hong & Reith, 2000). Foley-Nicpon, Rickels, Assouline and Richards (2012) examined self-concepts and self-esteem in gifted students (6-18 years old) with and without a diagnosis of ADHD. They found that the students with ADHD, despite having similar IQs to the control group, reported lower scores on measures of self-esteem, behavioural self-concept and overall happiness. The researchers were also explored if age played a significant role in how their participants perceived themselves. They compared the scores on self-esteem and self-concept between all participants under 12 years old with all participants over 12 years

old. The older group reported statistically significant lower levels of overall happiness than the younger group. No other differences were noted between the groups. However, the researchers did not analyse if age was a relevant factor when comparing those with and without an ADHD diagnosis.

Similarly, Dolgun, Savaser and Yazgan (2014) found that QoL and self-concept of young people with ADHD (9-12 years old) were negatively impacted by ADHD. Further, they found that as the children's QoL scores rose so did their self-concept scores. This suggests that children's perceptions of the quality of their life affects how they in turn see themselves. However, it is difficult to draw together and interpret the results of such studies, as different measures are often used and age ranges can vary considerably.

ADHD has a high co-morbidity rate. Therefore, findings regarding the self-perceptions of individuals diagnosed with ADHD may be affected the presence of another diagnosis. McNamara, Willoughby and Chalmers (2005) compared the self-perceptions of adolescents with learning disabilities and those with co-morbid ADHD. There was no significant difference in how the two groups perceived their intelligence, physical attributes, or self-reported symptoms of anxiety and popularity. However, the adolescents with ADHD had significantly lower self-concept about their behaviour and lower overall happiness and self-esteem.

Age is thought to play a key role in determining self-concept. As children get older they develop more complex self-concepts as they develop the ability to see how others perceive them (Hattie, 1992). Peer approval is also thought to become more influential (Harter, 2012). Houck, Kendall, Miller, Morrell and Wiebe (2011) assessed the relationship between ADHD and self-concept in relation to age, gender and ethnicity. They found that age and increased internalising behaviours were associated with poorer self-concepts. However, gender was not found to be a significant factor in determining self-concepts.

2.3.2.2. Conclusions from the research on self-concept in adolescents with ADHD

This research indicates the development of self is different for children and young people with ADHD. Research has found that holding some positive illusions about competence is normal and expected in the general population. However, the level positive illusions held by those with ADHD appears to be higher than is found in the general population. It has been suggested that some level of inflated competence is motivating and encourages people to perform better. However, children and young people with ADHD do not perform better and there is a substantial body of research that outlines the difficulties in several domains that those with ADHD experience. While this area is interesting, its' findings are limited as self-concept is most often measured using questionnaires and rating scales. Research has shown that children and young people with ADHD can present with PIB and therefore quantitative may be inappropriate. Qualitative methods may be able to offer alternative insights to how young people with ADHD perceive themselves and their condition.

2.3.3. Knowledge and Understanding of ADHD

People's perceptions of ADHD are likely to be influenced by their knowledge and understanding of the condition. Researches in the Europe and Asia have begun to examine the knowledge and understanding of ADHD amongst professionals. Most of this research has been carried out with teachers and general practitioners (GPs).

2.3.3.1. Research on knowledge and understanding of ADHD

Ghandizadeh and Zarei (2010) surveyed GPs in Iran and found that while there was awareness of the risk factors associated with ADHD, misconceptions existed with regard to its cause and developmental course. Only 6.6% of participants agreed that ADHD could continue to adulthood. In addition, 37.4% believed that a high sugar diet could cause ADHD and 52.3% agreed that a chaotic and dysfunctional family life could cause ADHD. Maniadaki, Sonuga-Barke, Kakouros, and Karaba (2006) found that parents in Greece were more likely to associate ADHD with biological causes than conduct problems which were more often attributed to parental practices.

The following two studies from the UK assessed GPs' knowledge of ADHD. Salt, Parkes, and Scammell (2005) used a combination of semi-structured interviews and questionnaires to explore GPs' understanding of ADHD as a disorder. They found that while most GPs could correctly identify the core symptoms of ADHD, over 75% thought that educational underachievement, anti-social behaviour and sleep problems were symptoms of ADHD. In addition, over half of the respondents reported that they lacked confidence in recognising ADHD. Dennis, Davis, Johnson, Brooks, and Humbi (2008) compared GPs' and parents' perceptions of the causes of ADHD by using a range of qualitative methods (focus groups, semi-structured interviews and narrative interviews). They found that GPs tended to see ADHD as a medical condition whereas parents were more likely to associate ADHD with socio-environmental causes. However, both of these studies were carried out over 10 years ago so it is possible that professional knowledge and confidence has improved since then.

Researchers have also looked at teachers' knowledge and understanding of ADHD. The majority of these studies consist of large samples assessed through the use of surveys and questionnaires. This research has shown that teachers' knowledge of ADHD is varied. This research has come from developed countries such as the UK, Australia, Iceland and parts of Asia such as South Korea and Sri Lanka.

In the UK, Akram, Thompson, Boyter and McLarty (2009) found that both qualified and student teachers had inadequate knowledge about ADHD. Although their sample size was relatively small, their findings seem to be in line with others. In Australia, Ohan et al. (2008) found that the majority of the teachers surveyed believed that children with ADHD were born with biological vulnerabilities and 38% believed that ADHD was not inherited. Their analysis of the teachers' responses indicated that those with an in-depth knowledge of ADHD were more likely to suggest that the child would benefit from assessment and that the children would benefit from treatment. In Iceland, Einarsdottir (2008) found that most teachers identified the children with ADHD as coming from all types of homes. However, some teachers felt that the children who have been experienced stresses such as parental divorce, were more likely to present with behavioural difficulties, and therefore receive an ADHD diagnosis.

There was a general consensus among the teachers that an ADHD diagnosis was helpful to the child as it allowed a better understanding of their needs and how they could be supported. At the time of Einarsdottir's (2008) study, the author commented that Iceland was ranked as the country with the highest number of children being diagnosed and treated for ADHD. This is likely to have impacted the teachers' knowledge and understanding of the condition.

Studies in Asia have reached similar conclusions, although some differences are noted. Hong (2008) surveyed and interviewed teachers in South Korea. They found that teachers could describe the behaviours associated with ADHD and they perceived ADHD negatively. However, the teachers felt that they did not know enough about ADHD to distinguish children with this diagnosis from typically developing children who misbehave. Neena (2013) explored how teachers in India understand ADHD. They saw behaviours as being developmental rather than being related to an underlying mental health condition. They were most likely to attribute behaviours such as those associated with ADHD to parent disciplining styles and environmental factors. Rodrigo, Perea, Eranga, Williams and Kuruppuarachchi (2011) assessed the knowledge of just over 200 primary school teachers in Sri Lanka. 80% of their participants made casual links between the behaviours associated with ADHD and parenting practices. Just under 50% correctly identified that hyperactivity, inattentiveness and impulsivity are the core symptoms of ADHD. Interestingly, they noted that teachers with prior training in child psychology were significantly more knowledgeable about ADHD and they expressed less negative attitudes towards children with ADHD. This again highlights the finding that perceptions of ADHD are closely linked to levels of knowledge and understanding.

Moldavsky and Sayal (2013) reviewed research on knowledge and attitudes of children, adolescents, parents, professionals and the public towards ADHD. They conclude that the misconceptions surrounding ADHD and its aetiology are likely to reinforce stigma related to ADHD.

2.3.3.2. Conclusions from the research knowledge and understanding of ADHD

Studies in Europe and Asia have shown that misconceptions about ADHD are common amongst professionals. It is important to consider this as young people

are likely to receive messages about ADHD from their environment. The misconceptions could be due to a variety of reasons including cultural perceptions of childhood mental health. In addition, the studies identified lack consistency in the methods used to assess knowledge of ADHD and many researchers designed their own assessment measures.

This research body indicates that the symptoms of ADHD are generally well understood. However, there is less consistency amongst teachers and other professionals across cultures and countries in terms of the causes of ADHD (Neena, 2013; Ohan, 2008). It also highlights a lack of confidence in managing and treating ADHD. In North America and the UK, there is acknowledgement of a biological cause of ADHD, however, stigma remains. Other studies found nutrition and parenting practice aetiologies were endorsed (Ghandizadeh & Zarei, 2010; Neena, 2013; Rodrigo et al, 2011).

Research has also identified that many professionals do not feel that their knowledge of ADHD is adequate (Ghanidzehah & Zarei, 2010; Hong 2008; Salt et al., 2005). However, as highlighted above, the research was carried out across different cultural contexts such in the US, in Asia and in Australia. In the UK, ADHD may be viewed differently. For example, in the study carried out by Neena (2013) in India, only one of their 15 participants was familiar with the term ADHD.

2.3.4. Attitudes towards ADHD

Research on attitudes towards ADHD as a condition (not treatment) primarily comes from Europe and North America. It is most often approached from the perspective of the general public rather than those diagnosed with ADHD. Further, this research typically explores the links between stigma and a variety of conditions such as ADHD, Autism and depression. Within this literature base, researchers do not appear to work from a unified definition of stigma. Link and Phelan (2001) argue that the concept of stigma is difficult to define as there are many components to it, their view is that that stigma “exists when elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows these processes to unfold” (p. 382). This definition seems to capture how stigma is discussed in relation to ADHD. Hinshaw (2005)

conceptualises stigma as encompassing stereotypes, prejudice and discrimination. In addition, the literature differentiates between three types of stigma associated with ADHD and mental health conditions in general: public stigma, self-stigma and courtesy stigma. Public stigma refers to members of the public perceiving individuals with ADHD in a negative light (Corrigan & Shapiro 2010). Self-stigma refers to an individual with ADHD internalising the negative perceptions of others (Hinshaw, 2005).

2.3.4.1. Research on attitudes towards ADHD

Researchers in the US have carried out large scale studies to examine stigmatization towards children with mental health conditions (Pescosolido et al., 2008). Pescosolido et al. (2008) have published many articles based on findings from this national survey. ADHD and depression are amongst the conditions explored in this study. In terms of ADHD, the authors conclude that it is a stigmatized condition and it is seen as less serious and less in need of treatment than other childhood mental health conditions such as depression. This is in line with other surveys in the US. For example, Walker, Coleman, Lee, Squire, and Friesen (2008) carried out a national survey with a sample of 1,318 children and adolescents (8-18 years old) to measure the levels of stigma for depression, ADHD and asthma. They were interested to note any differences in levels of stigma according to their participants' geographical location, gender, age and ethnicity. They also presented their participants with vignettes describing a typical child with one of these conditions and the participants were asked to rate the child in the vignette on a variety of items. Depression and ADHD were more stigmatized than asthma. In addition, depression was more stigmatized than ADHD. They also reported that levels of stigma did not seem to be dependent upon demographics with the exception that there was greater stigmatization amongst Asian/Pacific Islander young people. Cultural differences in perception of ADHD is an area of research that requires more attention. Norvilitis and Fang (2005) report significant differences in the perception of ADHD between teachers and college students in China and the US.

In Canada, Harnum, Duffy and Ferguson (2007) examined the difference between children's and adults' perceptions towards children with autism or with

ADHD. A total of 30 children and 30 adults were presented with a scenario featuring a child with either autism or ADHD, or a typically developing child. Results showed that children expressed the most dislike and avoidance towards the children with autism or ADHD and rated both as being different to them. By contrast, the adults did not express differences in dislike or avoidance for the ADHD, autistic or 'normal' child. Adults also did not perceive the child with ADHD as being any more unlike them than the normal child. This suggests that the age of the perceiver may play a role in the stigmatization of mental health conditions.

Research from Ireland and the UK reports similar findings. In the UK, Bellanca and Pote (2013) assessed children's attitudes towards ADHD, depression and learning disabilities. They presented 273 children (mean age 9.2 years) with vignettes to describe children with ADHD, depression and learning disabilities. They found that the children tended to show more negative attitudes to the vignettes of children with mental health difficulties (ADHD and depression) than towards children with learning disabilities. Further the children had a more negative attitude towards the ADHD vignette than the depression vignette. The authors conclude that these findings are largely in line with previous research in this area from the US and Ireland. They argue that this research highlights the need for stigma-reducing interventions which aim to teach the public about mental health conditions in children and young people. They cite a number of toolkits that have been developed in the UK to tackle this stigma, however, they argue that these toolkits are not informed by the literature.

O'Driscoll, Heary, Hennessy and McKeague (2012) examined how children and adolescents stigmatize their peers with depression or ADHD. They presented children and adolescents with vignettes of an age and gender matched individual who had depression, ADHD or "normal issues" (O'Driscoll, Heary, Hennessy and McKeague, 2012, p.1055). They assessed three explicit forms of stigma: stereotypes, prejudice and discrimination, alongside implicit attitudes towards ADHD. They found that stigma was dependent on the age and gender of the perceiver but also on the type of disorder. Additionally, it appears that peers stigmatized those with ADHD more than those with depression. Those with ADHD were seen as being more personally responsible for their condition.

Swords, Heary and Hennessy (2011) also used vignettes to assess the role of gender and age in stigma expressed by young people. They presented their participants with vignettes of peers with either ADHD or depression. Similarly, they found that the age and gender of the perceiver was an important factor in perceptions of both conditions and how responsible they held the peers with ADHD or depression for their behaviour. They found that as children and young people became older they were more accepting of their peer with ADHD or depression.

In contrast, Law Sinclair and Fraser (2007) did not find gender to be an important variable. They presented 11-12 year olds with vignettes describing a young person in terms of ADHD symptoms. They also presented some students with an additional sentence of 'Anon has Attention Deficit Hyperactivity Disorder'. They then asked their participants to complete the Adjective checklist. The most commonly used words selected to describe the person in the vignette were 'careless' (73%), 'lonely' (69%), 'crazy' (58%) and 'stupid' (53%). The least selected words used to describe the person were 'pretty' (0%), 'glad' (2%), 'smart' (3%) and 'helpful' (3%). Familiarity with Anon and the addition of the ADHD label did not affect the attitudes held by peers towards Anon. This suggests that labelling in itself may not necessarily led to stigmatization. However, it does not appear to offer additional understanding or elicit support either as more sympathetic views were not associated with the label.

2.3.4.2. Conclusions from the research on attitudes towards ADHD

Several international studies have highlighted that ADHD is perceived negatively across cultures. Research strongly indicates that both adults and children stigmatize children with mental health conditions. The majority of this research has explored the relationship between stigma and mental health conditions in general rather than focusing specifically on ADHD. Within this body of research there are conflicting views on how gender and age can impact the level of stigma. Some researchers have found that adolescent males express the most stigmatizing views (O'Driscoll, Heary, Hennessy & McKeague, 2012). This may be related to cultural differences or awareness of ADHD. This is an important body of research as public and professional perceptions of

ADHD may influence parents and children considering assessment and accessing treatment and services.

However, the majority of these studies are limited by methodological and design issues. A large proportion of the studies assess stigma by presenting the participants with vignettes. This often consists of description of the ADHD child with few favourable characteristics. The description of the child tends to follow the diagnostic symptoms of ADHD. So, while these vignettes present the core features of ADHD, they do not seem to include any other personal characteristics of the child. The problem focused depictions of those with ADHD are likely to evoke negative responses from the participants. Knowledge and understanding of ADHD is likely to play a key role in how it is perceived. It may be of significance to note that the identified studies that explored stigma did not include measures of knowledge and understanding of ADHD.

2.3.5. Perceptions and Experiences of Young People Diagnosed with ADHD

ADHD has been researched from many perspectives. There appears to be confusion in relation to its aetiology and ADHD appears to be the object of stigmatising attitudes. Research from the perspective of those diagnosed with ADHD typically explores their perceptions of ADHD through the lens of taking medication (Bussing, Zima, Mason, Porter, & Garvan, 2011; Singh, 2012). Attitudes towards ADHD amongst those with the condition has received much less attention. However, there is a developing body of research that provides insight to how those diagnosed with ADHD perceive the condition. The majority of this research employs qualitative methods such as semi-structured interviews and it comes mainly from North America and the UK.

2.3.5.1 Research on the perceptions and experiences of young people diagnosed with ADHD

In the US, Bussing, Zima, Mason, Meyer, White and Garvan (2012) used qualitative methods to assess the knowledge on ADHD of 374 adolescents who were diagnosed, or considered to be at risk of ADHD and their parents. Using data taken from interviews, they found that, although their participants rated themselves as having a good knowledge of ADHD, misconceptions existed about the condition. For example, many considered sugar a cause of ADHD.

Participants also believed that medication was over-prescribed. It is interesting that some of the participants were not diagnosed with ADHD but considered 'at risk' of developing it.

Bartlett, Rowe, and Shatell (2010) interviewed college students (16-25 years old) with ADHD taking a reflective look back at their childhood. There was a strong message from the participants that they had struggled with their ADHD symptoms and some expressed feelings of loneliness when they were not understood. Similarly, researchers in Canada recently explored how young people diagnosed with ADHD perceive their condition and the barriers to treatment (Walker-Noack, Corkum, Elik, & Fearon, 2013). Using focus groups with young people diagnosed with ADHD (10-21 years), they found that ADHD was perceived negatively. Further, the participants felt that the public are misinformed on ADHD, which has led to stigma and stereotyping.

In Israel, Brook and Boaz (2005) used a questionnaire method with adolescents with ADHD and learning difficulties (12-18 years) to explore their perspective on ADHD. Again, the participants stated that ADHD is not understood by others. The participants also expressed a feeling of being different peers. The researchers found that their participants were informed about ADHD by other pupils with similar needs, school advisors and the media. The young people reported that they felt that their peers and parents did not understand them and were often annoyed at them. This research provides insight to how young people with ADHD perceive their condition. However, this research did not provide an in-depth analysis of how they construct their condition. Rather, it suggests that those with ADHD often feel alone and misunderstood.

The VOICES (Voices On Identity, Childhood, Ethics & Stimulants) project is a Wellcome Trust funded research project led by Professor Ilina Singh at Kings College London. Its purpose is to include the perspective of children in debate about the rise in child psychiatric diagnoses and the increasing use of drugs in child psychiatry. The researchers interviewed 150 children in the US and the UK (Singh, 2011). The sample consisted of three groups: children with ADHD who took medication, children with ADHD who did not take medication and children who had no diagnosis. Singh (2011) found that respondents were generally

positive about the impact of their medication. Participants stated that the medication helped them to stop and think before responding and gave them more freedom to be themselves. The researchers found that children in the US and the UK perceive ADHD as stigmatizing. An interesting outcome was that many children reported that they did not know what ADHD was and they were not sure why they were being treated. The main concern with children in the UK was about 'being good' whereas the children in the US expressed the most concern about achieving academically.

Also in the UK, Travell and Visser (2006) used semi-structured interviews to assess the experiences, perceptions and views of 17 young people (11-16 years old) diagnosed with ADHD, and their parents. The young people described ADHD negatively. One participant said "It's like a disease eating on you" (p.207) and "ADHD does bad stuff to you...It gives you bad stuff to do and gives you a bad education in school" (p.208). Travell and Visser (2006) conclude that ADHD is seen as a phenomenon that includes symptoms and a diagnosis requiring medical treatment. The most common cited cause of ADHD was biological. Young, Chesney, Sperlinger, Misch and Collins (2009) used IPA to explore the life-course experiences of young people with ADHD who were in a young offenders' secure unit. They found that their participants expressed a sense of loss and a desire to find out where they belong. However, it is difficult to ascertain whether these findings are related to their ADHD or not.

Avisar and Lavie-Ajayi, (2014) used IPA to explore the experiences adolescents taking stimulant medication to treat ADHD. This study was included in the literature review as the analysis included in-depth insight into how the young people experienced ADHD. Their analysis of semi-structured interviews found that the young people experienced emotional side effects of taking medication and a loss of identity.

2.3.5.2 Conclusions from the research on the perceptions and experiences of young people diagnosed with ADHD

Primarily, this body of research has found that ADHD is perceived negatively by those diagnosed with the conditions. The research presents a problem saturated picture of ADHD that focuses on the barriers and difficulties that

ADHD can present for children and young people. Given current knowledge on the perception of ADHD of children and young people, we still do not have an in-depth understanding of how young people with ADHD perceive their condition and if they identify with it.

2.4. Conclusion of Chapter

Much of the research on perceptions of ADHD focuses on how it is perceived by the public, professionals and parents. This area of research was included in this review as it was felt that young people's perceptions of their condition are likely to be influenced by the views held by the public, professionals who work with them and their parents. From a public perspective, there are several international studies which assess how it is perceived. This has largely focused on examining levels of stigma associated with children's mental health condition including ADHD. Researchers have also examined professional perceptions of ADHD based on teacher or GP accounts. There is a growing body of research on parental perceptions of the quality of life of their children with ADHD. There is a small body of research examining how children and young people diagnosed with ADHD perceive their condition. This research aims to further explore this topic. The researcher chose to approach the topic using an IPA methodology (Smith et al., 2009), which will be discussed in the following chapter.

CHAPTER THREE: METHODOLOGY

3.1. Overview of the Chapter

This chapter is divided into two parts and provides a description of the methodology of the current study. Part one begins by considering epistemological positions in research and develops to justify the current researcher's position. Qualitative designs are then discussed and this study's use of IPA is described. The theoretical basis of IPA and its relevance to the study finishes the first part. The second section of the chapter provides a detailed description of the data collection procedures and the steps taken to thoroughly analyse the data. Potential ethical concerns are discussed and the researcher outlines how she addressed them. The researcher then addresses the trustworthiness of the data and discusses reflexivity and its importance to this research. The chapter concludes with a summary of the main points.

Table 3.1: Summary of Research Framework

Epistemological Position:	Social constructionist with consideration of symbolic interactionism.
Theoretical perspectives:	Phenomenology, hermeneutics, idiography, symbolic interactionism
Methodology:	Qualitative; Interpretative Phenomenological Analysis
Data Collection:	Semi-structured interviews
Participants:	Five 15 year old young people diagnosed with ADHD

3.2. PART ONE: Epistemological Positions

3.2.1. The importance of philosophy in research

Researchers can take up very distinct positions in this regard, so much so that two researchers can investigate the same event using completely different approaches and subsequently produce very different data. Researchers

approach their inquiry from two philosophical positions; an ontological position (beliefs about the nature of reality) and an epistemological position (beliefs about what one can accept as valid knowledge). These positions are closely related and are written about with considerable diversity (Creswell, 2009; Lincoln & Guba; 2000 Crotty, 1998). However, the main point to highlight here is the intertwined relationship between ontology and epistemology and to give consideration to the influence that philosophy has on a researcher's methodology

An ontological position should be stated and justified first as its concerns are fundamental. Ontology raises questions such as: What can exist? Is there a true reality independent of our representations of it? What is the relationship between reality and our observations of it? Ontological positions can be understood as ranging from relativist to realist (Willig, 2013). Realists propose that a reality exists independent of our representations of it. Realism can be seen along a continuum from naïve to critical. Naïve realists purport that what they can observe maps directly onto reality. Critical realists suggest that what we see does not necessarily map directly onto reality rather we can approximate reality but never truly know it (Willig, 2013). Relativists, on the other hand, assert that many interpretations of reality exist. As with realism, there are differing relativist positions.

As discussed, ontology and epistemology influence each other. Once, the researcher is clear about what can exist, they can then consider what kind of knowledge could be attained about this reality. Thus next the researcher must consider their epistemological position. There are many epistemological positions and which one a researcher adopts will depend on what they perceive reality to be.

Positivism is one position a researcher can take. Positivists would argue that objective knowledge can be gained which maps directly onto reality. Data is usually quantitative and hypotheses are tested against the data. Science is seen as being value free and its purpose is to create universal casual laws (Robson, 2011). This is largely criticized in social science research as the subject matter and the investigator are both people and it is not possible to

achieve complete objectiveness. Post-positivism is an alternative position that aims to address the main criticisms of Positivism whilst also maintaining the ethos of it (Robson, 2011). Post-positivists acknowledge the influence that a researcher's biases can have upon findings however they strive for as much objectivity as possible (Robson, 2011). They believe that no one study can determine the truth but that if many studies have similar findings then this is likely to be moving towards a conclusion. Interpretivist approaches offer a very different perspective. Social constructionism is an example of this. Social constructionists believe that meaning and reality are constructed by people through social interactions (Robson, 2011). They refute the idea of an objective reality. For a social constructionist researcher there are as many realities as they are participants (Robson, 2011).

An alternative approach to all of the above, is to adopt a pragmatic approach. This approach encourages the researcher to use whichever philosophical position, design and methods that best answer the research question. The pragmatist acknowledges that the researcher's values play a role in carrying out research. However, the position states that researcher should not be concerned about this and reflection upon it is not needed (Robson, 2011). However, this approach can be problematic. As pointed out by Robson (2011), a researcher will be in a much stronger position to address the research questions if there is an appreciation of the theoretical basis for the study. A well thought out study should naturally flow.

3.2.2. Current Researcher's Philosophical Position

The current researcher takes a social constructionist position. There are many interpretations of this position and the current researcher's view is in line with the interpretation as outlined by Burr (2015). The researcher locates this study at the "light end of the social constructionist continuum" (Eatough & Smith, 2008, p.12) and, in line, with this gives consideration to symbolic interactionism.

Burr (2015) draws together several writers in this area and outlines four shared tenets of social constructionists. Firstly, social constructionists take a "critical stance towards taken for granted knowledge" (Burr, 2015 p. 2). This means that one must be cautious of assumptions about how the world appears to be. Burr

(2015) gives the example of gender to demonstrate this point. We have constructed a division between people and labelled them 'male and female'. Whilst there is a natural division in terms of reproductive organs, Burr (2015) argues that we could also have also divided people in a different way such as tall and short people or those with earlobes and without. Thus social constructionism encourages taking a critical stance towards 'taken for granted' knowledge. In terms of ADHD, people have been categorized as presenting with behavioural characteristics that are considered either developmentally appropriate or maladaptive.

This leads onto the second shared tenant of social constructionists; the ways in which the world is understood, the concepts and categories that are used are culturally and historically relative. Any knowledge is therefore seen as being an artifact of that culture. It should not be assumed that one particular way of understanding the world is any closer to reality than another way of understanding the world. This is particularly relevant when considering ADHD. The core characteristics of inattentiveness, impulsivity and hyperactivity are currently viewed as problems in society. However, in another time, culture or setting these characteristics might be valued. For the purpose of this study, it was felt that the young people's discourses on ADHD will be influenced by their context and the language they hear others use to describe it.

Thirdly, social constructionists believe that knowledge of the world is constructed by people through social interactions, rather than coming from reality as it really is. Language is considered an important tool in constructing knowledge. For example, our concept of ADHD has emerged from our accepted way of viewing children and their behaviour. We have used language to construct a narrative around what is acceptable behaviour from children in our society. However, social constructionism encounters some problems at this point, as it does not address the idea of the self or people's individual psychology. This is important to consider in this study as viewing an individual's lifeworld as a purely linguistic and discursive activity does not allow for consideration of individual lived experiences and an individual's sense of self (Eatough & Smith, 2008). Burr (2015) suggests that the concept of the self can be incorporated into social constructionist thought without comprising its

theoretical foundations by considering symbolic interactionism. Symbolic interactionism originates from the work of Mead (1934). Individuals interact with each other and they affect, and are affected by, these interactions, which leads to the development of society. Some proposed that the individual or the self can only exist in relation to others. This is referred to as the relational self. However, Mead (1934) suggested an interactionist concept of the self. According to Mead (1934), language and social interactions play a key role in the development of the mind and of consciousness, which emerge from our ability to use symbols to represents things such as language and gestures. The ability to use symbols is developed in the context of social interactions. Thus, the mind is seen as the ability to reflect upon experiences through language and language development is dependent upon social interactions. It is through language that individuals internalise social interactions and reflect upon them to develop a sense of self.

In this research, ADHD is explored by examining the views that young people diagnosed with ADHD have about their condition. The researcher holds that the participants' lived experience of ADHD is influenced by their historical and cultural context. In addition, their experience of ADHD moves beyond this. There is a personal component to their experiences and perceptions (Eatough & Smith, 2008).

The fourth and final shared belief of social constructionists described by Burr (2015) is that knowledge and social action go together. People create many constructions to help them make sense of the world. These constructions contain information about what is deemed as acceptable and unacceptable for certain groups of people. Therefore, these constructions of reality can include or exclude, and promote or stigmatize certain groups. It can also inform how society responds to situations. In the case of ADHD, hyperactivity, impulsiveness and inattention are classified as a neurodevelopmental disorder by the DSM V (APA, 2013). The current research hopes to promote the voice of a group that is relatively unheard in research. Thus as Mead (1934) states, "there is nothing odd about a product of a given process contributing to, or becoming an essential factor in the further development of that process" (p. 226).

Ontological issues are subject to intense debate within social constructionism. This debate is the result of tensions between realist and relativist positions (Burr, 2003; Nightingale & Cromby, 2002). Bury (1986) critiques social constructionism, giving the example of disease. Bury (1986) suggests that social constructionists would deny any true reality and therefore imply that disease is a social construction. However, others and the current researcher would argue that social constructionism accepts that disease exists, but that way people talk about it is socially constructed. Therefore, current literature holds the view that social constructionism does accept an objective reality (Andrews, 2012; Burr, 2003). However, we cannot truly know this objective reality and the “idea that reality is somehow reflected in our talk and other symbolic systems” (Burr, 2015, p. 73) is problematic. What we can know is the way people construct reality through language.

Within the researcher’s social constructionist position “knowledges rather than knowledge” should be sought (Willig, 2013, p. 7). It is believed that we can only ever gain knowledge of subjective realities constructed by people. Therefore the only way to gain knowledge relevant to the research questions is to explore the topic by interviewing people. Further, this knowledge can be best gained through exploratory and curious approaches. The following section describes the chosen methodology for this research and how it draws upon phenomenology, hermeneutics, and idiography.

3.3 Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis aims “to explore in detail how participants are making sense of their personal and social world” (Smith & Osborn, 2007, p.53). IPA studies generally examine people’s lived experiences of a topic that is pertinent in their lives. It first emerged in the 1990s, in response to a call for a qualitative research approach grounded in psychology (Eatough & Smith, 2008). To understand the influences of IPA on this research, it is necessary to understand IPA’s theoretical underpinnings. IPA’s three main philosophical influences are phenomenology, hermeneutics and idiography (Smith et al., 2009). The following section outlines the key ideas from each of these theories and how they are relevant to this research.

3.3.1. Phenomenology

Phenomenology is a philosophical tradition that is concerned with the “experience of being human” (Smith et al., 2009, p11). Phenomenologists are interested in thinking about how we come to understand our experiences of the world. IPA has been influenced by the phenomenological writings of philosophers such as Husserl (1927), Heidegger (1962), Merleau-Ponty (1962) and Sartre (1956).

Husserl famously argued that if we are to understand human experience, we must “go back to the things themselves” (as referenced in Smith et al. 2009, p.12). By this, Husserl (1927) meant that people often try to situate phenomena within their existing beliefs and ideas about how things should be. Husserl felt that we needed to bracket off this inclination and focus on the experiential component of consciousness. Once this is achieved, everyday experience can be analysed from a phenomenological perspective.

Heidegger (1962), a student of Husserl’s, disagreed with this idea, as he felt that as humans we cannot ignore our natural attitude and move into a purely objective realm. Instead, Heidegger (1962) felt a reconsideration of the idea of being was needed. In his seminal work, *Being and Time*, he wrote about the nature of existence itself (Smith et al., 2009). He felt that dualisms such as object/subject and person/world should be replaced with the concept of *dasein* or being-in-the-world (Eatough & Smith, 2008). This means that we exist in a world with other objects and other people. In addition, our existence or being-in-the-world is “always perspectival, always temporal, and always ‘in-relation-to’ something” (Smith et al., 2009, p.18). As a result, Heidegger argued that the interpretation of people’s sense making is a pertinent topic for phenomenology.

Merleau-Ponty (1962) agreed with Heidegger’s idea of a phenomenology that considers context. However, Merleau-Ponty (1962) placed the body at the centre of meaning making. Smith et al. (2009) give the example of a hand reaching out to touch a desk to demonstrate this. It is at the point that the hand touches the desk that the self and the world connect. Sartre (1952) further added to our understanding of phenomenology. Sartre (1948) famously stated

that “existence comes before essence” (p.26). By this, Sartre meant that we are always ‘becoming’ ourselves rather than ‘being’ ourselves. Sartre felt that our experience of the world could be shaped equally by the presence and absence of things. In his major work, *Being and Nothingness*, Sartre (1956) introduced the concept of nothingness. Sartre gave the example of entering a café expecting to see a friend who is then absent. Had his friend been there, his attention would have been on him and the café would fit into place around him, however, in his absence, his nothingness, Sartre’s perception of the café changes as his focus shifts to all that is happening in the café (as described in Smith et al., 2009). Sartre also discussed how the presence of others shapes our experiences. He gave the example of him looking through a keyhole into another room only to become aware that someone is watching him, which results in a feeling of shame. However, this can only be understood when the interpersonal context of the situation is considered. Smith et al. (2009) argue that, through his work, Sartre offered the closest insight into what a phenomenological analysis of the human condition would look like.

3.3.2. Hermeneutics

Hermeneutics, the theory of interpretation offers much to IPA. Three influential hermeneutic theorists are Schleiermacher, Heidegger, and Gadamer (Smith et al., 2009). Schleiermacher (1998) wrote about the interpreter bringing to consciousness what may be unconscious to the author of a text. In IPA, this comes from having an overall view of the text but also from a detailed analysis of the text and through consideration of psychological theories. Schleiermacher suggested that the author gives a particular meaning to a text based on his or her intentions but one must also understand the context in which the author chose the words. Thus, part of the interpretation process involves understanding the writer and the text that he or she produced. Schleiermacher felt that if one engaged in a thorough detailed analysis then one could end up with an “understanding of the utterer better than he understands himself” (Schleiermacher, 1998, p.266).

Heidegger (1962) and Gadamer (1960) both helped to define the relationship between hermeneutics and phenomenology for IPA. Heidegger, as seen from the discussion above, saw phenomenology through a hermeneutic lens.

Heidegger (1962) introduced the idea of *appearing* by which he meant that things present themselves to us and they have can have visible meanings and hidden meanings. For the IPA researcher, this involves looking beyond the words as the participants tell their story to uncover hidden or alternate meanings. However, the researcher may be influenced by personal preconceptions. IPA looks to Heidegger's notion of fore-conception here. Heidegger argued that the reader of a text will always bring their fore-conception (which is prior experiences and assumptions about the world) to interpretation. Heidegger argued that the fore-conception is always there and it can hinder interpretation. However, instead of focusing on one's own preconceptions, the interpreter needs to focus on the phenomenon under analysis. Gadamer agreed with Heidegger that one may only become aware of one's preconceptions once interpretation has begun. In this way, the phenomenon under investigation can influence the fore-structure and thus the interpretation. So there is a dialogue between the text and the interpreter's preconceptions. This cycle is referred to as the hermeneutic circle. According to the hermeneutic circle, in order to understand the part, consideration must be given to the whole, and in order to understand the whole, consideration must be given to the parts. This captures the nature of interpretation very well for IPA. The current researcher was guided by this and stated her position on ADHD in the introduction. Further, the researcher engaged in reflexivity through the use of a reflective diary throughout the data collection and analysis stages of the research (see Appendix 9 for an example).

Another contribution of hermeneutic thought to IPA is the idea of the 'double hermeneutic'. People try to make sense of their lives and the stories they tell reflect their sense making journey. In the case of IPA, there is a double hermeneutic; the researcher is attempting to make sense of the participants' sense making. The researcher only has access to the participant's experience through the words that the participant chooses to use which in turn is seen through the researcher's own perspective.

3.3.3. Idiography

In Psychology, research is often making claims about a phenomenon at a group level. However, IPA is distinct from this as it examines individual lived

experiences. Idiography has played an influential role in supporting this aspect of IPA. Idiography is interested in the particular. Similarly, IPA is interested in understanding how a particular phenomenon is understood from the perspective of certain people within a certain context. IPA's approach is to use small carefully selected sample sizes and single case studies to examine lived experiences of individuals. IPA then involves a detailed examination of these lived experiences to produce a rich analysis of the data.

3.3.4. Why IPA?

The researcher considered a range of qualitative methodologies before selecting IPA. For example, a narrative psychology analysis was considered. Narrative psychology is interested in how people organize and bring order to experience (Willig, 2013). Further, it explores this through detailed examination of the stories that people tell. While it might have been interesting to explore the young people's narratives about ADHD, it was felt that this approach would be inappropriate to meet the research aims. The researcher was interested in the young people's experiences of ADHD and what it meant to them. Also, in narrative research, the participants are expected to provide a detailed account of themselves. However, for the participants in this study, the expectation of providing a narrative account of their experiences, may have felt like 'being put on the spot' and reduced their engagement with the research process.

Consideration was also given to using discursive psychology. Discursive psychology is an analysis of language use (Willig, 2013). This approach would have provided the researcher with a way to analysis the language that the young people use to describe ADHD. However, discursive psychology is interested in discourse only and it neglects the 'individual' (Willig, 2013). The researcher was interested in the young people's individual experiences and their understanding of ADHD rather than focusing solely on their use of language.

IPA is a qualitative research methodology that is interested in understanding experience and sense making. It was considered appropriate for the current study as the researcher was interested in how young people perceive their

condition and what ADHD means for them. IPA offered the researcher a strong theoretical basis to use as a guide to underpin the research.

In addition, IPA is aligned with the researcher's particular social constructionist position. The researcher also reflected upon symbolic interactionism which allows the researcher to explore the topic at a more meaningful level with each individual participant. It is believed that this is the best method to understand a topic. IPA aims to obtain insight into another person's thoughts and beliefs in relation to the phenomena of interest based upon their experiences (Smith, 2009). The current research was interested in what children and young people diagnosed with ADHD think and believe about their condition.

IPA assumes that the accounts that people give tells us about their private thoughts and feelings and further that these thoughts and feelings are based upon their experiences. This research was not only interested in their thoughts and feeling of ADHD but also in the experiences upon which these were based. Finally, IPA acknowledges the 'double hermeneutic' (Smith & Osborn, 2007). This refers to the process whereby the researcher will be interpreting the participants' interpretations of their worlds. This was important for the current researcher and cannot be ignored. To counterbalance this, the researcher acknowledged her influences and documented them.

3.4. Part Two: Research Methodology

3.4.1. A Qualitative Research Design

The purpose of the current research is to capture how young people perceive ADHD in their own words, rather than using pre-selected variables chosen by the researcher. The researcher needed a design that would allow her to adapt and engage with the participants in a manner that was appropriate. The researcher therefore required a design that would allow for considerable flexibility with few restrictions imposed. A qualitative research design was therefore selected as this design is most appropriate to address the research questions and guide data collection.

3.4.2. Data Collection

The data was collected using semi-structured interviews which were recorded using a recording device. A semi-structured interview was considered most appropriate as it allowed the researcher to show curiosity about participants' accounts and to use probing techniques. It also allowed the researcher to digress from the interview format. This was an important consideration in the study as it was of the up most importance that the researcher was in a position to engage with the participants. Following a rigid interview schedule might have lost some of the essence of the participants' experiences and not allowed them to open up and offer new ways of considering ADHD. The interviews were primarily led by the participants and questions were kept to a minimum.

Focus groups were not considered appropriate as the researcher was interested in individual experiences. The purpose of the research was to explore young people's personal experiences and meaning making processes in relation to ADHD. It was felt that this could be best achieved in a one to one setting rather than in a group setting, as the researcher would not be able to attend to each participant in the same detailed manner.

3.4.3. Design of the Interview Schedule

The researcher developed the research questions following guidance from Kvale (1996) and used Personal Construct Psychology (PCP) tools. PCP was devised by George Kelly (1955) as an alternative to the prevailing behavioural and psychoanalytical theories at that time. Kelly (1955) suggested that there are multiple interpretations of events and experiences and referred to these as constructive alternativism. Kelly (1955) argued that how someone interprets an event or experience is key to understanding that person's thoughts and beliefs. PCP fits with the current researcher's epistemological stance in that there is not one true reality, rather, there are multiple realities with no one reality being seeing as being more valid than another.

3.4.3.1. Pilot study

The original interview schedule was based Ravenette's "Who are you?" structured interview (Ravenette, 1999, p.183). It was adapted to probe how the

participants construct ADHD rather than themselves. For example, rather than providing words to describe themselves, the participants were asked to provide words to describe ADHD. The researcher prepared a list of 11 interview questions (see Appendix 3). These questions were piloted with one participant (James, 14 years old) across three sessions. Following this, the researcher adapted the questions as it was felt that the original schedule needed to include more creative methods to engage the participants. The researcher decided to use a wider range of PCP methods, drawing techniques and visual prompts to support the young people to tell their stories (see Appendix 4a and 4b). In the pilot interview, the researcher generally followed the order of the questions. However, this limited what the participant could share and so it was decided that the researcher would use the interview as a guide, whilst also following the lead of the participants. The final interview schedule consisted of three sessions which will be described below.

3.4.3.2. Session one

Each participant met with the researcher prior to the interview for one session which lasted for approximately 30-45 minutes. The aim of this session was to build rapport and to introduce the participants to the research. The participants were informed that they could withdraw or ask for breaks at any point that they wanted. The participants took part in three warm up activities (see Appendix 3). The first activity presented the young people with a series of images. They were asked to select three which they felt described them. The second activity explored how supported they feel at school, at home and in the wider community. They were presented with a page with their name in the centre and a large circle drawn around it. The circle was divided into four sections. This consisted of a section for home, for school, for friends and for the community. They were asked to write the names of people who supported them in each quadrant. For the final activity, the young people were presented with a scale ranging from 1-10, where one indicated the unhappiest person in school and 10 represented the happiest person in school. The young people were asked to rate themselves on this scale.

3.4.3.3. Session two to three

The main interview took place in the second session which lasted for anything between 30 to 60 minutes. The session began with problem free talk and the participants were gradually guided into the main interview. As discussed the researcher used the interview schedule with flexibility and adapted the language of the questions as required by the needs of the participant. The researcher wanted to support the young people to tell their stories in their own terms and so prompts were only provided if the young people required them such as the use of drawing techniques. The young people were debriefed about the study at the end of the third session.

3.3.4. Research Participants

IPA uses a purposive sampling method as the aim is to find an answer to the research question from a defined group for whom the research question is relevant (Smith et al., 2009). It is recommended to use a homogenous sample of between five to six cases to allow enough cases to explore similarities and differences (Smith et al., 2009). This research was carried out with five young people aged 14-15 years old with a diagnosis of ADHD. Please see, Table 3.2. for further details.

Table 3.2: Participant information

Name	Age (Years: Months)	Ethnicity	Taking medication	Received diagnosis	Co- diagnosis
David	15:06	White British	Yes; daily, Concerta	9 years old	No
Michael	14:11	Roma/Gypsy Traveller	Yes; daily, Concerta and Methylpheni- date	12 years old	No
Jack	15:00	White British	Yes, daily (25 mg)	13 years old	No
Gary	15:03	White British	Yes; Elavanse, 30mg, Bio- melotin 6mg, Clonidine, 50mg	5 years old	Yes
Sarah	15:9	White British	Yes; Methylphenid- ate 30mg	14 years old	Yes

Recruitment Method

The researcher followed the following steps to recruit participants for this study.

1. Inclusion criteria: ages between 14-16 years old.
2. Exclusion criteria: significant learning difficulties.
3. The participants were gathered by approaching EPs working within the same setting as the researcher. The EPs were provided with the research aims, questions and the inclusion/exclusion criteria. They were asked to suggest students whom were known to the service and meet the inclusion criteria.
4. Letters were then sent detailing the research to head teachers (See Appendix 5).
5. Once consent was granted from the head teacher, further consent was sought from the participants (see Appendix 5) and their parents or guardians (see Appendix 5). The researcher was available for further questions via phone and email.
6. Participants were given further information on the research at the first session and they were informed of their right to withdraw at any time.
7. If consent could not be obtained or if at any point a participant withdrew from the research, the researcher returned to the EPs in the service and proceeded through the same steps as above.

3.5. Data Analysis

The IPA researcher is interested in making sense of the participants' sense making processes, which leads to the double hermeneutic (Smith & al., 2009). In other words, the researcher is interpreting the participants' interpretation of events. The IPA analysis process consists of a series of steps that allow the researcher to identify themes for each participant and to then look for shared experiences and meanings across cases. The researcher in this study divided the analysis into five stages which are described below. Smith & al (2009) and Willig (2013) were referred to for guidance on analysis. For an example of the research process please see Appendix 6 which outlines the stages one to four for one of the research participants and Appendix 7 for an example of the group analysis.

3.5.1. Stage 1: The Researcher's Initial Encounter with the Text

The researcher transcribed the data of the interviews using Express Scribe Transcription Software Pro. Following transcription, the interviews were listened to again to check for accuracy and initial thoughts were noted in a reflective diary. To support the analysis of text, the researcher created document divided into the three columns using Microsoft Word. Each transcript was placed in the middle and the columns to the left and right were used to record the researcher's comments. The analysis cycle then began for each transcript in turn. Stage one consisted of three levels of exploratory comments. Firstly phenomenological comments, then linguistic comments finally and conceptual comments. At this stage of analysis, there were no rules about what was commented upon, rather, the researcher read the text with an open mind and noted anything of interest. The researcher began with a close line by line phenomenological reading of the text by focusing on the experiential claims of the participant. Comments were noted in the right hand column. This was followed by an additional reading of the text where the researcher reflected upon the language used by the participants and began to look for higher order more interpretative conceptual meanings in the text. For the linguistic comments, the researcher commented upon the significance of the words chosen by the participants and intonation in their speech. The conceptual comments required the researcher to focus her attention towards the participant's overarching understanding of what they were discussing. Comments were again added in the right hand column (language comments were noted in italics and conceptual comments were placed in brackets).

3.5.2. Stage 2: Identification of Emergent Themes

The researcher referred to the phenomenological, linguistic and conceptual comments noted during stage one to develop emergent themes. This time the emergent themes were noted in the left hand column. These themes reflected higher order conceptual themes in the data.

3.5.3. Stage 3: Clustering of Themes

All of the emergent themes were then placed into a table in chronological order using Microsoft Word. During this stage of analysis the researcher was summarising, looking for associations or connections and contradictions in the

text. The researcher reflected upon the themes and identified connections between them. The researcher moved the themes around in the document and organised them into clusters of related themes and began to assign preliminary names to the clusters. At this stage some themes were removed. For example, themes merging under a new theme label. The sub-ordinate themes were then identified.

3.5.4. Stage 4: Final Super-ordinate Themes

Once this was done, the researcher looked for higher order meaning within the cluster of sub-ordinate themes to identify the overarching theme, which is referred to as the super-ordinate theme. The researcher referred back to the transcript to ensure that the themes were consistent with what the participant said. This process was repeated for each transcript and the final super-ordinate themes were placed in a table. The researcher wanted to keep to the idiographic nature of IPA by giving each case a unique analysis that was not shaped by the analysis of the previous case. Following the analysis steps outlined above supported the researcher to start anew with each case and enter the lived world for that participant.

3.5.5. Stage 5: Integration of Cases

The researcher then looked across all five accounts to locate shared experiences and shared meanings as held by the participants whilst also reflecting upon divergences in their accounts. This process began with the researcher arranging the themes generated by each participant on strips of paper. Each participant was assigned a colour code to support the researcher to track how well-represented participants were in the group analysis and the original meaning of the theme (for example, David was coded blue, Sarah was coded purple). The researcher then began to arrange the themes into clusters to develop the final group super-ordinate themes. A summary table was created which provides an overview of the superordinate themes (see Table 4.2).

3.5.6. Reflexivity

Qualitative research requires a rich in-depth analysis of data where the researcher often becomes heavily immersed in the data. For this reason, it is imperative that researchers reflect upon their own experiences. Reflexivity is

defined by Mead (1934) as “the turning back of the experience of the individual upon her or himself” (p.134). Reflexivity is an important part of any IPA study. The IPA researcher is trying to make sense of the participants’ sense making processes which leads to the double hermeneutic. It is therefore necessary for IPA researchers to reflect upon their own values and perceptions and how these can impact upon data collection and data analysis. For this study, the researcher used Gibbs’ (1988) six stage reflection model. The stages are as follows:

1. Description.
2. Feelings.
3. Evaluation.
4. Analysis.
5. Conclusion.
6. Action Plan.

This model was used as a guide to support the researcher to reflect on her role in the research. As stated earlier, the researcher kept a reflective diary throughout the research process and kept this model in mind. (Please see Appendix 9 for an example extract).

3.6. Quality Assurance with Qualitative Research

There is ongoing debate in qualitative research on how it should be evaluated. Robson (2011) argues that, for research in social science, a scientific attitude can be adopted. Robson (2011) suggests that researchers should approach their study systematically, skeptically and ethically. Quantitative criteria of reliability, validity and generalisability do not fit the ethos or purpose of qualitative research. Instead, the quality of qualitative research is judged by the trustworthiness of the data. Guba and Lincoln (1989) outlined a set of criteria to judge the quality or trustworthiness of qualitative research as follows.

3.6.1. Credibility

Data that is credible will accurately represent what the participants said (Guba & Lincoln, 1989). To maintain credibility, excerpts of what the participants said

are presented in the findings section, with references to the transcripts. The researcher also used academic and peer supervision to discussion analysis of the data. The researcher also attended a peer supervisory group for IPA researchers. The researcher engaged with hermeneutics throughout the research process and notes were kept in a reflective diary.

3.6.2. Transferability

Transferability equates to external validity which refers to the extent that the results apply in other contexts (Guba & Lincoln, 1989). This is not the purpose of this research. However, the researcher provides rich in-depth information on the study for the reader to assess the transferability of the findings. It is then at the discretion of the reader to determine if they believe this is transferable.

3.6.3. Dependability

Dependability equates with reliability, which refers to the replicability of the research (Guba & Lincoln, 1989). In qualitative research, due to changes in real-life contexts, it may not be possible for a study to be repeated. The researcher has documented any changes that occurred in the context of the research and how these changes might impact the way in which the research was carried out.

3.6.4. Confirmability

Confirmability equates to objectivity, which refers to the extent that the researcher has minimised his or her influence on the data (Guba & Lincoln, 1989). To account for this in qualitative research, the data should be able to be traced to its source and the method of analysis should be made clear. The researcher engaged in reflexivity by considering the impact of her values and belief systems on the research. As mentioned, a reflective diary was kept and the researcher engaged in critical discussion with her academic supervisor and research peers. Critical discussion with peers supported the researcher to identify the influence of her values and biases upon the analysis.

3.7. Ethical Considerations of the Research

Ethics need to be considered in all psychological research. This research was carried out with young people. To guide the ethics of the research, the BPS ethical research guidelines were adhered to (BPS, 2010).

3.7.1. Informed Consent

The researcher wanted to ensure that fully informed consent is achieved. Consent was sought from the school, the participant's parent or guardian and directly from the participants. The participants were told the purposes of the research. The participants were informed of their right to withdraw from the research at any point without consequence.

3.7.2. Duty of Care and Impact of the Researcher

The researcher asked young people to discuss a topic that might or might not cause them distress. To support the participants, breaks were offered and the participants were reminded to ask for a break. A debrief session was carried out with four of the participants at the end of the research. The fifth participant was excluded from school before the debrief session was carried out. The researcher made alternative arrangements, however, the participant did not wish to attend. A debrief sheet was therefore posted out to the young person's home.

Attention was given to potential power imbalances in the relationship between the researcher and the participants. The researcher positioned herself as non-expert and took the role of facilitating participants to tell their stories. Consideration was given to the impact of the researcher in developing the research, carrying out the interviews and analyzing the data. The researcher was open and transparent about personal stances and positions and engaged in reflexive practice.

3.7.3. Anonymity

This research used a small sample of five participants. Using a small sample can have ethical implications. There is a possibility that participants may be

more identifiable. The researcher changed the names of all participants and did not include information about the specific location of the study.

3.7.4. Data Protection

The researcher has taken care to protect all data involved in the research. Any Word documents, such as the transcribed interviews were saved in password protected format and the participants' real names have not been used. The information will be stored in this format for a minimum of five years after which it may be deleted.

3.8. Conclusion of Chapter

This chapter described the methodology of the research. The first part of the chapter began with an overview of philosophical positions in research and outlined the researcher's position. This was followed by a description of the approach chosen by the researcher and its philosophical underpinnings. The second part of the chapter described the steps of the analysis with a discussion of the quality measures taken to ensure a high standard in this study and reflection on ethical considerations taken into account.

CHAPTER 4: RESULTS

4.1. Overview of the Chapter

Interpretative Phenomenological Analysis of data captured through the semi-structured interviews resulted in the emergence of four superordinate themes which represent the answer to this study's enquiry: How do young people diagnosed with ADHD perceive their condition, and to what extent do they identify with their diagnoses?

The themes were generated by a thorough reading and re-reading of each transcript followed by a detailed analysis of each individual case before moving onto the next transcript. Initial readings of each transcript was completed with a phenomenological focus. This is a descriptive analysis of what the participants are saying and it focuses on their experience and strives to get to the essence of what ADHD is like for the participant. The transcripts were then re-read with an interpretative lens and the researcher engaged with hermeneutics and reflected on the participants' use of language. The researcher noted pauses and intonations in the participants' accounts as it was felt that, on occasion, they shaped connotations (see Table 4.3 for the Transcription key). This led to emergent themes which were developed to create the super-ordinate themes and linked sub-ordinate themes for each individual participant (see Table 4.1). These themes were then analysed to draw out similarities and contrasts between the participants' accounts. This then generated the final super-ordinate and sub-themes which are summarised in Table 4.2. The findings are grouped into four super-ordinate themes and linked sub-themes which reflect the experiences of all participants.

Table 4.1: Individual Super-ordinate and sub-ordinate themes

Participant	Super-ordinate Themes			
	Sub-ordinate Themes			
Michael	Questioning ADHD Justifying ADHD Mocking ADHD Challenging ADHD	Feeling Silenced Feeling excluded from process Challenging the power of others Feeling powerless Resignation with medication	Conflicts for Identity Medication as a threat to identity Feeling different Rejecting ADHD Better me Fear of judgement from others	Emotional impact of ADHD Feeling forgotten Feelings of anger and resentment Feelings of injustice Internalising others comments
David	What is ADHD? Behavioural description Developmental condition ADHD as complex ADHD as a barrier to learning ADHD a hidden difficulty ADHD as a problem to be solved Attributing negatives to ADHD	ADHD in relation to others Other people noticing ADHD Difficulty for ADHD caused by other people ADHD diagnosis for other people ADHD in the background ADHD not my responsibility Awareness and control Listening to what others say about ADHD	Control Passivity in managing ADHD Other managing his ADHD Medication giving control Questioning medication Accepted parts of ADHD Uncertain relationship with impulsivity	Who Am I? Feeling isolated Wanting to blend in ADHD as part of him Diagnosis and self-realisation New self

Jack	Uncertain relationship with ADHD Distant from ADHD Normalising ADHD Unsure of the impact of ADHD on self Others making him aware		Making sense of me and ADHD Not understanding self and feelings Bouncing man Annoying other people Confusion with past self Medication not changing who he is Medicated vs un-medicated self
Gary	Understanding of ADHD Understanding ADHD through others ADHD as a Duality: Good vs Bad Hard to connect ADHD to feelings Factual understanding of ADHD		Relationship with ADHD Some distance from difficulties of ADHD Identifies with positive qualities about ADHD ADHD as not impacting him Medication controlling him
Sarah	Us vs Them Others noticing Passivity Other as expert on ADHD/powerful others Positioned by others Challenging others views on ADHD Importance of supportive relationships	Internal and External Disorder ADHD as biological ADHD as developmental Social/Psychological explanation, ADHD mind External disorder from others Emotional impact of ADHD	Conflicting selves and managing different selves Feeling different Rejecting self/ADHD Medicated and un-medicated self Doubting medication Old me vs new me Lack of control over self Fitting in with the 'norm' Normalising parts of ADHD

Table 4.2: Summary of Group Super-ordinate themes

Super-ordinate theme	Sub-ordinate theme	Summary
1) What is ADHD?	a) Something in their body b) My actions are speaking louder than my words	<p>This super-ordinate theme reflects the young people's interpretation of the aetiology and symptoms of ADHD. Many of the young people spoke of ADHD being related to the brain, and some described a genetic component to the condition. Many of the young people reflected that their ADHD would change as they matured.</p> <p>The theme develops to explore the young people's perceptions of the characteristics associated with ADHD. Many of the young people spoke of the behavioural characteristics associated with ADHD. However, from many of the accounts it was clear that there is also a strong emotional component to their experience of ADHD.</p>
2) The role and impact of others on ADHD	a) Us vs Them b) Understanding and Support	<p>This super-ordinate theme explores the role and impact that others have upon the young people's experience of ADHD. A common sentiment in the stories shared by the young people was that control and power were held by others and there was a sense of powerlessness or passivity from the young people.</p> <p>Many of the young people indicated that they looked to those around them to make sense of ADHD. The young people's accounts present divergent experiences of the support they received.</p>
3) Identity Conflict	a) I just don't feel like a normal kid b) Multiple Selves	<p>This super-ordinate theme considers the impact of an ADHD diagnosis upon young people's identity and how they perceive themselves. Some spoke of feeling different to their peers, this was most apparent when they spoke of taking medication.</p>

		<p>Many of the young people spoke of different versions of themselves. This often led to confusion as they tried to make sense of their past and parts of themselves that they can and cannot control and to clarify how, and if their medication changed who they were. A conflicted narrative emerged in relation to their medication, some reflected that medication did not change who they were however many of the young people also spoke of how much their medication did change them.</p>
<p>4) My relationship with ADHD</p>	<p>a) They are just concentrating on the wrong thing</p> <p>b) Challenging ADHD</p> <p>c) It just happens in the background</p>	<p>This theme explores the different ways that the young people managed their relationship with ADHD. At times, aspects of ADHD were normalised, at others it was challenged and/or the young people distanced themselves from ADHD.</p>

4.2. Analysis and Interpretation of Super-ordinate Themes

This section will outline the group super-ordinate and sub-ordinate themes which address the two research questions.

RQ1: How do young people diagnosed with ADHD perceive their condition?

RQ2: Do young people identify with ADHD?

It was evident throughout the interview sessions that many of the young people had not considered ADHD in such depth before. Some began their story tentatively. However, as the sessions progressed, more introspective accounts of ADHD emerged. The following super-ordinate themes represent the researcher's interpretation of the reflective journey taken by the participants. See Table 4.3 for the transcription key.

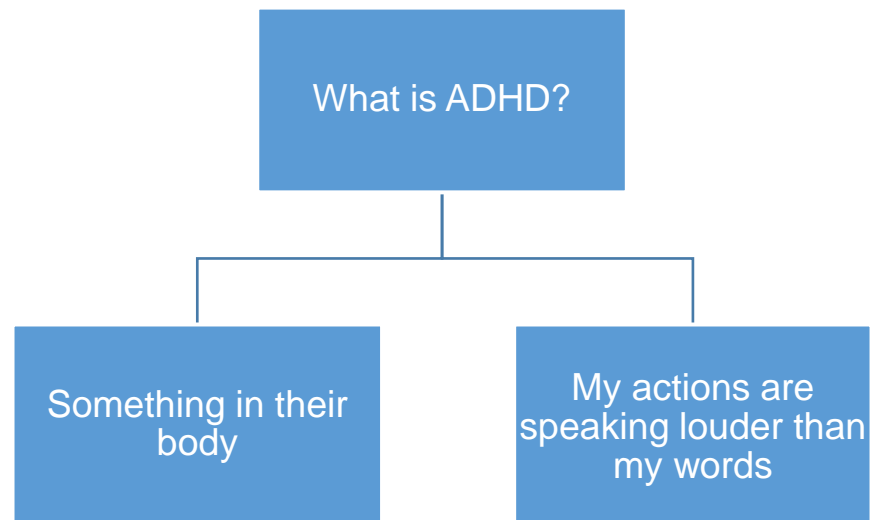
Table 4.3: Transcription Key

Code	Meaning
4:113	Transcript page number: Initial line number of quote
{ }	Describes an action
...	Short pause
[pause]	Long pause
(///)	Unclear speech
/	Interrupted speech
(-)	Lowered speech tone
In italics	Word emphasised
*	Agrees with researcher

4.2.1. Theme One: What is ADHD?

This super-ordinate theme reflects the participants' interpretation of the aetiology and symptoms of ADHD.

Figure 4.1: Super-ordinate theme one



4.2.1.1. Something in their body

Jack's statement of ADHD as stemming from '*something in their body*' (17:340) is reflective of many of the participants' interpretation of the aetiology of ADHD. However, one participant felt that he could not identify any causal factors for ADHD. All of the other participants offered tentative explanations, punctuated by long pauses and expressions of doubt. Despite this, many of the participants offered explanations for ADHD that are reminiscent of current research on its aetiology. The most common offered explanation for ADHD was a genetic cause with a link to the brain.

In the first half of his interview, David was asked about the causes of ADHD. Although he appeared uncertain at first, his response suggested that he had begun to identify some causal factors, based in part from a dialogue with his father:

David: "I don't know, I don't know, I think I think you are born with it. I don't think you could like develop it so it's probably to do with genes and...hyperactivity and stuff"

like that, like ...like, I think it was my Dad said he thought he had it but I don't know if he did but he said he did, so, maybe" (19:389).

David made a link between his diagnosis and comments from his father that suggested to him that ADHD may be a genetic condition. He further reflected upon this and expanded on a comment he made earlier in his interview which linked ADHD to the brain.

David: *"I think that you are born with it, so I guess it's just something like with the brain waves, like stuff like that, I don't know" (20:393).*

As can be seen throughout the above extracts, David tended to introduce and/or end his response with the phrase 'I don't know'. This suggests that although he has begun to make links about casual factors, he experienced a level of uncertainty.

Similarly, when Gary was asked to draw an image to represent ADHD, he hesitated at first and then commented:

Gary: *[long pause]. "Does it have something to do with the brain?" (7:125).*

Gary appeared to need reassurance or approval that ADHD was in fact linked to the brain before he could begin his drawing.

Sarah began with a suggestion of ADHD being a heritable condition, however, she further develops her model of ADHD to include psycho-social factors:

Sarah: *"Yeah, um it's mostly like...fam...like, part of your family.*

Interviewer: *um hmm*

- Sarah: Or it could be an emotional, like, an emotional mental state that you could have like, you could have gone through something and it could have triggered it.*
- Interviewer: Um hmm*
- Sarah: (-) but I don't know" (17:322).*

It is interesting to note that although Sarah began by offering two causes for ADHD she added 'I don't know' to the end of her statement. This reflects the level of uncertainty as seen in other accounts. However, Sarah identified causal factors for ADHD and her model is indicative of a bio-psychosocial model for ADHD. David also indicated that ADHD may be linked to the environment, however, he interpreted this link in a different way to Sarah:

- David: "Um depends on the environment as well, if people are talking in our class it's impossible to concentrate...so I guess it is down to what your environment is like as well. It's not, it's not just the cause, I guess at the end of the day, it's like in your brain (///), so if you can have the right conditions for the brain, I guess it makes it easier for it to focus" (19:378)*

Some of the young people expressed an expectation that their experience of ADHD will change as they mature. Sarah and David, both felt that as they get older they will be able to manage ADHD more effectively. Sarah reflects:

- Sarah: "Um...I think it will change because...I will be more...thinking about my actions, where I am quite young still. I don't actually know how to control it yet, but...I should learn soon" (7:122).*

David explained that he heard people say that you can 'grow out of' ADHD. He added that as the brain develops it will become easier to concentrate:

David: "I think I heard people say that you well, lots of actually grow out of it, cause I think it's a mental condition. So I guess as you grow up the brain develops to make it easier for you to concentrate, so like easier to control some of the like side effects of the condition, so I think as I grow up I will just learn to adapt to the ADHD and learn how to control it" (24:483).

Further, both David and Jack commented that they will not take medication in the future:

David: "Um once cause eh, I think a certain age you don't take them anymore.
Interviewer: You don't take what sorry?
David: The tablets" (43:874).

Similarly, Jack sees a future where he will not take medication:

Interviewer: "Okay and do you think that at um any point in the future you will not take medication?
Jack: Yeah, ah don't know when. I don't take it on weekends.
Interviewer: Um hm.
Jack: Ah, that's it really, I don't know, I know I will stop them" (44:897).

The above extracts suggest that some of the young people feel there is a developmental aspect to ADHD and they can envision a future where they are either in control of their ADHD or no longer need to take medication. It is interesting to note that only one participant, Michael, felt unable to identify any casual factors in relation to ADHD. Michael expressed the most anger about ADHD and the most rejection of his diagnosis. He shared that his first encounter of ADHD was in school when people used it as an excuse to get out of trouble.

Michael reflected:

Michael: "Cause there was like a thing, to get out of trouble, to say you got ADHD but it's not right that it's actually a problem" (3:52).

Michael spent a considerable amount of time during his interview justifying ADHD and establishing it as a valid condition, almost as if he felt the need to convince others of its genuine problematic status:

Michael: "I think that's just a bit stupid, cause it's actually a problem, like most like, if you had a problem, it's like one of them" (3:61).

However, towards the end of his interview, he was dismissive of ADHD and described people with ADHD as "Dim lows":

Michael: "Dim lows
Interviewer: What does that mean?
Michael: Like idiots
Interviewer: Oh okay and why do you say that?
Michael: Cause they are all off their heads.
Interviewer: Okay why?
Michael: They just act stupid, like most of them don't go to school" (33:702).

Michael's account in particular was full of contradictory statements on ADHD which is perhaps reflective of how he perceives ADHD.

4.2.1.2 .Summary of sub-theme

This sub-theme described a biological and developmental model of ADHD, with some references to the environment and social influences, as proposed by the young people. However, it was evident throughout all of the interviews that the young people were tentative in their explanations. The following theme outlines their perceptions of the symptoms of ADHD.

4.2.1.3. *My actions are speaking louder than my words*

Sarah's comment "*My actions are speaking louder than my words*" (15:282) is reflective of a sentiment expressed by several of the young people. ADHD was generally described through references to the behaviour characteristics associated with the condition. However, the young people also provided descriptions of a 'feelings' component to ADHD which was reflected in a series of stories on how the young people's behaviour often led to feelings of regret and isolation.

Firstly, the behavioural characteristics associated with ADHD were clearly articulated in David and Jack's accounts. Their descriptions were indicative of one or all of the core diagnostic symptoms of hyperactivity, inattention and impulsivity as outlined in the DSM-V (APA, 2013). However, they emphasised different aspects of ADHD. Throughout his interview, David seemed to be the most knowledgeable of all the participants about ADHD. He used the following words to describe someone with ADHD:

David: "Impulsive, hyperactive and concentration" (7:140).

David explained ADHD using these three words in terms of deficits and his reflections suggested that impulsivity is his main struggle.

Jack also talked about ADHD in line with the diagnostic criteria:

Jack: "Ah...hyperactive...ah...hard to focus and like listen, like always want to be doing different things, um...always on the move/" (16:323).

However, hyperactivity appeared to be the most salient characteristic of ADHD for Jack. When he was asked to draw a picture to represent ADHD, he drew a picture of a figure jumping and commented:

Jack: "Just like someone bouncing around" (11:226).

He also commented that someone with ADHD is:

Jack: "Just always swinging around, like a little monkey or whatever" (15:305)

David and Jack both spoke of ADHD as being something that can affect learning. For example, David reflected on the impact of inattention on learning:

David: "...not being able to keep attention. That like hinders learning a lot.

Interviewer: And do you think keeping attention, is that important?

David: Um hm.

Interviewer: What is it important for?

David: It's important for education, it's like cause I have bad memory already and not being able to keep attention, that doesn't help that so I guess I would, I'd need to focus even more than normal people" (22:436).

Similarly, Jack felt he needed medication to help him with his learning and he explained that he "wanted it for my GCSEs so I could settle down focus through them" (43:882).

In contrast, Gary viewed ADHD is an 'aggressive' disorder characterised by disruptive behaviours in school. He also presented a narrative of someone with ADHD as being creative. This duality of good vs bad characteristics of ADHD can be seen through his use of words such as "*tempered*" (8:165) and "*annoying*" (13:269) but also "*playful*" (12:234) and "*imaginative*" (10:204). Gary also linked ADHD and learning, however, he interpreted it differently to David and Jack:

Gary: "Like sometimes they, eh, they swear sometimes or they just um (unclear) their work...um

Interviewer: They what under their work?

Gary: Disrupt" (9:183).

Gary's description here references behaviour as the factor that affects learning, rather than a lack of concentration or attention.

As seen earlier, Sarah's interpretation of ADHD's aetiology was more holistic than the descriptions in the other participants' accounts. Her descriptions of ADHD were also more complex. As Sarah reflected upon the impact of medication, she outlined some of the 'core' symptoms of ADHD:

Sarah: "...um when they take their tablets they are more concentrated and...they can listen a lot more but with someone who hasn't taken them, they would probably find that they are more fiddly...um...they will talk a lot more and...and...it's weird that when, if you don't take them you are more in people's faces more..."
(21:414).

However, Sarah expanded upon this. At times, her account was similar to Gary's description of ADHD being 'aggressive'. This was most apparent as she described ADHD as she felt others would perceive it. Sarah felt her mother would describe ADHD using words such as:

Sarah: "{Laughs}...just for me she would say annoying/
Interviewer: Okay/
Sarah: Constantly destructive and stuff like that" (18:349).

And for the deputy principal:

Sarah: "Um {laughs}, he has to use professional words/
Interviewer: Okay {laughs}.
Sarah:uncontrollable" (20:392).

However, Sarah's self-description of ADHD portrayed it as something that caused her inner turmoil, rather than focusing on external behaviours:

Sarah: "...and I don't think cause some people don't, most people eh, don't think before they do stuff. That's why it's like they can't gradually slow their mind down to think and the same thing for thoughtless, they just don't think. And paranoid, it makes you more paranoid of what people say than the actual thing they are saying. Someone could say something but it won't be meaning what you think it's meaning, so you will take it more to heart" (14:264).

Sarah's account was rich with stories of the emotional impact of her behaviour upon herself. She reflected how her behaviour has in the past led to instances of regret for her:

Sarah: "...um...it's just, you feel stupid because if you had just waited or counted to ten, then you could have slowly counted them all down, and then you would feel better, like I'm fine now but..." (15:293).

Sarah ended her sentence by saying that she is fine now, however, she added a 'but' and let her sentence trail off, suggesting that she experiences uncertain control over herself and her actions. Sarah later described her behaviour as speaking louder than her words:

Sarah: "Um, I never used to think before I said or done something. It's like my actions are speaking louder than my words.

Interviewer: Um hm so, when you do something without thinking, after you done the thing, what thought would run through your mind?

Sarah: ...the thought you should have originally thought of {both laugh}" (15:281).

Sarah's articulation of feelings of regret in relation to behaviour were shared by other young people. Jack's story of his behaviour overpowering him was similar. As he reflected back on his past, he described himself as being "constantly naughty just swearing, hitting people" (42:863). This led to feelings of regret for Jack:

Interviewer: "And when you were naughty, what was going through your mind?"

Jack: ...don't know, no, I honestly don't know.

Interviewer: And how did you feel after?

Jack: Just like why did I do that, like after I settled down and calmed down, just like yeah" (42:865).

David shared a story about the emotional impact of the consequences of his behaviour from when he was first diagnosed with ADHD:

David: "I think all of my teachers put me on a desk on my own which I didn't like but I guess they thought that would help concentrate but it didn't it was terrible" (46:944).

David explained that his teachers put him there because they thought he misbehaved but at first he didn't understand why:

David: "The first time, I didn't really understand why they did it but I guess cause when you are that age, what the teachers says you just kind of do it, so I just went along with it" (48:998).

However, he was left feeling isolated from his peer group:

David: "...um it just it felt like just...eh, it felt kind of like that was like a prison or something, like that just put me away from everyone" (49:1001).

4.2.1.4. Summary of sub-theme

This sub-theme presents the behavioural descriptions of ADHD provided by the young people. ADHD was seen as being a collection of behavioural symptoms similar to the core symptoms associated with ADHD. However, the young people also introduced an emotional component to their experience of ADHD.

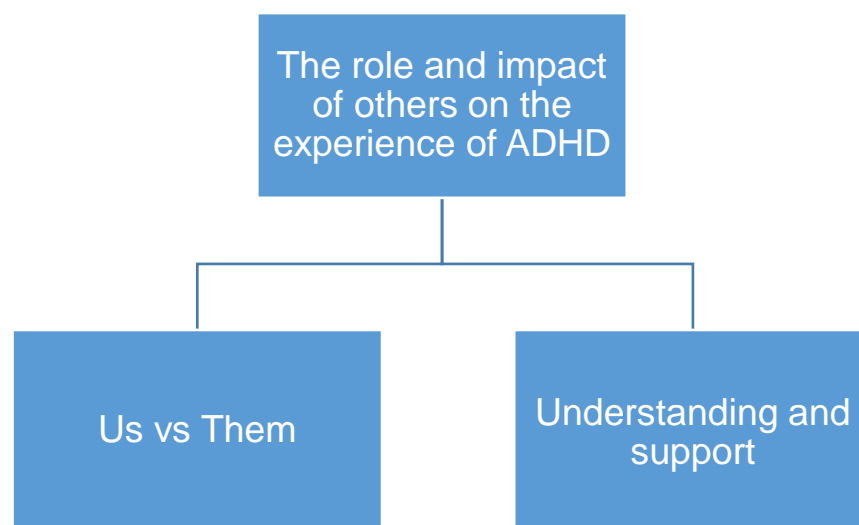
4.2.1.5. Summary of super-ordinate theme

This super-ordinate theme presented an account of the aetiology and symptoms that the young people felt described ADHD. The young people also provided insight to the emotional impact that their behaviour can have upon them. It was evident in all accounts that young people's model of ADHD was informed by their own experiences of the condition but also through their interactions with others. The following theme explores the role and impact of others on the young people's experience of ADHD.

4.2.2. Theme Two: The role and impact of others on the experience of ADHD

This super-ordinate theme moves the analysis on to consider the role and impact of others upon ADHD. Through analysis of the scripts two sub-themes emerged on the role and impact of others which are outlined below.

Figure 4.2: Super-ordinate theme two



4.2.2.1. *Us vs Them*

A prevalent discourse in all accounts was of a power dynamic between the young people and ‘others’. Through their stories a picture emerged of a divide between the young people with ADHD and those involved in their care, such as parents, teachers and medical professionals. Often, power was perceived to be held by others whilst the young people were passive and/or powerless.

Michael’s account strongly conveyed a sense of powerlessness. His drawing of ADHD, which is described in the following extract, suggests that he sees ADHD as something that restricts him and takes control away from him:

Interviewer: “Okay, what have you drawn?”

Michael: That’s a cell.

Interviewer: A cell? Okay, can you tell me a bit about that?

Michael: Cause you feel like, do you know like, when you get do you know like, when people say ah yeah you’re like under the thumb, like you have to do what they say, like when you go places. Actually that’s not right, school, that’s it school that’s the word. {writes school} school.

Interviewer: Okay school, you’ve written the word school. What do you mean by that?

Michael: School, you have to do what they say/

Interviewer: Okay/

Michael: You have to take the tablets, do what they say, go through this and that, and I don’t get no input. My Mum, only my Mum my Mum my Mum gets a lot of input because that’s my Mum. But I would like to have my own say” (13:278).

Michael’s account was peppered with feelings of powerlessness:

Michael: “The tablets that I’m on now cause I just got a new dose like double ones.

Interviewer: Double ones?/”

*Michael: Like every time I see my doctor, they like put me up”
(4:82).*

At several points in his interview, Michael comments reflected a sense of powerlessness for him whilst others were powerful:

*Michael: “And the tablets they put you on sleeping tablets
sometimes, and you’re just like...” {moves shoulders
down} (7:150).*

Michael commented that it was his Mum and not him who was active in the review meetings:

*Michael: “You have to go there as well, they’re asking my Mum
the questions. They don’t give me to do put my input.*

Interviewer: Okay

*Michael: And I’m the one the thing. I am the one who is
supposed to say how I feel” (10:195).*

It is evident from the stories that Michael shared that being involved in the process is important to him. However, he doesn’t appear to be and he challenges his diagnosis which has led to feelings of anger and resentment. This is in contrast to David, who appears reluctant to play an active role. David describe how his role in managing his ADHD is to “*take tablets in the morning*” (41:839).

Sarah’s account also conveyed a sense of powerlessness in relation to her ADHD:

*Sarah: “Because it’s something that I will probably have to
live with for most of my life or all of my life...(-)
probably. Nothing I can do about it” (6:116).*

Sarah's tone of voice indicated she feels overwhelmed by ADHD, as her final comment was whispered. Later again, Sarah's comment suggest a sense of being overwhelmed or powerless in relation to her ADHD:

Interviewer: "And do you think are people born with ADHD, or not born with it?"

Sarah: "...I think some kids are born with it, but you just can't tell cause they are too young to actually (-) deal with it" (17:329).

Again, Sarah's voice reduced to a whisper towards the end of her sentence. Whereas other people in Sarah's account appeared to be active:

Sarah: "Well...the people that actually push forward for me to have my tablets done is...the Youth Offending Team, when I had my first...triage" (5:95).

Other people in Sarah's account were seen as powerful. Sarah describes the deputy principal in her school:

Sarah: "He has a lot of work with ADHD.

Interviewer: Oh does he?"

Sarah: Yeah

Interviewer: What in this school?"

Sarah: In any school. He used to be a behaviour parole officer, I think.

Interviewer: Oh was he? Okay/

Sarah: In other schools and stuff like that, or used to work...the Head of behaviour (///)" (20:379).

Jack initially appeared to be quite passive in managing his ADHD. He spoke of attending assessment appointments where he met with *"a lady, she like interviewed me and then that's it"* (5:84). Following this, others appeared to be more actively involved than him:

Jack: "Oh we had to go back again. I think it was six weeks after.

Interviewer: Um hm.

Jack: Yeah....and that's when I got medicated.

Interviewer: So on the second visit you, they gave you medication?

Jack: Yeah.

Interviewer: Okay and what else happened on the second visit?

Jack: Don't know, that's it I think. They just spoke to Mum" (5:102).

However, Jack appears to have now taken a more active role in managing his ADHD. Later, he shared that it was him who wanted medication and his mother was concerned about him taking it:

Jack: "When I got diagnosed with it yeah, Mum didn't want me to be medicated cause she thought it would change my personality. But I wanted it for my GCSEs so I could settle down focus through them and then she read all the leaflets and spoke to Mr P, Mr P sorry/

Interviewer: Um hm

Jack: And then that's it, and then she was confident about it, and then I got medicated" (43:880).

4.2.2.2. Summary of sub-theme

This theme considered some many of the young people appeared to perceive others to play 'active' roles in making decisions about their lives while there is a lack of control from the young people themselves.

4.2.2.3. Understanding and Support

Much of the young people's knowledge and understanding of ADHD appeared to come from what they heard other people say. This journey often began prior to their diagnosis. Many of the young people shared stories of how other people were noticing their behaviour as being problematic. Their accounts tended to

portray them as bystanders observing conversations that others were having about their behaviour.

Sarah shared that her aunt noticed her behaviour:

Sarah: "Yeah because my Mum's like, she's like my aunty, I've been around her for ages. Her son had it really bad so/

Interviewer: Um hm

Sarah: It's like she was kind of explaining to my Mum. Cause I had the same sort of actions as him, so she was explaining to my Mum about it" (3:47).

Sarah repeated three times here that the explanation was to her mother. This creates a picture of her on the outside looking and listening in. Similarly, David shared how his teachers started to notice his behaviour and suspect ADHD:

David: "I guess that's when they started. Like cause I did a lot, so they probably thought that there must be like something like ADHD kind of thing going on" (46:937).

Similar to David and Sarah, it was others who noted Jack's behaviour as problematic. Jack recalled that he first heard about ADHD when his aunt suggested that he should go for an assessment:

Interviewer: "Yeah, um hm um, so when did you first hear about ADHD then?

Jack: Ah about a year ago cause my little cousin had it, and my aunty said to my Mum, like go get him tested.

Interviewer: Um hm

Jack: But that's it/

Interviewer: So do/

Jack: That's the first I ever heard of it.

Interviewer: About a year ago?

Jack: Yeah.

Interviewer: Okay and when did eh, what did you hear about it at that time?

Jack: Just getting tested. That's all I heard" (4:67).

Jack shared that on the day he was going for his assessment, he felt *"Just excited I had a day off school"* (5:99). He later expanded upon this and shared that he knew he was going for an assessment because of his behaviour:

Interviewer: So why did you think you were going to be assessed?

Jack: Ah, because I knew it was because of my behaviour and that and like how I was acting around.

Interviewer:so what kind of stuff?

Jack: Like hyperactivity, just I always wanted attention really. Like say if my Mum is paying attention to my sister, I would do something naughty to get seen or something" (7:130).

Post-diagnosis, the young people continued to look to others for understanding of ADHD. David and Sarah both made references to other people in their families having ADHD, which may have led to them suggesting a genetic factor being involved in ADHD. As can be seen, there were often comments such as 'they say'. This suggests that the young people are picking up messages about ADHD from those who are around them. For example, Sarah shared:

Sarah: "I have a really good memory but they said I shouldn't have a good memory.

Interviewer: Why not?

Sarah: Because most people that suffer with ADHD don't have a good memory" (4:66).

As noted in the first theme, Michael spoke of the aetiology of ADHD in a different manner to the others. He made references to people pretending to have ADHD and his comments indicated that he too may question it. Michael later shared a view on ADHD that was perhaps picked up in the media:

Michael: "I feel like society looks at me a different way.
Interview: Um hm and how do you think society looks at you?
Michael: Right have you ever heard them saying, kids they they say them kids are just off the rails...that's not it, it's just we need that extra little bit extra of help, I feel"
(19:409).

Earlier in his interview, Michael described himself as being "off the rails" (11:233). His comments here suggest that it is not a term that reflects how he feels. All of the young people spoke of attending hospital appointments with members of their families, most often parents. For example, Sarah spoke about the importance of relationships and having the right support in place:

Sarah: "It's to do with support from people as well.
Interviewer: Um hm
Sarah: Because I get support from Mum, school and stuff like that. So it does help a lot more when you got support in place for you" (8:148).

David also spoke about his parents managing his medication and hospital appointments for him:

David: "It's a lot of things like, it just happens in the background. Cause to be honest, everyone else like really, hospitals and parents they kinda deal with all the important kind of stuff for me" (41:836).

In the following extract, David reflects on what it would be like if everyone wasn't managing his ADHD in the background:

David: "Well I guess I would have to know a lot more about it. And if Mum wouldn't take me to doctors, I'd have to go there and have the conversations about what it is and

how I am, so that like cause when we go there the doctors always ask about how I am in school and stuff like that, so I guess I would be better informed about it” (42:852).

Whereas, Michael did not feel supported:

Michael: I’ve been waiting on this waiting list for bloody ages to see this woman called G.

Interviewer: Um hm

Michael: At this school, and they still haven’t gone through with it. And the ADH, the ADHD doctor who put it forward/” (12:2446)

Michael expressed a sense of rejection at this:

Michael: “She’s like the thingy woman. I get on with her really well but she still ain’t seeing me” (12:258).

Michael also expressed strong feelings of anger for what he feels is a lack of understanding from his doctors:

Michael: “But I do understand where the doctors and that are coming from. It’s just that, I don’t think they understand where I am coming from.

Interviewer: Um hm and if you could say something to the doctor what would you say?

Michael: ...F off” (22:473).

Michael compared the support he has seen people with Autism receive to the lack of support he feels he receives:

Michael: “That people with, I’m not being horrible but people with Autism, I know they can’t help that/

Interviewer: Um hm

Michael: But I can't help ADHD. So they do stuff like fun days for them, so why can't I do like fun days for people with ADHD" (20:415).

For Michael, this has created a feeling of being left behind:

Michael: It's I wish we could, I had a person I could do this a lot with. But it's just, no-one with ADHD. I don't think no-one actually cares. (15:313).

4.2.2.4. Summary of understanding and support

It was evident in many of the accounts that the young people developed their understanding of ADHD based on information they received from others. This appeared to have shaped in various way how they perceive ADHD.

The young people experienced different levels of support from others. All of the young people appear to receive support from their parents to manage their hospital appointments.

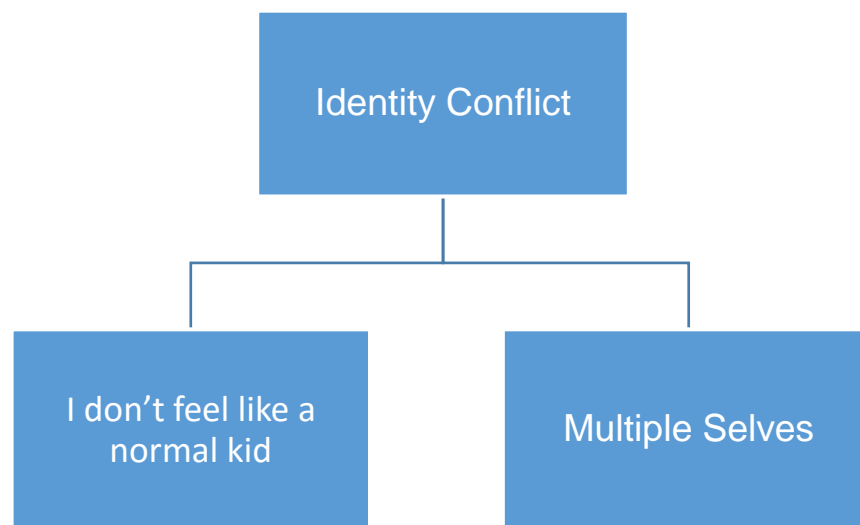
4.2.2.5. Summary of Super-ordinate theme

The young people presented a complicated picture of the role of others and this is due to the various perspectives that they have on others. Most of the young people looked to others as a higher authority, some challenged this power whereas others accepted it. As the interviews progressed, a more complex conceptualisation of ADHD was evident in nearly all the accounts. The accounts were rich with examples of internal conflict as the young people tried to make sense of what ADHD is and how it impacts who they are. This is explored in the next super-ordinate theme.

4.2.3. Theme Three: Identity Conflict

As mentioned in the Table 4.2 above, the Identity theme considers how the experience of an ADHD diagnosis impacts upon young people's identities. Following the data analysis, two subthemes were generated, which are described below.

Figure 4.3: Super-ordinate theme three



4.2.3.1. I don't feel like a normal kid

Most of the young people shared perspectives of feeling different and experiencing conflict in relation to their identities. For some, ADHD posed a challenge to their identities and was viewed as meaning that they are different to others. This feeling of being different was often in relation to taking medication. Many of the young people perceived receiving their diagnosis as being synonymous with taking medication. After receiving his diagnosis, Michael talked about feeling different to other people:

Interviewer: “You feel different, okay, how do you feel different?

Michael: Cause I have to take tablets and stuff. And I don't feel like a normal kid. You know what I mean? Like, I have to take medication” (6:113).

Michael struggled to see himself as someone who takes medication, and tablets in particular posed a threat to how he sees himself:

Michael: “These tablets now make you feel proper tired so when I'm in school, it don't help cause...I would like it in medicine form.

Interviewer: What do you mean medicine form?

Michael: Do you know, like Calpol? You like
Interviewer: Oh, like liquid
Michael: Yeah, yeah like when you
Interviewer: And why would you prefer that?
Michael: I just don't like taking tablets" (5:93).

Michael feels that taking medication makes him different and he expressed concern over how he would be perceived by others:

Michael: "Cause I felt different, I feel like people was going to start judging me
Interviewer: Okay
Michael: Cause I'm taking medication and they ain't" (10:212).

Similarly, after first hearing about ADHD, Sarah commented on her reaction:

Sarah: "At first, I was in denial. I was like no, I haven't got nothing wrong with me. I don't want to take tablets, that's not me, no, I'm normal" (3:62).

For Sarah, taking medication means that she isn't normal and at the time, this did not fit comfortably with how she perceived herself.

Sarah: "...um....it's hard to explain. It's like...don't know.
Interviewer: That's okay/
Sarah: I just felt different" (5:88).

For David, expressions of feeling different to others appeared in more subtle ways. Throughout his interview, David presented a narrative of someone who does not want to be different. He shared a story of being of placed in a social skills group in Year 7:

David: "In Year 7, but it wasn't...like normal work, it was eh, what's that...Do you know in primary school, when you get a social skills group to help you do that? They

had like a different version of that. But it was cause I used to get in a lot of trouble as well. They put me in that, so it's like teaching you how to work in a group. Well I knew how to do it, so I got out of there like straight away" (50:1026).

David's use of words "got out of there like straight away" is reminiscent of his earlier account of being "put away" (49:1002) from his peer group in primary school. His reflections suggest that he does not want to be part of something that separates him from his peer group. He continued and spoke about being placed in a special education class:

David: "I guess the reason I was in there was cause I didn't focus not cause I was bad at subjects...so they put me in that. But, I kind of got out instantly because it wasn't that I didn't know the stuff. It was that I didn't put it to use" (51:1041).

David's language again suggests that he wants to remain with his peer group and he does not want to be seen to be different. It was clear from his story that being separated from his peers had a big impact upon him.

4.2.3.2. Summary of sub-theme

This theme summaries feelings of being different. Some of the young people were quite vocal about this difference. However, for other young people, it was evident that they felt a difference but perhaps they could not articulate it. In addition to this feeling of being different to others, most of the participants presented a narrative of multiple versions of themselves which will be explored in the following sub-theme.

4.2.3.3. Multiple Selves

Many of the young people presented a confused narrative of who they were. For some, this involved merging a past self with "a more suitable" (Sarah, 23:488) present self. Many of the participants spoke about the difference they noticed in themselves when they take medication and when they don't.

However, some of the young people struggled to define the boundary between their medicated and un-medicated selves which led to confusion about who they really are. This confusion led to reflections on aspects of themselves that they felt they could control and aspects of themselves that they felt they could not control.

Past and present self

For some of the young people, past difficulties were not initially easily recalled. During the process of the interview, there was a feeling that many of the young people were trying to reconcile who they are now with who they were in the past. The following accounts from David, Jack and Gary highlight this. David struggled to form a coherent narrative about his past that fits with how he perceives himself now. Early in his interview David described himself as being happy in primary as his diagnosis didn't impact upon him:

David: "I didn't really know what it was so it didn't really change anything" (4:82).

However, as can be seen in the themes above, David felt isolated in primary school. As his interview progressed, perhaps as he reflected more, he was able to recall past difficulties:

David: "Well I did used to get in a lot of like trouble, for stupid things. Like not thinking about doing stuff like that, and not concentrating and messing about in class" (46:935).

David no longer sees himself as this person who presents with challenging behaviour but he feels that homework is now is struggle:

David: "Um, I'm doing pretty well with school work. Homework is one thing that I struggle on" (52:1071).

Jack also at first described himself as always being happy. However, later he reported:

Jack: "No, I just used to be constantly naughty, just swearing, hitting people" (42:863).

Jack also no longer identifies with his past self:

Interviewer: "No, okay so school for you generally is...

Jack: It's just chilled with my friends, work that's it really" (24:487).

Gary also no longer appeared to associate himself with the behaviour difficulties he presented with in the past. He spoke of the behavioural difficulties associated with ADHD in terms of what he saw other people with ADHD in school do. He continued to describe such characteristics through his observations of other people with ADHD. In the following example, Gary describes his brother who is also diagnosed with ADHD:

Gary: "Um cause sometimes, I know some people, like my brother, and eh like sometimes he gets easily tempered sometimes.

Interviewer: Does your brother have ADHD?

Gary: Yeah

Interviewer: Yeah okay. So what does he do when he is tempered?

Gary: Ehh.....like sometimes he will walk out of the house. Um he'll just do some..... silly stuff" (8:164).

The first indication of any struggle for Gary himself came much later in his interview, when he spoke about his medication:

Gary: "And the um, it makes me like not misbehave and it keeps me calm.

Interviewer: Okay, so the tablets helps keep you calm. Okay, can you remember when you didn't take the tablet? What was that like?

Gary: *"Ehh.....I was annoying sometimes. Like sometimes I would call out in class" (20:406).*

Medicated vs Un-medicated self

It was apparent through their accounts that the impact of medication was not clearly understood. Many of the young people presented simultaneous stories in which their medication had little or no impact or it was credited with changing them for the better. This confusion was partly related to aspects of themselves that the young people felt they could or couldn't control. Impulsive behaviours were an area of confusion for many of the young people. David, in particular seemed unsure of his ability to control his impulsivity:

David: *"You can't really control all of it. Like impulsiveness, stuff like that always happens" (5:102).*

David felt that his medication provided him with some sense of control however this appears to be uncertain or tentative control:

David: *"Because like I notice it in myself. If, sometimes when I don't take the tablets or something, I will do things and then think about it and it weren't such a great idea. Like impulsive like just do it without thinking.*

Interviewer: *Okay and can you give me an example of something like that?*

David: *Like if I am in class, like people are throwing stuff about, like I will pick something up and throw it to my mates without thinking of who it is going to hit or something and maybe it will hit someone else or the teacher will see me, something like that.*

Interviewer: *Okay and is there am, are there ever, where you can kind of stop that? Or {school bell rings}.*

David: *Usually...sometimes. It always it kind of happens, sometimes, or now and then" (7:144).*

David's language above suggests that he is uncertain as to how much he can control his impulsivity. He begins by stating that he *"usually"* (7:144) can control his impulsivity however after a pause he added *"It always kind of happens or now and then"* (7:144). He later talks about the subtle change that medication can have upon him:

David: "It's like, it's like um, a subtle change. I won't notice them while I have them but when I don't have them, I notice that it's worse" (17:330).

However, often David doesn't notice a change in himself, it is others who point this out to him:

David: "The medication it's ah...it's one of those things like, it doesn't seem important but it kind of is. It's like because you don't notice the change when you are on it, you just assume that it doesn't really do anything so like, I will be like to my Mum, I don't really see the change in me but she will be like everyone else does. Cause I guess that way I act, people notice that, even if I don't so um" (18:363).

David later reflects again that the medication doesn't change him. However, his comments suggest that perhaps his medication does alter him but others perceive differences.

David: "...I guess to be honest, I usually sometimes, when I don't take them, I don't really notice it. So I think I will be alright but I will just have to keep an eye on how I am more" (43:879).

Similarly, Sarah's descriptions of the impact of her medication are contradictory. At times, she credits her tablets with giving her more control over her behaviour:

Sarah: "Probably the tablets....because before I took tablets I would have fights every day but now I take them. I'm like, got a more suitable head {smiling}" (25:487).

Also, in the following extracts, Sarah provides a vivid account of the changes she experiences due to her medication:

Sarah: "Yeah, cause if not um, I get like a really hyper boost.

Interviewer: Okay, a hyper boost. What happens during a hyper boost?

Sarah: "It's like you can feel the tablets wearing out and you feel hyperness going up and up and up and up and up and then you just...wanna run around and stuff" (9:165).

This suggests that Sarah feels a lack of control over herself when her medication begins to leave her system. She continues:

Sarah: That's why it's so bad during night times, cause I think a lot of people struggle with it, with ADHD, cause where your tablets are keeping it low for the whole day, when they start to like, you can like start to feel them wearing out, you're more like up and awake. Like you wish you could feel this way in the morning. You're just like up and awake" (9:169).

However, at other points, Sarah questioned that impact of her medication and appeared to be unsure if it was responsible for any changes in her:

Sarah: "Because they do keep me calm...but sometimes when I forget about it and I won't take it for one day, I will be exactly the same as I am" (8:144).

Sarah was not confident in her assertion that she is the same when she doesn't take her medication. She then added *"It's just...except for when it*

gets really (-) late because that's when I think they wear out...really bad"
(8:146). This suggests that Sarah is uncertain about how her medication affects her.

Taking medication caused considerable distress for Michael. As seen earlier, Michael resists the idea of taking medication and he expressed concern that people would judge him for taking it. Michael also made references throughout his interview that suggested that he and others did not perceive ADHD to be a 'real' condition. Below, Michael recalls how his friends reacted when they found out he had ADHD:

Michael: "My mates were like, oh Mikey you're dizzy. Taking the mick and stuff.

Interviewer: Okay/

Michael: And I just felt why am I doing this? Why am I taking tablets?" (11:220).

Yet despite his reservations, Michael felt that taking medication worked to help calm him down:

Interviewer: "Um hm and did you notice any difference in yourself when you took the tablet?

Michael: Calmed down well loads

Interviewer: Um hm

Michael: Calmed down a lot and I would say it helped me. But the dose didn't help, like it worn out. It's supposed to last, like my tablets will wear out in another half an hour or something. Cause they don't last long. I think that's how a tablet, what last hours but watch when I get home. I will just be off the rails and I'm the first to admit that" (11:225).

Taking medication appears to mask ADHD for Michael:

Michael: "...because sometimes I feel like I ain't got it when I'm on the tablets and when I ain't on tablets, I feel like I got it.

Interviewer: Say that again sorry?

Michael: Sometimes I feel like I ain't got it/

Interviewer: Okay/

Michael: Cause when I'm have my tablets and it's all calm"
(37:802).

Similar to David, Michael reflects that he doesn't not always notice the impact of his medication:

Michael: "But when for like when my tablets run out, I feel I know I got it, like my Mum is like, aw tablets are running out, so it makes you think back, aw I have got it" (38:809).

Thus for Michael, taking medication cause conflict and confusion. However, the experience of taking medication is different for Jack. Jack spoke about medication giving him control over his ADHD symptoms.

Jack: "Not all the time. Cause when I am medicated I am calm. I can concentrate...like...I will think twice about things. Like if someone tells me to do something, I will think twice whereas if I wasn't medicated I would just do it, yeah I will do that" (22:449).

Jack was very clear that taking medication was not a threat to his identity. He spoke about how his mother was concerned about this:

Interviewer: "Do you think that has made a difference for you?

Jack: Yeah a lot of difference.

Interviewer: Um hm and erm did you said, your Mum was worried it might change your personality. Did it change anything about you?

Jack: Nothing" (43:890).

Jack feels that the medication does not change who he is. However, perhaps he views it as more of a temporary change than a permanent alteration to himself:

Jack: "There's nothing wrong with it. It's out of your body by like 4 o'clock, I think mine is.

Interviewer: It's out of your body by 4 O'clock?

Jack: Yeah, by the time I get home I am back to normal.

Interviewer: Back to normal, what does back to normal mean?

Jack: Just hyperactive jumping around" (46:940).

Gary felt that medication took control of his behaviour:

Gary: "And the um it makes me like not misbehave and it keeps me calm" (20:406).

4.2.3.4. Summary of sub-theme

For all the participants, ADHD presented them with multiple views of themselves; me in the past vs me now and medicated self vs un-medicated self. For some of the young people, this led to considerable confusion over what they could and couldn't control about their behaviour. Also, David and Michael both reflected that they often didn't notice how they changed on medication. Instead the changes in them were pointed out by other people.

4.2.3.5. Summary of Super-ordinate theme

The young people presented a clear narrative of opposing views in relation to their identity. They all took measures to make sense of these multiple versions of themselves in order to make sense of who they are, which is explored in the following super-ordinate theme.

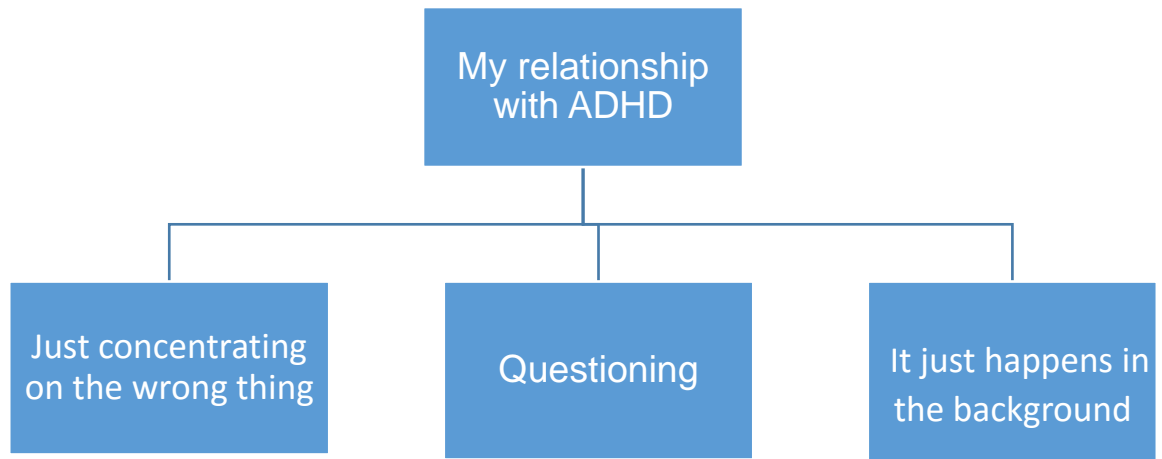
4.2.4. Theme Four: My relationship with ADHD

An IPA researcher's aim is to make sense of the participants' sense making.

This theme explores the ways that the young people had begun to define their

relationship with ADHD. For many of the young people, this was just the beginning of a life long journey with ADHD.

Figure 4.4: Super-ordinate theme four



4.2.4.1. *Just concentrating on the wrong thing*

For many of the young people certain aspects of ADHD were depicted as being more acceptable than others. Certain aspects of ADHD were normalised. Hyperactivity appeared to be an aspect of ADHD that some of the young people felt was common amongst other people too.

Interviewer: “Okay and eh now once that you are taking the tablets, do you do any of those things kind of apply now?”

Sarah: ...um...sometimes I get energetic but that’s just normal” (16:301).

David also positions ADHD as being like ‘normal’ and comments that everyone gets energetic:

David: “Really with ADHD, it feels like just being normal but really energetic and impulsive and stuff. So I guess that it’s like everyone gets energetic sometimes but that’s like all the time” (15:302).

Gary was the only participant to use words with positive connotations to describe ADHD. Thus he introduced a new narrative of someone with ADHD with admirable traits. For instance, Gary described people with ADHD as being “*playful*” (12:234) and commented that is okay to be playful:

Gary: *“Cause eh they are not doing anything bad. They are just concentrating on the wrong thing”* (14:286).

Jack described how the difference between those with and without the diagnosis is, that those without ADHD are:

Jack: *“Am...just more chillaxed”* (53:1087).

Jack’s description here suggests that ADHD is not something that causes many difficulties. His use of the word ‘more’ suggests only a slight difference in states of arousal or temperament.

4.2.4.2. Summary of sub-theme

This sub-theme presents a story of how some participants normalised aspects of ADHD. Being energetic, in particular, seemed to be seen as being less problematic, as many of the young people felt everyone could be so.

4.2.4.3. Questioning

Some of the young people challenged and questioned ADHD. Throughout his interview, Michael challenged the concept of ADHD the most. His challenges were often subtle, but at other times he was more direct in his comments. He began his interview by recalling how children in school used to pretend they had ADHD to get out of trouble:

Michael: *“Well then like sometimes when you got in trouble he was like oh miss it’s cause I’ve got ADHD and stuff”* (4:75).

It was evident throughout his transcript that he has a challenging relationship with ADHD and with those involved in his treatment. In the following extract, Michael speaks about his interactions with doctors, whom he sees as being in control:

Michael: "They just ask me silly questions and I just get wound up and I start messing around on purpose sometimes. It ain't on purpose. It's like when I go there. I'm not allowed to eh um some" (9:190).

Michael raised the point several times that he isn't involved in decisions about his treatment. In the above extract, it appears that he may have been about to reference this again, however he finishes his sentence with *"When I go there it's just stupid"* (9:193). Both Sarah and David expressed views that subtly challenged ADHD by suggesting the diagnosis is for other people's benefit, not theirs. At the beginning of her interview, Sarah spoke about her struggle to accept that she may receive a diagnosis of ADHD. In contrast, she feels that this brought a sense of relief to her mother:

Sarah: "Where I was so bad and my Mum thought it was just because I was being naughty and like I couldn't, that was just being against the world as a teenager. But when she actually found out, I think it made her more, a bit more happy, that it wasn't just me being rebellious. It was me actually not being able to do things" (5:90).

David also expressed views that suggested that an ADHD diagnosis is needed by other people not him:

David: ".....I guess for me how I feel is... if someone never told me I had it, I wouldn't even realise that I had anything like this. So I guess it's hard to tell. I mean it doesn't really feel different to have it. It just feels the

same as everyone else. So I guess if a doctor never told, I guess I would go on just being like this forever. Eventually, I guess it would probably sort itself out” (45:908).

4.2.4.4. Summary of sub-theme

This sub-theme explored the ways that some of the young people challenged ADHD. For some, this was a direct challenge and for others it was expressed more subtly.

4.2.4.5. Distancing

Another strategy for young people was to distance themselves from ADHD. This occurred in different ways, some participants did not strongly associate themselves with the behavioural symptoms of ADHD whilst others positioned ADHD very much in the background of their lives.

As noted, Gary created distance between himself and the negative connotations he held for ADHD. He spoke of the difficulties in terms of what he saw in other people and he related mainly to the positive attributes:

Gary: “Um cause me and my brother are normally playing games and making up stuff as we go and it’s um...yeah” (10:205).

David seems to have disengaged from ADHD and he has removed ADHD to the background of his life:

David: “Yeah it’s like I go to a hospital once every six months and or six weeks and get my height checked. Stuff like that but other than that, that’s about it cause I don’t really hear about it. Cause I have never really needed to um understand about it too much” (41:843).

For David, his relationship with ADHD is taking a tablet:

David: "So all I do is take tablets in the morning and that's the last I hear about ADHD" (41:839).

However, David spoke at length about how understanding ADHD is important for other people:

David: "I guess they seem unimportant but in the long run all that tiny bit of information could, like, lead up to big helping point, like all that information. Although it seems small, it can help the doctors figure out just how much medication I need, or just how long I might have it for, or something like that" (43:867).

It is interesting that David has created such distance between himself and ADHD. As discussed, he presented a narrative of wanting to 'blend in' which he now appears to do.

Jack's relationship with ADHD appeared to be different to those of the other young people and he is involved in making decisions about his treatment. His story suggested that he sees ADHD as only needing treatment during school hours. As the medication leaves his system towards the end of the school day, Jack feels that:

*Jack: "Yeah by the time I get home I am back to normal.
Interviewer: Back to normal, what does back to normal mean?
Jack: Just hyperactive jumping around" (46:943).*

However, Jack's relationship with ADHD also appears somewhat distant and uncertain:

*Jack: "No I have not really ever like sat down and thought about it.
Interviewer: And why do you think that is? Why you haven't?"*

Jack: Don't know just...just unknown really. Don't know really" (38:775).

Thus for Jack, his journey with ADHD may continue.

4.2.4.6. Summary of sub-theme

This sub-theme provides an analysis of how some of the young people have begun to distance themselves from ADHD. Some distanced themselves from the difficulties associated with ADHD whilst others removed ADHD to the background of their lives.

4.2.4.7. Summary of Super-ordinate theme

The young people adopted different strategies to manage the impact of ADHD on their identities. At times this involved normalising aspects of ADHD, at others it was challenged and/or distant relationships with ADHD emerged.

4.3. Conclusion of Chapter

This chapter presented the main findings from analysis of the data. The resulting super-ordinate themes are based upon the researcher's interpretation of the young people's accounts of their experiences of ADHD. It began by presenting the young people's interpretations of the aetiology and symptoms of ADHD and progressed to consider how others have impacted upon the young people's experience and understanding of ADHD. Next, the young people's experience of ADHD and what it means for their identities was explored. The analysis concluded by exploring the ways the young people have begun to make sense of their relationship with ADHD. The stories of the young people provide an alternative way of viewing ADHD.

CHAPTER FIVE: DISCUSSION

5.1. Overview of the chapter

This chapter provides a discussion of the findings in relation to the research aims and links the findings to current research on ADHD and relevant theory. This is followed by a critical evaluation of the study and suggestions for further exploration of the topic. The researcher then reflects upon the implications of the study for EPs in their practice. The chapter concludes with reflective comments from the researcher.

5.2. Discussion of Findings Related to the Research Aims

ADHD is cited as being one of the most common childhood diagnoses (Cooper, 2008), yet it remains one of the most controversial conditions. The purpose of this study was to provide a richer understanding of ADHD by exploring it from the perspective of young people living with a diagnosis. To achieve this, the researcher explored the following questions.

How do young people diagnosed with ADHD perceive their condition?

Do young people diagnosed with ADHD identify with their condition?

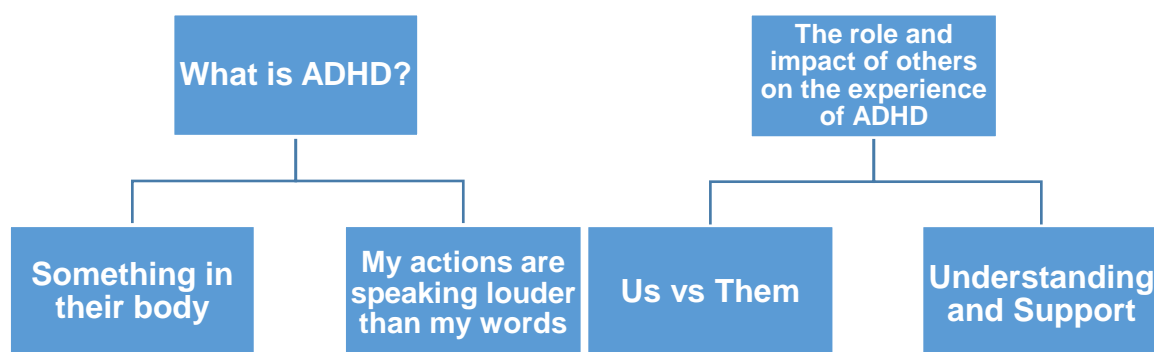
Semi-structured interviews were carried out with five young people diagnosed with ADHD, aged 14-15 years in an outer London borough. Analysis of the data through IPA resulted in four super-ordinate themes with linked sub-ordinate themes; What is ADHD: The role and impact of others on ADHD; Identity Conflict; My relationship with ADHD.

5.2.1. RQ1: How do young people diagnosed with ADHD perceive their condition?

The first super-ordinate theme that emerged from the current study reflects the participants' interpretations of ADHD, via its aetiology and symptoms (a graphical representation is available in Figure 5.1). The second super-ordinate theme discusses the role and impact of others upon ADHD and is represented

graphically in Figure 5.1. As both themes were felt to be closely inter-related, the author decided to discuss them together.

Figure 5.1: Super-ordinate themes one and two



5.2.1.1. Links to current research and theory

The young people's perceptions of ADHD varied, some portrayed ADHD as being a condition that consists of a series of behavioural characteristics reminiscent of the core symptoms associated with ADHD, whilst others described an 'aggressive' condition and/or something that caused them inner turmoil. Their accounts also communicated an emotional component to their experience of ADHD. As discussed in Chapter 2, Travell and Visser (2006) found that young people with ADHD described the condition in line with diagnostic criteria and references were made to the emotional impact of their symptoms upon their self-esteem. Singh (2011) interviewed children in the UK and US with a diagnosis of ADHD and found that the participants in her study either placed ADHD in a 'performance niche' or a 'conduct niche'. Children in the performance niche described ADHD as a disorder that impacted upon learning whilst those in the conduct niche spoke of ADHD as a disorder of anger and aggression. Further, the children from the UK tended to view ADHD from the conduct niche. This suggests that in the UK, ADHD is viewed as being a disorder that is related to behaviour. The participants in this study did not fit neatly into one or the other. Rather, at different points in their story, they touched upon elements of both.

The young people in this study mainly described ADHD from a biological and developmental perspective. References were made to ADHD being related to the brain and a genetic component was suggested. However, one of the participants, Sarah, acknowledged wider influences such as social and psychological causes. Although limited in number, studies in the UK have found that the most common cited reason for ADHD is a biological cause (Travell & Visser, 2006). Endorsement of a biological cause for ADHD has also been found through an analysis of media reports in the UK. Horton-Salway (2011) carried out a discourse analysis of UK media reports of ADHD between the years 2000-2009. This analysis found that the two most common representations of ADHD in the media were: ADHD as a biological condition (referencing the brain, chemical imbalances) and/or as a psychological condition (referencing social problems on children's behaviour). In the accounts preferring a biological aetiology, children with ADHD were depicted as presenting with a disorder that required medical treatment. However, purely biological accounts were rare as most articles also referenced the complexity of ADHD. In the media portrayals of ADHD as a psychological disorder, children with ADHD were depicted as being badly behaved but 'normal' and ADHD was seen as stemming from a dysfunctional society rather than from a dysfunctional individual. Research from the UK has found that stigma is attached to ADHD (Bellanca & Pote, 2013; Law et al., 2007). Interestingly, a complex and contradictory understanding of ADHD was also held by the participants in this study. As discussed, the young people's understanding of ADHD was tentative and it appeared to originate from their interactions and experiences with others.

As the researcher adopted a social constructionist position, it is considered that the participants' understanding and interpretation of ADHD is influenced by the society in which they live. Further, symbolic interactionist theories offer an interesting reflection point for the findings of this study. Cooley (1902) suggested that the self is not fixed and it evolves from interactions with others. Individuals internalise the feedback they receive from others which in turn shapes their identity. This has been termed the "looking glass self" (Cooley, 1902, p.189). Another influential theorist in this area is Mead (1934) who argues that the self develops through social interactions in a learning process whereby we try to make sense of our worlds. In terms of this research, it was felt that the

young people might have internalised conversations/interactions they had with others in relation ADHD. This might have influenced their idea of what ADHD is and how it fitted, or did not fit, with their sense of self (which is addressed by the second research question).

Michael, for instance, appears to have been exposed to comments that suggest ADHD is a social construction; *“them kids are just off the rails”* (19:412). Early in his interview, Michael said that ADHD was *“like a thing to get out of trouble to say you got ADHD”* (3:52). Michael’s interpretation of and relationship with ADHD appears to have been greatly impacted by such experiences. He spent a considerable amount of time during his interview justifying ADHD as a legitimate condition and he appeared to resent taking medication. Following this, his interview concluded with him mocking ADHD himself. Michael appears to have internalised these comments and it seems to have impacted upon his perception of ADHD. Similarly, David shared that his father suspected that he, himself has ADHD, which led David to feel that it may be a genetic condition. This appears to have influenced his interpretation of ADHD which he primarily sees as a biological condition. Sarah’s account also suggested that her interpretation of ADHD is partially based upon feedback from others. Sarah felt that others would describe ADHD using words with negative connotations related to observable behaviours. From the researcher’s social constructionist perspective, whether Sarah’s interpretation is true or not is irrelevant, as there are multiple realities. Sarah’s interpretation is based upon her experiences. What is important to reflect upon here is that Sarah at some point has internalised her interactions with others and added meaning to them to inform her opinion of ADHD.

Thus, ADHD appears to be generally viewed in terms of difficulties and deficits. However, in the debrief session, the researcher presented the young people with images of famous people who are thought to have ADHD. Many of the young people were surprised at first. However, when asked how ADHD might have helped them, some of the young people identified characteristics that they felt might have helped them achieve their goals (e.g. hyperactivity giving you lots of energy, using negative feedback from others as motivation, or having a good imagination). Only one participant, Gary, had been able to connect

independently with ADHD in this way. Gary described ADHD as being playful and imaginative. Gary's brother is also diagnosed with ADHD. This may impact how ADHD is viewed in his home. For the others, they were the only people in their immediate families with a diagnosis.

Many of the young people shared stories of how others were the ones to notice their behaviour as being different from 'others'. It is worth reflecting upon Social Identity Theory (Tajfel, 1978) to explore this. According to Tajfel (1978), social identity is a person's sense of who he or she is based upon the groups that he or she belongs to. These groups serve as an important source of self-esteem. Belonging to a group creates an in-group/out-group mentality. Tajfel and Turner (1979) suggested that three mental processes occur in developing in and out groups, after which the individual can accept or reject a place in the assigned group. The first stage is categorization, which refers to the human tendency to organise objects and people into categories to help us understand our world. For the young people in this study, categorization began as others noted their behaviour as marking them out as different from others. In their cases, this led to assessment and a diagnosis with a label of ADHD. The next two stages are social identification and social comparison which are discussed later, in relation to the final super-ordinate theme: My relationship with ADHD.

Control and power, or a lack of it, was a prominent theme in this research. Many of the young people told stories with an underlying current of a loss of control in making decisions in their lives. Singh (2011) noted that many of her participants did not have much contact with their doctor after their assessment. Further, contact with the doctor tended to be focus on the side effects of medication. The young people in this study also appeared to not perceive themselves as main contributors in their treatment decisions. For instance, Michael actively resisted this passive role and described feeling angry towards others for not involving him. In contrast, Jack appeared to be involved in his treatment decisions. For example, he chose to receive medication and he also chooses when to take it and whether to take it.

Self-Determination Theory (SDT) is interesting to consider here (Deci & Ryan, 2002). This theory considers that people are innately motivated towards

personal growth and fulfilment which, when achieved, will lead to a unified sense of self. According to SDT, people need three psychological needs to be met to have intrinsic motivation. People need to feel a sense of competence, relatedness and autonomy. SDT defines competence as a feeling of a sense of confidence and being effective, rather than attainment of actual skills (Deci & Ryan, 2002). Relatedness refers to a feeling of being connected to others and experiencing a sense of belongingness (Deci & Ryan, 2002). Finally, SDT defines autonomy as perceiving personal behaviours as being an expression of the self. Social environments that support development in these areas will foster intrinsic motivation and promote positive growth. This innate tendency towards fulfilment can be thwarted in these conditions are not met. In relation to ADHD and the participants of this study, some of these conditions appear to be comprised. The participants presented confused narratives of control over their own behaviour. There was also a sense that having ADHD made them different and separated them from 'others'. Some of the participants experienced a sense of competence, however, for others the school environment was challenging and perhaps did not instil feelings of competence.

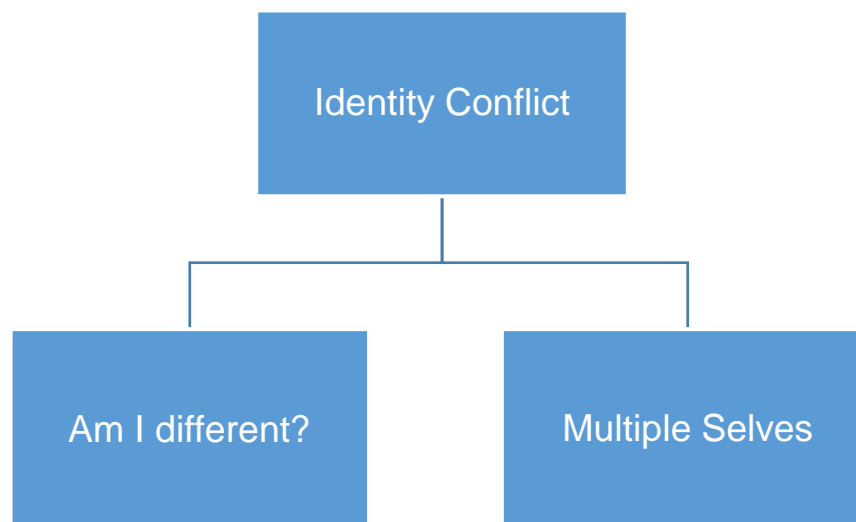
In summary, the young people presented with a complex and contradictory understanding of, and relationship with ADHD, which to some extent is mirrored in media depictions of ADHD in the UK. ADHD as a phenomenon was seen as having a biological basis whilst also being influenced by wider forces. The young people leaned towards negatively worded descriptions of ADHD, however when presented with a more positive narrative about ADHD, most of the young people could engage with it. Finally, involving the young people in the diagnostic process and management of their treatment could help foster a sense of autonomy and control in their lives and support the young people to 'own' ADHD rather be 'owned' by it.

5.2.2. RQ2: Do young people identify with their diagnosis?

The following section outlines how the current study addressed the second research question and considers how this relates to previous research. The third super-ordinate theme reflects how the young people experienced ADHD in relation to their identity. The fourth super-ordinate theme describes the young

people's relationship with ADHD. There is quite limited research in the UK on the impact of ADHD on a young person's identity.

Figure 5.2: Super-ordinate theme three



5.2.2.1. Links to current research and theory

The young people in this study appeared to be on a journey of self-discovery in relation to their ADHD. As such, Identity was a theme that emerged from all of the participants' accounts. Firstly, in exploring whether young people identified with their condition, stories of feeling different emerged. This is in line with findings from Young et al.'s (2009) study of the experiences of young people with ADHD who were in a young offenders' secure unit. They expressed a sense of loss and a desire to find where they belonged. However, it is possible that other factors contributed to these findings, as, in addition to being diagnosed with ADHD, these young people had been involved in crime. Only one participant in the current study reported involvement with a Youth Offending Team.

Secondly, there was a strong narrative of a conflicted self. Some of the young people saw ADHD as being synonymous with taking medication and this is where confusion about the self was most apparent. Previous research indicates that young people report struggling to maintain their identity or true self when taking medication (Avisar & Lavie-Ajayi, 2014; Loe & Cuttino, 2008; Pillow, Naylor, & Malone, 2014). Others conversely report that this is not the case

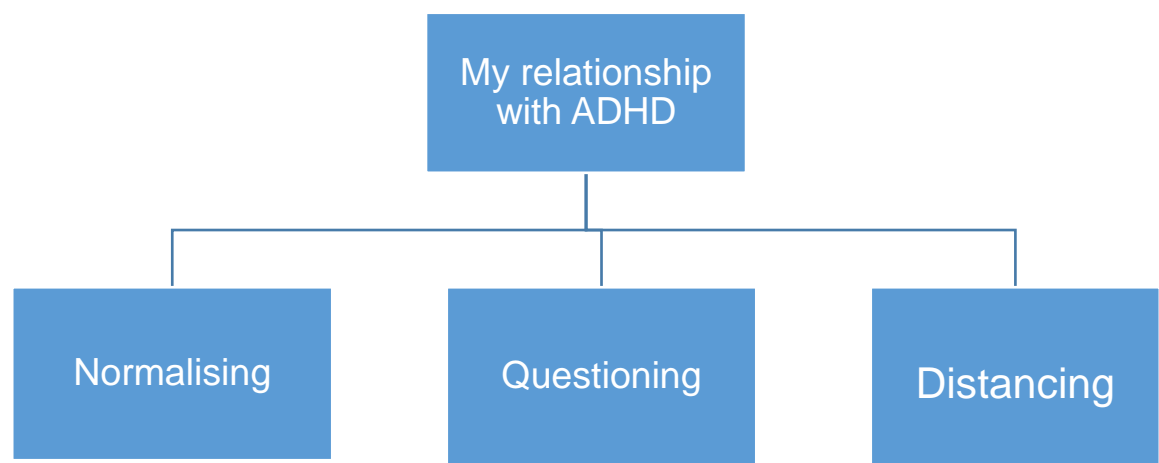
(Singh, 2011). However, it is apparent that the young people in this study did struggle to make sense of how their medication affected them. Several young people made comments that suggested that taking medication had improved their behaviour and changed them for the better. However, at other points, they reflected that their medication had little impact upon them.

As the participants in this study were aged between 14-15 years, it is important to reflect upon adolescent development and how this stage of development may have impacted upon their developing sense of self. In Western society, adolescence is characterized as a period when the individual develops increased autonomy from parents and as a period of self-exploration. As Identity was a prominent theme in this study, the researcher decided to draw upon aspects of Erickson's (1968) eight stage psychosocial model of development, for further reflection. According to this model, forming a sense of identity is one of the core developmental tasks of adolescence (Erickson, 1968). The adolescent is faced with an 'identity crisis' which is viewed as being a period of temporary crisis during which the adolescent makes sense of the physical, social and emotional maturational changes they are undergoing. It has been argued by some that identity formation neither begins nor ends during adolescence (McCrae & Costa, 1997). However, it is the first time that an individual has the cognitive ability to consciously reflect on who they are and what makes them unique (APA, 2002). Further, as the developing adolescent reaches a higher level of emotional maturity, a more coherent sense of self emerges (Santrock, 2001). Thus, forming a sense of self is emphasised during adolescence. This is important to consider in this study as the participants were between 14-15 years old, which can be considered early to middle adolescence.

Early adolescence is thought to be characterized by a proliferation of selves which are created depending on the social context such as self with a parent, self with peers, and self with teachers (Harter, 2012). The young people in this study, experienced additional selves related to their ADHD. For example, the medicated self, the un-medicated self and aspects of the self that could and could not be controlled. During mid-adolescence an awareness of multiple selves develops and with advancements in cognitive ability, abstract mappings

can be made (Fischer, Hand, & Russell, 1984). Abstract mapping refer to the individual's ability to compare and contrast different attributes. For example, an individual can be both extrovert in one context and introvert in another. The adolescent may not yet have the skills to co-ordinate these contradictory attributes, which can lead to conflict and distress (Fischer et al., 1984). The young people in this study were beginning to show signs of recognizing differing selves, however, for most this created a sense of confusion. This confusion seemed to be a result of the young people struggling to define the boundary between who they are, with and without medication.

Figure 5.3: Super-ordinate theme four



The final super-ordinate theme explored how the young people had begun to make sense of their relationship with ADHD. The majority of research on managing ADHD focuses on external support such as services, treatments, and support from significant others, rather than methods used by the young people themselves (Cheung et al., 2015). In this study, many of the young people struggled to make sense of and manage their relationship with ADHD. To resolve this, they developed ways to manage this internal conflict. At times, certain aspects of ADHD were normalised, at others the concept was challenged and questioned, and yet again distance was created between some of the young people and ADHD.

Social Identity Theory (Tajfel, 1978) offers a way to further interpret this theme. As discussed earlier, categorization is the first stage of three mental processes in Social Identity Theory. This occurred as the young people received their diagnoses. During social identification, an individual adopts the identity of the group to which he or she belongs to. The final process is social comparison. Once someone has identified the group to which they belong and identified with it, they look to compare their group to others. However, reflecting upon the findings of this study, some of the young people were resisting the 'social identification' process seemingly because they did not want to belong to the 'ADHD' group. According to Social Identity Theory, how people manage these processes depends on two factors: permeability and security. In terms of permeability, if people feel that they can still function well and prosper within their rejected group, they may try to create distance between themselves and the group. If they feel that they cannot create this distance they may begin to identify with the group and strive to improve their situation (Tajfel & Turner, 1986). As mentioned, some of the young people normalised aspects of ADHD such as hyperactivity. This could either reflect the young people beginning to identify with the group and as such they are attempting to diminish the problematic depiction of those with ADHD. Some of the young people also began to distance themselves from ADHD. This was most evident in David's account. David previously experienced difficulties in his school life seemingly related to his behaviour. However, he had found a way to minimise these difficulties and fit in with others. This has led him to develop a distant relationship with ADHD and as he says "for me so all I do is take tablets in the morning and that's the last I hear about ADHD" (41:839). Social Identity Theory (Tajfel & Turner, 1986), also theorises that if an individual perceives some aspect of their situation as unfair he or she will challenge the status quo of the group. In the sub-theme 'questioning', the young people challenged ADHD as a concept and Michael in particular challenges his role in managing his ADHD.

In summary, ADHD presented the young people with challenges relating to identity. Developing an increased sense of self is an important developmental task in adolescence. The participants in this study also faced the challenges being diagnosed with ADHD and taking medication. The young people

developed different ways to manage this through normalising, challenging or distancing themselves from ADHD.

5.3.1. Summary of Chapter

This chapter provided a discussion of the main findings from this study. The chapter began by reviewing the first research question: How do young people diagnosed with ADHD perceive their condition? This was discussed by linking the main findings from super-ordinate themes one and two with current research on ADHD whilst also making links to relevant theories. The researcher then discussed the second research question: Do young people diagnosed with ADHD identify with their condition? The main findings from super-ordinate themes three and four were reviewed in light of this question and again links were made to current research and relevant theories.

CHAPTER SIX: CONCLUSION

6.1. Summary of the Main Findings

This research aimed to present an understanding of ADHD from the perspective of young people diagnosed with the condition. It is hoped that, by exploring ADHD in this way, a fresh insight can be obtained on this controversial topic.

The author's interpretation of the data was that ADHD is generally viewed from a biological perspective with some references to social and environmental influences. ADHD as a condition was viewed by the participants in much the same way as the DSM-V (APA, 2013) defines it. However, many of the young people also spoke of an emotional component to the disorder. The young people spoke of significant others in their lives as playing the role of opponents and supporters. There was a sense of a lack of control for the young people in managing their ADHD with many taking a passive role.

For all of the young people, the diagnosis of ADHD created tensions for their identity formation. The young people questioned whether they were different and grappled to make sense of multiple identities. The young people managed their relationship with ADHD through distancing oneself from ADHD, questioning the condition or normalising aspects of it. Research indicates that ADHD is often associated with high levels of stigma (e.g. O'Driscoll et al., 2012). It is hoped that a greater understanding of ADHD and its impact will be achieved by listening to the voices of those diagnosed with the condition.

6.2. Strengths and Weaknesses of the Research

This research aimed to introduce an alternative voice to the debate on ADHD. Exploring how young people perceive and relate to their diagnosis can help enrich understanding of ADHD. The following sections provide an overview of the strengths and weaknesses of the research.

6.2.1. Sample Size and Characteristics

This study presented the detailed views of five young people, interpreted from an IPA perspective. This is a limited sample size and therefore, the researcher, is not making claims beyond the cases presented here or attempting to generalise from the findings. However, exploring ADHD in this way allowed the researcher to provide a rich, in-depth analysis of the lived experience of these young people. Phenomenologists argue that psychology needs to explore experiences in this way and understand phenomena by building a richer more meaningful picture through case by case analysis (Smith et al., 2009).

IPA requires a homogenous sample, which again limits the applicability of these results. The participants were all diagnosed with ADHD, aged between 14-15 years and lived in an outer London borough. However, there were differences in the sample. For example, four of the young people came from White British backgrounds whilst one young person came from a Roma/Gypsy Traveller background. In terms of gender, there were four males and one female. As such, female voices are under-represented. The participants had received their diagnoses at different points in their life and two of the participants had co-diagnoses. It was decided to include these young people as it was felt that it was appropriate considering that there is a high co-morbidity rate with ADHD.

6.2.2. Power Imbalance

When carrying out research it is important to reflect upon power imbalances and how such imbalances might influence participants' responses. The researcher aimed to balance the power by positioning herself as a non-expert and as an equal to the young people, rather than as a person of authority. I introduced myself as 'Orla' however, none of the young people addressed me as this. I was referred to as 'Miss' by all of the young people. This may have influenced how the young people interacted with me.

To encourage participant participation further and therefore reduce the image of the researcher as an authority figure, it would have been helpful to include young people in the design of the interview questions. However, this study was time limited.

6.2.3. Language Demands

This study presents a double hermeneutic whereby the researcher interpreted the young people's interpretations of their experiences. However, it cannot be assumed that the young people's language and drawings revealed their true thoughts and feelings on ADHD. It might have better supported the young people to have known the researcher better and to have had further sessions to explore their experiences of ADHD.

6.3. Future Research

There are several possible extensions to this research. For example, all of the young people in this study received medical treatment. Further research could be carried out with young people diagnosed with ADHD who do not use medication to explore if there are differences in how they experience, perceive and understand ADHD compared to those that take medication.

It would also be interesting to vary the characteristics of the sample to analyse the differences. For example, exploring ADHD in different cultural contexts or analysing how gender expectations may influence how males and females perceive their ADHD.

This study was interested in exploring how young people perceived their condition. The researcher did not want to direct the nature of the young people's responses. However, it would be interesting to carry out research with people with ADHD who have 'success' narratives in relation to their ADHD and what helped them achieve to develop these.

6.4. Implications for Practice

As discussed earlier, children and young people diagnosed with ADHD are clearly indicating that they are not involved in making decisions that affect their lives. According to Self-Determination Theory (Deci & Ryan, 2002), in order to achieve personal growth and fulfilment, people need three psychological needs to be met. An individual needs to achieve a sense of competence, relatedness and autonomy. It is therefore important that children and young people

diagnosed with ADHD are provided with opportunities to develop skills that will empower them to make sure that their views and wishes are respected. This could be achieved by teaching young people the skills needed to become self-advocates. Self-advocacy can be defined as a person's ability to effectively convey, communicate and assert his or her own rights, desires, wishes and goals (Van Reusen & Bos, 1994). This could be achieved either through direct or indirect work with young people. EPs could work jointly with schools and other professionals to create programmes to teach self-advocacy skills to students. Alternatively, EPs could work directly with young people to create a self-advocacy programme and teach such skills to young people. EPs have psychological knowledge and an understanding of children and adolescent development which can be utilised to inform how to teach self-advocacy skills. Providing young people diagnosed with ADHD with self-advocacy skills will place them in a much stronger position to voice their opinions and become actively involved in decisions that affect their lives. Further, teaching self-advocacy skills will provide young people with a life skill which might be beneficial in their future should they wish to continue or cease seeking treatment for ADHD.

EPs have an important role to play in the diagnostic process for ADHD. EPs have knowledge of schools, and child and adolescent development. They can therefore offer psychological theory to inform the assessment process by providing a framework to help generate holistic views of children and young people. Further, EPs could support the development of post-diagnostic interventions. This could involve engaging the professionals involved in working with young people diagnosed with ADHD in systemic thinking. An influential theory in systemic thinking is Bronfenbrenner's Ecological Systems Theory (1979). This theory argues that while an individual's biology will impact their development and functioning, this should be viewed in the context of the relationships in the individual's environment. The relationships are seen as occurring in a series of systems: the microsystems, the mesosystem, the exosystem and the macrosystem. The microsystem is the system that has direct contact with the child or young person. This can include family, friends, and teachers. These relationships are viewed as being bi-directional in that how you interact with someone impacts how they interact with you. The mesosystem

is where the systems in the microsystem interconnected and influence each other e.g. the relationship between the parent and the school. The relationship between systems on this level can have either a positive or negative impact of the child or young person's development. The exosystem refers to systems that the child and young person do not have direct contact with but these systems can still impact them e.g. a parent's workplace. The next system is the macrosystem is the cultural context in which the child or young person lives e.g. national government policies. Considering children and young people within such a framework can help how to best inform practice and help identify which systems need to be supported.

EPs also have a role to play in providing training to school about conditions such as ADHD. It might be helpful to shift the focus away from 'labels' and focus on identifying areas of needs. This could include supporting schools, parents, and children and young people, to take more critical and holistic approaches to supporting young people diagnosed with ADHD. For example, creating psycho-education groups that teach young people skills to target areas that they are struggling in such as self-regulation, listening and attending, and building and maintaining relationships. Further, EPs can help create positive narratives about people who are diagnosed with ADHD by highlighting the young people's strengths and achievements.

6.5. Closing Reflections

A reflective approach is important in qualitative research as it supports the researcher to track and monitor biases which may otherwise influence data analysis. As I used IPA for my research, this helped develop my reflection style. I am interested in the theory of hermeneutics. For me it highlights how one must always be reflective in when creating formulations. Engaging in reflexivity was immensely helpful throughout this study. As discussed earlier, I found it useful to look to Gibbs' (1988) reflective cycle to guide my overall reflections for this study. Further, approaching my study from a social constructionist perspective has strongly influenced my interpretations of events in my practice and in my personal life. It has challenged me to take a critical stance towards taken for granted knowledge. This has supported me to take a '360 degree' look at situations and to understand multiple perspectives which in turn has helped me

to gain richer insights to the challenges I face in my work. It also given me a renewed enthusiasm and appreciation of my upcoming role as a qualified EP in a borough rich with life and diversity.

I developed a much richer understanding of ADHD and insight into how receiving a diagnosis of ADHD can impact upon a young person. I was struck by Michael's comment that people say those with ADHD are "off the rails". This highlighted for me the impact the media and popular psychology can have on young people. It furthered my commitment to young people's right to be educated on the labels that are given to them. They reported that they were not included in the process of managing their condition. As a TEP, I place a value upon promoting the voice of the young person.

This study also highlighted for me the power of narratives about young people and how these can come to define a person. David presented a story of a young person who was previously isolated from his peers. This appeared to have a major impact on how he saw himself. David now has a distant relationship with ADHD. I feel that he may experience his relationship with ADHD in this way, as to embrace it may led to stigma and exclusion for him again.

I was struck by Gary and his story. Upon meeting him, he was very subdued and he struggled to articulate his thoughts. He was also taking three different types of medication daily and I wondered what impact this was having upon him.

Some participants were reluctant at first to engage in conversation about the difficulties they experienced. I learned to engage young people to talk about a topic where perhaps, they did not appear to have much factual knowledge. However, they all had an experiential knowledge of ADHD and how it made them feel.

The young people who took part in this research generously gave me their time. I would like to let the young people draw this study to a close. Below are some

memorable quotes from this study and their drawings of what ADHD means to them.

“At first, I was in denial. I was like no, I haven’t got nothing wrong with me. I don’t want to take tablets, that’s not me, no, I’m normal” (Sarah, 3:62).

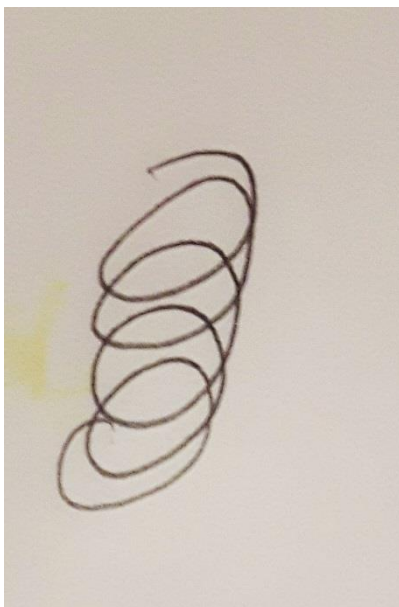
“Right have you ever heard them saying kids, they they say them kids are just off the rails...that’s not it. It’s just we need that extra little bit extra of help I feel” (Michael, (19:409).

“It felt kind of like that was like a prison, or something like that, just put me away from everyone” (David, 49:1001).

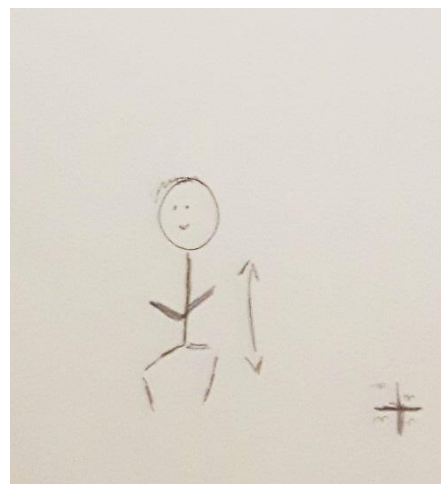
“They are not doing anything bad they are just concentrating on the wrong thing” (Gary, 14:286).

“Yeah by the time I get home I am back to normal. Just hyperactive jumping around” (Jack, 46:943).

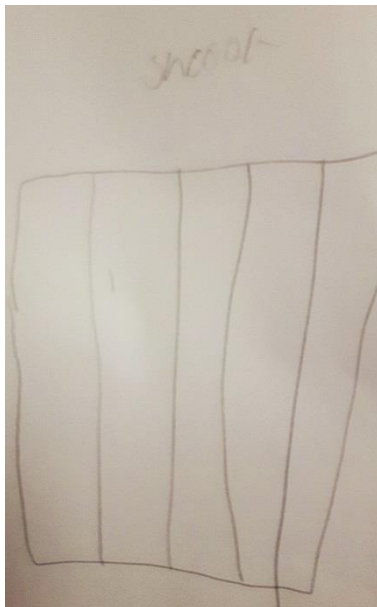
David



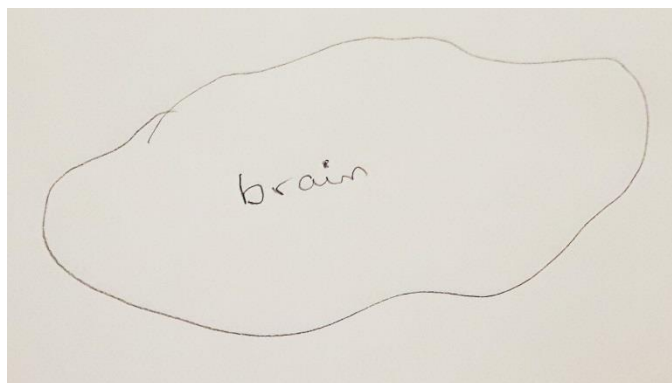
Jack



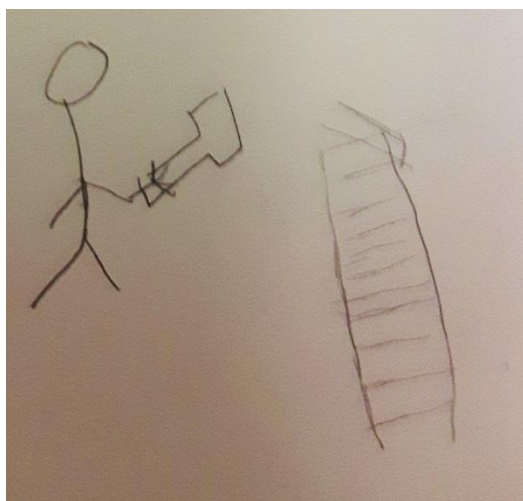
Michael



Gary



Sarah



7. References

- Akram, G., Thomson, A.H., Boyter, A.C., & McLarty, M. (2009). ADHD and the role of medication: knowledge and perceptions of qualified and student teachers. *European Journal of Special Educational Needs*, 24(4), 423-436.
- American Psychiatric Association (APA). (2013) *ADHD Fact Sheet*. Retrieved from DSM5: www.dsm5.org/Documents/ADHD%20Fact%20Sheet.pdf Retrieved November 2, 2015.
- American Psychiatric Association (APA). (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed). Washington, DC: American Psychiatric Publishing.
- American Psychiatric Association (APA) (2002). *A referencing guide for professionals: Developing adolescents*. Washington, DC: American Psychiatric Publishing.
- American Psychiatric Association (APA) (1987). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed). Arlington, VA: American Psychiatric Publishing.
- American Psychiatric Association (APA) (1980). *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed). Arlington, VA: American Psychiatric Publishing.
- American Psychiatric Association (APA) (1968). *Diagnostic and Statistical Manual of Mental Disorders* (2nd ed). Arlington, VA: American Psychiatric Publishing.
- Andrews, M., Squire, C., & Tambokou, M. (Eds.) (2008). *Doing narrative research*. London: Sage.
- Armstrong, T. (2010). *Neurodiversity: Discovering the extraordinary gifts of autism, ADHD, dyslexia, and other brain differences*. Cambridge, MA: Da Capo Press.
- Avisar, A., & Lavie-Ajayi, M. (2014). The burden of treatment: Listening to stories of adolescents with ADHD about stimulant medication use. *Ethical Human Psychology and Psychiatry*, 16(1), 37-50.
- Barkley, R.A. (2006). *Attention-deficit hyperactivity disorder. A handbook for diagnosis and treatment*. New York: Guildford Press.
- Barkley, R. A. (1997). Behavioral inhibition, sustained attention, and executive

- functions: constructing a unifying theory of ADHD. *Psychological Bulletin*, 121(1), 65–94.
- Bartlett, R., Rowe, T., & Shattell, M. (2010). Perspectives of college students on their childhood ADHD. *MCN: The American Journal of Maternal Child Nursing*, 35 (4), 226-31.
- Bax, M. & MacKeith, R. (1963). Minimal cerebral dysfunction. *Little Club Clinics in Developmental Medicine Series*, 10. London: Heineman.
- Bellanca, F.F., & Pote, H. (2013). Children's attitudes towards ADHD, depression and learning disabilities. *Journal of Research in Special Educational Needs*, 13(4), 234-241.
- Bhaskar, R. (1998). Philosophy and scientific realism. In M. S. Archer, R. Bhaskar, A. Collier, T. Lawson, & A. Norrie (Eds.), *Critical realism: Essential readings* (pp. 16-47). London: Routledge.
- Bradley, C. (1937). The behavior of children receiving benzedrine. *American Journal of Psychiatry*, 94, 577–585.
- British Psychological Society (2010). *Code of Human Research Ethics*. Leicester: BPS.
- British Psychological Society (2000). *Attention Deficit/Hyperactivity Disorder (AD/HD): Guidelines and principles for successful multi-agency working*. Leicester: British Psychological Society.
- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.
- Brook, U., & Boaz, M. (2005). Attention deficit and hyperactivity disorder (ADHD) and learning disabilities (LD): Adolescents' perspective. *Patient Education and Counseling*, 58(2), 187–191.
- Brown, W.A. (1998). Charles Bradley, M.D., 1902–1979. *American Journal of Psychiatry*, 155(7), 968-968. doi.org/10.1176/ajp.155.7.968. Retrieved April 2, 2016.
- Brown, T.E. (2006). Executive Functions and Attention Deficit Hyperactivity Disorder: Implications of two conflicting views. *International Journal of Disability Development and Education*, 53(1), 35-46.
- Bussing, R., Zima, B. T., Mason, D. M., Meyer, J. M., White, K., & Garvan, C. W. (2012). ADHD knowledge, perceptions, and information sources: Perspectives from a community sample of adolescents and their parents. *Journal of Adolescent Health*, 51(6), 593–600.

- Bussing, R., Zima, B. T., Mason, D. M., Porter, P. C., & Garvan, C. W. (2011). Receiving treatment for attention-deficit hyperactivity disorder: Do the perspectives of adolescents matter? *Journal of Adolescent Health, 49*(1), 7–14.
- Burr, V. (2015). *Social constructionism*. (3rd ed.). London: Routledge.
- Bury, M. (1986). Social constructionism and the development of medical sociology. *Sociology of Health and Illness 8*(2), 137-169.
- Cheung, K. K. W., Wong, I. C. K., Ip, P., Chan, P. K. L., Lin, C. H. Y., Wong, L. Y. L., & Chan, E. W. (2015). Experiences of adolescents and young adults with ADHD in Hong Kong: treatment services and clinical management. *BMC Psychiatry, 15*(1), 95. doi: 10.1186/s12888-015-0478-x. Retrieved July 4, 2015.
- Clements, S.D. (1966). *Minimal brain dysfunction in children: Terminology and identification: phase one of a three-phase project*. Washington DC: US Department of Health, Education and Welfare. Retrieved from: <https://www.ncjrs.gov/pdffiles1/Digitization/54558NCJRS.pdf>
- Conners, C.K. (2000). Attention-deficit/hyperactivity disorder: historical development and overview. *Journal of Attention Disorders, 3*(4), 173–191
- Conrad, P. (1976). *Identifying Hyperactive Children: The Medicalization of deviant behaviour*. Lexington, M.A.: Lexington Books.
- Cooley, C.H. (1902). *Human nature and the social order*. New York: Scribner's Sons.
- Cooper, P. (2008). Like alligators bobbing for poodles? A critical discussion of education, ADHD and the biopsychosocial perspective. *Journal of Philosophy of Education, 42* (3) 457-474.
- Corrigan, P.W., & Shaprio, J.R. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical Psychology Review, 30*(8), 907-922.
- Cortese, S. (2010). Review: ADHD impairs quality of life, but children and young people with ADHD perceive less impairment than parents. *13* (3), 76-76.
- Creswell, J.W. (2009). *Research design: Qualitative, quantitative and mixed methods approaches*. (3rd ed.). London: Sage.
- Crichton, A. (2008). An inquiry into the nature and origin of mental derangement on attention and its diseases. *Journal of Attention Disorders, 12*, 200–204.

- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London: Sage.
- Danckaerts, M., Sonuga-Barke, E. J. S., Banaschewski, T., Buitelaar, J., Döpfner, M., Hollis, C., Santosh, P., Rothenberger, A., Sergeant, J., Steinhausen, H.C., Taylor, E., Zuddas, A. & Coghill, D. (2010). The quality of life of children with attention deficit/hyperactivity disorder: a systematic review. *European Child & Adolescent Psychiatry*, 19(2), 83–105.
<http://doi.org/10.1007/s00787-009-0046-3>. Retrieved July 4, 2015.
- Deci, E.L., & Ryan, R.M. (2002). *Handbook of self-determination research*. Rochester, N.Y: University of Rochester Press
- Department of Education (2014). *Special Educational Needs and Disability Code of Practice: 0-25*. London: The Stationery Office (TSO).
- Dennis, T., Davis, M., Johnson, U., Brooks, H. & Humbi, A. (2008). Attention deficit hyperactivity disorder: parents' and professionals' perceptions. *Community Practitioner : The Journal of the Community Practitioners' & Health Visitors' Association*, 81(3), 24–28.
- Dolgun, G., Savaser, S., & Yazgan, Y. (2014). Determining the correlation between quality of life and self-concept in children with attention deficit/hyperactivity disorder. *Journal of Psychiatric and Mental Health Nursing*, 21(7), 601-8.
- Douglas, V.I. (1972). Stop, look and listen: the problem of sustained attention and impulse control in hyperactive and normal children. *Canadian Journal of Behavioural Science*, 4, 259–282.
- Eatough, V. & Smith, J.A. (2008). Interpretative Phenomenological Analysis. In C. Willig & W. Stainton-Rogers (Eds), *The Sage handbook of qualitative research in psychology* (pp. 179-194). London: Sage.
- Efron, D., Sciberras, E., & Hassell, P. (2008). Are schools meeting the needs of students with ADHD? *Australasian Journal of Special Education*, 32(2), 187-198.
- Einarsdottir, J. (2008). Teaching children with ADHD: Icelandic early childhood teachers' perspectives. *Early Child Development and Care*, 178(4), 375-397.
- Erikson, E. H. (1968). *Identity: Youth and crisis*. New York: Norton.
- Farrow, S.J. (2006). Sir George Frederick Still (1868-1941). *Rheumatology*, 45(6), 777–778.

- Fischer, K.W., Hand, H.H., & Russell, S. (1984). The development of abstractions in adolescence and adulthood. In M. Commons, F.A. Richards, and C. Armon (Eds.), *Beyond formal operations* (pp. 43-73). New York: Praeger.
- Foley-Nicpon, M., Rickels, H., Assouline, S. G., & Richards, A. (2012). Self-esteem and self-concept examination among gifted students with ADHD. *Journal for the Education of the Gifted*, 35(3), 220–240.
- Gadamer, H. (1960). *Truth and Method* (2nd Rev. ed). New York: Crossroad.
- Ghanizadeh, A., & Haghighi, H. B. (2010). How do ADHD children perceive their cognitive, affective, and behavioral aspects of anger expression in school setting? *Child & Adolescent Psychiatry & Mental Health*, 4, 1-7.
- Gibbs, G. (1988). *Learning by doing: a guide to teaching and learning methods*. Oxford: Further Education Unit.
- Guba, E.G., & Lincoln, Y.S. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage.
- Harnum, M., Duffy, J., & Ferguson, D.A., (2007). Adults' versus children's perceptions of a child with Autism or Attention Deficit Hyperactivity Disorder. *Journal of Autism and Developmental Disorder*, 37(7), 1337-1343.
- Harter, S. (2012). *The construction of the self: Developmental and Sociocultural foundations* (2nd ed.). New York: Guildford Publications. Retrieved from <http://www.eblib.com>. Retrieved September 12, 2015.
- Hattie, J. (1992). The levels of school accountability. *Education Research and Perspectives*, 19, 78-80.
- Heidegger, M. (1962). *Being and time*. Oxford: Blackwell.
- Hinshaw, S.P. (2005). The stigmatization of mental illness in children and parents: Developmental issues, family concerns and research needs. *Journal of Child Psychology and Psychiatry*, 46, 714–734.
- Hong, Y. (2008). Teachers' perceptions of young children with ADHD in Korea. *Early Child Development and Care*, 178(4), 399–414.
- Horton-Salway, M. (2011). Repertories of ADHD in UK newspaper media. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 15(5), 533–549.
- Houck, G., Kendall, J., Miller, A., Morrell, P., & Wiebe, G. (2011). Self-concept

- in children and adolescents with Attention Deficit Hyperactivity Disorder. *Journal of Pediatric Nursing*, 26(3), 239–247.
- Husserl, E. (1927). Phenomenology. In *Encyclopedia Britannica*, (14th ed.). 17, 699-702.
- Johnson, K. A., Wiersema, J. R., & Kuntsi, J. (2009). What would Karl Popper say? Are current psychological theories of ADHD falsifiable? *Behavioral and Brain Functions*, 5(1), 15. <http://doi.org/10.1186/1744-9081-5-15>. Retrieved April 2, 2016.
- Kelly, G. A. (1955). *The psychology of personal constructs*. New York: Norton.
- Klassen, A. F., Miller, A., & Fine, S. (2006). Agreement between parent and child report of quality of life in children with attention-deficit/hyperactivity disorder. *Child: Care, Health and Development*, 32(4), 397–406.
- Kovshoff, H., Williams, S., Vrijens, M., Danckaerts, M., Thompson, M., Yardley, L., & Sonuga-Barke, E. (2012). The decisions regarding ADHD management (DRAMa) study: Uncertainties and complexities in assessment, diagnosis and treatment, from the clinician's point of view. *European Child & Adolescent Psychiatry*, 21(2), 87-99.
- Kramer, F. and Pollnow, H. (1932a) Über eine hyperkinetische Erkrankung im Kindesalter. *Monatsschrift für Psychiatrie und Neurologie*, 82, 1–40.
- Kvale, S. (1996). *InterViews: an introduction to qualitative research interviewing*. London: Sage.
- Landgraf, J. M., Abetz, L., & Ware, J. E. (1996). *Child Health Questionnaire (CHQ): A user's manual*. Boston, MA: The Health Institute, New England Medical Center.
- Lange, K.W., Reichl, S., Lange, K.M., Tucha, L, & Tucha, O. (2010). The history of attention deficit hyperactivity disorder. *Attention Deficit and Hyperactivity Disorders*, 2(4), 241-255.
- Law, G. U., Sinclair, S., & Fraser, N. (2007). Children's attitudes and behavioural intentions towards a peer with symptoms of ADHD: does the addition of a diagnostic label make a difference? *Journal of Child Health Care : For Professionals Working with Children in the Hospital and Community*, 11(2), 98–111.
- Li, Z., Chang, S., Zhang, L., Gao, L., & Wang, J. (2014). Molecular genetic

- studies of ADHD and its candidate genes: A review. *Psychiatry Research*, 219, 10-24.
- Limbers, C. A., Ripperger-Suhler, J., Boutton, K., Ransom, D., & Varni, J. W. (2011). A comparative analysis of health-related quality of life and family impact between children with ADHD treated in a general pediatric clinic and a psychiatric clinic utilizing the PedsQL. *Journal of Attention Disorders*, 15, 392–402.
- Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N.K. Denzin & Y.S. Lincoln (Eds.), *The handbook of qualitative research* (second edition) (pp.163-188). London: Sage.
- Link, B.G., & Phelan, J.C. (2001). Conceptualising stigma. *Annual Review Of Sociology*, 27, 363-385.
- Loe, M., & Cuttino, L. (2008). Grappling with the medicated self: The case of ADHD college students. *Symbolic Interaction*, 31(3) 303-323.
- Maniadaki, K., Sonuga-Barke, E., Kakouros, E., & Karaba, R. (2007). Parental beliefs about the nature of ADHD behaviours and their relationship to referral intentions in preschool children. *Child: Care, Health & Development*, 33(2), 188-195.
- McCrae, R. R., & Costa, P. T. (1997). Personality trait structure as a human universal. *American Psychologist*, 52(5), 509.
- McNamara, J. K., Willoughby, T., & Chalmers, H. (2005). Psychosocial status of adolescents with learning disabilities with and without comorbid Attention Deficit Hyperactivity Disorder. *Learning Disabilities Research and Practice*, 20(4), 234–244. <http://doi.org/10.1111/j.1540-5826.2005.00139.x> Retrieved July 5, 2015.
- Mead, G.H. (1934). *Mind, self, and society*. Chicago, IL: Chicago University Press.
- Merleau-Ponty, M. (1962). *Phenomenology of perception*. London: Routledge.
- Moldavsky, M., & Sayal, K. (2013). Knowledge and attitudes about attention-deficit/hyperactivity disorder (ADHD) and its treatment: The views of children, adolescents, parents, teachers and healthcare professionals. *Current Psychiatry Reports*, 15(8), 337-344.
- Neena, D. (2013). ADHD in Indian elementary classrooms: Understanding teacher perspectives. *International Journal of Special Education*, 28(2),

- NICE (2016). *Attention deficit hyperactivity disorder: Evidence Update March 2016*. Manchester: NICE.
- NICE (2013). *Attention deficit hyperactivity disorder: Evidence Update July 2013*. Manchester: National Institute for Health and Care Excellence.
- NICE Guideline. (2008). *Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults*. Manchester: NICE.
- Nightingale, D.J., & Cromby, J. (2002). Social constructionism as ontology exposition and example. *Theory & Psychology*, 12(5), 701-713.
- Nijmeijer, J.S., Minderaa, R.B., Buitelaar, J.K., Mulligan, A., Hartman, C.A., & Hoekstra, P.J. (2008). Attention deficit/hyperactivity disorder and social dysfunctioning. *Clinical Psychology Review*, 28(4), 692-708.
- Norvilitis, J.M., & Fang, P. (2005). Perceptions of ADHD in China and the United States: A preliminary study. *Journal of attention disorders*, 9(2), 413-424.
- O'Driscoll, C., Heary, C., Hennessy, E., & McKeague, L. (2012). Explicit and implicit stigma towards peers with mental health problems in childhood and adolescence. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 53(10), 1054–1062.
- Ohan, J.L., Cormier, N., Hepp, S.L., Visser, T.W., & Strain, M.C. (2008). Does knowledge about attention-deficit/hyperactivity disorder impact teachers' reported behaviors and perceptions? *School Psychology Quarterly*, 23(3), 436-449.
- Owens, J. S., Goldfine, M. E., Evangelista, N. M., Hoza, B., & Kaiser, N. M. (2007). A critical review of self-perceptions and the positive illusory bias in children with ADHD. *Clinical Child and Family Psychology Review*, 10(4), 335–351.
- Pajo, B., & Cohen, D. (2013). The Problem with ADHD: Researchers' Constructions. *International Journal of Early Childhood*, 45(1), 11-33.
- Pescosolido, B.A., Jensen, P.S., Martin, J.K., Perry, B.L., Olafsdottir, S., & Fettes, D. (2008). Public knowledge and assessment of child mental health problems: Findings from the National Stigma Study Children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47, 339–349.

- Petticrew, M. & Roberts, H. (2006) *Systematic Reviews in the Social Sciences: a practical guide*. Oxford: Blackwell Publishing.
- Pillow, D. R., Naylor, L. J., & Malone, G. P. (2014). Beliefs regarding stimulant medication effects among college students with a history of past or current usage. *Journal of Attention Disorders*, 18(3), 247-257.
- Rafalovich, A. (2004). *Framing ADHD children: A critical examination of the history, discourse, and everyday experience of Attention Deficit/Hyperactivity Disorder*.
- Rafalovich, A. (2001). The conceptual history of attention deficit hyperactivity disorder: idiocy, imbecility, encephalitis and the child deviant. *Deviant Behaviour: An Inter-Disciplinary Journal*, 22, 93–115.
- Ravenette, T. (1999). *Personal Construct Theory in educational psychology: A practitioner's view*. London: Whurr Publishers Ltd.
- Robson, C. (2002). *Real world research. A resource for social scientist and practitioners*. (2nd ed.). Oxford: Blackwell.
- Rodrigo, M. D., Perera, D., Eranga, V. P., Williams, S. S., & Kuruppuarachchi, K. A. (2011). The knowledge and attitude of primary school teachers in Sri Lanka towards childhood attention deficit hyperactivity disorder. *Ceylon Medical Journal*, 56(2), 51–54.
- Ross, D.M. & Ross, S.A. (1976). *Hyperactivity: Research, theory and action*. New York: Wiley
- Rubia, K. (2007). Neuro-anatomic evidence for the maturational delay hypothesis of ADHD. *Proceedings of the National Academy of Sciences of the United States of America*, 104(50), 19663–19664.
<http://doi.org/10.1073/pnas.0710329105>. Retrieved April 2, 2016.
- Sagvolden, T., Johansen, E. B., Aase, H., & Russell, V. A. (2005). A dynamic developmental theory of attention-deficit/hyperactivity disorder (ADHD) predominantly hyperactive/impulsive and combined subtypes. *Behavioral and Brain Sciences*, 28(3), 397–419.
- Salt, N., Parkes, E., & Scammell, A. (2005). GPs' perceptions of the management of ADHD in primary care: A study of Wandsworth GPs. *Primary Health Care Research and Development*, 6(2), 162-171.
- Sanders, A.F. (1983). Towards a model of stress and performance. *Acta Psychologica*, 53, 61–97. doi: 10.1016/0001-6918(83)90016-1.
Retrieved April 2, 2016.

- Santrock, J. W. (2001). *Adolescence* (8th ed.). New York: McGraw-Hill.
- Sartre, J.P. (1948). *Existentialism and Humanism*. (P.Mairet, Trans.) London: Methuen.
- Sartre, J.P (1956). *Being and nothingness*. New York: Washington Square Press.
- Schleiermacher, F. (1998). *Hermeneutics and criticism and other writings* (A. Bowie, Trans.) Cambridge: CUP.
- Sergeant, J.A., & van der Meere, J.J. (1990). Convergence of approaches in localizing the hyperactivity deficit. In B.B. Lahey & A.E. Kazdin (Eds), *Advances in clinical child psychology* (pp 207–246). New York: Plenum Press.
- Shaw, P., Eckstrand, K., Sharp, W., Blumenthal, J., Lerch, J. P., Greenstein, D., Clasen, L., Evans, A., Giedd, J., & Rapoport, J. L. (2007). Attention-deficit/hyperactivity disorder is characterized by a delay in cortical maturation. *Proceedings of the National Academy of Sciences of the United States of America*, 104(49), 19649–54.
- Singh, I. (2012). Not robots: children's perspectives on authenticity, moral agency and stimulant drug treatments. *Journal of Medical Ethics*, 359–366.
- Singh, I. (2011). A disorder of anger and aggression: Children's perspectives on attention deficit/hyperactivity disorder in the UK. *Social Science and Medicine*, 73(6), 889–896.
- Smith, M. (2013). *Hyperactive: The controversial history of ADHD*. London: Reaktion Books.
- Smith, J.A., & Osborn, M. (2007). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to methods*. London: Sage.
- Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, method and research*. London: Sage Publications.
- Sonuga-Barke, E. J. S. (2003). The dual pathway model of AD/HD: An elaboration of neuro-developmental characteristics. *Neuroscience and Biobehavioral Reviews*, 27, 593–604.
- Sonuga-Barke, E., Bitsakou, P., & Thompson, M. (2010). Beyond the Dual Pathway Model: Evidence for the Dissociation of timing, inhibitory, and delay-related impairments in Attention-Deficit/Hyperactivity Disorder.

Journal of the American Academy of Child & Adolescent Psychiatry, 49(4), 345–355. <http://doi.org/10.1016/j.jaac.2009.12.018>

Retrieved April 2, 2016.

- Sonuga-Barke, E. J., Taylor, E., Sembi, S., & Smith, J. (1992). Hyperactivity and delay aversion I. The effect of delay on choice. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, 33(2), 387–398.
- Sternberg, S. (1969). The discovery of processing stages: Extensions of Donders' methods. *Acta Psychologica*, 30, 276–315. doi: 10.1016/0001-6918(69)90055-9. Retrieved April 2, 2016.
- Still, G.F. (1902). Some abnormal psychical conditions in children: The goulstonian lectures. *Lancet*, 1, 1008–1012.
- Strauss, A.A., & Lehtinen, L.E. (1947). *Psychopathology and education of the brain-injured child*. New York: Grune & Stratton.
- Strauss, A.A., & Kephart, N.C. (1955). *Psychopathology and education of the brain-injured child. Volume II. Progress in theory and clinic*. New York: Grune & Stratton.
- Swords, L., Hennessy, E., & Heary, C. (2011). Factors associated with acceptance of peers with mental health problems in childhood and adolescence. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, 52(9), 933-41.
- Tajfel, H. (Eds). (1978). *Differentiation between social groups: Studies in the social psychology of intergroup relations*. London: Academic Press.
- Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behaviour. In S. Worchel & W. G. Austin (Eds.), *Psychology of intergroup relations* (2nd ed.,)(pp. 7-24). Chicago: Nelson-Hall.
- Tajfel, H. & J. C. Turner (1979). An integrative theory of intergroup conflict. In W. G. Austin and S. Worchel (eds), *The Social Psychology of Intergroup Relations*, (pp. 33-47). Monterey, CA: Brooks-Cole.
- Thapar, A., Cooper, M., Eyre, O. & Langley, K. (2013). What have we learnt about the causes of ADHD? *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 54(1), 3-16.
- Timimi, S. (2010). The McDonaldization of childhood: Children's mental health in neo-liberal market cultures. *Transcultural Psychiatry*, 47(5), 686-706.
- Timimi, S. (2004). ADHD is best understood as a cultural construct. *British Journal of Psychiatry*, 184, 8-9.

- Travell, C., & Visser, J. (2006). "ADHD does bad stuff to you": Young people's and parents' experiences and perceptions of Attention Deficit Hyperactivity Disorder (ADHD). *Emotional and Behavioural Difficulties*, 11(3), 205–216.
- United Nations (1990). Convention on the Rights of the Child. London: UNICEF UK.
- Van Reusen, A., & Bos, C. (1994). Facilitating student participation in individualized education programs through motivation strategy instruction. *Exceptional Children*, 60(5), 466-475.
- Walker, J.S., Coleman, D., Lee, J., Squire, P.N., & Friesen, B.J. (2008). Children's stigmatization of childhood depression and ADHD: magnitude and demographic variation in a national sample. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47(8), 912-920.
- Walker-Noack, L., Corkum, P., Elik, N., & Fearon, I. (2013). Youth perceptions of Attention-Deficit/Hyperactivity Disorder and barriers to treatment. . *Canadian Journal of School Psychology*, 28(2), 193-218.
- Wehmeier, P. M., Schacht, A., & Barkley, R. A. (2010). Social and emotional impairment in children and adolescents with ADHD and the impact on quality of life. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, 46(3), 209–17.
- Wiener, J., Malone, M., Varma, a., Markel, C., Biondic, D., Tannock, R., & Humphries, T. (2012). Children's perceptions of their ADHD symptoms: Positive illusions, attributions, and stigma. *Canadian Journal of School Psychology*, 27(3), 217–242.
- Willcutt, E. G., Doyle, A. E., Nigg, J. T., Faraone, S.V., & Pennington, B. F. (2005). Validity of the executive function theory of Attention-Deficit/Hyperactivity Disorder: A meta-analytic review. *Biological Psychiatry*, 57(11), 1336–1346.
- Willig, C. (2013). *Introducing qualitative research in Psychology*. (3rd ed.) Maidenhead: Open University Press.
- Wilson, P. & Long, I. (2007). *The Big Book of Blob Feelings*. UK: Incentive Publishing.
- World Health Organization. (2016). *Adolescent development*. Retrieved April 5, 2016 from: http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en

- World Health Organization (2010). *International classification of mental health and behavioral disorders: Clinical descriptions and diagnostic guidelines* (10th ed). Retrieved April 5, 2016 from:
<http://apps.who.int/classifications/icd10/browse/2010/en#/F90>
- World Health Organization (1997). *WHOQOL: Measuring quality of life*. Geneva: WHO (WHO/MSA/MNH/PSF/97.4).
- Young, S., Chesney, S., Sperlinger, D., Misch, P., & Collins, P. (2009). A qualitative study exploring the life-course experiences of young offenders with symptoms and signs of ADHD who were detained in a residential care setting. *Criminal Behaviour and Mental Health*, 19, 54–63.

Appendix 1: Search methodology details

Table 1: Stage 1 - Scoping the literature

Database searched	Limit to	Search terms used	Papers found	Number excluded and reason	Number included
EBSCO* (21.7.15)	Peer reviewed Journals 2000-2015	Keywords: 'ADHD' and 'perceive'	108 papers	50 = duplicates removed 20 = main focus was not on ADHD 16= main focus was not on perceptions of some aspect of ADHD or perceptions of those with ADHD. Total excluded = 86	22 included
		Keywords: 'ADHD' and 'viewpoint'	44 papers	14 = duplicates removed 29 = main focus was not on ADHD 1 = main focus was not on perceptions of some aspect of ADHD or perceptions of those with ADHD. Total excluded = 44	0

Scopus (31.7.15)	Journals Social Sciences and Humanities 2005-2015	Keywords: “ADHD” AND ‘perceive’	24 papers	12 = Already identified 4 = main focus was not on ADHD 7 = main focus was not on perceptions of ADHD or perceptions of those with ADHD related to. 1 = full text could not be obtained. Total excluded = 24	0
		Keywords: “ADHD” AND ‘viewpoint’	8 papers	1 = main focus was not on ADHD 7 = main focus was not on perceptions of ADHD or perceptions of those with ADHD. Total excluded = 8	0

* EBSCO (including Academic Search Complete, British Education Index, Child Development and Adolescent Studies, CINAHL Plus, Education Abstracts, Education Research Complete, ERIC, PsycArticles, PsycInfo)

Table 2: Stage two - Filtered down search

Database searched	Limit to	Search terms used	Papers found	Number excluded and reason	Number included for full text reading
EBSCO (21.7.15)	Peer reviewed Journals 2005-2015 5-11 years	Keywords: 'ADHD' and 'child perspective'	33 papers	1 = duplicates removed 1 = main focus was not on ADHD 22 = main focus was not on perceptions of ADHD or perceptions of those with ADHD.	9
	Peer reviewed Journals 2005-2015 10-19 years	Keywords: 'ADHD' and 'adolescent perspective'	12 papers	7 = main focus was not on perceptions of ADHD or perceptions of those with ADHD.	5
Scopus (27.8.15)	Journals Social Sciences and Humanities 2005-2015	Keywords: "ADHD" AND 'child perspective'	113 papers	5 = already identified 1 = main focus was not on ADHD 105 = main focus was not on perceptions of some aspect of ADHD or perceptions of those with ADHD.	2
	Article	Keyword: "ADHD" AND 'adolescent perspective'	76 papers	72 = not relevant 4 = already identified	0

Table 2: continued

Database searched	Limit to	Search terms used	Papers found	Number excluded and reason	Number included For full text reading
EBSCO	Peer reviewed Journals 2005-2015 10-19 years	Keywords: 'ADHD in adolescents' and 'perceptions or attitudes or opinion'	99 papers	5 = already identified 2 = main focus was not on ADHD 80 = main focus was not on perceptions of some aspect of ADHD or perceptions of those with ADHD.	12
	Peer reviewed Journals 2005-2015	Keywords: 'ADHD in adolescents' and 'self-concept'	20	9 = duplicates removed 2 = already identified 7 = main focus was not on perceptions of some aspect of ADHD or perceptions of those with ADHD.	2
Scopus	2005-2015 Social sciences and humanities	Keywords: "ADHD in adolescents" and 'perceptions or attitudes or opinion'	2 papers	2 = main focus was not on perceptions of some aspect of ADHD or perceptions of those with ADHD.	0
EBSCO	2005-2015	Keywords: "ADHD" and 'interpretative phenomenological analysis'	3 papers	1= already identified 1= participants not diagnosed with ADHD. 1 = thesis	0
Scopus	2005-2015	Keywords: "ADHD" and 'interpretative	5 papers	1 = already identified 1 = focus on LD rather than ADHD 2 = Adults & ADHD	0

	Social Sciences and Humanities	phenomenological analysis'		1 = participants had a history of ADHD/CP symptoms	
--	---	-------------------------------	--	---	--

Table 3: Stage two – Filtered down search

Search engine	Limit to	Search terms used	Number	Study details	Included of relevant studies identified
Google Scholar 11.9.15	2005-2015 Searching first two result pages	Keywords: ADHD and stigmatization and UK	20	Moldavsky & Sayal (2013) plus snowballed (Ghandizadeh & Zarei (2010), Rodrigo, Perea, Eranga, Williams & Kuruppuarachchi (2011)) Law Sinclair & Fraser (2007) Swords, Hennessy & Heary (2011) <u>Plus snowballing</u> Ghandizadeh & Zarei (2010) Rodrigo, Perea, Eranga, Williams & Kuruppuarachchi (2011)	3 (2 snowballed) 5
		ADHD, GP perception, UK	20	Salt, Parkes, & Scammell, 2005 Dennis, Davis, Johnson, Brooks, & Humbi,(2008)	2
		ADHD, Teacher perception, UK	20	Akram, Thomson, Boyter & McLarty (2008) Norvilitis & Fang (2005)	2

		ADHD, adolescent perception, UK	20	No new studies identified	0
		ADHD, parent perception, UK	20	No new studies identified	0
		ADHD and IPA and UK	20	Young, Chesney, Sperlinger, Misch & Collins (2009)	1
		ADHD and self-concept and UK	20	Wehmeir, Schacht & Barkley (2010)	1
		ADHD and quality of life and UK	20	No new studies identified	0
Total number of studies included: 11					

Table 4: Stage 3 – Final Studies

Database searched	Limit to	Search terms used	Papers selected from Stage 1 & 2	Number excluded and reason	Studies included
EBSCO* (21.7.15)	Peer reviewed journals 2000-2015	Keywords: 'ADHD' and 'perceive'	22 papers	3 = main focus was on stress and anger. 3 = main focus was on social relationships. 1 = children did not have a diagnosis of ADHD. 1 = of 136 only 15 were diagnosed with ADHD. 3 = exploring of treatments/services/support only. 1 = main focus on teacher's experiences. 1 = commentary 1 = could not obtain full access	8 Snowballed (3) 11
	Peer reviewed Journals 2005-2015 5-11 years	Keywords: 'ADHD' and 'child perspective'	9	1 = focus was on family perspective. 3 = exploring of treatments/services only/support only.	5
	Peer reviewed Journals 2005-2015 10-19 years	Keywords: 'ADHD' and 'adolescent perspective'	5	1 = could not be obtained in English. 1 = exploring of treatments/services only/support only.	3
Scopus (27.8.15)	Social Sciences	Keywords: "ADHD" AND 'child perspective'	2	1 = main focus was on assessing a treatment and services.	0

	and Humanities 2005-2015 Article			1 = participants described only as having ADHD symptoms	
EBSCO	Peer reviewed Journals 2005-2015 10-19 years	Keywords: 'ADHD in adolescents' and 'perceptions or attitudes or opinion'	12	6 = main focus was on assessing a treatment, services or assessment tool only. 1 = not in English 1 = focus is on adult awareness of ADHD symptom 1 = Not original article or meta-analysis.	3 Snowballed (1) 4
	Peer reviewed Journals 2005-2015	Keywords: 'ADHD in adolescents' and 'self-concept'	2	None excluded	2
Google Scholar	2005-2015	<u>Various combinations</u>	11		11
	Searching first two result pages	See table 3			
Total number of studies included in systematic review: 36					

Appendix 2: Study Characteristics

Authors	Title	Main Topic	Population & Sample size	Measure	Location
Danckaerts, Sonuga-Barke, Banaschewski, Buitelaar, Döpfner, Hollis, Santosh, Rothenberger, Sergeant, Steinhausen, Taylor, Zuddas & Coghill (2010)	The quality of life of children with attention deficit/hyperactivity disorder: a systematic review	Quality of Life	36 studies.	Systematic review	Worldwide
Limbers, Ripperger-Suhler, Boutton, Ransom, & Varni (2011)	A comparative analysis of health-related quality of life and family Impact between children with ADHD treated in a General Pediatric Clinic and a Psychiatric Clinic utilising the PedsQL.	Quality of Life	Pediatric sample: 17 ADHD children (5-18 years) and their parents. Psychiatric sample: 179 ADHD children, 5-18 years and parents (181).	The PedsQL 4.0 Generic Core Scales, PedsQL Family Impact Module Scales, PedsQL Family Information Form, Vanderbilt ADHD Diagnostic	US

			Healthy sample (n= 1453)	Rating Scales Parent Version	
Klassen, Miller & Fine (2006)	Impact of co-morbid attention-deficit/hyperactivity disorder on self-perceived health-related quality-of-life of children with specific learning disability.	Quality of Life	58 ADHD children and parents	Child/Adolescent Symptom Inventory 4 (CSI), Child Health Questionnaire (CHQ)	Canada
Wehmeir, Schacht & Barkley (2010)	Social and emotional impairment in children and adolescents with ADHD and the impact on quality of life.	Quality of Life	Systematic Review	Systematic Review	Worldwide
Bartlett, Rowe & Shattell (2010)	Perspectives of College students on their childhood ADHD.	College students	16 ADHD college students (16-25 years old).	Semi-structured interviews	US
Ohan, Cormier, Hepp, Visser, Troy, & Strain (2008)	Does knowledge about Attention-Deficit/Hyperactivity Disorder impact Teachers' Reported Behaviors and Perceptions?	Teachers	140 primary (elementary) school teachers	ADHD Knowledge Scale, Vignettes.	Australia

Hong (2008)	Teachers' perceptions of young children with ADHD in Korea	Teachers	24 teachers and 1 occupational therapist	Survey and interview.	Korea
Neena (2013)	ADHD in Indian Elementary Classroom: Understanding Teacher Perspective	Teachers	Group of teachers (n=15) and students (n=15)	Interviews	India
Einarsdottir (2008)	Teaching children with ADHD: Icelandic early childhood teachers' perspectives	Teachers	8 playschool teachers and 8 first-grade teachers	Interviews	Iceland
Harnum, Duffy, Ferguson, & Duncan (2007)	Adults' Versus Children's Perceptions of a Child with Autism or Attention Deficit Hyperactivity Disorder	Attitude	30 children (7–12 years), 30 adults (19 to 72 years)	Vignettes	Canada
Pescosolido, Jensen, Martin, Perry, Olafsdottir, & Fettes (2008).	Public knowledge and assessment of child mental health problems: Findings from the National Stigma Study—Children.	Attitude	Data taken from a national survey (1,393 adults)	Interviews, Vignettes, Likert scale questionnaire.	US

O'Driscoll, Heary, Hennessy & McKeague (2012)	Explicit and implicit stigma towards peers with mental health problems in childhood and adolescence.	Attitude	203 children (10-11 years) and 182 adolescents (15-16 years)	Strength's and Difficulties Questionnaire, Vignettes, parts of the revised Attribution Questionnaire, The Shared Activity Questionnaire.	Ireland
Maniadaki Sonuga-Barke Kakouros, & Karaba (2006)	AD/HD symptoms and conduct problems: similarities and difference in maternal perceptions.	Public perception	317 mothers of boys and girls aged 4–6	The Parental Account of the Causes of Childhood Problems Questionnaire	Greece
Norvilitis & Fang (2005)	Perceptions of ADHD in China and the United States: A Preliminary Study	Public perception	College students (226) and teachers (328)	Questionnaire	US/China
Walker, Coleman, Lee, Squire, & Friesen (2008)	Children's stigmatization of childhood depression and ADHD: magnitude and demographic variation in a national sample.	Attitude		National survey	US

Bellanca & Pote (2013)	Children's attitudes towards ADHD, depression and learning disabilities.	Attitude	273 children (7-11 years)	Vignettes, The Shared Activities Questionnaire, The Adjective Checklist	UK
Moldavsky & Sayal (2013)	Knowledge and Attitudes about Attention-Deficit/Hyperactivity Disorder (ADHD) and its Treatment: The Views of Children, Adolescents, Parents, Teachers and Healthcare Professionals	Public perception/Stigma	Review paper	Review paper	UK
Swords, Heary & Hennessy (2007)	Factors associated with acceptance of peers with mental health problems in childhood and adolescence	Attitude	595 participants	Interviews	Ireland
Law Sinclair & Fraser (2007)	Children's attitudes and behavioural intentions towards a peer with symptoms of ADHD: does the addition of a diagnostic label make a difference?	Attitude	120 children (11-12 years)	Vignettes, self-report measures	UK
Ghandizadeh & Zarei (2010)	Are GPs adequately equipped with the knowledge for educating and	Knowledge and understanding	665 GPs	Questionnaire	Iran

	counseling of families with ADHD children?				
Rodrigo, Perea, Eranga, Williams & Kuruppuarachchi (2011)	The knowledge and attitude of primary school teachers in Sri Lanka towards childhood attention deficit hyperactivity disorder.	Knowledge and understanding	202 primary school teachers	Questionnaire	Sri Lanka
Salt, Parkes, & Scammell (2005)	GPs' perceptions of the management of ADHD in primary care: a study of Wandsworth GPs	Knowledge and understanding	13 GPs (interviews) 93 GPs (Questionnaire)	Semi-structured interviews and questionnaires	UK
Dennis, Davis, Johnson, Brooks, & Humbi,(2008)	Attention deficit hyperactivity disorder: parents' and professionals' perceptions.	Knowledge and understanding	GPs/Parents	Focus groups as well as semi-structured and narrative interviews	UK
Akram, Thomson, Boyter & McLarty (2009)	ADHD and the role of medication: knowledge and perceptions of qualified and student teachers	Knowledge and understanding	43 experienced teachers 25 student teachers	Anonymous self-questionnaire	UK
Walker-Novak, Corium, Elik & Fearon (2013)	Youth perceptions of Attention-Deficit/Hyperactivity Disorder and barriers to treatment.	Young people's perceptions of	25 young people with	Focus groups	Canada

		their condition and treatment.	ADHD (10-21 years)		
Travell & Visser (2006)	'ADHD does bad stuff to you': young people's and parents' experiences and perceptions of Attention Deficit Hyperactivity Disorder (ADHD).	Experience of ADHD	17 young people with ADHD and their parents	Interviews	UK
Bussing, Zima, Mason, Meyer, White & Garvan (2012)	ADHD knowledge, perceptions, and information sources: perspectives from a community sample of adolescents and their parents.	Experience of ADHD	374 adolescents and their parents	Survey	US
Singh (2011)	A disorder of anger and aggressions: Children's perspectives on attention deficit/hyperactivity disorder in the UK.	Experience of ADHD	150 ADHD children (9-14 years)	Interviews	US/UK
Foley-Nicpon, Rickels, Assouline & Richards (2012)	Self-esteem and self-concept examination among gifted students with ADHD.	Self-concept	112 children (54 gifted ADHD, 58 gifted)	Behavioral Assessment System for Children-Second Edition, Piers-Harris Children's Self-Concept Scale-	US

				Second Edition.	
Houck, Kendall, Miller, Morrell & Wiebe (2011)	Self-Concept in Children and Adolescents With Attention Deficit Hyperactivity Disorder.	Self-concept	145 children and adolescents (with ADHD and their mothers	The Child Behavior Checklist, Piers–Harris Children's Self-Concept Scale	US
Dolgun, Savaşer, & Yazgan (2014)	Determining the correlation between quality of life and self-concept in children with attention deficit/hyperactivity disorder.	Self-concept	70 ADHD children (9-12 years old).	ADHD Quality of Life Scales, Piers-Harris Children's Self-Concept Scale.	Turkey
McNamara, Willoughby & Chalmers (2005)	Psychosocial status of adolescents with learning disabilities with and without comorbid attention deficit hyperactivity disorder.	Self-perception	Adolescents with LD (N = 230), with comorbid LD/ADHD (N = 92), and without LD or ADHD (N = 322)	Self-report questionnaire, part and/or adapted measures.	Canada
Wiener, Malone, Varma, Markel,	Children's perceptions of their ADHD symptoms: positive illusions, attributions and stigma.	Children's perceptions their	152 children (86 with ADHD)	Weschler Abbreviated Scale of	Canada

Biondic, Tannock & Humphries (2012)		condition./Self-concept	aged 9-14 years.	Intelligence, Conner's Parent Rating Scale-Revised, Self-perception profile for children, Adapted Dominic-R interview, Attributions for ADHD questionnaire	
Avisar & Lavie-Ajayi (2014)	The Burden of treatment: listening to stories of adolescents with ADHD about stimulant medication use.	Experience of ADHD	14 ADHD adolescents (12-16 years)	Semi-structured interviews	Israel
Young, Chesney, Sperlinger, Misch & Collins (2009)	A qualitative study exploring the life-course experiences of young offenders with symptoms and signs of ADHD who were detained in a residential care setting	Experience of ADHD	5 adolescents with ADHD (14-16 years).	Semi-structured interviews	UK
Brook & Boaz (2005)	Attention deficit and hyperactivity disorder (ADHD) and learning	Experience of ADHD	308 students.	Interviews	Israel

	disabilities (LD): adolescent's perspective.				
--	--	--	--	--	--

Appendix 3: Interview Schedule

Original Interview Schedule

Session one: 30-45 mins

1. Problem free talk.
2. Go through the young person information sheet and answer any questions the young person has.
3. Activity 1: The young people were presented with a series of images and were asked to select three which they felt described them.
4. Activity 2: The young people took part in an activity that explored how supported they felt at school, at home and in the wider community. They were presented with a page with their name in the centre and large circle drawn around it. The circle was divided into four sections: home, school, friends and community. They were asked to write the names of people who supported them in each quadrant.
5. Activity 3: The young people were presented with a scale ranging from 1-10. 1 indicated the unhappiest person in school and 10 represented the happiest person in school. The young people were asked where they felt they were on this scale.

Session two: 60 mins approx.

1. Problem free talk.
2. Questions:
 1. When did you first hear about ADHD?
 2. Do you know what the letters in ADHD stands for?
 3. Can you mark on the scale (from session one) where you feel you were before you were diagnosed?
 4. What do you remember about getting your diagnosis?
 5. Can you mark where you were after getting your diagnosis?
 6. Can you give me three words that you would use to describe ADHD?
Explore the words (E.g. why is someone with ADHD X? Are they always X? Is being X ever helpful or not?).

7. Using your support circle, can you pick someone from it and imagine what words they might add? Why do you think they might pick that?

Session 3: 60 mins approx.

1. Problem free talk.
2. Re-cap of previous session.
3. Questions:
 1. The words they used were displayed on scales from 0-10. The young people were asked to rate themselves and their ratings of themselves were explored.
 2. What if anything, would you like other people to know about what it is like to have ADHD?
 3. What if anything, would you like to understand more about ADHD?
 4. Conclude: How did they find the conversation? Anything they would like to know more about?
4. Debrief discussion and gave young people signposting sheet.

Final interview schedule

Session one: 30-45 mins

1. Problem free talk.
2. Go through the young person information sheet and answer any questions the young person has.
3. Activity 1: The young people were presented with a series of images and were asked to select three which they felt described them.
4. Activity 2: The young people took part in an activity that explored how supported they felt at school, at home and in the wider community. They were presented with a page with their name in the centre and large circle drawn around it. The circle was divided into four sections: home, school, friends and community. They were asked to write the names of people who supported in each quadrant.
5. Activity 3: The young people were presented with a scale ranging from 1-10. 1 indicated the unhappiest person in school and 10 represented the happiest person in school. The young people were asked where they felt they were on this scale.

Session two: 45- 60 mins approx

1. Problem free talk

2. Questions: **Always follow a participant lead as new and interesting topics emerge.**

1. When did you first hear about ADHD?
2. Do you know what the letters in ADHD mean?
3. Can you mark on the scale (from session one) where you feel you were before you were diagnosed?
4. What do you remember about getting your diagnosis? (Prompts: How did it feel? Who were you with? Who told you about the diagnosis? What did you think?)
5. Can you mark where you were after getting your diagnosis?
6. Using the pens, can you draw something that you think shows ADHD? Explore what they have drawn.
7. Can you add some words to your picture or tell me some words that you think describe ADHD? (Explore the words. Why is someone with ADHD X? Are they always X? Is being X ever helpful or not?)
8. Follow participant lead based on above questions.

Session three: 30-45 mins approx.

1. Problem free talk

2. Questions:

1. Using your support circle, can you pick someone from it and imagine what words he or she might add? (Why do you think he/she might pick that?)
2. If needed use a range of PCP method and visual prompts to facilitate the young people to tell their story such as the school situation pictures, the ideal self, fill in the face).
3. What if anything, would you like other people knew about what it is like to have ADHD?
4. What if anything, would you like to understand more about ADHD?
5. Follow participant lead based on above questions.
6. Probe further any areas from previous session if it felt that the researcher didn't explore in enough detail in the previous session.

3. Debrief discussion and give young people signposting sheet.

Appendix 4a: Interview aids-Blob Tree

Please see:

Wilson, P. & Long, I. (2007). *The Big Book of Blob Feelings*. UK: Incentive Publishing.

Appendix 4b: Interview Aids-School situation pictures

(Provided by Maria Ionides-TEP)

Picture 1



Picture 2



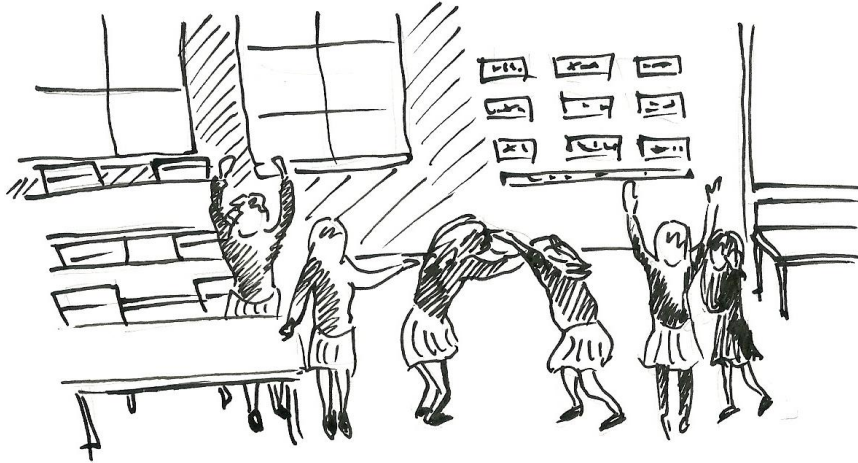
Picture 3



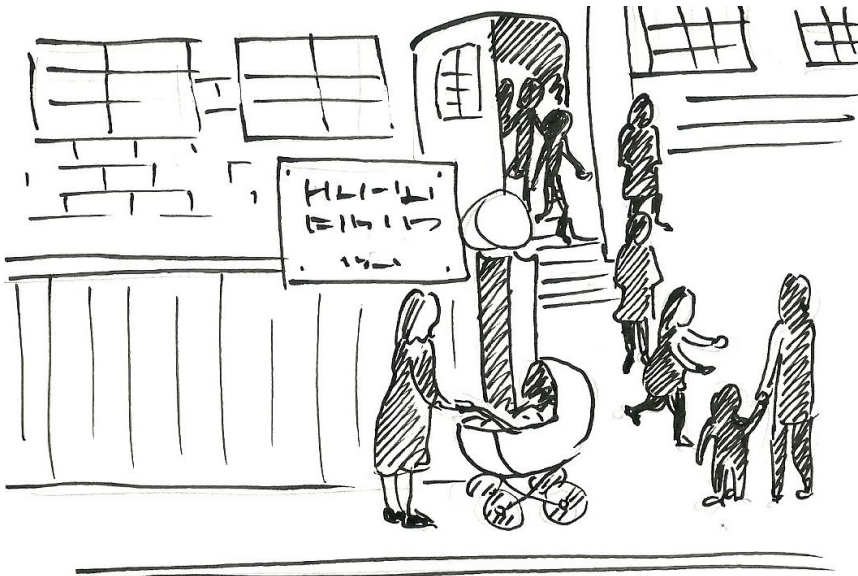
Picture 4



Picture 5



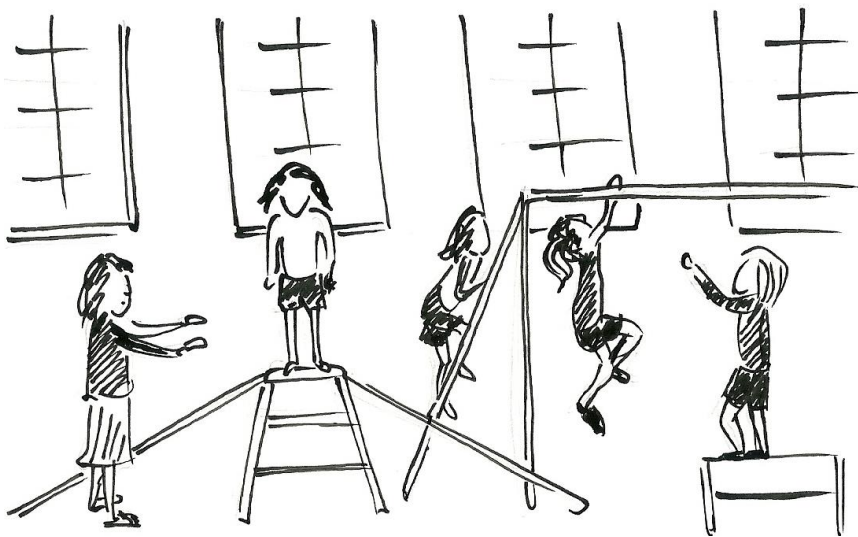
Picture 6



Picture 7



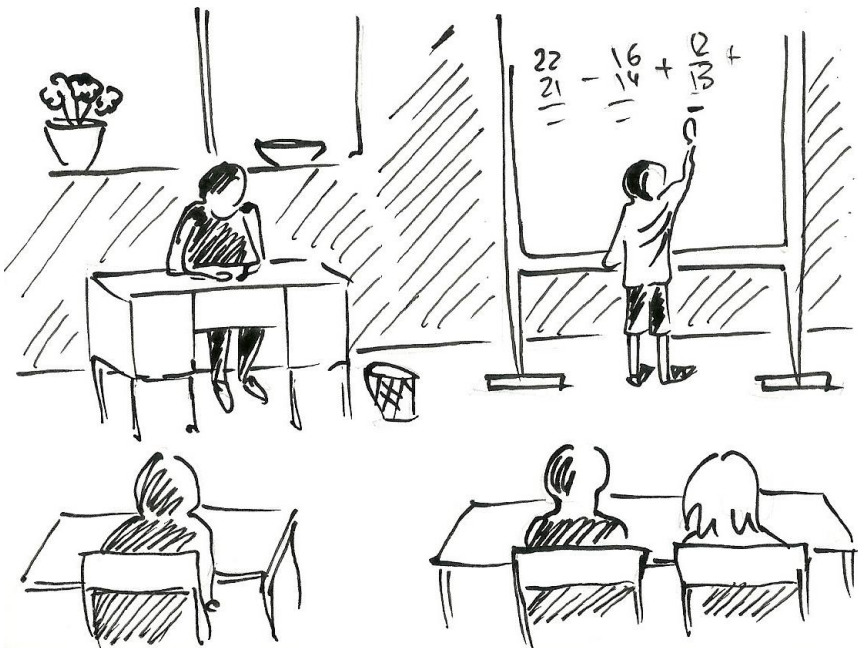
Picture 8



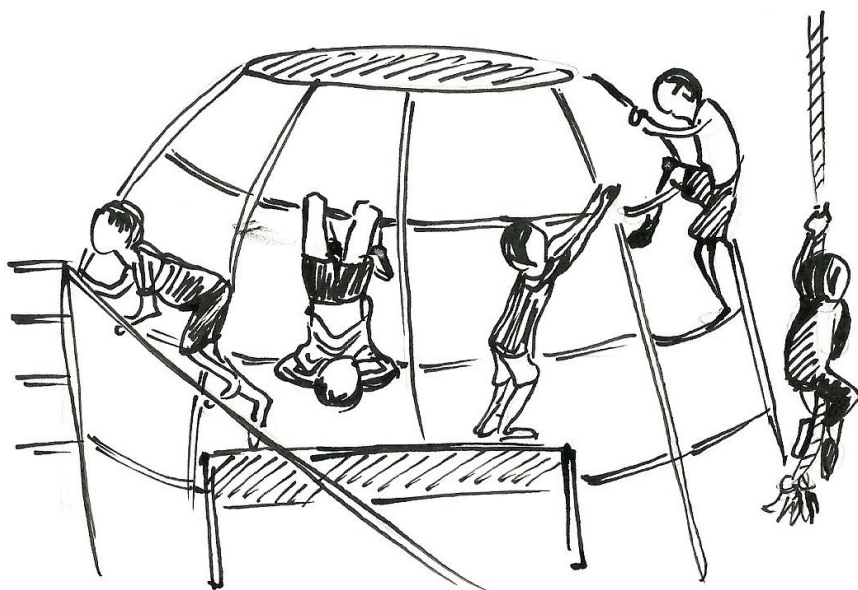
Picture 9



Picture 10



Picture 11



Appendix 5a: Research information sheet for schools

My name is Orla Kenny and I am training to become an Educational Psychologist at the University of East London. I am working as part of the xx Team I am looking to research the perceptions ADHD from the perspective of children and young people diagnosed with ADHD.

I am contacting you as a student at your school has been suggested by x, link Educational Psychologist that x may be an appropriate student to take part in the research.

Which children will be involved?

I will be inviting students ages between 14-16 years diagnosed with ADHD. Further, I am looking for students who have received their diagnosis for at least one year.

What will the research involve?

The research will involve carrying out interviews with the students which will last between one and half to two hours. It is expected that this will take place across 2-3 sessions. The first session will last approximately 45 minutes with aim of introducing the student to the research and building rapport. The next session will consist of the interview which may be carried out in two session or split into three depending on the needs of the student.

I will be in contact shortly to discuss the research with you if you are interested in x taking part in the research. Further consent will be sought from the parents or guardians and x.

In the meantime if you have any questions about this study or if you would like to discuss further please feel free to contact me:

Email:

Phone:

Thank you for taking the time to consider this study ☺

Appendix 5b: Consent form for schools



Dear Head Teacher

My name is Orla Kenny. I am an Educational Psychologist in Training. I am part of the xx Team in xx. As part of my training I am looking to research how young people diagnosed with ADHD understand and perceive their condition. This research has ethical approval from the University of East London and it is supervised by an Educational Psychologist and Lecturer from the university. Further supervision is provided by a Senior EP from the xx.

I am writing to ask for your permission to include students at xx in my study. If you are interested, I will be in contact shortly to discuss further. Further consent will be sought from the parents/guardians and the young person.

For further details, please see the attached information sheet.

If you have any questions or would like to discuss the study further, please feel free to contact me:

Email:

Phone:

.....

Consent and Permissions

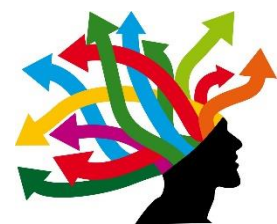
I agree that selected XX students can take part in the sessions pending further consent from parents/guardians and the young person.

Signed _____

Print name.....

Date.....

ADHD Research



My name is Orla Kenny and I am training to become an Educational Psychologist at the University of East London. As part of my training, I am researching ADHD from the perspective of children and young people diagnosed with the condition in xx.

Which children will be involved?

- Students ages between 14-16 years diagnosed with ADHD.
- Students who have received their diagnosis for at least one year.

What will the research involve?

- The research will involve carrying out interviews with the students which will last around two hours in total. It is expected that this will take place across 3-4 sessions.
- Session one: The first session will last approximately 45 minutes with aim of introducing the student to the research and building rapport.
- Session two: The next session will consist of the interview which may be carried out in two session or split into three depending on the needs of the student.
- Session three: The will consist of the second part of the interview. There will also be an opportunity for young person to task any questions they have.

I will be in contact shortly to discuss the research with you, if you are interested in [student] taking part in the research. In the meantime if you have any questions about this study or if you would like to discuss further please feel free to contact me:

Email:

Phone:

Thank you for taking the time to consider this study 😊

Appendix 6b: Consent form for parents

Dear parent

My name is Orla Kenny. I am an Educational Psychologist in Training working. I will be working with students in xx over the next two years. As part of my training, I am looking to study how young diagnosed with ADHD understand and perceive their condition.

I am writing to ask for your permission for this to happen. If you consent, I would meet your child at school three times. The sessions will provide your child with an opportunity for guided reflection on their thoughts about ADHD and their understanding of it. It will also be an opportunity to discuss how your child feels about school.

Sessions two and three will be taped recorded and shared with my supervisor from the university. Any identifying information will be removed in the presentation of the results. Please see the attached information sheet for further details of the study.

Consent and Permissions: sign below and return to the school

I agree to let _____ participate in this research. **I understand that I can withdraw my child at any time and do not have to state a reason.**

Signed _____ (parent/carer)

Print name.....

Date.....

Contact Information

If you would like further details on the sessions or have any questions or concerns, I would be happy to discuss them with you. Please contact me

on: Email: Phone:

Best wishes



Orla Kenny

Trainee Educational Psychologist

Appendix 6c: Consent form for young people

Dear Student

My name is Orla Kenny. I am an Educational Psychologist in Training working. I work with students, teachers and parents to help them think together about ways to support children and young people in school.

I am also interested in carrying out a study about ADHD. I am looking to talk with young people diagnosed with ADHD in xx. I would like to learn about what you think and feel about ADHD and what has made you think and feel that way.

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in the study.

If you would like to take part, I will come to your school and meet you three times. Please see the attached information sheet for what would happen each time.

.....

Consent and Permissions:

I agree to take part in the sessions. **I understand that I can withdraw at any time and I do not have to give a reason.**

Signed _____(young person)

Print name.....

Date.....

Contact Information

If you would like further details on the sessions or have any questions or concerns, I would be happy to discuss them with you. Please contact me:

Email:

Phone:

Best wishes



Orla Kenny

Trainee Educational Psychologist

Appendix 7: Example of analysis- Individual case

Stage 2: Emergent Themes

Sarah: Original Transcript

I: So I don't forget about it am this is the thing from your mum is it?

Sarah: yeah

I: Oh thank you,

Sarah: and she filled in it all.

I: and she filled in the last one. Yeah. Did you see that one before?

Sarah: no

I: so it's just some background information asks about your date of birth am ethnicity, I don't know if you know that word, it just means that country you come from ah where you are in the family your age a bit about your medication and if you anyone else if you have any other services helping you. Okay thank you for remembering to bring that in. good I will put this one with your other one and might keep it together and I will put yours in here as well. Am so remember yesterday I was telling you that this was going to be different to the work we did before cause before we were talking about you and school and how you were finding school ah whereas this is am I'm researching about ADHD and

Stage 1: Exploratory Comments

Key guide

Plain text =
Phenomenological
comments

Plain text in brackets =
Interpretative comments

Italics and bracketed
comments = Linguistic
comments

Introduction to research

Emergent Themes

young people who have it. Am cause lots of people have studied ADHD about what teachers think about it and about what parents think about it but not many people know what young people who are diagnosed with it what they think about it and know about it. Okay am so do you want a juice? No okay {laughs} so just tell me if you want a break at any time you don't need to wait for me to tell you, that's fine you can just ask am so I'm just going to ask you some questions about ADHD, it will probably be about half an hour maybe a bit longer and then I will need to come and see you one more after this as well. Am but I think maybe not tomorrow because from what you said you've got your English exam tomorrow. So probably Thursday, do you have anything on a Thursday?

Sarah:.....no...am

I: you're not sure, we can check your planner at the end anyway. I won't come..

Sarah: we don't have no exams or nothing

I: you don't have any exams but if there's anything, I know you said most of the celebrations things aren't happening but if there's any in class celebration or anything like that/

Exploratory Comments

Introduction to research

Emergent Themes

ADHD in relation to others/Others noticing

Explaining ADHD as biological/internal

Feeling overwhelmed/ADHD as complex

Sarah: It's only at tutor.

I: it's only at tutor times. Okay so I will make sure I don't come at like those times cause you don't want to miss that. It's your last time with your year group, it will be nice. am so the first question that I was kind of curious about, do you remember the first time you ever heard anybody say ADHD.

Sarah: yeah because my Mum's like she's like my aunty, I've been around her for ages. Her son had it really bad so/

I: um hm

Sarah: it's like she was kind of explaining to my Mum cause I had the same sort of actions as him so she was explaining to my Mum about it.

I: and did you hear about it at that time too?

Sarah: yeah

I: so what kind of things did you hear then?

Sarah: just heard that like it slows your heart rate down and stops you like when you've got adrenaline the rush of adrenaline it like helps it cause people with ADHD have higher adrenaline rushes than most people (///) fidgeting and...it's a lot of stuff.

Exploratory Comments

Sarah first heard about ADHD as her aunt explained it to her Mum. (Sarah is learning about ADHD through others-passively?).

Explaining ADHD as biological/internal; speaking about ADHD as related to heart rate and adrenaline (understanding ADHD from medical viewpoint).

'it's a lot of stuff' (ADHD as complex, her voice dropped to a whisper as she that).

Emergent Themes

A different
self/Challenge to
identity/rejecting

Positioned by
others/distancing from

ADHD/challenging
others

ADHD and suffering

I: and when you heard about that did you recognise that as being a bit like you or you thought it wasn't anything like you.

Sarah: at first I was in denial I was like no I haven't got nothing wrong with me I don't want to take tablets, that's not me, no I'm normal.

I: and did you what age were you back then?

Sarah: eh five or six I have a really good memory but they said I shouldn't have a good memory.

I: why not?

Sarah: because most people that suffer with ADHD don't have a good memory.

I: okay but you do.

Sarah: I can remember from...young.

I: you remember lots of things and do you remember about when you got diagnosed like what happened, where you went, who went with you?

Sarah: um when I actually got diagnosed...that was two years (-) ago.

I: um hm

Exploratory Comments

Sarah felt like that wasn't her and she did not want to take tablets (Challenge to identity- not someone who takes tablets. Diagnosis means she has to take medication?).

ADHD means not having a good memory (she's different to most people with ADHD? *'they said'.. 'suffer'*-others as knowing, ADHD as suffering)

Emergent Themes

Passive but alert/as a keen observer in process

Feeling different

Passivity in process

Diagnosis for others

Sarah: or something like that near enough and I went with....my Mum the first time and then when you go for this back up meeting I went with my Dad and his girlfriend and then.....(///) the other time after that I went with my Mum and my sister.

I: ...do you have to go much?

Sarah: I have to go every six months.

I: every six months and that first time when you found out that you had ADHD how did how did you feel going going at that time?

Sarah: ...am....it's hard to explain it's like... ..don't know.

I: That's okay/

Sarah: I just felt different like cause where I was so bad and my Mum thought it was just because I was being naughty and like I couldn't that was just being against the world as a teenager but when she actually found out I think it made her more a bit more happy that it wasn't just me being rebellious it was me actually not being able to do things...well...the people that actually push forward for me to have my tablets done is..YOT when I had my first.....triage.

I: what's the triage?

Exploratory Comments

Sarah can recall events in detail (Even though she seemed passive in the process she was taking it all in).

Sarah talks about how she felt different when she first got diagnosed (Sarah relates her diagnosis to her Mum and how it helped her but what about Sarah?).

Emergent Themes

Others active in
process/others
noticing

Rejecting self/ADHD

Feeling
overwhelmed/Passivity

Sarah: it's ah if you get arrested and it's your first offense you get a triage.

I: a triage.

Sarah: yeah and I broke the door and I got (-) arrested.

I: okay and then they pushed for you to take tablets.

Sarah: they when I was there they noticed that I was really fidgety and they asked the nurse to see me and the nurse asked me questions and then they come to my house and asked my Mum questions and then sent a form to the Doctor and got went to the doctors and then they said it that I have ADHD.

I: and when you found that out how did you feel about it then when you were told? Like Ellie you have ADHD.

Sarah: um...um I don't know.

I: you don't know, okay that's fine. Can you think was it a good or a bad feeling? Or just a really/

Sarah: it's kinda bad feeling cause I didn't really want to have it.

I: um hm

Sarah: because it's something that I will probably have to live with for most of my life or all of my life...(-) probably. Nothing I can do about it.

Exploratory Comments

The people from YOT noticed her behaviour and referred her for an assessment. (Mum and then YOT noticing her behaviour-'*they* said it'-other people as active but Sarah as a bystander?/Passive?).

Sarah describes how it felt bad when she got diagnosed as she didn't want to have ADHD (Rejecting self, also there is a feeling of being overwhelmed).

Emergent Themes

ADHD as
developmental

Parts of self that can't
be controlled

Others as
powerful/noticing

Old me vs new me

I: yeah and do you think that am cause you say that ADHD is something all your life, do you think it will always be the same? Or will it change?

Sarah: am...I think it will change because..I will be more...thinking about my actions where I am quite young still I don't actually know how to control it yet but...I should learn soon.

I: and if you compare yourself to when you were much younger and you would have still had ADHD then but maybe you just didn't know what it was then and you compare yourself to now. Is there a difference in that?

Sarah: yeah a big difference...even the school say it's a big difference.

I: um hm

Sarah: because now as if someone says something to me that I don't like, I won't kick off as bad I won't kick stuff and....and I'm not as agitated in like when I've got an exam I never used to be able to sit there, I used to walk out of it and run around or something...so it's just...because now I can just sit there and ..concentrate.

Exploratory Comments

Sarah feels that her ADHD will change in the future and she will learn how to control it when she is older (lack of control at the moment, ADHD as something to be controlled)

Sarah reflects on the differences in herself and comments that the school have noticed too. (is it important to Sarah that others notice the difference..does it make it more true?).

Sarah has changed, in the past she felt she was more agitated (Old me vs new me)

Emergent Themes

Doubting medication

Uncertain relationship
with medication and
self

Importance of
relationships

Supportive role of
others

Challenging others
views on ADHD

I: so you have already made loads of progress so who knows in another ten years when you are nearly 26 you might be very different again. And ah what do you has kinda helped you with that?...that difference

Sarah: ah um...people say it should be the tablets that help you with the difference but I don't think it actually is...because they do keep me calm...but sometimes when I forget about it and I won't take it for one day I will be exactly the same as I am, it's just...except for when it gets really (-) late because that's when I think they wear out ...really bad but um it's to do with support from people as well.

I: um hm

Sarah: because I get support from Mum, school and stuff like that. So it does help a lot more when you got support in place for you.

I: ..yeah so you see its not just the medication you need to have the people as well.

Sarah: yeah

I: yeah and eh do you am do you ever not take it. Do you ever give yourself breaks from medication?

Exploratory Comments

Others can help (a
different role for others-not
in opposition)

Emergent Themes

Implications of
medication on identity

Effects of medication

Sarah: no unless I forget but (///) like that. Or something or if I forget it and I stay at a friend's house then normally I will come back but I will take it a bit later and then it...doesn't wear out until later. But when I take it so early it wears out so early.

I: um and I remember you said that's why you go to CNC for the last class.

Sarah: yeah cause if not um I get like a really hyper boost.

I: okay a hyper boost what happens during a hyper boost?

Sarah: it's like you can feel the tablets wearing out and you feel hyperness going up and up and up and up and up and then you just...wanna run around and stuff. That's why it's so bad during night times cause I think a lot of people struggle with it at with ADHD cause where your tablets are keeping it low for the whole day when they start to like you can like start to feel them wearing out you're more like up and awake like you wish you could feel this way in the morning you're just like up and awake.

I: I wish I could feel like that in the morning too. So that's interesting so at the it keeps you calm during the day but then at night when you are not taking it./

Sarah; yeah because/

Exploratory Comments

Sarah talks about feeling a '*hyper boost*' as her tablets wear out towards the end of the day. Sarah also talks about the impact that her medication has on her sleep patterns. (is this a part of herself that she cannot control? ADHD needs to be controlled- the tablets '*are keeping it low*'-tablets as being effective here).

Taking medication affects Sarah's sleep patterns

Emergent Themes

Taking back some control

I: that must be very/

Sarah: I'm set just for one in the morning it like wears out during this time.

I: so how do you sleep, how do you sleep?

Sarah: um...I don't know but they suggested taking sleeping tablets but am on sleeping tablets I sleep walk really bad.

I: oh do you? Okay

Sarah: so I can't take them.

I: so you are not going to take them. And would you like most nights would you get many hours sleep? Would you say on average..

Sarah: probably fall asleep about 11 12

I: and then.

Sarah: yeah

I: must be up at what?

Sarah: six half six

I: that's only six hours sleep I mean for someone age that's little sleep.

Sarah: yeah

I: I think they say teenagers you probably need like nearly/

Exploratory Comments

'They suggested'
(challenge to others-she can't take sleeping tablets)

Emergent Themes

Sarah: eight hours/

I: eight hours or maybe even more when you're coming to school and doing exams. You need and good night's sleep and then when you are older like me you need less...although I need lots of sleep. Am so that's all kind of about when you were first diagnosed and that kind of thing. Am so can I give you a piece of paper am and this is just based on whatever you think am can you draw something that you think shows ADHD. So I've got colouring pencils and stuff there as well..so just take your time cause it might take you a while to think of something, there's no rush with it.

Sarah:...{drawing}.....I can't..

I: I really can't so I wouldn't worry about it if I was you. Are you finished?

Sarah: yeah

I: so what have drawn?

Sarah: it's a man knocking down a brick wall woman knocking down a brick wall.

I: okay and what made you think of that?

Exploratory Comments

Sarah was asked to draw a picture to show ADHD, she drew a picture of someone knocking a wall with a hammer (see below)

Emergent Themes

Medication as a
defense against others

Others as opposition
ADHD mind

Old self

Others 'getting to
you'/other people
making it hard

Sarah: because like when you takes tablets nothing...it's like...you've built up a brick wall but when you are taking them like the things people are saying are like the same things but you are just knocking them out with your mind because it doesn't matter.

I: um hm

Sarah: of what they are saying but where and I it's thinking before you act.

I: um hm

Sarah: whereas it's like...a few years ago if you say, what do you think of your behaviour or something like that like with someone kicking something not knocking it down slowly and slowly and gradually but..{indicates to hammer drawn in picture}.

I: okay so you think the the tablets help you kind of/

Sarah: gradually knock out what everyone is saying and stuff like that doesn't let things get to you.

I: um hm

Sarah: so it's like you build up a big brick wall.

I: um h

Exploratory Comments

Sarah talks about how the medication helps her to block out what people are saying and to not let things get her (other people making it hard)

Emergent Themes

ADHD thought
processes

Sarah: you start slowly knock it down so it doesn't what people say to you it doesn't affect you as much as what it used to.

I: um hm okay so it seems like the tablets have that you think they are helpful for you?

Sarah: yeah.

I: um hm and then if I asked you I mean you don't have to write you can just say am if I asked you to give me some words to describe ADHD so you don't have to think of yourself in particular but just someone generally with ADHD, how would you describe them?

Sarah:...energetic.

I: um hm

Sarah: um don't think.

I: um hm

Sarah: am...thoughtless...am...paranoid...don't know what else.

I: okay I will try to just write some of those down here so the first one you said was energetic...and then what was the next one you said? {writing}.

Sarah: don't think.

I: don't think yeah.

Exploratory Comments

To describe ADHD Sarah says; (mainly describes as ADHD thought processes for her. Later Sarah describes how others would perceive ADHD mainly terms of behaviour)

Emergent Themes

Unmedicated
ADHD/ADHD as
changing

ADHD as being
different to others

ADHD as vulnerable

Sarah: thoughtless and paranoid.

I: oh you do have a good memory...{writing}. Okay so what made you pick the words that you did?

Sarah:...am well for energetic someone with ADHD before they actually take the tablets they are *really* like..hyper and or jumpy and stuff like that.

I: jumpy

Sarah:...and I don't think cause some people don't, most people eh don't think before they do stuff that's why it's like they can't gradually slow their mind down to think and the same think for thoughtless, they just don't think. And paranoid it makes you more paranoid of what people say than the actual thing they are saying. Someone could say something but it won't be meaning what you think its meaning so you will take it more to heart.

I: um hm and do you think am that someone with ADHD are they always these things?

Sarah: um no....mostly.

I: mostly okay and can you think of times where these things have applied to you?

Sarah: before I took tablets.

Exploratory Comments

Un-medicated ADHD

Sarah feels that people with ADHD don't think before they act and that they misinterpret what people say (ADHD as being different to others, like a us vs them, other people are creating a challenge for ADHD)

'take it more to heart
(feels as though others are against you but maybe not?)

When describing ADHD, Sarah reflects that these words would describe her before she took medication

Emergent Themes

Lack of control over self

ADHD as different

Feelings of regret/anger at self

Distancing self from ADHD

I: before you took tablets. Was there anything in particular out of those that stands out for you?

Sarah: thoughtless.

I: thoughtless okay so how are you how are you thoughtless?

Sarah: am I never used to think before I said or done something.

It's like my actions are speaking louder than my words.

I: um hm so when you do something without thinking after after you done the thing what thought would run through your mind?

Sarah:...the thought you should have originally thought of {both laugh}.

I: okay so you come up with the solution after.

Sarah: yeah it's like the opposite way around. It's like (//) most people think before they spoke or done the action but not for everyone but for me it's like you do the action then you think.

I: okay..and how did you feel then when those things would happen?

Sarah:...am..it's just you feel stupid because if you had just waited or counted to ten then you could have slowly counted them all down and then you would feel better like I'm fine now but...

Exploratory Comments

Actions speaking louder than her words (Lack of control over self and later regret actions? Also Sarah talks about this in both the past and present tense..is she still this person?).

'most people' (ADHD not same as different to others)

(Sarah is different to most people, almost an impatience with herself. Sarah then puts distance between herself and this behaviour by adding *'I'm fine now but..and doesn't finish this sentence. Perhaps Sarah is okay now but she is not quite sure how stable that is?').*

Emergent Themes

Normalising ADHD

Lack of control over
self

Internal disorder/
External disorder form
others

I: okay so after you just kind of you kind of know what you should have done and maybe you are like not too happy with yourself that you did that kind of thoughtless thing.

Sarah: yeah

I: okay and eh now once that you are taking the tablets do you do any of those things kind of apply now?

Sarah:.....um...sometimes I get energetic but that's just normal.

I: yeah I mean everybody gets energetic don't they every so often. It's not anything strange and am why do you think someone with ADHD is those words that you've picked? What makes them that way?

Sarah:....um...I think it's just the way that they react...it's like your mind doesn't control your body your body controls your mind.

I: um hm

Sarah: so that's if you get angry you don't think about what you are gonna do you just do it you don't use your mind you just use your body and (-)....that's probably why.

I: so your body is controlling your mind so it's like the same thing its always like an opposite you have the thought after the action

Exploratory Comments

Now that Sarah is taking tablets, the main difficulty she encounters is being energetic but she feels that is normal. Sarah again reflects that people with ADHD's difficulty is that they react in a certain way. (Normalising ADHD, also Sarah uses the word energetic not hyperactive. She also raises the idea of control again and of not being in control of her actions)

Emergent Themes

Biological/Genetic
explanation

Social/Psychological
explanation

ADHD as
overwhelming

the body is controlling the mind not the mind the body so it's all this kind of opposite...yeah. And then am do you know anything about what causes ADHD? You know when you first got diagnosed did you get given any little leaflets or anything like that?

Sarah: yeah am it's mostly like..fam..like part of your family.

I: um hm

Sarah: or it could be an emotional like an emotional mental state that you could have like you could have gone through something and it could have triggered it.

I: um hm

Sarah: (-) but I don't know.

I: and do you think are people born with ADHD or not born with it?

Sarah:...I think some kids are born with it but you just can't tell cause they are too young to actually (-) deal with it. {noise from someone speaking in the office next door}.

I: I think she is going to be on my tape recorder...so sorry some people you think are born with it/

Sarah: yeah

Exploratory Comments

ADHD as being part of
your family (genetics)

Sarah was asked about the cause of ADHD, she explained it as being in your family or as getting triggered (for Sarah ADHD appears to be an internal disorder and that it requires some maturity/resilience? to *deal with it*..like it is too much for a younger child to cope with).

Emergent Themes

External disorder

Different selves

I: and then others/

Sarah: it triggers.

I: it just gets triggered okay and can you think of somebody who is like in your family or maybe somebody in school or just somebody that you feel is supportive to you and if I asked them to give me words to describe ADHD what do you think they would say?

Sarah: um

I: can you think of a person first?

Sarah: Mum

I: Mum okay so if Mum was here what would she tell me?

Sarah: {laughs}..just for me she would say annoying/

I: okay/

Sarah: constantly destructive and stuff like that.

I: okay and what do you think she would pick those things?

Sarah: because she doesn't get to see me when I've taken...so when I'm calm she doesn't see me but when I'm at home more hyper that's when she actually.

Exploratory Comments

Triggers (ADHD as something that can be triggered)

Sarah describes ADHD from her Mum's and Deputy Head's perspective in terms of behaviour (External disorder from others and much more of a behavioural description, Internal disorder; Sarah describes ADHD as internal conflict and as being a bit vulnerable)

Sarah sees herself as being different over-time

Emergent Themes

I: okay cause when you take the tablets that's when the times that you go to school so she doesn't get to see the school version of you. Okay and what about during the summer holidays do you take them then?

Sarah: yeah.

I: um hm and am what's the other word you said she would pick annoying and constantly destructive. Okay constantly okay do you think there's anything else she would say?

Sarah: eh...doesn't listen.

I: um hm

Sarah: um..mouthy.

I: and mouthy okay and why would she pick those ones?

Sarah: cause every time she tells me to do something it gets left for one or two weeks.

I: It gets left for like two weeks okay. And ah is there anything else you think your Mum would say? No? And can you think of another person? It can be someone who either helps you or somebody who they very opposite so actually doesn't help you but just another person someone else.

Sarah: Mr Farrell

Exploratory Comments

See above

Emergent Themes

Other as expert on
ADHD/powerful others

Others see observable
behaviours/negative
perceptions

I: Mr Farrell okay...so if Mr Farrell was sitting here and I asked him to am describe ADHD what would you think he would tell me?

Sarah: he has a lot of work with ADHD.

I: oh does he?

Sarah: yeah

I: what in this school?

Sarah: in any school he used to be a behaviour parole officer I think.

I: Oh was he? Okay/

Sarah: in other schools and stuff like that or used to work...the Head of behaviour (///)

I: so he would probably know quite a bit then wouldn't he? Okay so what words do you think he would tell me?

Sarah: am {laughs} he has to use professional words/

I: okay {laughs}.

Sarah: uncontrollable

I: uncontrollable

Sarah: that's without the tablets with the tablets I don't know.

I: um hm

Exploratory Comments

Sarah feels that Mr Farrell is knowledgeable about ADHD (as someone who is knowledgeable his opinion is important/true?)

Mr Farrell as 'expert' sees ADHD in negative terms

Others see someone with ADHD being '*uncontrollable*' without their tablets (Sarah is using very strongly emotive words)

Emergent Themes

Medication as helpful

Behavioural
description of ADHD

Sarah: probably has a difference...(///) {lots of noise from office next door}.

I:so if you are taking the tablets it's just very different, yeah. And so he might say uncontrollable. What else do you think he might say?

Sarah:...uh..don't know.

I: you are not too sure what else? Okay and am do you want to pick one other person? No kind of done with that one okay so I want you to imagine am that there is somebody in the room here and they have never heard of ADHD they don't know anything about it all and they've just heard the word and they've asked you to describe it to them. What would you tell them?

Sarah:...am...don't know..(-) I've no idea.

I: no you can just pick out the few kind of key messages or the most important things to know about ADHD to tell them.

Sarah: um....people with ADHD are more...hyperactive or...

I:...yeah that will probably help them, people with ADHD are more hyperactive.

Sarah:...um when they take their tablets they are more concentrated and...they can listen a lot more but with someone

Exploratory Comments

When asked very directly to summarise ADHD, Sarah says '*I've no idea*'

Emergent Themes

Confusion with medication

Effects of medication

who hasn't taken them they would probably find that they are more fiddly...um.. they will talk a lot more and...and...it's weird that when if you don't take them you are more in people's faces and you are like but when you do its like you are just more...chilled.

I: you are just more chilled, is that how you generally sum up you are just a bit more chilled if you have taken them. Are you tired now? Okay, do the tablets make you tired? Did you say that before?

Sarah: they kind of do...but if I didn't take them I wouldn't be I wouldn't I've never never normally tired when I do take them before but now I take them they do drain me a lot.

I: and is that kind of more after lunch or before?

Sarah: after

I: after lunch okay so maybe as they are starting to kind of leave your system a bit you start to come down a bit before you go back up by the sound of it {laughs}. Okay am so is there anything else you would add to help that person understand it?

Sarah: no

Exploratory Comments

Sarah describes how when she takes medication she is better able to concentrate and listen and she is calm. However, if she doesn't take them she will talk more and be more in people's faces. (Effects of medication, some confusion with how different you can be when not taking them-Sarah says 'it's weird').

'drain me a lot' (negative impact of medication)

Emergent Themes

Needing time alone

I: no okay if you want a break just tell if you are feeling too tired, I don't want to exhaust you, okay so I have some pictures here. Can I just ask you to go through am and pick one? {Sarah looking through pictures}.

I: there is probably about 12 in total I think (25.25).

(26.18) Sarah: in most of these pictures one person is alone.

I: oh okay...that's what you've noticed.

Sarah: I don't know which one....just had to be any random one.

I: just whatever one you want, yeah am so do you know what I'm going to ask you about the picture? Okay well the first thing I'm going to ask you to imagine that there's am..oh first of all just tell me what you think is happening in the picture?

Sarah: um.eh...playing horse or sitting on their own...I don't know what that is...people playing football.

I: um hm and then if I told you that one person in the picture has ADHD..who would you pick it to be?

Sarah: {indicates figure sitting alone}.

I: okay and why that one?

Sarah: because she's sitting on her own and most people with that do (-) who have ADHD like to be have their own time.

Exploratory Comments

Sarah is presented with the school situation pictures, she takes her time looking through and comments '*in most of these pictures one person is alone*' (reflective of how she feels?).

Sarah picked the first one and was asked to describe it; describing one as playing horse/sitting alone

Sarah felt the person with ADHD may be the person in the background sitting alone (ADHD as overwhelming needing a break from it all?)

Emergent Themes

I: okay so people with ADHD like to just kind of have their own time. And what do you kind of do in that time?

Sarah: Think

I: okay...do you get some of that time in school?

Sarah: depends...

I: depends okay is there anything else you would say about the person there sitting there?

Sarah:.....{indicates no}.

I: no okay that's fine. Am can I just ask you to pick one more?

One or two more maybe up to you. Whatever you want.

Sarah: which one is it that actually has...

I: hm?

Sarah: or is it just what I think?

I: It's just about what you think there isn't am a particular one to find. {shuffling papers} Sarah picks one

I: okay and if I asked you similar things about this picture what would you say?

Sarah: am....it's more likely to be one of the ones that...this one or that one.

I: okay so it's going to be this one here at the end.

Exploratory Comments

Sarah selects another picture and describes a scene of a fight indicating that the person with ADHD would either stop the fight or the figure in the background (ADHD forgotten/emotive feelings of ADHD, challenging perceptions-don't want to fight)

Emergent Themes

Challenging views held by others

Being overlooked/in the background

Fitting in with the 'norm'

Sarah: yeah

I: okay am I will just put a mark there so okay or which one?

Sarah: that one

I: or this one and why did you pick either one of those?

Sarah: because most people with ADHD don't actually like to fight they more like to solve..problems..but (-) I don't know.

Because they are in the background and that's practically what it's like.

I: okay so they are in the background and that's what it's like.

Okay so they don't they don't want to be that these two here, they don't want to be that so what kind of makes makes them be the way they are?

Sarah: probably the tablets....because before I took tablets I would have fights every but now I take them I'm like got a more suitable head {smiling}

I: {laughs} a more suitable head okay is that a phrase you come up with yourself?

Sarah: yeah {smiles}.

Exploratory Comments

People with ADHD want to solve problems (internal conflict-challenging others)

Sarah feels her medication gives her a more suitable head (Fitting in with the 'norm', medication giving her control?)

Emergent Themes

I: okay {laughs} am and is there anything else you would add to kind of describe ADHD? Anything else that comes to your mind with it?

Sarah:.....really fiddly

I: really fiddly you think that's a big thing.

Sarah: yeah/

I: okay/

Sarah: and have to be moving.

I: and does that help you then when you are kind of moving?

Sarah: yeah

I: it can okay so that's kind of the key message from you. Do you want to pick another one.

Sarah: no.

I: you don't need to you can put them away. Am so we will probably finish up quite soon am was there anything in the stuff that we did that you find hard or you found easier? {talking in background}.

I: Is that Mr Fallon? So what kind of things did you prefer doing of the activities we did?

Sarah:.....pictures...talking

Exploratory Comments

Conclusion comments of interview

Emergent Themes

I: talking so talking so kind of what works for you then yeah cause you like talking. Okay am so I'm gonna come one more day but we need to figure out a day that's good for me to come and it might be a bit kind of shorter than this as well. It will just be to kind of ask you a few more questions about ADHD probably to follow up some of the stuff you've said but maybe one or two new questions as well am then at the end of it all. I will write you a letter ah which will come to school in September am and it will just be in an enclosed envelope kind of just for you to see am then I've given it as an option if any of your parents would like I could do a feedback meeting with them. Is there anything that you kind of wouldn't want me to tell people about what you said anything you want to keep confidential?...Is that shaking your head for no. okay and do you have any questions for me?

Sarah:.....why did you choose to study ADHD?

I: why did I choose it? Am...I think it's just something that had always interested me and when I started working with young people I think I didn't know that much about ADHD. Am and I worked in a PRU before and I think some of the kids there had

Exploratory Comments

Emergent Themes

ADHD and kind of just couldn't understand their behaviour and why they did the things that they did am then especially cause then when after and you talk to them they would be able to tell what they should have done and I was just kind of like why didn't you do that? I just could not understand why they cause they knew and they were able to say it and they could I could tell that they regretted what they did but they still did it and then might do it again as well am so I think I just thought that was kind of really interesting am and its just I think it happens more than people realise as well I think more people have ADHD people know and am yeah I guess I just think its quite different cause there's lots of am conditions and things in school you have probably heard of autism and that people know lots about autism and I think we understand that really well am but I think ADHD is something that's not maybe understood as well and I think I used to be a bit like I didn't understand it. Am I think I understand it a bit better now. Am but a lot of the research like I was saying it doesn't ask young people and I think that's where you are really going to find out about it because you are the person who is diagnosed with

Exploratory Comments

Emergent Themes

it, you're the person that kind of knows you are the expert (//)

does that answer your question?

{Sarah nods} Yeah..do you have any other questions for me?....no? {Sarah shakes her head} are you okay? You are feeling fine?

Okay am so shall we I won't come tomorrow because you have the English thing. Do you think Thursday, do you have your planner with you? {shakes head}. No okay do you know what's happening on Thursday? {shakes head}

Sarah: there won't be no exams because

I: there will be no exams and am when do you have your tutor time?

Sarah: 10.50

I: 10.50 okay I'm just trying to think so on Thursday I could come the same time after lunch? What do you have after lunch on a Thursday?

Sarah: Science

I: Science and are you happy to come out of that one?

Sarah: yeah

Exploratory Comments

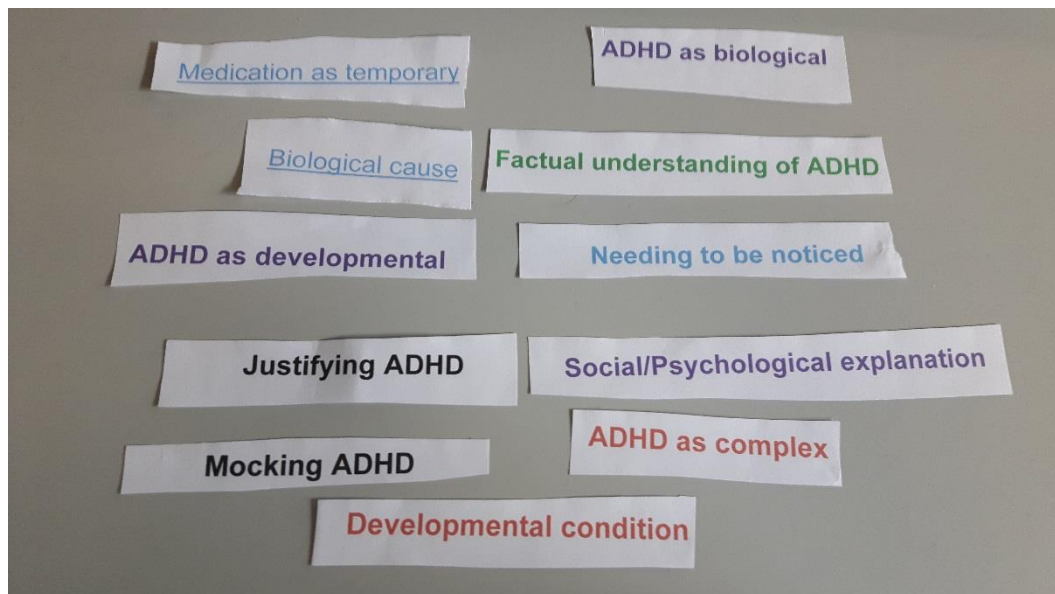
I: okay so maybe I will come at 1.30 on Thursday am that will be the last time and I will have something to..I will give you something on that day, it's to tell you about ADHD and then am like I said the letter will come in September as well. Okay so will just..{turns off Dictaphone}.

Appendix 8: Example of analysis-Group

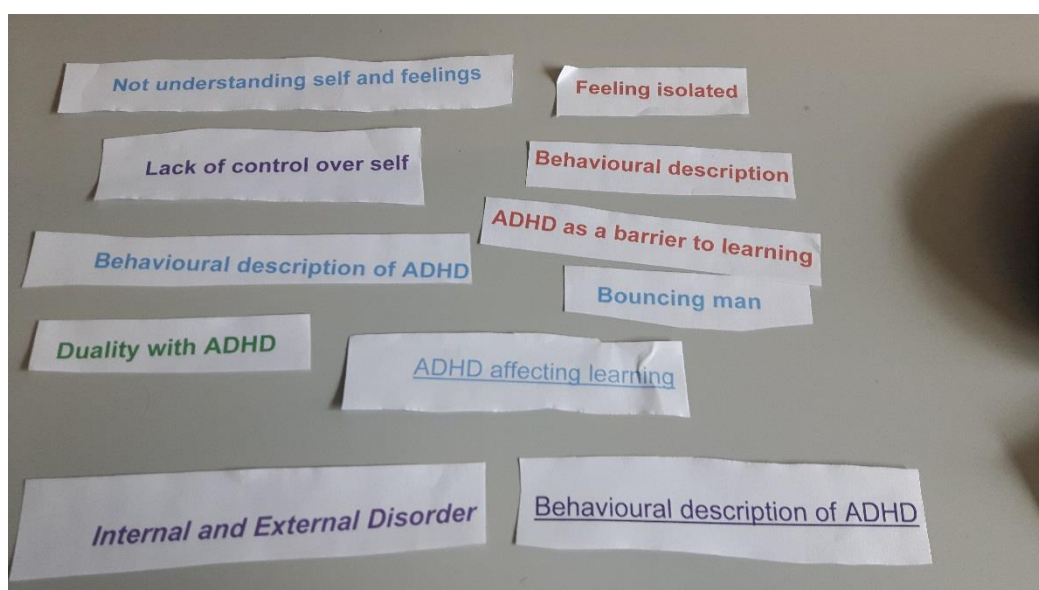
Colour codes: **David** **Gary** **Jack** **Michael** **Sarah** (underlined indicates an emergent theme that was revisited during group analysis)

Super-ordinate theme one: What is ADHD?

Something in their body

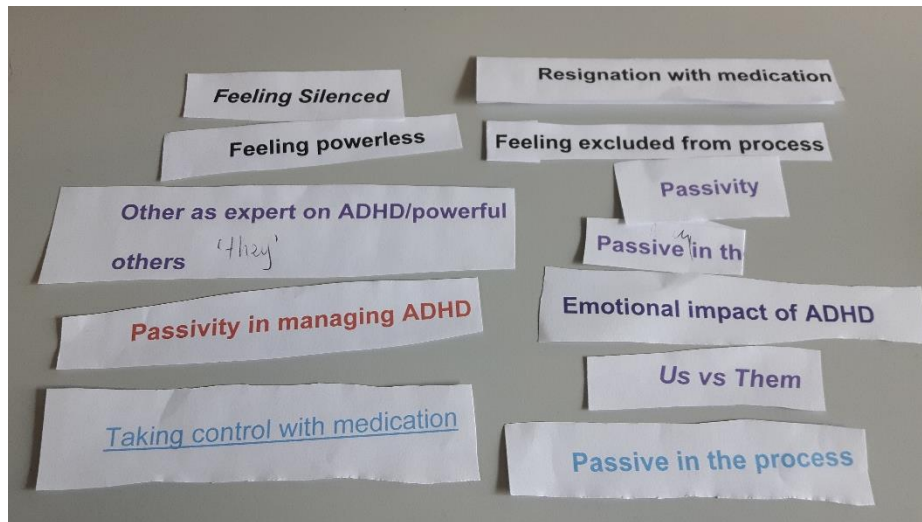


My actions are speaking louder than my words

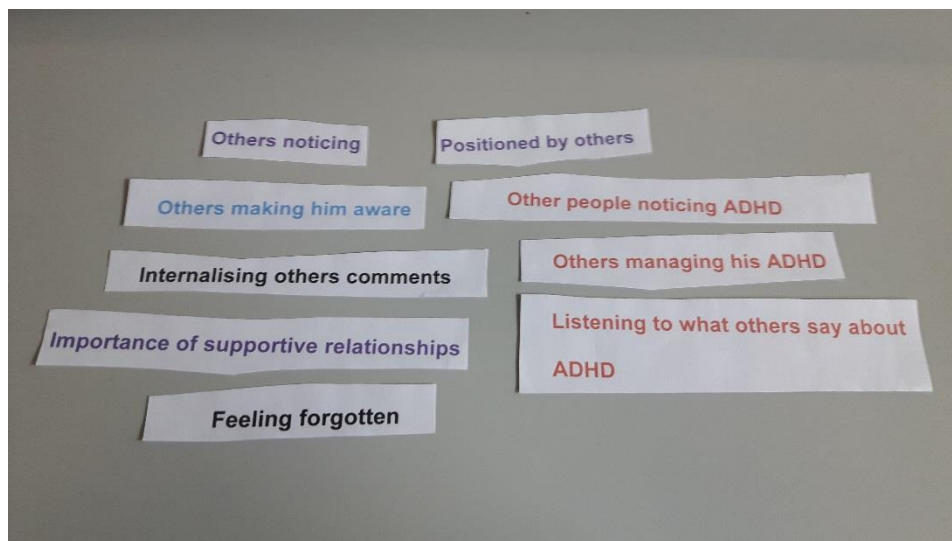


Super-ordinate theme two: The Role and Impact of other upon the experience of ADHD

Us vs Them

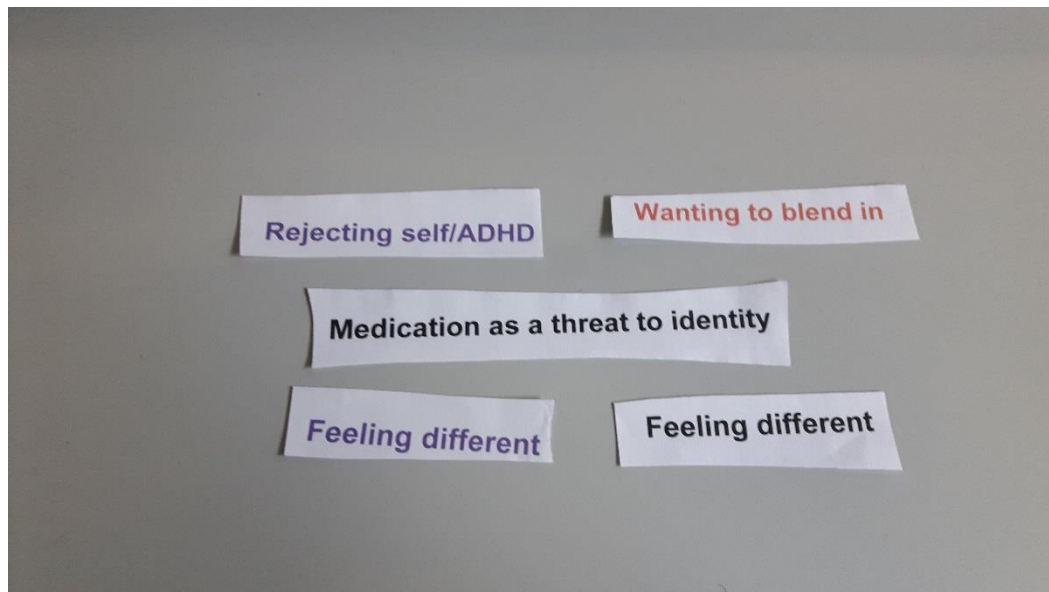


Understanding and Support

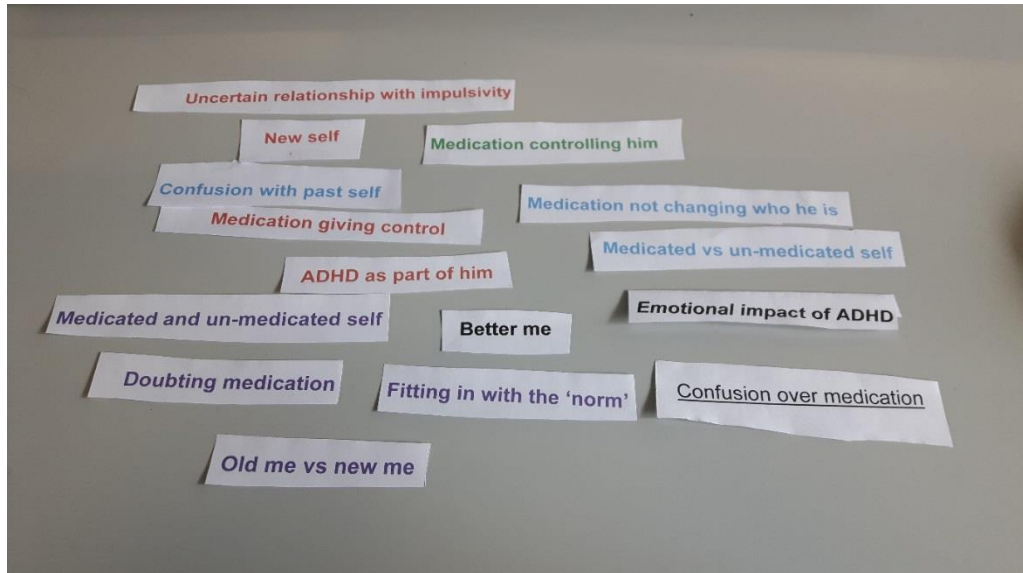


Super-ordinate theme three: Identity Conflict

I don't feel like a normal kid

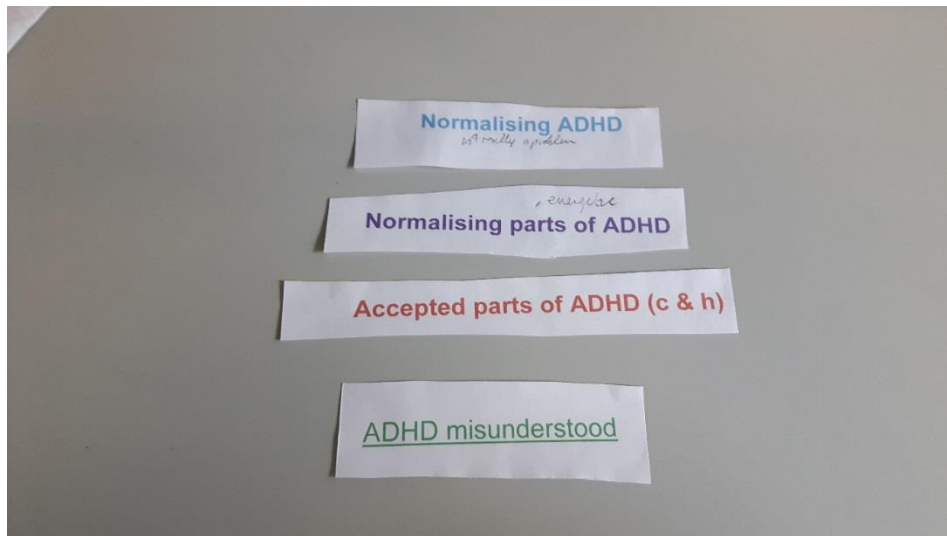


Multiple Selves

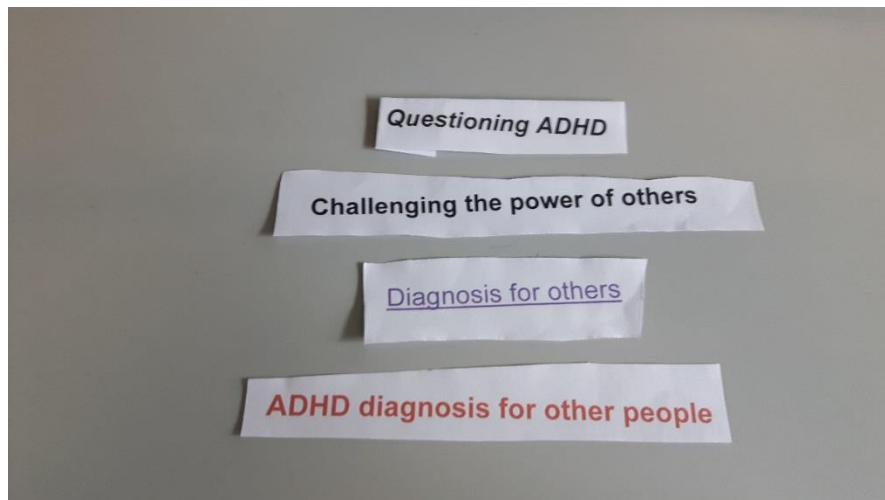


Super-ordinate theme four: My relationship with ADHD

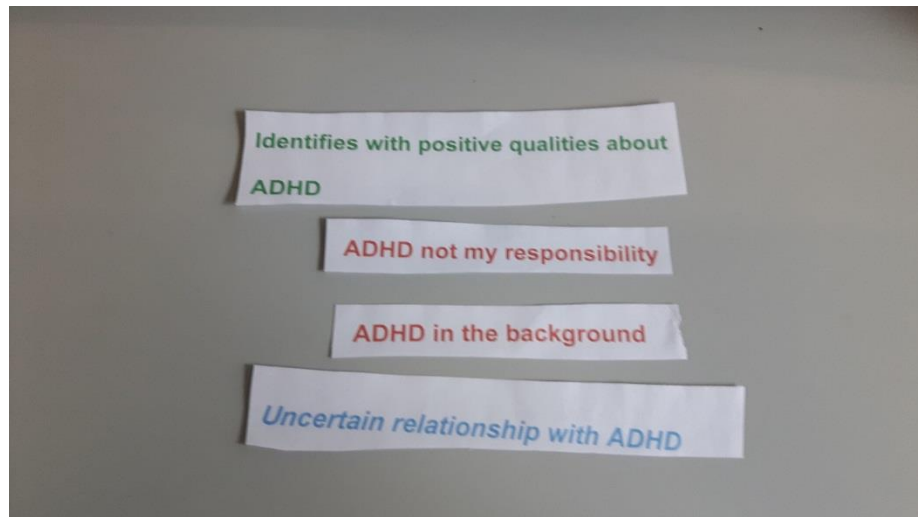
Normalising



Questioning

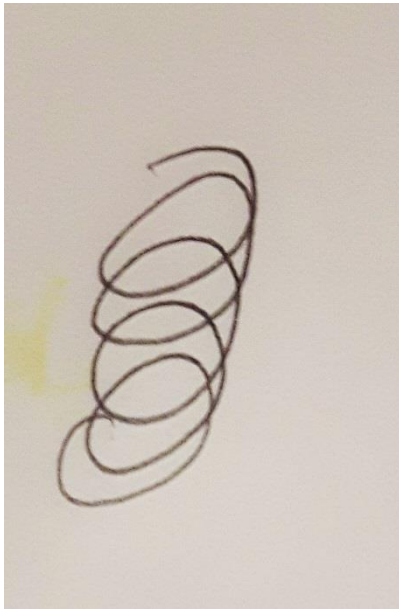


Distancing



Appendix 9: Young people's drawings of ADHD

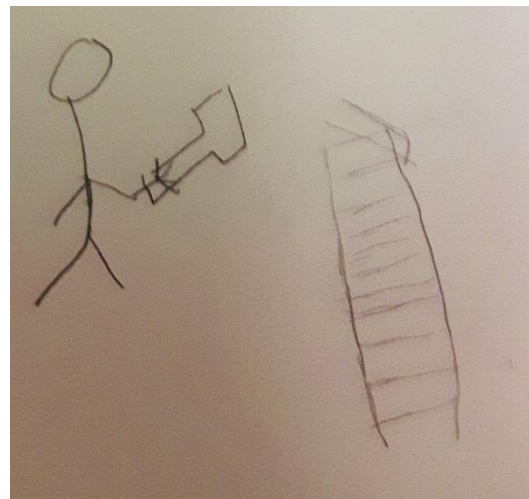
David



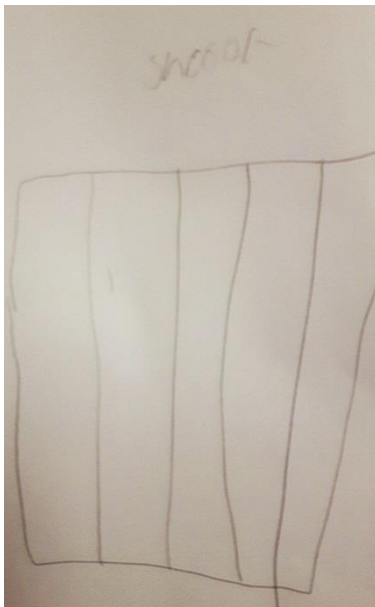
Jack



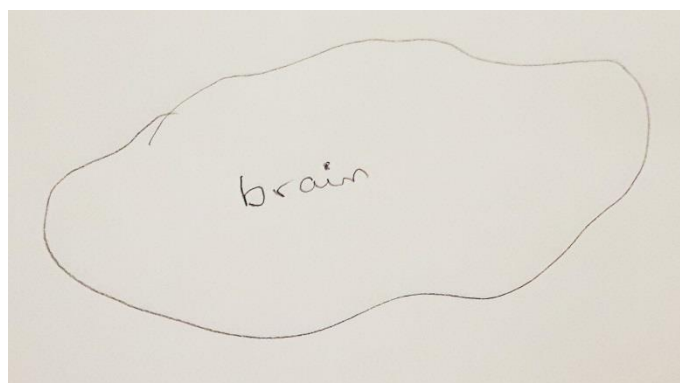
Sarah



Michael



Gary



Appendix 10: Extract from research diary

10th July 2015,

I have just interviewed David for the second time. He appears to be a 'good student' and he performs well in school. In the first half of his interview, he spoke of ADHD quite matter-of-factly and he was articulate. He seemed at first, quite distant from the symptoms associated with ADHD. It was only about half-way through his interview that he began to recall experiencing any difficulties and a more emotive account began to emerge. I was struck by how different his story now seemed. I am wondering how well semi-structured interviews support young people to tell their story. It has taken some time for David to reach this point. I wonder what helped him come forward with this alternative perspective on his early experience of ADHD? Had the power imbalance struck a balance and he felt able to share such a story? Or was he feeling more relaxed with the interview style? Or perhaps this was not 'late' in his interview. It being 'late' in the interview is my interpretation and perhaps more reflective of my own anxiety in wanting to support the young people to best to tell their story.

8th August, 2015

I am analysing David's transcript at the moment and at times listening back to his interview. Listening back to his recording, I am beginning to wonder if his story of past struggle, only emerged later on in his interview as it was a story that he had long forgotten. He does well in school now and maybe this is a part of himself that he no longer associates with. Perhaps, it was only at this late point, when in a deeper reflection, that David began to bring back to his conscious mind, his past difficulties.

Appendix 11: Contents of USB Stick

David's Transcript

Gary's Transcript

Jack's Transcript

Michael's Transcript

Sarah's Transcript

Appendix 12: Ethical Approval

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Dr Helena Bunn

REVIEWER: Mark Holloway

STUDENT: Orla Kenny

Title of proposed study: How do young people with ADHD perceive their condition?: An Interpretative Phenomenological Analysis.

Course: Professional Doctorate in Educational and Child Psychology

DECISION (*Delete as necessary*):

*APPROVED

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

Minor amendments required (*for reviewer*):

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students):*

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*

Student number:

Date:

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐

HIGH

☐

MEDIUM

☐

LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer (Typed name to act as signature):

Mark Holloway

Date: 17.2.15

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here:

<http://www.uel.ac.uk/gradschool/ethics/fieldwork/>

