Educational practitioners' perceptions of ADHD. A qualitative study of views of the home lives of children with ADHD in the UK

Accepted manuscript: British Journal of Special Education

Abigail Emma Russell[1], Marianne Tay[2], Tamsin Ford[1], Ginny Russell[1] and Darren Moore[3]

[1]Child Mental Health, University of Exeter

[2]Psychology, University of Exeter

[3]Graduate School of Education, University of Exeter

Corresponding author

Abigail Russell, University of Exeter Medical School, St Luke's Campus, Exeter EX1 2LU

a.e.russell@exeter.ac.uk (+44)1392 722985

Funding

This study was conducted as part of a PhD studentship funded by the University of Exeter Medical School. Preparation of this manuscript was supported in part by NIHR Collaboration for Leadership in Applied Health Research and Care South West Peninsula (PenCLAHRC).

Acknowledgements.

We would like to thank Sophie Arnell for her help with data collection and coding, and the educational professionals who participated in this study.

Abstract

There is little research exploring educational practitioners' experiences of working with children with attention deficit/hyperactivity disorder (ADHD). The current study aimed to understand educational practitioners' beliefs concerning the home lives of children with ADHD, and how their perception of home lives affects children's behaviour in school. Forty two practitioners from Primary, Secondary and pupil referral schools participated in focus groups or interviews. Thematic analysis was used to identify themes arising from the data. Three themes emerged relevant to beliefs about the home lives of children with ADHD: inconsistency, psychosocial adversity and isolation. Educational practitioners relate their experiences of working with children to what they believe occurs at home. We make recommendations for strategies school practitioners can use when working with children with ADHD based on these findings.

Introduction

Attention deficit/hyperactivity disorder (ADHD) is a prevalent neurodevelopmental disorder that emerges in childhood (APA, 2013). It affects between two and seven percent of school-aged children, more boys than girls (Sayal, Prasad, Daley, Ford, & Coghill, 2017). By clinical definition children with ADHD experience symptoms and impairment across settings; that is they struggle both at home and at school. Expanding research interest in the past 30 years has improved our understanding of the complex cause of ADHD. Multiple genetic and environmental factors interact to influence aetiology (Faraone et al., 2015). No two children with ADHD are the same (Faraone et al., 2015) but the core difficulties of inattention, impulsivity and hyperactivity are detrimental for the child, and impact on schools and families (Kos, Richdale, & Hay, 2006). A review of non-pharmacological interventions for ADHD delivered in school settings noted the lack of qualitative evidence about school experiences of children with ADHD in UK schools, particularly of teachers understandings of ADHD (Richardson et al., 2015). A meta-synthesis of 73 qualitative studies

involving parents of children with ADHD found that parents experience high levels of stress in managing their child. This impacted on intimate relationships and occupational functioning. Home lives were characterised by "constant mess, chaos and conflict" (Corcoran, 2016 p16), which led to a wide range of negative emotions experienced by parents including isolation, anger and powerlessness (Corcoran, Schildt, Hochbrueckner, & Abell, 2017).

Qualitative research into the experiences of parenting children with ADHD has focussed on mothers and sons (Singh, 2004), with the emergent themes of blame and guilt: mothers feel that they are blamed for their child's behaviour, by teachers, others family members or indeed themselves (Broomhead, 2013; Gwernan-Jones et al., 2015; Harborne, Wolpert, & Clare, 2004; Singh, 2004). School-home relationships are critical for all children, but are of particular importance for children with ADHD. This is because the behavioural difficulties caused by symptoms are present in both settings, so there is an increased need for parents and teachers to communicate about managing child behaviour. Positive school-home relationships are associated with lower levels of difficulties, as such promoting positive relationships may help to manage the child's behaviour (Kim, Sheridan, Kwon, & Koziol, 2013). Unfortunately many contacts between parents and teachers of children with ADHD are negative and regard discussion of problems that have occurred in school, the quality of these school-home relationships are poor (Gwernan-Jones et al., 2015).

There is little research of teachers perceptions: whether teachers actually blame parents for the difficulties the child experiences in school is not well understood (Harborne et al., 2004). One study interviewed both educational practitioners and parents of children with behavioural and emotional difficulties (including ADHD), and reported that educators blamed ineffective parenting for children's difficulties (Broomhead, 2013). Another study investigated teachers' attributions for ADHD behaviour described in vignettes. They found that the cause of behaviour problems was sometimes attributed to the home or parenting: *"I have students like this and it is mostly because the parents haven't given him rules, consequences and appropriate praise for small improvements*" (Hillman,

2011 p28). As part of a wider study into the experiences of educators working with children with ADHD, we asked a question about their perception of home lives. The data reported in this journal article stem from striking finding that educators held well-formed beliefs about the home lives of children with ADHD. The current study aims to understand educational practitioners' beliefs concerning the home lives of children with ADHD, and their perceptions of how home lives affect children's behaviour in school.

Methods

Forty two educational practitioners were recruited from 10 schools in <<area>>. Participants included Special Educational Needs [and Disabilities] Co-ordinators (SEN[D]Co's), teachers, teaching assistants (TA's) as well as more senior staff such as deputy head and head teachers (see Table 1). Six focus groups and three interviews were conducted across Primary, Secondary and pupil referral unit (PRU) educational provisions. Focus groups explored a wide range of topics on practitioners' experiences working with young people with ADHD.

Interviews and focus groups were conducted by the lead author, an undergraduate student assisted (MT or SA). The study sample was self-selected: schools were recruited through a gate-keeping member of senior staff, then individual practitioners volunteered to participate. Focus groups were conducted in order to allow for discussion among participants (e.g. questioning one another, commenting on each other's experiences) to increase the depth of the knowledge gained, as well as to understand the social context these views operate in (Lambert & Loiselle, 2008). Individual interviews collected detailed accounts of participants' thoughts, attitudes, beliefs, and knowledge pertaining to working with pupils with ADHD in schools. The methods can be considered complementary (Ritchie, Lewis, Nicholls, & Ormston, 2013) and many studies have used both focus groups and interviews.

Ethical approval for this study was provided by the <<ethics committee>>. Practitioners provided informed consent before taking part and chose a pseudonym to be used for analysis and write-up.

Any names mentioned and potentially identifying details were anonymised or removed during transcription and the original recordings deleted in order to protect the identities of any children mentioned. Interviews and focus groups deliberately used open questioning in order to prevent leading participants based on researcher preconceptions. The topic guide was updated as the study progressed when participants discussed issues that were not originally included (topic guide available from the corresponding author). Participants were given explicit opportunities to raise any issues or topics that had not been covered by the facilitator's questions.

Focus groups and interviews lasted between 40 and 60 minutes. They were conducted in almost all cases on school premises in a private room, after school hours or during lunch break. One interview was conducted at the university campus due to participant preference. These were audio recorded and transcribed verbatim. Thematic Analysis, a method for analysing qualitative data that can be used to identify, analyse and organize repeating patterns within data, and which assumes no specific epistemological or theoretical approach, was used (Braun & Clarke, 2006).

Data were analysed reflexively in a cyclical process in order to identify emerging themes and subthemes. AER and DM initially read and discussed two focus group transcripts and generated a draft coding framework. Each transcript was then independently coded by AER and either MT or SA. Similar codes were merged using NVivo version 10, and novel codes were preserved to retain maximum detail. Following this, initial themes and subthemes were drawn from the coding framework by AER and DM. The themes were reviewed in the context of the data to ensure that all relevant data were coded and that the themes were credible in the context of the wider dataset, and a thematic map was conceptualised.

Table 1 here

Results

Three themes and six subthemes were identified that related to the research questions: what are educational professional's beliefs concerning the home lives of children with ADHD, and how do they perceive home lives affect children's behaviour in school? These are outlined in Table 2.

Table 2 here

Theme 1: Perceived inconsistency

This theme refers to the perception of inconsistent and unstable aspects of the home lives of children with ADHD. It contains three subthemes; unstable home lives; lack of boundaries and inconsistent use of rewards.

Unstable home lives

Participants described the home contexts of children with ADHD as unstable, although examples of stable and supportive home lives were also provided:

"I can think of a couple of examples who you genuinely would say have had a very stable and kind of supportive type of [home life]… you're talking a very minor percentage" (Victor, teacher, Primary school).

Participants believed one of the key roles of the school was to provide stability: *"certainly the key, the core of this is consistency*" (Rose, *SENDCo, Secondary*).

Lack of boundaries

Participants mentioned lack of boundaries as a parenting practice that could exacerbate behavioural problems seen in school:

Perceptions of home lives

"Some of the behaviours are exacerbated by the parents lack of understanding on how to manage that and in those early days the lack of routines and structures and boundaries and discipline that are put in place so the behaviour just gets bigger" (Nicky, team leader, Primary).

One participant suggested that the lack of boundaries resulted from parents' struggle to cope with their own lives and that of their child. He empathised with the role of being a parent and the expectations that are put upon parents:

"Maybe it's because they're struggling to really make sense of how to parent as well, so I think sometimes what I really appreciate when you see in parents is actually an openness and an honesty, actually even if there are…things going on at home which that aren't the best, actually they're able to go 'yeah I know, I'm really struggling, I need help'" (Ryan, pastoral staff, Primary)

Inconsistent use of rewards

Participants believed that rewards were often used incorrectly by parents. They discussed how rewards were often ineffective in the school environment and attributed this to the way in which rewards were used at home. Participants perceived rewards were given inconsistently at home and sometimes after episodes of poor behaviour:

"I can think of several parents who will…go out and spend hundreds of pounds following a particularly poor episode of behaviour" (Patrick, teacher, PRU)

This caused problems at school as rewards are often used as incentives and to reinforce positive behaviour:

"Because quite often when you offer a reward they ask for more, they don't accept the reward and I think it's to do with the way that rewards are being used at home"

(Louise, co-ordinator, PRU)

Participants made a distinction between rewards used at school as being correct and rewards used at home as being inappropriate. Participants considered parents to be under a lot of pressure from

their child for these, and thought they may give in to this, unlike educational practitioners: *"they just are waiting for you to cave in maybe or even up the ante but we're not going to do that but at home maybe it does happen" (Sue, TA, PRU).*

Theme 2: Psychosocial adversity

Participants discussed factors present in the lives of children with ADHD that represent psychosocial adversity: "some of them have very similar factors and its usually there's usually domestic violence or mental health or…substance misuse" *(Rebecca, pastoral, PRU).* There are three subthemes within this theme; difficulties with the parent-child relationship; parent mental health difficulties; and lack of positive male role model. Resilience to adversity was rarely mentioned: participants discussed factors that exacerbated symptoms rather than ameliorated them.

Difficulties with the parent-child relationship

Participants reported difficulties in parent-child relationships and the impact of this on how the child behaved and related to others in school. They believed inappropriate parenting strategies were used, for example mothers who were perceived as being dominated by their son would then use rewards inappropriately in order to appease them. Problems with parent-child attachment were seen to have an early negative impact:

"They've always had…difficulties with their relationships and so for a lot of them [children with ADHD difficulties]…that we think might have ADHD it's difficult because actually they've got attachment difficulties as well" (Rebecca, pastoral, PRU).

Participants perceived that this made their behaviour more difficult to manage:

"…the inappropriate relationship, no matter what way it manifests itself is critically important, and we find that sometimes the conflict that comes into school from those youngsters can be just the simple fact that…they're actually treated inappropriately…at home that they're allowed to develop those debating skills" (Victor, teacher, Primary)

Participants reflected that in the school setting this led to children being unresponsive or rebellious towards staff who tried to put boundaries in place to ensure appropriate behaviour. Participants believed that to ameliorate this they first had to build a relationship with the child so that they would respond to boundary setting as their peers might. Participants also felt that parent-child interactions had a direct effect on the child's behaviour in school, for example:

"*Sometimes his dad would drop him off…and say, 'you're going to have a really bad day today' and he'd come in saying to me, 'Miss …, my dad told me I'm going to have a really bad day today', and then…how do you get back on to the track" (Stephany, TA, Primary).*

Parent mental health difficulties

Parent mental health was raised by participants when talking about the home lives of children with ADHD. Mental health issues in general were mentioned as well as specific disorders such as parent ADHD.

"My biggest concern around our ADHD children [is that] there are quite crippling family backgrounds in quite a lot of the cases where…there's child protection, quite severe mental health issues with a parent, and the impact that must be having on these children"

(Jennifer, head teacher, Primary).

Participants believed that parental mental health problems could impact negatively on the child's home environment and subsequently their behaviour, for example by *"showing risk-taking behaviour"*. Risk-taking behaviour is closely tied to impulsivity, a core symptom of ADHD. Other parent mental health issues that were perceived to impact negatively on the child included substance and alcohol abuse/misuse: *"serious drug users…and alcoholics, so they've got their own needs so their children's aren't first" (Barnaby, head teacher, PRU).* Participants generally believed that parent mental health issues showed an inherited reason for the child's difficulties in school, but

that they were also exposed to risk factors that would impact on brain development or learned behaviour, such as exposure to violence.

Lack of positive male role model

The absence of a father-figure was brought up by participants as having a detrimental impact on the child with ADHD: *"Yes a lot of them at the minute who never met their dad hate their dads, [have] nothing to do with them" (Jane, SENDCo and teacher, PRU)*. This was linked in particular to participants' beliefs that the child with ADHD was in control of the home environment and exerting power over their mothers with their behaviour. This in turn made it more difficult for their mother to manage the child's behaviour. Participants who had worked with children with ADHD who had fathers living at home felt that they could be exacerbating symptoms of ADHD by being a negative role model:

"What we need actually is a positive role model, male role model who's quiet and is going to offer consistent boundaries" (Rose, SENDCo, Secondary).

These problems at home were considered to lead to ADHD-related difficulties for some children:

"Some children seem to be able to cope mentally with trauma in the family home, we have families with [many] children, and some of those family members can go through the school without any issues at all witnessing the same family issues, and other children will go through and they fall apart and display the symptoms that we're talking about here"

(Jennifer, head teacher, Primary)

Theme 3: Isolation

This theme is about the social isolation of children and parents. Participants saw this occurring in two directions, firstly the negative impact on the child when their parents are perceived to not want to take them to do age-appropriate activities, and in contrast the isolating impact that having a child with ADHD has on their parents: *"It's impossible they can't go shopping, they can't do anything, they*

can't go to the park, they can't go out on a bike ride because [child with ADHD] ruins it for everybody" (Monica, teacher, PRU).

There was some disagreement in focus groups as to whether the parents were to blame for this, one participant empathised with the difficulty of knowingly putting yourself (as a parent) and your child in a situation where they are likely to be isolated:

"You know it's hard to take your child isn't it to the park and then watch everybody else playing and your child to be on their own, so you think actually I don't want to put myself through watching all of that, I don't want my child to then think, say 'why didn't anyone play with me?' So I won't do that" (Maisy, SENDCo, Primary).

However, other participants suggested a range of reasons for this isolation based on lack of a strong relationship between the parent and the child, with little sympathy for the parent:

"Very often those parents…don't take their children to the park though so they don't get the isolation cos either their too busy cos they've got high powered lives or they can't be bothered cos they're not really that bothered about taking their kids to the park, I've had the two extremes to deal with, and so either way the parents are not being isolated by it" (Sally, TA, Primary).

Participants felt this was a reflection of children with ADHD lacking experiences that are *"just things you do as a child" (Helen, TA, PRU)* and limit children's experiences outside the home.

Discussion

We aimed to understand educational practitioners' beliefs concerning the home lives of children with ADHD, and how they perceived home lives to affect children's behaviour in school. The three themes that arose from a thematic analysis of qualitative data were perceived inconsistency, psychosocial adversity and isolation. These themes draw parallels with qualitative research that has

explored the home lives of children with ADHD both from the perspective of teachers and of parents, as well as supporting quantitative evidence that ADHD is associated with psychosocial adversity (Johnston & Mash, 2001) and low socioeconomic status (Russell, Ford, Williams, & Russell, 2015). Our data lacked positive accounts of home lives: participants focussed on factors that they thought were related to challenging behaviour that they then had to manage in school. They rarely discussed experiences where improvement in an area of home life had resulted in improved symptoms at school. We now discuss our findings in more depth and make recommendations for practitioners working with children with ADHD as well as future research directions.

There were instances where educational practitioners clearly attributed parental behaviour and home routines or lack thereof, as having caused the specific behaviour challenges that they managed in the school context, fitting with evidence that parents report feeling blamed by others for their child's ADHD (Broomhead, 2013; Harborne et al., 2004; Singh, 2004). For the most part, educators in this study discussed factors at home as not being directly due to parents neglect or mistreatment of a child, more to the complex struggles that parents with ADHD also report in their home lives. We suggest that 'blame' is an unhelpful way to view the complex interactions between parent, child and school. Instead, explicitly seeking to build positive relationships and a shared understanding of the challenges faced by the school and family may foster a collaborative home-school relationship and lead to improved outcomes for children. This is important to address as there is evidence that poor teacher-pupil relationships are associated with both poorer family functioning and child psychopathology three years later (Lang, Marlow, Goodman, Meltzer, & Ford, 2013).

The context in which the current study was conducted should be explicitly considered. Practitioners were sharing their experiences from their professional position and focus groups took place during their working day. They had extensive experience and varied levels of training working with children with ADHD and other special educational needs. Practitioners explicitly stated that they were making

generalisations from their own experiences, and that they wanted this to be clear in reporting of findings. They discuss specific experiences with specific families that they use as examples to frame their understanding of the home lives of children with ADHD. They were aware that they had limited insight into home lives because of their role as school-based practitioners. However their experiences and beliefs about the home environment allowed them to build an understanding of why children with ADHD displayed the difficulties they do.

As the symptoms of ADHD occur across settings, and the effect of behaviour management strategies delivered in one setting do not necessarily generalise (Evans, Owens, Wymbs, & Ray, 2017), positive relationships and open communication between school and home may help teachers, parents and children with ADHD develop a shared understanding of the child's difficulties. Effective strategies to best support the child in both settings can be put in place (Harborne et al., 2004). One effective intervention with ADHD is Daily Report Cards (DRCs): goals for child behaviour are developed between the child, teacher and parents and rewards are given for meeting these goals. Crucially, DRCs are a communication link between home and school that is maintained regularly (Moore, Whittaker, & Ford, 2016). Educational practitioners working with children with ADHD may want to consider using this or similar strategies to promote home-school communication.

Participants in our study may be attributing difficulties with rewards to home experiences rather than difficulties inherent in ADHD. Two core tenets of behaviour management used by schools are covered in the theme instability: setting of boundaries to define appropriate behaviour, and the use of reward and reinforcement to improve areas where children struggle. Practitioners perceive these to be lacking or incorrectly used in the home environment, and attribute the lack of success in using these strategies in school to the home. However, a meta-synthesis of qualitative studies that explored parenting children with ADHD reported that parents found that behavioural techniques of reward and reinforcement only work "in a limited way" (Corcoran et al., 2017). According to Sonuga-Barke (2011), children with ADHD have neurological differences that result in their understanding

and processing rewards in a different manner to other children. Practitioners may be incorrect in attributing their failures to use traditional reward systems effectively to the home environment. Moreover, there is evidence that reward sensitivity in children with ADHD affects how they respond to positive and negative parenting (Li, 2018). The perceptions of educators in the current study may be accurate, but the attribution for this is currently on parent behaviour, rather than core ADHD symptoms or even an interaction between the two. Educators working with children with ADHD should be aware that reward strategies that are effective with typically developing children may not be effective with children with ADHD. Instead children with ADHD express a preference for "smaller sooner" rewards, which has been theorised as being due to an aversion to delay (Sonuga-Barke, 2005). Creating a menu of varied small rewards that a child with ADHD can earn as soon as possible after displaying the target behaviour is likely to work more effectively than larger rewards given more infrequently. In the case of DRCs this may for example be more effective if the child receives their rewards on a daily rather than weekly basis.

The parent-child relationship is crucial in child development, especially for children with ADHD where disrupted parent-child relationships, parenting stress and psychopathology are common (Johnston & Mash, 2001). Although practitioners perceive difficulties with the parent child relationship, that they believe exacerbates ADHD symptoms, they do not acknowledge other reasons for this association. Parental mental health problems are common in parents of children with ADHD (Lesesne, Visser, & White, 2003). These may result from the stress of parenting a child with ADHD. In addition as ADHD is highly heritable, parental traits or symptoms of ADHD may impact on their parenting skills (Weiss, Hechtman, Weiss, & Jellinek, 2000). Adults with ADHD are more likely to be of low socioeconomic status, have functional and social impairments that impact on family life and have mental health and substance use problems than adults without ADHD (Able, Johnston, Adler, & Swindle, 2007): the home environments described by practitioners may be a result of parental ADHD. Educators believe that one of the foundations for managing behaviour in children with ADHD is forming a bond with the child. This facilitates implementing clear expectations and boundaries.

The perceived importance of good relationships between educator and child for successful management of ADHD has been echoed in other studies (Moore et al., 2016); however, although a good relationship is needed in order to improve children's responses to setting boundaries, this does not necessarily have to be preceded by poor relationships in other areas.

Educators also discussed how they attribute the controlling nature of boys with ADHD to the lack of a positive male role model or poor parent-child relationship. Children with ADHD are significantly more likely than their peers to live in a single parent household (Russell, Ford, & Russell, 2015). It is a common misconception that conflictual parent-child relationships are due to attachment problems or disorder. Attachment is often used as a catchall term, when in fact there are a set of overlapping concepts: attachment behaviour, attachment figure, attachment disorder. Conflictual relationships can occur in the presence of secure attachment, the two are not synonymous. This may have been mentioned frequently by educational practitioners as their training often incorporates basic psychology and attachment styles, but not more detailed training on other psychiatric disorders. Attachment disorder occurs in around 4% of children with ADHD (Jensen & Steinhausen, 2015).

Participants in the current study viewed inconsistency and instability in the home environment to be detrimental to children with ADHD. They did not conceptualise this as being caused in part by the presence of a child with the core features of ADHD. The subtheme *unstable home lives* reflects these views. In another study with educators and parents of children with emotional and behavioural difficulties, themes around blame mirrored our subthemes and involved phrases such as "chaotic, dysfunctional and no boundaries", although other participants saw this as an over-simplification (Broomhead, 2013). There is a tension between the appropriate amount of structure: our study and others report a lack of boundaries, structure and instability as problematic in managing children with ADHD in school (Broomhead, 2013; Lee, 2008). Teachers and parents in other studies expressed beliefs that highly structured interventions for ADHD were an appropriate response to children's symptoms (Moore et al., 2016), yet some research suggests flexibility is also important (Lee, 2008).

The tension between individualising behaviour management strategies for children based on their specific needs and offering a highly structured approach requires further research. Practitioners working with children with ADHD could offer the child flexibility and choice in which behaviour management strategy they use, but then provide structured and consistent expectations when implementing this with the child.

Social isolation of parents and children with ADHD also arose as a theme in the current study. Other studies report similar findings indicating that educators views of isolation are accurate (Harborne et al., 2004; Peters & Jackson, 2009). This isolation is reinforced by negative perceptions of both parents and children with ADHD and may exacerbate the peer relationship problems that children with ADHD commonly experience (Gardner & Gerdes, 2015). Focus on working to ensure that children with ADHD are given ample opportunity within the school environment to develop positive peer relationships may be beneficial, given that they may struggle to do this on their own or outside of school.

Strengths and Limitations

The themes arising from the data are linked to pertinent issues for educational practitioners who work with children with ADHD in the school setting. Although the current study had a moderate sample size of educators recruited from one geographical area, many of our key findings are echoed in existing qualitative research from both parent and teacher perspectives, indicating that these experiences may extend beyond the study sample. The data we collected from interviews and focus groups were diverse and covered many aspects of the ADHD and school experience, with only one question being asked about the home lives of children. The varied data presented here were spontaneously provided in response to this or in the context of other questions. Separate papers have been published discussing educators causal attributions for ADHD (Russell, Moore, & Ford, 2016), and strategies that professionals report using in school to manage the behaviour of children with ADHD (Moore, Russell, Arnell, & Ford, 2017). A third of the participants in our study worked in

pupil referral units: specialist education provision for children with severe emotional, behavioural or physiological needs who cannot be accommodated within mainstream school settings. This is a strength of our study as it does not only include children with ADHD who are in mainstream school. We captured a wide range of types of children with ADHD and educators experiences relevant to this population.

Future studies should explore the functioning and communication in relationships between schools and parents when a child has ADHD in more depth, and explicitly consider the concept of blame in this relationship. We are aware of only one study that has investigated both parent and teacher perspectives of children with special educational needs (a subsample of whom had ADHD) and reported that parents experience blame and guilt (Broomhead, 2013). In several instances throughout the themes, teachers' attribution for behaviours is on the home lives of children, rather than finding an alternative explanation. Whether teachers' attributions for behaviours impact on the support children are given should be investigated. It would also be of use to examine whether educators respond in the same manner to the behavioural challenges of children with ADHD regardless of their beliefs about their home lives. Further research to inform possible targets for intervention to improve school-home relationships for children with ADHD is needed, and to support parents and teachers to work together to improve children with ADHD's ability to cope with school.

In conclusion, educational practitioners characterise the home lives of children with ADHD as being inconsistent and socially isolating. They also report that children with ADHD are exposed to significant psychosocial adversities. Practitioners relate beliefs about the home environment to behaviour seen in school and difficulties in managing this effectively. We have made recommendations for strategies that educational practitioners working with children with ADHD may wish to try, based on their reports of the behaviour they manage in school on a daily basis.

References

Able, S. L., Johnston, J. A., Adler, L. A., & Swindle, R. W. (2007). Functional and psychosocial impairment in adults with undiagnosed ADHD. *Psychological Medicine, 37*(1), 97-107.

Association, A. P. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*: American Psychiatric Pub.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101.

Broomhead, K. (2013). Blame, guilt and the need for 'labels'; insights from parents of children with special educational needs and educational practitioners. *British Journal of Special Education, 40*(1), 14-21.

Corcoran, J. (2016). *Living with mental disorder: Insights from qualitative research*: Routledge.

Corcoran, J., Schildt, B., Hochbrueckner, R., & Abell, J. (2017). Parents of children with attention deficit/hyperactivity disorder: A meta-synthesis, part I. *Child and Adolescent Social Work Journal, 34*(4), 281-335.

Evans, S. W., Owens, J. S., Wymbs, B. T., & Ray, A. R. (2017). Evidence-based psychosocial treatments for children and adolescents with attention deficit/hyperactivity disorder. *Journal of Clinical Child & Adolescent Psychology*, 1-42.

Faraone, S. V., Asherson, P., Banaschewski, T., Biederman, J., Buitelaar, J. K., Ramos-Quiroga, J. A., . . . Franke, B. (2015). Attention-deficit/hyperactivity disorder. *Nature Reviews Disease Primers*, 15020. doi:10.1038/nrdp.2015.20

Gardner, D. M., & Gerdes, A. C. (2015). A review of peer relationships and friendships in youth with ADHD. *Journal of Attention Disorders, 19*(10), 844-855.

Gwernan‐Jones, R., Moore, D. A., Garside, R., Richardson, M., Thompson‐Coon, J., Rogers, M., . . . Ford, T. (2015). ADHD, parent perspectives and parent–teacher relationships: grounds for conflict. *British Journal of Special Education, 42*(3), 279-300.

Harborne, A., Wolpert, M., & Clare, L. (2004). Making sense of ADHD: a battle for understanding? Parents' views of their children being diagnosed with ADHD. *Clinical Child Psychology and Psychiatry, 9*(3), 327-339.

Hillman, M. K. (2011). *An Examination of Teachers' Recommendations for Children with ADHD*: THE CHICAGO SCHOOL OF PROFESSIONAL PSYCHOLOGY.

Jensen, C. M., & Steinhausen, H.-C. (2015). Comorbid mental disorders in children and adolescents with attention-deficit/hyperactivity disorder in a large nationwide study. *ADHD Attention Deficit and Hyperactivity Disorders, 7*(1), 27-38. doi:10.1007/s12402-014-0142-1

Johnston, C., & Mash, E. J. (2001). Families of children with attention-deficit/hyperactivity disorder: review and recommendations for future research. *Clin Child Fam Psychol Rev, 4*(3), 183-207.

Kim, E. M., Sheridan, S. M., Kwon, K., & Koziol, N. (2013). Parent beliefs and children's social-behavioral functioning: The mediating role of parent–teacher relationships. *Journal of school psychology, 51*(2), 175-185.

Kos, J. M., Richdale, A. L., & Hay, D. A. (2006). Children with attention deficit hyperactivity disorder and their teachers: A review of the literature. *International Journal of Disability, Development and Education, 53*(2), 147-160.

Lambert, S. D., & Loiselle, C. G. (2008). Combining individual interviews and focus groups to enhance data richness. *Journal of advanced nursing, 62*(2), 228-237.

Lang, I. A., Marlow, R., Goodman, R., Meltzer, H., & Ford, T. (2013). Influence of problematic child-teacher relationships on future psychiatric disorder: population survey with 3-year follow-up. *The British Journal of Psychiatry, 202*(5), 336-341.

Lee, K. (2008). ADHD in American early schooling: From a cultural psychological perspective. *Early Child Development and Care, 178*(4), 415-439.

Lesesne, C. A., Visser, S. N., & White, C. P. (2003). Attention-deficit/hyperactivity disorder in school-aged children: Association with maternal mental health and use of health care resources. *Pediatrics, 111*(5), 1232-1237.

Li, J. J. (2018). Children's Reward and Punishment Sensitivity Moderates the Association of Negative and Positive Parenting Behaviors in Child ADHD Symptoms. *Journal of abnormal child psychology*. doi:10.1007/s10802-018-0421-y

Moore, D. A., Gwernan-Jones, R., Richardson, M., Racey, D., Rogers, M., Stein, K., . . . Garside, R. (2016). The experiences of and attitudes toward non-pharmacological interventions for attention-deficit/hyperactivity disorder used in school settings: a systematic review and synthesis of qualitative research. *Emotional and Behavioural Difficulties, 21*(1), 61-82. doi:10.1080/13632752.2016.1139296

Moore, D. A., Russell, A. E., Arnell, S., & Ford, T. J. (2017). Educators' experiences of managing students with ADHD: a qualitative study. *Child: care, health and development*, 43(4), 489-498.

Moore, D. A., Whittaker, S., & Ford, T. J. (2016). Daily report cards as a school‐based intervention for children with attention‐deficit/hyperactivity disorder. *Support for Learning, 31*(1), 71-83.

Peters, K., & Jackson, D. (2009). Mothers' experiences of parenting a child with attention deficit hyperactivity disorder. *Journal of advanced nursing, 65*(1), 62-71.

Richardson, M., Moore, D. A., Gwernan-Jones, R., Thompson-Coon, J., Ukoumunne, O., Rogers, M., . . . Morris, C. (2015). Non-pharmacological interventions for attention-deficit/hyperactivity disorder (ADHD) delivered in school settings: systematic reviews of quantitative and qualitative research. *Health technology assessment (Winchester, England), 19*(45), 1.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*: Sage.

Russell, A. E., Ford, T., & Russell, G. (2015). Socioeconomic Associations with ADHD: Findings from a Mediation Analysis. *PloS one, 10*(6), e0128248. doi:10.1371/journal.pone.0128248

Russell, A. E., Ford, T., Williams, R., & Russell, G. (2016). The association between socioeconomic disadvantage and attention deficit/hyperactivity disorder (ADHD): a systematic review. *Child Psychiatry & Human Development*, *47*(3), 440-458.

Russell, A. E., Moore, D. A., & Ford, T. (2016). Educational practitioners' beliefs and conceptualisation about the cause of ADHD: A qualitative study. *Emotional and Behavioural Difficulties*, *21*(1), 101-118.

Sayal, K., Prasad, V., Daley, D., Ford, T., & Coghill, D. (2017). ADHD in children and young people: prevalence, care pathways, and service provision. *The Lancet Psychiatry*.

Singh, I. (2004). Doing their jobs: Mothering with Ritalin in a culture of mother-blame. *Social Science & Medicine, 59*(6), 1193-1205.

Sonuga-Barke, E. J. (2005). Causal models of attention-deficit/hyperactivity disorder: from common simple deficits to multiple developmental pathways. *Biological psychiatry, 57*(11), 1231-1238.

Sonuga-Barke, E. J. (2011). ADHD as a reinforcement disorder–moving from general effects to identifying (six) specific models to test. *Journal of Child Psychology and Psychiatry, 52*(9), 917-918.

Weiss, M., Hechtman, L., Weiss, G., & Jellinek, M. S. (2000). ADHD in parents. *Journal of the American Academy of Child & Adolescent Psychiatry, 39*(8), 1059-1061.

Table 1. Participant details

Characteristic	**N**
Female	32
Primary	19
Secondary	7
PRU	15
Worked with ages 0-4	14
Worked with ages 5-11	33
Worked with ages 11 and up	25
Worked with <10 children with ADHD diagnosis	13
Worked with ≥10 children with ADHD diagnosis	12
Teacher	16
TA/LSA	11
Co-ordinator or team leader or head of year	11
Pastoral support	3
SENDCo	6
Head/deputy head teacher	5

Notes: N=42. Numbers may not add up as several practitioners had several roles within the school and some had worked with a large range of age groups. PRU: pupil referral unit (school for children with special educational needs, medical or behavioural problems that are considered to be unmanageable in mainstream education settings). TA: Teaching assistant, LSA: learning support assistant, SENDCo: special educational needs and disabilities co-ordinator

Table 2. Overview of themes and subthemes

Theme	Subthemes	Summary of Findings
Perceived inconsistency	unstable home lives	Participants described the home lives of children with ADHD as being unstable, few mentioned instances in which they understood the child to have a stable and secure home life, these were often framed as exceptions. Instability was thought to exacerbate child behavioural difficulties.
	lack of boundaries	Educational practitioners considered parents' insufficient use of boundaries to impact on behaviour management. These impacted on the school environment due to the child not being able to interact appropriately with peers and struggling to conform to classroom conventions.
	inconsistent use of rewards	Inconsistent use of rewards at home and inadvertently rewarding bad behaviour was perceived by participants to result in children with ADHD not valuing rewards used in the school environment: a strategy commonly used in schools to promote good behaviour.
Psychosocial Adversity	difficulties with the parent-child relationship	Practitioners considered that difficulties in the parent-child relationship were common for children with ADHD. This was thought to impact on parenting strategies used, and both of these aspects were reflected in the behaviour and challenges faced by the child in school.
	parent mental health difficulties	Participants mentioned that parents of children with ADHD often had mental health issues of their own. They thought that these parents struggled to model appropriate behaviours to their children, who

		behaved differently to their peers at school. Other related factors were experiences of drug and alcohol abuse and misuse by parents.
	lack of positive male role model	Educational practitioners often report strained or no relationships between children with ADHD and their father figures, both biological and non-biological. Practitioners believed that absence of a positive male role model meant that the child was allowed to be in control of the home environment, exerting power over their mothers. These controlling behaviours are reportedly displayed in school.
Isolation		Having a child with ADHD is considered isolating both for the child and the parents. Some practitioners are sympathetic about this, whereas others consider it the responsibility of parents to take their child to do age-appropriate activities.