

Utilising the views of Special Educational Needs Coordinators (SENCOs) and the findings of two case studies to explore the potential impact of how young people with Attention Deficit Hyperactivity Disorder (ADHD) understand and perceive their diagnosis. A study on well-being.

Submitted by Kate Gribble to the University of Exeter
as a thesis for the degree of
Doctor of Educational, Child and Community Psychology
May 2019

This thesis is available for Library use on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

I certify that all material in this thesis which is not my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other University.

Signature:

Acknowledgements

First and foremost, I would like to thank the students, staff and parents who participated in my study and shared their experiences with me. Your time and commitment were hugely appreciated. I hope I have done your stories justice.

Secondly, I would like to thank the University of Exeter and the staff on the DEdPsych course. Special and great thanks to Dr Shirley Larkin and Dr Will Shield for their supervision, guidance and support.

Thank you to my cohort and fellow trainees, without your support, understanding and encouragement I would not have achieved what I have done. We have looked after one another, and I hope we continue to do so throughout our careers.

The team at the Educational Psychology Service where I completed my 2nd and 3rd year placement, who offered their endless support and advice. I have learnt and achieved so much as a direct result of their kindness, knowledge and skills.

Special mention to my Grandad David for inspiring my journey into working with children and young people.

Finally, thank you to my friends and family for their tireless support and tolerance of my needs. A special thanks to Auntie Emma, Rose Astor, Jill Hannam and Richard Luckman.

Abstract

Attention Deficit Hyperactivity Disorder (ADHD) is predicted to affect 5% of young people (APA, 2013) with increasing rates of diagnosis across the western world (Safer, 2018). Young Minds (2018) also report that one in four young people are experiencing mental ill health. High comorbidity rates have been identified between ADHD and negative mental health outcomes, which has sparked a wealth of research into this relationship (Roy, Oldenhinkel, Velhurst, Oremi & Hartman, 2013; Booster, DuPaul, Eiraldi and Power, 2012; & Becker, Luebbe & Langberg, 2012). With this in mind, the aims of this research were to explore the understanding, perceptions and experiences of young people with ADHD. Although this research employed a mixed methods design, utilising both qualitative and quantitative methods, it aligns with an interpretivist perspective, seeking the views and experiences of young people and those around them. There were two phases to the research; the first used an online questionnaire and semi-structured interviews to seek the views of Special Educational Needs Coordinators (SENCOs) about young people's experiences of ADHD. The second phase employed a case study design exploring the experiences of two young people with ADHD. Phase Two also sought to explore the use of tools derived from Personal Construct Psychology (Kelly, 1955) as a means to support young people with ADHD. The findings of this study are consistent with previous literature around the experiences of young people, their schools and their parents in that there may be a discrepancy between young people's awareness of their needs and their understanding of their ADHD diagnosis. The findings also suggest that parents are not being adequately supported following their child's diagnosis. Consistent with the literature, this thesis concluded that the ways in which young people perceive and understand their diagnosis is likely to affect their wellbeing.

Table of Contents

Acknowledgements	2
Abstract.....	3
Table of Contents	4
Lists of Tables and List of Figures	Error! Bookmark not defined.
List of Abbreviations	14
Chapter 1 Introduction	15
1.1. Definitions and clarity of terms	15
1.2 Personal Relevance	16
1.3 Current Contextual Relevance	17
1.4 Professional Relevance	18
1.4.1 Other professionals	20
1.5 Overview of Thesis.....	20
Chapter 2 Literature Review	22
2.1 Literature Search	22
2.2 Attention Deficit Hyperactivity Disorder.....	23
2.2.1 Definition.	23
2.2.2 Diagnosis.....	24
2.2.3 Intervention and treatment.	26
2.2.4 Controversies and dilemmas.	27
Existence of ADHD.....	27
Gender differences.	28
Labelling.	29
Medication.....	30
Inclusion.	31
2.3 Mental Health	32
2.3.2 Prevalence.....	32
2.3.3 Green paper and school responsibility.	32
2.4 Mental Health and ADHD	33
2.4.1 Young people's perceptions of their ADHD.	36
2.5 Personal Construct Psychology.....	39
2.5.1 Constructive Alternitavism.....	39
2.5.2 What is Personal Construct Psychology?.....	39
2.5.3 Personal Construct Psychology in Practice.	40
2.5.4 Criticisms of Personal Construct Psychology.	40

2.5.5 Personal Construct Psychology and ADHD.....	41
2.7 Conclusion and Underpinning models	42
Chapter 3 Methodology	43
3.1 Aims and Research Questions	43
3.1.1 Phase One aims and research questions.....	43
3.1.2 Phase Two aims and research questions.....	43
3.2 Theoretical Perspective and Reflexivity	44
3.3 Ethics.....	44
3.3.1 Consent.....	45
3.3.2 Reduction to risk of harm.	46
Chapter 4 Phase One Methods	47
4.1 Research Design.....	47
4.2 Participants.	47
4.2.1 Recruitment.	48
4.3 Procedure.....	49
4.3.1 Analysis	50
Chapter 5 Phase One Findings.....	52
5.1 Research Question One: How do Special Educational Needs Coordinators Think That Young People With ADHD Perceive Their ADHD and The Severity of Their Symptoms?	55
5.1.1 Questionnaire results.....	55
Item 1: Young people with ADHD tend to have a good understanding of what ADHD is.....	55
Item 2: Young people with ADHD tend to know how their ADHD affects them.....	56
Item 3: Young people with ADHD don't tend to know how severe their symptoms are.....	56
Item 4: Young people with ADHD tend to underestimate or not recognise the severity of their symptoms.....	57
Item 5: Young people with ADHD tend to overestimate how severe their symptoms are.....	57
Summary.	58
5.1.2 Interview Findings.....	58
Level of understanding.....	60
Level of awareness.....	60
Young person's perceptions of their ADHD.....	61
5.2 Research Question Two: How Do Special Educational Needs Coordinators Think Young People With ADHD Develop The Perceptions They Have Of Their ADHD And The Severity Of Their Symptoms?	62

5.2.1 Questionnaire results.....	63
Item 6: Young people with ADHD have usually been well informed by external professionals (e.g medical practitioners) regarding the nature of their disorder.....	63
Item 12 - Based on the list below, how do you feel young people develop their perceptions of their symptom severity?	64
<i>12i. Based on how the staff at their school treat them or talk to them.</i>	<i>64</i>
<i>12ii. Based on how their parents treat them or talk to them.</i>	<i>64</i>
<i>12iii. By comparing themselves to their peers or siblings</i>	<i>65</i>
<i>12iv. Based on how their peers or siblings treat them or talk to them.</i>	<i>65</i>
<i>12v. Based on how they are treated in the wider community.....</i>	<i>66</i>
<i>12vi. By being self-reflective about their own feelings and/or behaviours.....</i>	<i>66</i>
Summary of online results.....	67
5.2.2 Interview findings.....	67
How young people develop an understanding of their ADHD.	69
How young person develops their awareness.	70
How young person was told.....	71
Parents.....	71
People talking to young people about their ADHD.	72
Young person comparing themselves to others.	72
Perceptions of others.....	73
5.3 Research Questions Three: How And To What Extent Do Special Educational Needs Coordinators Believe That These Perceptions Impact Their Wellbeing?	73
5.3.1 Online questionnaire results.....	74
Item 7. The better a young person understands their ADHD the more likely they are to experience positive wellbeing.....	74
Item 8. A young person who does not recognise the severity of their symptoms is at higher risk of poor wellbeing.	74
Item 9. The better a young person recognises the severity of their symptoms, the more likely they are to achieve positive academic outcomes in school.	75
Item 10. Schools should support young people with ADHD in better understanding their diagnosis.	76
Item 11. Schools should support young people with ADHD in recognising the severity of their symptoms.....	76
Summary of online results.....	77
5.3.2 Interview findings.....	77
Challenges in School	79
<i>ADHD as a barrier.</i>	<i>79</i>

<i>School feeling unskilled</i>	80
<i>Transition</i>	81
Mental Health and Wellbeing	81
<i>Feelings and wellbeing</i>	82
<i>Resilience and self esteem</i>	82
Symptoms and behaviour	83
<i>Challenging behaviour</i>	83
<i>Symptoms and ADHD associated behaviours</i>	84
Diagnosis and medication	85
<i>Medication</i>	85
<i>Impact of a Diagnosis</i>	86
Impact of understanding	87
Young person’s awareness affecting wellbeing	88
Friendships and relationships with peers	88
<i>Peer understanding</i>	89
<i>Difficulties with peers</i>	89
Perceptions of others	90
Chapter 6 Phase One Discussion	91
6.1 Research Question One: How Do Special Educational Needs Coordinators Feel That Young People With ADHD Perceive Their ADHD And Symptoms? ...	91
6.2 Research Question Two: How Do Special Educational Needs Coordinators Feel Young People With ADHD Develop The Perceptions They Have Of Their ADHD And Symptoms?	93
6.3 Research Questions Three: How And To What Extent Do Special Educational Needs Coordinators Believe That These Perceptions Impact Their Wellbeing?	95
6.4 Link Between Phase One and Phase Two	100
Chapter 7 Phase Two Methods	101
7.1 Research Design	101
7.2 Participants	103
7.2.1 Recruitment	103
7.3 Procedure	104
7.4.1 Interview design	107
7.4.2 Analysis	108
Chapter 8 Phase Two Findings	109
8.1 Case One Solomon	109
8.1.1 Outcomes associated with ADHD	110
Feelings	110

Challenging behaviour	111
Relationships with others	112
Symptoms	113
Educational outcomes	114
9.1.2 Young person’s understanding of ADHD	114
Level of understanding	114
<i>Using ADHD as an excuse</i>	115
How young person knows they have ADHD	115
<i>How young person was told</i>	115
<i>Self-reflection</i>	116
<i>How young person was treated by others</i>	116
<i>Parent understanding</i>	117
8.1.3 Intervention data and follow up interview	118
The Ideal Self	118
The Salmon Line and The Three Comment Technique	118
Post intervention interviews	120
<i>Positive outcomes</i>	120
<i>Young person noticing things about themselves</i>	121
<i>Staff learning more about young person</i>	121
<i>Learning more about ADHD</i>	121
<i>Intervention had no impact</i>	122
<i>Intervention was too difficult</i>	122
<i>Young person is happy as they are</i>	122
<i>‘I don’t know’</i>	122
8.1.4 Case 1 summary	123
8.2.1 Young person’s understanding of ADHD	124
Level of understanding	124
How young person knows they have ADHD	125
8.2.2 Young person’s awareness	125
Symptoms and awareness of symptoms	125
How young person see themselves	126
8.2.3 Outcomes associated with ADHD	126
Feelings	126
Impact on school	127
Relationships	128
8.2.3 Intervention data and follow up interview	130
The Ideal Self	130

Salmon Line and The Three Comments Technique	131
Post intervention interviews	133
<i>Positive outcomes</i>	133
<i>Negatives and recommendations</i>	134
<i>Intervention was too difficult</i>	134
<i>Practical difficulties</i>	135
8.2.4 Case two summary	135
Chapter 9 Phase Two Discussion	137
9.1 Research Question 1: How Do Young People With ADHD Perceive Their ADHD And The Severity Of Their Symptoms?	137
9.2 Research Question 2: What Influences the Perceptions That Young People With ADHD Have Of The Severity Of Their Symptoms?	138
9.2.1 Understanding	138
9.2.2 Awareness	138
9.3 Research Question Three: How And To What Extent Do These Perceptions Impact The Young People’s Wellbeing?	139
9.4 Research Question 4: How and To What Extent Can Tools And Activities Derived From Personal Construct Psychology Be Used To Effectively Support Young People With ADHD?	141
Chapter 10 Discussion	142
10.1 Overall Aims	142
10.2 Overarching Findings	142
10.2.1 Parent understanding	142
10.2.2 Awareness and Understanding	143
10.2.3 Schools feel unequipped	143
10.2.4 Anger and frustration	144
10.2.5 Naughty	144
10.2.6 Personal Construct Psychology and ADHD	145
10.2.7 A Common Sense and Ecological Model of ADHD and Wellbeing	145
10.3 Limitations and Future Research	148
10.4 Implications For Practice	149
10.4.1 Assessment and exploration	150
10.4.2 Training	150
10.4.3 Therapeutic support	151
10.5 Conclusion	151
References	153
Appendices	165
Appendix 1 – Ethics	165

Appendix 1.1 - Certificate of Ethical Approval	165
Appendix 1.2 – Initial Ethical Application Form	165
Appendix 1.3 – Amended Ethical Application Form	179
Appendix 2 – Information Letters and Consent	188
Appendix 2.1 – Phase One Information and Consent: SENCOs	188
Appendix 2.3 – Phase Two Information and Consent: Parents	193
Appendix 2.4 – Phase Two Information and Consent: Young People	196
Appendix 2.5 – Phase Two Information and Consent: School staff	198
Appendix 3 – Online Questionnaire	200
Appendix 4 – Development of Online Questionnaire	201
Appendix 4.1 Draft one	201
Appendix 4.2 Feedback from pilot one.....	203
Appendix 4.3 Draft two.....	203
Appendix 4.4 feedback from pilot two	205
Appendix 4.5 Relationship Between Literature, Research Questions And Items.	205
Appendix 5 – Interview Schedules	206
Appendix 5.1 – Phase One Interview Schedule: SENCOs	206
Appendix 5.2 – Phase Two Initial Interview Schedule: Parents	207
Appendix 5.3 – Phase Two Initial Interview Schedule: Young People	207
Appendix 5.4 Phase Two Initial Interview Schedule: Staff members	208
Appendix 5.5 Phase Two Post Intervention Interview Schedule: Young People	209
Appendix 5.6 Phase Two Post Intervention Interview Schedule: School Staff	210
Appendix 5.7 Interview and research questions Phase One	211
Appendix 5.8 Interview and research questions Phase Two	212
Appendix 6 Phase One Analysis	214
Appendix 6.1 Phase One transcript sample with Coding	214
Appendix 6.2 – Phase One nodes	215
Appendix 6.3 – Phase One theme and node tables.....	219
Appendix 6.4 – Phase One theme example	222
Appendix 7 Phase Two Analysis.....	227
Appendix 7.1 Phase Two transcript sample with Coding	227
Appendix 7.2 Phase Two Theme Example.....	228

List of tables

Table 2.1 Core Search Terms and Alternates	22
Table 4.1 Phase One Participants	47
Table 5.2 Overview of Themes: Phase One.....	53
Table 6.1 Pathways to Young People’s understanding.....	93
Table 7.1 Phase Two Participants	104
107	
Table 8.1 Overview of Themes: Phase Two, Case One, Initial Interviews	111
Table 8.2 Three Comments Technique: Case One	121
Table 8.3 Overview of Themes: Phase Two, Case One, Post Intervention Interviews.....	121
Table 8.4 Overview of Themes: Phase Two, Case Two, Initial Interviews	125
Table 8.5 Three Comments Technique: Case Two	133
Table 8.6 Overview of Themes: Phase Two, Case Two, Post Intervention Interviews.....	134

List of Figures

Figure 1. Flow chart of global and main themes from Phase One interviews.....	52
Figure 2. Bar graph showing frequency of responses for item 1.....	54
Figure 3. Bar graph showing frequency of responses for item 2.....	55
Figure 4. Bar graph showing frequency of responses for item 3.....	55
Figure 5. Bar graph showing frequency of responses for item 4.....	56
Figure 6. Bar graph showing frequency of responses for item 5.....	56
Figure 7. Thematic Map for research question 1, Phase One.....	58
Figure 8. Bar graph showing frequency of responses for item 6.....	62
Figure 9. Bar graph showing frequency of responses for item 12i.....	63
Figure 10. Bar graph showing frequency of responses for item 12ii.....	63
Figure 11. Bar graph showing frequency of responses for item 12iii.....	64
Figure 12. Bar graph showing frequency of responses for item 12iv.....	64
Figure 13. Bar graph showing frequency of responses for item 12v.....	65
Figure 14. Bar graph showing frequency of responses for item 12vi.....	65
Figure 15. Thematic Map for research question 2, Phase One.....	67
Figure 16. Bar graph showing frequency of responses for item 7.....	73
Figure 17. Bar graph showing frequency of responses for item 8.....	74
Figure 18. Bar graph showing frequency of responses for item 9.....	75
Figure 19. Bar graph showing frequency of responses for item 10.....	75
Figure 20. Bar graph showing frequency of responses for item 11.....	77
Figure 21. Thematic Map for research question 3, Phase One.....	119
Figure 22. Timeline of Phase Two Sessions	<u>106</u>
Figure 23. Scanned copy of Solomon’s ideal self.	119
Figure 24. Scanned copy of Solomon’s Salmon Line and Three Comments Technique	120
Figure 25. Scanned copy of Michael's ideal self.....	131
Figure 26 Scanned copy of Michael’s Salmon Line and Three Comments Technique	132
Figure 27. Model One	147
Figure 28. Model Two.....	148

List of Abbreviations

ADHD – Attention Deficit Hyperactivity Disorder
ASD – Autistic Spectrum Disorder
APA – American Psychological Society
BPS – British Psychological Society
CA - Constructive Alternativism
CAMHS – Child and Adolescent Mental Health Services
DFE – Department for Education
DSM - Diagnostic and Statistical Manual of Mental Disorders
EP – Educational Psychologist
EPS – Educational Psychology Service
ICD - International Classification of Diseases
NICE – National Institute for Health and Care Excellence
PCP – Personal Construct Psychology
PDD – Pervasive Developmental Disorder
SENCo – Special Educational Needs Coordinator
SEND – Special Educational Needs and Disability
SIPD – Speed of Information Processing Difficulties

Chapter 1 Introduction

Attention Deficit Hyperactivity Disorder (ADHD) and mental health and wellbeing are receiving increasing attention from researchers and the media (Hinshaw, 2018; Kelly, Zilanawala, Booker & Sacker, 2019). This is likely due to statistically significant increases in the rates of both across western countries. In other words, the increase in rate of ADHD and poor mental ill health are so great that they can not be accounted for by natural variance. Young Minds (2018) reported one in four young people now experience mental ill-health, while ADHD diagnosis was reported to have increased by 42% between 2003 and 2011 with rates still rising (Safer, 2018). These statistics alone warrant further investigation of the causes and outcomes associated with both mental ill-health and ADHD. Of further relevance is the relationship that has been reported between ADHD and mental ill health. High co-morbidity rates have been evidenced and reported frequently throughout the literature, as will be explored in depth throughout the Literature Review (Chapter 2). The majority of papers which explore this relationship align at least in part with an ecological view of ADHD, by which the young person's development across all areas is affected by the accumulative interactions of factors in and around their environment (Bronfenbrenner, 1979). As such, I sought to explore the relationship between mental health and wellbeing, and ADHD in the context of the understanding and perceptions held by young people, exploring how they develop and what impact they have. This ecological model and its relevance to ADHD research has been outlined in greater detail in the literature review. Brief definitions of key terms are provided below to ensure clarity throughout reading.

1.1. Definitions and clarity of terms

ADHD is a diagnosis given to individuals whose difficulties around attention, hyperactivity and impulsivity reduce their ability to function day to day (Polanczyk, Willcut, Salum, Kieling & Rohde, 2014). The DSM-V (American Psychiatric Association, 2013), describes ADHD as the most common childhood disorder, however there is ongoing controversy and inconsistency around the definition, prevalence rates, and even existence (Epstein & Loren, 2013; Denckla, 1992; Hinshaw, 2018; Laurence & Mcallum, 1998). These controversies are discussed in more detail during the literature review.

In 2014, the World Health Organisation (WHO) described Mental Health as a state of wellbeing by which a person is able to be productive and contribute in their own lives and within the community, manage normal levels of stress, and recognise and realise their own potential (WHO, 2014). By this definition, mental ill-health could be defined as a state of diminished wellbeing resulting in a disruption of these functions. Throughout this thesis I will refer to either mental ill-health, poor wellbeing, or where relevant, specific mental health disorders if they are directly referenced within the literature.

Personal construct theory was developed by Kelly (1955) who posed that there are as many ways to interpret a phenomenon as there are those experiencing it. Further, that these interpretations will be impacted by the context within which they are experienced and the personal constructs each interpreter already holds. Tools derived from personal construct psychology (PCP) are used to support a better or deeper understanding of the personal constructs a person holds and how this may be influencing or impacting upon them (Ravenette, 1999). PCP is explored in greater detail throughout the literature review.

1.2 Personal Relevance

At the time of submitting this thesis I am in my third and final year of a doctorate training course, training to be an educational psychologist. Educational psychologists are concerned with the learning and wellbeing of young people, working in a variety of settings, most commonly schools.

My background is predominantly in primary school and early years, but I also worked for a year with vulnerable adults with complex needs. Throughout my career working with young people I have had numerous experiences of children diagnosed with ADHD. Further, there is evidence of high levels of ADHD diagnosis across the local authority within which I have been placed for my final year of training. Throughout these experiences I have developed a keen interest in this area and continue to reflect upon my views regarding diagnosis and labelling of children. I would argue, however, that irrelevant of my personal beliefs, we are in a climate of increasing labels and it is therefore important to explore the impact that they might have.

The second phase of this research was in part concerned with the personal constructs developed and held by young people with ADHD. This person centred

perspective is of particular interest to me. My education differed from the conventional as I went to a democratic school within which adults and young people are considered equal and run the school together. During and following this experience I worked with the European Democratic Education Community and as trustee for a charity which aims to promote democratic education in mainstream schools. What the principles of democratic education have instilled in me, is that at the basis of any relationship is a mutual respect, and that if given the opportunity, young people are amongst the best equipped to understand their own needs. These principles have followed me through my professional career and meant that I am often looking for ways that young people and adults can work collaboratively to develop effective strategies and solutions.

1.3 Current Contextual Relevance

Having touched upon the personal relevance of this research, the following sections will explore the professional and contextual relevance, where this research sits within our political and educational climate. This section briefly explores how this research is relevant to contemporary context. Literature surrounding these topics is largely addressed throughout the literature review.

This research explored the perceptions of young people with ADHD, and aimed to gain some insight into the relationship between ADHD and mental health and wellbeing. Pitchforth et al., (2018) argue that the needs and difficulties associated with mental ill-health need to be addressed. The distressing and uncomfortable symptoms associated with mental ill-health are in themselves rationale for research and progress towards effective treatment. The outcomes associated with mental ill-health are also well documented, with risk of self-harm and suicidal ideation (Iyengar et al, 2018) and heightened risk of unemployment and poor life outcomes (Olsen, Butterworth, Leach, Kelaheer & Pirkis, 2013), although the causal nature of this relationship has come under debate (Olsen et al., 2013).

ADHD is more widely associated with challenging behaviour and poor academic attainment (Faraone & Buitelaar, 2010; Meijere, Faber, Van Den & Tobi, 2009; Shaw et al, 2012) Research has uncovered ADHD-related negative outcomes both throughout and following school. Sayal, Washbrook and Propper (2015) found high risk of poor academic attainment associated directly with the inattentive symptoms of ADHD. Sciberras, Ohan and Anderson (2012) found that girls with ADHD were at a significantly higher risk of victimisation and negative

social encounters. As a more rounded research example, Shaw et al (2012) conducted a systematic literature review exploring the long-term outcomes of ADHD. Their results showed that ADHD was associated with negative outcomes in nine categories: “Academic, antisocial behaviour, driving, non-medicinal drug use/addictive behaviour, obesity, occupation, services use, self-esteem, and social function outcomes.” (p. 6). Finally, it is important to reiterate here that there has been a significant relationship found between ADHD and poor mental health outcomes (Becker, Luebbe, & Lanberg, 2012; Booster, DuPaul, Eiraldi, & Power 2012; Roy, Oldenhinkel, Velhurts, Ormel & Hartman, 2014). These ideas provide rationale for this research and are critically explored throughout the Literature Review (Chapter 2).

Mental health has also been a tool for political rivalry in the United Kingdom, with opposing parties announcing how their policies may tackle the increasing problem. A recent green paper from the Conservative government: Transforming Children and Young People’s Mental Health Provision (Department of Health and Social Care & Department for Education, 2017), places an onus on schools and educational professionals to identify and tackle mental health needs. Some schools may need additional support from external professionals in order to up-skill and to better understand risk and protective factors. Phase Two of this research used tools derived from PCP in order to support staff in better understanding the young people they are working with. This is directly applicable to the proposals in the green paper which call for greater responsibility and action on behalf of schools and their staff. This, in turn, leads into the following section, which will discuss the professional relevance of the research. To conclude, we are aware of numerous negative outcomes associated with mental health and ADHD, and that there is a relationship between the two. This research both acknowledges and responds to the national call for support and development of strategies within school to tackle these issues.

1.4 Professional Relevance

The final section of this introduction will explore the practical and professional relevance of the research, and how this research may be helpful or implemented in practice. As a trainee educational psychologist, my initial interest was the practical relevance within our role, such as how we might provide support and guidance to schools or families about ADHD and mental health. Following

reflection and drawing upon the literature around the different components of role of the EP, some practical examples have been discussed below.

There is a wealth of support for a consultation model of educational psychology, whereby educational psychologists facilitate development of thought and strategy through reflective and explorative conversations (Wagner, 2000). The outcomes and information gathered from both phases may be helpful for EPs working with schools or families managing the needs of young people with ADHD. Educational psychologists could support schools in developing appropriate ways to speak with parents or supporting parents in developing appropriate ways to speak with their children. By better understanding the relationship between self-perceptions of ADHD and wellbeing, educational psychologists are better able to support the understanding and practice of others.

Although some educational psychology services practice a solely consultation model, others offer a more pragmatic, assessment or therapeutic model, working 1:1 or in groups with young people (Boyle & Lauchlan, 2009). In the instance that they were found to be valuable, the PCP tools administered in Phase Two could be applied directly by educational psychologists when working with young people with ADHD.

Moses (2010), explored the perceptions and experiences of stigma amongst young people with ADHD by looking at the treatment of young people by parents, peers and school staff. Although only 22% of young people in the sample reported being treated differently by school staff, it was concluded that it was important to educate parents, peers and staff in order to reduce the risk of negative assumptions surrounding the diagnosis and behaviours. It was hypothesised that by supporting staff members in better understanding young people's experiences, we can improve those experiences and reduce risk of negative outcomes.

Finally, many educational psychology services also provide training to schools and other professionals (Cameron, 2006). In the instance that tools derived from PCP were evidenced as effective or valuable when working with young people with ADHD, educational psychologists could be supporting schools in developing the skills to use them themselves.

1.4.1 Other professionals.

The ideas discussed above regarding training, lead to questions about which other professions may take interest in this research.

According to NHS information around assessment of ADHD, there are a number of professionals who may be involved in a diagnosis (National Health Service, 2019). These include psychiatrists, paediatricians, learning disability specialists, social workers and occupational therapists. If, as previous literature suggests, the perceptions and understanding that young people have about their ADHD can impact on their wellbeing, then arguably all of these front-line professionals should have access to the most up to date information regarding the most appropriate way to discuss a diagnosis. It could be said, therefore that research of this nature is valuable not only to psychologists, but to these professionals also, in order to maintain up to date knowledge on the subject.

1.5 Overview of Thesis

This thesis is made up of two distinct phases, each using predominantly qualitative methods to explore the experiences of young people with ADHD. Both phases aimed to explore the perceptions young people with ADHD have regarding their diagnosis and the severity of their symptoms, and how these perceptions may impact on their mental health and wellbeing.

The first phase of the research used semi-structured interviews and an online questionnaire to explore the views of Special Educational Needs Coordinators (SENCOs) regarding the perceptions young people with ADHD have of their diagnoses and symptoms. The second phase of the research employed a case study design exploring the experiences of two year three children with ADHD. Phase Two used semi structured interviews to elicit the views of each young person, a parent and a key member of staff. Based on literature that demonstrated the potential impacts of personal perceptions of ADHD on young people (Wong, Hawes, Clarke, Kohn, & Dar-Nimrod, 2017), Phase Two also utilised tools derived from PCP to explore the potential benefits of using these tools to support young people with ADHD and the staff who work with them.

This chapter comprises an introduction to the research including personal, contextual, and professional relevance, providing a broad rationale for the research. Chapter 2 provides a literature review covering diagnostic criteria, interventions and treatments, and dilemmas and controversies. It also provides

the research based rationale for the research. Chapter 3 is a comprehensive methodology section, defining the aims and objectives and how they were influenced by my ontological and epistemological beliefs. As this research is broken up into two phases, Chapters 4 through 6 cover the methods, findings and discussion of Phase One. Chapters 7 through 9 cover the methods, findings and discussion of Phase Two. The thesis is then concluded with an overall discussion and conclusion.

Chapter 2 Literature Review

The following literature review aims to identify two separate targeted gaps in the literature and provide a comprehensive rationale for the proposed research. The review will address four topics; ADHD, mental health, the co-morbidity between ADHD and mental health, and the theory and practice of PCP. Each section aims to critically address key content within the literature and provide an overview of relevant, historical and contemporary arguments.

2.1 Literature Search

The literature search for the review below was conducted between October 2017, and March 2018 and updated in May 2019. The search engines used were OVID, Psycinfo and Google Scholar. Ovid allows users to search multiple databases at one time and so the following databases were searched.

- PsycArticles FULL TEXT
- Embase
- Psycinfo
- Social Policy and Practice

Any relevant search output was accessed through The University of Exeter, and saved in folders labelled with date, search engine and search terms. In order to gather as much relevant literature as possible, for every core term potential alternatives were also included. The table below (Table 2.1) shows the core search terms and their alternates. Other searches included, prevalence, legislation, co-morbidity, age of onset, and systematic literature reviews. Additional papers were sourced from bibliographies.

The initial search generated a wealth of relevant papers including a number of systematic literature reviews which provided a comprehensive background to the research. Papers were categorised into relevant headings, as can be seen throughout the literature review, and further articles were sought to support or add critique or depth to arguments throughout the writing process.

Table 2.1

Core search terms and alternates

ADHD	Personal Construct Psychology	Mental Health
“Attention Deficit Hyperactivity Disorder”	PCP	Anxiety
	PCT	Depression
ADD	Personal Construct Psychology	
“Attention Deficit Disorder”	“Personal Construct Theory”	
	Personal Construct Therapy	

2.2 Attention Deficit Hyperactivity Disorder

2.2.1 Definition.

Individuals with significant difficulties around attention, hyperactivity and impulsivity may meet the criteria for a diagnosis of ADHD. They will receive this diagnosis in the instance that it impedes their daily activities (Polanczyk et al., 2014). The DSM-IV (American Psychiatric Association, 2001), described ADHD as the most common childhood disorder, however there is ongoing controversy and inconsistency around the definition, prevalence rates, and even existence (Epstein & Loren, 2013; Deckla, 1992; Laurence & Mcallum, 1998). These ideas are discussed in greater detail later in the literature review as they have received extensive research attention. According to the DSM-V, ADHD is present in 5% of young people (American Psychiatric Association, 2013). However, there is controversy and disagreement around prevalence figures as they vary significantly both nationally and in a broader global context (Rodríguez, García, & Areces, 2017). As there is currently no medical test for ADHD, all diagnosis is based on a subjective assessment (Hetchman, 2000). Accordingly, the diagnostic

pathways across the world and even across counties within the UK may be significantly different (Rodríguez et al., 2017).

2.2.2 Diagnosis.

There are two diagnostic manuals used globally to classify and diagnose ADHD. The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychological Association (APA); and the International Statistical Classification of Diseases (ICD), published by The World Health Organisation (WHO). The following section will briefly cover the relevant differences between the two.

Doernberg and Hollander (2016) discussed the DSM-V and ICD-10 with regards to both autistic spectrum disorder (ASD) and ADHD, arguing that both disorders had undergone significant changes following the DSM-IV to V update. It is important to note at this stage that since this paper was published the ICD 11 has been released. Doernberg and Hollander (2016) note that the purpose or goals of the two diagnostic manuals are significantly different; the DSM aims to support diagnostic pathways, whereas the ICD was developed to support classification. They argue that this may be the reason for some of the discrepancies between the two manuals. Doernberg and Hollander (2016) provided a table outlining the core differences between the two manuals with regards to the both ADHD and ASD (P.298). A significant discrepancy is that the ICD-10 refers to ADHD as hyperkinetic disorder, as it was once termed before the DSM-III was published (American Psychological Association, 1952). Further, unlike the DSM-V the ICD-10 categorises ADHD and ASD separately; ASD is categorised as a “Pervasive Developmental Disorder” (PDD) whereas ADHD is categorised in the section titled, “Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence”. What makes this significant, is that whereas the update from DMS-IV to V eliminated ASD as an exclusionary disorder for the diagnosis of ADHD, PDDs are still exclusionary for ADHD in the ICD-10. The final significant difference between the two manuals is the age criteria for onset, the ICD-10 requires young people to be presenting with symptoms by age 5, rather than age 12 as suggested by the DMS-V.

Therefore, although the two manuals are providing a similar list of symptoms, they are offering different diagnostic opportunities (Rodríguez et al., 2017). The proposed research will refer to the DSM-V, as opposed to the ICD-11 for two

reasons. First and primarily that as this research is interested in experiences of young people with ADHD it seemed more appropriate to refer to the manual that was developed to support the diagnostic pathways that the young people are experiencing (Doernberg & Hollander, 2016). Second, that the ICD-11 names ASD as an exclusionary disorder, which would have significantly decreased the available sample. In the DSM-V ADHD is described as “A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development” (American Psychiatric Association, 2013, pp.97).

The diagnostic criteria for ADHD has also undergone several significant changes over time (Epstein & Loren, 2013). As such, when exploring the literature, it is important to be mindful of the time in which it was published and which diagnostic manual the authors are referring to. Although there is a wealth of literature surrounding ADHD, various authors may have used different definitions and diagnostic criteria. Epstein and Loren (2013) described some significant changes from the DSM-IV to the DMS V, some of which could be argued to increase the probability of receiving a diagnosis. They note that the DSM-V reduced the minimum number of symptoms required for a diagnosis from 6 to 5 (American Psychiatric Association, 1994; 2013; Epstein & Loren, 2013). Furthermore, in the DMS-V it states that the onset of symptoms need only occur before the age of twelve rather than seven as was previously the case. Epstein and Loren (2013) also note that ASD is no longer an exclusionary diagnosis, which may mean that young people with ASD who may previously have not received a diagnosis of ADHD, now could. It is therefore crucial to recognise that these inconsistencies over time are significant when referencing previous research since they demonstrate the instability of the criteria for diagnosis. They may also explain the increases that are being recorded in diagnosis rates (Safer, 2018).

NICE guidelines state that a diagnosis of ADHD must be made by “a specialist psychiatrist, paediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD” (National Institute of Care for Health and Care Excellence, 2018, para, 1.3.1) They also say that any diagnosis must meet the criteria of either the ICD-11 or the DSM-V, and the difficulties must be causing daily impairment to the patient. Most significantly, NICE guidelines provide extensive advice on the support that should be given to young people and the families and care following a diagnosis of ADHD. These

include support in developing understanding of ADHD and the impact that it may have on the young person. Banerjee and Kewley (2009), explored the barriers to paediatricians offering this type of support and found that paediatricians were finding it difficult to meet the demands of the workload. It may be, therefore, that paediatricians are not currently able to offer the levels of support necessary following a diagnosis.

2.2.3 Intervention and treatment.

Pharmacological interventions are the most common treatment for ADHD (Moore et al, 2015). Psychostimulants such as dexamphetamine and methylphenidate are commonly used to increase dopamine uptake within the young person's neural pathways (Faraone & Buitelaar, 2010). The visible results of this are a reduction of the ADHD characteristics most commonly associated with challenging and un-productive behaviours (Faraone & Buitelaar, 2010). These characteristics include inattention, hyperactivity and impulsivity (American Psychological Association, 2013). Although there is evidence for the positive results of these medical treatments (Hinshaw & Arnold, 2015), there is still ongoing controversy around the use of psychostimulants, and arguments to promote the use of non-pharmacological treatments (Moore et al, 2015). These controversies are discussed later in the review.

Moore et al (2015) conducted a systematic literature review exploring non-pharmacological treatments of ADHD, examining the findings of four separate systematic reviews concerned with non-pharmacological treatments. They concluded from this review that these methods are an essential feature of effective intervention for ADHD, and that further research is needed to develop a comprehensive evidence base available to schools. Moore et al (2015) reported a number of limitations to their review, in particular that there was no standardised method of synthesis between the various interventions and measures throughout the literature. Fortunately, although this is relevant to the accumulative conclusions drawn from the review it does not impact the relevance of the comments and individual analysis of the papers which are reviewed. The authors also highlighted difficulties with finding UK based studies and research into the voice and experience of the young people who are receiving the interventions.

In another systematic literature review, Carr (2009) explored the use of systemic interventions for a number of difficulties faced by young people. Included in this

review was the use of systemic or family interventions when working with young people with conduct disorders including ADHD. The authors concluded that the most effective interventions for ADHD were multi-modal and would include systemic and family interventions. The evidence of high correlations between ADHD and insecure attachment, as reported in another systematic literature review produced by Storebø, Rasmussen and Simonsen(2016), provides a strong argument to work with the family. The National Institute for Health and Care Excellence (NICE) guidelines also state “Group-based parent-training/education programmes are recommended in the management of children with conduct disorders” (National Institute for Health and Care Excellence, 2008).

This multi-faceted approach is also further supported by the NICE guidelines (2018) which require medications to be administered alongside non-pharmaceutical intervention to support the young person. These guidelines also align with an ecological model of ADHD, which was introduced at the beginning of this thesis and is explored in greater depth below.

2.2.4 Controversies and dilemmas.

Existence of ADHD.

Although ADHD has been accepted internationally as a genuine diagnosis (Wong et al, 2018), there has long been controversy around its existence (Laurence & Mcallum, 1998). One argument against the legitimacy of ADHD as a disorder, is its historical and frequent reimagining. The definition, diagnostic criteria, and even title of ADHD has undergone notable changes since it was first introduced (Epstein & Loren, 2013) suggesting that there is a pervasive lack of consensus around the genuine nature of the disorder. It could be argued, however, that this process has been developing a more precise and appropriate description of a disorder, in the face of the increasing attention it has received from researchers (Wong et al, 2018).

Denckla (1992) argues that there should not be debate around the existence of ADHD, and instead the debate should be focused on the label’s inappropriate application to numerous different behaviours and conditions. She argues that until the development of a neurological assessment, or the discovery of biological markers to identify ADHD, practitioners should apply a broader term such as “disorders of mental or emotional self-control/regulation” (P.458). Although this

paper is now over 20 years old, there is still no definitive or clinical test for ADHD, and these ideas are now represented in the most recent updates to the NICE guidelines (NICE, 2018). The 2018 guidelines stress the significance of exploring environmental explanations for the presenting symptoms before diagnosing ADHD (NICE, 2018). As will be discussed in more detail below, even with rigorous testing, there are still no biological markers of the disorder and therefore a completely reliable diagnosis is not achievable (Singh, 2007).

Although the above discussion does not cover the breadth of the debate around the reality of ADHD, it indicates the complexity of the argument, and the need to be critical when approaching the literature.

Gender differences.

It is well established that there are significantly higher rates of ADHD diagnosis in boys than in girls (Arnett, Pennington, Wilcutt, DeFries & Olson, 2015). This divide is particularly relevant when exploring the literature around ADHD, as there is likely to be consistently uneven sample distribution. There is debate, however, around the accuracy of these statistics. Meijere. et al (2009) note that rather than a genuine imbalance in prevalence between the two genders, this may be due to the disruptive behaviours often associated with ADHD being more prevalent in boys than in girls, causing increased rates of diagnosis. This theory is supported by the balanced prevalence rates between men and women in adulthood (Meijere et al., 2009).

In their study exploring the gender difference in ADHD, Arnett et al (2015) concluded that the higher rates of ADHD in boys could be explained by the natural variance in behaviour between boys and girls. Using a sample of 2332 twins and siblings to explore sex as a mediator factors in ADHD symptoms, they found not only that boys mean behaviour scores were closer statistically to the diagnostic levels for ADHD, but that boys had significantly higher levels of variance across all behaviour types. This suggests that the boys in their study were naturally more likely to present with behaviour at both far ends of the spectrum, than were the girls. This could suggest that conduct difficulties like those that would lead to a diagnosis of ADHD, are genuinely more likely to be present in boys than in girls.

These results raise more controversy in that they suggest young boys' natural behaviours could be diagnosable as disordered, placing them at a potential

disadvantage. Given the relationship between ADHD and mental ill health, it could also be argued that research like this highlights boys as more vulnerable to negative outcomes.

Labelling.

The controversy around labelling young people is prevalent across many childhood disorders (Riddick, 2000) with concerns largely being around adopting a medical model and placing the difficulties within the child (Lauchlan & Boyle, 2007). The fundamental criticisms of the medical model are that it breeds marginalisation and stigma, and that if intervention focusses so heavily on the individual it will distract from issues within society and politics (Matthews, 2009; Wiener et al, 2012). Lauchlan and Boyle (2007) argue that creating a within-child deficit model could have numerous risks including lower expectations and associated reduced opportunity for success: lowered expectations may lead to lower attainment, lower self-esteem, and lower overall outcomes (Loe & Feldmen, 2007; Madon, Guyll & Scherr, 2011). These ideas are mirrored in the research around outcomes associated with ADHD, as will be discussed later in this review.

The NICE guidelines stress constant evaluations of each child's needs and severity of their behaviour, as well as assessment of their environment in order to ensure the most appropriate support (National Institute for Health and Care Excellence, 2008). It is arguable, however, that these steps should be taken when supporting young people irrelevant of their diagnosis, the argument being that the needs will not change dependent on the application of a label. If this is the case, then it could be theorised that the negative impacts of a diagnosis, associated with stigma and self-fulfilling prophecy, are enough to warrant an end to the diagnosis of ADHD.

It is important now, to consider the other side of this debate. The literature presents numerous arguments for the diagnosis of ADHD, the first being to access to appropriate support. Adler and Cohen (2004) explored the diagnosis of ADHD in adults, also reporting on the outcomes associated undiagnosed ADHD. They argued in their paper that un-recognised and untreated ADHD was a significant predictor of negative mental health and life outcomes. Alternatively, it could be argued that these are results of unmet needs due to societal attitudes and that support cannot be implemented without a diagnosis.

In their article directly addressing the labelling of young people with special educational needs, Lauchlan and Boyle (2007) posed three core arguments in favour of diagnosis. First that labels function to increase awareness and therefore promote understanding and tolerance. Second, that for some young people having a diagnosis creates a social identity and a sense of belonging. These are juxtaposing arguments to the literature which suggests labels can be stigmatizing (Ohan, Visser, Moss, & Allen, 2013). Finally, Lauchlan and Boyle (2007) discussed the

practical arguments; having a diagnosis of ADHD may open up funding opportunities to support the young person's access to education or support the parents at home. It could be said however that this is less an argument for diagnosis as it is an argument that the system should be changed to better fit a social model.

As a further example of how the structure of society might perpetuate the needs for labels, Lauchlan and Boyle (2007) also discuss the psychological and emotional benefits for parents. Parents and families may benefit from a diagnosis due to exemption from blame, and an explanation of cause (Lauchlan & Boyle, 2007). Essentially, if a child is diagnosed with a condition, this creates the perspective that their child has an unavoidable problem and that they are therefore exempt from any judgment. This could be described as a direct product of the anxiety created by stigma and current societal attitudes and further adopting a medical model (Matthews, 2009).

Medication.

The controversy around psychostimulant drugs is based largely on ethical concerns around medically modifying young people's behaviour and the risks associated with the medication (Singh, 2007). There are numerous negative side effects associated with common forms of ADHD medication including, but not limited to, disrupted sleep, poor appetite and reduced growth (Pajo & Cohen, 2013). These concerns are emphasized in the face of the controversies around inappropriate diagnosis as discussed above. Further, as rationale for their systematic literature review exploring non-pharmacological treatments for ADHD, Moore et al (2015) noted a number of evidenced issues with ADHD medication. They note that not all young people will respond to ADHD medication, that the long-term compliance rates are fairly low, and that some

young people or their parents may either choose not to take medication or not tolerate the side effects when they begin taking them.

In her paper looking into the moral self-perceptions of young people, Singh (2007) explored the more psychological effects of psychostimulant drugs. Singh (2007) interviewed 23 young people in her pilot study and utilised a novel method of asking the young person to take photos prior to their interview of things that represented how they felt when they had or had not taken their medication. These photos were used as stimuli for the interview discussion and were intended to gain insight into the worlds and views of the young people. Referencing her results, Singh (2007) reported that taking medication for a disorder was associated with feelings of being intrinsically bad. Singh noted herself that it was important to acknowledge that qualitative data of this kind is not generalisable, further that as a pilot study this research needed to be taken as preliminary. All the above considered, this paper does still highlight the risk that medicating young people could communicate to them that they are in some way ill or bad. Further research exploring individuals' identity when taking medication is therefore important in better understanding the support networks that psychologists and related professionals could offer.

Snider, Busch and Arrowood (2003) explored teacher understandings and views of ADHD medication. Gathering the views of 400 educators, Snider, Busch and Arrowood (2003) reported limited understanding on the behalf of teachers. In the context of the study above, in which Singh (2007) discussed the risks of misunderstandings associated with medication, this limited understanding and knowledge could be argued to pose greater risk to young people.

Despite the controversies alluded to above, psychostimulant drugs have proven to be effective in symptom relief (Faraone & Buitelaar, 2010), and are still the most common treatment for ADHD (Moore et al, 2015).

Inclusion.

The Special Educational Needs and Disability (SEND) Code of Practice (2014) states that all children and young people in England have a right to mainstream education, therefore that full inclusion of all young people should be the goal of mainstream schools (Norwich, 2012). However, researchers have suggested that that school staff are finding it difficult to meet the demands of additional needs

and the increasing academic pressure within their classroom and that this is leading un-inclusive practice across the country (Wheeler, Pumfrey, Wakefield, Quill, 2008; Thorley, 2016). These difficulties faced by teachers are of particular relevance when considered in the context of ADHD as the nature of ADHD symptoms are such that they are regularly associated with challenging behaviour in school (Meijere, Van Den & Tobi, 2009; Faraone & Buitelaar, 2010). Understanding these challenges within an ecological systems framework (Bronfenbrenner, 1987) can help educators to understand the possible relationships between

There has been a push for more inclusive practice associated with ADHD, in the form of classroom strategies and increased awareness and understanding amongst school staff (Moore, Russell, Arnell & Ford, 2017). However, the discrepancy between the academic outcomes of those with ADHD and those without (Washbrook, Propper, & Sayal, 2013) would suggest that progress is still needed before young people with ADHD are being adequately included into mainstream schools. According to the findings of Moore, Russell, Arnell and Ford (2017), the effectiveness of in-class interventions for ADHD is heavily dependent on external and social factors such as adult student relationships. This aligns again with an ecological model of ADHD by evidencing the impact of factors within the young person's environment and is important to consider throughout the discussions around intervention and inclusion.

2.3 Mental Health

2.3.2 Prevalence.

Mental health, specifically that of young people, has been gaining attention over recent years (Social Care Institute for Excellence, 2017). In their paper exploring engagement and access to mental health services for young people, Anderson, Howarth, Vainre, Hones and Humphrey (2017) reported that 10% of young people between the ages of five and 16 had a diagnosable mental health condition. However, it is difficult to accurately predict the prevalence of mental health needs within a school-age population due to various factors such as under reporting.

2.3.3 Green paper and school responsibility.

In response to high rates of mental health conditions, in December 2017 the UK government released a new green paper discussing the efforts to support the

mental health of young people across the country: “Transforming Children and young people’s Mental Health Provision: a Green Paper” (Department of Health and Social Care & Department for Education, 2017). This paper examined the increasing responsibilities of schools, suggesting that by 2020 all schools should have a designated mental health lead. Regardless of whether this paper evolves into legislation, schools are now expected to have a comprehensive understanding of the complex mental health needs their students may have and to provide adequate support (Feuchtwang, 2016). In the face of budget cuts and increasing pressure on school (Thorley, 2016), this may well cause difficulties for schools going forward.

2.4 Mental Health and ADHD

Previous research has highlighted significant co-morbidity rates between ADHD and common mental health disorders such as anxiety and depression (Roy et al., 2013). Roy et al (2013) reported that one in three young people with ADHD will, at some point, develop depression. Amongst others, these rates were reported by Booster et al. (2012) and Becker et al. (2012). However, both papers report inconsistency across records of co-morbidity rates, and a lack of clarity around how the relationship between ADHD and mental health conditions functions.

Roy et al. (2013) conducted a study to explore the relationship between ADHD and depression. They hypothesised first that young people with ADHD were at higher risk of depression, and second that this relationship would be mediated by one of two things: anxiety or disruptive behavioural disorders. Their findings support previous research that suggests high co-morbidity rates between ADHD and depression. They also found that the relationship between ADHD and depression was, in their study, at least partially mediated by anxiety and disruptive behaviour. Roy et al (2013) argue that this provides some evidence to support early intervention to avoid the onset of depression in young people with ADHD. Roy et al. (2013) recruited 1584 participants, each assessed for ADHD using the same parameters. This large sample size and standardised testing support the validity of the study, however there are some aspects that call into question the generalisability of the findings. First, as discussed previously, it is important to note that this study used the diagnostic criteria from the DSM-IV, which have since been updated. Secondly, the pupils in this study did not need

to have a previously recognised diagnosis of ADHD, only to be presenting with suggestive symptoms. Thirdly, this study was conducted using students from the Netherlands, where the education system is notably different. The Dutch education system differs from Britain in that Dutch students will undertake exams at the end of their primary education, which will determine which nature of secondary school they will attend (Borghans, Golsteyn & Stenberg, 2015). The options are one of three, each preparing the young person for a particular type of career: vocational, professional or university (Borghans, Golsteyn & Stenberg, 2015). This is noteworthy with regard to the discussed paper as there is extensive evidence connecting poor academic achievement with ADHD. It could be argued, therefore, that high pressures to achieve at such a young age could increase the risk of depression in Young people with ADHD in the Netherlands. These criticisms aside, Roy et al's (2013) finding do offer a potential hypothesis to explain the relationship between ADHD and mental health.

It has also been suggested that young people with ADHD are at higher risk of social adversity than their peers without a diagnosis (Becker et al., 2012). Pelham and Fabiano (2008) note that children with ADHD are likely to experience significantly higher numbers of negative interactions throughout their lifetime than their peers. Looyeh, Kaali, and Sahfian (2012) expand on this, reporting that young people with ADHD have been found to be more likely to be left out of social events, experience verbal arguments, and to feel different from other people. In the same paper Looyeh et al. (2012) suggest that young people with ADHD are likely to have increased levels of loneliness, isolation and shyness, and decreased levels of self-esteem. Self-esteem alone has been evidenced as a predictor of depression and anxiety (Sowislo & Orth, 2013) which supports the argument that social interactions may be a significant mediator in the relationship between ADHD and mental health conditions. However, there is an argument regarding causality. Becker's (2012) review included papers published between 1994 and 2011 which explored the relationship between comorbid mental health difficulties, and social relationships in young people with ADHD.

Amongst other findings Becker et al. (2012) report that both depression and anxiety are associated with social information processing difficulties (SIPD), these SIPD may in turn be impacting on the young person's ability to interact with their peers resulting in the social phenomena described above.

Another perspective can be seen from Seymour and Miller (2017) who set out to explore and review the limitations of the research around the comorbidity of ADHD and depression. They looked into the impact of frustration and lowered tolerance in young people with ADHD. The year previous, Seymour, Macatee and Chronis-Tuscano (2016) found that young people with ADHD were significantly more likely to experience frustration than their typically developing peers. As with all mental health needs it is important to distinguish between normative responses to negative experiences and disordered or problematic responses. Seymour and Miller (2017) note that although frustration is a natural response to difficulties attaining a goal, it is a limited tolerance for frustration that leads to negative affect such as irritability. They go on to note that frustration and irritability have been highlighted as a phenomenon in both depression and ADHD. Seymour and Miller (2017) and Scime and Norvilitis (2006) also report that young people with ADHD are more likely to give up in response to frustration and to experience feelings associated with hopelessness. Scime and Norvilitis (2006) conducted an experiment in which young people with and without a diagnosis of ADHD were presented with a frustrating arithmetic task. Overall, their study included sixty-four young people. What makes their findings particularly poignant, is that they found no significant differences in ability between the two groups, the only detectable differences were in the ADHD groups' likelihood to give up.

As a final note, it is worth acknowledging that one of the core symptoms associated with ADHD is impulsivity (American Psychiatric Association, 2013). Impulsivity is also frequently featured in research around poor mental health and suicide (Peters, Balbuena, Marwaha, Baetz, & Bowen, 2016). In a recent quantitative study working with adults with a history of suicidal behaviour, Conejero et al (2019) note that there is a significant relationship between ADHD and suicidal behaviour. They go on to report that there is enough literature to evidence impulsivity as the mediating factor in this relationship, a model that was supported by the findings.

Although the points raised above are not an exhaustive list of the possible explanations for the relationship between ADHD and negative mental health outcomes, they do give some insight into the complexity of it.

2.4.1 Young people's perceptions of their ADHD.

When considering the relationship between ADHD and mental health, it is important to consider young people with ADHD's perceptions of their disorder or label. This topic has gained more attention from authors in recent years (Wong et al, 2018) and there is now convincing evidence to suggest that the way in which young people with ADHD perceive themselves and their ADHD may have an impact on their behaviour, mental health and wellbeing (Wong et al, 2018).

Wong et al (2018) conducted a systematic literature review of the perceptions that young people and their parents have regarding the young people's ADHD. They found strong evidence in the literature to suggest that the ways in which young people perceive their ADHD is likely to affect their coping and wellbeing. They used the Common-Sense Framework of illness (Leventhal, 1980) to categorise the literature into eight different elements of illness: identify, cause, timeline, cure, control, coherence, personal control and emotional responses. The Common-Sense Framework of illness proposes that the ways in which we understand and perceive illness directly impacts on the way in which we cope with it (Leventhal, Meyer, & Nerenz, 1980). Further, according to this framework, the way in which we cope with an illness or condition, also has a direct impact on its outcomes (Leventhal et al. 1980). Wong et al (2018) argued that by applying this framework, they were offering a unique outlook, from which it would be clear exactly what the possible outcomes were of differing perspectives. It could be argued, however, that applying this framework to research that has been conducted under a different model does not present a true picture. This paper provides an indication that the perceptions that young people and their parents have of the young person's ADHD will have significant impact on potential outcomes.

Arora and Mackey (2004) cite Cooper and Shea (1998) as the first authors to explore young people's perceptions of their ADHD diagnosis. Cooper and Shea (1998) write that at the core of their study was the argument that ADHD is a bio-psycho-social concept and should be understood as such. By this they mean that ADHD should be recognised as a product of biological, psychological and social factors. What they found, however, was that was that young people predominantly understood their diagnosis through medical or biological terms. As

cited above, Wong et al (2018) discussed some of the potential consequences of these beliefs in their review, citing two studies, Honkasilta, Vehmas and Vehkakoski (2016) and Mukherjee, Shah, Ramanathan and Dewan (2016). Both studies reported that young people's biological etiological beliefs regarding ADHD were associated with the perception of having less control over their own behaviour. Wong et al (2018) also cited Moses (2010), who reported a significant correlation between young people who were self-stigmatizing and those who believed their condition was biologically based. Honkasilta et al. (2016) supported this view, identifying that in Finnish youth, there was inadequate discourse to support their understanding. They found that young people were developing self-condemning behaviours which led to young people developing a maladaptive ADHD identity. The above are just some of the potential outcomes cited in the literature around etiological beliefs regarding ADHD. Wong et al (2018) report that the most significant limitation of their review is that the existing research in this topic is uneven, with some areas relatively unexplored. Wong et al reported that despite the pre-existing research into young people's perceptions of the presence or severity of their symptoms, they were unable to find a study that explored the corresponding impact of these perceptions. This absence of research on the links between young people's perceptions of their symptoms and the corresponding outcomes on health and wellbeing is the first of the two literature gaps that were targeted in this thesis.

Cooper and Shea (1998) argued that it could be beneficial for young people with ADHD to be supported in better understanding their diagnosis. Targeting this, Looyeh et al (2012) conducted their study using narrative therapy to support girls with ADHD. Amid various difficulties, they refer to research that suggests students with ADHD are more likely to experience loneliness and low self-esteem. Looyeh et al (2012) argue that these difficulties are both the cause and result of negative perceptions regarding both themselves and their ADHD. These researchers argue that using narrative therapy to re-frame these perceptions may have a positive impact on their mental health. Their study described positive teacher and parent reported behavioural outcomes as a result of narrative therapy. Although these results are positive, their measure for improvement was objective ratings from adults, rather than from the child. Further, the outcome

measure was based on behaviour, and not the internal difficulties which may be associated with the diagnosis.

Singh (2007) explored the self-perceptions of young people with ADHD in association with their medication. Singh (2007) was particularly interested in the young people's moral selves. Singh (2007) found that children with ADHD had a tendency to consider themselves as intrinsically "bad", and that the medication they were being given was what was making them "good". Trivell and Visser (2006) also found that young people with ADHD were likely to describe themselves as "naughty" or "stupid". These studies offer support for the argument that the way in which young people are perceiving their ADHD is significant and deserves empirical attention.

The research cited above provides support for how young people's wellbeing is likely affected by how they understand or perceive their ADHD diagnosis. It is important, then, to explore how these perceptions are developed. A great deal of the literature around ADHD and wellbeing aligns with an ecological model by which external and interacting factors affect outcomes. Bronfenbrenner (1979) proposed a model of development by which different components within a young person's life can be categorised, and each will impact on the ways in which that young person develops. Bronfenbrenner's (1979) ecological model poses that there are four layers of impact and influences surrounding a young person as they develop. These layers affect and interact with one another and the young person, which in turn impacts on their development in all areas. In the centre of the model is the young person and any internal factors, for example biological factors such as health conditions or sex. The first layer, immediately surrounding the young person is the micro-system, these are factors with which the young person directly interacts. The microsystem might include family, school, peers or community. The second level is the meso-system, this is defined as the relationships or interactions between factors within the microsystem. As an example, the relationships between home and school. The third layer, the exo-system, includes factors which are further removed from the young person, for example, neighbours or distant relatives. The final layer is called the macro-system, this includes the broader social picture such as culture or social attitudes. Although the neurological components of ADHD may be considered an internal factor, if you apply this model of development, the way in which ADHD and

outcomes develop or affect the young person is likely to be affected by factors within the micro, meso, exo and macro levels. This research sought to explore not only how young people with ADHD are perceiving their diagnosis, how they came to perceive it in that way.

2.5 Personal Construct Psychology

2.5.1 Constructive Alternativism.

To understand PCP, it is necessary to first understand the underpinning philosophy, claimed by Kelly (1995) to be Constructive Alternativism (CA). CA is the principle that although the world is intrinsically the same for all people, the ways in which individuals construe it is unique to them, and therefore each individual experiences the world differently. For as many people there are experiencing one thing, there are as many different ways of construing it (Winter, 1985).

2.5.2 What is Personal Construct Psychology?

PCP was introduced by Kelly in 1955 and is concerned with the meanings which people attribute to their world. Kelly (1955) describes the way in which an individual interprets different parts, events, or situations within the world as personal constructs. Kelly (1955) goes on to argue that these constructs directly affect the way in which a person will predict, experience and react to the world around them. Kelly (1955) further proposes that these constructs are developed in response to our personal experiences, creating a cycle of experience influencing constructs which in turn influence our experiences. Kelly (1955) developed a metaphor for this process which is that all people are scientists. By this he meant that as humans we are constantly theorising the world around us and trying to make sense of it. Humans constantly seek to understand the world which they are experiencing and will draw upon experiences and personal constructs to support our understanding of what is happening. In other words, although two people may be experiencing the same event, their interpretations of it may be completely different, which in the case of a student and teacher could cause significant friction. PCP states that individuals can be unaware of the constructs they have formed but that they are likely to affect behaviour and responses (Kelly, 1955).

2.5.3 Personal Construct Psychology in Practice.

PCP has been adapted by several different authors and psychologists to develop techniques and tools for working with young people. Ravenette (1999) presents a number of papers, case studies and detailed examples of useful techniques, which are all rooted in Kelly's theory. Ravenette (1999) writes at length about the significance of such methods to elicit a young person's understanding of their world, and the ways in which these understandings are developed into personal constructs.

The practice of using PCP therapeutically is largely based around supporting an individual and those around them, by encouraging them to develop an understanding of their personal constructs. Recognising that you are being influenced by a personal construct, and subsequently that your constructs may directly contradict those of others around you, has been shown to have immense therapeutic value (Ravenette, 1999). As an example, Hardman (2001) reported positive outcomes in her study using PCP to support a Year 10 boy who had been identified as at risk of permanent social exclusion.

2.5.4 Criticisms of Personal Construct Psychology.

Although PCP has been accepted as an effective tool for working with young people (Caputi, Hunter & Tan, 2009) there are still practical issues associated with it. PCP relies on the underlying assumption that the young people will recognise any flaws or contradictions in their personal constructs. Although PCP may aid young people in recognising their constructs, it should not presume to change them.

Further, Kelly (1955) argues himself, that our personal constructs will influence the way we interact with and interpret our experiences. This is of pragmatic relevance as the practitioner will need to be consciously aware of their own personal constructs to both not influence the young person and account for any bias in their interpretations. It is also necessary to acknowledge the impact that personal constructs may have on the therapeutic relationship. The young person may hold views or preconceptions around therapy or even adult support that will impact the outcomes of the support.

This leads to the final point which is that, as with all talking therapy or interventions, there is the assumption that the young person will want to engage (O'Reilly, & Parker, 2013). In their review of engagement in therapeutic interventions, Dixon, Holoshitz and Nossel (2016) note that there are many influences which may prevent people from engaging with therapy or intervention. They note that individuals may be distrustful of the person or the process, and that there is no blanket method to support all people. There are a magnitude of factors which a practitioner will need to consider in order to promote engagement. Although this is not a criticism specific to PCP, it is of particular relevance to the use of PCP by educational psychologists, as described by Ravenette (1999). In the wake of the 2007/8 recession, educational psychology services saw a move towards a traded model and away from a model in which their work was free at the point of delivery. It has been argued that with this increase in traded services, educational psychologists are presented with reduced time to work with young people (Lee & Woods, 2017). It could be argued that with less time, the pressures of achieving and maintaining engagement are increased.

To conclude, although the practical applications of PCP have been found to be effective for working with young people, (Caputi et al. 2009), it is important to be aware of the practical and social difficulties associated with the practice.

2.5.5 Personal Construct Psychology and ADHD.

As previously discussed, there is evidence to support the idea that the ways in which young people perceive their ADHD may have a significant impact on their behaviour, mental health and wellbeing (Wong et al, 2018, Mukherjee et al, 2016; Moses, 2010). These findings are reflective of the basic principles of PCP: that the way in which we understand our world impacts how we behave in it (Kelly, 1955). It is therefore argued that PCP techniques may be of particular value when working with young people with a diagnosis of ADHD. A literature search conducted between January and March 2018 found no previous research literature exploring specifically the use of PCP with ADHD. A final search was completed in May 2019, which also brought back no results. This gap in the literature and the arguments set out above, are presented as the rationale for the proposed research.

2.7 Conclusion and Underpinning Models

To conclude, the above literature review has identified gaps in the extant research and outlined literature which provides the rationale for this research. First, the need to explore the potential outcomes of perceived symptom severity in young people with ADHD. Second, to explore the use of tools derived from PCP when working with young people with ADHD. These topics are argued to be of particular relevance due to the rising national concerns around mental health and ADHD.

This research aligns with two models which have been mentioned throughout the literature review. An ecological model of development (Bronfenbrenner, 1979), and the common sense framework of illness (Leventhal, 1980; Wong et al, 2018). The common sense framework of illness poses that the way in we understand our illness or diagnosis impacts our outcomes and coping mechanisms. Wong et al (2018) applied this model to ADHD reporting that it is applicable to young people with ADHD. An ecological model poses that there are pervasive, interacting, external factors which influence the development of young people. Research around the relationship between ADHD and mental health suggest that there are numerous external factors that affect outcomes for young people for young people with ADHD. Further that there are likely to be external factors which influence the ways in which young people understand their ADHD. These models combined provide rationale to explore the experiences and views of young people with ADHD, those around the young person, and the ways in which these views develop.

Chapter 3 Methodology

In this chapter the overall aims and research questions of this research are presented, followed by a section on the philosophical underpinnings, and finally the ethical considerations.

3.1 Aims and Research Questions

The overall aims of this research were to explore the experiences and perceptions of young people with ADHD. The separate aims of Phase One and Two are set out below.

3.1.1 Phase One aims and research questions.

The overall aim of Phase One was to explore the views held by Special Educational Needs Coordinators (SENCOs) with regards to the experiences of young people with ADHD.

RQ1) How do Special Educational Needs Coordinators think that young people with ADHD perceive their ADHD and the severity of their symptoms?

RQ2) How do Special Educational Needs Coordinators think young people with ADHD develop the perceptions they have of their ADHD and the severity of their symptoms?

RQ3) How and to what extent do Special Educational Needs coordinators believe that these perceptions impact their wellbeing?

3.1.2 Phase Two aims and research questions.

The aims of Phase Two were twofold. First to explore experience and perceptions of ADHD among young people, their parents, and their teachers. Second to explore the use of tools derived from PCP when working with young people with ADHD, by facilitating staff members' understanding of the views and experiences of Young people with ADHD.

RQ1) How do young people with ADHD perceive their ADHD and the severity of their symptoms?

RQ2) What influences the perceptions that Young people with ADHD have of the severity of their symptoms?

RQ3) How and to what extent do these perceptions impact the young people's wellbeing?

RQ4) How and to what extent can tools and activities derived from personal construct psychology be used to effectively support young people with ADHD?

3.2 Theoretical Perspective and Reflexivity

This research aligns with an interpretivist perspective in that the aims were to explore the beliefs and perceptions of individuals. It is my view that everyone will experience the world differently as a result of their own personal context. I believe that there is no way to perfectly predict how people will feel about or respond to their environments, nor is it possible to uncover absolute truths in relation to social experiences. This conforms to the argument that that existence relies on the perception of it, whereby things exist only as they are perceived or reacted to (Yanow & Schwartz-Shea, 2011).

My favoured interpretive perspective embraces the use of qualitative data and a respect for the search for the meaning within the data.

My perspective and therefore choice of methodology and analysis acknowledge the certainty of multiple realities created by differing perspectives. I acknowledge that by this reasoning, interpretivist research cannot be generalised, but can instead be added to an evidence base to develop a rich and multi-faceted view of a topic. The research respects the claim that the closest we can get to an absolute truth about phenomena, is by exploring the first hand experiences of those experiencing it. The research questions of both Phase One and Phase Two were concerned with the experiences and views of young people, their parents, and the staff who work with them. As the research is concerned with experiences, there was no attempt at uncovering universal truths, but instead at uncovering the individual truths of each participant.

3.3 Ethics

In their article exploring the ethics of qualitative psychological research Brinkmann and Kvale (2008) argue that such research is always ethically complex. The impossibility of objectivity, and the inevitability of social interactions between researcher and subject make qualitative research methods ethically complex. With unavoidable ethical issues such as these, it is the role of the researcher to practice with as minimal risk and bias as is possible, within the remits of human nature and pragmatism (Brinkmann & Kyale, 2008)., Further, to report with transparency and to acknowledge any limitations or conflicts. This is in line with the British Psychological Society's (BPS) Code of Human Research Ethics (BPS, 2014) which was complied with throughout this research.

Ethics approval was gained from both the Graduate School of Education at the University of Exeter, and the Local Authority where the research was conducted (Appendix 1).

3.3.1 Consent.

Participants of both Phase One and Two provided active informed consent. For each young person consent was received from both the young person and a parent. In the case of Phase One, participants were provided with information letters (Appendix 2). If they decided to participate a meeting was arranged at which time they were given an opportunity to ask further questions before providing active written consent. In the case of Phase Two before any contact was made directly with parents, or they were provided with information letters, the school SENCOs were asked to discuss their participation with them in order to assess whether they would like to explore participation further. Finally, information letters (Appendix 2) were provided to school and sent home to the parents or legal guardians. These letters informed potential participants that:

- *All identity would be kept confidential.*
- *All data collected and reported would be kept anonymous.*
- *Participants had the right to withdraw their consent and participation at any time.*
- *Participants and young people had the right to withdraw their data from the research up until the point that this thesis was submitted.*

All participants were provided with contact details of the researcher and supervisors. Young people were also reminded prior to signing consent and at the beginning of each session that they had the right to withdraw their consent and participation at any time. It was made clear to all participants that participation was voluntary, using the following script upon our first meeting.

“You’ll now have a chance to read over this short information sheet. If following this you have any questions, do let me know. If you then decide you would like to participate in this research I’ll ask you to sign at the bottom, however participation is not compulsory so this is entirely up to you”

While working with young people, the script was modified to be age appropriate, and it was reiterated on numerous occasions that they could leave at any stage. In order to check their understanding, young people were asked to explain what they had just been told in different words. Throughout the interviews young people were asked on regular occasions whether they were happy to continue or would like to finish. However, there were no instances of any participants asking to finish early.

3.3.2 Reduction to risk of harm.

As a trainee educational psychologist, I had to be particularly aware of the role I was adopting throughout data collection; being careful to act only as a researcher and not a practitioner. Further I had to be aware of how my previous experiences as a practitioner might have been influencing my interpretations throughout analysis, and when this was or was not appropriate. As referenced in the methods sections of this thesis, at the analysis stage I was supported by colleagues who checked my codes, themes and interpretation of the data.

Although the risk of harm was anticipated to be low, it was acknowledged that this research aimed to explore personal experiences and that this requires an appropriate level of sensitivity and respect. All participants were provided time to ask questions before and after each interview or session, and parents and school had access to my email address if they required any further information or support. Any reference to mental health was non-specific and led by the participant in order to avoid sensitive topics which were not relevant to the research. School and parents were given information about available support in their area should they wish to seek mental health support elsewhere.

Finally, the use of tools derived from PCP sought only to explore the young person's constructs around their ADHD and school experience, and not those around complex topics such as mental health or family background.

Chapter 4 Phase One Methods

4.1 Research Design

Phase One employed both quantitative, and qualitative research methods to explore the views of Special Educational Needs Coordinators (SENCOs) in the form of semi structured interviews and an online questionnaire. It was decided to employ semi-structured, open ended interview techniques to allow the participants to guide the topic of conversation according to their personal experiences (Longhurst, 2003). The topics and questions were guided by the research questions (See Appendix 5.7).

The online questionnaire was developed and distributed to SENCOs across England (appendix 3). The questionnaire used Likert scales (Likert, 1952) to address eighteen questions. Although sometimes criticised (Hartly, 2014), Likert scales have been found to be valid and reliable (Hasson & Arnetz, 2005) and are a popular method for eliciting opinions (Willits, Theodori & Luloff, 2016). The questionnaire was designed to explore the range of views held by SENCOs and addressed perceptions and beliefs about the experiences of young people with ADHD. It was not intended to draw any comparisons or significance markers, so the use of Likert scales was considered appropriate. This research only extracted descriptive statistics from the data set. It was therefore decided that ordinal data was an appropriate form of output for the questionnaires (Norman, 2010).

Where a standard Likert Scale would offer a choice of five responses, *strongly disagree, disagree, undecided, agree, or strongly agree*; the questionnaire developed for this research offered six. This decision was made in order to reduce the risk of neutral responses. Although there is some argument that removing the option of a neutral response forces participants to align with a view, Garland (1991) noted that a neutral option increases the risk for social desirability bias, a phenomenon that could dilute the data. Further, exploration into the validity of Likert Scales found no significant difference in validity based on the number of response options (Leung, 2011).

4.2 Participants

Participants were forty-seven SENCOs from both secondary and primary mainstream and grammar schools across England, all of whom participated in the questionnaire stage of Phase One. Demographic information, including

gender and age was not deemed relevant to the research questions and therefore not collected. Six of these SENCoS also participated in the interview stage, as shown in table 4.1.

Table 4.1

Phase One participants

Primary	School type
SENCo 1	Mainstream Primary
SENCo 3	Mainstream Primary
SENCo 4	Mainstream Primary
Secondary	-
SENCo 2	Grammar School
SENCo 5	Mainstream Secondary
SENCo 6	Grammar School

It is a legal requirement of all mainstream schools to appoint a SENCo (Department for Education, 2014). It is also required that this person is a qualified teacher working within the school (Department for Education, 2014). According to The National College for Teaching and Leadership (2014) the SENCo is responsible for coordinating all of the special educational needs provision within a school. With some exceptions, in order to work as a SENCo a candidate must complete or be completing the national SENCos award (National College for Teaching and Leadership, 2014). This is a training course designed to upskill teachers around special educational needs. It was argued therefore that SENCoS were likely to have experiences working with young people with ADHD; understanding, meeting and coordinating the provision for their needs.

4.2.1 Recruitment.

Recruitment for the online questionnaire was a convenience sample. SENCoS were approached through a number of online and professional networks for educational psychologists and SENCoS including EPNET and The SENCo Forum. Further, SENCoS were contacted and approached through the school's link educational psychologist. In order to distribute this questionnaire, it was mounted onto a free online programme (Google Forms) and the link was circulated to participants (appendix 3). Participants were asked to confirm their role by providing a school-based email address. This address could also be used

to track data on the occasion that any participant chose to withdraw their participation, although there were no instances of participants asking to do so.

The interview stages employed another convenience sample. SENCOs were approached through their link educational psychologist at the local authority where I completed my final year placement. The first six who confirmed their participation were automatically selected.

4.3 Procedure

Questionnaire: Questionnaire items were informed directly by the research questions. The questionnaire was piloted once on a colleague who was also completing qualitative research as part of their doctorate training, and then by a SENCO working at a mainstream secondary school. Feedback from both pilots was used to develop the questionnaire. The development process can be seen in Appendix 4 alongside the flowchart displaying how each item relates to the research questions and then the literature. In order to complete the questionnaire, participants were required to read the information letters again, and provide an email address to confirm that they had read the information and were giving consent. Items were then listed in turn, and participants could provide their answer by selecting one of the six choices. Participants were required to respond to every questionnaire item in order to submit their answers.

Interviews: Six semi-structured interviews were conducted with six the SENCOs. The interview schedule was initially checked by the research supervisors, who recommended rewording in order to ensure the questions were open. The schedule was then piloted by a SENCO who retired in 2016, who fed back that the questions were clear and related appropriately to the research questions. Topics covered throughout the interview were:

- How and to what extent young people with ADHD are aware of their symptoms
- How and to what extent young people with ADHD understand their diagnosis.
- How young people with ADHD develop the perceptions they have surrounding their diagnosis.

- How the perceptions young people with ADHD have regarding the severity of their symptoms may be impacting on their wellbeing.

Interviews were conducted at the SENCo's schools and arranged around their timetables. The SENCo's numbers as indicated above in table 4.1, are indicative of the order in which they were interviewed. Interviews lasted between 20 and 40 minutes. At the beginning of each interview, SENCos were provided with an information sheet and their rights to choose not to participate or withdraw their contribution at any time before submission were reiterated. Interviews were recorded using a digital dictaphone, and each interview was then transcribed. Transcription were then imported into Nvivo where they were subject to thematic analysis (described below).

4.3.1 Analysis.

Questionnaire: Data was extracted from google forms into Microsoft Excel where scores for each response were calculated into percentages. In the results section of thesis, these percentages are presented in graphics and discussed in the context of each research question.

Interviews: All interview transcriptions were imported into Nvivo where they were subject to thematic analysis. The analysis followed Braun and Clark's (2006) model, which involves the following six steps;

- 1) Familiarising with the data and identifying items of potential interest

This step was primarily completed during transcription. Braun and Clark (2006) suggested that transcribing data first hand is a good way for the researcher to emerge themselves in and familiarise themselves with the data. Transcripts were read once over again before they were coded.

- 2) Generating initial codes

Each interview was analysed individually using the software Nvivo. Using this software, sections of transcript are essentially labelled by the researcher in order for the sections to be collated into themes during step 3 (see below). See Appendix 6 for an excerpt of coded transcript, all of the generated nodes, theme tables and a theme example.

- 3) Searching for themes

Codes from all six interviews were collated, and duplicates were reduced to a single node. E.g SENCOs 1, 3, 4, 5 and 6 all referenced medication, and so there were 5 nodes for Medication but in the final list, there was only one. These are then grouped into categories based on mutual topics or meaning. As an example the following nodes were grouped together to develop the theme Impact Of Understanding: *Not understanding affecting wellbeing, wants to understand their ADHD, consequences of ADHD not being explained well, how young person understands themselves affects how they feel, and young person's understanding of ADHD affecting how they feel* (Appendix 6).

4) Reviewing potential themes

Another trainee educational psychologist reviewed the themes which lead to them being regrouped on two occasions. Regrouping was primarily in response to the feedback that connections between nodes were too vague and needed to be clearer.

5) Defining and naming themes

After reviewing and finalising themes, there were twenty-eight themes. These were then labelled and grouped into main themes. Main themes were then named and grouped in global themes (Appendix 6).

6) Producing the report

Finally, themes were explored in relation to each research question, and the most appropriate or relevant themes for each were selected, presented and discussed (See findings and discussion sections).

Chapter 5 Phase One Findings

The following section presents the findings of Phase One. These include responses to an online survey and thematic analysis of six semi-structured interviews with SENCOs in primary or secondary schools. A thematic analysis of the interview transcripts identified 6 global themes:

- Knowledge of ADHD,
- Relationships and impact of others,
- Young person's awareness and perceptions
- Challenges in school
- Symptoms, feelings and behaviour
- Diagnosis and medication

These global themes are each subdivided into main themes containing a number of subthemes as set out in table 5.1. This chapter will explicate how these themes were constructed from the data set and explore what they can tell us about how SENCOs interpret the experiences of young people living with ADHD.

Using these themes and findings from the online questionnaire, each research question has been addressed in turn and presented below. Although all themes are discussed at least once throughout this section, groups of themes have been selected for each research question as those which were deemed most appropriate to address that question. Some themes were believed to not directly relate to particular questions and have so not been included and discussed in relation to questions they are deemed relevant to.

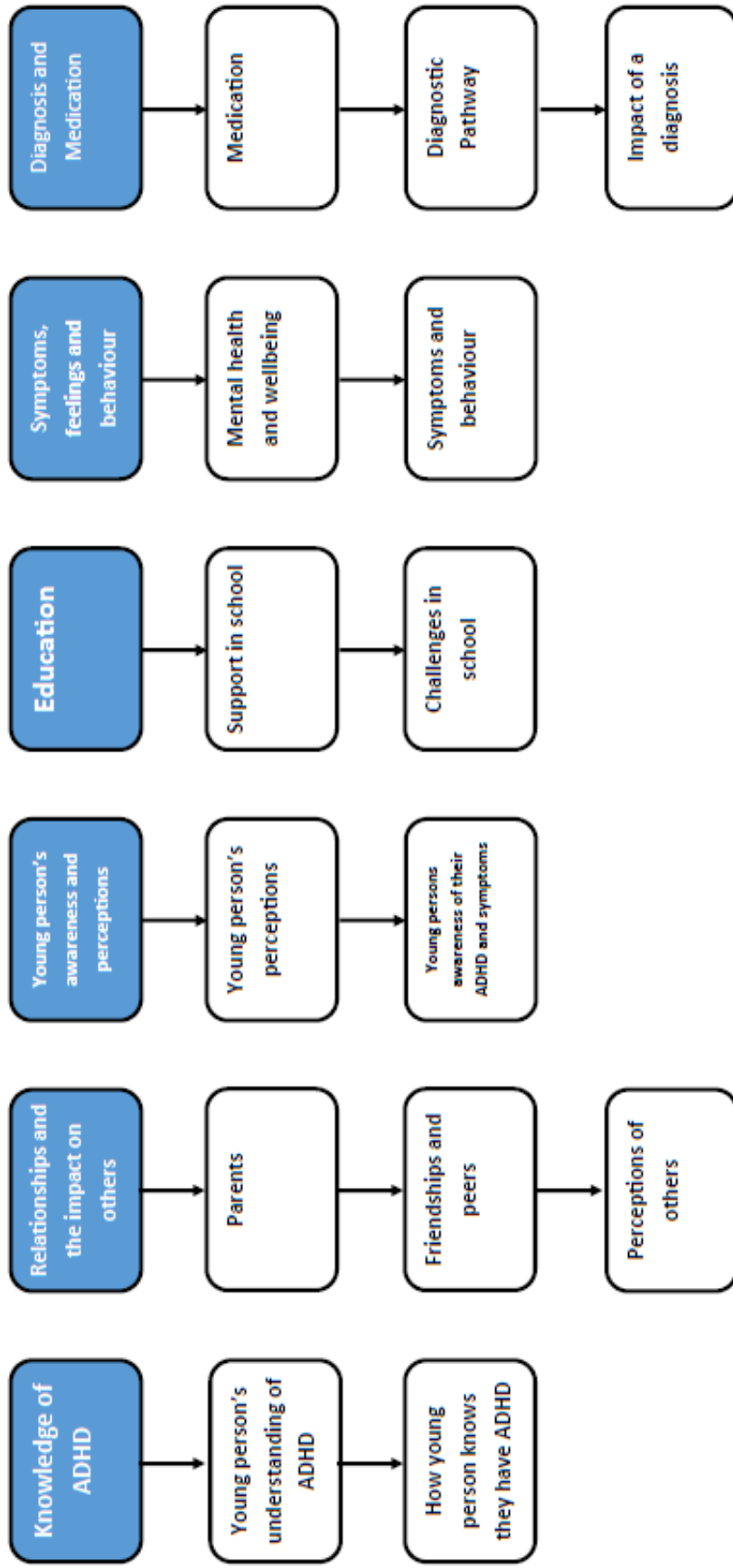


Figure 1. Flow chart of global and main themes from phase one interviews

Table 5.1

Overview of themes from Phase One

Global Theme	Main Theme	Subthemes
Knowledge of ADHD	Young person's understanding of ADHD	<ul style="list-style-type: none"> • Impact of understanding • Level of understanding • How young person develops an understanding
	How Young person knows they have ADHD	<ul style="list-style-type: none"> • How young person was told • People talking to young person about their ADHD
Relationships and impact of others	Parents	
	Friendships and peers	<ul style="list-style-type: none"> • Peer understanding • Young person comparing themselves to peers • Difficulties with peers
	Perceptions of others	<ul style="list-style-type: none"> • Perceptions of others
Young person's awareness and perceptions	Young person's perceptions	<ul style="list-style-type: none"> • Young person's perceptions
	Young Person's awareness of their ADHD and symptoms	<ul style="list-style-type: none"> • Young person's awareness affects wellbeing • Level of awareness • How young person's awareness develops
Challenges in school	ADHD as a barrier to learning	
	Transition	
	School feeling unskilled	

Symptoms, feelings and behaviour	Mental health and wellbeing	<ul style="list-style-type: none"> • Feelings and wellbeing • Resilience and self esteem
	Symptoms and behaviour	<ul style="list-style-type: none"> • Challenging behaviour • Symptoms and ADHD associated behaviours
Diagnosis and Medication	Medication	
	Impact of diagnosis	

5.1 Research Question One: How do Special Educational Needs Coordinators Think That Young People With ADHD Perceive Their ADHD and The Severity of Their Symptoms?

In order to address research question one, the responses from the questionnaire items one to five have been presented and then summarised below. Following this, the subthemes Level of Understanding and Level of Awareness, as well as the main theme Young Person’s Perceptions of Their ADHD are presented and explored.

5.1.1 Questionnaire results.

Item 1: Young people with ADHD tend to have a good understanding of what ADHD is.

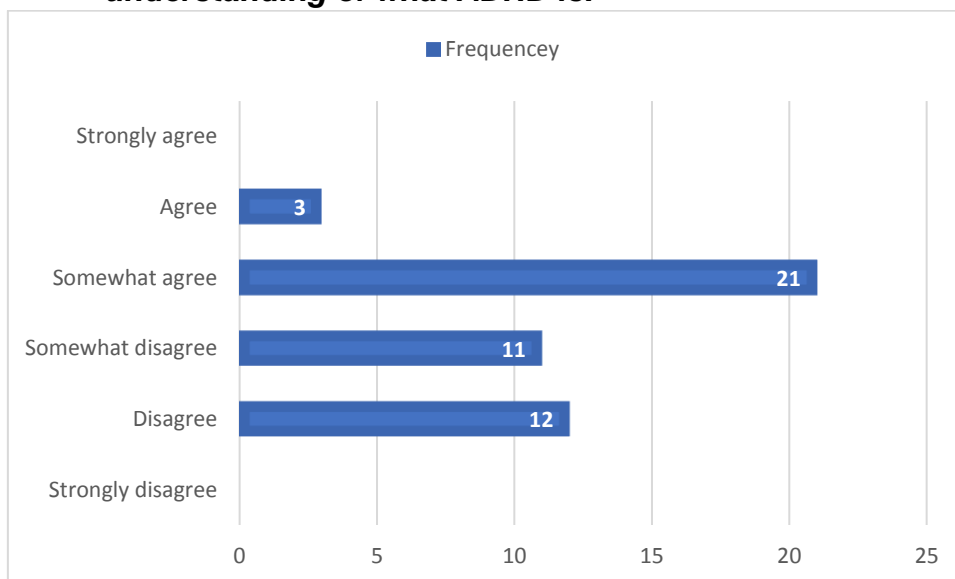


Figure 2. Bar graph showing frequency of responses for item 1.

What is interesting to note here is that the responses are more or less evenly split between 24 SENCOs who believed young people with ADHD tend to have a good

understanding of their ADHD (>51%), and the 23 who believe they did not (<50%).

Item 2: Young people with ADHD tend to know how their ADHD affects them.

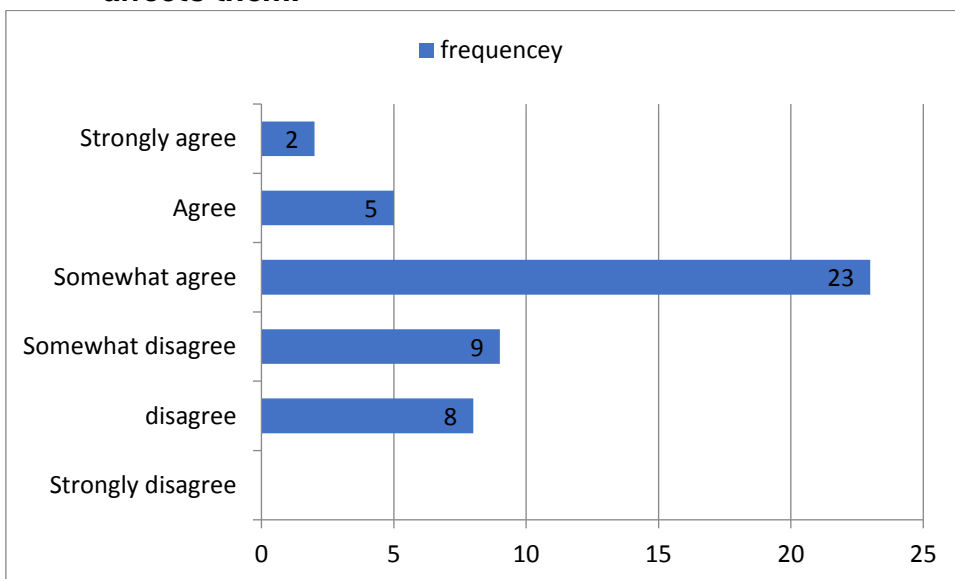


Figure 3. Bar graph showing frequency of responses for item 2.

Although these results do not provide any clear findings, there does appear to be a stronger response (>63%) from the SENCOs who believed young people with ADHD tend to know how their ADHD affects them.

Item 3: Young people with ADHD don't tend to know how severe their symptoms are.

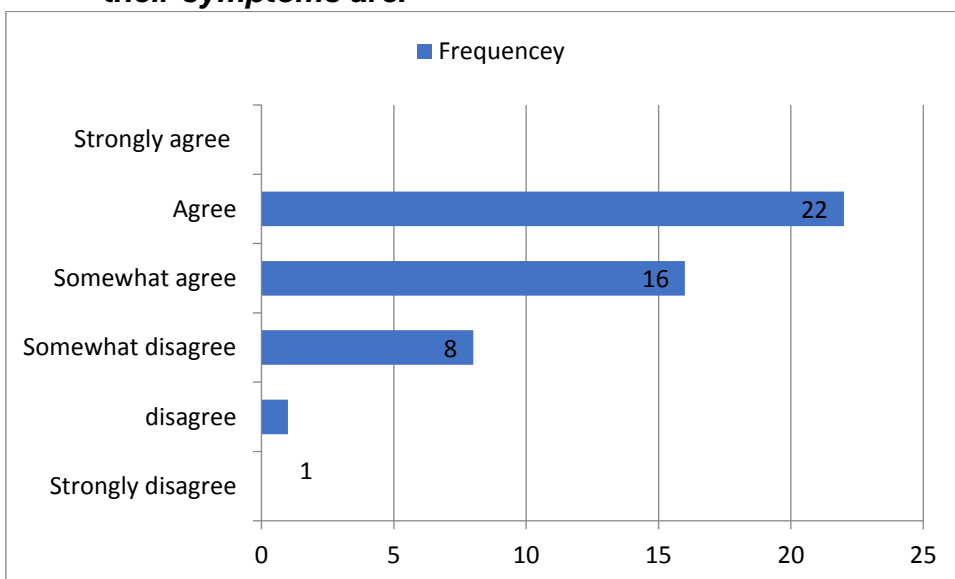


Figure 4. Bar graph showing frequency of responses for item 3.

Figure 4 shows that the majority of SENCOs (>80%) who participated in this research agreed to some degree that young people with ADHD do not tend to know how severe their symptoms are. Only 2% of participants reported that they disagreed to a greater degree than “somewhat”.

Item 4: Young people with ADHD tend to underestimate or not recognise the severity of their symptoms.

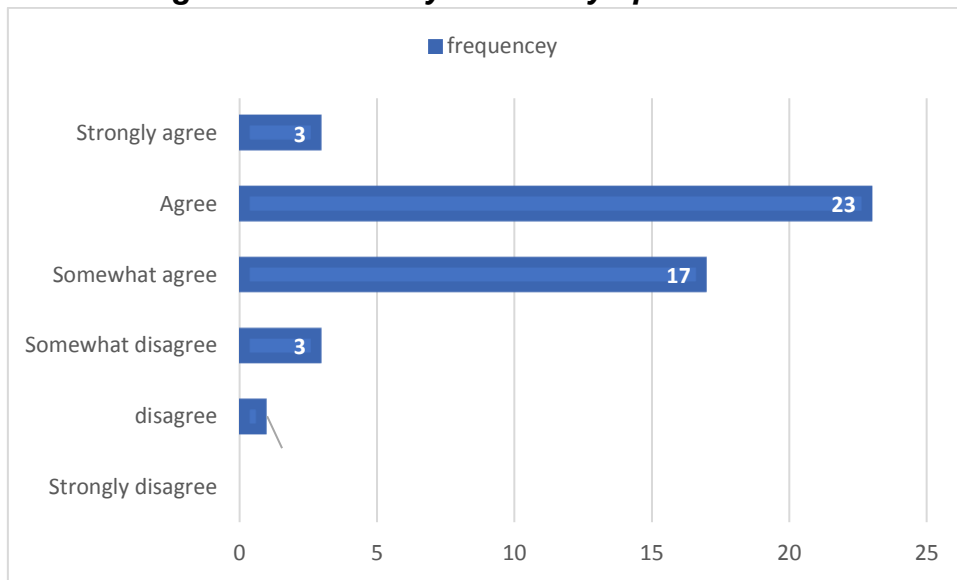


Figure 5. Bar graph showing frequency of responses for item 4.

Figure 5 presents another majority, showing that most of the SENCOs (>91%) who responded to the online questionnaire agreed to some degree that young people with ADHD tend to underestimate or not recognise how severe their symptoms are.

Item 5: Young people with ADHD tend to overestimate how severe their symptoms are.

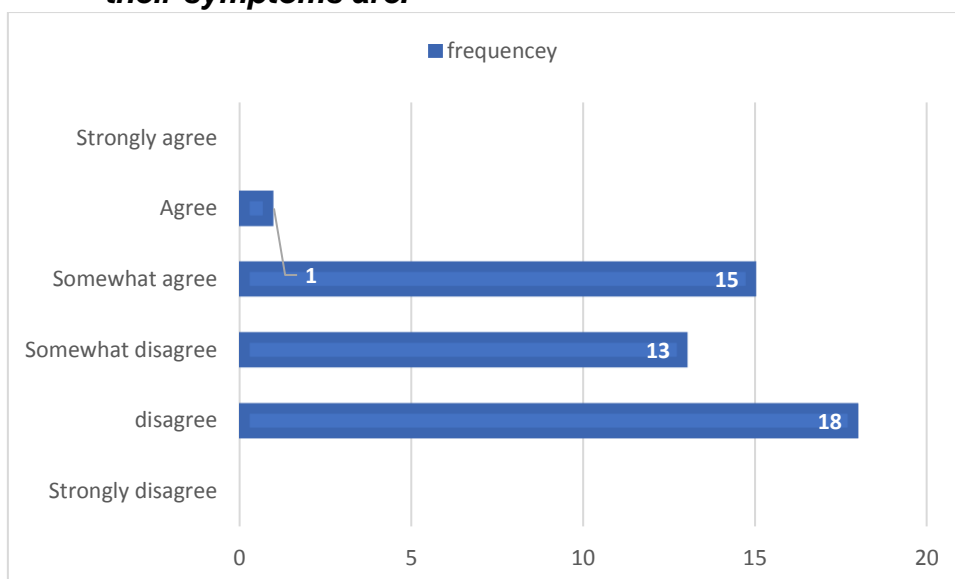


Figure 6. Bar graph showing frequency of responses for item 5.

Figure 6 shows that over half of the SENCOs (<65%) disagreed to some degree with the statement that young people with ADHD tend to overestimate how severe their symptoms are. Although these results are not as clear as some of the previous items, it is interesting to note that only 2% of participants selected a stronger positive response than “somewhat agree”.

Summary.

In summary there was no overall consensus among the SENCOs who responded to questions one to five about how young people with ADHD perceive their symptoms. However, although 64% of these SENCOs agreed (to some degree) that young people with ADHD tend to be aware of their symptoms, the majority did not believe that they were aware of the degree to which it affected them. 81% of participants felt that ‘young people with ADHD do not tend to know how severe their symptoms are’. Responses also indicated that 91% believed that young people with ADHD tend to underestimate the severity of their symptoms. This response was reinforced by the fact that 68% reported disagreeing (to some degree) with the statement that young people with ADHD tend to overestimate the severity of their symptoms.

5.1.2 Interview Findings.

For research question one, two subthemes and a main theme were selected from the two global themes: Knowledge of ADHD, and Young Person’s Awareness and Perceptions. These themes were believed to be most relevant to address this research question. Figure 7 is a thematic map to show the relationship between the global, main and subthemes which were selected. Each of the selected three themes are then discussed below.

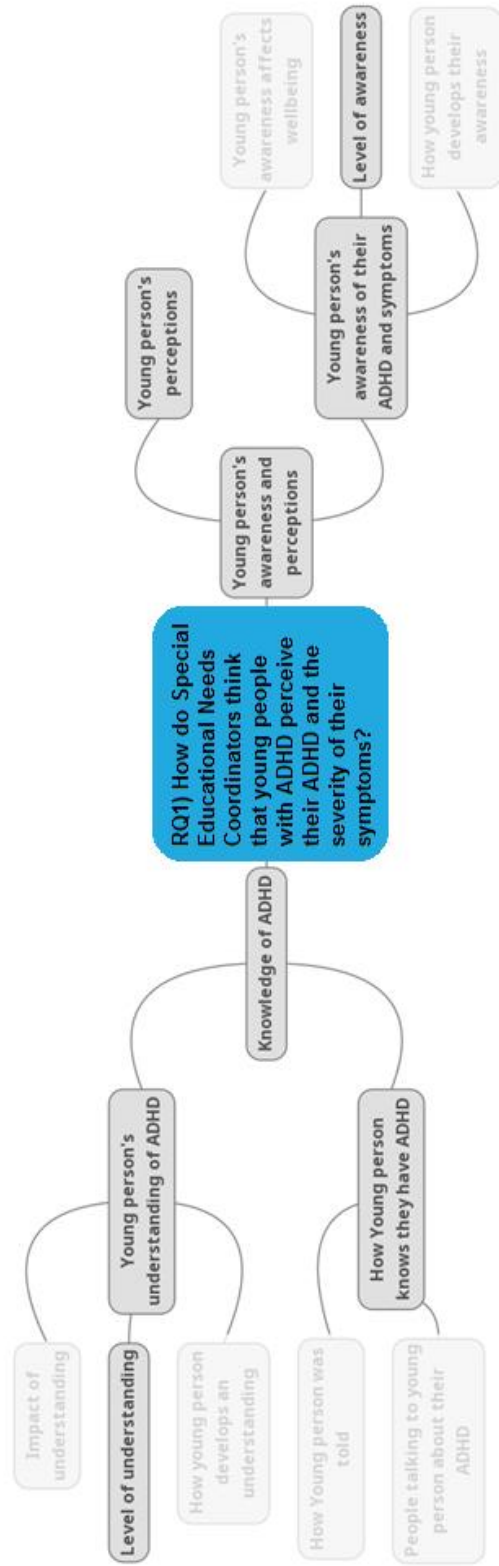


Figure 7. Thematic map for research question 1, Phase One.

Level of understanding.

This subtheme was selected from within the global theme Knowledge of ADHD, and the main theme Young Person's Understanding of ADHD. This theme captures the extent to which the SENCOs who participated in this study believe that young people with ADHD understand their ADHD. All six interviews indicated that these SENCOs did not believe that young people with ADHD have a good understanding of their ADHD. This finding was consistent across both primary and secondary SENCOs. When asked how the young person whom they were thinking of understood their ADHD, SENCO 2 replied "*I don't think they did*", while SENCO 1 replied "*This particular child, I don't think he understood it at all*". One SENCO spoke explicitly about how the young person was aware of the effects of ADHD but did not understand why they were there.

"The child didn't understand that he had ADHD, it was more a case of [...] he didn't grasp why he couldn't control the way that he was feeling, or the way that he was behaving and that made him really confused." – SENCO 5

Level of awareness.

This subtheme was from the global theme Young Person's Perceptions and Awareness, and the corresponding main theme Young Person's Awareness of Their ADHD. This theme illustrates the extent to which the SENCOs who participated in this study believe that young people with ADHD are aware of their ADHD and symptoms. Responses were mixed with regards to the level at which SENCOs believed young people were aware of their ADHD, although most SENCOs felt that young people were aware to some degree of the needs or symptoms with which they present. SENCO 4 gave an example of a young person describing how it felt having ADHD, suggesting that this young person was to some degree aware of their needs.

"[...]he said "it feels like I've got a permanent disco going on inside my head" and he went "I can't stop it"" – SENCO 4

However, a common theme throughout the interviews was the distinction between awareness and understanding. That is to say that SENCOs felt that most young people were aware of their symptoms, or of the fact that they had ADHD, but very few understood what they meant. This is illustrated using three quotes

below. When asked how aware the young person they had in mind was of their symptoms, SENCo 2 responded with the following.

“Initially, very aware of their symptoms, but didn't understand, in any way, shape or form, how or why.” - SENCo 2

These ideas were supported by SENCo 4 who discussed a young person who was not explicitly aware of their ADHD in such a way that they could name their needs, symptoms or diagnosis. However, this young person was aware of the ways in which they “struggled” in school.

“he knew that he struggled, but because he had a few complex needs, he knew he struggled in a few areas” – SENCo 4

Finally, there appeared to be a view that young people with ADHD were more aware of the level of support and provision in place for them, than they were of their own observable symptoms. This again suggests a level of awareness without the appropriate level of understanding and is illustrated below in an example given by SENCo 3.

“They are very aware of the hyperactivity stuff, the fidgety stuff, cause, you know, that's much more visible, in terms of the support you're getting for that, so "I've got a fiddle toy" or "I've got elastic bands round my chair leg" or "I've got a wobble cushion" you know, all those kinds of things, so it's kind of, that's what that's there for. So that's quite obvious if you like.” SENCo 3

Young person's perceptions of their ADHD.

This main theme came from the global theme Young Person's Perceptions and Awareness. This theme captures the ways in which the SENCos who participated in this research believe that young people with ADHD perceived themselves, their ADHD and their symptoms. A common theme was the idea that young people with ADHD perceived themselves as badly behaved or “naughty”. Two examples have been selected to illustrate how these perceptions may present themselves. The first example shows how young people with ADHD might develop a negative perception of themselves and their ADHD, based around the constructs of negative or challenging behaviour. In this instance SENCo 2 described a young person who he believed had developed a perception of themselves as badly behaved, which had created a “*Negative cycle*”.

“what happened with this particular instance, is that the child perceives themselves, as badly behaved, which then, sort of starts, I think, as a little bit then of a negative cycle, because they perceive their behaviour to be bad, which then means that they will play up to that to a certain extent.” – SENCo 2

In this second example, the young person was described as being distressed to receive a diagnosis of ADHD as they held preconceptions of what it meant to have ADHD based on his experiences of others with the same diagnosis. This illustrates further the perception that ADHD is associated with naughty or challenging behaviour.

“but when he got diagnosed, I don't really think it was explained to him, particularly well. so he came back to school, and he does a lot of work with our learning mentor, and his behaviour declined slightly and his self-esteem was lower, so our learning mentor was talking to him as well, and he came out and he was saying to us that, actually he thought he was naughty, cause he had a preconceived perception, the ADHD children were naughty children” SENCo 4

SENCo 4 went on to say, *“and he said “but I'm not naughty, so how can I have ADHD?””*

5.2 Research Question Two: How Do Special Educational Needs Coordinators Think Young People With ADHD Develop The Perceptions They Have Of Their ADHD And The Severity Of Their Symptoms?

In order to address research question two, the responses from items 6, and 12i to 12vi have been presented and then summarised below. Following this, the interview findings are presented and discussed.

5.2.1 Questionnaire results.

Item 6: Young people with ADHD have usually been well informed by external professionals (e.g medical practitioners) regarding the nature of their disorder.

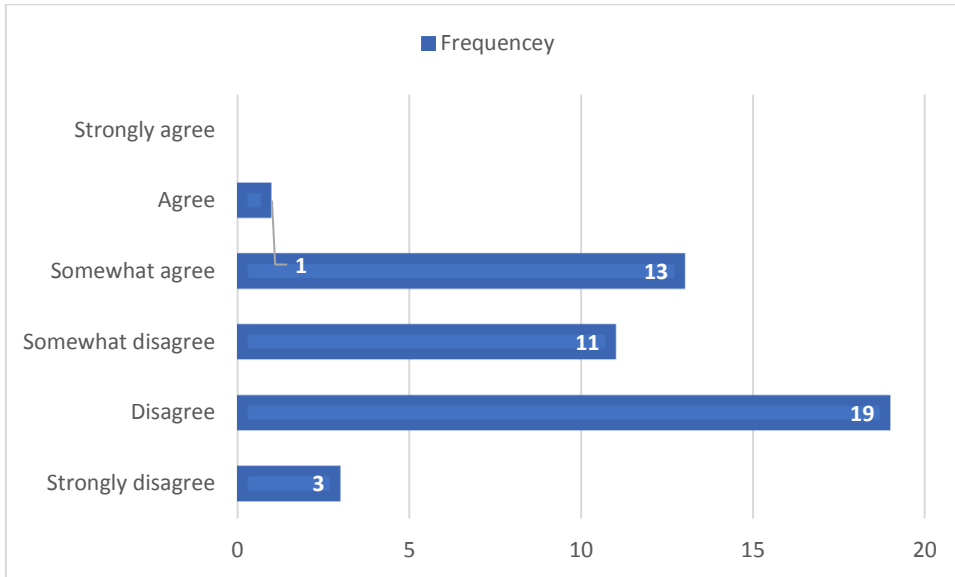


Figure 8. Bar graph showing frequency of responses for item 6

Figure 8 indicates that only a small minority (>29%) of participants felt that young people with ADHD were being well informed by external professionals. In this instance only 2% of participants felt more strongly than “somewhat” that young people were being well informed.

Item 12 - Based on the list below, how do you feel young people develop their perceptions of their symptom severity?

12i. Based on how the staff at their school treat them or talk to them.

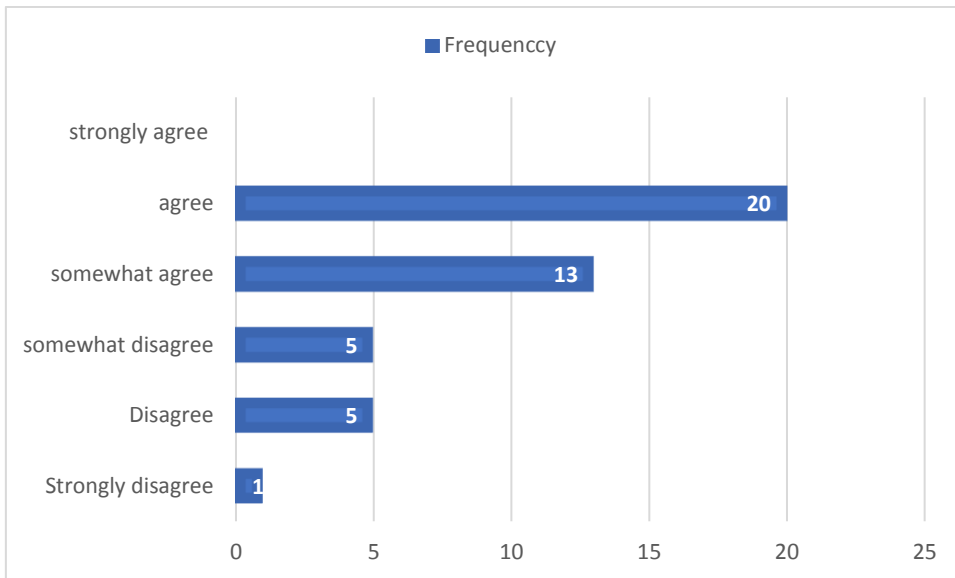


Figure 9. Bar graph showing frequency of responses for item 12i

Figure 9: suggests that the majority of participants (>70%) agreed (to some degree) that young people develop the perceptions they have of the severity of their ADHD symptoms based on how staff and their school treat them.

12ii. Based on how their parents treat them or talk to them.

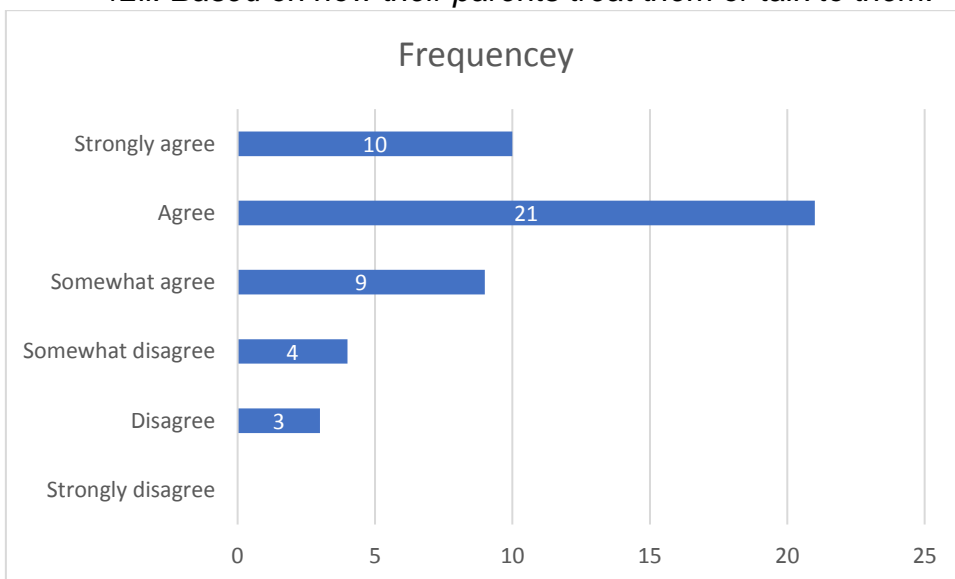


Figure 10. Bar graph showing frequency of responses for item 12ii

Figure 10 shows that most participants (<85%) felt that young people develop the perceptions they have of the severity of their ADHD symptoms based on how their parents treat them or talk to them.

12iii. By comparing themselves to their peers or siblings

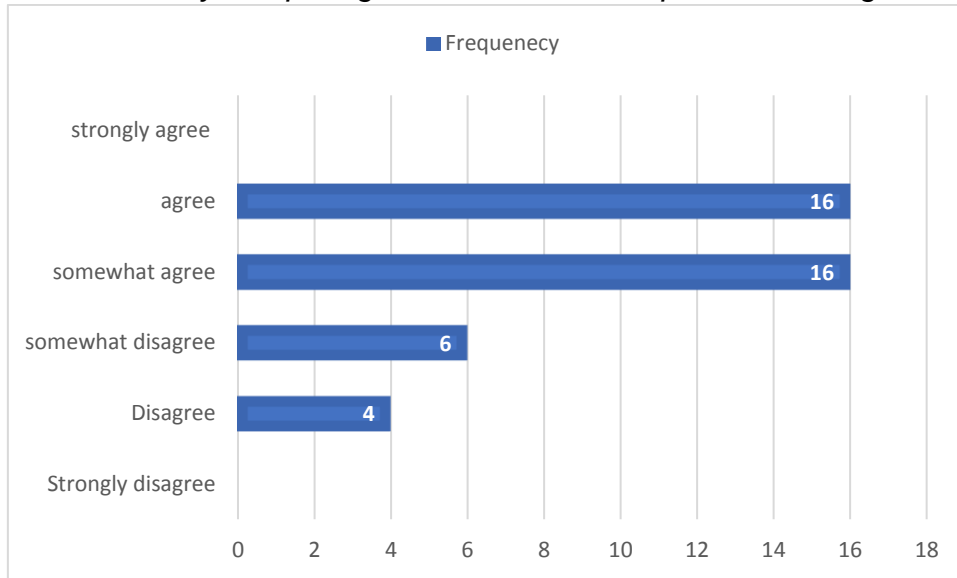


Figure 11. Bar graph showing frequency of responses for item 12iii

Figure 11 shows that three quarters of participants (>68%) believed that young people develop the perceptions they have of the severity of their ADHD symptoms by comparing themselves to their peers or siblings.

12iv. Based on how their peers or siblings treat them or talk to them.

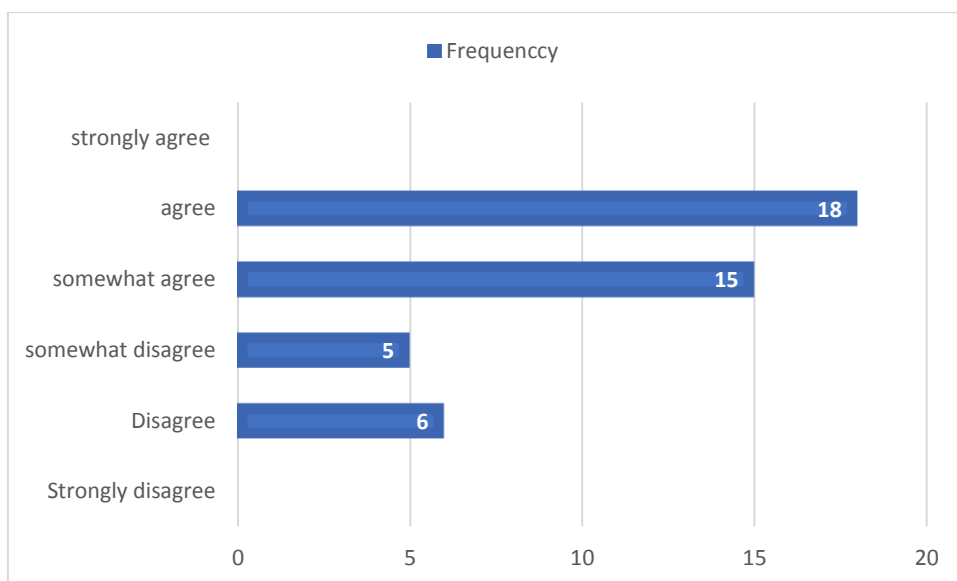


Figure 12. Bar graph showing frequency of responses for item 12iv

Figure 12 shows that a large proportion of participants (>70%) believed that young people develop the perceptions they have of the severity of their ADHD symptoms based on how their peers or siblings treat them or talk to them.

12v. Based on how they are treated in the wider community.

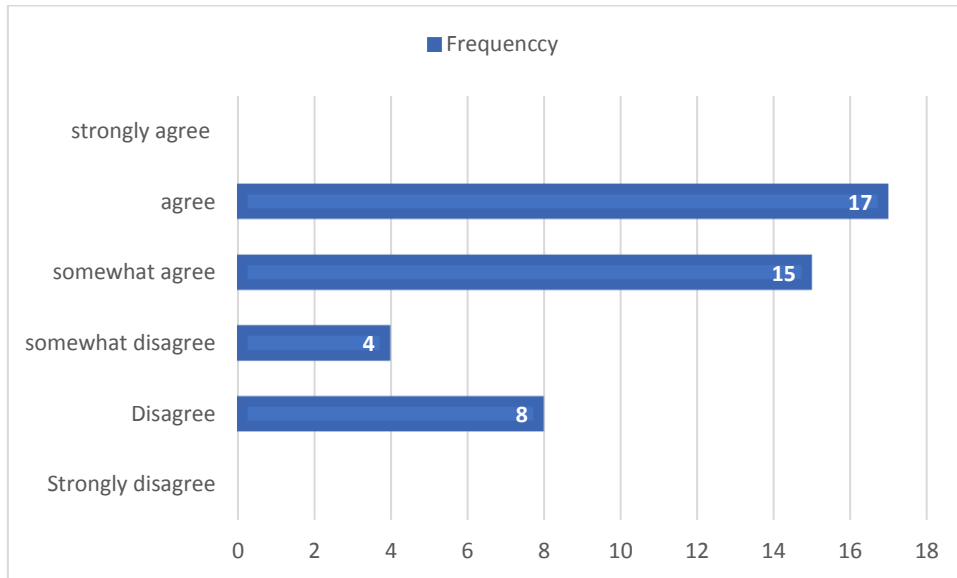


Figure 13. Bar graph showing frequency of responses for item 12v

Figure 13 shows that 73% of participants agreed to some degree that young people develop the perceptions they have of the severity of their ADHD symptoms based on how they are treated in the wider community.

12vi. By being self-reflective about their own feelings and/or behaviours.

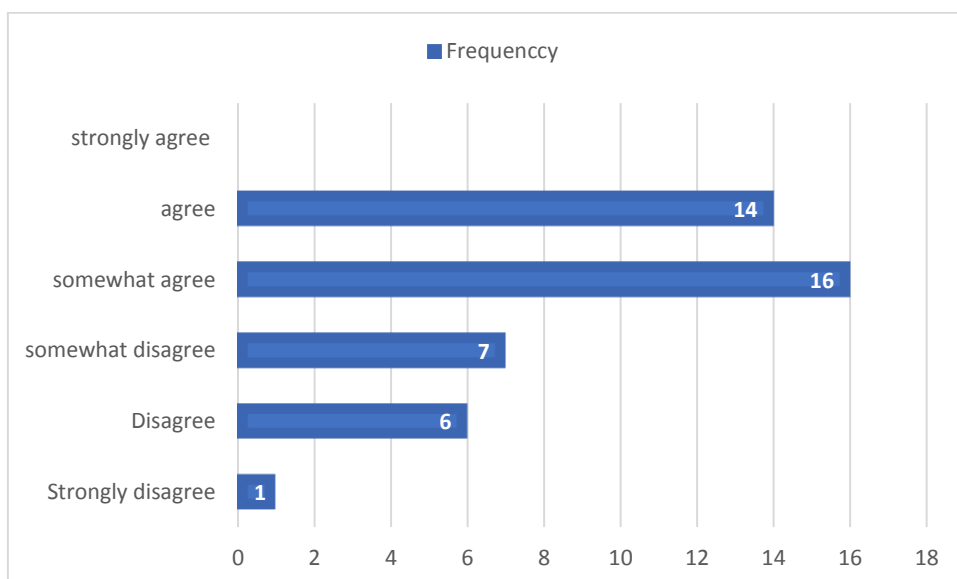


Figure 14. Bar graph showing frequency of responses for item 12vi

What is important to note here is that the fewest number of participants agreed to this item (63%). This suggests that although participants felt there may be a component of self-reflection, some were sceptical of the notion that young people develop the perceptions they have of the severity of their ADHD symptoms by being self-reflective about their own feelings and/or behaviours.

Summary of online results.

These results suggest that SENCOs believe young people with ADHD are developing their perceptions based on a number of different inputs. SENCOs seemed to feel most strongly that young people were being influenced by their parents with an agreement response of 81%, while the least favoured selection was self-reflective behaviours. As reported in the qualitative findings below as well, most participants felt that young people were not well informed by external professionals.

5.2.2 Interview findings.

In order to address research question two, the following main and sub themes are discussed in turn: How young people develop an understanding of their ADHD, How young person develops their awareness, How young person was told, Parents, People Talking to Young People About Their ADHD, Young Person Comparing Themselves to Others, and Perceptions of Others. These are represented in the diagram below.

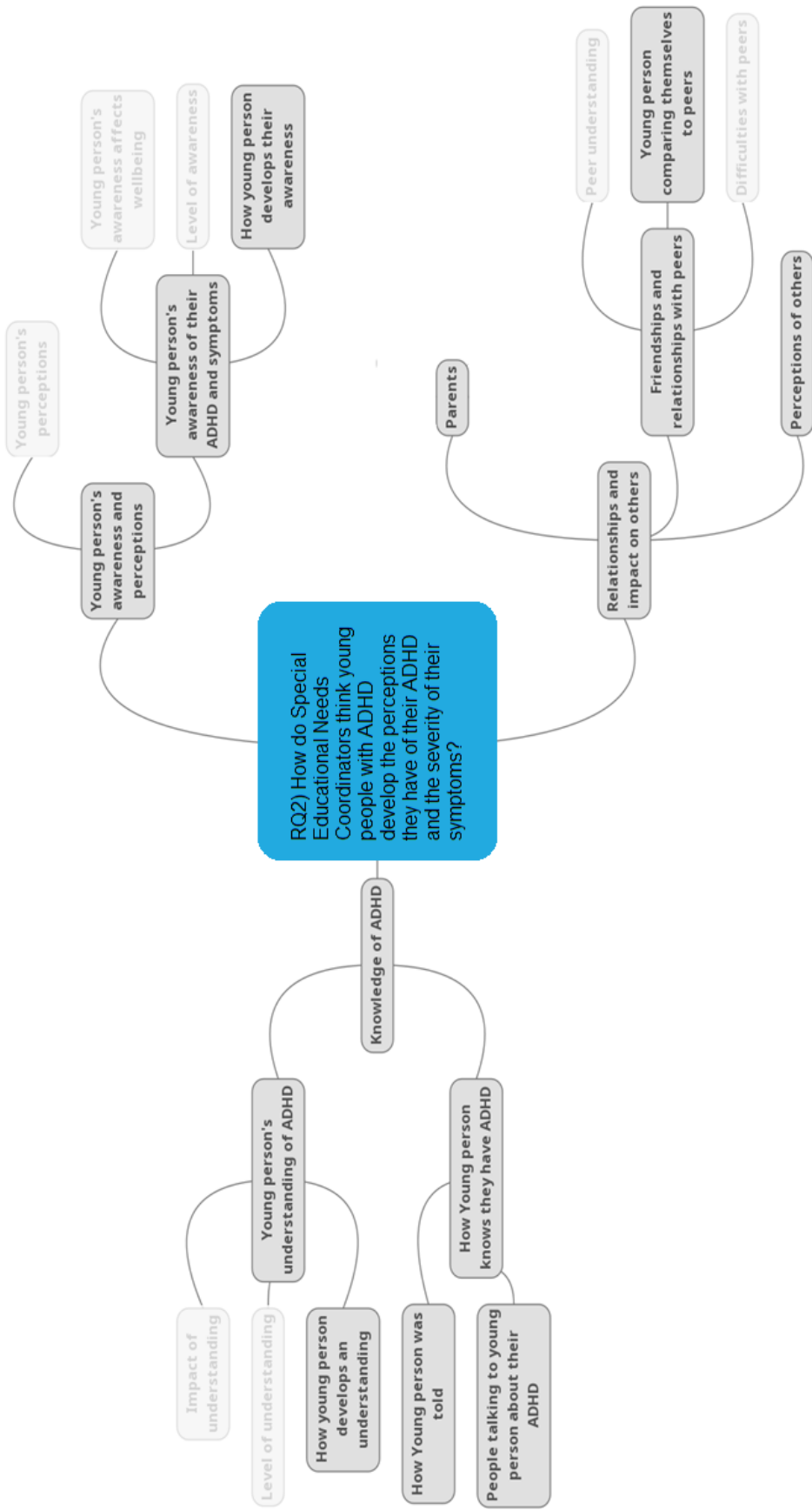


Figure 15. Thematic Map for research question 2, Phase One.

How young people develop an understanding of their ADHD.

This sub theme came from the global theme Knowledge of ADHD and the main theme Young Person's Understanding of ADHD. This theme covers the ways in which the SENCoS who participated in this study believed that young people with ADHD may be developing an understanding of their ADHD. There were two key findings that emerged from this theme. First, was a consensus across all interviews that young people do not have a good understanding of their ADHD and that this was largely a result of adults not providing adequate explanation. Second, that those young people who had developed some form of understanding of their ADHD are thought to be developing it in response to the information that they are being given with regards to their medication, and the self-reflection they have of the effects of the medication.

Below is an example from SENCo 2 of the view that young people are not being appropriately educated by the adults around them.

"I don't remember at any stage, I include myself in this actually, which is a bit embarrassing, but I don't remember any stage, anybody actually sitting down with the child, and saying "this is your diagnosis, this is what it means for you"

A number of the participants placed the responsibility for this inadequate explanation onto the paediatricians. SENCo 4 said they did not think *"Enough is done from the paediatric point of view, to explain to the children what specifically is ADHD"*. SENCo 1 reported a similar opinion, explaining their view that although a paediatrician may give parents some information at the initial appointment, neither parents nor paediatricians then made any effort to support the young person's understanding.

"They were at the paediatrician when the diagnosis was made so they heard it there, and then parent explained to them the medication they were having was for that. but I don't think they ever had it explained to them what it actually was, and what it looked like."

There is suggestion, however, as illustrated in the quote from SENCo 2 below, that some young people are thought to be developing some form of understanding around their diagnosis.

“because I think as the young person gets older, they will learn, it’s amazing how unbelievably adaptive young people are, and the young person will learn what works for them and will learn how to do that.”

What needs to be explored, therefore, is how young people are developing these understandings and what is influencing them as they do this. From the findings of this research, one possible answer is that young people are acknowledging the effects of their medication and making inferences through this. This is illustrated below in a quote from SENCo 6.

“the ADHD she is medicated for, and I think she understands the impact that the medication has on her, so I think she has got a relatively good... she's got a comparison of who she is on the medication and when she isn't, and I think she can see the difference.”

How young person develops their awareness.

This sub theme came from the global theme Young People’s Perceptions and Awareness, and the main theme Young Person’s Awareness of Their ADHD and Symptoms. This theme illustrates how young people become aware of their ADHD symptoms and any differences between them and their peers.

SEnCo 6 spoke about a mother who she believed was hypervigilant of her child’s needs. She suggested that the mother’s hypervigilance made, her daughter very aware of the levels of support she needed.

“I think that mum has massively kind of, overestimated and makes a bigger deal out of them than there are and I think that some of that has then worn off on her over the years. So I think that this student is very aware of the support that she needs”

In line with the results above, the most common suggestion from all participants, was that young people develop their awareness through the effects of their medication. This is illustrated by a later quote from SENCo 6.

“She is quite aware, cause any odd day, that she has forgotten to take her medication in the morning, she has always come to see me, straight away, and said “I haven't had my medication” [...] she's had her times, when she hasn't taken her medication and felt so much that she can't concentrate in class, that she's had to have time out, come and see me, so I think she is aware of when it is affecting her.”

How young person was told.

This sub theme came from the global theme Knowledge of ADHD, and the main theme How a Young Person Knows They Have ADHD. This theme covers any explicit reference given to how the young person was told that they have ADHD. All participants reported that the young person was either told by a parent, or a paediatrician at the point of diagnosis. The following theme, Parents, explores this in further detail. It also provides some examples of the associated risks.

Parents.

This main theme came from the global theme Relationships and Impact of Others. This theme captures the extent to which the SENCoS who participated in this research believe that the parent's understanding, skills, perceptions and abilities might shape young people's understanding and perceptions of their ADHD.

SENCo 2 expressed their belief that the understanding held by parents and adults around a child is more important than the understanding of the young person. This SENCo believes that it is the responsibility of the adult and not the young person to manage their ADHD until they are cognitively mature enough to begin managing it themselves.

"In all honesty, I don't know how much of a different impact it would make for the child to understand. I think what's much more valuable, is for the grownups around that child to understand, be it parents or schools, and the reason I say that is, a child of 11 or 12, isn't yet of a cognitive maturity to really understand, how structuring things differently, will impact on them differently"

However, what was clear from all the interviews was that the SENCoS who participated in this study believed that parents are not well equipped with the knowledge and understanding of ADHD that they need to be able to support their children. Further, that paediatricians should be offering more support. This is summarised in the quote below.

"I think it would be helpful, in the diagnostics process, for it to be a little bit more work with parents about that sort of thing. You know, how can you talk to your child about this? If they have ADHD, how could you support your child to understand their own needs." – SENCo 4

People talking to young people about their ADHD.

This sub theme came from the global theme Knowledge of ADHD, and the main theme How Young Person Knows they have ADHD. This theme illustrates instances reported by the SENCOs who participated in this research of people speaking with young people about their ADHD.

Interviewees did not make many references to school staff having conversations with young people about their ADHD, and any references that were made appeared to be predominantly around discussing challenging behaviour as illustrated below in a quote from SENCO 2.

“So actually, I think, really part of our job in education, with these young people, is for us to better understand what that child’s triggers might be. Now in my experience, the most successful way of doing that, is to sit down with that child, and in a language they understand, talk them through what the issues are. So you could print off the behaviour logs, for example, and say “look, this is coming up all the time, what’s causing it?” the problem is, sometimes, they will just say “I don’t know” in which case that’s a bit more difficult. But sometimes they will say “well I don’t get this” or “I struggle with that” or “I struggle with the other” and that way you’re educating them at the same time.”

Young person comparing themselves to others.

This sub theme came from the global theme Relationships and The Impact of Others, and the main theme Friendships and Relationships With Peers. This theme captures how the SENCOs who participated in this research believed young people with ADHD compare themselves, their behaviour and their experiences to those of their peers. The SENCOs who participated in this research appeared to believe that young people with ADHD were regularly comparing themselves to their peers. This was most commonly described as not understanding why they are experiencing difficulties where their peers are not. SENCO 2 spoke about a young person with ADHD who he believed did not feel “normal” because of the comparisons he was making between himself and his peers.

“just wanted to be, as they would put it sometimes “normal” they didn’t understand why they were behaving on impulse in the way that they were, and therefore, why they were different to other people, they could see their friends who could

concentrate, sit still, engage, whatever, and they couldn't, and they didn't know why."

Perceptions of others.

This main theme came from the global theme Relationships and The Impact of Others. This theme illustrates the ways in which the SENCOs who participated in this research believe others are perceiving young people with ADHD. It appeared to be the view of these SENCOs that other people's perceptions and consequential behaviours were an important influence in how young people with ADHD perceive themselves and their ADHD. This theme is explored in much greater detail throughout Research Question 3. The only reference presented below is an example given by SENCO 3 of the impact that different approaches to explanation can have on a young person.

"...where it was presented very positively, I think he, it was almost a relief, to kind of hear that there was something there, that, almost wasn't his fault, and that people, kind of, would understand that he had that difficulty, and there were things that could be done to support him a little bit more. So, I think that in some ways, there's that, almost relief that "it's not just me being naughty". Whereas with the ones where it is presented in that way of, you know, of "you're such a nightmare and you've got ADHD" and you know it is more of a negative thing, and they hear a lot of that as an excuse [...] so again I think it's quite different, depending on, the individual. and the family and all of those circumstances. "

5.3 Research Questions Three: How And To What Extent Do Special Educational Needs Coordinators Believe That These Perceptions Impact Their Wellbeing?

In order to address research question three, the responses from items 7 to 11 have been presented and then summarised below. Following this, the interview findings are discussed.

5.3.1 Online questionnaire results.

Item 7. The better a young person understands their ADHD the more likely they are to experience positive wellbeing.

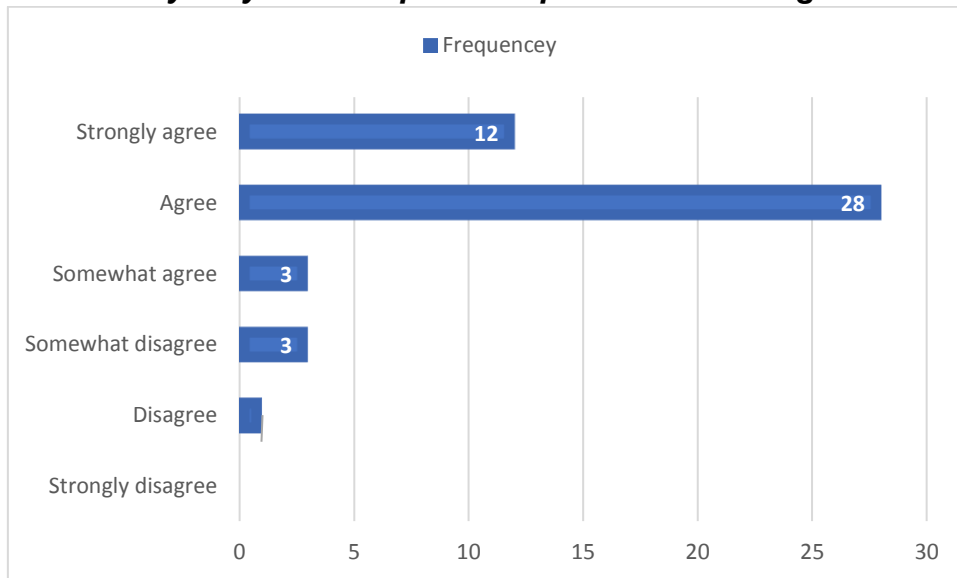


Figure 16. Bar graph showing frequency of responses for item 7

Figure 16 shows that the majority of participants (>80%) believed that young people having a better understanding of their ADHD was likely to have a positive impact on their wellbeing.

Item 8. A young person who does not recognise the severity of their symptoms is at higher risk of poor wellbeing.

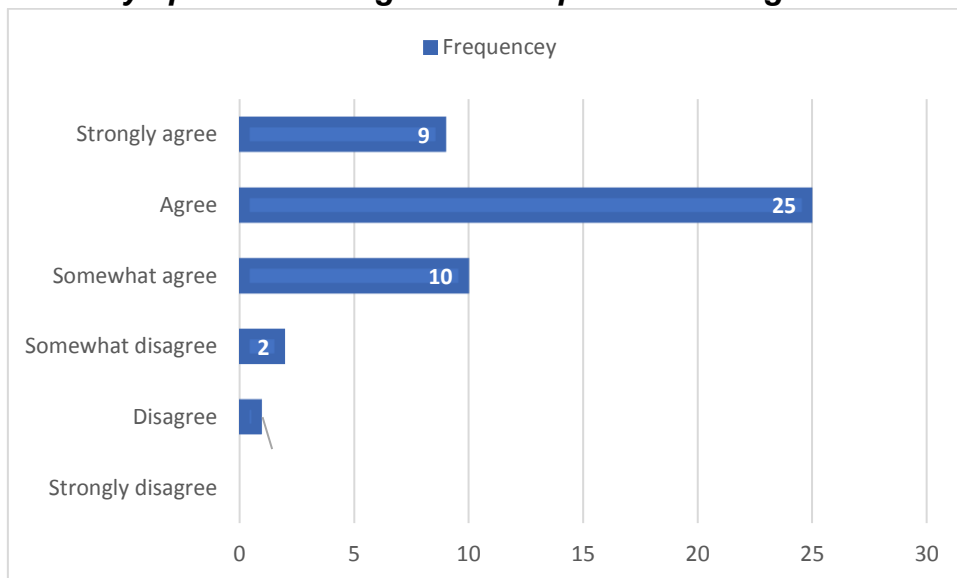


Figure 17. Bar graph showing frequency of responses for item 8

With a 19% “Strongly Agree” response rate, Figure 17 shows a clear majority of the participants (>93%) believed that young people who do not recognise the severity of their symptoms are at higher risk of experiencing poor wellbeing

Item 9. The better a young person recognises the severity of their symptoms, the more likely they are to achieve positive academic outcomes in school.

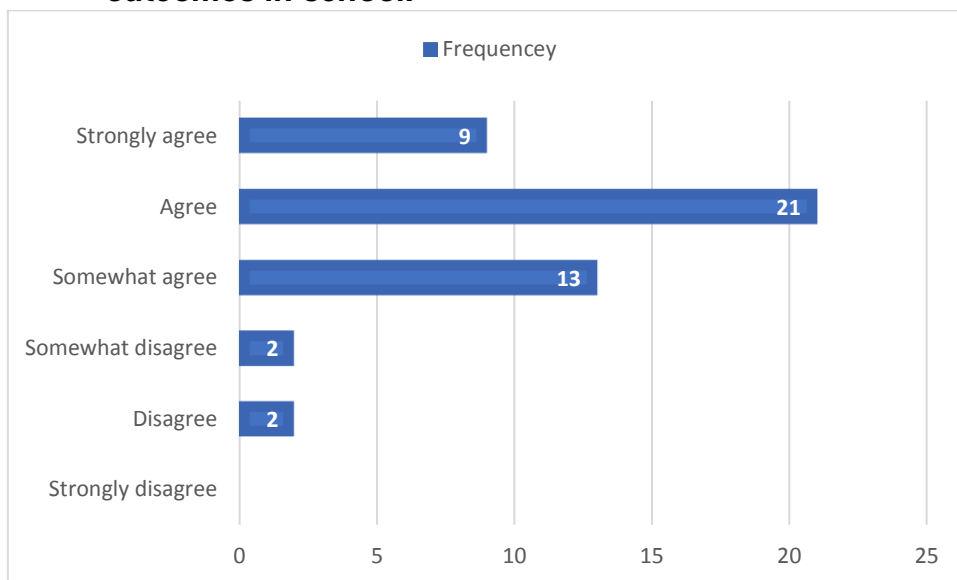


Figure 18. Bar graph showing frequency of responses for item 9

Presenting similar figures to those above, Figure 18 shows a strong majority of participants (>91%) felt that young people who were more aware of the severity of their symptoms were more likely to achieve positive academic outcomes. Suggesting that these SENCOs believe that the degree to which young people are aware of their ADHD symptoms, directly relates to their academic progress.

Item 10. Schools should support young people with ADHD in better understanding their diagnosis.

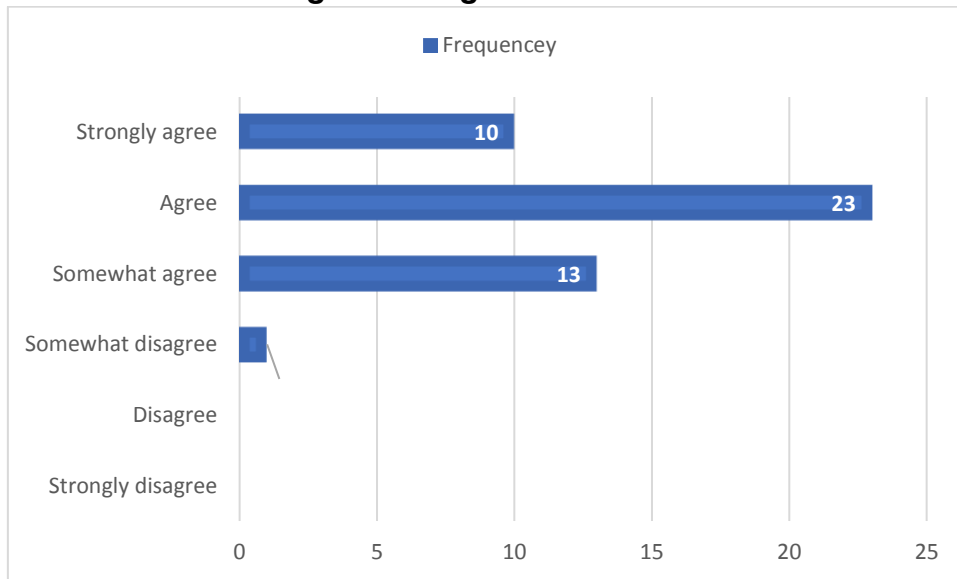


Figure 19. Bar graph showing frequency of responses for item 10

This item produced the most clear-cut responses of all those included in this research. Figure 19 shows that not only did almost all participants agree (46 out of 47, >98%) that young people should be supported in better understanding their ADHD, but that the only person who disagreed only disagreed “somewhat”.

Item 11. Schools should support young people with ADHD in recognising the severity of their symptoms.

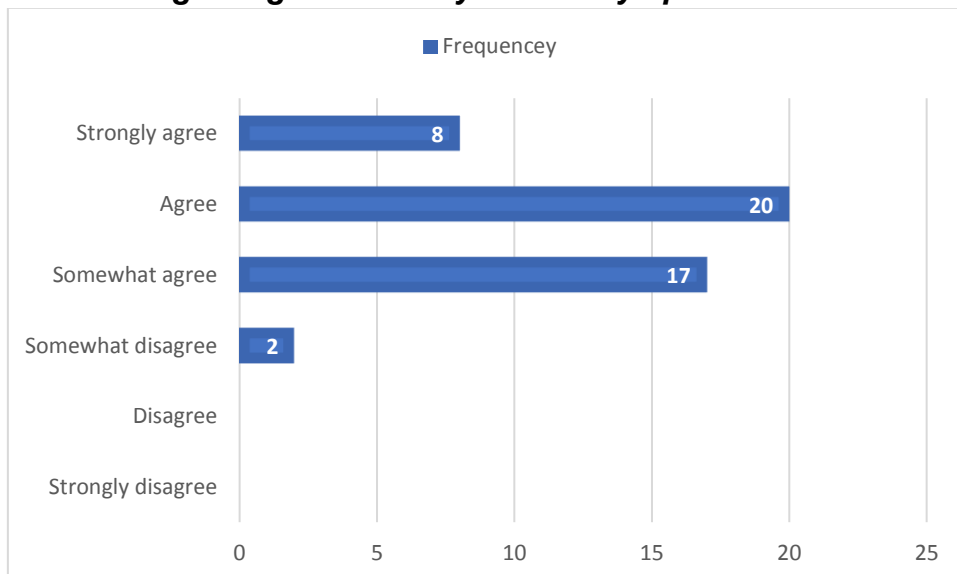


Figure 20. Bar graph showing frequency of responses for item 11

Similar to the findings of Item 10, Figure 20 show a clear majority of participants (>95%) agreeing that schools should support young people with ADHD in recognising the severity of their symptoms.

Summary of online results.

All of the data from these items supports the notion that we should be supporting young people with ADHD in better understanding their symptoms and diagnosis. 82% of participants believe that young people who have a better understanding of their ADHD are more likely to experience positive wellbeing, and 92% believed that those who are not aware of the severity of their symptoms were at greater risk of poor wellbeing. Finally, 92% believed that the more aware young people are of the severity of their symptoms, the greater the chance of academic success. It is clear from these findings that the view of the SENCOs who participated in this research is that the level of understanding, and the perceptions that young people have of their ADHD has an impact on their wellbeing.

5.3.2 Interview findings.

For research question three, the following global, main and subthemes were selected: The global theme Challenges in school including the main themes ADHD as a Barrier, School Feeling Unskilled and Transition; The global theme Symptoms, Feelings and Behaviour, including the main themes Mental Health and Wellbeing, and Symptoms and Behaviour, and the sub themes Feelings and Wellbeing, Challenging Behaviour, and Symptoms and ADHD Associated Behaviours; the global theme Diagnosis and Medication including the main themes Medication and Impact of Diagnosis; the sub theme Impact of Understanding from the global theme Knowledge of ADHD, and the sub theme Young Person's Awareness Affecting Wellbeing from the global theme Young Person's Awareness and Perceptions; finally the global theme Relationships and Impact of Others, including the main themes Friendships and Relationships With Peers and the Perceptions of Others, and the sub themes peer Understanding and Difficulties with Peers.

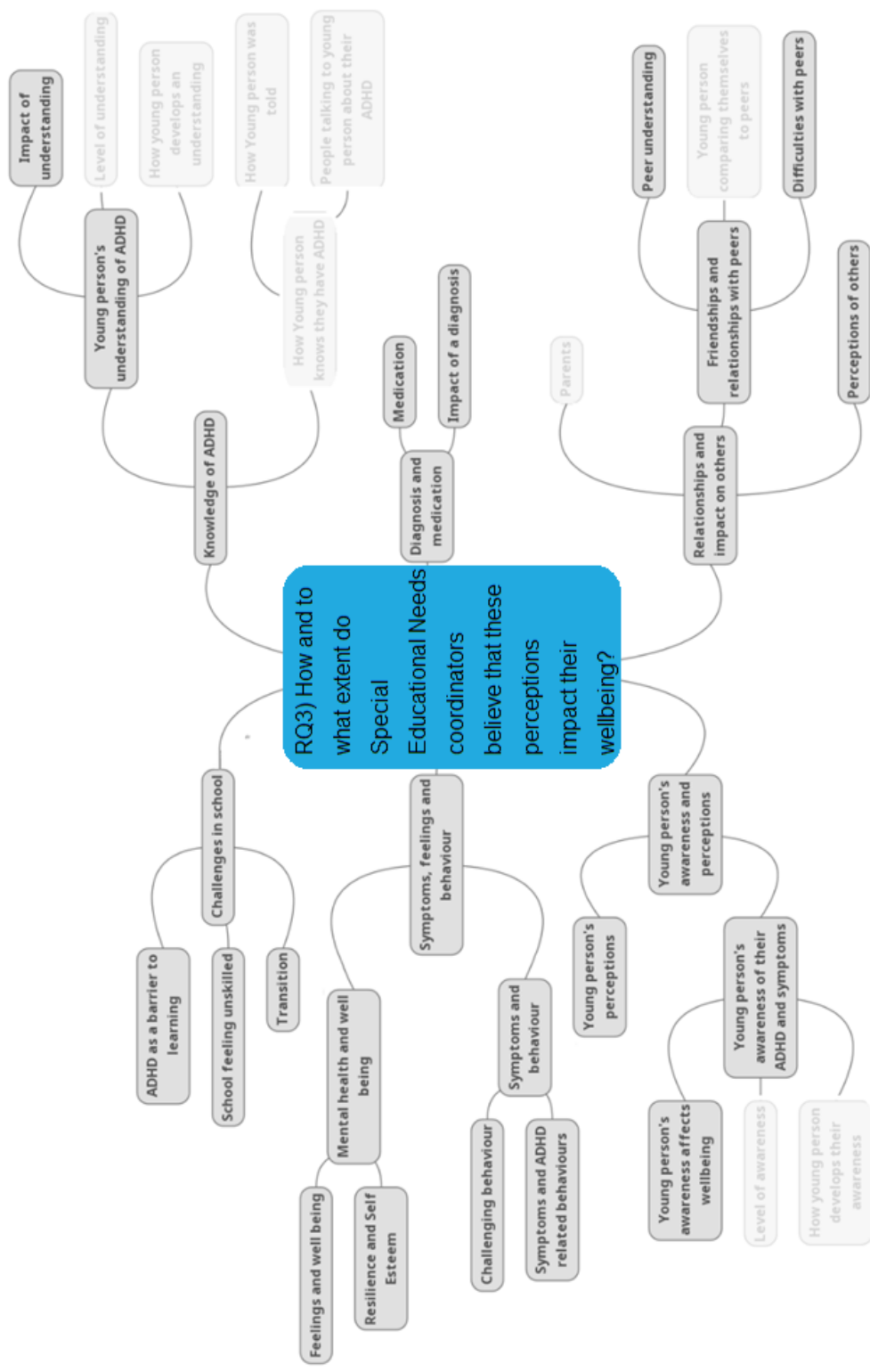


Figure 21. Thematic Map for research question 3, Phase One.

Challenges in School.

Challenges in School is a global theme that explores the challenges faced by staff and by the young people with ADHD in an academic setting. Within this global theme there are three main themes, which will now be discussed in turn: ADHD as a Barrier, School Feeling Unskilled, and Transition.

ADHD as a barrier.

The consensus over all six interviews was that young people with ADHD are not achieving at the same levels as their peers. This is illustrated in the quote below from SENCo 3, who described feeling that this was a more or less universal problem. She also discussed the issues around some of the methods used to support young people with ADHD.

“Most of the children I’ve worked with, with ADHD I would say, they’re not attaining as well as they should be. I can only think of one, where he’s actually still got really good levels of attainment. Because obviously, their concentration and focus on tasks, is so limited, so they’re needing a lot of support, a lot of re-focussing, a lot of tasks being broken down, and even the things that you’re doing, to try and support them, so things like having movement breaks, that kind of thing, you know, that’s losing out on learning time.”

There were core views which emerged around this idea that young people with ADHD were struggling in schools. First, was that the SENCos who participated in this research felt that the staff working with young people with ADHD had a duty to better understand the young person’s needs. This is demonstrated in the quote below from SENCo 1.

“I think staff sometimes expect too much from them in the wrong ways. So they may expect them to sit and write for an hour, when actually they need to write for fifteen minutes and have a movement break, and then come back to it. I think staff need to be more aware of strategies that can be used to support the children, rather than than just assuming that they are not capable.”

The other clear consensus across all interviews was that the mainstream school system is not adequately structured or supported to meet the needs of young people with ADHD. This view is illustrated using two separate quotes below from SENCo 2. First, he describes in detail the incongruence between the needs of young people with ADHD and the traditional classroom setting, second he uses an analogy to describe the problem.

“You put someone in a traditional classroom, for an hour, you know they’re going to struggle to sit still for 15 or 20 minutes, and then you wonder why they can’t. You know, it would be like putting me on an American football field, and I don’t know the rules, and saying yeah go play. What am I going to do?”

“It’s not that they weren’t academically capable, it’s just that the way that the school day is structured, the way that lessons are timed and structured, didn’t give them a fighting chance of actually being able to show what they could do academically. That then had the behaviour effect, which meant that they missed loads of lessons, through being kicked out, or excluded. which then just compounded their inability to keep up academically.”

However, where some SENCOs were calling for the mainstream system to be improved, others discussed the option of placing young people with ADHD in special schools in order for their needs to be met. Below is an example from SENCO 5 who was exploring options outside of mainstream education to support a young person whose needs have resulted in him being excluded from most lessons

“I think a mainstream school is just, the environment itself doesn’t work for him, doesn’t suit him, he needs to be somewhere smaller, that’s a lot more focused, ratio of adults to children would be a lot higher for him.”

School feeling unskilled

This theme explores the feelings of helplessness described by the SENCOs with regards to their teaching staff and the barriers to their capacity to effectively support young people with ADHD. SENCO 2 discussed the limits on time, and teacher capacity to deliver.

“I think staff are quite well trained generally, but I just don’t think they have the time, is the brutal truth. You’ve got 31 kids in a room, you know, and you’re being bashed for exam results. So yeah I know what, lets also ask you to devise a whole different lesson for child A. [...] not going to happen.”

SENCO 2 then went on to discuss the outcomes of this in the context of challenging behaviour, Child and Adolescent Mental Services (CAMHS), and young people with ADHD underachieving.

“So as a knock on effect of that, they underachieve academically and then because of their behaviour, and that behaviour not always being understood,

certainly not in the early days, and with CAMHS taking such a frighteningly long time to make diagnoses, you then get a behaviour bash. So, you've got this young person, who knows there's something wrong, is confused, and probably angry about that, is underachieving academically and then also been told their badly behaved. Which completely pulls any rug of any self-esteem, out from under them. So I think those two, sort of pincer movements things on that child, is the reason why there is such a high SEMH limit."

Another example of schools feeling unable to meet the needs of their students due to financial or timeconstraints is presented below using a quote from SENCo 5.

"one thing that's recommended is CBT, but it's a case of obviously not every school can afford to follow that through"

Transition

This sub theme explores the difficulties that people with ADHD might face when transitioning between primary and secondary education. These findings suggest that a well-managed transition could be a component in promoting positive wellbeing in young people with ADHD. This is illustrated below in a quote from SENCo 2, who spoke explicitly about the risk to mental health that presents when the move from primary to secondary is not well managed.

"The other big divide is between primary and secondary. In primary school, you're going to have a very bubbly, 5,6,10, whatever, year old. There's nothing wrong with them, they're just a very bubbly young child. But you track that child forwards, to the age of 12, generally starting to grow out of it. You certainly track that forwards, child, to the age of 13, 14, and they have grown out of it. So, when children transition, from primary to secondary, they're blissfully unaware that they might be different. and then you get towards the end of year 7 and into year 8, and it starts to become quite striking? comparison, and that is when, if you're not very careful, these kids then get mental health issues."

Mental Health and Wellbeing.

Mental health and Wellbeing is a global theme that explores any reference made to the mental health and wellbeing of the young person in relationship to their ADHD. Within this global theme there were two main themes, which will now be discussed in turn: Feelings and well-being, and Resilience and Self Esteem.

Feelings and wellbeing.

There were two emotions which were commonly referenced throughout the interviews, these were feelings of frustration, and feelings of sadness and distress.

A number of participants discussed instances of young people feeling frustrated by their own symptoms and behaviour. This is illustrated below in a quote from SENCo 1.

“I think she became frustrated by the inattentiveness, because she wanted to learn, and then couldn’t, because she couldn’t focus on it long enough”

While young people’s feelings of frustrations were invariably associated the symptoms of ADHD, their feelings of distress were described by SENCos in two distinct ways. Firstly participants expressed the idea that young people with ADHD were more emotionally volatile, as demonstrated below in a quote from SENCo 1.

“Very very bouncy, couldn’t stop talking, very emotionally...I want to say unstable, but I don’t mean that, her emotions used to be very changeable very quickly”

However, there was also some suggestion that young people could be upset as a direct response to being diagnosed. When asked how they believed the young person felt about receiving a diagnosis, SENCo 4 said *“Devastated initially, devastated”*.

Resilience and self esteem.

All SENCos who participated in this research reported believing that ADHD had a significant and negative effect on the young person’s self-esteem. This is illustrated in the quote below from SENCo 1

“I think they affected her self-esteem, she spent a long time feeling quite... quite down on herself, and not understanding that her behaviours were like they are and I think she still does have days like that”

What is interesting to note here, and is directly related to the aims of this research, is that SENCo 1 also discussed what she believes the consequences are of young people overestimating their symptoms. Her views are represented in the excerpt below. This SENCo feels that young people who overestimate the way that ADHD affects them are less likely to develop the levels of resilience they need to overcome their difficulties

"I think it'd have an adverse effect, because they would almost not develop the resilience and the skills to fail. So if they think they are always going to do something because of their ADHD they might be prepared never to have a go, which would then be a barrier to their, their self-esteem and their self-confidence, that feeling of pride they'd get, by achieving something, and pushing themselves to a limit they might be scared to fail."

Symptoms and behaviour.

This is a main theme that was extracted from the global theme Symptoms, Feelings and Behaviour. This theme explores any reference to ADHD Symptoms, and behaviours which may be associated with ADHD. This theme also explores challenging behaviour. Within this theme there are two sub themes which will now be explored in turn: Challenging Behaviour, and Symptoms and ADHD associated Behaviours.

Challenging behaviour.

Challenging behaviour in various forms came up frequently throughout the interviews. It was evident from these interviews that the SENCOs who participated in this research associated ADHD with challenging behaviour in school.

A common theme around challenging behaviour was the difficulties that are presented when trying to distinguish between ADHD symptoms, and challenging behaviour that staff believe the young person should be able to control. The consensus view was that ADHD symptoms can be challenging for both the young person, and the adults around them. However, participants argued that it is the adults who are find these- behaviours challenging who need to develop their understanding. The argument being that without this understanding, adults risk perpetuating the challenging behaviour.

In the excerpt below SENCO 3 talks about the complicated nature of making an assessment between ADHD associated and non-ADHD related challenging behaviours.

"I think it's difficult sometimes, because everyone's an individual, so two children with ADHD, you know, one of them may be naturally more inclined to be slightly less compliant, and so on, anyway, even if that ADHD hadn't been there you know, you just don't know do you."

Three quotes from SENCo 2 have been presented below, each slightly different and highlighting the potential risks of the adults around young people perpetuating bad behaviour due to mis-management of their needs. First SENCo 2 describes young people with ADHD giving up in response.

“Imagine going through, what was then, six hours of lessons a day, 5 days a week. genuinely trying your best, and constantly being told that you’re being poorly behaved or you weren’t good enough, in some way, shape or form. I think if you do that to any person, there’s going to come a point, where they basically give up”

“I know, there was a certain amount of “I find this really hard, I can try my best and I know I’m going to get told off, and then I look dumb [...] or, I can play up to this, I can be the funny naughty kid, which means I’m going to get told off, and I’ll probably get sent out, but that’s going to happen anyway, so at least I get sent out with a bit of kudos”

“Yeah “and some control, and then don’t have to worry about sitting and writing this essay... or whatever it might be, because I’ve been kicked out” rather than try and write the essay, fail anyway, and then get kicked out.”

Symptoms and ADHD associated behaviours.

The most common symptoms associated with ADHD are inattentiveness, hyperactivity and impulsiveness. All of these symptoms were referenced across the interviews, in varying degrees of severity. The most commonly referenced, however, was impulsivity. Impulsivity was described as having a negative effect on the young person for two reasons, first as illustrated below in a quote from SENCo 6, because it led to the sorts of behaviours that teaching staff find difficult to tolerate.

“Impulsivity is quite a big one, she doesn’t think before she speaks, quite a lot, and that can result in behaviour sanctions and things like that, or teachers having more of a negative view of her, cause she can be quite argumentative because she isn’t thinking before she speaks”

The second consequence of impulsivity was the idea that young people feel out of control and unable to predict their own behaviours. Arguably-this means that

self management of their ADHD would be a real challenge. SENCo 2 expressed view and is referenced below.

“they couldn't predict or judge what mood they were going to be in, or how they were going to react, from one lesson, or sometimes one segment of a lesson, to the next. which I can only imagine, could be quite scary, in a way. And just not having that security, of "oh I'm going into lesson X I can sit there and get on with it" which I think we just take for granted.”

The impact of hyperactivity was also discussed at length under two core streams of thought. The first is illustrated below in a quote from SENCo 6 who felt that hyperactive behaviours were only a problem in the context of a school environment, and were in fact a help rather than a hinderance in other more active environments.

“Hyperactivity, I think, sometimes it works for her for the better, for example, she didn't take her medication at all when we went on the residential trip, but actually that was quite a good thing, in terms of the hyperactivity because she was then, really involved in doing all of the activities that were planned for her. But obviously, in a classroom environment, I don't know if that would be suitable.”

The second consequence of hyperactivity was its impact on social dynamics and relationships. This is illustrated using a quote from SENCo 1 below.

“She was almost isolated at times because she was so boisterous and physical and hands on, and the other children didn't like her being so, in their face. She'd got no idea of personal space.”

Diagnosis and medication.

This is a global theme created to contain any reference made to the process of receiving a diagnosis, and or medication. This Global Theme contains two main themes which will now be discussed in turn. Medication and The Impact of a Diagnosis.

Medication.

Medication was referenced frequently throughout all of the interviews, some of these references have been used in discussing other themes. Overall, medication appears to be considered to have a positive impact on the functioning and wellbeing of young people with ADHD as illustrated in the quote below from SENCo 4.

“I think of maybe a different child, so you've got the ones that are particularly hyperactive, and again it depends if they're medicated or not, personally. If they're not. I'm not saying medication is the answer to everything... but I've seen the ones that are medicated, and you notice a big difference if they come in and they are not medicated.”

Throughout the interviews reference was made to the process of parents choosing to medicate their children. As illustrated by SENCo 4 below, some SENCos felt that other options of treatment were not adequately explored as parents were so keen to find a quick solution. This suggests that although medication could be having positive effects on young people, it is not possible to claim that other options of treatment or support would not be equally-effective. By this reasoning, the perceptions, views and education of parents around ADHD and medication may be having a significant impact on the young person because they will inform treatment choices.

“some parents get the diagnosis, they want medication straight away, cause they just want a child who is more compliant. They've been woken up in the night, they've had the stress, and you know, they are finding their child very difficult to manage, or its impacting on their family, so they kind of see "ooo I can put him on medication now, and it will be a lot..." you know, and again, I think sometimes, all of the options aren't explored.”

Impact of a Diagnosis

There was no clear consensus on the impact of being given a diagnosis, although there did appear to be two main positions. The first is that a diagnosis provides validation for young people with ADHD. The diagnosis acts as an explanation for the difficulties that they had been facing up until the point at which they were diagnosed. This is illustrated using a quote from SENCo 3 below.

“I think for some of them, it does help to understand that there is a condition underlying it, so if they do feel they've got, sort of, you know, severer difficulties with a particular thing, then we kind of can explain to them, that, you know, it's not because you're doing anything wrong, it's just that, you know, that's how your brain works.”

In direct contradiction of this view is the suggestion is that young people can be distressed by receiving a diagnosis if they are do not have it properly explained

to them. This view is illustrated by SENCo 4 who describes a young person who she believed had been misinformed around ADHD, and therefore had negative preconceptions which led him to be extremely distressed by his diagnosis.

“Devastated initially, devastated. So like I said, it affected his self-esteem, he then perceived himself to be naughty, but he knew he wasn't naughty. So he started questioning his whole being initially, I think.”

What is interesting to note here, is that it could be argued that although there was no consensus view with regards to the outcomes associated with receiving a diagnosis, this could be due to the variability of circumstance under which young people receive their diagnosis. It could be argued therefore, that it is the way in which the diagnosis is explained to the young person, and not the diagnosis itself, that is having an impact on their wellbeing.

Impact of understanding.

This sub theme came from the main theme Young Person's Understanding of ADHD and the Global theme Knowledge of ADHD. This theme illustrates the potential impacts raised by the SENCos who participated in this research, of different levels of understanding young people have of their ADHD. In support of the findings from the online questionnaire, the key findings from this theme were that participants appeared to believe that the better a young person understands their ADHD then the lower the risk to their wellbeing. This view is illustrated below in the quote from SENCo 4.

“I definitely think, the lack of understanding around what it is, effects them greatly, and that does affect their wellbeing, cause they just don't understand it.”

As an example of some of the direct consequences of misunderstanding, SENCo 5 discussed a young person with ADHD being confused by their own behaviours due to a lack of understanding-

“The child didn't understand that he had ADHD, it was more a case of, he couldn't... he didn't grasp why, he couldn't control the way that he was feeling, or the way that he was behaving and that made him really confused”

Further, SENCo 2 spoke about a negative impact on behaviour in response to limited or misunderstanding of ADHD.

“I don’t think we’re always very good at explaining to the children, why they may react, or behave, as they do. and so what tends to happen, and what happened with this particular instance, is that the child perceives themselves, as badly behaved. which then, sort of starts, I think, as a little bit then, of a negative cycle, because they perceive their behaviour to be bad, which then means that they will play up to that to a certain extent.”

Young person’s awareness affecting wellbeing.

This subtheme came from the main theme Young Person’s Awareness of their ADHD and Symptoms, and the global theme Young Persons Awareness and Perceptions. This theme explores the potential consequences, as highlighted by the SENCOs who participated in this study, associated with the level of awareness that young people have of their ADHD. The findings below provide further support for the arguments in the theme above: young people with ADHD should be helped to understand their condition and become more aware of their diagnosis and symptoms. This view is illustrated below in a quote from SENCO 4.

“I think once he understood the diagnosis, he was quite aware of them, and became accepting, and then like I said, he kind of understood them more, knew how to deal with the symptoms.”

Although this view was supported across all interviews, there were some SENCOs who felt it was of great importance to ensure any awareness of their symptoms was matched with adequate understanding. This view is illustrated below using a quote from SENCO 1.

“I think we need to make them aware of their symptoms and how they are different, but I also think that we need to give them strategies to manage their symptoms, so that they can then find ways to communicate how they are feeling in different ways, and help other people accept that that’s the way that they are.”

Friendships and relationships with peers.

This main theme was extracted from the global theme Relationships and The Impact of Others, and it explores any references made to peers both positive and negative. Within this theme there are two sub themes, Peer understanding, and Difficulties with peers. The findings below suggest that some of these outcomes may be associated with the limited understanding of their peers.

Peer understanding.

There was agreement amongst a number of the SENCoS who participated in this study, that the level of understanding held by peers was likely to have an impact on the wellbeing of the young person. These views are illustrated below using two separate references.

SENCo 5 spoke about the difficulties that arise when peers around a young person with ADHD do not understand or are not aware of their ADHD.

“Well a lot of children obviously, that actually want to be in lessons and they actually want to learn, and unfortunately they don't see the condition that affects him, they just see him being a disruptive child.”

Finally, SENCo 3 spoke about the efforts they make in school to support and educate others in the class in order to reduce perceptions like those discussed in the quote above.

“Yeah, we do quite a lot of work around it, if a child gets a diagnosis of anything, we sort of talk to them about it, and we also work with the other children. So we talk a lot about, you know, this child will have trouble with this kind of thing.”

Difficulties with peers

There was frequent reference made to the view that young people with ADHD have difficulties associated with friendships, developing relationships, and social skills. This is illustrated in the quote below from SENCo 1. It is interesting to note, and directly relevant to the aims and research questions of this research, that the young person described below was not only facing difficulties socially, but did not understand why.

“She found it hard to make friends, hard to socialise, didn't understand why other children found her annoying.”

Another interesting reference below from SENCo 5 presents the view that young people with needs are likely to spend time with other young people in a similar position.

“But what's interesting, is that I find those that have a need, kind of, or behavioural issues, gravitate towards each other. So I don't know whether that is something that kind of, they've got in each other, or how they perceive themselves to be, but it's very rare for a child that has a diagnosis, in my experience, to be hanging round with peers that don't.”

Perceptions of others.

This main theme came from the global theme Relationships and the Impact of others. This theme was discussed briefly in section 5.2 Research Question 2. It is discussed at greater length here with deeper exploration into the effects of the perception's others hold around the young person and their ADHD. The common theme throughout any reference to the perceptions of others people was the term "*naughty*". SENCOs referenced staff, parents, other family members and peers all perceiving young people with ADHD as "*naughty*".

"I think very much at first it was thought that it was parenting, and I think that very much affected the perception we had, we had, some members of staff had, of the child, and just assumed she was a naughty child, when actually there was far far more to it." - SENCo 1

"The perception from other children, was just that he was the funny, naughty kid."
– SENCo 2

"I think there is definitely a lack of understanding, I think, also, like I said a lack of understanding from parents, but also other family members, who do perceive it sometimes to be naughty behaviour" – SENCo 4

The consequences of these sorts of perceptions are referenced below in a quote from SENCo 2. What is interesting about this excerpt is that he goes on to explain the benefits of changing these perceptions.

"Yeah staff I think initially just thought that they were just badly behaved, just a behaviour issue, and of course I think, no matter where you teach, or work, teachers are only human, and they get to a point where they think "oh its person X again on this register, they're going to completely kibosh my lesson, and it's going to be an absolute disaster" so I had to do quite a lot of work with the staff, to get them to realise, that actually, this child wasn't doing it to be a complete pain in the posterior, and that they were trying, but they really couldn't help themselves, and oh and by the way there are some things that you can do that, not only will help them, but help you as well because if you help them to concentrate, and stay calm in your lesson, then low and behold, your lesson will run a lot more smoothly"

Chapter 6 Phase One Discussion

6.1 Research Question One: How Do Special Educational Needs Coordinators Feel That Young People With ADHD Perceive Their ADHD And Symptoms?

Following an analysis of the data from Phase One, this research question has been approached through two concepts: understanding and awareness. Within this research the following distinction has been made between understanding and awareness:

- Understanding is an explicit knowledge of ADHD and its symptom.
- Awareness is an acknowledgement of the needs, feelings or experiences associated with ADHD

Understanding The first core finding is that the SENCOs who participated in this research did not believe that young people with ADHD tend to have a good understanding of their diagnosis. This position was illustrated using a quote from SENCO 5 who described a child as confused by their own behaviours. This finding is consistent with the findings of Cooper and Shea (1998) and Arora and Mackey (2004). It is important to note, however, that the results from the questionnaire were evenly split between those SENCOs who believed that young people with ADHD tended to understand their diagnosis, and those who believed they did not. Further research into how these SENCOs assessed young people's understanding of their diagnosis might explain these differing views. For instance, are SENCOs interpreting the concept of 'understanding' differently or are they using different kinds of information to make their assessments?

Awareness The majority of SENCOs who completed the questionnaire reported believing that young people were not aware of the of their symptoms. This finding runs counter to the majority of previous studies which argue that young people with ADHD are largely aware of their symptoms (Wiener et al, 2012). However, over half of the SENCOs who completed the questionnaire did report believing that young people tend to know how their ADHD affects them which is more consistent with previous literature (Arora & Mackey, 2004). The lack of a clear consensus among the participants on the question of young people's awareness of their symptoms is also consistent with the findings of Wong et al's (2018) literature review. However, although it is not possible to draw a clear conclusion regarding these SENCOs perceptions of young people's levels of awareness, the

difference in their responses to questions about understanding and awareness does indicate a second core findings. The SENCOs appeared to believe that there was a distinction between a young person's awareness of their ADHD, and a young person's understanding of it. This is consistent with the findings of Arora and Mackey (2004), who sought the views of young people with ADHD. The consequences of this discrepancy between young people's awareness and their understanding will be discussed in relation to research question three where it will be argued that this discrepancy may have a negative impact on the wellbeing of young people with ADHD.

The final finding associated with research question one, was the regular reference to young people with ADHD perceiving themselves as naughty. This rhetoric has been reported throughout the literature (Travell & Visser, 2006) and will be discussed in relation to research question two, *How do Special Educational Needs Coordinators think young people with ADHD develop the perceptions they have of their ADHD and the severity of their symptoms?* and research question three, *How and to what extent do Special Educational Needs coordinators believe that these perceptions impact their wellbeing?*

Unlike previous research (Cooper & Shea, 1998, Wong 2018), this study does not illuminate any specific guidance about how ADHD is understood by young people. It could be argued that these findings provide a narrative around a lack of understanding and unhelpful views, however that narrative does not extend to a description of a more positive view. Cooper and Shea (1998) were explicit in their view that ADHD is a bio-psycho-social construct and should be understood as one. Although Cooper and Shea's research was carried out over 20 years ago, it is still largely accepted that ADHD is a complex and multi-faceted diagnosis (Wong et al, 2018). Large systematic reviews (see Moore et al, 2017) which explore potential interventions are important in providing some guidance into the complexities of ADHD. However, smaller scale research, like the study presented in this thesis, provides an in-depth understanding that cannot always be captured in larger more empirical research.

6.2 Research Question Two: How Do Special Educational Needs Coordinators Feel Young People With ADHD Develop The Perceptions They Have Of Their ADHD And Symptoms?

Exploring the literature, it was striking that there was so little research into how young people develop their understanding of ADHD. This is especially striking when considered in the context of the research from Wong et al (2018) which suggests that the perceptions which young people with ADHD have of their symptoms may have a powerful effect on their wellbeing, and when applying an ecological model that poses the influence of factors around young person (Bronfenbrenner, 1978). These ideas will be discussed further in the relation to research question three. From the data collected and presented in this research, it is argued that the SENCos believe there may be several pathways through which young people develop an understanding, or perception of their ADHD. These are set out in the table below:

Table 6.1

Pathways to young person's understanding.

1	Direct experience and self reflection
2	Interactions with others e.g parents, siblings, peers, teachers, wider community
3	Verbal explanations from parents, teachers or other professionals
4	Interpretation of interventions to mitigate symptoms e.g wobble board
5	Experience of medication
6	Reflection including comparison with others and framing behaviour as 'naughty'

It is argued further, that these pathways are flawed and put the young person at risk of limited understanding and negative perceptions of themselves and their diagnosis.

Findings associated with research question one were that SENCos did not believe young people with ADHD had a good understanding of their ADHD. There was some suggestion, however, that young people are developing some form of awareness around their symptoms. A common theme throughout the interviews was that young people are believed to be recognising the effects of their

medication and developing an awareness and understanding of their ADHD in response to this. This is consistent with the research of Singh (2007) who explored beliefs associated with medication. The risk associated with this will be discussed in greater detail in relation to research question 3.

All of the SENCOs who participated in the interviews reported that the young person was told about their ADHD by their parents. It is argued, therefore that being informed by parents is a key pathway towards young people developing an understanding or perception of their ADHD. This aligns well with an ecological model of ADHD as introduced in the literature review and will be revisited in the overall findings of this thesis. In their study exploring in-school strategies for young people with ADHD, Moore et al. (2017) reported that the understanding of parents was of high importance. However, the findings from this research suggest that SENCOs believe parents are not well informed or equipped to support their children. There was a consensus, across all interviews that there is insufficient support for parents following their child's diagnosis. This finding suggests that the NICE guidelines to offer parents training, and support understanding following a diagnosis, are not being followed. The SENCOs who participated in this study, all of whom work within the same local authority, placed the blame on the paediatricians who were providing the diagnosis. They argued that not enough was being done by the medical professionals. This was illustrated using a quote from SENCO 4, and by reference to the fact that 70% of respondents to the online questionnaire agreed with the statement that young people were not well informed by external professionals. These ideas are in line with the research from Banerjee and Kewly (2009) who found paediatricians were not able to meet the demands of their workload.

Analysis of the semi-structured interviews suggests that participants of this research believed that young people are making comparisons between themselves and their peers. In the examples provided by the participants of this study, young people with ADHD are recognising how they are different from their peers through observations. This is distinct from the self-stigmatising described by Moses (2010) in which young people adopt and internalise other people's perceptions of them. In the examples from this research, young people appear to be developing their own internal models of ADHD, based not on what they are told, but with information they are seeking independently.

As will be discussed at length with regards to research question three, and as illustrated by SENCo 2, ADHD has been associated with challenging behaviours at school and at home. Further, there was regular reference throughout the interviews to staff discussing these behaviours with these young people amidst conversation about their ADHD. Arguably, these conversations could be what is leading to the self-perceptions young people with ADHD have around being “naughty”, as referenced in the literature (Travell & Visser, 2006). Especially if, as suggested above, adults around children with ADHD are not appropriately equipped to explain ADHD to young people. This is a closer model to that which was described by Moses (2010), in which young people internalise the views of other.

Finally, SENCo 5 highlighted the impact that having additional needs may have on a young person’s understanding of their ADHD. She discussed a pupil with a diagnosis of both ADHD and ASD and reported feeling that this pupil’s ASD traits were reducing both her ability and desire to understand her ADHD diagnosis. This highlights the necessity of the NICE guidelines which advise that those offering support should take into account any “developmental level, cognitive style, emotional maturity and cognitive capacity, including any learning disabilities, sight or hearing problems, delays in language development or social communication difficulties” (National Institute for Health and Care Excellence, 2018).

The results associated with this research questions align with the wealth of literature in that they suggest there are multiple pathways through which young people with ADHD are developing an understanding of their diagnosis. They align further with an ecological model in that they suggest the significant influence of external factors on the development of these understandings.

6.3 Research Questions Three: How And To What Extent Do Special Educational Needs Coordinators Believe That These Perceptions Impact Their Wellbeing?

The findings from research questions one and two indicated that young people are not being well informed around their ADHD. A key finding of research question three is that SENCos believe that there are a number of negative outcomes for children with ADHD that might be explained by the limited or misinformed understanding that they have of their difficulties.

Data from the questionnaire showed that almost all the SENCOs who participated in this research believed that young people should be supported in better understanding their ADHD. There does not appear to be any previous research that replicates this data, however they are supported in this view by the NICE guidelines and by the literature. As an example, Moses (2010) found that young people holding only biological beliefs about their diagnoses lead to self-stigmatisation. If this link is causal, then this is a phenomenon which could be avoided by better supporting the understanding of young people with ADHD. Further, Honkasilta et al. (2016) found that a lack of adequate understanding of young people with ADHD and a failure to discuss their condition with them was leading to self-condemning behaviours. They also argue that this was leading to maladaptive ADHD identities. Self-condemning behaviours and maladaptive ADHD identities are two examples of how the level of understanding held by young people with ADHD may be impacting their wellbeing. The core findings presented below are around education and academic outcomes, social interactions, diagnosis, self-esteem and frustration. All of the findings from this research question align with either the Common Sense Framework of illness (Leventhal, 1980) in which young people's perceptions are impacting their skills to manage; or an ecological model (Bronfenbrenner, 1978) in which the factors surrounding the young person are interacting and influencing their development in different areas.

Education Consistent with findings from Shaw et al (2012) and Daley and Birchwood (2010), the SENCOs interviewed for this study agreed that young people with ADHD are less likely to achieve at the same rate as their peers. The findings of this research, alongside previous literature provides some possible explanations for this phenomenon.

Consistent with a wealth of previous research, the SENCOs participating in this research felt that the mainstream school system was not adequately structured, or financially supported, to meet the needs of young people with ADHD (Washbrook et al., 2013; Moore, et al., 2017; Daley & Birchwood, 2010; Wheeler et al., 2008). This is particularly relevant in the context of the recent government push for schools to take on greater responsibility over children's mental health and wellbeing (Department of Health and Social Care & Department for

Education, 2017). These findings highlight the difficulties schools are likely to face without structural and financial change (Thorley, 2016).

Consistent with findings from Moore et al. (2017), there was some suggestion from the participants of this research that staff do not have an adequate understanding of ADHD. It was suggested that this limited understanding is having a negative impact on the ability of schools to support and appropriately manage the needs of young people with ADHD. From this literature, and the findings from this research it is arguable that, at least in part, the educational difficulties faced by young people with ADHD may result from the poor fit between these young people and the conventional educational model they find themselves in. Exploring this idea with young people and helping them to reflect on the idea that the 'problem' might lie, at least in part, in their situation rather than in them might help reduce self-stigmatisation.

Challenging behaviour in various forms was referenced by all of the SENCOs who participated in this research. Given the nature of ADHD behaviours, this was not unexpected (Meijere et al., 2009; Faraone & Buitelaar, 2010). As an example, some SENCOs discussed the difficulties associated with impulsivity. This is particularly relevant when considered in the context of Peter et al., (2016) and Conejero et al (2019). These papers explored the significant and mediating relationship between ADHD, impulsivity and suicidal behaviours. Impulsivity is also relevant when considered in the context of how staff are able to manage the needs of these young people. Arguably, limited staff understanding of ADHD could lead to inappropriate or ineffective behavioural management strategies. It is argued further, that these ineffective strategies could be leading to the self-perceptions that young people with ADHD have around being "naughty", as referenced above and in the literature (Travell & Visser, 2006). It may also be useful to reflect on the use of the term 'challenging behaviour' to describe behaviour which is 'challenging' to others rather than to the young person themselves. Using the term in this way privileges the teacher or parent over the young person and fails to recognise the significance of context. A given behaviour will be considered challenging in some contexts but not in others, as referenced by SENCO 6, and it is important to note that young people may find themselves in situations not of their choosing and over which they have little

control. This needs to be taken into account by staff when developing behavioural management strategies.

Another theme which arose from the interviews was around the difficulties faced by young people with ADHD around transition. This was not a concept that was explored in the introduction or literature review, however, upon further inspection of the literature, this transition has been subject to research. As an example, Evans, Borriello, and Field (2018) report a significant relationship identified in previous literature between ADHD in primary school, and negative academic outcomes following transition.

Social Interactions The literature around ADHD and relationships has highlighted many patterns of negative outcomes, including isolation, negative social peer interaction, being left out, and poor social communication (Pelham & Fabiano, 2008; Looyeh et al., 2012). What we know already is that ADHD as a label has been long associated with stigma and marginalisation (Matthews, 2009; Wiener et al, 2012), two phenomena which are heavily associated with negative mental health outcomes (Lebowitz, 2016). We can assume therefore, that the perceptions, attitudes and behaviours of others towards young people with ADHD will have a significant effect on their wellbeing. The findings of this research, as illustrated by a quote from SENCo 1 are consistent with previous literature. SENCos described Young people with ADHD as finding it difficult to make friends, and as experiencing social interactions in different ways from their peers. This research suggests that negative social interactions could be reduced by supporting peers in a better understanding of ADHD, a strategy that SENCo 3 reported already practicing in their school.

Diagnosis Mirroring the ongoing debates around the impact of labelling young people, (Riddick, 2000) there was no clear consensus on the impact of being given a diagnosis. Some of the participants reported believing that young people with ADHD may feel a sense of validation or explanation in response to a diagnosis. This view has been explored and supported in the literature (Moore et al, 2017). However, others reported believing that young people could be distressed or upset. Honkasilta et al. (2016) discussed at length the risk of limited discourse with young people who have ADHD, and how this might affect the development of their identities. In other words, although some of the findings from

this research suggest that young people may be distressed at receiving a diagnosis, there was also a suggestion both within this research and in previous literature that this would only occur in response to inadequate education around the diagnosis. This supports the argument that levels of understanding around ADHD could be a key variable in the development of well-being in young people with ADHD.

Frustration, Resilience and Self-Esteem What the literature has already shown is that there is a comorbid relationship between ADHD and common mental health disorders such as anxiety and depression (Roy et al., 2013). Consistent with research from Seymour and Miller (2017) and Looyeh et al. (2012) the findings of this research suggest that it could be helpful to look at this relationship through the lens of frustration, resilience and self-esteem. It is argued here, that these concepts may be a mediating factor in a relationship between mental health and wellbeing outcomes, and the level of understanding held by young people with ADHD around their diagnosis. In other words, the limited understanding of young people with ADHD is leading to experiences of frustration when they are unable to access the world in the same way as their peers and reduced self-esteem when they struggle to negotiate their social environments. If, as argued here young people's poor understanding of their diagnosis exacerbates their feelings of frustration and low self-esteem then this could help explain the negative mental health outcomes which have been so regularly referenced in the literature.

Medication The SENCOs who participated in this study reported their belief that medication for ADHD had a positive impact on functioning and wellbeing which is consistent with a significant proportion of the literature (Hinshaw & Arnold, 2015). However, it is interesting to note that these SENCOs did not refer to the controversies around psychostimulant medication (Moore et al, 2015), or comment on how the young person felt about being medicated. There has, however, been extensive research on this topic (Singh, 2007; Moldavsky & Sayal, 2013).

A key finding, associated with medication and consistent with Singh (2007), is the suggestion (as referenced in research question two), that young people are developing an understanding of their ADHD based on the reactions they are

having to their medication. Singh (2007) explored the beliefs associated with medication, and his conclusions as they relate to this study are concerning. Singh (2007) found that by developing an understanding through these means, young people were perceiving their ADHD as something intrinsically “bad” that needed resolving. What this highlights is that young people may not be being well enough informed about their ADHD, and are therefore being left to develop their own strategies for understanding it. As has been suggested, when young people develop their own strategies for understanding their condition, particularly when they do so using their reactions to medication, this can be problematic. This provides further support for the argument that young people with ADHD need to be well educated and informed around their diagnosis.

6.4 Link Between Phase One and Phase Two

Where Phase One of this research explored the views of Special Educational Needs Coordinators, Phase Two consists of a case study design exploring the views of young people with ADHD, their parents, and teaching assistants working closely with them. This was intended to provide a different perspective on similar themes and research questions. Further, as Phase One only collected the views of SENCOs, it could be argued that the findings are largely, if not solely, associated with how the young person presents in a school environment. The research design of Phase Two aimed to provide a broader picture of the young people. In addition, Phase Two of this research also employed tools derived from PCP as discussed in the introduction and literature review of this research. This was intended to support a deeper understanding of the themes which were discussed throughout the phase, but also to explore whether these tools could be useful when working with young people with ADHD. Previous literature as well as the findings from Phase One indicated the significance of how young people understand their ADHD. Therefore, it was believed that tools derived from PCP, a theoretical perspective that stressed the impact and importance of our own perceptions, may have been a useful tool.

Chapter 7 Phase Two Methods

7.1 Research Design

Phase Two employed a case study design made up of two independent cases of young people with ADHD. Each case included:

- The views of the young person, a parent and a key member of staff. These were gathered using three separate semi-structured interviews, as described below.
- Demographic information – age, gender, family information.
- School information – capacity, SEND provision, catchment area; and any additional information that naturally presented itself throughout the process.
- Data collected from two sessions of an intervention based in Personal Construct psychology. These sessions are described in detail below.
- A follow up interview with the young person
- A follow up interview with the staff member.

Yin (2003) advised that researchers should use case studies when their research questions ask “why?” or “how?”, when the context is highly relevant to the phenomena being explored, and when the research design is not experimental or manipulative. All of these conditions were believed to be met in phase two of this research, as evidenced by the three points outlined below.

1)The research questions in Phase Two are exploring *how* young people perceive their ADHD symptoms, *how* this affects them, and *how* they experienced the intervention.

- Q1) How do young people with ADHD perceive their ADHD and the severity of their symptoms?
- Q2) What influences the perceptions that young people with ADHD have of the severity of their symptoms?
- Q3) How and to what extent do these perceptions impact the young people’s wellbeing?
- Q4) How and to what extent can tools and activities derived from personal construct psychology be used to effectively support young people with ADHD?

2) The research design of phase two is a non-experimental design and is solely exploratory and descriptive.

3) As explored in the literature review, there is ongoing debate in the literature surrounding the contributing factors of ADHD symptomology and diagnosis (Hinshaw, 2018). Debates between those who adopt a medical model of ADHD and those who consider that environment and social relationships have a powerful influence on how individuals experience their symptoms. It is argued, therefore that social context cannot be discounted when considering perceptions of ADHD. This fits the third criteria set by Yin (2003) and means that case study design is an appropriate choice.

As with Phase One, it was decided to employ semi-structured, open ended interview techniques to allow the participants to guide the topic of conversation according to their personal experiences (Longhurst, 2003). The topics and questions were guided by the research questions (Appendix 5.8). For the initial interviews, topics covered across all participant groups were:

The principles of PCP were explored in the introduction and literature review of this thesis, alongside the rationale for using tools derived from these theories when working with young people with ADHD. It was argued there, that the ways in which young people with ADHD understand their ADHD are likely to have an impact on their wellbeing. It was decided, therefore, to utilise some of these tools to explore the experiences and perceptions of these two young people, and to explore the potential usefulness of these tools for use with young people with ADHD.

This research employed techniques described by Ravenette (1999) and are described in table 5 below. These techniques use predominantly abstract ideas, to try and elicit the views or experiences of young people without directly asking the young person. The work consisted of two meetings with the young person and the key member of staff identified by school. The aims of these sessions were to support both the young person, and the staff member in understanding the young person's personal constructs surrounding their ADHD.

7.2 Participants

Participants were two young people with ADHD, their mothers and a teaching assistant from their school as represented in the table 8.1 below.

Table 7.1

CASE ONE: Solomon (pseudonym)	CASE TWO: Michael (pseudonym)
Year Group: Three	Year Group: Three
Gender:	Gender:
Diagnoses: ADHD, ASD	Diagnoses: ADHD, ASD,
Parent recruited: Mother	Hypermobility, OCD, Dyspraxia
Staff Member Recruited: Teaching Assistant	Parent recruited: Mother
School Information	Staff Member Recruited: Teaching Assistant
- Mainstream Primary	School Information
- Capacity - 420	- Mainstream Primary
Location – Urban Area in South East of England	- Capacity - 420
	Location – Urban Area in South East of England

7.2.1 Recruitment.

Mainstream schools were approached through their link educational psychologist in the local authority. The decision not to approach special schools or alternative provisions was based on the more specialist methods which are likely to be used within these institutions. It was hoped that by using mainstream schools, the results of the research can be more widely applicable to similar populations of young people with ADHD.

The key contact for each school was the SENCo. It was these SENCos who identified the two young people who took part in the research. It was also they who then contacted parents to request their consent and participation. See Appendix 2 for information letters and consent forms. SENCos were asked to select appropriate participants using the following criteria:

Young people

- A diagnosis of Attention Deficit Hyperactive Disorder (ADHD).

- From years 3, 4 or 5. This was decided in order to avoid any SATs, exams or transition times.
- Young person is aware of their diagnosis.

Parents

- There were no restrictions on which parent (mother or father) were approached.

Staff

- Staff member must work directly with the student at least three days out of the week.
- There was no restriction during recruitment on the role of the staff member within school.

Once parents agreed to participate the arrangements were made with the SENCo for each meeting. Upon each meeting all participants re-read the information around the research and signed a consent form.

7.3 Procedure

Data collection for Phase Two consisted primarily of two separate sets of interviews alongside two sessions of personal construct psychology service. The first set of interviews consisted of six semi-structured interviews (Appendix 4), three for each case study, meeting with the young people, parents, and staff separately. It was decided to use semi-structured interviews in order to ensure there was a consistency of topics covered, while also eliciting rich, subjective and detailed accounts of the experiences. Using these methods, it was possible to both explore the specific research questions which were set and to explore the topics which arose from the interviews.

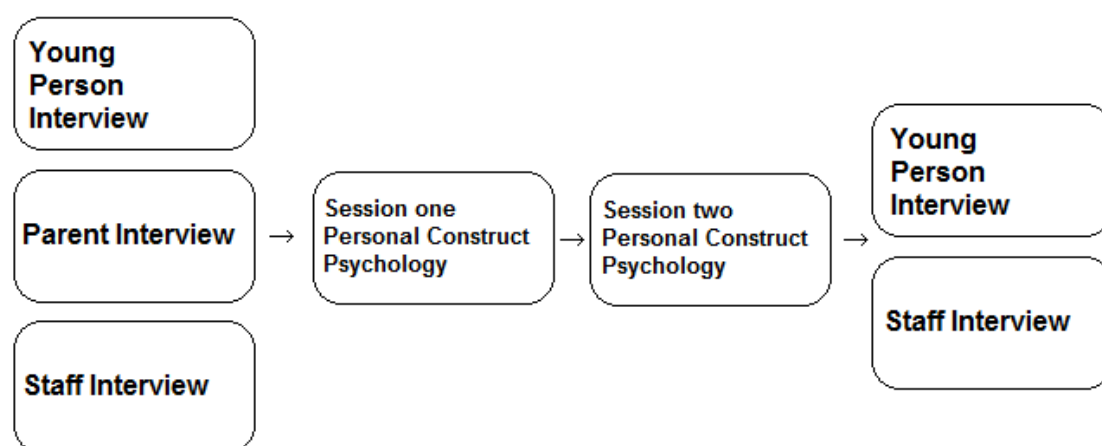
The second set of interviews conducted following the intervention (as described below) consisted of four semi-structured interviews, two for each case study. Separate meetings were held with both the young person and the staff member. These interviews elicited rich and detailed accounts of the experiences of the intervention described above.

All interviews were recorded using a Dictaphone and manually transcribed into Microsoft Word.

Figure 22 below shows the timeline of these components of the research. All meetings took place at school and the schedule for each of the interviews and meetings were arranged around the school's schedule.

Figure 22.

Timeline of Phase Two Sessions



Data collection for phase was conducted over four weeks. The initial interviews took place over two days, parents were interview separately over two mornings in order to fit in with dropping their children at school. Both young people were met on day one, and both teaching assistants on day two. The two sessions of PCP took place the following week over two separate days. The final interviews took place in the final week and were all conducted over one day. Demographic information was collected during parent interviews. This included age, gender, and family background. Parents and staff were also given the opportunity at the end of their interviews to provide any further information surrounding the young person which they thought may be relevant.

Information about the school was predominantly gathered from the government school comparison website - www.compare-school-performance.service.gov.uk. This included school capacity, school type, and admission.

Information regarding the schools SEND provision and policies was gathered from the schools' websites, and through conversations with the schools' Special Educational Needs Coordinators (SENCO).

The table below provides a detailed account of what was involved in each of the two sessions of PCP. These sessions were not piloted as part of this study in order not to reduce the number of available participants although this has been recognised as a limitation to the study. Nevertheless, the techniques have been used regularly in my own professional practice with other children who have a range of SEND, including ADHD. Both the young person and key member of staff attended both sessions together.

Table 7.2

Timetable of Personal Construct Psychology sessions

Session 1

Introduction (5 minutes)

- Who I am.
- What we are going to do over the next two sessions.

Warm up game (10 minutes)

Establishing concerns (10 minutes)

- Ask the young person why they think they may have been identified as needing some extra support.

Drawing the ideal self (30 minutes)

- The young person will be asked to draw a picture of their “ideal self” and then a picture of how they see their “true self”. The young person will then be invited to explain the difference.

Closing comments and summary (5 minutes)

Session 2

Introduction, recap and warm up game (15 minutes)

The Salmon Line technique (Salmon, 1988– as cited in Beaver, 2011) (20 minutes)

The young person is asked to identify someone whom they admire or look up to. They are then supported in developing 3 bi-polar constructs based on three positive attributes that they can name about this person?

The young person is then asked to place themselves on this scale, and then place themselves where on this scale they would like to be.

The 3 comments technique (20 minutes)

- Exploring how the young person believes they are perceived by others. The young person is asked the following
-

“ If I were to ask X to describe you in 3 words or phrases, what would they say)

Closing comments and Summary (5-10 minutes)

- Inform that in our next meeting I will be meeting with staff and student separately to discuss their experiences of the intervention.
 - Provide space for young person and staff to ask any questions.
 - Advise that any further concerns should be discussed with school.
-

7.4.1 Interview design.

As with Phase One, it was decided to employ semi-structured, open ended interview techniques to allow the participants to guide the topic of conversation according to their personal experiences (Longhurst, 2003). The topics and questions were guided by the research questions (Appendix 5.8). For the initial interviews, topics covered across all participant groups were:

- The young person’s knowledge and understanding of ADHD symptoms.
- The young person’s perception of the severity of their own symptoms.
- How, if at all, the young person’s symptoms impact on their day to day life. *(impact of severity was explored throughout this topic).*
- How, if at all, the young person’s symptoms impact on their mental health and wellbeing *(impact of severity was explored throughout this topic).*

The wording of each open-ended question differed slightly across each participant group e.g

Young person: How does your ADHD affect you?

Parent: How does your child’s ADHD affect them?

For the second, post intervention set of interviews, the questions were guided directly by the research question 4 and explored what participants felt was beneficial, what was less beneficial, and what could have been improved (Appendix 5).

Interviews were not piloted, however the content was discussed through research supervision. This is discussed in further details in the limitations section (10.3).

7.4.2 Analysis.

Each case was analysed separately, before being considered together throughout Chapter 9 – Phase Two Discussion. All interviews were analysed using the same thematic analysis method as described in Phase One (Braun & Clark, 2006). All interviews were analysed individually and then nodes from all three interviews (parent, young person and teaching assistant) were collected and organised into themes. See Appendix 7 for a transcript example with associated nodes as well as an example theme. The same process was used to analyse the post intervention interviews. The data collected from the PCP sessions is discussed in full and is intended to offer a richness to the data. This data was not subject to formal thematic analysis, but any relevant data was included in case summaries and mentioned in the discussion.

Chapter 8 Phase Two Findings

Two case studies are presented separately below. Names of both young people have been changed to ensure confidentiality. Following the presentation of both cases each research question will be explored in turn, drawing overarching themes across the two cases, and referencing the literature.

8.1 Case One Solomon

Solomon (pseudonym) is a year three child with a diagnosis of ADHD of which he is aware and for which he is being medicated. Solomon has a diagnosis of Autistic Spectrum Disorder (ASD) and lives at home with both parents and three siblings, one of whom is still a baby. Solomon attends an academy led mainstream primary school in a suburban area in the east of England. The school's capacity is around 420, although at the time of collecting this data, the school was not at full capacity. This case study includes interviews with Solomon, Solomon's mother, and a teaching assistant who works one-to-one with Solomon each day and supports him in class. Global themes were drawn across the three interviews; parent, staff and young person. These two global themes, their main themes and their subthemes have been presented in the table below. Each theme is discussed in turn.

Table 8.1

Overview of themes: Phase Two Case One, Initial Interviews.

Global Theme	Main Theme	Sub Theme
Outcomes associated with ADHD	Feelings	
	Challenging behaviour	
	Relationships with others	
	Symptoms	
Young person's understanding of ADHD	Level of understanding	<ul style="list-style-type: none"> • Using ADHD as an Excuse
	How young person knows they have ADHD	<ul style="list-style-type: none"> • How young person was told • Self-Reflection • How others treat them • Parent Understanding

8.1.1 Outcomes associated with ADHD.

This theme covers experiences the young person has had which were arguably associated with their ADHD, that is how having ADHD has affected them day to day. Within this main theme there are six subthemes which will now be explored in turn.

Feelings.

Solomon, his mother and his teaching assistant all made reference to Solomon experiencing negative feelings associated with his ADHD and behaviour. Sadness and anger were the emotions they referred to most frequently. All three spoke about Solomon getting angry or even aggressive. I would argue that this could highlight that anger is a key issue for Solomon, and needs to be addressed. It also indicates that all three parties are in some way associating Solomon's anger with his diagnosis.

"...they just make me get really really strong and once I punch someone and I get really really angry and it really hurt someone and I really didn't mean to it's just that I couldn't control my anger." - Solomon

Aside from anger, and sadness the other common feeling referred to by all three participants was remorse. Solomon spoke about feeling “*guilty*”, and even said he felt that he did not “*deserve to live*”. Solomon’s mother also spoke about him “*blaming himself*”. Below is as an example of Solomon describing feelings of remorse after losing control or doing something by accident.

“It always make me feel sad and it just makes me feel very very mean and once I do something bad and I really wish that I could that I didn't that I can't always do things bad, like I don't always do things bad but I just wish I didn't do anything.” – Solomon

Finally, Solomon’s mother spoke about Solomon being upset that the ADHD prevented him from being able to do the same things as his siblings and peers

Interviewer: “Do you think it [ADHD] makes him sad?”

Solomon’s mother: “Yeah definitely. Yeah, 100%. he always says to me “[inaudible] is doing this [sister] is allowed out at my age, I'm nearly 8 now mum can I go out. Linus (pseudonym) was going out when he was 8”, And I’m like “no baby you can’t””

What these findings evidence is that Solomon experiences negative affect which he and the adults around him attribute to his ADHD.

Challenging behaviour.

Challenging behaviour was referenced regularly throughout this case. Solomon’s mother report that he “*has hit*” her, while Solomon reported finding it extremely difficult to control his own behaviour.

“...I couldn't control what I was doing right then and then I just pushed him into the house...” – Solomon

Both Solomon and his mother discussed ways in which they try to manage this behaviour. However the examples given below suggest that these strategies are not working. Solomon discussed trying to make the right choices, while his mother discussed the boundaries she is putting in place.

“ ... didn't know whether to choose to trust the devil side or the angel side and I just chose the devil side once and it got me in a load of trouble.”- Solomon

“...gets to a certain extent like I've got boundaries with Solomon, like I don't use the ADHD to let him misbehave, that's not me, like I'm trying to control it myself”
– Solomon’s mother

Solomon appears to be exhibiting challenging behaviour which he is perceived to be unable to control.

Relationships with others.

Solomon appears to be well supported by those around him. His mother reported that *“the teachers are very supportive”*, while his teaching assistant discussed the support of his siblings.

“... his brother and his sister are quite supportive, he’s got a brother in the older year who will come if he’s upset, he sees him in the playground he’ll look after him.” – Solomon’s teaching assistant.

In terms of friendships and peer relationships, Solomon indicated that he found social situations difficult to navigate, while his mother reported *“It’s hard for him to make friends.”* The excerpt below provides an example of Solomon struggling to negotiate a social situation.

“Like when they were like annoying me one of my friends was annoying me [inaudible] and I asked that it wasn't all my fault. it was actually some of my friends fault cause I asked them if we could stay a little bit quiet while I am trying to hide because he could give my attention away and he got really [inaudible] and annoying and it got me really angry and I then he but it wasn't my fault because he was actually [inaudible] me and I was asking him to stop and I asked him nicely and then I asked him nicely again and again and then I just asked really really because he really was ignoring me and then he got me very angry so I and I couldn't control what I was doing right then and then I just pushed him into the house in year 2” - Solomon

It is important to note here that it possible that these difficulties are associated with Solomon’s other needs such as those associated with his ASD, and not with his ADHD.

Finally, Solomon spoke about his relationship with his parents, and how he felt that he annoyed them and other people as a result of his ADHD.

“Once I started to really annoy my parents they started to really treat me badly because I was annoying them” - Solomon

Then, when the interviewer asked *“So when we say, how does your ADHD affect how people treat you? You think that sometimes you're annoying people and they are getting cross with you?”*. Solomon Nodded.

As this interaction was not referred to by Solomon’s mother, it is difficult to know whether Solomon is right in thinking that he is ‘really annoying’ his parents.

Symptoms.

This sub theme covers references made to the core symptoms associated with ADHD: Impulsivity, hyperactivity and inattentiveness. Solomon appears to experience all of these symptoms, with some causing greater disruption than others.

Solomon, his mother and his teaching assistant all indicated the presence of common ADHD symptoms, including hyperactivity, impulsivity and inattention. Solomon’s mother described his hyperactivity as being unable to *“switch off”*.

“he gets well hyper, he can't switch off. if he is excited about something, the people down the road can hear him, and we are indoors, and he will be running around” – Solomon’s mother

References made to impulsivity were only addressed in terms of a lack of control, or acting before thinking. Solomon himself only referred to impulsivity when heavily prompted. When asked *“Do you find it really hard to stop yourself from doing things?”*, Solomon replied *“Really really difficult”*. However, Solomon’s mother spoke unprompted about the concerns she has associated with Solomon’s impulsivity and his difficulties in controlling himself.

“Now if he is out and a child makes him angry I am not there to control it so if he ends up flipping out, one he could possible, because he is quite a strong boy, two he could possible do damage to someone else” – Solomon’s mother

Further, Solomon’s teaching assistant spoke about impulsivity in terms of not thinking before he speaks

“if someone upset him he would then shout or say something before he actually realised what he was saying” – Solomon’s teaching assistant

Finally, Solomon made reference to inattentiveness by claiming *“I can’t really focus a lot when there is a lot of noises”*. Solomon’s teaching assistant spoke about how these symptoms impact Solomon in school

“So say you give him a task to do he struggles to just get on with that task you kind of have to go and see him while he is sitting down to remind him of what he has got to do.” – Solomon’s teaching assistant.

Educational outcomes.

Solomon’s teaching assistant made regular reference to the high levels of support that he needs in class. She reported that he will struggle to work independently and that he needs regular prompting to complete a task.

“Yeah I think he is quite slow in the way he does his tasks and obviously as I said we have to go over things with him he can’t just get it first off. But that’s the same last year and this year really we’ve always had to go and “come on Solomon keep going! You can do it!” – Solomon’s teaching assistant

9.1.2 Young person’s understanding of ADHD.

This global theme explores how Solomon understood his ADHD, and how he came to develop this understanding. There are two main themes within this global theme, Level of Understanding, and How Young Person knows they have ADHD. There is one sub theme within the main Level of understanding – Using ADHD as an excuse. Within that second main theme there were four sub themes: How young person was told, Self-reflective behaviours, how young person was treated by others, and Parent Understanding.

Level of understanding.

Solomon’s teaching assistant was explicit in her view that Solomon did not have a good understanding of his ADHD. Reporting that although he may say that he has ADHD, he would be using it as an “excuse” without knowing what it meant.

“I don’t think he knows too much about it if I’m honest, he does know that he needs to have his tablet and that his tablet has an effect on his body. And I think when he...like In year two he was on different medication and used to get quite angry and whenever he got angry he used to say “well I can’t control myself cause I’ve got ADHD” he kind of used that as an excuse as the way he would lash out and think it was that. But I don’t think he knows really what it is and how it affects him.” Solomon’s teaching assistant.

Solomon's perspective on ADHD appears to be based solely in anger, when asked what he thought ADHD meant, Solomon replied "*I think it means that you have trouble with your angry issues*". Solomon showed further misunderstanding when speaking about the process of diagnosis. Solomon appeared to believe that ADHD was something that had been done to or given to him.

"Yeah cause they had to get ADHD to me because I was I think that well all I remember was that they did ADHD to me but I can't remember why." – Solomon

Using ADHD as an excuse.

Young people, and parents using ADHD as "*an excuse*" or to validate challenging behaviour is a concept that has been explored in the literature (Moore et al., 2017). As these ideas were referenced so frequently by Solomon's mother and teaching assistant, they were developed into their own theme. Solomon's mother reported that Solomon would regularly say things like "*Well that's not my fault, I've got ADHD*". Solomon's teaching assistant went on to say "*whenever he got angry he used to say 'well I can't control myself cause I've got ADHD'*". These findings suggest some misunderstanding with the young person attributing his anger directly to his diagnoses.

How young person knows they have ADHD.

This main theme explores the ways in which Solomon developed an understanding of his diagnosis. Each subtheme will now be discussed in turn.

How young person was told.

All three participants discussed how Solomon was told about his ADHD, each confirming that he was initially told by his mother. Where Solomon reported "*my mum told me*", his teaching assistant was explicit in her view that it was the parent's responsibility to discuss the young person's ADHD with them, and that this was not happening at school.

"I think it should mostly be parents who have spoken to him about it. [...] Yeah we don't really speak about it in school" – Solomon's teaching assistant

Solomon's mother also disclosed that she made the decision to tell Solomon about his ADHD at the point he became medicated.

"...I have been upfront with him from obviously when he started taking the medication" - Solomon's mother

Self-reflection.

Some references were made that would suggest a certain level of self-reflection, particularly based around medication and feeling different from his peers. Solomon's mother reported "*he knows he's different to other children*", she went on to say that she thinks Solomon's medication helped him be more reflective and develop an understanding of his ADHD.

"So he didn't really understand that he then realized that this tablet was helping him because he realized he could concentrate better in his lessons and stuff like that" – Solomon's mother

Solomon's teaching assistant also suggested that Solomon's understanding and awareness of his ADHD was based on his experience of medication, and his ability to reflect on its effects

"he does know that he needs to have his tablet and that his tablet has an effect on his body." – Solomon's teaching assistant

How young person was treated by others.

Solomon's mother spoke explicitly about her attempts to reduce the risk of Solomon feeling different in class, she explained that she has asked the school to stop using personalised interventions in class. However, she also reported that she thought this sort of intervention had led to Solomon developing an awareness of how he is different from his peers.

" he also knows like I won't allow him to be treated any different to other children whether that being in school or at home, cause there's certain things they put into place for him as a school which is brilliant, its fantastic, with if he gets a certain amount of marbles a day he gets 10 minutes of something he wants to do. Whereas I put a stop to that , the way I see it is that I have chosen to put him in a mainstream school because I want him to follow the rules, it wasn't fair that out of a class of 30 just because he's got this issue." – Solomon's mother

There were conflicting reports from Solomon's mother and teaching assistant around whether or not his peers were aware of his needs. Solomon's mother gave an example of Solomon being identified by a peer as the "*naughty boy*"

"one of the kids went "that's the naughty boy mum, that's that Solomon". and he...I heard it...and it upset me, and Solomon heard it and it upset Solomon. But

now because he is getting older and he's got a more of an understanding of it now" – Solomon's mother

Whereas, Solomon's teaching assistant reported that she did not *"think in a group of friends that they would label him as being any different from any of the others."*

Parent understanding.

Throughout the interview with Solomon's mother she made a number of comments which would suggest that her understanding of ADHD was low. For example she referred to ADHD as part of the autistic spectrum.

"really the first appointment the consultant told me that he was on the autistic spectrum and obviously the ADHD does stand in the autistic spectrum." – Solomon's mother

Solomon's mother also spoke about the idea that medication should have resolved any of the difficulties he had been facing

"if a child is on the right medication they shouldn't be doing stuff like that." – Solomon's mother

Finally, Solomon's mother spoke about using the internet as a means to help explain ADHD to Solomon and his siblings.

Interviewer: "So you've had those conversations with him where you've tried to explain?"

Solomon's mother "Yeah we've had quite a few, even my other two my older two, cause it was a lot the time they were like "well he gets away with this and he gets away with that why doesn't Solomon have to do that" so I've had to sit and explain to them and they were like, they still didn't really understand it, so we got the computer out and googled it so I've got more of an understanding"

She then went on to say

"Cause I know that I am not very good with my words so getting google, then if they were look "what does that mean?" I was like "Google it and it will tell you the meaning"

These findings would suggest that Solomon's mother has not been well supported, which may partly explain why Solomon's level of understanding is reported to be so low.

8.1.3 Intervention data and follow up interview.

Following the first set of interviews, two sessions were set up to work with Solomon using tools derived from PCP. The data from these session is presented below. Then the findings from the post intervention interviews are presented and discussed.

The Ideal Self.

In this activity, the young person is asked to first draw an “ideal self”, and then to draw a picture of himself, and discuss the differences. Below is a scanned copy of Solomon’s work, followed by a detailed account of what was drawn.



Figure 23. Scanned copy of Solomon’s ideal self.

For Solomon’s ideal self, he drew a picture of a boy wearing a t-shirt that says “help the poor”. When asked what this young person would bring to school in his back pack, he said food and drink, but also money to give to the poor. Solomon spoke frequently about kindness and looking after other people. When then asked to draw himself, Solomon drew a similar picture and explained that he felt he was very much like the picture he had drawn of his ideal self.

The Salmon Line and The Three Comment Technique.

In the Salmon Line Activity, the young person is asked to identify someone whom they admire or look up to. They are then supported in developing three bi-polar constructs based on three positive attributes that they can name about this

person. The young person is then asked to put themselves on the scale with one mark, and then again on the scale to demonstrate where they would like to be.

For the three comments technique the young person is asked to identify 3 people they consider important to them, and are then asked the following

“If I were to ask X to describe you in three words or phrases, what would they say?”

Below is a scanned copy of both of these activities, followed by a detailed account of the session.

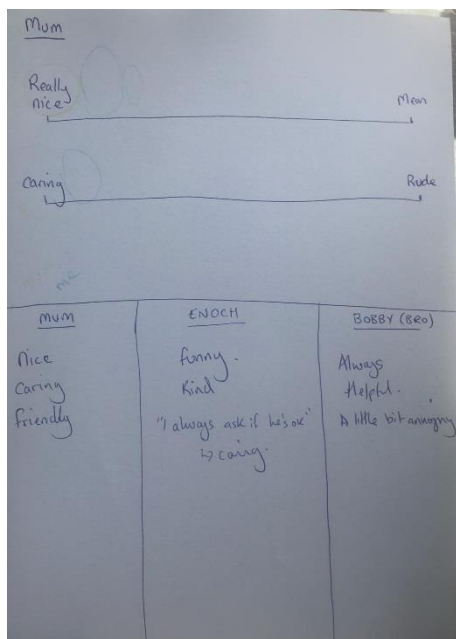


Figure 24. Scanned copy of Solomon’s Salmon Line and Three Comments Technique

Solomon chose his mum as the stimulus for the Salmon Line activity. He described his mother as “really nice” and as “caring”, but found it too difficult to identify a third attribute. He then chose “mean” and “rude” to go at either ends of his salmon line Using yellow to indicate his mother, he circled the furthest positive end of the scale, and then using blue to indicate himself he drew just a little bit further up the scale. Solomon explained that he felt he was also “really nice” and “caring”.

For the three comments technique, Solomon chose three people who he felt were important in his life, his mother, a close friend, and his brother. The table below

shows clearly how he felt he would be described by each, this can also be see in Figure 23 above.

Table 8.2

Three Comments Technique – Case One

Mum	Friend	Brother
Nice	Funny	Always helpful
Caring	Kind	A little bit annoying
Friendly	“I always ask he if is ok” – Caring	

Post intervention interviews.

Following the intervention, Solomon and his teaching assistant (TA) were met and interviewed separately to explore their experiences of the sessions. These interviews were analysed, and two themes were identified. These themes are presented in the table below and then discussed in turn.

Table 8.3

Overview of themes – Phase Two, Case One, Post Intervention Interviews

Themes	Sub themes
Positive outcomes	<ul style="list-style-type: none"> • Young person noticing things about themselves • Young person opening up • Learning more about ADHD
Intervention had no impact	<ul style="list-style-type: none"> • Intervention was too difficult • Intervention had no impact • Young person is happy as they are

Positive outcomes

Although, as can be seen below, Solomon’s teaching assistant did not feel that the intervention had had any significant impact on how she thought about Solomon or how he thought about himself, there were a number of references to positive outcomes which have been explored below.

Young person noticing things about themselves

Solomon's teaching assistant reported that she observed Solomon recognising positive things about himself and opening up about his homelife. However, she also reported that she was not sure if this was relevant to ADHD.

"I think it was nice to see Solomon talk about home and express, he talked a lot about his mum which is nice, but relevant to ADHD I don't know [...] and noticing things which were good about himself that were linked to mum and things that he knew he had to work on as well I suppose."

She went on to say

"I think it was good when Solomon was talking about, you know when he was drawing the person he would want to be and the person they are. I thought that was quite nice to see what he thought about himself, and it's nice to see that he is happy with himself."

Staff learning more about young person.

Solomon's TA said twice that she had learnt some new things about Solomon as a direct outcome of the intervention, first that he was "*happy with himself*", as noted above, and second that he had a relationship with a peer which he considered more significant than she had realised.

"I suppose it has made me see a few things differently.[...] Not so much his understanding, but the way he, like his friends he know he can play with his friends. like especially when he was talking about Sam (pseudonym), it was also Sam every time and I didn't realize that it was just Sam that he thought of as just his friend."

Learning more about ADHD

Solomon reported having enjoyed the intervention, and having learnt more about his ADHD. However, he was not able to articulate what he had learnt, and his answer was arguably heavily prompted.

Interviewer: "the work that we were doing together, how did you find it?"

Solomon: "Good."

Interviewer: "Yeah, what was good about it?"

Solomon: "That we can learn more about my ADHD."

Intervention had no impact

Although there was no rich data gathered from this second set of interviews, it was clear that Solomon's teaching assistant did not believe that the intervention had had any impact. When asked whether the intervention had changed her practice at all she replied, "*No I don't think it has I'm afraid*". From the perspective of Solomon's teaching assistant, this lack of impact was down to two things. First, the intervention was pitched too high for someone of Solomon's age and needs; and second Solomon was already happy with himself, and therefore did not need this form of support.

Intervention was too difficult

The quote below demonstrates Solomon's teaching assistant's view that the intervention was too difficult for the young person to understand.

"Maybe change it to make it a bit easier for them, I think because their understanding is not as advanced. I think they did find that a bit challenging."

Young person is happy as they are

While further discussing how she thought the intervention may have been too difficult for Solomon, his teaching assistant also noted that she thought Solomon was comfortable without self-analysis. She noted that he appears to be happy with himself.

"I do think it was a little bit tricky for them to understand what they was meant to do. When talking to them about like emotions, like last when you were talking about how do you think a person should be or things like that, I don't think they understand the concept, like they know themselves and that's fine"

'I don't know'

It is important to note at this stage that there were numerous occasions during this interview that Solomon admitted not knowing what to say. This also highlighted that some of his positive responses were not valid as they may not have been genuine responses.

Interviewer: "How did it change how you think about your ADHD? or did it change how you think about your ADHD?"

Solomon: "Yeah."

Interviewer : "Yes? How did it change it?"

This will be discussed at greater length in the overall discussion of this thesis, while exploring some of the limitations of the research.

8.1.4 Case 1 summary.

Reports from home and school would suggest that Solomon does not display a good understanding of his ADHD. Solomon appears to relate his ADHD to his anger issues, and is reported by parents and school to struggle with his anger in school and at home. Solomon's mother does not appear to have a thorough understanding of ADHD either, and it may be that this has affected Solomon's own understanding. Solomon was told about his diagnosis by his mother when he was first medicated for his ADHD. Although the school is supporting him, and will staff discuss his needs with him, they do not discuss his ADHD directly, Solomon's TA felt that this was the responsibility of his parents.

Although overall Solomon appears to have a positive self-image, all three interviews discussed negative feelings associated with academic achievement, friends, and difficulties with anger.

Finally, even though Solomon reported having enjoyed the intervention, and learning more about his ADHD, he did not display a good level of engagement during the follow up interview. Solomon's teaching assistant was explicit in her views that the work was pitched too high for someone with Solomon's needs. However, she did report some positive outcomes, including learning a bit more about how the young person thinks. Solomon's teaching assistant does not believe that this work will influence her practice.

8.2 Case Two Michael

Michael (pseudonym) is a child in Year 3 with a diagnosis of ADHD which he is aware of and for which he is being medicated. According to Michael's mother, Michael has a diagnosis of ADHD, OCD and ASD as well as grommets in both ears. Michael attends the same school as Solomon and lives at home with both his parents and his twin sister. Michael's twin sister is reported to have different needs to Michael. This case study includes interviews with Michael, his mother and his teaching assistant who works one-to-one with him each day, and supports him in class.

Table 8.4

Overview of Themes: Phase Two, Case Two, Initial Interviews

Theme	Subs themes
Young person's understanding of ADHD	<ul style="list-style-type: none"> • Level of understanding • How young person knows they have ADHD
Young person's awareness	<ul style="list-style-type: none"> • Symptoms and awareness of symptoms • How young person sees themselves
Outcomes associated with ADHD	<ul style="list-style-type: none"> • Feelings • Impact on school • Relationships

8.2.1 Young person's understanding of ADHD.

This theme covers how, and to what extent Michael understood his ADHD. It also touches upon how he developed this understanding.

Level of understanding.

All three interviews suggested that Michael does not have a good understanding of ADHD. Michael's mother reported that she thought he believed ADHD meant *"That he can get away with stuff"*. She went on to say that she didn't feel that he was cognitively mature enough to understand even in if someone spoke to him directly about it

"he doesn't need to have a conversation about it...he's not...his brains not compact to take something like that he just knows he is special." – Michael's mother

Further, from Michael's perspective, it would appear that he associates ADHD with two things: learning and anger. When asked how his ADHD affected him Michael replied, *"I don't know how to read [...] or write."* Michael? went on to refer-anger as another aspect of his ADHD.

"Well my ADHD does kind of make me angry and ummm I really don't know how to write, I just, all I know is that I just get help writing, and that's a lot of help of me, and I have a lot of help and that's it." – Michael

Further, when asked how his ADHD affected him Michael replied, *“Well my ADHD does kind of make me angry”*, he then went on to elaborate on this.

“Well if I do something like bad I leave I try my body goes more like stronger than everyone else and some people, if someone makes me angry I might push them over and pin them” - Michael

How young person knows they have ADHD

Michael, his mother and his teaching assistance made little reference to how Michael knew he had ADHD and what they did say was contradictory. Michael’s teaching assistant reported that she did not speak with Michael about his ADHD, Michael reported being told by his mother, and Michael’s mother said that she did not know how he found out about his ADHD. Although this does not give any great insight into how Michael found out about ADHD, it could suggest that there is limited communication between home and school. Further, that it is entirely possible that no one has been speaking with Michael about his ADHD.

8.2.2 Young person’s awareness.

In the previous section it was suggested that understanding of his ADHD is fairly limited. This section will explore how aware Michael is of his ADHD and needs.

Symptoms and awareness of symptoms.

All three interviewees suggested that Michael is somewhat aware of this symptoms. When asked what happens when he ‘gets hyper’ Michael replied *“I be very crazy”*. Further, when given the prompt *“Another symptom of ADHD is inattentiveness. Another big word. it means finding it difficult to focus and to pay attention.”*, Michael said *“Yes I don’t focus a lot”*. He went on to say, *“Yeah I can’t focus on stuff, I just try to work but I get stuff wrong a lot.”*. Michael’s teaching assistant reiterated this in the example provided below.

“I would call inattentive yes, but it's very difficult when he is very low ability you don’t know if you have just pitched it wrong or if he just cannot focus that day for some reason.” – Michael’s teaching assistant

However, Michael’s mother felt that although he was aware of his symptoms, he did not understand them. This is consistent with the finding that Michael has a limited understanding of his ADHD.

“I think he is aware of them, [his symptoms] but I don't think he really cares about them enough...or he knows about them but he don't really understand them.” - Michael's Mother.

How young person see themselves

When Michael was asked how he felt about having ADHD he replied “*different*”. He went on to describe feeling different from his family, and later, as referenced below, feeling different from his peers.

“Cause everyone else in my family don't have kind of stuff like me, all I have is my big brother has braces and he's got to get braces. I am different to my family.”
– Michael

Michael and his teaching assistant made regular reference to him feeling different or *special*. The quote below demonstrates Michael's feelings about being different from his peers.

“... it feels like I'm stupid and dumb cause I don't know about sounds, but Leo (pseudonym) does, Leo knows all about sounds and he knows how to write even though he has ADHD I just don't, I'm different from everyone in this school even jack (pseudonym). Even though Leo has ADHD.” – Michael

Michael's teaching assistant reported “*I think he has come to accept that he can't do the work*” and that “*he just knows he's special*”. Both these comments indicate that Michael is aware that he has different needs from other children.

Although the data gathered during this research does not evidence that Michael felt different as a direct result of his ADHD what these findings highlight is the risk to self esteem associated with an awareness of difference, in the absence of adequate support in understanding needs.

8.2.3 Outcomes associated with ADHD.

This theme covers the experiences Michael has had which were arguably associated with his ADHD; that is how having ADHD has affected him day to day. Within this main theme there are three subthemes which will now be explored in turn.

Feelings.

Michael's feelings have also been discussed where relevant to other themes, the references below cover Michael's negative feelings towards his diagnosis. Below

is an example of Michael's mother reporting how he is frustrated by his symptoms.

Michael's Mother: "He struggles with impulsiveness. He doesn't just get up and do something cause he thinks about it, it's just it has to be something that is set in his head".

Interviewer: "And how do you think he feels about those things? Do you think he struggles with the fact that he can't sit still?"

Michael's mother: "Oh yes it does, it frustrates the crap out of him"

Similarly, Michael's teaching assistant discussed the consequences of Michael's impulsivity, reporting that he can be upset by his own actions because he tends to act without thinking.

"They do something and then it's like, well no. I've just got to take longer. You wouldn't get that, he would just do what he wanted to do and then get upset about it afterwards." – Michael's teaching assistant

Impact on school

Michael's teaching assistant also suggested that he has fallen behind in school by saying *"The targets have been pretty similar for a long time"*. Michael's mother reiterated this concern as illustrated in the quote below.

"He's at the level of a 3 year old isn't he, writing, reading, he can't read actually. He can just about do his name" – Michael's mother

However, Michael's teaching assistant made point of the fact that when Michael does not feel challenged, or when he is enjoying a task, then he is significantly more able. This is demonstrated in the following two quotes.

"He could read a three letter word but it would depend on what context. He wouldn't want to read in...he wouldn't read flashcards for you. But he if you brought in an iron man book and you read some and then said "oh you can read that one"" – Michael's teaching assistant

Further support for the argument that Michael would benefit from highly tailored approaches to learning was the regular reference Michael's teaching assistant made to the effect of Michael's low self-esteem on his ability to learn. She

reported *“I don't know if he would associate that with his ADHD. He would tell you he can't do things, he's got very low self-esteem”*.

In the excerpt below, she discussed the strategies she is using in school to try and support Michael.

“If you've tailored the activity to something he wants to do, he would sit and concentrate for 10-15 minutes. But if he saw it as work, he wouldn't settle at all. Even to the state of he would see playing cards as work because they've got numbers on them and he would see a reading book as work, so if you bought in a different book he would enjoy listening to a story because he doesn't associate that with work. But he has got very low self-esteem so if he considers anything to be with work, he will assume that he can't do it.” – Michaels teaching assistant

Michaels teaching assistant also discussed how staff might misinterpret his behaviour in class.

“Yeah because he has got low self-esteem he would just assume he can't do things, which might make him appear inattentive” – Michaels teaching assistant

Finally, both Michael's mother and his teaching assistant referred to how to Michael's emotions affected his ability to engage at.

“Oh yeah he'd stay like that all day long if he is in one of his moods. Which then the teachers will know they won't get a thing out of him” – Michael's mother

“He gets very angry because he'll fall out with his friends a lot and then you don't know if that's because he doesn't want to do the work. You know, everything will spill over from play time.” – Michael's teaching assistant

These examples are further support to the argument that we should be supporting the self-esteem of young people with ADHD.

Relationships.

As referenced in Solomon's case, it has been highlighted in the literature that young people with ADHD are at greater risk of negative social interaction (Pelham & Fabiano, 2008; Looyeh et al.,2012). In Michael's case, however, there appears to be evidence of both positive and negative social engagements. Michael made regular reference to his friend Leo (pseudonym), who Michael appears to feel he can relate to.

“Leo, he has ADHD like me, and I don't know what else he has, he is my bestest friend, he is like kind of like special like me” – Michael

Michael's teaching assistant also made reference to Michael having close friends and being supported by his twin sister and his peers. Although she notes that they recognise his differences, in this instance their awareness appears to have had a positive impact.

“He's got two very good friends. He's got a twin, and she looks after him, and the other children would look after him. They would know he was different. He wouldn't play.” – Michael's teaching assistant.

Although the findings above suggest that Michael is having some positive interactions within this school, he also reported feeling as though he did not have a lot of friends in school. When Michael was asked why he thought that he did not have many friends he replied *“cause a lot of people don't like me in this school”*. He went on to say *“They don't really want to play with me but Leo tries to get people to play with us, but they just say no no no no.”*

Michael's teaching assistant also made reference to Michael struggling to get on with his peers, she comments on regular social misunderstandings and negative social interactions.

“He is always falling out with his friends, and they completely misunderstand each other. Like when they explain it, one of them could have said we will play with two people now and the other one will take that to mean "I'm not your best friend". misunderstanding social situations all the time.” – Michael's teaching assistant.

Finally, Michael's mother made a number of references to difficulties she is having integrating Michael into their home life. She reported that they can't play games together at home as Michael *“gets frustrated with everyone”*. Michael's mother then went on to talk fairly openly about how she and her family are struggling in response to Michael's needs.

“Drives us nuts, it's not an easy life. He has to share everything with the 13 year old brother, they fight, council won't help us to separate them cause it's not helpful, but it's not just ADHD Michael has. He has OCD, ADD, dyspraxia, grommets in both ears.” – Michael's Mother.

8.2.3 Intervention data and follow up interview.

Presented below is the data collected from the two sessions using tools derived from PCP. Then, in the following section the findings from the post intervention interviews are presented and discussed.

The Ideal Self.

In this activity, the young person is asked to first draw an “ideal self”, and then to draw a picture of himself, and discuss the differences. Below is a scanned copy of Solomon’s work, followed by a detailed account of what was drawn.

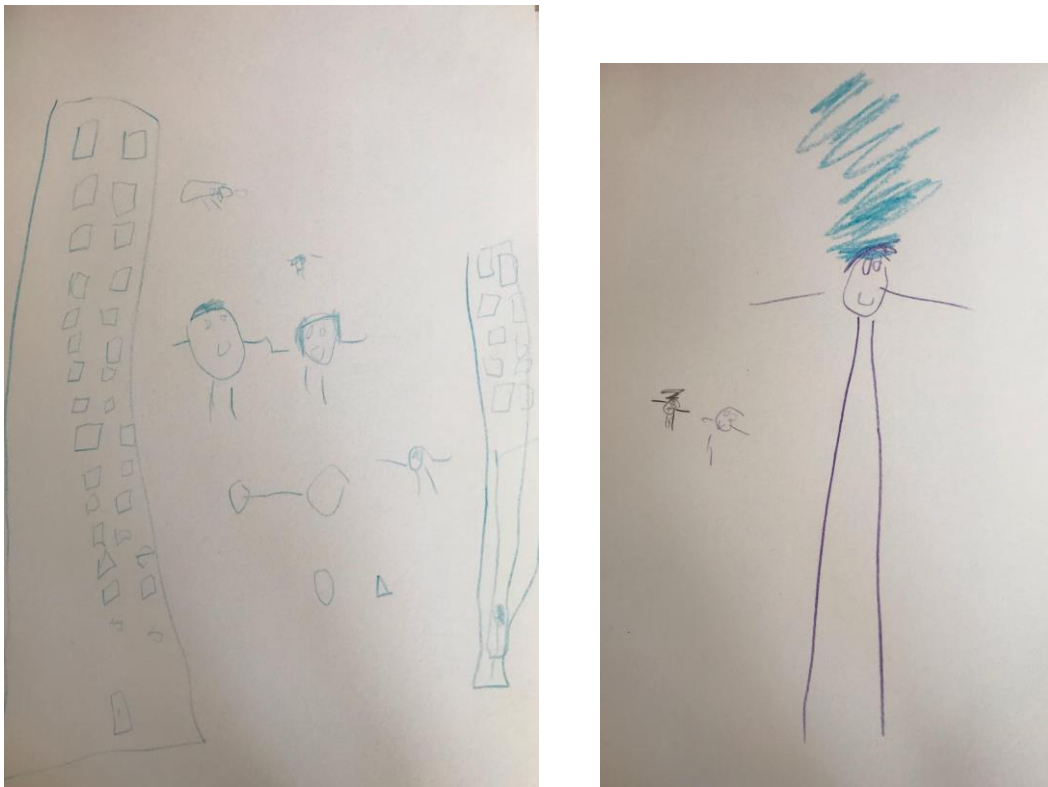


Figure 25. Scanned Copy of Michael’s ideal self (left) and real self (right)

For Michael’s ideal self he drew a police man who lives in a large building in which he keeps many animals. He explained that he wanted to be a police officer so that he could arrest people. Michael did not want to go into much greater detail than this. Michael’s teaching assistant commented at this stage that she felt he had not thoroughly understood the task. When Michael was asked to draw his true self, he drew a person with long legs and one friend. Michael explained that this was him, except that he did not know whether or not he was tall. It appeared

that Michael had not thoroughly understood what he had been asked to do but he reported that he liked drawing and animals.

Salmon Line and The Three Comments Technique.

In the Salmon Line Activity, the young person is asked to identify someone whom they admire or look up to. They are then supported in developing 3 bi-polar constructs based on three positive attributes that they can name about this person. The young person is then asked to put themselves on the scale with one mark, and then again on the scale to demonstrate where they would like to be.

For the 3 comments technique the young person is asked to identify 3 people they consider important to them, and are then asked the following

“If I were to ask X to describe you in 3 words or phrases, what would they say?”

Below is a scanned copy of both of these activities, followed by a detailed account of the session.

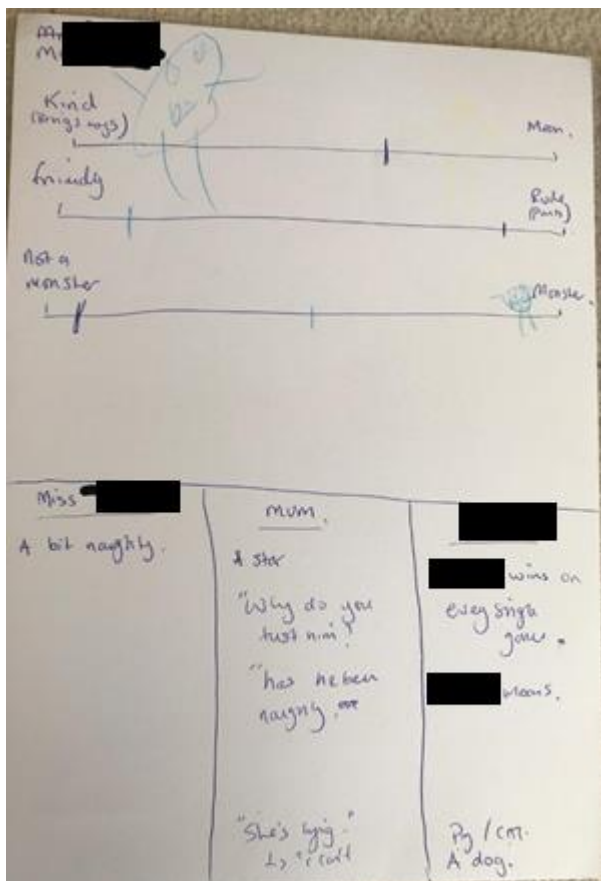


Figure 26 Scanned copy of Michael’s Salmon Line and Three Comments Technique

Michael identified his teaching assistant as the stimulus for the Salmon line activity. He described her as kind, friendly and “not a monster”. Michael then identified mean, rude and “a monster” to go at the far end of each scale. Michael also drew monsters on his scale, but explained that he did not feel he wanted to talk about them. Michael placed himself just over half way towards “mean” on his first scale, almost at the far end of his second scale towards “rude”, but near the “not a monster” end of his third scale. When he was asked to mark where he would like to be he drew himself as a monster on the first scale, significantly closer to the “kind” end of the spectrum. He then marked himself much closer to the friendly end on his second scale. Finally, Michael indicated that he would like to be more of a monster, by placing himself half way up his third scale, closer to the “monster” end. It is difficult to draw any conclusions around how Michael feels about himself, although his responses do suggest some level of self reflection, and possibly negative self image.

For the three comments technique Michael selected his teaching assistant, his mother, and his friend Leo.

Table 8.5

Three comments technique – Case Two

Teaching assistant	Mum	Leo
A bit naughty	A star	Michael always wins on every single game
	“Why do you trust him?”	
	“Has he been naughty?”	Leo Moans
	“She’s lying, I can’t”	Pig/cat A dog

The common theme across these answers, is that Michael believes that adults around him perceive him as a “naughty” or badly behaved child. In the case of his mother, Michael appeared to be referencing things his mother had said to him,

which may give us some indication how Michael's beliefs about the way other people perceive him have developed.

Michael appeared to lose interest by the time we were speaking about Leo's views, his answers were based on a conversation that he had Leo had recently had, and then he started listing animals and laughing.

Post intervention interviews

Following the intervention, Michael and his teaching assistant (TA) were met and interviewed separately to explore their experiences of the sessions. Michael was reluctant to answer any of the questions in this session and answered "I don't know" to every question unless heavily prompted. For example:

Interviewer: "*Did you find the intervention difficult or easy?*"

Michael: "*Easy*"

Consequently, there are no excerpts from Michael's post intervention interview included in the results below. However, the themes from the interview with Michael's teaching assistant are presented in the table below. These themes will then be discussed in turn.

Table 8.6

Overview of Themes: Phase Two, Case Two, Post Intervention Interviews

Themes	Sub themes
Positive outcomes	
Negatives and recommendations	<ul style="list-style-type: none">• Intervention was too difficult• Practical difficulties

Positive outcomes

Michael's teaching assistant felt that the intervention was pitched at too high a level for a young person of Michael's needs, and therefore reported very little positive impact. However, she did make the following comments which indicate some form of positive outcome.

"It was interesting to find out what he thought about it"

"You just realise how innocent he is."

Both of these quotes are examples of Michael's teaching assistant learning something about the young person. However, she was not able to see any positive impact of these realisation.

Negatives and recommendations

Intervention was too difficult

Like the teaching assistant working with Solomon, Michael's teaching assistant suggested that the intervention was pitched too high for a young person at Michael's level.

"Yeah I think he seemed to respond well to it. The last one, he's not got the language for scales and things like that."

However, she went on to recommend ways to make the content of the session more needs appropriate.

Teaching assistant: "I would just change that last session a bit, make it more appropriate to his language level"

Interviewer :" How do you think we could have changed the scaling to be more language appropriate. if we are thinking about how it needs to be these two bi-polar constructs like that, so how might we make that age appropriate".

Teaching assistant: "You get like opposites books, if you had an opposite book you could say you could put something in the middle[...] Mr tall and Mr small or whatever. Standing things in lines. Doing it physically like in year R rather than drawing it own on a piece of paper if he was moving he might understand it a bit more."

Finally, Michael's teaching assistant went on to report that she had felt Michael was not mature enough for this type of intervention. She questioned, even, whether it was helpful for him to be as self-reflective as the intervention requires.

"I don't think Michael is at the place mentally where it is good for him to know he is different in that way. I think he is too immature to take it on in that way. Like I'd imagine some children they could identify where they have got problems and maybe take themselves out of the situation and maybe respond well to it because they identify their difference so I'll do this, whereas I don't think Michael is mature enough to think "I can't concentrate on this"

Practical difficulties

Michael's teaching assistant brought up two points regarding the barriers to these techniques being applied in school: engagement and limitation on time.

First, she reported that she felt Michael would probably not engage in activities like this with a teaching assistant at school. She felt that he was willing to engage only because he was working with a novel adult and he knew he would not be expected to do it again.

"I think some of the things he did for you, he did for you because you're a visitor and he knows he's not got to do it again"

Michael's teaching assistant's second concern is demonstrated in the quote below. She felt that there was not time in a school day to offer interventions of this nature, even if they were helpful or necessary. If it were found that other teaching assistants felt the same, it would highlight some of the difficulties schools may face in responding to the government's push for schools to take on greater responsibility for children's mental health and wellbeing.

"It is just tricky because often when you are taking children, like I am told you've got to take Leo and Michael for maths and you might want to start with something else and then move on but you're always, you've got your maths targets and that's what you're doing. So it is hard to bring in something that they might need themselves because you know "I've got them for an hour, we are going to do maths, we are going to do a story and we are going to talk about it" It's a limited time."

8.2.4 Case two summary

Michael did not seem to have a good understanding of his ADHD. He associated it directly with his learning needs and anger. Due to conflicting reports, it was unclear how Michael learnt he had ADHD or how he will be learning about his ADHD going forwards.

It did not appear that Michael had a positive self-image. Michael recognised he had needs and acknowledged that they were different from his peers. Although Michael described himself as "special", he also described himself as "stupid" and "dumb". Michael also reported believing that the adults around him thought that he was naughty or not trustworthy, as presented in the findings from the intervention.

Michael's teaching assistant reported thinking that he had enjoyed the intervention, but that it had been pitched too high. She also reported recognising some things about Michael that she had not noticed before. However she still felt that the intervention would have no influence over her future practice.

Chapter 9 Phase Two Discussion

Each research question will now be discussed in relation to previous literature and the two cases described above.

9.1 Research Question 1: How Do Young People With ADHD Perceive Their ADHD And The Severity Of Their Symptoms?

Both Solomon and Michael appeared to have a limited understanding of their ADHD. This is consistent with previous research (Cooper & Shea, 1998; Arora & Mackey; 2004), and with Phase One. Their low level of understanding also limited their capacity to discuss the severity of their symptoms. Both young people spoke about finding it difficult to control themselves and saw anger as a core component of their disorder. It is worth noting at this stage that equating their disorder to an observable trait, could be an age appropriate mechanism. Although neither young person described their behaviour as “impulsive”, the behaviours which they described were intrinsically impulsive behaviours e.g violent outbursts. It is argued, therefore, that although neither young person was able to describe their behaviour as impulsive, they were able to identify negative behaviours in themselves that are objectively impulsive. This finding is consistent with the findings of Singh (2011) who explored the aggressive components and perceptions of ADHD.

Although both Michael and Solomon made reference to finding it difficult to focus, neither was able to articulate the degree to which this affected them. Solomon did report finding it “*really really*” difficult to focus, however this was heavily prompted and it is arguable that he was expressing the views of the adults around him as opposed to being self-aware. Consequently, it is suggested here that apart from recognising that they lacked control over their own behaviour, neither Solomon nor Michael expressed an awareness of the severity of their symptoms. Previous research has found young people with ADHD to be adequately aware of their symptoms (Wong et al, 2018). So it is possible that the age and additional needs of these young people reduced their awareness of ADHD symptoms or limited their ability to talk about them.

The key finding associated with research question one, is that there was a disparity for both young people between their level of awareness and their level of understanding. Both young people appeared to have some level of awareness

that they were “*different*” or impulsive, and Michael made regular reference to underachieving academically. However, neither was able to articulate an understanding of their needs. It will be argued below, in research question three and in the overall discussion of this thesis, that it is this disparity that may be affecting the wellbeing of young people with ADHD. A reflection of how appropriate the data collection methods were, given the needs of these young people, will also be discussed in the overall discussion of this thesis.

9.2 Research Question 2: What Influences the Perceptions That Young People With ADHD Have Of The Severity Of Their Symptoms?

This research question has been separated into two parts, first how the young person has developed their understanding of ADHD, and second how they have become aware of their ADHD and/or symptoms.

9.2.1 Understanding.

For both young people it appeared that they were told about their ADHD by their mother, although there was some contradictions with regards to this in Michael’s case. Neither teaching assistant reported having explicit conversations with the young person about what ADHD is, or what it might mean for them. This is of significance as one of the key findings of Phase Two was that neither parent appeared to have an in depth understanding of ADHD themselves. This is consistent with the findings of Phase One and could explain the limited understanding presented by both young people. These ideas support the findings of Moore et al. (2017), who argued the importance of parent understanding in order to support the understanding and wellbeing of young people.

9.2.2 Awareness

Partly consistent with the literature and with the findings of Phase One, both young people appeared to have some degree of awareness of their needs (Wong et al, 2018). For Solomon and Michael this awareness appeared to be influenced by the ways in which others treated them, as well as a level of self-reflection and assessment. Both young people were aware of the needs they had around self-control or impulsivity as evidenced by their ability to report on their own behaviours. Michael also showed awareness of his academic needs and inability to concentrate in class as evidenced both by his dialogue about them but also his ability to compare himself to his friend Leo. The above examples suggest that these young people are developing their awareness through some degree of self-reflection. Further, it was suggested that both young people were in some way

aware of the effects that their medication had on their behaviours, which could also suggest a level of self-awareness. As referenced in Phase One, this is consistent with findings from Singh (2007) who explored young people with ADHD's perceptions of their medication. It was also reported that Solomon and Michael were aware of the additional support they received in school. They were also aware of how others treated them or spoke about them. These experiences appear to have raised the young people's awareness of how they are different from their peers, but they do not appear to have supported them in understanding exactly how or why they are different from their peers. This is further support for the argument that the adults around these two young people should be adequately educated around ADHD, to reduce risk of misinformation or negative perceptions being passed down.

9.3 Research Question Three: How And To What Extent Do These Perceptions Impact The Young People's Wellbeing?

The findings associated with research questions one and two have highlighted the disparity between both young people's awareness and their understanding. Below are two worked examples of how this may have affected their wellbeing.

Solomon reported feeling that he was not always in control of his behaviour and would do things he regretted afterwards. This shows some level of awareness that he experiences impulsivity. Solomon also reported feeling incredibly remorseful and upset following these experiences. It could be argued that if Solomon had a better understanding of his ADHD, then he would be better equipped to manage these sorts of behaviours. As an example, Parker, Zaboski, and Joyce-Beaulieu (2016) conducted a case study exploring the use of Cognitive Behavioural Therapy with a young person experiencing anger as part of their ADHD. Cognitive Behavioural Therapy, amongst other things, supports young people in better understanding the relationship between their feelings, thoughts and behaviours (Dobson & Dozois, 2019). Parker et al. (2016) reported positive results across the young person's behaviour and their social experiences. It is important to note, however that the young person in Parker et al. (2016) study was significantly older than both Solomon and Michael.

Michael made regular reference to not being able to work at the level of his peers. This shows a certain degree of self-reflection and awareness of his own needs. It is also well supported in the literature that young people with ADHD are at risk of lower academic achievement (Daley and Birchwood, 2010; Shaw et al, 2012; Washbrook, et al., 2013), Michael was also reported to experience low self-esteem and reported that these needs made him feel “*stupid*”. It could be argued that if Michael had a better understanding of his needs, and the reasons he might find it more difficult to focus or engage with academic tasks, then his self-esteem would be less at risk. It is argued, therefore, that being aware of symptoms but not understanding them could create risk of low self-esteem, social interaction difficulties, and genuine distress and remorse. References made throughout both cases to self-esteem are consistent with its regular occurrence throughout the literature. (Looyeh et al., 2012). There is also a wealth of research connecting self-esteem to more complex negative outcomes (Sowislo & Orth, 2013; Looyeh et al., 2012) highlighting self-esteem as a potential area to target for improvement in young people with ADHD.

Another core finding was that young people appeared to be developing some awareness of their ADHD based on the effects of their medication. As discussed in Phase One this is relevant when considered in the context of the research conducted by Singh (2007) who found that young people with ADHD who were taking medication, had a tendency to consider themselves as intrinsically bad. By not supporting young people with ADHD in adequately understanding their ADHD or their medication, it could be argued that they are being put at risk of the phenomena reported by Singh (2007).

The other findings of Phase Two associated with the wellbeing of young people appear to replicate the findings of previous studies. The relationship between anger and ADHD has been referenced throughout the literature (Singh, 2011), as have the difficulties that young people are facing within their education and social relationships (Washbrook et al., 2013). By presenting some of the difficulties Solomon and Michael have faced, this thesis aligns with the existing evidence base that shows young people with ADHD are at significant risk of negative outcomes.

9.4 Research Question 4: How and To What Extent Can Tools And Activities Derived From Personal Construct Psychology Be Used To Effectively Support Young People With ADHD?

This study does not provide sufficient evidence to conclude whether or not tools derived from PCP could be used to effectively support young people with ADHD. However, some findings do suggest that these techniques would be effective when working with young people with ADHD. On the other hand, they also indicate that there may be barriers to implementing them. It is argued here that the ways in which young people understand and are aware of their ADHD symptoms and how they affect their experiences at home and at school is likely to affect their wellbeing. This argument is supported by the literature (Wong et al, 2018). These ideas are in line with those of PCP (Kelly, 1955), and it is therefore argued that tools derived from PCP could still be of value to young people with ADHD.

There were two core limitations reported associated with the use of tools derived from PCP. However, neither limitation is necessarily specific to working with young people with ADHD. First was that school staff felt they did not have the time to offer additional support of this kind. This is not surprising given the additional pressures which are reported by school staff across the country in response to reduced budgets and increasing expectations (Wheeler et al. 2008). Second was that both teaching assistants reported the tasks were too complex for young people of this age and level. If tools developed from PCP are going to be used to support young people with ADHD, the approach will need to be highly tailored to each young person and their needs.

Chapter 10 Discussion

Having presented the findings from both phases, this final chapter aims to conclude the research by reiterating the overall aims and linking the two phases together. This chapter will explore and discuss the overarching findings across both phases, bringing together the findings of this research in the context of previous literature and then presenting two interlinking models which draw the findings together. Limitations of both phases are explored, as well as suggestions for future research, before presenting a final conclusion.

10.1 Overall Aims

The overall aims of this thesis were to explore the perceptions and experiences of young people with ADHD. Within this the aims were twofold: First, to explore the perceptions of ADHD and symptoms as well as the impact that these perceptions may have; Second, to explore the use of tools derived from PCP when working with young people with ADHD. It is argued below that all of the above aims were partially met, however there were significant limitations to the research and extensive further research would be needed to draw any firm conclusions.

10.2 Overarching Findings

10.2.1 Parent understanding.

Parents' attitudes and understanding of ADHD have been explored extensively in the literature (Harborne, Wolpert, & Clare, 2004; Wong et al, 2018). A coherent theme throughout both phases was the idea that parents of young people with ADHD may not be being adequately supported following diagnosis. The SENCOs who were interviewed in Phase One reported consistently that they experienced parent understanding as low, and that this was directly impacting the young people. Parents in Phase Two also showed limited understanding of their child's diagnosis and needs.

Some of the SENCOs in Phase One directed the responsibility onto the paediatricians. There were numerous references to parents not being given, or being able to then provide, adequate explanation to their children with regards to their ADHD. These SENCOs felt that more should be done on behalf of the paediatrician to improve parent understanding. According to NICE guidelines, parents should be receiving this support, however as reported by Banerjee and Kewly (2009), it can be difficult for paediatricians to meet the demands of their

workload. As will be discussed below, schools are also reporting that they do not have the time or resources to support young people or parents in this way.

The findings presented in this thesis, although gathered from a small sample, align with extant literature which strongly supports the notion that adult understanding of ADHD is relevant to the understanding and wellbeing of the young people (Moore, et al., 2017). This highlights the necessity to explore effective ways to support parents of young people with ADHD.

10.2.2 Awareness and Understanding

A key finding across both phases was a discrepancy between awareness and understanding held by the young people with ADHD discussed within this research. Although it was generally agreed that young people were aware of their ADHD and their symptoms, it was also agreed that they were unlikely to have an in depth understanding of them. Both of these findings are consistent with the literature (Wong et al, 2018). However, there does not appear to be extensive research specifically exploring the outcomes of this discrepancy.

It is posed here that by allowing young people to be self-reflective, or by drawing their attention to their ADHD and symptoms without supporting their understanding, we could be putting their wellbeing at risk. As is discussed at greater length below, and has been discussed in the literature, young people with ADHD are at risk of developing their own negative, wrong or problematic understandings of ADHD (Singh, 2007). For the young people in this study, this led to negative self-image, low self-esteem, and lack of motivation to engage in work

10.2.3 Schools feel unequipped.

As was referenced in the rationale for this research, young people with ADHD are at heightened risk of a number of negative outcomes (Leaberry, Rosen, Slaughter, Resse, & Fogleman, 2019). This literature alone provides argument for additional support in school for these young people. Further, as argued above, the literature and findings of this research suggest that young people and their parents should be better educated around their diagnosis. However, participants of both Phase One and Phase Two discussed financial and time constraints on providing young people with ADHD the adequate support in school. This is unsurprising with the increasing pressure on schools which has been documented and explored both in the literature and the media, with an onus being

placed on a reduction in school funding and capacity (Thorley, 2016). What this highlights is that the mental health and wellbeing outcomes associated with ADHD, though thoroughly researched, may not yet be being appropriately targeted. Suggestions for future research are predominantly referenced below, however it is argued here that research into possible interventions should be employed in the context of the financial and time constraints which schools are facing in contemporary Britain: helping schools to support young people with ADHD with the limited time and resources they currently have available to them.

10.2.4 Anger and frustration.

There were numerous references to the emotions of young people with ADHD throughout both phases of the research, most common however, were anger and frustration. This is directly in line with previous research and provides further argument to the work of Seymour and Miller (2017) who identified frustration as a possible mediating link between ADHD and depression. In a recent study Leaberry et al. (2019) used quantitative methods to directly relate anger dysregulation to negative affect in young children with ADHD. Although these findings are not novel, they are supportive of previous literature and arguably support the development of interventions which target feelings of anger and frustration in young children with ADHD.

10.2.5 Naughty.

Across both phases, the term “naughty” was been used by parents, staff and young people as a descriptive for young people with ADHD. Challenging behaviour was referenced frequently throughout Phase One and Phase Two and has been explored in relation to ADHD extensively (Meijere, Van Den & Tobi, 2009; Faraone & Buitelaar, 2010). The relevance of these findings and the previous literature is twofold. First, in the context of the challenges schools are facing while managing the needs of up to 31 pupils per class. Challenging behaviours like those described extensively in the literature and referenced in both phases of this research, are likely to cause disruption within the classroom. Although there is research and recommendations around classroom strategies (Moore et al. Ford, 2017; Moore et al, 2015), previous literature and the findings from this research suggest that they are not consistently effective. While this may be difficult for teaching staff and the other young people in class, it also may

account for the academic gap which has been reported between young people with ADHD and their typically developing peers.

Second, and perhaps more importantly when discussing concepts of well-being, is the perceptions that others have of young people with ADHD. Aside from the risks of stigma and marginalisation based on the negative perceptions of others, Moore et al. (2017) notes the difficulties associated with negative relationships between students and staff. By perceiving a young person as “naughty” a staff member is arguably at greater risk of negative affect towards them, and this in turn can impact the effectiveness of their teaching and interventions.

10.2.6 Personal Construct Psychology and ADHD.

It was argued in the literature review that the ideas and theory of PCP (Kelly, 1955) were in line with the evidence that the way in which young people experienced their ADHD was impacting on their wellbeing (Wong et al, 2018; Mukherjee et al, 2016; Moses, 2010). The hypothesis was that it may have been of value for the school staff and the young person to develop a better understanding of the young person’s personal constructs: how the young person understands, perceives and experiences the world in the context of their diagnosis. This research did not produce any practical evidence that the tools derived from PCP could be of value. However, nor did it produce any evidence against this notion. What was indicated was that the tools which were selected were too complex for the young people who were recruited, given their needs and levels. What was found, however, was support for the arguments presented in Wong et al’s (2018) literature review, that the ways in which young people understand their ADHD impacts on their wellbeing. It is argued therefore, that although this research was not able to report positive or pervasive effects of tools derived from PCP, further research into its use could still be of value.

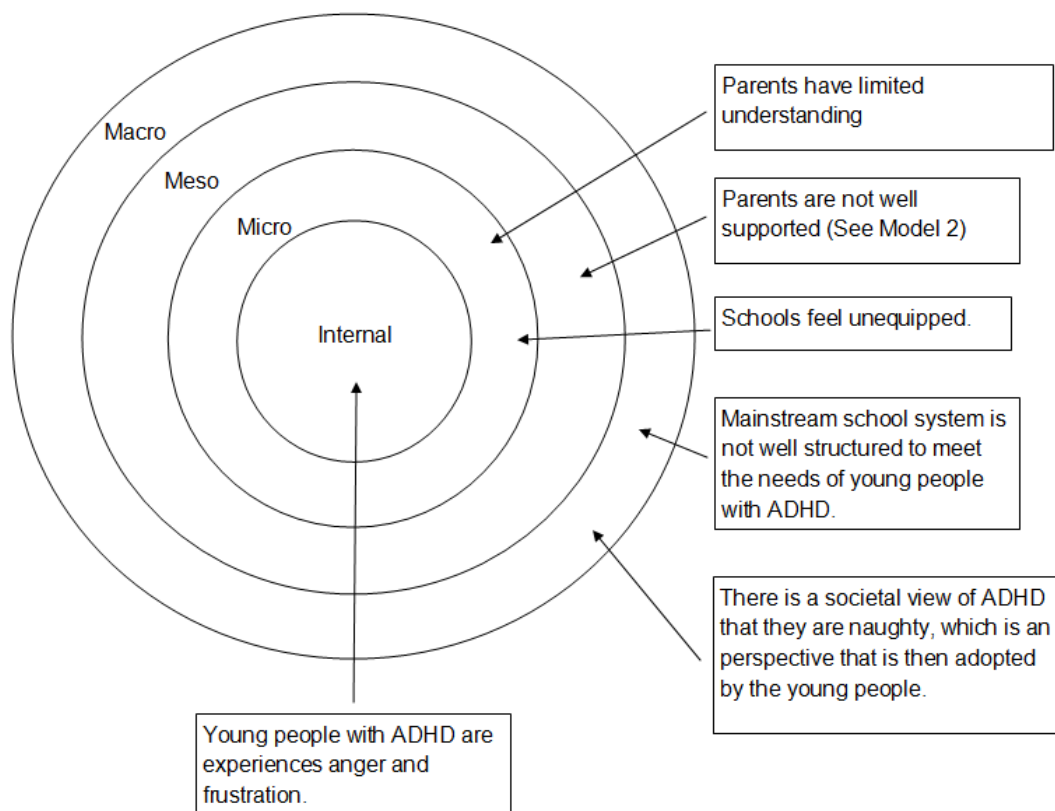
10.2.7 A Common Sense and Ecological Model of ADHD and Wellbeing

Drawing together these overarching findings, presented below are two interconnecting models which could help contribute to our knowledge about the interaction between ADHD and wellbeing. The findings of this research align with the Common Sense Framework of Illness (Leventhal, 1980). They suggest that the ways in which young people with ADHD perceive and understand their ADHD could affect their wellbeing. However, the results from this research and qualitative and small scale and therefore not generalisable. These ideas are

better represented in the systematic literature review from (Wong et al, 2018) who found a wealth of literature supporting the claim that perceptions are likely to impact coping and wellbeing. What distinguishes the findings presented here from those of Wong et al (2018) is that this thesis explored in greater detail the ways in which young people are developing these perceptions. As can be seen in the model below, this research also aligns directly with an ecological model, and as such Bronfenbrenner's (1978) ecological theory has been used as a base for the visual representation below. Each item can be mapped onto sections 11.2.1-11.2.5 above.

Figure 27

Model one.

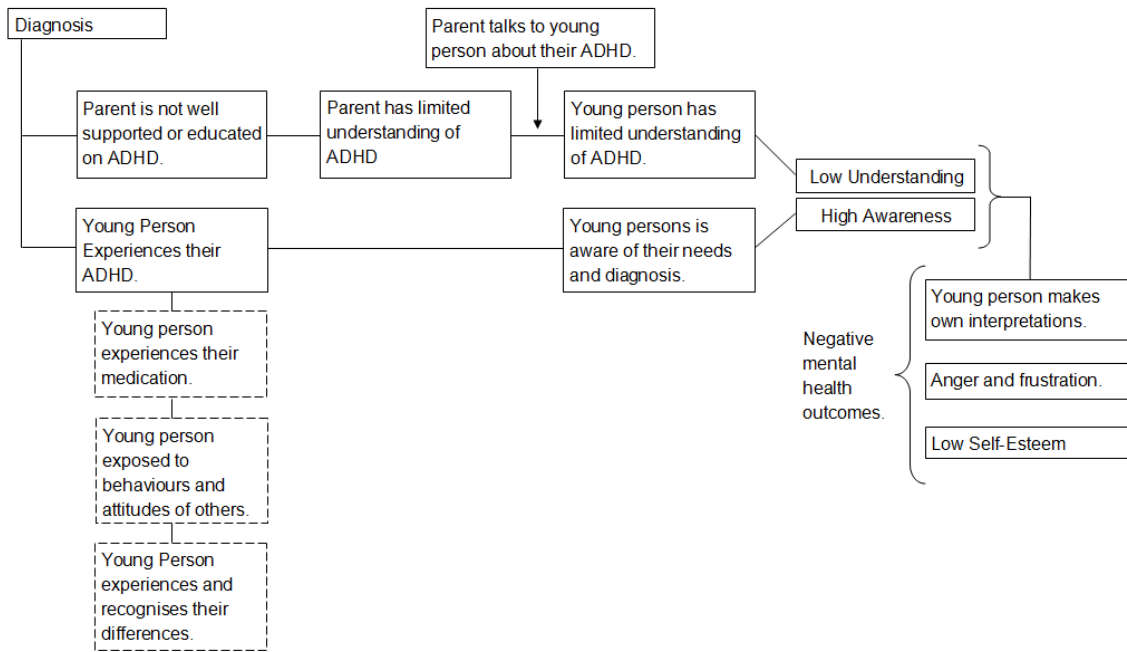


The model above demonstrates the possible factors influencing the young person, the model below is intended to provide a more explicit picture of how and these influences might impact their wellbeing. Developed in response to the findings of this research, but still aligning with an ecological model, this second model could explain the discrepancy between understanding and awareness in young people, the role of parents understanding, and the impact that this might

have on their wellbeing. The model is visually presented below, and then described in detail.

Figure 28

Model two



In this model the young person receives a diagnosis of ADHD, but the parent is not offered appropriate levels to support in understanding what this means or how to support their child. While the parent continues supporting the young person with limited understanding, the young person is exposed to the various ways in which their ADHD affects them (medication, behaviour of others, academic and social differences). While the young person’s awareness of their difficulties increases, there is no catalyst for their understanding of their ADHD to do the same, as their parents are not equipped to support them in this way. In this model it is this timeline that leads to the discrepancy between awareness and understanding. It is then this discrepancy which may then lead to lowered self-esteem, anger, frustration and the young person developing their own, perhaps maladaptive, interpretations of their experiences.

This model fits within an ecological perspective, acknowledging the impact of interacting factors,. It has been acknowledged historically that paediatricians may not be able to offer the necessary level of support to parents (Banerjee & Kewley, 2009), a view that was reiterated throughout the findings of this

research. Self-esteem, as references throughout the research findings, has been explored in relation to ADHD previously (Looyeh et al, 2012) and has also been found to be a significant predictor of negative mental health outcomes (Sowislo & Other, 2013), anger and frustration (Seymour, Macatee & Chronis-Tuscano, 2016). The distinction, however, between this model and the literature referenced above, is the suggestion of a possible causal explanation from ADHD to these outcomes. In this case, parents understanding is acting as a catalyst. Further explorative research would be needed to establish the accuracy and transferability of this model.

10.3 Limitations and Future Research

As can be seen in Appendix 1.3 this research underwent redesign part way through data collection. This was in response to difficulties in recruiting parents and young people within the time constraints set by the thesis deadline. It was decided at this time to recruit SENCOs in order to explore the research aims and questions. This research adopted an interpretivist stance which would dictate that the best way to explore a phenomenon is to ask those directly experiencing it. As such, it could be that future research would explore the views of parents or young people, rather than the views of SENCOs who are arguably further removed from the actual phenomena. Although this was addressed at least in part during Phase Two, the case study design limits extensive coverage of multiple views or experiences. Further, time constraints on data collection meant that the sample size for the online questionnaire was not as large as had been anticipated. Although qualitative research of this sort could never be claimed to be generalisable, a larger and more diverse sample could have made the findings more applicable or transferable to practice.

There were three key limitations to Phase Two, the first of which was also identified in the discussion and key findings. The young people who participated in the research were not able to adequately understand or therefore engage with the tools which were selected for the intervention. It would be worth exploring its use with more needs and age appropriate techniques. This limitation extends to the use of interviews as a data collection method, in that both young people found it difficult to articulate their views. Although this was an appropriate and fruitful data collection technique for the adults who participated in this research, future research would benefit from visual, or practical data collection when working with

the young people. It is acknowledged that this limitation could have been avoided through the use of pilot interviews. As referenced in the methods section of Phase Two, however, this was not possible due to the limited available participants, and the significant time restraints.

A second limitation was the homogenous nature of the sample. Both young people who were recruited were enrolled in the same year of the same school, and both from similar backgrounds. Further, each had a diagnosis of ASD as well as their ADHD diagnosis. It could be valuable in future research to recruit a more diverse sample, however the interpretivist stance of this research did not require a population representative sample.

Finally, it is necessary to acknowledge the diagnosis of ASD held by both young people in Phase Two. ASD is a neurological condition that, amongst other things, affects young people's social communication skills (APA, 2014). Staying in line with the ecological model of ADHD, these needs are likely to be interacting with the outcomes for both young people, especially with references to their social experiences. This is further support for further research to gather a more diverse sample of young people.

10.4 Implications For Practice

This section will explore the potential implications for practice in educational psychology. However, before doing so it is important to acknowledge again the traded nature of educational psychology services across England. Following the recession in 2007/8/9 new budgets were imposed across the country, resulting in educational psychology in the UK moving in the direction of a traded model (Lee & Woods, 2017). Lee and Woods (2017) reported that very few educational psychology services across England are still free at point of delivery. This has led to heterogenous access or use of educational psychology services between schools. There has been argued to be an increased risk of reactive as opposed to preventative models of practice (Islam, 2013), and a model by which schools act as a customer and have greater agency over the sort of support that is offered by their educational psychologist (Lee & Woods, 2017). It is argued that this means that although research of this kind, and all of the literature that preceded it, could be of immense value, and reduce the negative outcomes associated with ADHD, it may not lead to intervention and support available to all. An alternative perspective however, also reported by Lee and Woods (2017), is that a traded

model allows greater autonomy and therefore an opportunity for educational psychologists to be more bespoke with the support they offer schools. From this perspective, it could be argued that research of this kind opens up new or developed avenues for the work of educational psychologists.

The above considered, it is still argued that there are practical implications of this research. It is argued below that there are three components of the role of the educational psychologist which this research may have implications for: assessment and exploration, training, and therapeutic support.

10.4.1 Assessment and exploration.

Educational psychologists are arguably most well-known for completing assessments of young people and their needs (Cameron, 2006; Lee & Woods, 2017). What research of this kind provides is some insight into the experiences of young people with ADHD, and how these experiences may be affecting them. When making assessment of social, emotional, mental health, it will be valuable to educational psychologists to be up to date with research of this kind in order to better understand how ADHD and related experiences may be impacting young people. This research highlighted anger, frustration, low self-esteem, and negative self-image, all as negative affect associated with ADHD. These are all concepts which have been explored in the literature before, however what this research suggested was that it may be helpful to assess the needs of parents as well as young people when working with ADHD. It is argued above that parent and adults understanding of ADHD has a significant impact on the young person.

10.4.2 Training.

Educational psychologists will often offer training to parents, schools or other professionals (Fallon, Woods, & Rooney, 2010). What this research, and the preceding literature has indicated is that parents are in need of additional support and education around ADHD. It is argued, therefore, that there is a place for educational psychologists in supporting or training parents in the skills and knowledge they need to appropriately support and educate their children. The findings of this research would suggest that parents may need support in recognising the importance of their children's understanding of their ADHD. However, beyond this there were no specific findings from this research that would indicate which are the best ways to educate or support parents. It is

suggested therefore, that exploring the core gaps in parent understanding would be a valuable direction for future research.

10.4.3 Therapeutic support.

Boyle and Lauchlan (2009) speak of a therapeutic model of practice that sees educational psychologists working 1:1 or in groups with young people. Although this research did not provide any evidence for the effectiveness of tools derived from PCP when working with young people, it did highlight the need to explore and understand their experiences. There may be a role, therefore, for educational psychologists to support young people in exploring these. It may be that by using more age appropriate tools derived from PCP could be useful in this kind of work. There is also indication from the literature that CBT could be a useful tool when working with young people with ADHD (Parker et al., 2016). There are components of CBT which explore maladaptive thought patterns, and the negative impacts that these might have (Beck, 2011). These theories relate to the findings of research and previous literature which has highlighted the importance of how young people with ADHD think about their disorder.

10.5 Conclusion

The rates of ADHD diagnosis are increasing across most western countries (Safer, 2018), and there has been a wealth of response to this in the literature. This thesis was predominantly interested in the relationship between ADHD, mental health and wellbeing. This research has added to the collection of research exploring the views and experiences of young people with ADHD, and its findings support the preceding literature. This research supports the argument that the ways in which young people understand their ADHD will affect their wellbeing. Further that a lack of understanding in the face of awareness of their symptoms puts young people with ADHD at heightened risk. This research also drew attention to the negative perceptions that both young people and the adults around them have of ADHD, and the associated behaviours. It also highlighted the necessity to better support parents in developing an adequate understanding of the diagnosis, what it means, and how they might best support their children. No concrete conclusions have been drawn about the use of PCP, however suggestions for future research have been made. Limitations of both phases have been recognised and reported, and implications for practice have been acknowledged.

References

- Adler, L., & Cohen, J. (2004). Diagnosis and evaluation of adults with attention-deficit/hyperactivity disorder. *Psychiatric Clinics of North America*, 27(2), 187-201. doi.org/10.1016/j.psc.2003.12.003
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Anderson, C. (2010). Presenting and evaluating qualitative research. *American journal of pharmaceutical education*, 74(8), 141. doi.org/10.5688/aj7408141
- Anderson, J. K., Howarth, E., Vainre, M., Jones, P. B., & Humphrey, A. (2017). A scoping literature review of service-level barriers for access and engagement with mental health services for children and young people. *Children and Youth Services Review*, 77(C), 164-176. doi: 10.1016/j.childyouth.2017.04.017
- Arora, T., Mackey, L., (2004). Talking and Listening to children diagnosed with ADHD and taking psychostimulants. In *Children at the Margins: Supporting Children, Supporting Schools*. Billington T, Pomerantz M (eds.). Trentham Books: Stoke on Trent
- Arnett, A. B., Pennington, B. F., Willcutt, E. G., DeFries, J. C., & Olson, R. K. (2015). Sex differences in ADHD symptom severity. *Journal of Child Psychology and Psychiatry*, 56(6), 632-639. doi: 10.1111/jcpp.12337
- Banerjee, S., & Kewley, G. (2009). ADHD service provision by paediatricians: UK survey. *Clinical Governance: An International Journal*, 14(3), 236-241. doi.org/10.1108/14777270910976175
- Beaver, R. (2011). *Educational Psychology Casework: A Practice Guide Second Edition*. Jessica Kingsley Publishers.
- Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond*. Guilford press.
- Becker, S., Luebke, A., & Lanberg, J., (2012) Co-occurring mental health problems and peers functioning among young people with attention-deficit/hyperactivity disorder: a review and recommendations for future research. *Clinical Child and Family Psychological Review* (15). 279-302. DOI 10.1007/s10567-012-0122-y
- Booster, G. D., DuPaul, G. J., Eiraldi, R., & Power, T. J. (2012). Functional impairments in children with ADHD: Unique effects of age and comorbid status. *Journal of Attention Disorders*, 16(3), 179-189. Doi: 10.1177/1087054710383239
- Borghans, L., Golsteyn, B. H., & Stenberg, A. (2015). *Does expert advice improve educational choice?* 10(12).

- Boyle, C., & Lauchlan, F. (2009). Applied psychology and the case for individual casework: some reflections on the role of the educational psychologist. *Educational Psychology in Practice*, 25(1), 71-84.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77-101.
- Brinkmann, S., & Kvale, S. (2008). Ethics in qualitative psychological research. *The Sage handbook of qualitative research in psychology*, 24(2), 263-279. doi.org/10.1080/02667360802697639
- British Psychology Society. (2014). Code of Human Research Ethics [Online]. Available: <https://www.bps.org.uk/news-and-policy/bps-code-human-research-ethics-2nd-edition-2014>
- Bryman, A. (2008). Of methods and methodology. *Qualitative Research in Organizations and Management: An International Journal*, 3(2), 159-168. doi.org/10.1108/17465640810900568
- Cameron, R. J. (2006). Educational Psychology: The distinctive contribution. *Educational Psychology in Practice*, 22(4), 289–304. doi.org/10.1080/02667360600999393
- Caputi, P., Hunter, M. G., & Tan, F. B. (2009). Personal Construct Theory. *In Handbook of Research on Contemporary Theoretical Models in Information Systems* (496-515).
- Carr, A. (2009). The effectiveness of family therapy and systemic interventions for child-focused problems. *Journal of family therapy*, 31(1), 3-45. doi.org/10.1111/j.1467-6427.2008.00451.x
- Conejero, I., Jausent, I., Lopez, R., Guillaume, S., Olié, E., Hebbache, C., ... & Lopez-Castroman, J. (2019). Association of symptoms of attention deficit-hyperactivity disorder and impulsive-aggression with severity of suicidal behavior in adult attempters. *Scientific Reports*, 9(1), 45-93. doi.org/10.1038/s41598-019-41046-y
- Cooper, P., & Shea, T. (1998). Pupils' perceptions of ad/hd. *Emotional and Behavioural Difficulties: A Peer Reviewed Journal*, 3(3), 36-48.
- Daley, D., & Birchwood, J. (2010). ADHD and academic performance: why does ADHD impact on academic performance and what can be done to support ADHD children in the classroom?. *Child: care, health and development*, 36(4), 455-464. doi:10.1111/j.1365-2214.2009.01046.x
- Denckla, M. B. (1992). The myth of ADHD. *Journal of Child Neurology*, 7(4), 458-461. doi.org/10.1177/088307389200700424
- Department of Health and Social Care, and Department for Education. (2017). *Transforming children and young people's mental health provision: a green paper*.
- Department of Education. (2014). *Special educational needs and disability code of practice: 0 to 25 years*. Crown.

- Dixon, L. B., Holoshitz, Y., & Nossel, I. (2016). Treatment engagement of individuals experiencing mental illness: review and update. *World Psychiatry, 15*(1), 13-20. doi:10.1002/wps.20306
- Dobson, K. S., & Dozois, D. J. (2019). Handbook of cognitive-behavioral therapies. *Guilford Publications*
- Doernberg, E., & Hollander, E. (2016). Neurodevelopmental Disorders (ASD and ADHD): DSM-5, ICD-10, and ICD-11. *CNS spectrums, 21*(4), 295-299. doi.org/10.1017/S1092852916000262
- .
- Emmer, E. T., & Stough, L. M. (2001). Classroom management: A critical part of educational psychology, with implications for teacher education. *Educational psychologist, 36*(2), 103-112. doi.org/10.1207/S15326985EP3602_5
- Epstein, J. N., & Loren, R. E. (2013). Changes in the definition of ADHD in DSM-5: subtle but important. *Neuropsychiatry, 3*(5), 455. doi:10.2217/npv.13.59
- Evans, D., Borriello, G. A., & Field, A. P. (2018). A review of the academic and psychological impact of the transition to secondary education. *Frontiers in psychology, 9*. doi.10.3389/fpsyg.2018.01482
- Evangelista, N. M., Owens, J. S., Golden, C. M., & Pelham, W. E. (2008). The positive illusory bias: Do inflated self-perceptions in children with ADHD generalize to perceptions of others? *Journal of Abnormal Child Psychology, 36*(5), 779-791. doi.org/10.1007/s10802-007-9210-8
- Fallon, K., Woods, K., & Rooney, S. (2010). A discussion of the developing role of educational psychologists within Children's Services. *Educational Psychology in Practice, 26*(1), 1-23. doi.org/10.1080/02667360903522744
- Faraone, S. V., & Buitelaar, J. (2010). Comparing the efficacy of stimulants for ADHD in children and adolescents using meta-analysis. *European child & adolescent psychiatry, 19*(4), 353-364. doi.org/10.1080/02667360903522744
- Farrell, P., Woods, K., Lewis, S., Rooney, S., Squires, G., & O'Connor, M. (2006). A review of the functions and contribution of educational psychologists in England and Wales in light of "Every Child Matters: Change for Children". *Nottingham: DfES Publications*.
- Feuchtwang, A. (2016). Schools need better support to tackle mental health. *British Journal of School Nursing, 11*(3), 113-114. doi.org/10.12968/bjsn.2016.11.3.113 .2015.12.030
- Gabriel, Y. (2015). Reflexivity and beyond—a plea for imagination in qualitative research methodology. *Qualitative Research in Organizations and*

- Management: An International Journal*, 10(4), 332-336.
doi.org/10.1146/annurev-clinpsy-050817-084917
- Garland, R. (1991). The midpoint on a rating scale: Is it desirable? *Marketing Bulletin*, 2, 66–70.
- Gillham, B. (2000) *Developing a Questionnaire 2nd Edition*. London. Continuum International Publishing Group.
- 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.
doi.org/10.1177/1359104504043915
- Hardman, C. (2001). Using personal construct psychology to reduce the risk of exclusion. *Educational Psychology in Practice*, 17(1), 41-51.
doi.org/10.1080/02667360120039979
- Hartley, J. (2014). Some thoughts on Likert-type scales. *International Journal of Clinical and Health Psychology*, 14(1). doi.org/10.1016/S1697-2600(14)70040-7
- Hasson, D., & Arnetz, B. B. (2005). Validation and findings comparing VAS vs. Likert scales for psychosocial measurements. *International Electronic Journal of Health Education*, 8, 178-192.
- Hechtman, L. (2000). Assessment and diagnosis of attention deficit/hyperactivity disorder. *Child and adolescent psychiatric clinics of North America*, 9(3), 481- 498. doi.org/10.1016/S1056-4993(18)30102-0
- Hinshaw, S. P., & Arnold, L. E. (2015). Attention-deficit hyperactivity disorder, multimodal treatment, and longitudinal outcome: evidence, paradox, and challenge. *Wiley Interdisciplinary Reviews: Cognitive Science*, 6(1), 39-52. doi: 10.1002/wcs.1324
- Hinshaw, S. P. (2018). Attention deficit hyperactivity disorder (ADHD): controversy, developmental mechanisms, and multiple levels of analysis. *Annual review of clinical psychology*, 14, 291-316.
doi.org/10.1146/annurev-clinpsy- 050817-084917
- Honkasilta, J., Vehmas, S., & Vehkakoski, T. (2016). Self-pathologizing, self-condemning, self-liberating: Youths' accounts of their ADHD-related behavior. *Social Science & Medicine*, 150, 248-255.
doi.org/10.1016/j.socscimed
- Islam, S. (2013). *An investigation of educational psychologists' perceptions of traded service delivery* (Unpublished doctoral thesis). University of Birmingham.
- Iyengar, U., Snowden, N., A sarnow, J. R., Moran, P., Tranah, T., & Ougrin, D. (2018). A further look at therapeutic interventions for suicide attempts and self-harm in adolescents: an updated systematic review of

- randomized controlled trials. *Frontiers in psychiatry*, 9. doi: 10.3389/fpsy.2018.00583
- Kelly, G. (1955). *The Psychology of Personal Constructs*, New York: Norton.
- Kelly, Y., Zilanawala, A., Booker, C., & Sacker, A. (2019). Social media use and adolescent mental health: findings from the UK Millennium Cohort Study. *EClinical Medicine*, 6, 59-68. doi.org/10.1016/j.eclinm.2018.12.005
- Krauss, S. E. (2005). Research paradigms and meaning making: A primer. *The qualitative report*, 10(4), 758-770.
- Laurence, J., & McCallum, D. (1998). The myth-or-reality of attention-deficit disorder: a genealogical approach. *Discourse: studies in the cultural politics of education*, 19(2), 183-200. doi.org/10.1080/0159630980190204
- Leaberry, K. D., Rosen, P. J., Slaughter, K. E., Reese, J., & Fogleman, N. D. (2019). Temperamental negative affect, emotion-specific regulation, and concurrent internalizing and externalizing pathology among children with ADHD. *ADHD Attention Deficit and Hyperactivity Disorders*, 1-14. doi.org/10.1007/s12402-019-00294-8
- Lebowitz, M. S. (2016). Stigmatization of ADHD: A developmental review. *Journal of Attention Disorders*, 20(3), 199-205. doi.org/10.1177/1087054712475211
- Lee, K., & Woods, K. (2017). Exploration of the developing role of the educational psychologist within the context of “traded” psychological services. *Educational Psychology in Practice*, 33(2), 111-125. doi.org/10.1080/02667363.2016.1258545
- Leung, S. O. (2011). A comparison of psychometric properties and normality in 4-, 5-, 6-, and 11-point Likert scales. *Journal of Social Service Research*, 37(4), 412-421. doi.org/10.1080/01488376.2011.580697
- Leventhal, H., Meyer, D., & Nerenz, D. (1980). The common sense representation of illness danger. *Contributions to medical psychology*, 2, 7-30.
- Likert, R. A. (1952). A technique for the development of attitude scales. *Educational and psychological measurement*, 12, 313-315.
- Loe, I. M., & Feldman, H. M. (2007). Academic and educational outcomes of children with ADHD. *Journal of pediatric psychology*, 32(6), 643-654. doi.org/10.1093/jpepsy/jsl054
- Longhurst, R. (2003). Semi-structured interviews and focus groups. *Key methods in geography*, 3, 143-156.
- Looyeh, M. Y., Kamali, K., & Shafieian, R. (2012). An exploratory study of the effectiveness of group narrative therapy on the school behavior of girls

- with attention-deficit/hyperactivity symptoms. *Archives of psychiatric nursing*, 26(5), 404-410. doi.org/10.1016/j.apnu.2012.01.001
- Mackenzie, N., & Knipe, S. (2006). Research dilemmas: Paradigms, methods and methodology. *Issues in educational research*, 16(2), 193-205.
- Madon, S., Willard, J., Guyll, M., & Scherr, K. C. (2011). Self-fulfilling prophecies: Mechanisms, power, and links to social problems. *Social and Personality Psychology Compass*, 5(8), 578-590. doi.org/10.1111/j.1751-9004.2011.00375.x
- Matthews, N. (2009). Teaching the 'invisible' disabled students in the classroom: disclosure, inclusion and The Social Model of disability. *Teaching in higher education*, 14(3), 229-239. doi.org/10.1080/13562510902898809
- Maxwell, J. A. (2010). Using numbers in qualitative research. *Qualitative inquiry*, 16(6), 475-482. doi.org/10.1177/1077800410364740
- Meijer, W. M., Faber, A., van den Ban, E., & Tobi, H. (2009). Current issues around the pharmacotherapy of ADHD in children and adults. *Pharmacy world & science*, 31(5), 509-516. doi.org/10.1007/s11096-009-9302-3
- 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), 377. doi.org/10.1007/s11920-013-0377-0
- Moore, D. A., Richardson, M., Gwernan-Jones, R., Thompson-Coon, J., Stein, K., Rogers, M., ... & Ford, T. J. (2019). Non-pharmacological interventions for ADHD in school settings: an overarching synthesis of systematic reviews. *Journal of attention disorders*, 23(3), 220-233. doi.org/10.1177/1087054715573994
- 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. doi.org/10.1111/cch.12448
- Moran, H. (2006). A very personal assessment: using personal construct psychology assessment technique (drawing the ideal self) with young people with ASD to explore the child's view of the self. *Good Autism Practice*, 7(2), 78-86.
- Moses, T. (2010). Adolescent mental health consumers' self-stigma: Associations with parents' and adolescents' illness perceptions and parental stigma. *Journal of Community Psychology*, 38(6), 781-798. doi.org/10.1002/jcop.20395
- Moses, T. (2010). Being treated differently: Stigma experiences with family, peers, and school staff among adolescents with mental health

disorders. *Social science & medicine*, 70(7), 985-993.
doi.org/10.1016/j.socscimed.2009.12.022

Mukherjee, S., Shah, H. R., Ramanathan, S., & Dewan, M. (2016). Knowledge and attitudes about attention-deficit/hyperactivity disorder and specific learning disorder in an urban Indian population. *The Journal of nervous and mental disease*, 204(6), 458-463. doi: 10.1097/NMD.0000000000000524

National College for Teaching and Leadership (2014). *National Award for Special Educational Needs Co-ordinator: learning outcomes*. Retrieved from <https://www.gov.uk/government/publications/national-award-for-sen-co-ordination-learning-outcomes>

National Institute for Health and Clinical Excellence (NICE) (2017). *Attention Deficit Hyperactivity Disorder: Diagnosis and management of ADHD in children, young people and adults; draft for consultation*. Accessible at: <https://www.nice.org.uk/guidance/ng87/documents/short-version-of-draft-guideline>

National Health Service (2019). Getting Diagnosed, autism. Retrieved from <https://www.nhs.uk/conditions/autism/diagnosis/>

Norman, G. (2010). Likert scales, levels of measurement and the “laws” of statistics. *Advances in health sciences education*, 15(5), 625-632. doi.org/10.1007/s10459-010-9222-y

Norwich, B., (2012). How inclusion policy works in the UK (England): successes and issues. *What works in inclusion*, 53-65

Ohan, J. L., Visser, T. A., Moss, R. G., & Allen, N. B. (2013). Parents' stigmatizing attitudes toward psychiatric labels for ADHD and depression. *Psychiatric Services*, 64(12), 1270-1273. doi.org/10.1176/appi.ps.201200578

Olesen, S. C., Butterworth, P., Leach, L. S., Kelaher, M., & Pirkis, J. (2013). Mental health affects future employment as job loss affects mental health: findings from a longitudinal population study. *BMC psychiatry*, 13(1), 144. doi.org/10.1186/1471-244X-13-144

O'Reilly, M., & Parker, N. (2013). You can take a horse to water but you can't make it drink': Exploring children's engagement and resistance in family therapy. *Contemporary Family Therapy*, 35(3), 491-507. doi.org/10.1007/s10591-012-9220-8

Pajo, B., & Cohen, D. (2013). The problem with ADHD: Researchers' constructions and parents' accounts. *International Journal of Early Childhood*, 45(1), 11-33. doi.org/10.1007/s13158-012-0064-z

Parker, J., Zabolski, B., & Joyce-Beaulieu, D. (2016). School-based cognitive-behavioral therapy for an adolescent presenting with ADHD and explosive anger: A case study. *Contemporary School Psychology*, 20(4), 356-369. doi.org/10.1007/s40688-016-0093-y

- Pelham Jr, W. E., & Fabiano, G. A. (2008). Evidence-based psychosocial treatments for attention-deficit/hyperactivity disorder. *Journal of Clinical Child & Adolescent Psychology, 37*(1), 184-214. doi.org/10.1080/15374410701818681
- Peters, E. M., Balbuena, L., Marwaha, S., Baetz, M., & Bowen, R. (2016). Mood instability and impulsivity as trait predictors of suicidal thoughts. *Psychology and Psychotherapy: Theory, Research and Practice, 89*(4), 435-444. doi.org/10.1111/papt.12088
- Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal, 20*(1), 7-14. doi: 10.14691/CPJ.20.1.7
- Pitchforth, J., Fahy, K., Ford, T., Wolpert, M., Viner, R. M., & Hargreaves, D. S. (2018). Mental health and well-being trends among children and young people in the UK, 1995–2014: analysis of repeated cross-sectional national health surveys. *Psychological medicine, 1*-11. doi.org/10.1017/S0033291718001757
- Polanczyk, G. V., Willcutt, E. G., Salum, G. A., Kieling, C., & Rohde, L. A. (2014). ADHD prevalence estimates across three decades: an updated systematic review and meta-regression analysis. *International journal of epidemiology, 43*(2), 434-442. doi.org/10.1093/ije/dyt261
- Ravenette, T. (1999). *Personal Construct Psychology in educational psychology: A practitioner's view*. London: Whurr.
- Riddick, B. (2000). An examination of the relationship between labelling and stigmatisation with special reference to dyslexia. *Disability & Society, 15*(4), 653-667. doi.org/10.1080/09687590050058233
- Rodríguez, C., García, T., & Areces, D. (2017). New and future challenges concerning the use of virtual reality tools for assessing ADHD. *Current Developmental Disorders Reports, 4*(1), 8-10. doi.org/10.1007/s40474-017-0103-4
- Roy, A., Oldehinkel, A. J., Verhulst, F. C., Ormel, J., & Hartman, C. A. (2014). Anxiety and disruptive behavior mediate pathways from attention-deficit/hyperactivity disorder to depression. *The Journal of clinical psychiatry, 75*(2), 108-113. DOI: 10.4088/JCP.13m08648
- Safer, D. J. (2018). Is ADHD really increasing in youth?. *Journal of attention disorders, 22*(2), 107-115. doi.org/10.1177/1087054715586571
- Sayal, K., Washbrook, E., & Propper, C. (2015). Childhood behavior problems and academic outcomes in adolescence: longitudinal population-based study. *Journal of the American Academy of Child & Adolescent Psychiatry, 54*(5), 360-368. doi.org/10.1016/j.jaac.2015.02.007

- Sciberras, E., Ohan, J., & Anderson, V. (2012). Bullying and peer victimisation in adolescent girls with attention-deficit/hyperactivity disorder. *Child Psychiatry & Human Development*, 43(2), 254-270. doi.org/10.1007/s10578-011-0264-z
- Scime, M., & Norvilitis, J. M. (2006). Task performance and response to frustration in children with attention deficit hyperactivity disorder. *Psychology in the Schools*, 43(3), 377-386. doi.org/10.1002/pits.20151
- Seymour, K. E., Macatee, R., & Chronis-Tuscano, A. (2016). Frustration tolerance in youth with ADHD. *Journal of attention disorders*, 1-11. doi.org/10.1177/1087054716653216
- Seymour, K. E., & Miller, L. (2017). ADHD and depression: the role of poor frustration tolerance. *Current Developmental Disorders Reports*, 4(1), 14-18. doi.org/10.1007/s40474-017-0105-2
- Shaw, M., Hodgkins, P., Caci, H., Young, S., Kahle, J., Woods, A. G., & Arnold, L. E. (2012). A systematic review and analysis of long-term outcomes in attention deficit hyperactivity disorder: effects of treatment and non-treatment. *BMC medicine*, 10(1), 99. doi.org/10.1186/1741-7015-10-99
- Singh, I. (2007). Clinical implications of ethical concepts: Moral self-understandings in children taking methylphenidate for ADHD. *Clinical Child Psychology and Psychiatry*, 12(2), 167-182. doi.org/10.1177/1359104507075920
- Singh, I. (2011). A disorder of anger and aggression: Children's perspectives on attention deficit/hyperactivity disorder in the UK. *Social science & medicine*, 73(6), 889-896. doi.org/10.1016/j.socscimed.2011.03.049
- Social Care Institute for Excellence. (2017). Improving mental health support for our children and young people. Retrieved from https://www.scie.org.uk/children/care/mental-health/report?utm_source=The%20King%27s%20Fund%20newsletters&utm_medium=email&utm_campaign=8848297_NEWSL_HMP%202017-1107&dm_i=21A8,59NE1,QUW9YG,KBTHA,1
- Snider, V. E., Busch, T., & Arrowood, L. (2003). Teacher knowledge of stimulant medication and ADHD. *Remedial and Special Education*, 24(1), 46-56.
- Sowislo, J. F., & Orth, U. (2013). Does low self-esteem predict depression and anxiety? A meta-analysis of longitudinal studies. *Psychological bulletin*, 139(1), 213. doi.org/10.1037/a0028931
- Storebø, O. J., Rasmussen, P. D., & Simonsen, E. (2016). Association between insecure attachment and ADHD: environmental mediating factors. *Journal of attention disorders*, 20(2), 187-196. doi.org/10.1177/1087054713501079

- Thorley, C. (2016). Education, education, mental health: Supporting secondary schools to play a central role in early intervention mental health services. *Institute for Policy Research*.
- 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. doi.org/10.1080/13632750600833924
- Volpe, R. J., Dupaul, G. J., Loney, J., & Salisbury, H. (1999). Alternative selection criteria for identifying children with ADHD: Observed behavior and self-reported internalizing symptoms. *Journal of Emotional and Behavioral Disorders*, 7(2), 103–109. doi.org/10.1177/106342669900700205
- Wagner, P. (2000). Consultation: Developing a comprehensive approach to service delivery. *Educational Psychology in Practice*, 16(1), 9-18. doi.org/10.1080/026673600115229
- Wahyuni, D. (2012) The research design maze: understanding paradigms, cases, methods and methodologies, *Journal of Applied Management Accounting Research*. 10 (1), 69-80
- Washbrook, E., Propper, C., & Sayal, K. (2013). Pre-school hyperactivity/attention problems and educational outcomes in adolescence: prospective longitudinal study. *The British Journal of Psychiatry*, 203(4), 265-271. doi.org/10.1192/bjp.bp.112.123562
- Wheeler, L., Pumfrey, P., Wakefield, P., & Quill, W. (2008). ADHD in schools: prevalence, multi-professional involvements and school training needs in an LEA. *Emotional and Behavioural Difficulties*, 13(3), 163-177. doi.org/10.1080/13632750802253137
- 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. doi.org/10.1177/0829573512451972
- Willits, F. K., Theodori, G. L., Luloff, A. E. (2016). Another look at likert scales. *Journal of Rural Social Science*. 31 (3). 126-139.
- Wong, I. Y., Hawes, D. J., Clarke, S., Kohn, M. R., & Dar-Nimrod, I. (2018). Perceptions of ADHD Among Diagnosed Children and Their Parents: A Systematic Review Using the Common-Sense Model of Illness Representations. *Clinical child and family psychology review*, 21(1), 57-93. doi.org/10.1007/s10567-017-0245-2
- World Health Organisation., (2019). ICD-10 Revision. Retrieved from <http://www.who.int/classifications/icd/revision/en/>
- Yanow, D., & Schwartz-Shea, P. (2011) *Interpretive Approaches to Research Design: Concepts and Processes*. Netherlands: Routledge.

Yin, R. K. (2003). Case study research: Design and methods (Vol. 5).

Young Minds (2019) Mental Health Statistic. Retrieved from
<https://youngminds.org.uk/about-us/media-centre/mental-health-stats/>

Appendices

Appendix 1 – Ethics

Appendix 1.1 - Certificate of Ethical Approval.



GRADUATE SCHOOL OF EDUCATION

St Luke's Campus
Hartline Road
Exeter UK, EX1 1LU

<http://ods.education.exeter.ac.uk/education/>

CERTIFICATE OF ETHICAL APPROVAL

Title of Project: Young people with ADHD's perceptions of themselves and the severity of their symptoms; an exploration of mental health outcomes and personal construct psychology.

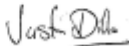
Researcher(s) name: Kate Gribble

Supervisor(s): Will Shield and Shirley Larkin

This project has been approved for the period

From: 21/06/2018
To: 31/03/2019

Ethics Committee approval reference:

Signature:  Date: 21st June 2018
(Professor Justin Dillon, Professor of Science and Environmental Education, Ethics Office)

Appendix 1.2 – Initial Ethical Application Form

Applicant details

Name	Kate Gribble
Department	DEdPsych
UoE email address	Kg369@exeter.ac.uk

Duration for which permission is required

<p>You should request approval for the entire period of your research activity. The start date should be at least one month from the date that you submit this form. Students should use the anticipated date of completion of their course as the end date of their work. Please note that <u>retrospective ethical approval will never be given.</u></p>		
Start date: 01/05/2017	End date: 31/03/2019	Date submitted: 20/04/2018

Students only

All students must discuss their research intentions with their supervisor / tutor prior to submitting an application for ethical approval. The discussion may be face to face or via email.

Prior to submitting your application in its final form to the SSIS Ethics Committee it should be approved by your first and second supervisor / dissertation supervisor/tutor. You should submit evidence of their approval with your application, e.g. a copy of their email approval.

Student number	660053571
Programme of study	Doctor of Educational Psychology (DEdPsych)
Name of Supervisor(s)/tutors or Dissertation Tutor	Will Shield and Shirley Larkin
Have you attended any ethics training that is available to students?	<p>Yes, I have taken part in ethics training at the University of Exeter</p> <p>For example, the Research Integrity Ethics and Governance workshop:</p> <p>http://as.exeter.ac.uk/rdp/postgraduateresearchers</p> <p>If yes, please give the date of the training: 01/11/2016</p>

Certification for all submissions

I hereby certify that I will abide by the details given in this application and that I undertake in my research to respect the dignity and privacy of those participating in this research. I confirm that if my research should change radically I will complete a further ethics proposal form.

Kate Gribble

Double click this box to confirm certification

Submission of this ethics proposal form confirms your acceptance of the above.

TITLE OF YOUR PROJECT

Young people with ADHD's perceptions of themselves and the severity of their symptoms; an exploration of mental health outcomes and personal construct psychology.

ETHICAL REVIEW BY AN EXTERNAL COMMITTEE

N/A

MENTAL CAPACITY ACT 2005

N/A

SYNOPSIS OF THE RESEARCH PROJECT

As a guide - 750 words.

The proposed research will explore the views and experiences of young people (YP) who have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), as well as the impact that this may have on their wellbeing. The first phase of research will explore the perceptions YP with ADHD have regarding the severity of their symptoms. The research will explore how these perceptions may impact on their mental health and wellbeing.

Based on the literature that informed phase 1, which demonstrated the potential and significant impacts of personal perceptions of ADHD, the second phase of research will explore the use of personal construct psychology when working with YP with ADHD. Specifically, the benefits of facilitating staff members in better understanding the YP's constructs.

Aims of Phase 1

- To explore perceptions of ADHD amongst the young people, their parents, and their teachers. Exploring specifically, the perceptions of symptom severity and the impact which these perceptions may have.

Research Questions

- How do YP with ADHD perceive the severity of their symptoms?
- What influences the perceptions that YP with ADHD have of the severity of their symptoms?
- How and to what extent do YP believe that these perceptions impact their wellbeing?
- How and to what extent do parents believe that these perceptions impact the YP's wellbeing?

- How and to what extent do teachers believe that these perceptions impact the YP's wellbeing?

Aims of Phase 2

- To evaluate the use of personal construct psychology when working with YP with ADHD.
- To evaluate the use of personal construct psychology in facilitating staff member's understanding of the views and experiences of YP with ADHD.

Research Questions

- To what extent is PCP a useful tool to facilitate staff members in understanding the views and experiences of young people with ADHD?
- What, if any, do staff members feel are the potential outcomes of using PCP to develop an understanding of YP's views and experiences?
- What, if any, do YP feel are the potential outcomes of using PCP to facilitate staff in understanding their views and experiences?
- What, if any, do YP feel are the potential outcomes of participating in a PCP intervention?

Phase 1

Phase 1 will consist of semi-structured interviews which will explore 3 topics.

- 1) How YP with ADHD perceive the severity of their symptoms.
- 2) What influences YP's perceptions of the severity of their symptoms?
- 3) How these perceptions impact of the young person's mental health and wellbeing.

Phase 2

Phase 2 will use semi-structured interviews to evaluate the potential benefits of an adapted PCP intervention.

The aim of the intervention is to support both the young person, and their teacher in understanding the YP's personal constructs surrounding their ADHD.

INTERNATIONAL RESEARCH

N/A

The following sections require an assessment of possible ethical consideration in your research project. If particular sections do not seem relevant to your project please indicate this and clarify why.

RESEARCH METHODS

Data /Information Collection

Phase 1

Phase 1 will interview YP, their parents, and staff.

Interviews will take place in the school setting.

Interviews

In phase 1, semi-structured interviews will be recorded on a Dictaphone and then fully transcribed into Microsoft word. All transcriptions will be saved on a password protected hard drive in a locked room until analysis has been completed.

The schedule for the semi-structured interviews will be developed based on a hierarchical focusing approach, described and used by Tomlinson (1989). The questions will be based around the following topics.

- The young person's knowledge AND understanding of ADHD symptoms.
- The young person's perception of the severity of their own symptoms
- How, if at all, the young person's symptoms impact on their day to day life. (*impact of severity will be explored throughout this topic*).
- How, if at all, the young person's symptoms impact on their mental health and wellbeing (*impact of severity will be explored throughout this topic*).

- PARENTS AND STAFF will be asked in addition, how they feel the young person perceives their symptoms impact on their mental health and wellbeing, and their day to day life. (*impact of severity will be explored throughout this topic*).

Phase 2

PCP based intervention:

The intervention will consist of two meetings at with the young person and their teacher (or key member of staff) will both be present. The practitioner will use the PCP techniques listed below. The aim of the intervention is to support both the young person, and their teacher in understanding the YP's personal constructs surrounding their ADHD.

This intervention is an adaption of a technique described by Ravenette (1999) in which a practitioner will work first with the YP to elicit and understand their personal constructs, and then share these constructs with a staff member.

PCP Techniques

- i) *Establishing concerns –*
 - o Ask the young person why they think they may have been identified as needing some extra support.
- ii) *Drawing the ideal self –* The young person will be asked to draw a picture of their "ideal self" and then a picture of how they see their "true self". The young person will then be invited to explain the difference.
- iii) *The Salmon Line technique (Salmon, 1988– as cited in Beaver, 2011)–* A method to help the young person develop "bi -polar constructs" (pp. 130). Using concerns identified in previous exercises the young person will be asked to identify the construct from the opposite end of the scale.
(e.g *Finds maths hard*-----*Finds maths easy*)

The young person will then be asked to place other people and themselves on the scale. The discussions that follows will be around where the young person would like to be on the scale, and how they might move up or down the scale.

- iv) *The 3 comments technique* – Exploring how the young person believes they are perceived by others. The young person is asked the following “*If I were to ask X to describe you in 3 words or phrases, what would they say*)

(X = Mum/dad/friend/teacher/enemy)

Evaluative interviews:

Following the intervention, participating students and staff will be interviewed. As with stage 1 these will be semi structured interviews and will be developed based in a hierarchical focusing approach, described and used by Tomlinson (1989).

These interviews will elaborate on the following questions.

YP interviews

- What, if anything, was helpful about this intervention?
- What do you predict, if anything, will change now following this experience?

Staff Interviews

- What, if anything, was helpful about this intervention?
- Do you have a new or changed understanding of the YP and their views?
- How, if at all, do you think this will influence your practice...
...over all?
...specifically, when working with this YP?

Data/Information Analysis

Descriptive statistics

The only descriptive statistics that will be recorded and reported will be the age and gender of each young person. The research is not concerned with the demographic information for either parent or staff.

The decision to record this information is based on an interest in exploring whether there are differences in the experiences of male and female, or older and younger participants.

Phases 1 & 2

All interview transcriptions will each be imported into Nvivo where they will be subject to thematic analysis. According the Braun and Clark's (2006) model, this will involve 6 steps of analysis.

- *Familiarising yourself with the data and identifying items of potential interest*
- *Generating initial codes*
- *Searching for themes*
- *Reviewing potential themes*
- *Defining and naming themes*

- *Producing the report*
(Braun & Clark, 2006)

PARTICIPANTS

Participants will be recruited through schools using the networks available at the researcher's current placement. SENCOs will be asked to identify appropriate candidates and to contact parents.

Phase 1 and 2 will recruit:

- 6 YP from years 3,4, 7 and 8.
- A teacher or key member of staff for each young person.

Phase 1 will also recruit:

- A parent or guardian for each young person.

YP

- All YP will have an official diagnosis of ADHD. As the proposed research is interested in YP's perceptions of their symptoms, and not their experience of having a diagnosis, there is no minimum time limit on having a diagnosis.
- The decision to recruit from these year groups was based on trying to avoid exam periods, and to gather the views and experiences of both primary and secondary students.
- The decision not to include participants from early years is based on the assumption that less life experience would mean less time to shape or construct a view of their diagnosis.
- All participants will be attending mainstream schools.
 - The decision not to approach special schools or alternative provisions is based on the atypical approaches which are likely to be used within these institutions. By using mainstream schools, the results of the proposed study can be more widely generalised to other similar populations of YP with ADHD.
- Throughout, recruitment matching for gender will be a priority, however due to the higher prevalence in males compared to females and subsequent higher rates of diagnosis in – this may be reflected in the gender distribution of the final sample.

Parents / Guardians

- Both parents and legal guardians will be recruited depending on the young person's circumstances.
- There will be no restrictions on which parent attends, however this will be reported in the report.

Teacher / key member of staff

staff members must work directly with the student at least 3 days out of the working week

THE VOLUNTARY NATURE OF PARTICIPATION

Participants of both phases 1 and 2, will be subject to informed active consent. Potential candidates will be identified by the special educational needs coordinator at each school, who will provide those parents and staff members with the relevant information letters for them to read in their own time. Participants will be given contact details for the researcher and invited to contact them should they want any further information before signing consent.

All participants will be made aware that they have the right to withdraw their or their child's participation at any time prior to write up.

YP will be reminded prior to signing consent and at the beginning of each session that they have the right to withdraw their consent and participation at any time.

SPECIAL ARRANGEMENTS

N/A

THE INFORMED NATURE OF PARTICIPATION

Participants of both phases 1 and 2, will be subject to informed active consent.

Information letters (See below) will be sent home to the parents or legal guardians of the YP selected by school. Letters will inform parents of the research procedure and that:

- All identity will be kept confidential
- All data collected and reported will be kept anonymous
- Parents and YP have the right to withdraw their consent and participation at any time
- Parents and YP have the right to withdraw their data from the research up until the point that it is submitted.

All participants will also be provided with contact details of the researcher.

ASSESSMENT OF POSSIBLE HARM

Although the research proposes to work with YP, the risk of harm is anticipated to be low. Any reference to mental health will be non-specific and led by the young person.

The researcher is a trainee educational psychologist with training and experience working with YP with special educational needs and managing sensitive topics and times of distress.

Further, school and parents will be given information about available support in their area should they wish to seek mental health support elsewhere.

The proposed intervention seeks only to explore the young person's constructs around their ADHD and school experience, and not around complex topics such as mental health of family background. Should these topics naturally arise, the researcher is trained to manage this sensitively and appropriately. All participants of the intervention will be reminded that the researcher is acting as a practitioner and not as a counsellor or therapist, they will be advised where mental health or counselling support could be available should they ask.

DATA PROTECTION AND STORAGE

All recordings and transcripts will be saved on a password protected hard drive which will be kept in a locked room. Vocal recordings will only be kept for transcription purposes and then destroyed.

All participants names will be coded, and the key will be kept separate from the data set.

Data will be transferred to NVivo without names or personal details attached. All research will be presented in anonymised form.

Confidentiality within school

With such small sample sizes, keeping confidentiality within schools will be difficult. In order to reduce this risk, and to maintain anonymity, the names of participating schools and the area will not be reported in the final report.

- The YP in Phase 2 will be made explicitly aware that the process involves sharing their constructs with their teachers.

Parents and YP will be informed that should anything be disclosed within any part of the research that arouses genuine concern of harm of the young person or others,

will override the rights of confidentiality, and the researchers will follow the safeguarding procedure set by the school.

DECLARATION OF INTERESTS

No commercial interests.

USER ENGAGEMENT AND FEEDBACK

N/A

INFORMATION SHEET

Information for schools and attached consent form:

Young people with ADHD's perceptions of themselves and the severity of their symptoms; an exploration of mental health outcomes and personal construct psychology

The proposed research will aim to explore the views and experiences of young people (YP) who have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), as well as the impact that these may have on their wellbeing. The first phase of research will explore the perceptions YP with ADHD have regarding the severity of their symptoms. The research will explore how these perceptions may impact on their mental health and wellbeing.

Based on the research that informed phase 1, which demonstrated the potential and significant impacts of personal perceptions of ADHD, the second phase of research will explore the use of Personal Construct Psychology (Kelly, 1955) when working with YP with ADHD.

Personal Construct Theory:

Personal Construct Theory was introduced by George Kelly in 1955 and is commonly used by Educational Psychologists to work with and support young people. The underlying principle of the theory is that way we interpret or understand the world around us, is influenced by our own personal constructs which have developed over our life as a response to our experiences. The practice of using PCT therapeutically is largely based around supporting an individual and those around them, by encouraging them to develop an understanding of their own personal constructs.

What will it involve?

Your school will be asked to identify up to 2 young people based in the below inclusion criteria:

- Has an official diagnosis of Attention Deficit Hyperactivity Disorder. As the proposed research is interested in YP's perceptions of their symptoms, and not their experience of having a diagnosis, there is no minimum time limit on having a diagnosis.
- Is from year 3,4,7 or 8.

For each young person we will be requesting participation from a parent or guardian, and a key member of staff.

- There will be no restrictions on which parent attends the interview, however this will be recorded in the report.
- Staff members must work directly with the student at least 3 days out of the working week.

Phase 1 – Interviews

- A researcher will attend your school at a convenient time to conduct interviews with young people, their parents/guardians, one key member of staff.
- Each interview is expected to take between half an hour and an hour.

Phase 2 – The intervention

- A researcher will meet with the young person and their key member of staff on two occasions, each session is expected to take 1 hour.
- Each session will use PCP techniques to support the young person and staff member in developing a joint understanding of the young person's personal constructs.
 - This intervention is expected to have positive outcomes for young persons within school.
- Following the intervention, the researcher will re-attend school to conduct interviews with both the young person and key member of staff, to explore their experiences of the process.

Next Steps should your school wish to participate:

- School will be asked to identify potential candidates for the study based on the inclusion criteria described above.
- School will be provided a template letter to be distributed to the identified parents/ guardians. This will contain information about the study and ask parent's whether they are willing to give consent for their child to participate in the study.
- Once consent has been received from parents, school will be contacted to arrange convenient times to complete the work.

Output and data protection:

All data will be anonymous and confidential. It will be accessible only to the research team and stored on a password protected computer kept in a locked room. Once the analysis is completed the data will be deleted.

From our analysis will be produced a 40,000 word thesis, to be submitted to the University of Exeter as part of the researchers doctorate training. The paper may also be submitted for further publication in an academic journal. No identifiable information will be included in any publication of the thesis.

This study is being conducted by Kate Gribble, trainee educational psychologist in associated with the University of Exeter (kg369@exeter.ac.uk). Kate is being supervised by Dr Shirley Larkin (S.Larkin@exeter.ac.uk) and Dr Will Sheild (W.Shield@exeter.ac.uk). Should you have any further questions with regards to the above study, please contact Kate Gribble in the first instance.

Thankyou for your interest in our research

Staff member Consent: Young people with ADHD’s perceptions of themselves and the severity of their symptoms; an exploration of mental health outcomes and personal construct psychology

Please read and amend the statements below

I have read and understood the above information regarding the proposed research and **GIVE/DO NOT GIVE** (Delete as appropriate) consent to take part in the research outlined above.

Name of young person: _____

Relationship to young person: _____

Print name: _____

Signature: _____ **Date:** ___ / ___ / ___

Information and consent letter for parents:

Dear Parent/Guardian,

You are being contacted as your child has been identified as a potential candidate for some doctoral research being conducted by the University of Exeter. Below is a brief summary of the research, should you have any further questions, please do not hesitate to contact us.

Young people with ADHD's perceptions of themselves and the severity of their symptoms: an exploration of mental health outcomes and personal construct psychology

Purpose of the research:

The proposed research will explore the views and experiences of young people (YP) who have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), as well as the impact that this may have on their wellbeing.

What will it involve:

Output and data protection

Phase 1

Phase 1 will consist of 3 separate interviews with the young person, a parent/guardian and one key member of staff.

Interviews will explore 3 topics.

- 1) How YP with ADHD perceive the severity of their symptoms.**
- 2) What influences YP's perceptions of the severity of their symptoms?**
- 3) How these perceptions impact on the young person's mental health and wellbeing.**

Phase 2

Phase 2 will require the young person to participate in a short-term intervention based on the principles of Personal Construct Psychology. The aim of the intervention is to support both the young person, and their teacher in understanding the YP's personal constructs surrounding their ADHD.

The young person and a key member of staff will meet in school on two occasions with a practitioner.

Phase 2 will use semi-structured interviews to evaluate the potential benefits of the intervention.

All data will be anonymous and confidential. It will be accessible only to the research team and stored on a password protected computer kept in a locked room. Once the analysis is completed the data will be deleted.

If at any time throughout the research yourself, or the young person wishes to withdraw their participation from the study, you can do so simply by contacting the researcher. You will not be expected to give any reason for this decision.

From our analysis will be produced a 40,000 word thesis, to be submitted to the University of Exeter as part of the researchers doctorate training. The paper may also be submitted for further publication in an academic journal. No identifiable information will be included in any publication of the thesis.

Personal Construct Theory:

Personal Construct Theory was introduced by George Kelly in 1955 and is commonly used by Educational Psychologists to work with and support young people. The underlying principles of the theory are that for every one person who

is experiencing something, there are as many different ways of interpreting and understanding it. The ways we interpret or understand the world around us, is influenced by our own personal constructs which have developed over our life as a response to our experiences. The practice of using PCT therapeutically is largely based around supporting an individual and those around them, by encouraging them to develop an understanding of their personal constructs. Recognising that you are being influenced by a personal construct, and subsequently that your constructs may directly contradict those of others around you, has been shown to have immense therapeutic value

Researcher and supervision

This study is being conducted by Kate Gribble BSc, Trainee Educational Psychologist in association with the University of Exeter (kg369@exeter.ac.uk). Kate is being supervised by Dr Shirley Larkin (S.Larkin@exeter.ac.uk) and Dr Will Sheild (W.Shield@exeter.ac.uk). Should you have any further questions with regards to you and your child's participation in the above study, please contact Kate Gribble in the first instance.

Thankyou for your interest in our research

Consent: Young people with ADHD's perceptions of themselves and the severity of their symptoms; an exploration of mental health outcomes and personal construct psychology

Please read and amend the statements below

I have read and understood the above information regarding the proposed research and **GIVE/DO NOT GIVE** (Delete as appropriate) consent to take part in an interview exploring my child's perception of their ADHD symptoms.

I have read and understood the above information regarding the proposed research and **GIVE/DO NOT GIVE** (Delete as appropriate) consent for my child to take part in phases 1 and 2 of the research as outlined above.

Name of young person: _____

Relationship to young person: _____

Print name: _____

Signature: _____ **Date:** ____ / ____ / ____

CONSENT FORM

(See above)

Appendix 1.3 – Amended Ethical Application Form

Applicant details	
Name	Kate Gribble
Department	Dedpsych
UoE email address	Kg369@exeter.ac.uk

Duration for which permission is required		
<p>You should request approval for the entire period of your research activity. The start date should be at least one month from the date that you submit this form. Students should use the anticipated date of completion of their course as the end date of their work. Please note that <u>retrospective ethical approval will never be given.</u></p>		
Start date:21/06/2018	End date:31/03/2019	Date submitted:15/01/2019

Students only	
<p>All students must discuss their research intentions with their supervisor/tutor prior to submitting an application for ethical approval. The discussion may be face to face or via email.</p> <p>Prior to submitting your application in its final form to the SSIS Ethics Committee it should be approved by your first and second supervisor / dissertation supervisor/tutor. You should submit evidence of their approval with your application, e.g. a copy of their email approval.</p>	
Student number	660053571
Programme of study	<p>Doctor of Educational Psychology (DEdPsych)</p> <p>If you selected 'other' from the list above please name your programme here</p>
Name of Supervisor (s)/tutors or Dissertation Tutor	Will Shield and Shirley Larkin
Have you attended any ethics	Yes, I have taken part in ethics training at the University of Exeter

training that is available to students?	<p>For example, the Research Integrity Ethics and Governance workshop: http://as.exeter.ac.uk/rdp/postgraduateresearchers</p> <p>If yes, please give the date of the training: 01/11/2016</p>
---	---

Certification for all submissions

I hereby certify that I will abide by the details given in this application and that I undertake in my research to respect the dignity and privacy of those participating in this research. I confirm that if my research should change radically I will complete a further ethics proposal form.

Kate Gribble

Double click this box to confirm certification

Submission of this ethics proposal form confirms your acceptance of the above.

TITLE OF YOUR PROJECT

Young people with ADHD's perceptions of themselves and the severity of their symptoms; an exploration of mental health outcomes and personal construct psychology.

ETHICAL REVIEW BY AN EXTERNAL COMMITTEE

N/A

MENTAL CAPACITY ACT 2005

N/A

SYNOPSIS OF THE RESEARCH PROJECT

Maximum of 750 words.

Please refer to my previous ethics application form (attached). Below is an addendum and covers the additional data collection I will be completing.

		Aims and research questions	Methods
ORIGINAL STRUCTURE	Phase 1	<ul style="list-style-type: none"> - How do YP with ADHD perceive the severity of their symptoms? - What influences the perceptions that YP with ADHD have of the severity of their symptoms? - How and to what extent do YP believe that these perceptions impact their wellbeing? - How and to what extent do parents believe that these perceptions impact the YP's wellbeing? - How and to what extent do teachers believe that these perceptions impact the YP's wellbeing? 	<p>Case studies of 6 young people.</p> <ul style="list-style-type: none"> - Demographic information - Semi-structured interviews with Parent, Staff and young person
	Phase 2	<ul style="list-style-type: none"> - To what extent is PCP a useful tool to facilitate staff members in understanding the views and experiences of young people with ADHD? - What, if any, do staff members feel are the potential outcomes of using PCP to develop an understanding of YP's views and experiences? - What, if any, do YP feel are the potential outcomes of using PCP to facilitate staff in understanding their views and experiences? - What, if any, do YP feel are the potential outcomes of participating in a PCP intervention? 	<p>Using semi-structured interviews to evaluate the potential benefits of an adapted PCP intervention.</p> <ul style="list-style-type: none"> - The aim of the intervention is to support both the young person, and their teacher in understanding the YP's personal constructs surrounding their ADHD.
AMENDED STRUCTURE	Phase 1	<ul style="list-style-type: none"> - How do Special Educational Needs Coordinators feel that young people with ADHD perceive their symptoms? - How do Special Educational Needs Coordinators feel young 	<p>An online questionnaire developed for the purposes of this study and based on the literature that informed the research. The questionnaire will be circulated to Special Educational Needs</p>

		<p>people with ADHD develop the perceptions they have of the severity of their symptoms?</p> <ul style="list-style-type: none"> - How and to what extent do Special Educational Needs coordinators believe that these perceptions impact their wellbeing? 	<p>Coordinators through professional connections.</p> <p>6 Semi structure interviews with Special Educational Needs Coordinators exploring these themes.</p>
	Phase 2	<ul style="list-style-type: none"> - How do YP with ADHD perceive the severity of their symptoms? - What influences the perceptions that YP with ADHD have of the severity of their symptoms? - How and to what extent do these perceptions impact the YP's wellbeing? - How and to what extent can tools and activities derived from personal construct psychology be used to effectively support young people with ADHD? - How and to what extent can tools and activities derived from personal construct psychology be used to effectively support staff in understanding the young person's views and experiences? 	<p>Two case studies with young people who have a diagnosis of ADHD.</p> <ul style="list-style-type: none"> - Demographic information - Semi structure interviews with staff, parents and young people. - The use of PCP tools to support staff and young people in better understanding their personal constructs. - Follow up interviews with staff and young people to explore their experiences of the intervention.

N/A

The following sections require an assessment of possible ethical consideration in your research project. If particular sections do not seem relevant to your project please indicate this and clarify why.

RESEARCH METHODS

I will use and develop an online questionnaire, which will be circulated to Special Educational Needs Coordinators (SENCo's) using professional links. The sample for this phase of the research will therefore be randomly collected through whichever SENCo's have access and agree to take part.

In addition to this questionnaire I will meet with 6 SENCo's to explore their views using semi-structured interviews.

PARTICIPANTS

Special Educational Needs Coordinators from secondary and primary schools across the country will be recruited using professional networks and connections. As an example, asking the Educational Psychologists in the team at my current practice placement to circulate the questionnaire with their schools.

I will also approach schools insentiently enquiring about their interest in taking part.

THE VOLUNTARY NATURE OF PARTICIPATION

No change from the previous application Informed active consent

SPECIAL ARRANGEMENTS

N/A

THE INFORMED NATURE OF PARTICIPATION

No change from the original application

ASSESSMENT OF POSSIBLE HARM

The risk of harm is not predicted to have changed from the original application as the only addition is to work with professional adults under informed and active consent.

None of the questions which have been added are expected to touch on personal or difficult content.

DATA PROTECTION AND STORAGE

No Change from the original application

DECLARATION OF INTERESTS

No change from the original application

USER ENGAGEMENT AND FEEDBACK

N/A

INFORMATION SHEET

Online questionnaire consent:

Thankyou for your interest in my doctoral research. Your time is highly appreciated. Below is a brief explanation of the research and research aims, as well as a summary of your involvement should you choose to participate.

Participation in this study is voluntary, and you have the right to withdraw your data up until the point of submission in May 2019. In order to withdraw, please email the researcher. You are under no obligation to give explanation for this decision.

The proposed research will aim to explore the views and experiences of young people (YP) who have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), as well as the impact that these may have on their wellbeing. The first phase of this research seeks to gather the views of Special Educational Needs Coordinators using this online questionnaire. This is part of a wider piece of doctoral research.

This online questionnaire is not predicted to take longer than 10 minutes. Questions explore your views with regards to:

- Young people with ADHD's understanding and perception of their diagnosis
- The development of these perceptions
- The impact that these perceptions may have on their wellbeing.

All data will be anonymous and confidential. It will be accessible only to the research team and stored on a password protected computer kept in a locked room. Once the analysis is completed the data will be deleted.

From our analysis will be produced a 40,000 word thesis, to be submitted to the University of Exeter as part of the researchers doctorate training. The paper may

also be submitted for further publication in an academic journal. No identifiable information will be included in any publication of the thesis.

This study is being conducted by Kate Gribble, trainee educational psychologist in associated with the University of Exeter (kg369@exeter.ac.uk). Kate is being supervised by Dr Shirley Larkin (S.Larkin@exeter.ac.uk) and Dr Will Shield (W.Shield@exeter.ac.uk). Should you have any further questions with regards to the above study, please contact Kate Gribble in the first instance.

By clicking 'NEXT', you are confirming that

- You have read and understood the above information
- You give consent to partake in the research
- You are at least 18 years of age

Thankyou for your participation.

Interview information and consent:

Kate Gribble (DEdPsychology)

University of Exeter

St Lukes Campus

Heavitree

Exeter

Devon

EX1 2LU

To Whom it may concern,

Thank you for your interest in my research. Below is a brief summary of your participation. Please do not hesitate to ask any questions. Once you have read the below, if you choose to participate, you will be asked to sign to confirm you have understood and to give your consent.

Purpose of the research:

The proposed research will explore the views and experiences of young people (YP) who have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), as well as the impact that this may have on their wellbeing. The research is broken up into two phases, your participation is requested only for phase 1.

Phase 1

Phase 2

Using an online questionnaire and 6 semi structure interviews, phase 1 of this research aims to explore the following research questions:

- How do Special Educational Needs Coordinators feel that young people with ADHD perceive the severity of their symptoms?
- How do Special Educational Needs Coordinators feel young people with ADHD develop the perceptions they have of the severity of their symptoms?
- How and to what extent do Special Educational Needs coordinators believe that these perceptions impact their wellbeing?

Phase 2 sought the participation of young people with ADHD, a parent or guardian and a key member of staff. Gathering demographic information, completing semi structure interviews, and with the staff and young person. Phase 2 will analyse two case studies in order to answering the following research questions.

- How do YP with ADHD perceive the severity of their symptoms?
- What influences the perceptions that YP with ADHD have of the severity of their symptoms?
- How and to what extent do these perceptions impact the YP's wellbeing?
- How and to what extent can tools and activities derived from personal construct psychology be used to effectively support young people with ADHD?
- How and to what extent can tools and activities derived from personal construct psychology be used to effectively support staff in understanding the young person's views and experiences?

What will it involve:

YOUR PARTICIPATION: You are invited to take part in an interview seeking to gather your views surrounding the perceptions young people with ADHD have about their diagnosis. This interview is expected to last between 30 and 60 minutes.

Output and data protection

All data will be anonymous and confidential. It will be accessible only to the research team and stored on a password protected computer kept in a locked room. Once the analysis is completed the data will be deleted.

If at any time throughout the research yourself, or the young person wishes to withdraw their participation from the study, you can do so simply by contacting the researcher. You will not be expected to give any reason for this decision.

From our analysis will be produced a 40,000 word thesis, to be submitted to the University of Exeter as part of the researchers doctorate training. The paper may also be submitted for further publication in an academic journal. No identifiable information will be included in any publication of the thesis.

Researcher and supervision

This study is being conducted by Kate Gribble BSc, Trainee Educational Psychologist in association with the University of Exeter (kg369@exeter.ac.uk). Kate is being supervised by Dr Shirley Larkin (S.Larkin@exeter.ac.uk) and Dr Will Shield (W.Shield@exeter.ac.uk). Should you have any further questions with regards to you and your child's participation in the above study, please contact Kate Gribble in the first instance.

Thankyou for your interest in our research

Special Educational Needs Coordinator Consent: Young people with ADHD's perceptions of themselves and the severity of their symptoms; an exploration of mental health outcomes and personal construct psychology

Please read and amend the statements below

I have read and understood the above information regarding the proposed research and **GIVE/DO NOT GIVE** (Delete as appropriate) consent to take part in the research outlined above.

Print name: _____

Signature: _____ **Date:** ____ / ____ / ____

CONSENT FORM

(See above)

Appendix 2 – Information Letters and Consent

Appendix 2.1 – Phase One Information and Consent: SENCos

Kate Gribble (DEdPsychology)
University of Exeter
St Lukes Campus
Heavitree
Exeter
Devon
EX1 2LU

To Whom it may concern,

Thank you for your interest in my research. Below is a brief summary of your participation. Please do not hesitate to ask any questions. Once you have read the below, if you choose to participate, you will be asked to sign to confirm you have understood and to give your consent.

Purpose of the research:

The proposed research will explore the views and experiences of young people (YP) who have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), as well as the impact that this may have on their wellbeing. The research is broken up into two phases, your participation is requested only for phase 1.

Phase 1

Using an online questionnaire and 6 semi structure interviews, phase 1 of this research aims to explore the following research questions:

- How do Special Educational Needs Coordinators feel that young people with ADHD perceive the severity of their symptoms?
- How do Special Educational Needs Coordinators feel young people with ADHD develop the perceptions they have of the severity of their symptoms?
- How and to what extent do Special Educational Needs coordinators believe that these perceptions impact their wellbeing?

Phase 2

Phase 2 sought the participation of young people with ADHD, a parent or guardian and a key member of staff. Gathering demographic information, completing semi structure interviews, and with the staff and young person. Phase 2 will analyse two case studies in order to answering the following research questions.

- How do YP with ADHD perceive the severity of their symptoms?
- What influences the perceptions that YP with ADHD have of the severity of their symptoms?
- How and to what extent do these perceptions impact the YP's wellbeing?
- How and to what extent can tools and activities derived from personal construct psychology be used to effectively support young people with ADHD?
- How and to what extent can tools and activities derived from personal construct psychology be used to effectively support staff in understanding the young person's views and experiences?

What will it involve:

YOUR PARTICIPATION: You are invited to take part in an interview seeking to gather your views surrounding the perceptions young people with ADHD have about their diagnosis. This interview is expected to last between 30 and 60 minutes.

Output and data protection

All data will be anonymous and confidential. It will be accessible only to the research team and stored on a password protected computer kept in a locked room. Once the analysis is completed the data will be deleted.

If at any time throughout the research yourself, or the young person wishes to withdraw their participation from the study, you can do so simply by contacting the researcher. You will not be expected to give any reason for this decision.

From our analysis will be produced a 40,000 word thesis, to be submitted to the University of Exeter as part of the researchers doctorate training. The paper may also be submitted for further publication in an academic journal. No identifiable information will be included in any publication of the thesis.

Researcher and supervision

This study is being conducted by Kate Gribble BSc, Trainee Educational Psychologist in association with the University of Exeter (kg369@exeter.ac.uk). Kate is being supervised by Dr Shirley Larkin (S.Larkin@exeter.ac.uk) and Dr Will Shield (W.Shield@exeter.ac.uk). Should you have any further questions with regards to you and your child’s participation in the above study, please contact Kate Gribble in the first instance.

Thankyou for your interest in our research

Special Educational Needs Coordinator Consent: Young people with ADHD’s perceptions of themselves and the severity of their symptoms; an exploration of mental health outcomes and personal construct psychology

Please read and amend the statements below

I have read and understood the above information regarding the proposed research and **GIVE/DO NOT GIVE** (Delete as appropriate) consent to take part in the research outlined above.

Print name: _____

Signature: _____ **Date:** ___/___/_____

Appendix 2.2 – Phase One Information Page of Online Questionnaire.

Thank you for your interest in my doctoral research. Your time is highly appreciated. Below is a brief explanation of the research and research aims, as well as a summary of your involvement should you choose to participate.

This online questionnaire is not predicted to take longer than 10 minutes.

Questions explore your views with regards to:

- Young people with ADHD's understanding and perception of their diagnosis
- The development of these perceptions
- The impact that these perceptions may have on their wellbeing.

Participation in this study is voluntary, and you have the right to withdraw your data up until the point of submission in May 2019. In order to withdraw, please email the researcher. You are under no obligation to give explanation for this decision.

The proposed research will aim to explore the views and experiences of young people (YP) who have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), as well as the impact that these may have on their wellbeing. The first phase of this research seeks to gather the views of Special Educational Needs Coordinators using this online questionnaire. This is part of a wider piece of doctoral research.

All data will be anonymous and confidential. It will be accessible only to the research team and stored on a password protected computer kept in a locked room. Once the analysis is completed the data will be deleted.

From our analysis will be produced a 40,000 word thesis, to be submitted to the University of Exeter as part of the researchers doctorate training. The paper may also be submitted for further publication in an academic journal. No identifiable information will be included in any publication of the thesis.

This study is being conducted by Kate Gribble, trainee educational psychologist in associated with the University of Exeter (kg369@exeter.ac.uk). Kate is being supervised by Dr Shirley Larkin (S.Larkin@exeter.ac.uk) and Dr Will Shield (W.Shield@exeter.ac.uk). Should you have any further questions with regards to the above study, please contact Kate Gribble in the first instance.

By clicking 'NEXT', you are confirming that

- You have read and understood the above information
- You give consent to participate in the research
- You are at least 18 years of age
- You have professional experience of working with young people with ADHD
- You are a qualified SENCo with experience of the role.

Thank you for your participation.

Appendix 2.3 – Phase Two Information and Consent: Parents

Kate Gribble (DEdPsychology)
University of Exeter
St Lukes Campus
Heavitree
Exeter
Devon
EX1 2LU

Dear Parent/Guardian,

You are being contacted as your child has been identified as a potential candidate for some doctoral research being conducted by the University of Exeter. Below is a brief summary of the research, should you have any further questions, please do not hesitate to contact us.

**Young people with ADHD’s perceptions of themselves and the severity of their symptoms;
an exploration of mental health outcomes and personal construct psychology**

Purpose of the research:

The proposed research will explore the views and experiences of young people (YP) who have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), as well as the impact that this may have on their wellbeing.

Phase 1

Phase 1 will consist of 3 separate interviews with the young person, a parent/guardian and one key member of staff.

Interviews will explore 3 topics.

- 1) How YP with ADHD perceive the severity of their symptoms.
- 2) What influences YP’s perceptions of the severity of their symptoms?
- 3) How these perceptions impact on the young person’s mental health and wellbeing.

Phase 2

Phase 2 will require the young person to participate in a short-term intervention based on the principles of Personal Construct Psychology. The aim of the intervention is to support both the young person, and their teacher in understanding the YP’s personal constructs surrounding their ADHD.

The young person and a key member of staff will meet in school on two occasions with a practitioner.

Phase 2 will use semi-structured interviews to evaluate the potential benefits of the intervention.

What will it involve:

Output and data protection

All data will be anonymous and confidential. It will be accessible only to the research team and stored on a password protected computer kept in a locked room. Once the analysis is completed the data will be deleted.

If at any time throughout the research yourself, or the young person wishes to withdraw their participation from the study, you can do so simply by contacting the researcher. You will not be expected to give any reason for this decision.

From our analysis will be produced a 40,000 word thesis, to be submitted to the University of Exeter as part of the researchers doctorate training. The paper may also be submitted for further publication in an academic journal. No identifiable information will be included in any publication of the thesis.

Personal Construct Theory:

Personal Construct Theory was introduced by George Kelly in 1955 and is commonly used by Educational Psychologists to work with and support young people. The underlying principles of the theory are that for every one person who is experiencing something, there are as many different ways of interpreting and understanding it. The ways we interpret or understand the world around us, is influenced by our own personal constructs which have developed over our life as a response to our experiences. The practice of using PCT therapeutically is largely based around supporting an individual and those around them, by encouraging them to develop an understanding of their personal constructs. Recognising that you are being influenced by a personal construct, and subsequently that your constructs may directly contradict those of others around you, has been shown to have immense therapeutic value

Researcher and supervision

This study is being conducted by Kate Gribble BSc, Trainee Educational Psychologist in association with the University of Exeter (kg369@exeter.ac.uk). Kate is being supervised by Dr Shirley Larkin (S.Larkin@exeter.ac.uk) and Dr Will Sheild (W.Shield@exeter.ac.uk). Should you have any further questions with regards to you and your child's participation in the above study, please contact Kate Gribble in the first instance.

Thankyou for your interest in our research

Consent: Young people with ADHD's perceptions of themselves and the severity of their symptoms; an exploration of mental health outcomes and personal construct psychology

Please read and amend the statements below

I have read and understood the above information regarding the proposed research and **GIVE/DO NOT GIVE** (Delete as appropriate) consent to take part in an interview exploring my child's perception of their ADHD symptoms.

I have read and understood the above information regarding the proposed research and **GIVE/DO NOT GIVE** (Delete as appropriate) consent for my child to take part in phases 1 and 2 of the research as outlined above.

Name of young person: _____

Relationship to young person: _____

Print name: _____

Signature: _____ **Date:** ____ / ____ / ____

Appendix 2.4 – Phase Two Information and Consent: Young People

Kate Gribble (DEdPsychology)
University of Exeter
St Lukes Campus
Heavitree
Exeter
Devon
EX1 2LU

To participant,

My name is Kate Gribble, I am a student at the University of Exeter. You have been selected by your school to take part in a study. The reason you have been selected is because, like many other young people in the UK, you have a diagnosis of ADHD. I am hoping to learn about your experiences of having ADHD.

If you want to be a part of my study, you will be asked to take part in an interview, then we will meet for 2 sessions with a member of staff from your school during which time we will do some work together. This work will be activities that focus on you and your experiences. Finally, we will meet once more for another interview to find out how you felt about the whole experience.

Throughout the study, if there is anything you don't want to talk about you do not need to. If at any time you want to stop being a part of the study, that is absolutely fine. You just need to let me know or ask a member of staff to let me know.

All the information that I gather throughout my research, will be written up and handed in to my university. Your name will not appear in the research, so everything you tell me will be confidential. This means no one will know what you have said.

The only time I might share your name with others, would be if you had told me something which I believe puts you or someone else at risk.

Thankyou for you time in reading this,

If you choose to take part, I very much look forward to working with you.

Kind regards,

Kate Gribble,

Trainee Educational Psychologist

University of Exeter

Young people with ADHD's perceptions of themselves and the severity of their symptoms; an exploration of mental health outcomes and personal construct psychology.

Kate Gribble, University of Exeter

CONSENT FORM

Item	Yes	No
I understand that they may ask me questions about how I feel about my ADHD.		
I understand that these questions may be recorded on digital audio and I am happy with this.		
I understand that it is up to me whether I take part in the study. I can change my mind and withdraw at any time without giving a reason.		
I understand that all the information collected will be kept confidential (unless the researchers feel I am in danger or at risk) and that my name will never be used in anything that is written about the study.		
I can ask to see or have read to me what has been written down about me before it is used.		
I agree that the information that is collected about me will be used and potentially shared with other researchers but that my name will not be shared.		

I agree to take part in the study	Yes	No
Print Name:	Date:	
Signature		
Witness name:	Date:	
Witness signature		

Appendix 2.5 – Phase Two Information and Consent: School staff.



Kate Gribble (DEdPsychology)
University of Exeter
St Lukes Campus
Heavitree
Exeter
Devon
EX1 2LU

Dear Staff Member,

You have been identified by your school as an appropriate member of staff to take part in this research. You have been selected as you are thought to be a member of staff who has adequate exposure to, and understanding of the focus child. Below is a brief summary of your participation. Please do not hesitate to ask any questions. Once you have read the below, if you choose to participate, you will be asked to sign to confirm you have understood and to give your consent.

Purpose of the research:

The proposed research will explore the views and experiences of young people (YP) who have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), as well as the impact that this may have on their wellbeing.

Phase 1

Phase 1 will consist of 3 separate interviews with the young person, a parent/guardian and one key member of staff.

Interviews will explore 3 topics.

- 1) How YP with ADHD perceive the severity of their symptoms.
- 2) What influences YP's perceptions of the severity of their symptoms?
- 3) How these perceptions impact on the YP's mental health and wellbeing.

Phase 2

Phase 2 will require the young person to participate in a short-term intervention based on the principles of Personal Construct Psychology. The aim of the intervention is to support both the young person, and their teacher in understanding the YP's personal constructs surrounding their ADHD.

The young person and a key member of staff will meet in school on two occasions with a practitioner.

Phase 2 will use semi-structured interviews to evaluate the potential benefits of the intervention.

What will it involve:

STAFF PARTICIPATION: You are invited to take part in both phase 1 and phase 2 of this research as described above:

- An interview of up to one hour exploring themes around the focus child's ADHD.
- 2 sessions of Personal Construct Psychology interventions with the young person.
- Further interviews to discuss the experience of this intervention.

Output and data protection

All data will be anonymous and confidential. It will be accessible only to the research team and stored on a password protected computer kept in a locked room. Once the analysis is completed the data will be deleted.

If at any time throughout the research yourself, or the young person wishes to withdraw their participation from the study, you can do so simply by contacting the researcher. You will not be expected to give any reason for this decision.

From our analysis will be produced a 40,000 word thesis, to be submitted to the University of Exeter as part of the researchers doctorate training. The paper may also be submitted for further publication in an academic journal. No identifiable information will be included in any publication of the thesis.

Researcher and supervision

This study is being conducted by Kate Gribble BSc, Trainee Educational Psychologist in association with the University of Exeter (kg369@exeter.ac.uk). Kate is being supervised by Dr Shirley Larkin (S.Larkin@exeter.ac.uk) and Dr Will Shield (W.Shield@exeter.ac.uk). Should you have any further questions with regards to you and your child's participation in the above study, please contact Kate Gribble in the first instance.

Thankyou for your interest in our research

Staff Consent: Young people with ADHD's perceptions of themselves and the severity of their symptoms; an exploration of mental health outcomes and personal construct psychology

Please read and amend the statements below

I have read and understood the above information regarding the proposed research and **GIVE/DO NOT GIVE** (Delete as appropriate) consent to take part in the research outlined above.

Name of young person: _____

Relationship to young person: _____

Print name: _____

Signature: _____ Date: ____/____/____

Appendix 3 – Online Questionnaire

1. Young people with ADHD tend to have a good understanding of what ADHD is.

[Insert Likert 6-point Likert scale]

2. Young people with ADHD tend to know how their ADHD affects them.

[Insert Likert 6-point Likert scale]

3. Young people with ADHD don't tend to know how severe their symptoms are.

[Insert Likert 6-point Likert scale]

4. Young people with ADHD tend to underestimate or not recognise the severity of their symptoms.

[Insert Likert 6-point Likert scale]

5. Young people with ADHD tend to overestimate how severe their symptoms are.

[Insert Likert 6-point Likert scale]

6. Young people with ADHD have usually been well informed by external professionals (e.g medical practitioners) regarding the nature of their disorder.

[Insert Likert 6-point Likert scale]

The World Health Organisation define wellbeing as “a state of complete physical, mental and social well-being and not merely the absence of disease or. Infirmity”. Please refer to this definition when answering the following questions.

7. The better a young person understands their ADHD the more likely they are to experience positive wellbeing.

[Insert Likert 6-point Likert scale]

8. A young person who does not recognise the severity of their symptoms is at higher risk of poor wellbeing.

[Insert Likert 6-point Likert scale]

9. The better a young person recognises the severity of their symptoms, the more likely they are to achieve positive academic outcomes in school.

[Insert Likert 6-point Likert scale]

10. Schools should support young people with ADHD in better understanding their diagnosis

[Insert Likert 6-point Likert scale]

11. Schools should support young people with ADHD in recognising the severity of their symptoms.

[Insert Likert 6-point Likert scale]

12. Based on the list below, how do you feel young people develop their perceptions of their symptom severity?

i. Based on how the staff at their school treat them or talk to them

[Insert Likert 6-point Likert scale]

ii. Based on how their parents treat them or talk to them

[Insert Likert 6-point Likert scale]

iii. By comparing themselves to their peers or siblings

[Insert Likert 6-point Likert scale]

iv. Based on how their peers or siblings treat them or talk to them.

[Insert Likert 6-point Likert scale]

v. Based on how they are treated in the wider community

[Insert Likert 6-point Likert scale]

vi. By being self-reflective about their own feelings and/or behaviours.

[Insert Likert 6-point Likert scale]

Appendix 4 – Development of Online Questionnaire

Appendix 4.1 Draft one

1. Young people with ADHD tend to have a good understanding of what ADHD is. [Insert Likert 6-Point Likert Scale]

2. Young people with ADHD tend to know how their ADHD affects them.

[Insert Likert 6-Point Likert Scale]

3. Young people with ADHD don't tend to know how severe their symptoms are.

[Insert Likert 6-Point Likert Scale]

4. Young people with ADHD tend to underestimate or not recognise the severity of their symptoms.

[Insert Likert 6-Point Likert Scale]

5. Young people with ADHD tend to overestimate how severe their symptoms are.

[Insert Likert 6-Point Likert Scale]

6. The better a young person understands their ADHD the more likely they are to experience positive wellbeing.

[Insert Likert 6-Point Likert Scale]

7. The better a young person recognises the severity of their symptom, the more like they are to achieve positive outcomes.

[Insert Likert 6-Point Likert Scale]

8. A young person who does not recognise their symptoms is at higher risk of poor wellbeing

[Insert Likert 6-Point Likert Scale]

9. Schools should support young people with ADHD in better understanding their diagnosis.

[Insert Likert 6-Point Likert Scale]

10. Schools should support young people with ADHD in recognising the severity of their symptoms.

[Insert Likert 6-Point Likert Scale]

11. Based on the list below, how do you feel young people develop the perceptions they have of the severity of their symptoms?

[Insert Likert 6-Point Likert Scale]

i. How their parents treat them or talk to them

[Insert Likert 6-Point Likert Scale]

ii. How the staff at their school treat them or talk to them

[Insert Likert 6-Point Likert Scale]

iii. Comparison to their peers

[Insert Likert 6-Point Likert Scale]

iv. The behaviour of their peers

[Insert Likert 6-Point Likert Scale]

v. Comparison of siblings

[Insert Likert 6-Point Likert Scale]

vi. How they are treated in the wider community

[Insert Likert 6-Point Likert Scale]

vii. How they feel

[Insert Likert 6-Point Likert Scale]

Appendix 4.2 Feedback from pilot one

Definition/clarification of wellbeing needed.

Clarification of positive outcomes needed.

Rewording of question 11.

Adding “based on” to items throughout question 11 in order to clarify.

11 vi. How do they feel about what?

Appendix 4.3 Draft two

1. Young people with ADHD tend to have a good understanding of what ADHD is.

[insert 6 point Likert scale]

2. Young people with ADHD tend to know how their ADHD affects them.

[insert 6 point Likert scale]

3. Young people with ADHD don't tend to know how severe their symptoms are

[insert 6 point Likert scale]

4. Young people with ADHD tend to underestimate or not recognise the severity of their symptoms.

[insert 6 point Likert scale]

5. Young people with ADHD tend to overestimate how severe their symptoms are.

[insert 6 point Likert scale]

The World Health Organisation define wellbeing as “a state of complete physical, mental and social well-being and not merely the absence of disease or. Infirmity”. Please refer to this definition when answering the following questions.

6. The better a young person understands their ADHD the more likely they are to experience positive wellbeing.

[insert 6 point Likert scale]

7. A young person who does not recognise the severity of their symptoms is at higher risk of poor wellbeing.

[insert 6 point Likert scale]

8. The better a young person recognises the severity of their symptom, the more like they are to achieve positive outcomes in school.

[insert 6 point Likert scale]

9. Schools should support young people with ADHD in better understanding their diagnosis

[insert 6 point Likert scale]

10. Schools should support young people with ADHD in recognising the severity of their symptoms.

[insert 6 point Likert scale]

11. Based on the list below, how do you feel young people develop the perceptions they have of their symptom severity?

i. Based on how their parents treat them or talk to them

[insert 6 point Likert scale]

ii. Based on how the staff at their school treat them or talk to them

[insert 6 point Likert scale]

iii. By comparing themselves to their peers or siblings

[insert 6 point Likert scale]

iv. Based on how their peers or siblings treat them or talk to them.

[insert 6 point Likert scale]

v. Based on how they are treated in the wider community

[insert 6 point Likert scale]

vi. By being self-reflective about their own feelings and/or behaviours.

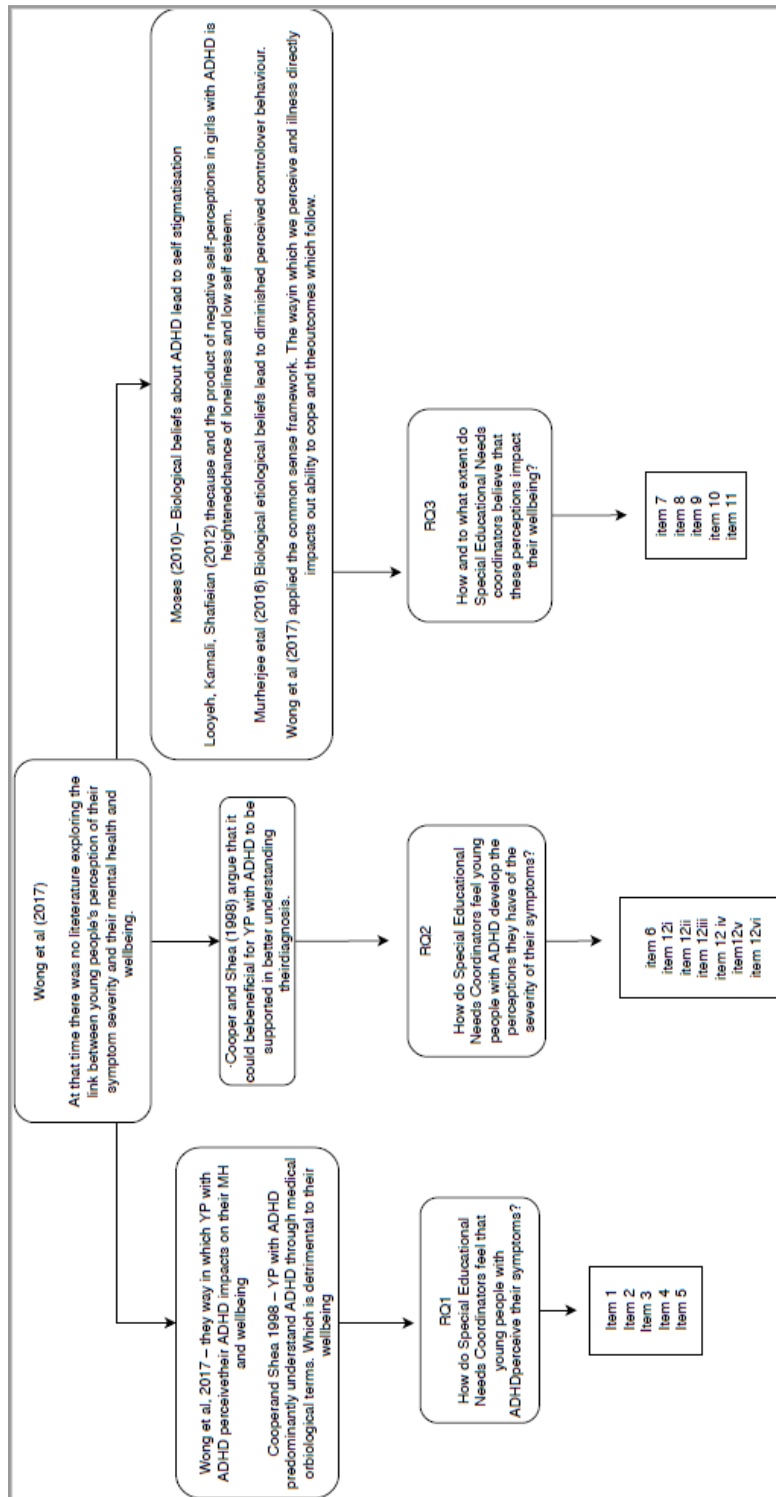
[insert 6 point Likert scale]

Appendix 4.4 feedback from pilot two

Question 11 onwards was unclear.

Why aren't there any questions about the impact of the medical professionals?

Appendix 4.5 Relationship Between Literature, Research Questions And Items.



Appendix 5 – Interview Schedules

Appendix 5.1 – Phase One Interview Schedule: SENCos

	<p>Introduce myself Reminder of confidentiality and right to withdraw – Check understanding Reminder that they will be being recorded on a Dictaphone – Check understanding</p> <p><i>“Without sharing any personal information, can you think of a young person with ADHD that you have worked with. We will use this person as a stimulus for the following questions, however if while we are talking you think of another young person who may be relevant, it is totally appropriate to discuss them as well. Or, if neither is appropriate, please talk about your experience of ADHD more broadly”</i></p>	
	Questions	Prompt
1	<p>How do you think this young person understood their ADHD?</p> <ul style="list-style-type: none"> - Or more broadly, how do you think young people with ADHD understand their diagnosis? 	
2	<p>How do you think this young person knew that they had ADHD?</p>	
3	<p>How was this young person affected by their ADHD?</p> <ul style="list-style-type: none"> - Or more broadly, in your experience how does ADHD affect young people in school? 	
4	<p>How do you think this young person felt about having ADHD?</p>	
5	<p>How did ADHD affect the way that this young person was treated by others?</p> <ul style="list-style-type: none"> - Or more broadly, in your experience, how, if at all, do you think young people with ADHD are treated differently? 	
X	<p><i>INFORMATION GIVE: The most common symptoms associated with ADHD are hyperactivity, inattentiveness, and impulsiveness.</i></p>	
7	<p>How aware was this young person of their symptoms?</p> <ul style="list-style-type: none"> - Or more broadly, how aware do you think young people with ADHD of their symptoms? 	
7.1	<ul style="list-style-type: none"> - How do you think these perceptions affected the young person? 	
8	<p>This research is hoping to explore how the perceptions young people have around their ADHD impacts on their</p>	<p>Under/overestimate</p>

	<p>wellbeing. Specifically, how their perceptions of the severity of their symptoms affect them.</p> <p>With that in mind, how do you think the way in which young people with ADHD perceive the severity of their symptoms impacts on their wellbeing?</p>	
--	---	--

Appendix 5.2 – Phase Two Initial Interview Schedule: Parents

	<p>Introduce myself Reminder of confidentiality and right to withdraw – Check understanding Reminder that they will be being recorded on a Dictaphone – Check understanding</p>	
	Questions	Prompt
1	What do you think your child thinks ADHD means?	<i>What is ADHD?</i>
2	How does your child know they have ADHD?	<i>Can you feel it? Do people tell you? How did you find out?</i>
3	How does their ADHD affect your child?	<i>At home? At school?</i>
4	How do you think your child feels about having ADHD?	
5	How does your ADHD affect the way people treat your child?	<i>Teachers? Parents? Other children?</i>
X	INFORMATION GIVE: The most common symptoms associated with ADHD are hyperactivity, inattentiveness, and impulsiveness.	<i>Check if the young person understands all 3 of these concepts If the young person needs any of these explained, they do so.</i>
6	How much do these symptoms apply to your child?	<i>How much do they affect you?</i>
7	How do these symptoms make your child feel?	
8	Is there anything else you would like to tell me about your child's ADHD?	

Appendix 5.3 – Phase Two Initial Interview Schedule: Young People

	<p>Introduce myself Reminder of confidentiality and right to withdraw – Check understanding Reminder that they will be being recorded on a Dictaphone – Check understanding</p>	
--	--	--

	Questions	Prompt
1	What do you think ADHD means?	<i>What is ADHD?</i>
2	How do you know you have ADHD?	<i>Can you feel it? Do people tell you? How did you find out?</i>
3	How does your ADHD affect you?	<i>At home? At school?</i>
4	How do you feel about having ADHD?	
5	How does your ADHD affect the way people treat you?	<i>Teachers? Parents? Other children?</i>
X	INFORMATION GIVE: The most common symptoms associated with ADHD are hyperactivity, inattentiveness, and impulsiveness.	<i>Check if the young person understands all 3 of these concepts If the young person needs any of these explained, they do so.</i>
6	How much do these symptoms apply to you?	<i>How much do they affect you?</i>
7	How do these symptoms make you feel?	
8	Is there anything else you would like to tell me about your ADHD?	

Appendix 5.4 Phase Two Initial Interview Schedule: Staff members

	Introduce myself Reminder of confidentiality and right to withdraw – Check understanding Reminder that they will be being recorded on a Dictaphone – Check understanding	
	Questions	Prompt
1	What do you think this child thinks ADHD means?	<i>What is ADHD?</i>
2	How does this child know they have ADHD?	<i>Can you feel it? Do people tell you? How did you find out?</i>
3	How does their ADHD affect this child?	<i>At home? At school?</i>
4	How do you think this child feels about having ADHD?	
5	How does this ADHD affect the way people treat this child?	<i>Teachers? Parents? Other children?</i>
X	INFORMATION GIVE: The most common symptoms associated with ADHD are	<i>Check if the young person understands all 3 of these concepts</i>

	hyperactivity, inattentiveness, and impulsiveness.	<i>If they young person needs any of these explained, the do so.</i>
6	How much do these symptoms apply to this child?	<i>How much do they affect you?</i>
7	How do these symptoms make this child feel?	
8	Is there anything else you would like to tell me about this child's ADHD?	

**Appendix 5.5 Phase Two Post Intervention Interview Schedule:
Young People**

	Question	Prompt
	How did you find the intervention overall?	What was helpful? What was challenging? What did you enjoy?
1	How has the intervention changed how you think about the young person?	If at all?
2	How do you think the intervention will influence your practice...	If at all?
3	... <u>specifically</u> when working with this young person?	" "
4	... <u>over all</u> ?	" "
5	How would you change the intervention?	

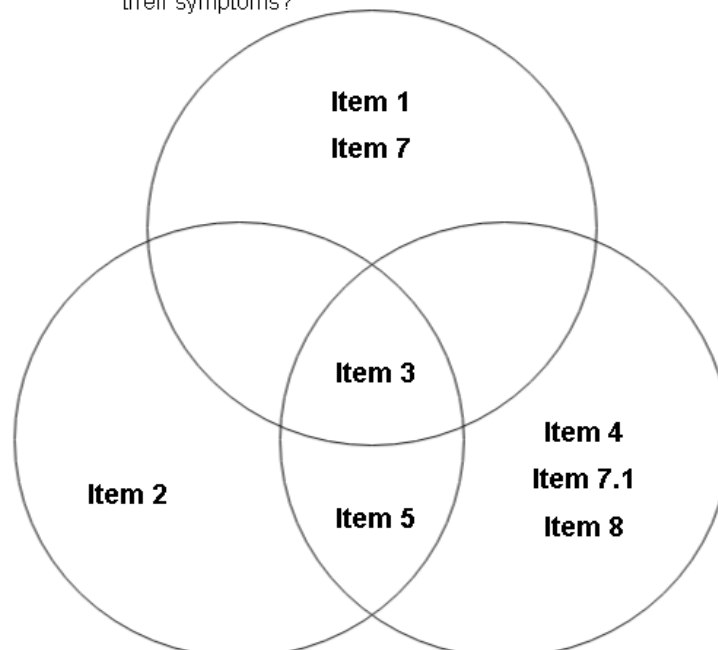
**Appendix 5.6 Phase Two Post Intervention Interview Schedule:
School Staff**

	Question	Prompt
	How did you find the work that we did together with {Staff member}?	What was helpful? What was Difficult? What did you enjoy?
1	How do you think the work we did might change your experience at school?	Do you think people will treat you differently? Do you think it will make things better or worse?
2	How has the work we did changed how you think about yourself and your ADHD?	Do you think you understand things that maybe you didn't before? Did you find anything out about yourself? Do you feel better about yourself?
5	If you could change something about the experience, what would it be?	What would you tell me to do differently? Imagine you were teaching me how to do it better, what would you tell me?

Appendix 5.7 Interview and research questions Phase One

1. How do you think this young person understood their ADHD? - Or more broadly, how do you think young people with ADHD understand their diagnosis?
2. How do you think this young person knew that they had ADHD?
3. How was this young person affected by their ADHD - Or more broadly, in your experience how does ADHD affect young people in school?
4. How do you think this young person felt about having ADHD?
5. How did ADHD affect the way that this young person was treated by others? - Or more broadly, in your experience, how, if at all, do you think young people with ADHD are treated differently?
6. How aware was this young person of their symptoms? - Or more broadly, how aware do you think young people with ADHD of their symptoms?
7. How do you think these perceptions affected the young person?
8. This research is hoping to explore how the perceptions young people have around their ADHD impacts on their wellbeing. Specifically, how their perceptions of the severity of their symptoms affect them. With that in mind, how do you think the way in which young people with ADHD perceive the severity of their symptoms impacts on their wellbeing?

RQ1) How do Special Educational Needs Coordinators think that young people with ADHD perceive their ADHD and the severity of their symptoms?



RQ2) How do Special Educational Needs Coordinators think young people with ADHD develop the perceptions they have of their ADHD and the severity of their symptoms?

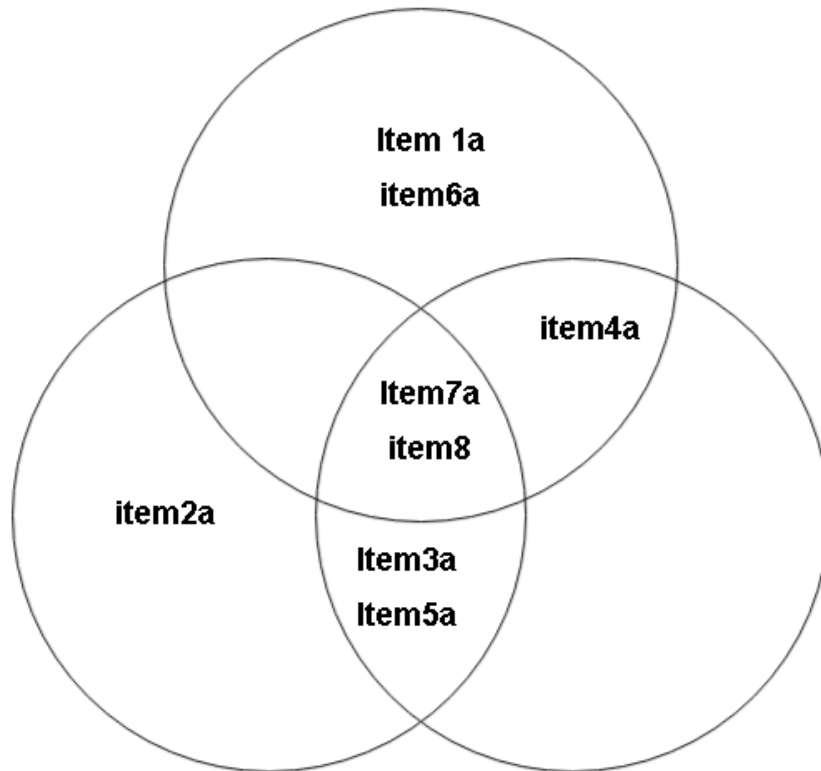
RQ3) How and to what extent do Special Educational Needs coordinators believe that these perceptions impact their wellbeing?

Appendix 5.8 Interview and research questions Phase Two

- 1.a. What do you think ADHD means?
- 2.a. How do you know you have ADHD?
- 3.a. How does your ADHD affect you?
- 4.a. How do you feel about having ADHD?
- 5.a. How does your ADHD affect the way people treat you?
- 6.a. How much do these symptoms apply to you?
- 7.a. How do these symptoms make you feel?
- 8.a. Is there anything else you would like to tell me about you ADHD?

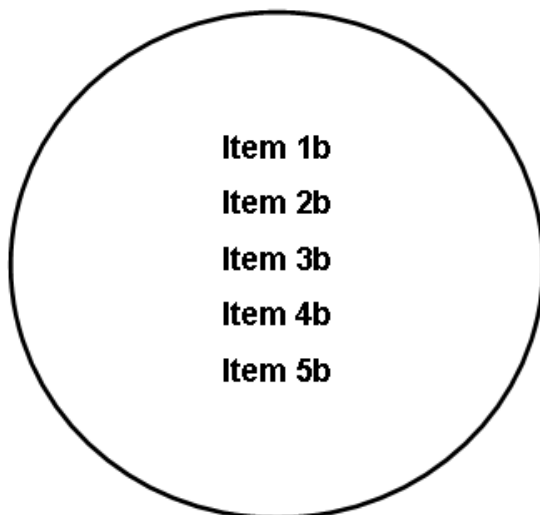
- 1.b. How did you find the intervention overall?
- 2.b. How has the intervention changed how you think about the young?
- 3.b. How do you think the intervention will influence?
- 4.b. Specifically when working this young person?
- 5.b. Over all?
- 6.b. How would you change the intervention

RQ1) How do young people with ADHD perceive their ADHD and the severity of their symptoms?



RQ2) What influences the perceptions that Young people with ADHD have of the severity of their symptoms?

RQ3) How and to what extent do these perceptions impact the young people's wellbeing?



RQ4) *How and to what extent can tools and activities derived from personal construct psychology be used to effectively support young people with ADHD?*

Appendix 6 Phase One Analysis

Appendix 6.1 Phase One transcript sample with Coding

	YP aware of their symptoms
Upset	
Other people not understanding YP's behaviour	
Low expectations of young person	
Naughty	
YP has not had it explained to them well	
Paediatrician	
YP found out about ADHD when diagnosed	
YP used to their symptoms	
All Children have needs	
Doesn't matter if there is a diagnosis	
Perceptions affecting how YP is treated	
YP should be supported in developing resilience	
	YP's understanding of ADHD affecting how they feel
	YP frustrated by their symptoms
Others should be supported in understanding the YP better	
YP should be given strategies to manage their ADHD	
	YP struggling in mainstream environment
	YP Self esteem
What would happen if the YP overestimated their symptoms	
Medication	
What children with ADHD need	
Coding Density	
SC: I think she became frustrated by the inattentiveness, because she wanted to learn, and then couldn't, because she couldn't focus on it long enough.	
I: so leading almost directly on from that, how do you think these perceptions, so how she was aware of her symptoms, how do you think they affected her?	
SC: i think they affected her self esteem, she spent a long time feeling quite... quite down on herself, and not understanding that her behaviours were like they are. and i think she still dose have days like that, times like that.	
I: and so do you think, the fact that she was more aware of her symptoms, was that a helpful change, or was that...?	
SC: i think its, its proved much better for her, because she's aware of her symptoms now, and knows why she is like she is.	
I: ok	
SC: and she's also found some strategies to help (inaudible)	
I: ok. do you think she's aware of how severe they are now?	
SC: yes YES	
I: this research is hoping to explore how the perception yp have around their ADHD impacts on their wellbeing, specifically how their perceptions of the severity of their symptoms affect	

Appendix 6.2 – Phase One nodes

SENCO 1	SENCO 2
<p>ADHD as a barrier All Children have needs Blaming the parent Difficulties with peers Doesn't matter if there is a diagnosis Emotional Finding out at Paediatrician appointment Hyperactivity Inattentive Learning to communicate themselves Low expectations of young person Medication Naughty Other children finding YP annoying Other people not understanding YP's behaviour Others should be supported in understanding the YP better Paediatrician Parent talking to YP about their diagnosis People NOT talking to YP about their ADHD People with ADHD can achieve Perceptions affecting how YP is treated Personal space Upset What children with ADHD need What would happen if the YP overestimated their symptoms Young person should be made aware of their symptoms YP aware of their symptoms YP being different YP can't control what they're doing YP Can't stop talking YP doesn't understand ADHD YP found out about ADHD when diagnosed YP frustrated by their symptoms YP has not had it explained to them well</p>	<p>YP will learn to understand their own needs YP using ADHD as an excuse YP trying to learn YP taking back control by misbehaving YP perceiving their behaviours as bad YP not given the skills or strategies they need YP not able to predict how they'll behave YP giving up on learning YP getting in trouble on purpose to avoid work YP Doesn't understand their symptoms YP doesn't understand their ADHD YP comparing themselves to their peers YP can't concentrate YP being told they are badly behaved YP being sent out of class YP Being different YP aware of their symptoms YP acting out We are not explaining ADHD to YP well enough We are better at explaining to parents than students Underachieving academically Transition from primary to secondary The more informed adults around a YP are the more able they are to support Swearing Strategies to support YP in school Staff should talk YP through their needs Staff perceiving YP as badly behaved Staff don't have the time Staff behaviour affecting YPs wellbeing Staff assuming YP will be badly behaved</p>

<p>YP knows that medication affects them</p> <p>YP Self esteem</p> <p>YP should be given strategies to manage their ADHD</p> <p>YP should be supported in developing resilience</p> <p>YP struggling in mainstream environment</p> <p>YP understands better if it is explained to them</p> <p>YP used to their symptoms</p> <p>YP's understanding of ADHD affecting how they feel</p>	<p>Self esteem</p> <p>School never spoke to YP about their ADHD</p> <p>School don't know how YP was told</p> <p>Process of diagnosis</p> <p>Perceptions from peers</p> <p>Parents not able to explain to YP</p> <p>Parents needs</p> <p>Parent thinking a diagnosis means YP can behave badly</p> <p>Parent shifting responsibility onto a diagnosis</p> <p>Naughty</p> <p>Mismanagement of ADHD causing mental health issues</p> <p>Mainstream education not suitable for YP with ADHD</p> <p>Increase in diagnosis</p> <p>Impulsivity</p> <p>How YP was told</p> <p>How YP understands themselves affects how they feel</p> <p>How YP perceives themselves affects their behaviour</p> <p>Having to establish between ADHD and challenging behaviour</p> <p>Frustrated</p> <p>Doesn't matter if the YP understands or not</p> <p>Discussing ADHD with YP</p> <p>Challenging behaviour</p> <p>Challenging behaviour</p> <p>CAHMS waiting times</p> <p>Adults around YP need to be better informed</p> <p>ADHD and exams</p>
---	--

SENCO 3

SENCO 4

<p>ADHD as an excuse</p> <p>Challenging behaviour</p> <p>Diagnosis as validation</p> <p>Diagnosis being a relief for the young person</p> <p>Difference in approach from different parents</p> <p>Differentiating between ADHD</p>	<p>Age as a variable for how aware YP is</p> <p>Anxiety caused by ADHD</p> <p>Awareness of symptoms affecting wellbeing</p> <p>Awareness of symptoms meant YP was more able to deal with them</p>
---	---

and challenging behaviour	Consequences of ADHD not being explained well
Difficult for families	Diagnosis as a quick fix
Having a diagnosis was positive for YP	Frustrated
Impulsive behaviour	Low self esteem
Inclusive environments reducing self stigma	Medication
Medication	Medication making YP more aware of their symptoms
Naughty	Naughty
Not everyone with ADHD is the same	Not being medicated made YP feel less helpless
Parent approach affecting YP understanding	Not understanding affecting wellbeing
Parent understanding	Paediatrician should explain better
Parents not educated enough by external services	Parents not supported enough
Parents not supported enough by external services	Peers are more accepting
Parents should be supported better	Perceptions of other family members
Parents understanding affects child's understanding	School responding to ADHD needs
Resilience	Validation through diagnosis
School meeting needs irrelevant of a diagnosis	YP aware of their symptoms but not knowing why they are there
School supporting YP in understanding their ADHD	YP being proud of their ADHD
School talking to parents	YP doesn't like to be different
School working with peers to help them understand	YP holding pre-conceptions of ADHD
Support in school	YP not explained to well enough
The effect of other needs	YP not questioning their ADHD
The way others perceive ADHD impacts on YP	YP recognising their needs
Trying medication before other options	YP upset by being given ADHD diagnosis
Under achieving academically	YP wants to understand their ADHD
YP aware of their symptoms	
YP comparing themselves to their peers	
YP have a good understanding of their ADHD	
YP made aware of their symptoms by provision at school	
YP more aware of some symptoms than other	
YP told about their diagnosis by their parents	
YP understanding develops over time	
YP with ADHD need a lot of	

support

SENCO 5

YP people with needs being friends with other young people who have needs
YP not aware of their symptoms
YP not accessing mainstream education
YP does not understand their ADHD
Young person aware of his symptoms
We should be educating parents better
Using ADHD as an excuse
Suggestion of misdiagnosis
School talking to YP about their ADHD
School not making allowances
School making adjustments
School feel unable to support due to finances
Peers not understanding
Parent using ADHD as an excuse
Medication
How YP understand their ADHD affects how they feel
Couldn't help what he was doing
ADHD affective YP socially

SENCO 6

YP wouldn't admit a feeling bad about ADHD
YP not affected in a negative way
YP knew from a young age
YP is demanding
YP aware of support they need
Teachers adjusting their methods to support needs
Symptoms being a good thing in particular environments
Staff developing a negative view
SENCo Describing YP's symptoms
schools differ
Parents told YP about their ADHD
Parents over supportive due to needs
Parent perception impacting YP
Parent knowledgeable
Medication helping YP's understanding
Medication helping YP's awareness
Medication
Impulsivity
Hyperactivity
Doesn't think before speaking
ADHD mildly affecting social life
Additional needs impacting understanding
Additional needs impacting perception
Additional needs

Appendix 6.3 – Phase One theme and node tables

Global Theme	Knowledge of ADHD				
Main Theme	Young Person's Understanding of ADHD		How Young Person Knows they have ADHD		
Sub Theme	Impact of understanding	Level of Understanding	How young person Develops an understanding	How Young Person was Told	People talking to young person about their ADHD
Nodes	<p><i>Not understanding affecting wellbeing</i></p> <p><i>Wants to understand their ADHD</i></p> <p><i>Consequences of ADHD not being explained well</i></p> <p><i>How YP understands themselves affects how they feel</i></p> <p><i>YP's understanding of ADHD affecting how they feel</i></p>	<p><i>YP aware of their symptoms</i></p> <p><i>YP recognising their needs</i></p> <p><i>YP aware of their symptoms but not knowing what they are</i></p> <p><i>YP not aware of their symptoms</i></p>	<p><i>YP not explained to well enough</i></p> <p><i>We are not explained ADHD to YP well enough</i></p> <p><i>Addition needs impacting understanding</i></p> <p><i>Medication helping YP's understanding</i></p> <p><i>Young person has not had it explained well enough</i></p>	<p><i>How YP was told parent told YP about their ADHD</i></p> <p><i>Young person knew from a young age</i></p> <p><i>Young person found out when they were diagnosed</i></p>	<p><i>Discussing ADHD with YP</i></p> <p><i>School talking to YP about their ADHD</i></p> <p><i>Parent talking to YP about their diagnosis</i></p>

Global Theme	Relationships and impact of others				
Main Theme	Parents	Friendships and peers		Perceptions of others	
Sub Theme		Peer understanding	Young person comparing themselves to peers	Difficulties with peers	

Nodes	<p><i>Blaming the parent</i></p> <p><i>Parents shifting responsibility onto diagnosis</i></p> <p><i>Parents needs</i></p> <p><i>Parents thinking a diagnosis means YP can behave badly</i></p> <p><i>Parent using ADHD as an excuse</i></p> <p><i>Parents not able to explain to YP</i></p> <p><i>The more informed adults around YP are the more able they are to support</i></p> <p><i>Parents understanding affects child's understanding</i></p> <p><i>Different approach from different parents</i></p> <p><i>Parents perceptions impacting YP</i></p>	<p><i>School working with peers to help them understand</i></p> <p><i>Peers not understanding</i></p>	<p><i>Comparing against peers</i></p>	<p><i>Difficulties with peers</i></p> <p><i>Other children finding YP annoying</i></p> <p><i>young people with needs being friends with other young people with needs</i></p> <p><i>ADHD affecting YP socially</i></p> <p><i>ADHD mildly affecting YP socially</i></p> <p><i>(6)</i></p>	<p><i>Perceptions affect how YP is treated</i></p> <p><i>Other people not understanding YP's behaviour</i></p> <p><i>YP being told they are badly behaved</i></p> <p><i>Staff behaviour affecting wellbeing</i></p> <p><i>Perceptions from peers</i></p> <p><i>The way other people perceive ADHD affects YP</i></p> <p><i>perceptions of family members</i></p>
--------------	---	---	---------------------------------------	--	--

Global Theme	Young person's awareness and perceptions			
Main Theme	Young person's perceptions	Young Person's awareness of their ADHD and symptoms		
Sub Theme		Young person's awareness affects wellbeing	Level of awareness	How young person's awareness develops

Nodes	<i>How YP perceives themselves affects their behaviour YP perceiving their behaviour as bad Additional needs impacting perceptions YP holding preconceptions of ADHD What would happen is a young person estimated their ADHD</i>	<i>awareness of symptoms affecting wellbeing Awareness of symptoms mean that YP was more able to deal with them YP should be made more of their symptoms</i>	<i>YP aware of their symptoms YP recognising their needs YP aware of their symptoms but not knowing what they are YP not aware of their symptoms</i>	<i>Medication supporting awareness Age as a variable for how aware YP is Medication making YP more aware of their symptoms YP made more aware of their symptoms by provision YP aware of how their ADHD affects them</i>
--------------	---	--	--	--

Global Theme	Challenges in School		
Main Theme	ADHD as a barrier to learning	Transition	School feeling unskilled
Sub Theme			
Nodes	<i>under achieving academically ADHD and exams YP not accessing mainstream education ADHD as a barrier YP with ADHD Can achieve YP struggling in mainstream environment Mainstream environment not suitable for YP with ADHD</i>	<i>transition from primary to secondary</i>	<i>Staff don't have time School feeling unable to support due to finances</i>

Global Theme	Symptoms, feelings and behaviours			
Main Theme	Mental health and wellbeing		Symptoms and behaviour	
Sub Theme	Feelings and wellbeing	Resilience and self esteem	Challenging Behaviour	Symptoms and ADHD associated behaviours
Nodes	<p><i>YP wouldn't admit feeling bad about ADHD</i></p> <p><i>YP upset by being a diagnosis</i></p> <p><i>Anxiety caused by ADHD</i></p> <p><i>Frustrated</i></p> <p><i>Mismanagement of ADHD causing mental health problems</i></p> <p><i>Emotional upset</i></p>	<p><i>Resilience</i></p> <p><i>YP should be supported in developing resilience</i></p> <p><i>Low Self Esteem</i></p> <p><i>Self Esteem</i></p>	<p><i>YP is demanding</i></p> <p><i>Challenging behaviour</i></p> <p><i>Having to distinguish between ADHD and challenging behaviour</i></p>	<p><i>Doesn't think before speaking</i></p> <p><i>YP not able to predict how they will behave</i></p> <p><i>YP not able to concentrate</i></p> <p><i>Personal space</i></p> <p><i>YP can't control what they're doing</i></p> <p><i>Can't control what he is doing</i></p>

Global Theme	Symptoms, feelings and behaviours	
Main Theme	Medication	Impact of diagnosis
Sub Theme		
Nodes	<p><i>Trying medication before other options</i></p> <p><i>Medication</i></p>	<p><i>Diagnosis positive for young person</i></p> <p><i>Diagnosis as validation</i></p> <p><i>Validation through diagnosis</i></p>

Appendix 6.4 – Phase One theme example
THEME: ADHD as barrier

NODE: under achieving academically

Reference 1 - 4.63% Coverage

SENCO 2: I just don't think they have the time, is the brutal truth. You've got 31 kids in a room, you know, and your being bashed for exam results. So yeah I know what, lets also ask you to devise a whole different lesson for child A.

I: yeah

SENCo 2: Not going to happen. So as a knock on effect of that, they under achieve academically and then because of their behaviour, and that behaviour not always being understood, certainly not in the early days, and with CAMHS taking such a frighteningly long time to make diagnoses, you then get a behaviour bash. So you've got this young person, who knows there's something wrong, is confused, and probably angry about that, is under achieving academically and then also been told their badly behaved, which completely pulls any rug of any self esteem out from under them. So I think those two, sort of, pincer movement, things, on that child, is the reason why there is such a high SEMH limit.

Reference 2 - 4.53% Coverage

SENCo 2: the inattentiveness impacted quite severely at secondary level, where, obviously, lessons are sort of an hour long. and generally speaking, as in a secondary setting, you wouldn't have like, rest breaks every 20 minutes, or something like that. So in many ways, it was sort of setting children up to fail, if they had that type of diagnosis, really, so I think that inattentiveness, really, affected the child, in just that they didn't know the answers, it's not that they weren't academically capable, it's just that the way that the school day is structured, the way that lessons are timed and structured, didn't give them a fighting chance, of actually being able to show what they could do academically. That then had the behaviour affect, which meant that they missed loads of lessons, through being kicked out, or excluded. which then just compounded their inability to keep up academically.

NODE: ADHD and exams

Reference 1 - 2.55% Coverage

SENCo 2: adept at, yeah yeah, I mean obviously, there comes a point at the end of year 11, and certainly sixth form, where you sit there for two hours, three hours, and do an exam, and that's it, isn't it, you sit there and you write, that's it. Whereas for some of these young people they can't sit there and write for 20 minutes. So I guess that, I mean, I don't know whether it's part of your thing, but it begs a slightly different question I suppose, about the education system in general, and what its actually set up for.

NODE: YP not accessing mainstream education

Reference 1 - 0.91% Coverage

SENCO 5: he's not accessing main stream education, he's more, over in our haven, on a reduced timetable, until we can find somewhere more suitable for him.

Reference 2 - 3.31% Coverage

SENCO 5: he hasn't attended any lessons since September. he dose do some work in haven, but its (inaudible) goes, there's nothing complete and as much s we try and support him, I think a main street school is just, the environment itself docent work for him, doesn't suit him, he needs to be somewhere smaller, that's a lot more focused, ratio of adults to children would be a lot higher for him . something that's not, I don't want to say "not structured" we're very much (inaudible... possibly regimental?) here you have to follow (inaudible) routine.

Reference 3 - 1.32% Coverage

SENCO 5: we put those adjustments in place (those reasonable?) adjustments in place (for a child?) that has (needs/need?) but that child, even with the reasonable adjustments... it unfortunately hasn't had a positive impact.

Reference 4 - 2.57% Coverage

SENCO 5: as a school, there are those rules, there are those expectations, and they are.... they need to follow that, and they are expected to, because ultimately, and iv said this to a number of parents, if allowed every child with a diagnosis to carry on as they pleased, this school would just be chaotic, and thats not fair on the... whatever the percentage, that don't have (needs?) or even those that do, whatever percent..

NODE ADHD as a barrier

Reference 1 - 3.10% Coverage

SENCO 1: I think that its a major barrier to pupils reaching their full potential, and i think we need to be aware that it is a hindrance to them. but i think that we also need to be aware that its possible to support them through that, so that they can then reach that full potential,

NODE YP with ADHD Can achieve

Reference 1 - 1.98% Coverage

SENCo 1: no, just that I think we need to understand the children more fully, and carefully. and not see it as a barrier to life. people with ADHD achieve very highly and very well.

NODE YP struggling in mainstream environment

Reference 1 - 4.19% Coverage

SENCo 1: I think staff sometimes expect to much from them in the wrong ways. so they may expect them to sit and write for an hour, when actually they need to write for 15 minutes and have a movement break, and then come back to it. i

think staff need to be more aware of strategies that can be used to support the children, rather than them just assuming that they are not capable

Reference 2 - 1.69% Coverage

SENCo 1: I think she became frustrated by the inattentiveness, because she wanted to learn, and then couldn't, because she couldn't focus on it long enough.

NODE Mainstream environment not suitable for YP with ADHD

Reference 1 - 2.55% Coverage

SENCO 2: adept at, yeah yeah, I mean obviously, there comes a point at the end of year 11, and certainly sixth form, where you sit there for two hours, three hours, and do an exam, and that's it, isn't it, you sit there and you write, that's it. Whereas for some of these young people they can't sit there and write for 20 minutes. So I guess that, I mean, I don't know whether it's part of your thing, but it begs a slightly different question I suppose, about the education system in general, and what its actually set up for.

Reference 2 - 2.44% Coverage

SENCO 2: the fact is, that whether we like it or not, whether we believe in it or not, the fact is that there are an ever-increasing number of young people being diagnosed, be it ADHD, be it ASD or whatever, and these people are going to need to find places in the world. they are going to need to find work places in the world. So actually, as an education system, telling someone that, our way of certificating their success, is to say "well done, you've sat down for two hours and written an essay"

Reference 3 - 4.53% Coverage

SENCO 2: : the inattentiveness impacted quite severely at secondary level, where, obviously, lessons are sort of an hour long. and generally speaking, as in a secondary setting, you wouldn't have like, rest breaks every 20 minutes, or something like that. So in many ways, it was sort of setting children up to fail, if they had that type of diagnosis, really, so I think that inattentiveness, really , affected the child, in just that they didn't know the answers, it's not that they weren't academically capable, it's just that the way that the school day is structured, the way that lessons are timed and structured, didn't give them a fighting chance, of actually being able to show what they could do academically. That then had the behaviour affect, which meant that they missed loads of lessons, through being kicked out, or excluded. which then just compounded their inability to keep up academically.

Reference 4 - 2.21% Coverage

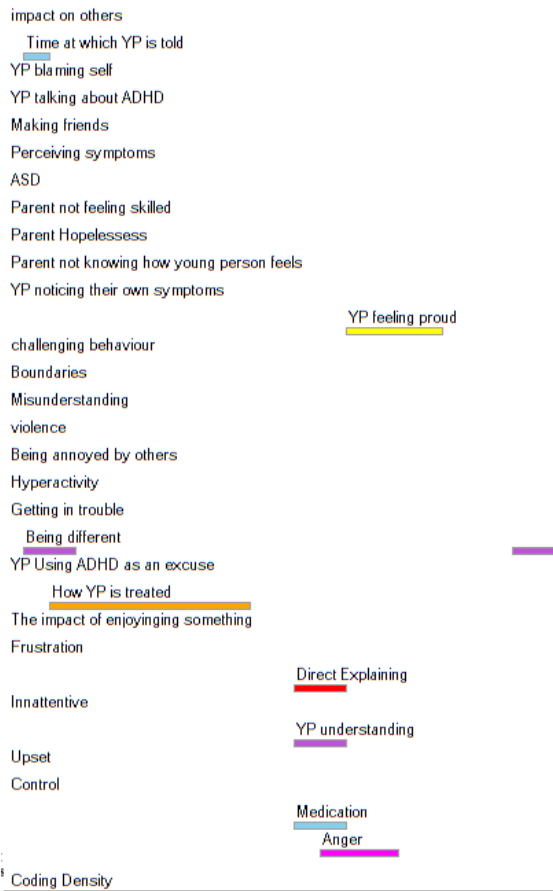
SENCO 2: just, just, just, kick them out, the fidgetiness, whatever you want to call it, I think likewise, you put someone in a traditional classroom, for an hour, you know they're going to struggle to sit still for 15 or 20 minutes. and then you wonder why they can't.

I: yeah

SENCO 2: you know, it would be like... I don't know... putting me on an American football field, and I don't know the rules, and saying yeah, go play. What am I going to do?

Appendix 7 Phase Two Analysis

Appendix 7.1 Phase Two transcript sample with Coding



P: Ummmm To be honest because I've told him about it from a young age, he knows he's different to other children, but he also knows like I won't allow him to be treated any different to other children whether that being in school or at home, cause there's certain things they put into place for him as a school which is brilliant, its fantastic, with if he gets a certain amount of marbles a day he gets 10 minutes of something he wants to do. Whereas I put a stop to that. I...the way I see it is that I have chosen to put him in a mainstream school because I want him to follow the rules, it wasn't fair that out of a class of 30 just because hes got this issue he got that.

I: You really really don't want him to be singled out.

P: No, no I don't. Like at the end of the day he is medicated, he knows the situation I have been upfront with him from obviously when he started taking the medication and obviously I tried to say to him if "If you get angry, take yourself away from the situation" which he finds difficult, but sometimes you might find you get 1/6 he might do that and he would be really proud of himself that he has done that.

I: So actually if we are talking about how he feels about having it, what you're trying to do is make it so that actually the medication and the way that you...

P: Yeah I don't want him to feel any different from another child. Dyou know what I mean?

Appendix 7.2 Phase Two Theme Example

THEME: Feelings

TEACHING ASSISTANT

NODE: Anger

Reference 1 - 0.82% Coverage

like In year two he was on different medication and used to get quite angry

Reference 2 - 0.87% Coverage

I: so you think for him it means being cross or being angry

S: Yeah being angry.

Reference 3 - 1.36% Coverage

Umm socially he can play a game with someone but sometimes if it doesn't go his way he can get quite angry and upset about it.

Reference 4 - 3.26% Coverage

S: I don't think he thinks he can't do things because of it, I think he is still willing . the anger issue cause he gets quite angry or upset about things I think he thinks that is because of it, but in class and doing activities in class, I don't think he thinks it's got anything to do with his ADHD.

Reference 5 - 1.36% Coverage

he would never hit or anything like that it was just get angry he would get frustration stamp his feet a little bit and shout

Reference 6 - 1.30% Coverage

if he gets so angry he will take himself away from everyone and just sit on his own. And that his way of dealing with it.

Reference 7 - 4.37% Coverage

Yeah I think he gets quite upset when he gets angry he doesn't know how to deal with his anger, so I think he gets quite stressed and upset cause he doesn't know how to express himself but shout at someone and try and tell. So when he shouts back at, so say he is upset he shouts and me, and I'm like "no

you don't need to shout at me" but that's his way of expressing, that's the only way he knows I think.

NODE: *managing their own feelings*

Reference 1 - 1.30% Coverage

if he gets so angry he will take himself away from everyone and just sit on his own. And that his way of dealing with it.

PARENT

NODE: *Anger*

Reference 1 - 0.30% Coverage

He puts it down to a lot of ummm like to do with anger

Reference 2 - 0.34% Coverage

"I cant help it I've got anger issues" he says "Ive got ADHD"

Reference 3 - 0.28% Coverage

its its more his anger like he cant control it so.

Reference 4 - 0.73% Coverage

when he gets to a certain point I know there is nothing i can do. I just have to let him crack on, get himself out of his bad temper,

Reference 5 - 0.62% Coverage

he will come and apologies to me, and he's like "Im sorry mummy I don't know what happened, I just got so angry."

Reference 6 - 1.41% Coverage

when he is indoors if he gets angry, I can control in. Now if he is out and a child makes him angry I am not there to control it so if he ends up flipping out, 1 he could possible cause he is quite a strong boy, 1 he could possible do damage to someone else,

Reference 7 - 0.59% Coverage

I tried to say to him if "If you get angry, take yourself away from the situation" which he finds difficult,

Reference 8 - 0.33% Coverage

he does try and "Well I've got anger issues I can't help it"

Reference 9 - 0.65% Coverage

I: Does he ever get upset that he cant control himself?

P: Yes, yes he gets upset quite a bit and when he lashes out,

Reference 10 - 1.45% Coverage

Not to be nasty, there's a lot of children out there who absolutely beat their molythers because of they've got the issue, and they can't control their anger, whereas to me that's no respect, I know it can get to a certain extent but that's why they have medication

Reference 11 - 0.58% Coverage

Anger is a bit one for K, so it is like the hyper, the hypo and the anger come, they clash i reckon with K

Reference 12 - 0.29% Coverage

the hyperactive kicks in but the anger comes with it.

Reference 13 - 0.74% Coverage

he'll be running around the house screaming like a lunatic. where as if you or me were angry we would sit down and be like [angry noise]

Reference 14 - 0.54% Coverage

he gets angry, there is no him sitting there and getting angry. the whole house knows he is angry.

Reference 15 - 1.92% Coverage

It all depends on what, it sound stupid, but it's like a ruler. right so if you look at a ruler if he's at like nought to thirty ruler, if his anger is between 0 to say 15, he can stop it. But if it goes past that certain ...such a stupid example....but if it goes past an example, past a certain CM say, you can't, you just literally have to let him

Reference 16 - 1.82% Coverage

is was 6 weeks holidays he starting taking his anger out on the floor or on the door, so he would start punching the floor or head butting the floor or punching the door and stuff like that, i was literally I was sat in my front room, he's in his bedroom cause im in a town house, and I heard the bang where he headbutted the floor,

Reference 17 - 0.44% Coverage

Yeah he wouldn't care how old they are how big they are if he was angry he'd go.

NODE: Upset

Reference 1 - 0.41% Coverage

sometimes he can get quite emotional, he can get emotional because of it.

Reference 2 - 0.65% Coverage

I: Does he ever get upset that he cant control himself?

P: Yes, yes he gets upset quite a bit and when he lashes out,

Reference 3 - 1.52% Coverage

But his uncle and then his grandad, they love to wind him up. Weve been out to a restaurant before now, and thye've wound him up that much and I've said to them "ENough". but he literally just flopped in my lap crying his eyes out. and that's when I'm like, enough, like stop.

Reference 4 - 1.36% Coverage

I: do you think it makes him sad?

P: yeah definitely. Yeah, 100%. he always says to me "[inaudible] is doing this [sister] is allowed out at my age, I'm nearly 8 now mum can I go out. Bobby was going out when he was 8". And Im like "no baby you cant"

Reference 5 - 0.61% Coverage

"that's the naughty boy mum, that's that K". and he...I heard it...and it upset me, and K heard it and it upset K.

NODE: Frustration

Reference 1 - 3.55% Coverage

P: Because yeah to be honest that can get him into trouble, because where I think he is listening, and then 10 minutes later I'm like "Kaylen! Why haven't you put your socks on?" "Well when did you tell me to put my socks on?" "I told you 10 minutes ago mate to put your socks on. So it's...he can...it can be...that bit can be frustrating for him as well...but because of...like He will be watching the telly and I'll go "Kaylen" and he'll look at me, "get your socks on boys" he'll look back. So to me, he has heard me. But in his head, he may be looking at me but he is still still thinking about that TV. So you know it's not all to do with...

NODE: Being annoyed by other

Reference 1 - 0.53% Coverage

but if someone annoys him on that computer, the hyperactive kicks in but the anger comes with it.

Reference 2 - 1.36% Coverage

but you'll find a lot of the time hes like cause my family love to wind K up. But his uncle and then his grandad, they love to wind him up. Weve been out to a restaurant before now, and thye've wound him up that much and I've said to them "ENough".

NODE: Feeling Proud

Reference 1 - 1.11% Coverage

If you get angry, take yourself away from the situation" which he finds difficult, but sometimes you might find you get 1/6 he might do that and he would be really proud of himself that he has done that.

NODE: YP Blaming self

Reference 1 - 0.65% Coverage

I'm trying to be good I'm trying to listen mummy and it does get really upsetting sometimes because he blames himself.

NODE: The impact of enjoyment

Reference 1 - 3.22% Coverage

he can tell when his tablets wearing off, if he hasn't had that tablet, unless it's something he enjoys, then he can focus. If it is something that he doesn't enjoy, then he cant. Because like that's how we found it, one of the things at nursery, he was sat there, once he gets into something ...like he was really into trains, if he sat there, he was sat, like they told me, he was sat on that carpet into those trains by himself and he would just play. to the point where when it was tidy up time he was so intrigued in that, that he would have to go over to him like "K it's time to..."

SOLOMON

NODE: Anger

Reference 1 - 0.73% Coverage

I: What do you think ADHD means?

YP: I think it means that you have trouble with your angry issues

Reference 2 - 0.86% Coverage

if I said "could you explain what adhd is?" what would you tell me it ws?

YP: well angry have trouble with your anger

Reference 3 - 2.11% Coverage

I once people make the ADHD adds to me like when people make me really really angry then they just makes me get really really strong and once I punch someone and I get really really angry and it really hurt someone and I really didn't mean to it's just that I couldn't control my anger.

Reference 4 - 5.39% Coverage

Like when they were like annoying me one of my friends was annoying me [inaudible] and I asked that it wasn't all my fault. it was actually some of my friends fault cause I asked them if we could stay a little bit quiet while I am trying to hide because he could give my attention away and he got really [inaudible] and annoying and it got me really angry and I then he but it wasn't my fault because he was actually [inaudible] me and i was asking him to stop and I asked him nicely and then I asked him nicely again and again and then I just asked really really because he really was ignoring me and then he got me very angry so i and I couldn't control what I was doing right then and then I just pushed him into the house in year 2

NODES: *Feeling guilty*

Reference 1 - 2.73% Coverage

after dinner I didn't I couldn't see my little brother [inaudible] i stepped on my little brothers foot [inaudible] he actually screamed and I actually started crying because i didn't mean to hurt him and I really felt bad for him and when he was gone I was thinking about what I've been and all I've done and I was thinking he if would die or survive when that happened

Reference 2 - 1.60% Coverage

I: How does that make you feel when you do these things that you don't mean to do?

YP: Like very very very guilty.

I: Very guilty. And how does being guilty make you feel?

YP: That I really don't deserve to live.

Reference 3 - 2.32% Coverage

I: Is there anything else you want to tell me about your ADHD?

YP: It always make me feel sad and it just makes me feel very very mean and once i do something bad and I really wish that I could that I didn't that I can't always do things bad, like I don't always do things bad but I just wish i didn't do anything.

NODE: *Feeling sad about ADHD*

Reference 1 - 2.32% Coverage

I: Is there anything else you want to tell me about your ADHD?

YP: It always make me feel sad and it just makes me feel very very mean and once i do something bad and I really wish that I could that I didn't that I can't always do things bad, like I don't always do things bad but I just wish I didn't do anything.

NODE: *Feeling stupid*

Reference 1 - 0.36% Coverage

Like really really it makes me feel really stupid