Newcastle University

Doctorate in
Applied Educational Psychology

An Exploration of the Diagnostic Label 'Attention Deficit Hyperactivity Disorder'.

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Date of Submission: June 2017

<u>Acknowledgements</u>

Overarching Abstract

The diagnostic label Attention Deficit Hyperactivity Disorder (ADHD) is classed as an acute disorder in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-V). However, ADHD is contextualised within various disciplines - biomedical, psychological and sociological, each of which provide conflicting discourses that confuse the meaning of this diagnostic label.

Research suggests children with ADHD diagnoses experience difficulties in social and educational settings. However, contrasting literature exists regarding how children with ADHD diagnoses view themselves. The first chapter of this thesis critically reviews existing research purporting children with ADHD diagnoses overestimate their social competencies. This overestimation is known as the Positive Illusory Bias (PIB). Three conclusions were drawn from the systematic literature review: research in this area does not account for individual differences between children with ADHD diagnoses, quantitative measurement of children's self-concept is problematic, the concept of the PIB relies upon the assumption that adults' views are more valid than children's and does not consider the impact the label ADHD may have on individuals. The conclusions of this Systematic Literature Review informed the empirical research question; what does the diagnostic label ADHD mean to a diagnosed child and the adults who support him?

The empirical research used a qualitative methodology to explore the perceptions of a child who has received an ADHD diagnosis, his mother, his teacher and his learning support assistant (LSA) regarding the meaning and impact of the diagnostic label ADHD. Subsequently, the transcripts of four semi-structured interviews were analysed using Interpretive Phenomenological Analysis (IPA). Three master grouped themes were discovered that encapsulate the participants' perceptions of the label ADHD; Blame, Fear and Support. The master group themes are discussed in consideration of the findings of the Systematic Literature Review, quotes from the participants' accounts of their lived experience and my interpretations. Due to the research design and context, this empirical research offers novel findings about the views of different stakeholders regarding the diagnostic label ADHD. The associated implications for educational psychologists are discussed.

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Chapter 1: Systematic Literature Review

Do Children with a diagnosis of attention deficit hyperactivity disorder (ADHD) demonstrate a Positive Illusory Bias (PIB) in their social self-concepts?

Abstract

It is estimated that 1 in 100 UK children between the ages of 5 and 16 manifest the most profound symptoms and acute difficulties associated with ADHD and around 5 in 100 children manifest less severe symptoms (National Institute for Health and Clinical Excellence, 2008). This Systematic Literature Review explores the literature surrounding the self-concepts of children with ADHD diagnoses. Firstly, ADHD is discussed, outlining key features of ADHD and the associated difficulties with the aetiology of this diagnostic label. After this, children's self-concept is discussed, specifically focusing upon social self-concept and the measurement of this specific domain. Next, a phenomenon known as the Positive Illusory Bias (PIB) is examined and key papers are identified using the framework outlined by Petticrew and Roberts (2006). The papers are then critically appraised using the Weight of Evidence Tool (Gough, 2007). Finally, implications for educational psychologists and future research are discussed.

1.1 Introduction

1.1.1 What is ADHD?

This section seeks to provide a definition of the diagnosis ADHD. Despite ADHD being classed as an acute disorder in the Diagnostic and Statistical Manual – Fifth Edition (American Psychiatric Association, 2013) much debate exists regarding the nature of this diagnosis. Visser and Jehan (2009) discuss that such disparity stems from the way ADHD is contextualised within various disciplines (biomedical, psychological and sociological), each of which provide conflicting discourses that confuse the nature of ADHD. It is likely that complex aetiology of ADHD relates to the large set of neuro-biological and environmental factors which operate in a complex fashion to contribute to the likelihood of an individual receiving this diagnosis. Despite this disparity, Timimi and Radcliffe (2005) discuss that the biomedical discourse of ADHD seems to have become embraced by a wide range of professionals and practitioners, including psychiatrists, psychologists and teachers.

For the purpose of this Systematic Literature Review, the current formal definition of ADHD provided in the DSM-V (American Psychiatric Association, 2013) has been employed. This definition characterises ADHD as a disorder that begins in childhood but can continue through adulthood. ADHD is characterised by patterns of behaviour that are present in multiple settings (e.g. school and home), which can result in difficulties in social, educational or work settings. Symptoms are divided into two categories; inattention and hyperactivity/impulsivity. These categories include various behaviours such as failure to pay close attention to detail, difficulty with organisation, excessive talking and fidgeting.

To receive an ADHD diagnosis, the DSM-V (American Psychiatric Association, 2013) states children must have at least six symptoms from either (or both) the inattention group of criteria or the hyperactivity/impulsivity group of criteria. People over the age of 17 must have five symptoms. The main difference between the diagnostic criteria provided by The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV) (American Psychiatric Association, 1994) and the DSM-V is age of symptom onset. The DSM-V states that several symptoms must be present before the age of 12 whilst the DSM-IV previously stated symptoms had to be present before the age of 7. It is estimated that 1 in 100 UK children between the ages of 5 and 16 manifest the most profound symptoms and acute difficulties associated with ADHD and around 5 in 100 children manifest less severe symptoms (National Institute for Health and Clinical Excellence, 2008). Diagnosis of ADHD is made by a qualified medical clinician, an assessment requires evidence of pervasiveness and should be based on detailed information from multiple sources; such as parents, teachers, educational psychologists and other professionals (Baldwin & Cooper, 2000; Cooper & Bilton, 2013).

Considering the lack of consensus as to the nature of ADHD, for the purpose of this review, children are referred to as having an 'ADHD diagnosis' rather than 'having ADHD'.

1.1.2 What is Social Self-Concept

This section explores the notion of self-concept; the latter part provides a specific definition of social self-concept.

Self-concept has been of major interest to educationists and psychologists for decades, yet the literature surrounding it is contrasting and confusing (Bracken & Lamprecht, 2003; Hattie, 1992). There is no agreed term used to refer to self-concept; within the literature the term self-concept is often used synonymously with; 'self-efficacy', 'self-esteem', 'self-attributions' and 'self-awareness'. However, whilst these concepts may be related, it can be argued they

are not synonymous (Fleming & Courtney, 1984; Gecas, 1982; Tabassam & Grainger, 2002). Similarly, whilst some researchers may use the terms 'self' and 'self-concept' interchangeably, Gecas (1982) suggests these two terms are different, with 'self' referring to a reflexive process and 'self-concept' being a result of this process. Contrastingly, within the literature the terms 'self-concept' and 'self-perception' seem to be used interchangeably (Harter, 2012b). Consequently, this review employs the term 'self-concept' when referring to both self-concept and self-perception.

A further difficulty associated with self-concept is identified in the contrasting schools of thought regarding its nature. Self-concept is described in its simplest form as 'cognitive appraisals of attributes about ourselves' (Hattie, 1992, p. 10). However, there is much debate as to whether self-concept exists in a unitary form or whether it is domain specific.

The original view of self-concept posits that it exists as a unitary construct, which consists of the learned beliefs, attitudes and opinions a person holds about themselves (Purkey, 1988). Similarly, Weinreich (2003, p. 151) suggests self-concept is 'the totality of one's self-construal'.

However, in recent years the literature has moved away from this notion. The current widely accepted view suggests self-concept is a multi-dimensional construct and specific self-concepts exist across many domains (Begley & Lewis, 1998). Shavelson, Hubner, and Stanton (1976) originally proposed a multidimensional and hierarchically ordered self-concept structure. This view implies self-concept domains, although inter-correlated, can be measured separately (Byrne & Shavelson, 1996). The specific self-concept domains that are widely accepted include; social-competence, affect, physical, academic and family (Delugach, Bracken, Bracken, & Schicke, 1992). This review adheres to the multi-dimensional model and focuses specifically on social self-concept, which may be broadly defined as children's cognitive self-perceptions of their functioning in the social domain (Harter & Pike, 1984).

The importance of self-concept is highlighted when considering whether individuals may have either positive or negative self-concepts (Shavelson et al., 1976). Harter (2012a) states self-concepts have three core purposes; organisational, motivational and protective. Developing positive self-concepts is proposed as central to a sense of self, integral to healthy psychological development and associated with greater achievement of positive outcomes: psychologically, physically, socially and academically (Marsh & Hau, 2003). Specifically, a negative social self-concept in children is thought to link to peer rejection and the development of internalising problems (Spilt, Lier, Leflot, Onghena, & Colpin, 2014). Furthermore, children with low social self-concept have been shown to demonstrate more

antisocial behaviour when compared to children with high social self-concept (Pisecco, Wristers, Swank, Silva, & Baker, 2001).

Within the available literature, the most widely used measure of self-concept is the Self-Perception Profile for Children (SPPC) (Harter, 1985, 2012b) which takes a developmental and multi-dimensional view of self-concept. However, methodological difficulties exist in regard to the measurement of social self-concept. Namely, measures particularly fail to account for individual, family and cultural difference (Barton, 2006) . For example, children within families where social skills are regarded as important, may form different social self-concepts to children within families where social skills are not considered as important. Furthermore, individualist and collectivist societal views may have different social expectations resulting in difference in social self-concept (Barton, 2006; Parkes, Schneider, & Bochner, 1999). However, Parkes et al. (1999) argue that due to the universal importance of social relations, social self-concept is more likely to remain a domain of emphasis regardless of society or culture.

In summary, self-concept is difficult to define as it is often viewed as synonymous with other constructs. However, it is generally accepted that self-concept exists as multi-dimensional, hierarchical and domain specific construct (Harter & Pike, 1984). This review focuses specifically on social self-concept, which may be defined as children's cognitive self-perceptions of their functioning in the social domain (Harter & Pike, 1984).

1.1.3 The impact of an ADHD Diagnosis on Social Self-Concept: The Positive Illusory Bias (PIB)

This section seeks to examine the relationship between an ADHD diagnosis and social self-concept. Specifically, focusing on a phenomenon known as the Positive Illusory Bias (PIB).

Children with ADHD diagnoses are said to experience difficulties with social functions in both peer and family contexts. Specifically, children with higher levels of ADHD symptoms are reported to experience difficulties developing and maintaining relationships with their peers (Hinshaw, Zupan, Simmel, Nigg, & Melnick, 1997; Hodgens, Cole, & Boldizar, 2000). Therefore, it may be stated that it is likely children with ADHD diagnoses hold differing social self-concepts to their non-diagnosed peers.

Some studies have suggested children with ADHD diagnoses experience lower self-concepts than those without ADHD diagnoses. A study by Houck, Kendall, Miller, Morrell, and Wiebe (2011) involving 145 children and their mothers suggested children with ADHD diagnoses experience low overall self-concept. Specifically, they suggested older children and those

with internalising behaviour, experienced the lowest overall self-concept. Similarly, Bussing, Zima, and Perwien (2000) suggested children with ADHD diagnoses reported significantly lower overall self-concept on the Piers-Harris Self-Concept Scale (Piers, 2002) than children without ADHD diagnoses.

Despite the evidence suggesting children with ADHD diagnoses experience low overall self-concept, there is an increasing body of contrasting research which suggests children with ADHD diagnoses experience high overall self-concept, regardless of their reported difficulties (Owens, Goldfine, Evangelista, Hoza, & Kaiser, 2007). Harter (2012a) discusses that in the general population, young children typically tend to overestimate their abilities and thus their self-concept scores tend to be high. However, this phenomenon, known as the PIB (also known as the Self-protective Bias/Positive Illusory Self-concept), refers to a tendency for children with ADHD diagnoses to report much more positive self-concept (in all domains) than actual ability would warrant (Hoza, Pelham Jr, Dobbs, Owens, & Pillow, 2002). Within the population of children with ADHD diagnoses, the PIB refers to the discrepancy between children's subjective ratings of their competencies and objective measures/others' ratings of their competencies (Owens et al., 2007). For example, Hoza et al. (2002) compared self-reported competencies of 195 boys with ADHD diagnoses with those of 73 boys without an ADHD diagnosis. Findings suggested boys with ADHD diagnoses overestimated their competencies more than the control group did, indicating the diagnosed group held higher self-concepts than the control group.

The PIB's function has been attributed to various factors including cognitive immaturity, neuropsychological deficits and the need for self-protection (Hoza et al., 2002; Ohan & Johnston, 2002; Owens et al., 2007; Owens & Hoza, 2003). Consequently, much debate remains as to whether these children's positive self-reports of competence are a product of conscious inflation, misperception, or unconscious psychological protection (Hoza et al., 2002).

Contrasting information exists regarding the impact of an ADHD diagnosis on social self-concept. Whilst some might assume an ADHD diagnosis would result in low social self-concept, much research exists highlighting that children with an ADHD diagnosis demonstrate high and somewhat unrealistic social self-concepts. The PIB may provide an explanation for why children with ADHD diagnoses report differing levels of social self-concept accuracy compared to children without ADHD diagnoses.

1.1.4 Importance of this Review for Educational Psychologists

The impact of PIB on social self-concept in children diagnosed with ADHD is particularly pertinent to the field of Educational Psychology. As discussed, ADHD is widely diagnosed despite a lack of consensus regarding its nature; educational psychologists may be asked to play a role in supporting these children (Holowenko & Pashute, 2000). Having a positive social self-concept is vital for organisational, motivational and protective success (Harter, 2012a). However, research states children with ADHD diagnoses may form inaccurate social self-concepts (E.g. Hoza et al., 2004; Hoza et al., 2002; Linnea, Hoza, Tomb, & Kaiser, 2012). It may be stated that understanding more about the nature of the PIB may enable those working in education to better understand and support children with ADHD diagnoses, to ensure that the impact of the ADHD diagnosis on their social self-concepts it not overlooked. Furthermore, this Systematic Literature Review may highlight ways in which the theory of the PIB may promote/inhibit support for children with ADHD diagnoses.

1.2 Methodology

This section details the methods employed in this Systematic Literature Review and outlines the ontological/epistemological stance taken. This section also seeks to discuss procedural details and the ethical implications associated with this Systematic Literature Review.

1.2.1 Ontological and Epistemological Stance

Grix (2002) discusses that 'ontology is the starting point of all research, after which one's epistemological and methodological positions largely follow' (p. 177). Ontology may be described as, 'what is out there to know about' (Grix, 2002, p. 175) whilst epistemology may be described as 'what and how can we know about it' (Grix, 2002, p. 175). An objectivist ontological stance implies social phenomena and their meanings exist independently of social actors (Bryman, 2012). A positivist epistemological stance suggests it is possible to describe a phenomenon correctly and there is a straightforward relationship between what is real and our perceptions/understanding of it (Willig, 2008). All of the studies included in this Systematic Literature Review rely upon the assumptions that ADHD is a biological certainty and self-concept is a measurable phenomenon. Therefore, it may be suggested all of the studies in this review adopt an objectivist ontological and positivist epistemological stance.

<u>1.2.2 Method – (Petticrew & Roberts, 2006)</u>

Given the reviewed studies' positivist epistemological stance (Willig, 2008), this review employs Petticrew and Roberts' (2006) systematic review methodology, which involves the stages outlined in Table 1. These stages are referred to throughout this Systematic Literature Review.

Table 1: Stages of the systematic review method, adapted from Petticrew and Roberts (2006).

1. Clearly define the review question.
2. Determine the types of studies needed to answer the question.
3. Carry out a comprehensive literature search to locate these studies.
4. Screen studies found using inclusion criteria to identify studies for in-depth review.
5. Describe the included studies to 'map' the field and critically appraise them for quality and relevance.
6. Synthesise studies' findings.
7. Communicate outcomes of the review.

Stage 1 – Review Question

This review aims to synthesise the findings of recent research regarding social self-concepts of children diagnosed with ADHD to explore if these children demonstrate a PIB. This review aims to increase understanding of this relationship, as well as identify areas for additional empirical research. The question addressed by this review was: **Do Children with ADHD diagnoses demonstrate a PIB in their social self-concepts?** Specifically, this Systematic Literature Review seeks to examine studies in which the SPPC (Harter, 1985) is used to measure social self-concepts of children diagnosed with ADHD.

Stage 2 and 3 – Initial Searches

To locate relevant studies, several forms of initial search took place using a set of pre-defined search terms (Table 2) and specified inclusion/exclusion criteria (Table 3). Search terms were identified after reading current literature in the area of PIB. Inclusion criteria are a set of agreed conditions, based upon the research question that studies must meet in order to be included in the Systematic Literature Review. The following initial searches were completed:

1. Electronic databases were searched using the combination of the keyword search terms (Table 4).

2. Controlled Vocabulary Searches were also undertaken within three of the databases using the terms (Table 5).

3. Several journals were hand searched for articles.

4. Key articles underwent reference and citation searches.

5. Grey literature was searched for further information.

All searches were carried out between July-September 2015.

Table 2: List of search terms used for the electronic database searches.

Phenomenon Terms	Positive Illusory Bias
	Positive Illusion*
	Positive Illusory Self-concept*
	PIB
	Positive bias*
	Positive Self-perceptual Bias*
	Positive Self-evaluation*
	Positive Self-protective Bias*
Population Terms	Child*
	Young pe*
	Student*
	Pupil*
	Youth*
	Adolescent*
	Teenager*
	Minor*
Condition Terms	ADHD
	Attention Deficit Hyperactivity Disorder

Table 3: Initial Inclusion/Exclusion criteria.

Participants	• Studies with participants of primary school age (mean age under 12) were included.
Settings	• Studies that used any setting - home and/or school.
	• Studies that focused on ADHD - summer camp programmes were not included.
Study Design	• Studies that measured the PIB and/or self-concept were included.

Time, Place and Language	• Studies completed in English since ADHD was first defined in the DSM-III-R (American Psychiatric Association, 1987) were included.

Initial Searches

Keyword Database Searches

Table 4: Keyword Database Searches.

Search Terms Employed:	The following inclusion criteria were employed for the initial keyword search:
("positive illusory bias" OR "positive illusion*" OR "positive illusory self-concept*" OR PIB OR "positive bias*" OR "positive self-perceptual bias" OR "positive self-evaluation OR "positive self-protective bias*") AND (child* OR "young pe*" OR student* OR pupil* OR youth OR minor) AND (ADHD or "attention deficit hyperactivity disorder")	English, published after 1987, participants aged 0-16. *(Note: SCOPUS, Web of Science and ProQuest do not allow search results to be filtered by participant age).*

Keyword Database Searches	Number of Search Results
British Education Index, Child Development and Adolescent Studies, Cinahl, Education Abstracts, Education Administration Abstracts, ERIC, Medline, Teacher References (via EBSCO)	10
EMBASE, PsychInfo, Medline (via Ovid)	50
SCOPUS	31
Web of Science	7
ProQuest	9

Controlled Vocabulary Database Searches

Table 5: Controlled Vocabulary Database Searches.

Search Terms Exploded:	The following inclusion criteria was employed for the initial controlled vocabulary search:
Positive Illusory Bias, Child, ADHD (The search terms employed were exploded by the search provided to search for the idea/concept rather than searching by keywords).	English, published after 1987, participants aged 0-16.

Controlled Vocabulary Database Searches	Number of Search Results
EMBASE, PsychInfo, Medline (via Ovid)	454

Journals generating two or more studies of interest during the Keyword and Controlled Vocabulary Searches ('Journal of Attention Disorders' and 'Journal of Abnormal Clinical Psychology') and two Educational Psychology journals ('Educational Psychology in Practice' and 'Educational and Child Psychology') were selected for Hand Searching. No additional eligible studies were identified for this review.

Grey Literature Searches

'Grey literature' refers primarily to unpublished literature (Littell, Corcoran, & Pillai, 2008). The keyword database search accessed records of items other than journal articles including an unpublished thesis, which was of value to this review. After acquiring this thesis, a separate grey literature search was undertaken for additional grey literature (Newcastle Library Catalogue, Open Grey and Bielefeld Academic Search Engine). No additional eligible studies were identified for this review.

Citation and Reference Searches

'Reference harvesting' is the process of using the reference list of key studies to identify other studies of potential relevance for review (Littell et al., 2008). The reference list of the three articles deemed 'most relevant', Barton (2006), Emeh and Mikami (2014) and Hoza et al. (2004), were searched. However, no additional eligible studies were identified for this review.

Initial search results yielded a total of 460 studies after deduplication. These were then screened for relevance by title and abstract leaving a total of 45 search results.

Stage 4 – The In-Depth Review

Additional inclusion/exclusion criteria were applied to the 45 studies identified in the initial literature search to identify those to be included in the in-depth review:

Table 6: In-Depth Review Inclusion/Exclusion criteria.

Participants	• Studies with participants of primary school age were included (mean age of 12 or younger). • Studies where participants did not have an official ADHD diagnosis were excluded.
Settings	• Studies that used any setting - home and/or school were included.

	• Studies that focused solely on the impact of ADHD summer camp programmes were excluded.
Study Design	• Studies that used the SPPC (Harter, 1985, 2012b), specifically the social-acceptance subscale, as a measure of social self-concept were included. • Studies that included a measure of PIB with regard to social self-concept were included. • Studies that solely monitored the impact of a specific treatment programme on the PIB were excluded.
Time, Place and Language	• Studies completed in English, since 1987, when ADHD was first defined (American Psychiatric Association, 1987) were included. • Studies that were not accessible after 'reasonable attempt' to access them (Petticrew & Roberts, 2006, p. 100) were excluded. Reasonable attempt included searching every database available to the researcher and where possible contacting authors directly to request access.

After applying the inclusion/exclusion criteria to the 45 studies identified from the initial search 12 studies remained.

1.3 Results

Stage 5 - Describing and Appraising the Studies

The 12 studies identified from the second screen are outlined in the table below (Table 7). The 12 studies include 11 published journal articles and 1 unpublished thesis. Table 7 describes the selected studies.

1.3.1 Effect Sizes

Cohen's d is a measure of effect size that is defined as the difference between two means divided by the pooled standard deviation for those means. Effect sizes of 0.20 are small, 0.50 are medium and 0.80 are large (Cohen, 1988). Some of the studies included effect sizes, for others effect sizes were calculated using the Effect Size Calculator available online at the Centre for Evaluation and Monitoring (Durham University). For some studies, insufficient information was available to calculate effect size. The usefulness of effect sizes in this

systematic literature review remains unclear as the PIB was calculated in different ways for each study – this information has been included in [Table 7](#).

Title/Authors	Purpose	Participants and Context	Instruments	PIB Measures and Procedure	Outcomes	Effect Size Calculation
Self-perception in Children with Attention Deficit/ Hyperactivity Disorder (Barber, Grubbs, & Cottrell, 2005)	- To describe the self-perceptions of children with ADHD diagnoses compared with their control counterparts.	- 77 children (aged 8-12 years), 53 boys and 24 girls -38 had an ADHD diagnosis. - Children were recruited through a paediatrician. - Completed in the USA.	**Child Measures** - SPPC (Harter, 1985).	**PIB Calculation** - SPPC (Harter, 1985) ratings were taken from children with ADHD diagnoses and compared with control counterparts. **Follow Up** - No specific follow up was completed.	- Findings suggested children with ADHD diagnoses perceived themselves differently to other children their age scoring lower (although not significantly) on the SPPC (Harter, 1985) social-acceptance subscale when compared to their control counterparts.	Effect size calculated for social-acceptance subscale. **-0.31** (Small)

Table 7: Details of the Selected Studies.

Social Self-Concept and Positive Illusory Bias in Boys and Girls with and without ADHD (Barton, 2006) - **Unpublished thesis.**	- To compare children's self-reported social self-concepts with their teacher's report of their social-competence. - To assess whether children with ADHD diagnoses are more likely to demonstrate the PIB than control counterparts. - To investigate the purported self-protective function of a PIB.	- 96 children (aged 8-13). - 48 children (31 boys/ 17 girls) with ADHD diagnoses. - Children were recruited through a school setting as part of a larger study. - Completed in the USA.	**Child Measures** - SPPC (Harter, 1985). - Child Depression Inventory (CDI) (Kovacs, 1992). **Parent Measures** - Background Information Form. - ADHD Rating Scale: Home Version (DuPaul, Power, Anastopoulos, & Reid, 1998). - Child Behaviour Checklist (CBC) (Achenbach, 1991). **Teacher Measures** - Teacher Background Information Form. - Child Background Information Form. - ADHD Rating Scale: School Version (DuPaul et al., 1998). - Teacher Rating Scale (SPPC) (Harter, 1985).	**PIB Calculation** - This study used the PIB calculation method outlined by (Owens & Hoza, 2003). - Discrepancy scores were calculated between standardised child and teacher scores reported on the SPPC (Harter, 1985). Discrepancy scores for both groups of children were then compared. **Follow Up** - This study was completed as part of a larger study. However, no specific follow up was completed.	- Children with ADHD diagnoses were more disliked by their peers and rated as less socially competent by teachers. - Girls with ADHD diagnoses overestimated their social-competence compared to their teacher's reports; while control girls underestimated their competence. Boys with/without ADHD diagnoses reported social self-concept that was equal to teacher reports. - Children who reported their social self-concept higher than teachers reports of competence did not report lower depressive symptoms than children who reported low social self-concept.	Data was not provided and therefore effect sizes were incalculable.

The Influence of Parent Behaviors on Positive Illusory Bias in Children with ADHD. (Emeh & Mikami, 2014)	- To explore the relationship between parental feedback and the accuracy of children's self-perceptions.	- 56 children (aged 7-10). - 28 with ADHD diagnoses. - Children were recruited through a school. - Completed in the USA.	**Child Measures** - SPPC (Harter, 1985). - Child Depression Inventory – Short Version (CDI-S) (Kovacs, 2003) - The Pictorial scale of Perceived Competence and Social Acceptance for Young Children (PCSA) (Harter & Pike, 1984). **Parent Measures** - Child Symptom Inventory (Gadow & Sprafkin, 1994). - Schedule for Affective Disorders and Schizophrenia – School Age Children (K-SADS) (Kaufman et al., 1997). - Analysis of video feedback from parents to children. **Teacher Measures** - Child Symptom Inventory (Gadow & Sprafkin, 1994). - Social Skills Rating System (Gresham & Elliott, 1990).	**PIB Calculation** - The PIB was calculated using the method suggested by (De Los Reyes & Kazdin, 2004). - Social self-concept PIB was obtained by subtracting the teachers standardised score on the Social Skills Rating System from the children's scores on the social-acceptance subscale of the SPPC (Harter, 1985) or PCSA (Harter & Pike, 1984). Discrepancy scores for both groups of children were then compared. **Follow Up** - No specific follow up was completed	- Children with ADHD diagnoses did not differ significantly from comparison children in self-report ratings on the SPPC (Harter, 1985) or PCSA (Harter & Pike, 1984). However, teachers rated children with ADHD diagnoses as demonstrating more problem behaviours and fewer social skills than did comparison children on the Social Skills Rating System (Gresham & Elliott, 1990). - Parents of children with ADHD diagnoses gave significantly more criticism to them regarding their social behaviour, as opposed to parents of children without ADHD diagnoses. - Findings suggested a relationship between parent criticism and social PIB in children with ADHD diagnoses, supporting the self-protective hypothesis.	Data was not provided and therefore effect sizes were incalculable.

The Self Perceptions and Attributions of Attention Deficit Hyperactivity Disordered and Nonreferred Boys (Hoza, Pelham, Milich, Pillow, & McBride, 1993)	- To examine the importance of cognitive-motivational variables in children with ADHD diagnoses. - To compare children with and without ADHD diagnoses on measures of attributions, self-perceptions and depression.	- 52 boys (aged 8.3 and 13. - 27 boys with ADHD diagnoses. - Children were recruited through the 1990 Children's Summers Day Treatment Programme and through schools. - Completed in the USA.	**Child Measures** - SPPC (Harter, 1985). - Peer Social Attribution Questionnaire (Hoza, Bukowski & Pelham, 1990, cited by Hoza et al., 1993) . - Children's Attributional Style Questionnaire (Kaslow, Tanenbaum, & Seligman, 1978). - CDI (Kovacs, 1992). - Wechsler Intelligence Scale for Children – Revised (WISC-R) (Wechsler, 1974). **Parent Measures** - IOWA Conners (Milich & Loney, 1982). - CBC (Achenbach, 1991). **Teacher Measures** - IOWA Conners (Milich & Loney, 1982). - Disruptive Behaviour Disorders Rating Scale (DBDRS) (Pelham Jr, Gnagy, Greenslade, & Milich, 1992).	**PIB Calculation** - SPPC ratings (Harter, 1985) were taken from children with ADHD diagnoses and compared with control counterparts. **Follow Up** - No specific follow up was completed.	- Boys with ADHD diagnoses did not rate themselves significantly worse than boys without on global self-worth or most other self-perception scales. - Boys with diagnoses of ADHD were more likely to make internal attributions for positive social outcomes, but less likely to accept responsibility for negative social outcomes. - Boys with diagnoses of ADHD were more likely to be depressed than those without. - Attributions, self-worth and depressive symptoms were not related in the same ways for boys with and boys without ADHD diagnoses.	Effect size calculated for social-acceptance subscale. **-0.23** (Small)

Do Boys with Attention Deficit/ Hyperactivity Disorder Have Positive Illusory Self-Concepts (Hoza et al., 2002)	- To reconcile previous conflictual findings regarding self-perceptions of boys with ADHD diagnoses. - To understand relation of comorbidities to the self-systems of boys with ADHD diagnoses.	- 268 boys were aged between 7.66 and 12.75 years of age (mean = 9.83). - 195 boys had ADHD diagnoses. - Children were recruited through a summer programme, media and university laboratory. - Completed in the USA.	**Child Measures** - SPPC (Harter, 1985). - CDI (Kovacs, 1992). - Woodcock-Johnson tests of abilities (Woodcock & Johnson, 1989). - WISC-R (Wechsler, 1974) or WISC–III (Wechsler, 1991). **Parent Measures** - DBDRS (Pelham Jr et al., 1992) **Teacher Measures** - Teacher Rating Scale (SPPC) (Harter, 1985). - DBDRS (Pelham Jr et al., 1992). - CBC: Teacher Report Form (Achenbach, 1991).	**PIB Calculation** - Discrepancy scores were calculated between standardised child and teacher scores reports on the SPPC (Harter, 1985). Discrepancy scores for both groups of children were compared. - Further analysis was provided which included additional factors such as depressive symptoms, aggression and achievement. **Follow Up** - No specific follow up was completed. However, the data used in this study was also used for McQuade, Hoza, Murray-Close, Waschbusch, and Owens (2011).	- Findings suggest boys classed as aggressive and low-achieving with ADHD diagnoses tend to overestimate their competence the most in the domains in which they were the most impaired. Specifically, boys classed as aggressive overestimated their social and behavioural competencies whilst boys classed as low-achieving overestimated their academic competencies.	Effect size provided for the social-acceptance subscale. **1.04** (High)

Self-perceptions of competence in children with ADHD and comparison children. (Hoza et al., 2004)	- To consider comparability of results across three different criterion raters (teachers, mothers, and fathers). - To consider both main effects and interactions involving the gender of participants. - To use ratings linked to DSM–IV (1994) symptoms of conduct disorder in establishing an aggressive subgroup.	- Participants were 487 children with ADHD diagnoses (mean age – 9.76) and 287 control counterparts (mean age – 9.85). - Participants were part of the ongoing follow-up portion of the Multimodal Treatment Study of Children with ADHD and were assessed at 10 months after last treatment. - Completed in the USA.	**Child Measures** - SPPC (Harter, 1985). - CDI (Kovacs, 1992). - Wechsler Individual Achievement Test–Screener (Wechsler, 1992). **Parent Measures** - Teacher Rating Scale (SPPC) – Adapted (Harter, 1985). - *DSM–IV* Conduct Disorder Checklist (Hinshaw, March, et al., 1997). **Teacher Measures** - Teacher Rating Scale (SPPC) (Harter, 1985).	**PIB Calculation** - Discrepancy scores were calculated between standardised child and mother/father/teacher scores reported on the SPPC (Harter, 1985). Discrepancy scores for both groups of children were then compared. **Follow Up** - This study was completed as part of a larger study. However, no specific follow up was completed.	- This study identified evidence of the PIB regardless of who was used as the criterion rater (mother/ father/ teacher).	Effect size provided for the social-acceptance subscale. 1. **Teacher = 0.63 (medium)** 2. **Mother = 0.52 (medium** 3. **Father = 0.25 (small)**

Time-dependent changes in positively biased self-perceptions of children with attention-deficit/hyperactivity disorder: a developmental psychopathology perspective. (Hoza, Murray-Close, Arnold, Hinshaw, & Hechtman, 2010)	- To evaluate the relative utility of the cognitive immaturity and self-protective perspectives in explaining the positively biased self-perceptions of children with ADHD, using a developmental psychopathology framework.	- Participants included 797 children (aged 8–13 years - at Time 1) - Participants were part of the ongoing follow-up portion of the Multimodal Treatment Study of Children with ADHD and were assessed at 10 months after last treatment (Time 1) and then 1,4 and 6 years after (Time 2,3 and 4). - Completed in the USA.	**Child Measures** - SPPC (Harter, 1985). - Self-Perception Profile for Adolescents (SPPA) (Harter, 1988). - CDI (Kovacs, 1992). **Parent Measures** - DBDRS (Pelham Jr et al., 1992) - Conduct Disorder Checklist (Hinshaw, March, et al., 1997). - Swanson, Nolan & Pelham IV Rating Scale (J. M. Swanson, 1992). **Teacher Measures** - Teacher Rating Scale (SPPC/SPPA) (Harter, 1985, 1988).	**PIB Calculation** - Discrepancy scores were calculated between standardised child and teacher scores reports on the SPPC (Harter, 1985). Discrepancy scores for both groups of children were then compared. **Follow Up** - This study was longitudinal, conducted over 6 years.	- This study compared the cognitive immaturity and self-protective explanations for the PIB among children with ADHD in two distinct competence domains: social and behavioral. - Consistent with the self-protective explanation of positively biased self-views, results differed substantially by domain. Hence, little support was found for the cognitive immaturity perspective.	Data was not provided and therefore effect sizes were incalculable.

Can children with ADHD be motivated to reduce bias in self-reports of competence? (Hoza, Vaughn, Waschbusch, Murray-Close, & McCabe, 2012)	- To examine in a domain-specific manner whether levels of bias in the self-perceptions of children with ADHD could be decreased via manipulations introduced to reduce bias. - To consider the extent to which any improvements obtained through the use of these manipulations normalised levels of bias in the self-perceptions of children with ADHD diagnoses.	Participants were 264 children (aged 7-12). - 178 had ADHD diagnoses. - Children were recruited via media, pediatricians, psychologists, psychiatrists, schools and ADHD specialty clinics/summer programs. - Completed in the USA.	**Child Measures** - SPPC (Harter, 1985). - CDI (Kovacs, 1992). - Children took part in an experiment which involved completing the SPPC (Harter, 1985) firstly as a baseline, secondly with the aim of matching teacher ratings and thirdly with a monetary incentive to match teacher ratings. **Teacher Measures** - Teacher Rating Scale (SPPC) (Harter, 1985).	**PIB Calculation** - Discrepancy scores were calculated between standardised child and teacher scores reports on the SPPC (Harter, 1985). Discrepancy scores for both groups of children were compared. - Three sets of domain-specific discrepancy scores were computed to reflect the three conditions under which bias was assessed: (a) at baseline, (b) when children were asked to match their teacher, and (c) when money was awarded for matching their teacher. **Follow Up** - No specific follow up was completed.	- Findings suggested maximal reductions in bias were obtained in the monetary incentive condition. - The authors were not able to reduce bias to a significant degree in the social domain, despite being able to do so in the scholastic and behavioral domains. - This study demonstrates levels of bias in self-perceptions of children with ADHD can be reduced to a limited degree if children are motivated to reduce such bias. Nonetheless, even when motivated to do so, children with ADHD were not able to completely eliminate the bias in their self-perceptions.	Comparison children's baseline discrepancy scores to the money manipulation discrepancy scores for children with ADHD for the social domain: **0.65 (Medium)**

Does a Positive Bias Relate to Social Behaviour in Children with ADHD? (Linnea et al., 2012)	- To examine whether positively biased self-perceptions relate to social behaviours in children with ADHD diagnoses.	- 125 children (aged 7-11). - 26 girls, 99 boys. - 87 children with ADHD diagnoses. - Children recruited from local universities, clinics, schools, radio and newspaper. - Completed in the USA.	**Child Measures** - Assessment for ADHD based on the DSM-IV (American Psychiatric Association, 1994). - SPPC (Harter, 1985). - TV Talk Show - (Social Interaction Task). **Parent Measures** - DBDRS (Pelham Jr et al., 1992). - The Computerised Diagnostic Interview Schedule for Children – Parent Version (Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000). **Teacher Measures** - DBDRS (Pelham Jr et al., 1992). - CBC: Teacher Report Form (Achenbach, 1991). - Teacher Rating Scale (SPPC) (Harter, 1985).	**PIB Calculation** - Discrepancy scores were calculated between standardised child and teacher scores reports on the SPPC (Harter, 1985). - A cut-off score of 1 was used to categorise children into three groups; ADHD+PIB, children with ADHD-PIB and children without ADHD or PIB. The three groups were compared during the social interaction TV Talk Show Task. **Follow Up** - No specific follow up was completed	- The study provides association between positively biased self-perceptions and actual social behaviours. - Children with ADHD diagnoses with and without a PIB displayed more disruptive behaviour during the task. - Children identified as having ADHD+PIB displayed less pro-social behaviour and less effortful behaviours.	Data was not provided and therefore effect sizes were incalculable.

| Changes in Self-Perceptions in Children with ADHD: A Longitudinal Study of Depressive Symptoms and Attributional Style (McQuade, Hoza, et al., 2011) | - To examine positive self-perceptions in relation to depressive symptoms and attributional style in a sample of 88 boys with ADHD diagnoses assessed at baseline and at a 2-3 year follow up. | - 88 boys with ADHD diagnoses (aged 9.9-15.3).

- Children recruited through a summer programme for boys with ADHD.

- Completed in the USA. | **Child Measures**
- Hollingshead Four Factor Index (Hollingshead, 1975) assessment of socio-economic status.
- WISC-R (Wechsler, 1974) or WISC-III (Wechsler, 1991).
- SPPC (Harter, 1985).
- CDI (Kovacs, 1992).
- Children's Attributional Style Questionnaire Revised (Kaslow et al., 1978; Thompson, Kaslow, Weiss, & Nolen-Hoeksema, 1998).

Parent Measures
- DBDRS (Pelham Jr et al., 1992).

Teacher Measures
- DBDRS (Pelham Jr et al., 1992).
- Teacher Rating Scale (SPPC) (Harter, 1985). | **PIB Calculation**
- Discrepancy scores were calculated between standardised child and teacher scores reports on the SPPC (Harter, 1985).

Follow Up
- This study provided a follow up to a previous study by (Pelham Jr & Hoza, 1996). This data was also used in another study by (Hoza et al., 2002). | - Results provide support for a protective function of self-perceptions in relation to depressive symptoms and attributional style for boys with ADHD diagnoses over a 2 to three-year period.

- Analyses also suggested a reduction in self-perceptions in the social domain was the strongest predictor of later depressive symptoms and also predicted greater depressive attributional style at follow up. | Data was not provided and therefore effect sizes were incalculable. |

Cognitive Deficits and Positively Biased Self-Perceptions in Children with ADHD (McQuade, Tomb, et al., 2011)	- To examine executive functioning differences in children with/without ADHD diagnoses and children with/without a PIB. - To examine the relationship between cognitive deficits and positive bias in children with and without an ADHD diagnosis.	- 272 children (aged 7-11) (77% male). - 184 with ADHD diagnoses. - Children recruited via paediatricians, psychologists, psychiatrists, schools, ADHD clinics, media and ADHD summer camps. - Completed in the USA.	**Child Measures** - SPPC (Harter, 1985). - CDI (Kovacs, 1992). - Woodcock-Johnson tests of abilities (Woodcock & Johnson, 1989). **Parent Measures** - DBDRS (Pelham Jr et al., 1992). **Teacher Measures** - DBDRS (Pelham Jr et al., 1992) - CBC: Teacher Report Form (Achenbach, 1991). - Teacher Rating Scale (SPPC) (Harter, 1985).	**PIB Calculation** - Discrepancy scores were calculated between standardised child and teacher scores reports on the SPPC (Harter, 1985). Discrepancy scores for both groups of children were compared. - A cut-off score of 1 was used as in the overall sample a positive bias score of 1 or greater corresponded to a score that was approximately one standard deviation above the mean. **Follow Up** - No specific follow up was completed	- The study demonstrated differences in cognitive deficits among children with ADHD diagnoses who do and do not demonstrate PIB. Specifically, children with an ADHD diagnosis and PIB demonstrated greater cognitive deficits than those without a PIB. - The study suggests cognitive deficits may be one factor that contributes to the PIB in children with ADHD diagnoses.	Data was not provided and therefore effect sizes were incalculable.

| Is the Positive Illusory Bias Illusory? Examining Discrepant Self-Perceptions of Competence in Girls with ADHD.

(E. N. Swanson, Owens, & Hinshaw, 2012) | - To examine whether girls with ADHD diagnoses demonstrate positive illusory self-perceptions in scholastic competence, social-acceptance, and behaviour conduct domains.

- To determine whether self-perceptions versus constituent informant ratings or test scores were more strongly predictors of impairment and positive adjustment. | - 228 girls (aged 6-12).

- 140 girls with ADHD diagnoses.

- Children recruited through medical centres, schools, paediatricians, newspapers and support groups.

- Completed in the USA. | **Child Measures**
- The Diagnostic Interview Schedule for Children (Shaffer et al., 2000).
- SPPC (Harter, 1985).
- Wechsler Individual Achievement Test (Wechsler, 1992).
- Peer Socio-metric Positive Nominations.
- CDI (Kovacs, 1992).

Parent Measures
- The Diagnostic Interview Schedule for Children – Parent Version (Shaffer et al., 2000).
- Maternal ratings of popularity.

Teacher Measures
- CBC: Teacher Report Form (Achenbach, 1991).
- Teacher Ratings of Peer and Social Skills (Dishion & Kavanagh, 2003). | **PIB Calculation**
- Discrepancy scores were calculated between standardised child scores on the SPPC (Harter, 1985) and peer/teacher/mother scores on various measures of social-competence. Discrepancy scores for both groups of children were compared.

Follow Up
- This study re-tested 209 participants 5 years later to inform longitudinal study. This data has not been included in this review. | - The study suggested girls with ADHD diagnoses rated themselves as more positive than controls as indicated by external ratings, but these self-reports were still in a negative direction.

. | Three effect sizes were provided for the three discrepancy scores for the ADHD diagnosed group and compared with discrepancy scores for the ADHD non-diagnosed group.

1) **Peer Ratings -0.12 (Small)**
2) **Teacher Ratings -0.45 (Medium)**
3) **Mother Rating -0.56 (Medium)** |

<u>1.3.2 Assessing the Quality of the Studies and the Weight of Evidence</u>

The 12 studies selected from the in-depth review were subjected to intense scrutiny to establish the overall quality and relevance of each study to the review. Despite its subjective nature, the Weight of Evidence tool provides both generic and specific criteria for assessing quality, which can then be combined to make an overall judgement (Gough, 2007). The Evidence for Policy and Practice Information and Coordinating Centre (EPPI- Centre) Weight of Evidence tool, adapted from (Gough, 2007), was used and studies were assessed against the following criteria:

- A - Soundness of study (internal methodological coherence), based upon the study only.
- B - Appropriateness of the research design and analysis used for answering the review question.
- C - Relevance of the study topic focus (from the sample, measures, scenario, or other indicator of the focus of the study) to the review question.
- D - An overall weight, taking into account A, B and C.

Three studies were rated as 'High' using the Weight of Evidence tool; Barton (2006), Emeh and Mikami (2014) and Hoza et al. (2004) therefore these studies are most commonly referred to throughout the discussion. However, it should be noted that, despite adherence to the guidance provided, the Weight of Evidence rating is a subjective process which is open to influence from individual bias.

Table 8: Weight of Evidence and Effect Size of Chosen Studies.

Study	A– Trustworthy	B– Appropriate Design and Analysis	C– Relevance of Focus	D- Overall WoE
Self-perception in Children with Attention Deficit/ Hyperactivity Disorder (Barber et al., 2005).	Low	Medium	High	Medium
Social Self-Concept and Positive Illusory Bias in Boys and Girls with and without ADHD (Barton, 2006).	Medium/ High	High	High	High
The Influence of Parent Behaviors on Positive Illusory Bias in Children with ADHD (Emeh & Mikami, 2014).	Medium/ High	Medium/ High	High	High
The Self Perceptions and Attributions of Attention Deficit Hyperactivity Disordered and Nonreferred Boys (Hoza et al., 1993).	Low	Low/ Medium	Medium	Low Medium
Do Boys with Attention Deficit/ Hyperactivity Disorder Have Positive Illusory Self-Concepts (Hoza et al., 2002).	Medium	Medium	High	Medium
Self-perceptions of competence in children with ADHD and comparison children (Hoza et al., 2004).	Medium	High	High	High
Time-dependent changes in positively biased self-perceptions of children with attention-deficit/hyperactivity disorder: a developmental psychopathology perspective (Hoza et al., 2010).	Low/ Medium	Low	Medium	Low Medium
Can children with ADHD be motivated to reduce bias in self-reports of competence? (Hoza et al., 2012).	Medium	Medium	Medium	Medium
Does a Positive Bias Relate to Social Behaviour in Children with ADHD (Linnea et al., 2012).	Medium	High	Medium/ High	Medium/ High
Changes in Self-Perceptions in Children with ADHD: A Longitudinal Study of Depressive Symptoms and Attributional (McQuade, Hoza, et al., 2011).	Low	Low/ Medium	Low	Low
Cognitive Deficits and Positively Biased Self-Perceptions in Children with ADHD (McQuade, Tomb, et al., 2011).	Medium	Low	Low	Low
Is the Positive Illusory Bias Illusory? Examining Discrepant Self-Perceptions of Competence in Girls with ADHD (E. N. Swanson et al., 2012).	Medium	High	Medium	Medium

1.4 Discussion

1.4.1 Summary of Findings

Stages 6 & 7: Synthesise Findings and Disseminate Findings

Almost every study examined in this Systematic Literature Review claimed to provide evidence for the PIB in the social self-concept domain. However, despite utilising the same instruments to test for PIB, evidence for the presence of the PIB was presented using several different methods. The following findings discussed refer solely to child and adult ratings on the social-acceptance subscale of the SPPC (Harter, 1985).

Two studies reported the presence/lack of the PIB by comparing the social-acceptance ratings of children with ADHD diagnoses to those of children without ADHD diagnoses; Barber et al. (2005) proposed children with ADHD diagnoses scored lower (although not significantly) than their control counterparts, the authors deemed this did not demonstrate a PIB. Contrastingly, Hoza et al. (1993) suggested boys with ADHD diagnoses did not rate themselves as significantly worse than boys without ADHD diagnoses, the authors deemed this did demonstrate a PIB.

One study McQuade, Hoza, et al. (2011) solely compared the ratings of boys with ADHD diagnoses to teacher ratings on the SPPC (Harter, 1985). Findings suggested the boys over-estimated their competence compared to their teachers both at baseline and follow-up. Furthermore, findings suggested reductions in self-perceptions over time predicted greater depressive symptoms, especially in the area of social self-concept.

Six studies used a compilation of the two aforementioned methods, calculating a range of adult-child discrepancy scores and then comparing these discrepancy scores between children with and children without ADHD diagnoses to demonstrate the presence/lack of PIB. E. N. Swanson et al. (2012) suggested girls with ADHD diagnoses rated themselves more positively than girls without ADHD diagnoses, when compared to teacher ratings. Although these self-reports were still in a negative direction, the authors deemed this to be evidential of the PIB. Similarly, Barton (2006) proposed girls with ADHD diagnoses overestimated their social-acceptance compared to their teacher's reports, whilst boys with ADHD diagnoses reported social-acceptance that was equal to their teacher's reports. McQuade, Tomb, et al. (2011) compared child and teacher social-acceptance ratings to determine the presence/lack of the PIB. After this, they compared the cognitive skills of three groups of children; those

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with ADHD diagnoses who demonstrated a PIB, those with ADHD diagnoses who did not demonstrate a PIB and those without ADHD diagnoses. Findings suggested children with an ADHD diagnosis and a PIB demonstrated greater cognitive deficits than those without a PIB. The authors concluded children with ADHD diagnoses who demonstrate a PIB may do so as a result of a cognitive deficit. Hoza et al. (2002) reported boys with ADHD diagnoses over-estimated their social-acceptance rating when compared to their counterparts, the authors deemed this demonstrated a PIB. Similarly, Hoza et al. (2004) concluded children with ADHD overestimated their competencies when compared to mother, father and teacher ratings. Hoza et al. (2010) conducted a longitudinal study which involved comparing SPPC (Harter, 1985) ratings of children and teacher over a period of six years and comparing changes in self-concept in children with and without ADHD diagnoses. The authors concluded the presence of the PIB in the social-acceptance domain remained consistent across the six years.

Three studies investigated the PIB in terms of a specific experimental design. Linnea et al. (2012) suggested an association between positively biased self-perceptions and actual social behaviours. They categorised children with ADHD diagnoses as having PIB or not using comparisons of child and teacher ratings on the SPPC (Harter, 1985) and then compared these two groups of children on a social task. Findings suggested children identified as having ADHD and a PIB displayed less pro-social behaviour and expressed a lesser effort than their counterparts. Using a similar design Hoza et al. (2012) calculated discrepancies between teacher and child ratings on the SPPC (Harter, 1985) and then compared the discrepancy scores of children with and without ADHD before and after children were given an incentive to match their teacher's ratings. Findings suggested, when given an incentive, children with ADHD diagnoses were not able to reduce bias to a significant degree in the social domain, despite being able to do so in other domains. Similarly, Emeh and Mikami (2014) calculated discrepancies between teacher and child ratings on the SPPC (Harter, 1985) and then observed each child in a laboratory setting interacting with a parent. Findings suggested parent criticism was positively correlated with greater PIB about social-competence in children with ADHD.

It may be summarised that the available literature in this area is contradictory and lacks consistency in calculation method. Several issues have arisen throughout the systematic literature review which contribute to the lack of reliability and generalisability in the available literature. These issues are explored throughout this section.

1.4.2 Effect Size Outcomes

Almost every study in this review claimed to provide evidence for the PIB in the social self-concept domain in children with ADHD diagnoses. However, when results are reduced to effect sizes, a number of issues are raised. Six authors (Barton, 2006; Emeh & Mikami, 2014; Hoza et al., 2010; Linnea et al., 2012; McQuade, Hoza, et al., 2011; McQuade, Tomb, et al., 2011) did not include effect sizes or the necessary data to calculate them. Instead these authors reported their findings in terms of statistical significance. Two authors (Barber et al., 2005; Hoza et al., 1993) provided data from the social-acceptance subscale for children with ADHD diagnoses and their counterparts – from this data I was able to calculate effect sizes, both of which were in the small range. Four authors provided their own effect size calculations (Hoza et al., 2004; Hoza et al., 2002; Hoza et al., 2012; E. N. Swanson et al., 2012).

However, the notion of reducing subjective constructs, such as social self-concept, to linear measurements raises questions with regard to construct validity (the degree to which a test measures what it claims to be measuring) (Cronbach & Meehl, 1955). Consequently, it may be the effect sizes provided do not adequately encapsulate differences in social self-concept between groups.

Furthermore, all of the effect sizes were calculated from discrepancy scores, which are prone to low reliability (Tisak & Smith, 1994). Several statistical difficulties exist with regard to discrepancy scoring. Firstly, discrepancy scores rely upon combining measurements and so are subject to combined measurement error compromising their reliability (Edwards, 2001). This low reliability results in an increased likelihood of a Type II error, this refers to a failure to detect a statistically significant relationship (Edwards, 2001). Secondly, discrepancy scores are often correlated with their components and consequently subject to errors (Zuckerman & Knee, 1996). Furthermore, Zuckerman and Knee (1996) propose discrepancy scores are linearly related to their components, meaning any difference in score is no more than the sum of its constituent parts. Consequently, Griffin, Murray, and Gonzalez (1999) argue correlations between discrepancy scores and other variables may reflect any number of underlying patterns between variables. Similarly, Colvin, Block, and Funder (1996) discuss any significant results that are calculated as a result of discrepancy scores should serve as nothing more than conservative estimates of relationships between discrepancy scores and other variables.

1.4.3 Impact of Individual Differences

One area of difficulty identified in this review is the impact of individual differences on the findings of the studies. This section discusses the impact of gender, socio-cultural factors and co-morbid diagnoses.

Many of the studies did not take into account the impact gender may have on children's social self-concepts. Echoing the trend that ADHD is predominantly diagnosed in boys (Arnold, 1996), many of the studies in this review included only boys (4/12 studies) or mostly boys (6/12 studies) in their sample. However, E. N. Swanson et al. (2012) specifically focused on the self-concepts of girls with ADHD diagnoses and found results contrasting to prior research involving boys. In the same way, Barton's (2006) study highlighted gender differences in the social self-concepts of children with ADHD diagnoses. Consequently, the generalisability of the 10 predominantly male studies can be questioned.

None of the studies included in this review examined the effect of socio-cultural factors on social self-concept. However, there is evidence social self-concept may be related to socio-cultural factors, for example C. David and Kistner (2000) found African-American children were more likely to report disproportionally higher ratings of likeability than Caucasian children. Similarly, none of the studies considered how the socio-economic status of participants may have impacted upon participants' social self-concepts.

Given the high rates of comorbid mental health diagnoses experienced by children with ADHD diagnoses (Jensen, Martin, & Cantwell, 1997), as well as the different subtypes of ADHD (American Psychiatric Association, 2013), it is widely accepted this population is highly varied. Previous reviews of comorbidity in ADHD have estimated that between 43% and 93% of children with ADHD diagnoses have comorbid disruptive behaviour disorders and 13–51% have comorbid internalising disorders (Jensen et al., 1997). It is possible that as such comorbid diagnoses may also impact upon children's social self-concepts.

1.4.4 The Measurement of Self-Concept

This review included only studies that measured self-concept using the SPPC (Harter, 1985, 2012b) as Owens et al. (2007) suggests between-group differences are better detected when a more sensitive multi-dimensional assessment method, such as the SPPC (Harter, 1985, 2012b) is used. However, several issues arose with regard to the SPPC and quantitative measurement of self-concept.

Social self-concept is a subjective construct which may be heavily influenced by recency

effects of experiences and social encounters (Marsh & Parker, 1984). Furthermore, the SPPC requires that children compare themselves with others when making judgments of their competencies. The use of such comparison processes requires children have the ability to compare the attributes of another child simultaneously with themselves. However, it has been suggested that children do not develop this skill until between the ages of 8 and 12 (Byrne & Shavelson, 1996). Furthermore, children of primary school age might evaluate themselves in terms of how many of their classmates like them, whilst children of secondary school age are more likely to evaluate themselves in terms of how well they get along with their classmates (Montemayor & Eisen, 1977). Therefore, the reliability of the data generated from the SPPC, especially in younger children, may be disputed.

1.4.5 The Impact of the Diagnostic Label ADHD

The ways in which the PIB is identified is problematic. As previously discussed, within the 12 chosen studies, the PIB (or lack of) was calculated using three different methods. The first method involved self-concept ratings being compared between children with and without ADHD diagnoses. The second method involved disparity scoring whereby discrepancy scores are calculated by subtracting a criterion score (e.g. teacher report) from the child's self-report of competence (Owens et al., 2007). The third method involved combining these two methods.

Nine of the studies in this review employed the third method and used mother, father, and teacher reports of social-competence as comparison criteria to children's ratings of their social-acceptance. Advocates of discrepancy scoring argue discrepancy scores represent constructs that are theoretically distinct from the constructs represented by the component variables (Tisak & Smith, 1994). Colvin et al. (1996) argued discrepancy scores provide researchers with the opportunity to investigate the concepts that might otherwise be difficult to assess. Hoza et al. (2004), suggested the PIB was observed in both boys and girls with ADHD regardless of the informant ratings used (mothers, fathers, and teachers), reducing the potential of rater bias on the part of teachers as an explanation for the phenomenon.

However, discrepancy scoring relies upon the assumption that teacher/parent ratings provide a more accurate view of competence than children provide of themselves. It may be argued the differences in self-concepts in children with ADHD diagnoses are a result of rater bias on the part of the teacher/parent providing the criterion rating (Owens et al., 2007). It has been suggested that adult ratings of children, especially of children with high levels of ADHD symptoms and conduct problems, are not free from bias. For example, adults tend to overestimate children's ADHD symptoms when the child also demonstrates conduct

problems and this is known as a negative halo effect (Abikoff, Courtney, Pelham, & Koplewicz, 1993; Stevens & Quittner, 1998). It is possible, given the difficulties associated with teaching/caring for children with ADHD diagnoses, that teachers/parents may provide overly negative evaluations of these children, resulting in the self-concepts of them appearing inflated. This may be echoed by Emeh and Mikami's (2014) findings which suggested parental criticism was positively correlated with greater PIB about social-competence in children with ADHD diagnoses.

1.5 Limitations and Recommendations

Several limitations of this review were identified. Firstly, the use of electronic databases as the primary means of searching and identifying relevant studies may be critiqued. Despite additional hand searches being carried out, it is possible further studies may exist that were not identified for inclusion in this study. Furthermore, some studies of interest were identified that I was unable to gain access to. However, it should be noted, as Petticrew and Roberts (2006) recommend, reasonable measure was taken to identify the relevant literature and estimate the likely effect of missing studies. Additionally, this review was conducted by a single reviewer. This has particular implications for judgment based aspects of this review, such as the Weight of Evidence (Gough, 2007) calculation. Only 12 studies were included in this Systematic Literature Review, which has implications for generalisability as external validity is limited (Petticrew & Roberts, 2006). Generalisability is also compromised as all of the studies included were based on USA populations, making it difficult to apply to the UK context. Importantly, this review is also subject to Rosenthal's (1979) 'file drawer problem' which highlights that studies which present significant findings are more likely to be accepted for journal publication, leading to a bias in the studies available for review. Despite including unpublished studies, it is possible that the low proportion of studies that provide evidence against the existence of the PIB can be attributed to this bias.

1.6 Conclusions and Recommendations for Further Research

The Systematic Literature Review highlighted children with ADHD diagnoses may rate their social-competence differently from adults/their non-diagnosed counterparts. However, the Systematic Literature Review also raised several issues regarding the PIB phenomenon and the measurement of social self-concepts of children with ADHD diagnoses. Three conclusions were drawn from the Systematic Literature Review: research in this area does not adequately account for individual differences between children with/without ADHD

diagnoses; quantitative measurement of children's self-concept is problematic; the concept of the PIB relies upon the assumption adults' views are more valid than children's and does not take into account the impact the label ADHD may have on children/teachers/parents.

Given the conceptual and methodological issues raised, it may be recommended further research is needed to explore qualitatively the lived experience of having a diagnosis of ADHD for a child and the adults who support them, in order to attempt to gain an understanding of what individuals say and think about the label ADHD. Finally, none of the 12 studies identified in this Systematic Literature Review were conducted in the UK. Research conducted in the UK would extend the currently small knowledge base and allow for safer generalisation to UK context.

Chapter 2: Bridging Document

2.1 Formulating the Empirical Research Question

This section outlines some of the issues raised in the Systematic Literature Review and how these influenced the empirical question.

The Systematic Literature Review highlighted children with ADHD diagnoses may rate their social-competence differently to adults/their non-diagnosed counterparts. However, the Systematic Literature Review also raised several issues regarding the PIB phenomenon and the measurement of social self-concepts of children with ADHD diagnoses. Three conclusions were drawn from the Systematic Literature Review: research in this area does not adequately account for individual differences between children with/without ADHD diagnoses; quantitative measurement of children's self-concept is problematic; the concept of the PIB relies upon the assumption that adults' views are more valid than children's and does not take into account the impact that the label ADHD may have on children/teachers/parents.

The issues outlined above highlight several potential areas for further exploration regarding the self-concepts of children with ADHD diagnoses. However, within the confines of this thesis, I decided to focus specifically on, individuals' perceptions of the diagnostic label ADHD. This chapter seeks to explain and how my Empirical Research was constructed as a result of this.

2.2 Refining the Methodology

2.2.1 Ontology and Epistemology

This section outlines how my own ontology/epistemology led to my chosen method. As I was interested in the subjective experience of the diagnostic label ADHD, I chose to employ a qualitative methodology to enable me to explore, in depth, individuals' perspectives. This is echoed by Willig (2008) who states that qualitative research tends to be concerned with meaning; how people make sense of the world and how they experience events.

Ontology may be described as, 'what is out there to know about' (Grix, 2002, p. 175). Ontology can broadly be defined as either objectivism or constructivism. My personal ontological stance can be classed as objectivist which implies that social phenomena and their meanings exist independently of social actors (Bryman, 2012).

Grix (2002) discusses that 'ontology is the starting point of all research, after which one's epistemological and methodological positions largely follow' (p. 177). Epistemology may be described as 'what and how can we know about' the world (Grix, 2002, p. 175). Therefore, my objectivist ontological stance influences my epistemological stance of critical realism. Critical realism combines the realist ambition to gain a better understanding of what is 'really' going on in the world, with the acknowledgement that the data the researcher gathers may not provide direct access to this reality (Willig, 2008). The critical realist stance assumes that all knowledge is fallible and that it is not possible to reveal the exact nature of the social world due to researchers describing it from a third person perspective (Scott, 2005). Consequently, it may be argued that critical realism lends itself to interpretivist methodologies that recognise that there may be multiple subjective views of what is objectively real. This view is highlighted by Larkin, Watts, and Clifton (2006, p. 107) who state that the emergent 'reality' (i.e. the resultant explanation and/or understanding of the nature of the subject-matter) can thus be seen to be dependent upon the processes of intellectual construction that shaped the 'structure of encounter'.

2.2.2 Interpretive Phenomenological Analysis (IPA)

Phenomenology is described as a 'philosophical approach to the study of experience' (J. A. Smith, Flowers, & Larkin, 2009, p. 11) and is concerned with how individuals make sense of their major life experiences (J. A. Smith et al., 2009). Willig (2008) explains that phenomenology focuses upon the content of consciousness and the individual's experience of the world. Given my critical realist epistemological stance, I believed that a phenomenological methodology, specifically Interpretive Phenomenological Analysis (IPA), would be most suitable for my empirical research.

IPA is a recently developed and rapidly growing approach to qualitative research which originated in health psychology (J. A. Smith et al., 2009). It is distinct in that is combines rich, descriptive accounts of participants' experiences with more speculative development of interpretive accounts by the researcher (Larkin et al., 2006). Pertinent to my empirical research, IPA can be used with both single and multiple participants, as it focuses upon perceptions and subjective experiences of the world, but recognises that individuals can experience the same objective conditions in radically different ways (Willig, 2008).

IPA recognises that the researcher will make assumptions about the meaning of what they are trying to understand. This is termed a 'double hermeneutic' (J. A. Smith et al., 2009, p. 3)

meaning that the researcher makes an interpretation of the participant's interpretation of the phenomenon. Therefore, the phenomenological analysis produced by the researcher is always an interpretation of the participant's experience (Willig, 2008). This echoes a critical realist epistemological stance that it is possible to discover a range of subjective views of what is objectively real (Scott, 2005). For example, (J. A. Smith, 1996) discusses that a researcher may use IPA to focus on the way individuals subjectively interpret medically categorised conditions.

In summary, considering the findings of the Systematic Literature Review, I chose to use IPA to explore and interpret the perceptions of several individuals regarding the diagnostic label ADHD. Whilst findings from the study were not intended to be generalisable, it should be noted some researchers state that all research may be generalisable in some way. For example, Haug (1987, p. 44) states 'if a given experience is possible, it is also subject to universalisation'. Furthermore, Smith, Flowers and Larkin (2009) discuss generalisability may be possible through the process of theoretical generalisability, 'where the reader of the report is able to assess the evidence in relation to their existing professional and experiential knowledge' (p. 4).

2.2.3 Comparison with Other Methods

This section discusses alternative methodological approaches that were considered when planning the Empirical Research.

Many similarities exist between Grounded Theory and IPA (Willig, 2008). However, unlike IPA, Grounded Theory aims to draw on larger samples in order to be inductive rather than arising from research (Payne, 2007). Consequently, Grounded Theory aims to establish claims for a broader population and may provide data which is more generalisable. However, whilst IPA is generally concerned with in-depth examination of smaller samples, Smith, Flowers and Larkin (2009) discuss that generalisability may be possible through the process of theoretical generalisability. Similarly, it may be argued that 'It is possible to state that each individual mode of appropriation of the social… is potentially generalisable' (Kippax, Crawford, Benton, Gault, & Noesjirwan, 1988, p. 25). Additionally, Grounded Theory does not recognise the active role of the researcher as IPA does. Instead, Grounded Theory sees the role of the researcher as a witness (Willig, 2008). As a result of these differences, Grounded Theory was deemed unsuitable for my empirical research.

Discourse Analysis (Potter & Wetherell, 1994) focuses on a move away from cognition and towards language and representation. Discourse Analysis adopts a social constructionist epistemological stance and thus posits, to make sense of what people say, we need to take

into account the social context within which they speak (Willig, 2008). Echoing this, J. A. Smith (1996) highlights that Discourse Analysis is not concerned with understanding what participants think/believe about the topic in hand. Ideally, Discourse Analysis should be used to analyse naturally occurring, unsolicited conversations because discursive psychology is concerned with how people manage accountability and stake in everyday life (Willig, 2008). However, there are both ethical and practical issues in obtaining such naturally occurring data, especially involving children. Considering these issues, this approach was not compatible with the research aims.

Narrative psychology is interested in the ways in which people organise and bring order to experience (Willig, 2008). Narrative Analysis shares many similarities with IPA, focusing on the content and structure of individual's stories in order to find out about the ways in which people construct meaning in and for their lives (Gergen & Gergen, 1988). Narrative Analysis assumes that the way in which people experience the world is the product of the social construction of meaning within certain social relations (Willig, 2008) which suggests that Narrative Analysis may be compatible with a critical realist epistemological stance. Despite the epistemological compatibility of this approach I felt that a deeper exploration and interpretation of the participants' responses was needed for this particular study.

2.3 Designing the Research Method

2.3.1 Research Questions

Based on the findings of the Systematic Literature Review and my own epistemological stance, two over-arching research questions were devised;

1. What does the label ADHD mean to a child who has received an ADHD diagnosis?

The chosen studies in the Systematic Literature Review provide contrasting information regarding the social self-concepts of children with ADHD diagnoses. However, it is possible that the lack of consensus regarding children's social self-concepts stems from the lack of consensus as to what it means to have ADHD. The chosen studies also provide contrasting theories as to *why* children with ADHD diagnoses might overestimate their competencies. The most prevalent theory is that it provides a self-protective function as children with ADHD diagnoses experience various social difficulties. However, it is possible that simply having the label ADHD may affect children's social self-concept, as children may over/under estimate their social-competence due to their beliefs about their diagnosis. This is exemplified in previous literature, for example, Harris, Milich, Johnston, and Hoover (1990) and Harris,

Milich, Corbitt, Hoover, and Brady (1992) both examined the effects of the label ADHD on peer interactions among primary school aged boys. Findings indicated that boys labelled as having ADHD enjoyed the interaction less, believed they did less well on the task, accepted less credit for good performance, and believed that their partners were meaner when compared to their non-labelled counterparts.

2. What does the diagnostic label ADHD mean to teachers/LSAs/parents who support a diagnosed child?

The Systematic Literature Review highlighted issues relating to quantitatively measuring social self-concept by comparing children's own ability ratings with teachers'/parents' ratings of children's. This method relies upon the assumption that teachers'/parents' ratings of children's abilities are 'true' whilst children's own ratings are 'false'. It is possible that, due to the negative connotations associated with the label ADHD, teachers/parents underestimate these children's abilities, which in turn gives the impression that these children overestimate their abilities. This effect has also been exemplified in prior research whereby 34 elementary school teachers and 32 education students from Canada rated their reactions towards vignettes describing children who met ADHD symptom criteria that included or did not include the diagnostic label ADHD (Ohan, Visser, Strain, & Allen, 2011). Findings indicated a significant impact of the ADHD label on the feelings and behaviors of both current and future teachers.

These questions led me to devise the title for my Empirical Research; what does the label ADHD mean to a diagnosed child, his parent and his school staff?

2.3.2 Semi-Structured Interviews

This section focuses on my chosen method of data generation: semi-structured interviews.

Qualitative data generation methods are designed to minimise data reduction (Willig, 2008). This is especially important when using a method such as IPA, which is concerned with rich detail and stories of participants' lived experiences. As a means of eliciting such rich and detailed stories, IPA requires that researchers and participants engage in a 'conversation with a purpose' (J. A. Smith et al., 2009, p. 57). J. A. Smith and Eatough (2007) assert that IPA is not considered to be a prescriptive approach but a set of flexible guidelines which can be adapted in light of individual research aims. Whilst IPA does not prescribe one form of data generation, one-to-one interviews are popular in IPA studies as they allow for in-depth

discussion between researchers and participants (K. Reid, Flowers, & Larkin, 2005).
Consequently, I chose to use semi-structured, one-to-one interviews to generate the data for
my Empirical Research.

I created an interview guide based upon the theoretical constructs identified through my
engagement with the literature and my subsequent research questions, as well as the
guidance provide by J. A. Smith et al. (2009). Tables 9 and 10 detail the questions that were
asked, prompts that were used and the category of question they fit into.

Table 9: Child Semi-Structured Interview Questions.

Question Type	Interview Question
Descriptive	How would you describe yourself to someone who doesn't know you? *(Follow up: What does that mean?)*
Contrast	Would it be right or wrong if someone said you had ADHD? *(Follow up: What do you mean by…)*
Narrative	What does it mean to have ADHD? *(Follow up: How? What does that mean to you?)*
Narrative	How did you learn about what ADHD means? *(Follow up: When? Who?)*
Evaluative	What did it feel like to be told you have ADHD? *(Follow up: How? What does that mean to you?)*
Evaluative	How does knowing you have ADHD affect you? *(Follow up: Can you tell me a bit more about that?)*
Comparative	What has changed for you since you were told you have ADHD? *(Follow up: Can you tell me a bit more about that?)*
Comparative	How would things be different if you hadn't been told you have ADHD? *(Follow up: When? Who?).*
Prompt	Is there something else you would like to talk about/tell me?

Table 10: Adult Semi-Structured Interview Questions.

Question Type	Interview Question
Descriptive	Could you tell me about what your relationship is to Child A? *(Follow up: What does that mean? What is your job?)*
Contrast	How would you describe Child A to someone who doesn't know them? *(Follow up: Can you give me an example of…?)*
Narrative	What does the label ADHD mean to you? *(Follow up: How? Can you tell me a bit more about that?)*

Narrative	How did learn about what ADHD means? *(Follow up: When? Who?).*
Evaluative	What did it feel like for you to be told Child A has ADHD? *(Follow up: How? What does that mean to you?)*
Evaluative	How does knowing Child A has ADHD affect you? *(Follow up: Can you tell me a bit more about that?)*
Comparative	What has changed for you since you were told Child A has ADHD? *(Follow up: Can you tell me a bit more about that?)*
Comparative	How would things be different if you hadn't been told Child A has ADHD? *(Follow up: When? Who?)*
Prompt	Is there something else you would like to talk about/tell me?

I aimed to use the funnelling technique discussed by J. A. Smith et al. (2009) whereby a broad question is asked to initiate the participant's descriptive experience before subsequent follow-up prompts are used to encourage deeper discussion.

It is recognised that limitations exist when using semi-structured interviews. Firstly, the interview questions could be seen to lead the participants to talk about particular issues. The questions/prompts asked and my interactions during the interviews could influence the nature of the data generated. This is acknowledged by the assumptions of semi structured interviews, IPA (the 'double hermeneutic') and the critical realist epistemological stance (J. A. Smith et al., 2009). However, as suggested by J. A. Smith et al. (2009) I took a 'light touch' approach to the interview process, only using follow up questions/prompts when needed. Despite these limitations, semi-structured interviews allow for open discussion and exploration as deemed appropriate by both the researcher and the participant (Willig, 2008).

2.3.3 Participants

This section focuses on the sample of participants that was chosen to take part in the study.

As an idiographic approach to research, J. A. Smith et al. (2009) recommend that between four and ten interviews is appropriate for a professional doctorate. They stress the importance of allowing ample time to analyse interview transcripts, as reflection and dialogue are central to successful research. As a solo researcher, I wanted to maintain a small number of participants in my sample, to ensure that adequate depth of analysis could be achieved. As the aim of this study was to explore and interpret the essence of individual's perspectives in a specific situation, I decided to conduct one-to-one interviews with one

young person, his mother and two members of his school staff (see Chapter 3, p. 57 for further information).

Interview studies commonly adopt 'purposive sampling methods to recruit participants who have experiences of the phenomenon under study' (Starks & Brown Trinidad, 2007, p. 1374). In my role as a trainee EP I have established strong, professional relationships with the staff, families and children with whom I work. Consequently, with support from school management, I approached a young person and his family, with whom I had already formed a relationship. This young person was approached due to his interest and openness to discuss receiving an ADHD diagnosis.

2.4 Ethical Considerations

When engaging in any research, there is a number of ethical issues to be considered; these issues are particularly salient when undertaking research with vulnerable members of society, such as children (Flewitt, 2005). Prior to beginning the Empirical Research, full ethical approval was obtained from Newcastle University. Throughout the remainder of the study I worked proactively to ensure that the study was completed to the highest of ethical standards. The following section focuses on the ethical considerations that I made to ensure that the empirical research met all of the ethical requirements of Newcastle University and the British Psychological Society's Code of Ethics and Conduct (British Psychological Society, 2009).

Each participant was provided with an information sheet that detailed the aims and structure of the research (see Appendix A, p. 81). This also explained the measures taken to ensure anonymity and confidentiality. Each participant was informed that they could withdraw, without question, from the research at any point up until analysis of the research was complete (approximately within three months of the interview). This ensured adequate time for participants to reflect on their participation. Participants were also informed about data storage and sharing of findings. Duncombe and Jessop (2002) highlight that fully informed consent is almost impossible, as participants have no knowledge of the exact questions and extent to which they may be asked to make personal revelations. I believe I approached the issue of informed consent with as much clarity and transparency as possible. Each participant provided full, written, informed consent before participating in the study (see Appendix B, p. 85). All of the aforementioned documents were also provided in child-friendly versions so the young person was able to access them and was afforded the same considerations as the adult participants were. The participants were also invited to seek further clarification at any point during or after the data generation. I ensured that I

maintained an open and honest stance throughout the research process.

Whilst the ethical considerations above are helpful in order to minimize harm to the participant, it is important not to assume that all ethical issues and concerns can be satisfied through planning (Brinkmann & Kvale, 2008). This is echoed by Willig (2008, p. 20) who called for qualitative researchers to remain 'ethically attuned throughout' research and to acknowledge and act upon ethical dilemmas as they arise. One ethical dilemma that I considered when undertaking my Empirical Research involved the power dynamics present in my relationships with the participants. T. David, Tonkin, Powell, and Anderson (2005) emphasize the importance of an equitable power relationship, but that this can be problematic in research with children due to the inequality in power and status between adults and children. Whilst I took a proactive stance in eliminating power imbalances, for example by selecting rooms which were familiar and comfortable for the participants, it may be that participants perceived me differently than I intended. Such power imbalances may stem from participants' views regarding the EP role. It is therefore reasonable to assume a power imbalance may have existed between myself and each participant during the interview, given that all participants were aware of my role as a trainee EP. However, I believe that by working with participants with whom I had already formed positive, professional relationships, maintaining an approachable demeanor and carefully choosing my language I helped to alleviate any such power imbalances. Furthermore, utilising IPA enabled me to maintain a flexible approach to my interviews and follow the initiatives of the participants when they wanted to discuss a particular topic or perspective.

Another factor that I considered relates to beneficence (how the research is intended to benefit the participants). The benefit of qualitative research to participants can often be unclear, however, K. Smith and MacNaughton (2005) suggest that when we use children's voice in research, there should be a commitment to use this in a transformational way to challenge truths that already exist. As the researcher, I aimed to communicate to participants the hope that in sharing the information gained, it can be used to better understand how having an ADHD diagnosis may be perceived by children and the adults that care for them.

2.5 Reflexivity

Willig (2008, p. 10) highlights the need for 'personal reflexivity' during the research process. Throughout the Empirical Research I regularly reflected on how my interests, beliefs and experiences contributed to the research process. This section focuses more on the role that reflexivity played in my empirical research.

Although every attempt was made to prepare unbiased interview questions/prompts, I acknowledge that the questions could have been interpreted in a different way than was intended. However, as previously mentioned, IPA acknowledges the researcher as an active participant in the research process and states that the outcomes of IPA are the products of a 'double hermeneutic' (J. A. Smith et al., 2009, p. 3). Brocki and Wearden (2006) identify, the researcher's role is not passive but active – even before the analysis and interpretation process. Whilst researcher influence may be regarded as a limitation of IPA, Brocki and Wearden (2006) acknowledge its acceptance as part of the IPA process but highlight a need for transparency in any research report. This need for personal reflexivity is further supported by my critical realist stance which proposes that subjective interpretations of objective realities are influenced by individual history, culture and prior experience.

I acknowledge that my previous experiences and values may have influenced the way in which I engaged in the research process; I am currently studying for a doctorate in Educational Psychology. Previously, I have taught in a mainstream primary school, where I taught several pupils diagnosed as having ADHD. As a Trainee EP, I am professionally committed to the principle of inclusion and to supporting the diverse needs of children I engage with and have undertaken work with several children who have diagnoses of ADHD.

2.6 Conclusions

This bridging document seeks to record the process of moving from the findings of the Systematic Literature Review to the Empirical Research. The Systematic Literature Review highlighted the limitations encountered when undertaking a nomothetic, quantitative study with children with ADHD diagnoses. I decided to undertake an idiographic, qualitative study and use IPA to explore perceptions of the label ADHD. In using IPA to engage in in-depth exploration of one example of receiving an ADHD diagnosis it is hoped that I will illuminate different perspectives of this label.

Chapter 3: Empirical Research

What does the label ADHD mean to a diagnosed child, his parent and his school staff?

Abstract

ADHD is characterised by patterns of behaviour that are present in multiple settings (e.g. school and home), which can result in difficulties in social, educational or work settings. Symptoms are divided into two categories; inattention and hyperactivity/impulsivity.

Existing research suggests that children who have an ADHD diagnosis experience negative outcomes when compared to their non-diagnosed peers. Research also suggests that receiving an ADHD diagnosis can have an impact upon how children are perceived by the adults and peers around them.

The present study used Interpretative Phenomenological Analysis (IPA) to explore two research questions that arose from a Systematic Literature Review, investigating if children with ADHD diagnoses demonstrate a Positive Illusory Bias (PIB) in their social self-concepts.

A child, his mother, his teacher and his learning support assistant (LSA) completed semi-structured interviews focusing on their lived experiences of the children receiving the diagnostic label ADHD. These interviews were recorded verbatim and then analysed to seek an understanding of their experience of receiving the child's ADHD diagnosis.

During the analysis three master group themes were identified. These themes are discussed alongside the existing literature in this field. Finally, the implications for educational psychologists are discussed in terms of promoting an awareness of the research surrounding ADHD, supporting and empowering school staff with regards to children who experience attention/concentration difficulties and advocating for the 'voice' of these children to be heard.

3.1 Introduction

3.1.1 The Impact of Diagnostic Labelling

This section explores what is meant by diagnostic labelling, it also examines the purpose, benefits and challenges associated with diagnostic labelling. Labelling may be described as 'the recognition of differences and the assignment of social salience to those differences' (Green, Davis, Karshmer, Marsh, & Straight, 2005, p. 197).

Lewis, Chard, and Scott (1994) discuss that historically children were given labels as a means of categorising and segregating. Satterly Roig (2011) discusses that diagnostic labels may be effective tools when they are linked to funding and assist with an individual's access to resources. Satterly Roig (2011) also highlights that labels may also be useful to assist in life and educational planning, to increase public awareness, provide others with starting places for future learning, and help labelled individuals relate with a group. Diagnostic labelling can enable children to access resources as well as providing understanding for others, and help professionals communicate clearly about the needs of an individual (Lauchlan & Boyle, 2007).

However, it may be argued that diagnostic labels are also associated with negative outcomes for those who receive them due to detrimental attributions that lead to stigma (Day, Edgren, & Eshleman, 2007). Stigma is defined as 'the co-occurrence of its components-labeling, stereotyping, separation, loss of status, and discrimination in the presence of exercised power' (Link & Phelan, 2001, p. 363) and is often discussed with regards to psychological disabilities (Hinshaw & Stier, 2008). Stinson (2009) reported diagnostic labels given to children may elicit stereotypes, negative perceptions, and bias. This bias, known as labelling bias, refers to expectations that others might have for a person given a particular label (Fox & Stinnett, 1996).

The negative impact of diagnostic labelling on the recipient is exemplified by Harris et al. (1990) and Harris et al. (1992) who both examined the effects of the label ADHD on peer interactions among primary school aged boys. Findings indicated that boys labelled as having ADHD enjoyed the interactions less, felt they did less well on the task, accepted less credit for good performance, and felt that their partners were meaner when compared to their control counterparts.

3.1.2 The Impact of the Diagnostic Label ADHD

This section seeks to first outline the difficulties associated with the diagnostic label, ADHD, and then explore the benefits and challenges related to this label.

ADHD is a diverse diagnosis whereby symptoms are divided into two categories; inattention and hyperactivity/impulsivity (National Institute for Health and Clinical Excellence, 2008). ADHD is of particular interest to those who work in education because attention and hyperactivity are processes that may affect academic attainment (Iudici, Faccio, Belloni, & Costa, 2014). Diagnosis of ADHD is complex due to various factors, predominantly the absence of any form of diagnostic testing (biological, genetic or radiological) and subjective assessment for diagnosis means that diagnosis is problematic (Iudici et al., 2014). Another difficulty associated with an ADHD diagnosis relates to the very high coexistence of comorbidity associated with the diagnosis (Iudici et al., 2014) (see Chapter 1 for a discussion of ADHD).

Diller (2009) discusses that receipt of an ADHD diagnosis is often associated with parental relief and gratitude related to the assumption that the child's behaviour is a result of a within-child issue rather than a social issue. For the family, the diagnosis may be used to ask the teacher to adjust their expectations/tolerance of the child's behaviour in light of the diagnosis (Iudici et al., 2014); this increased understanding may be seen as a positive outcome for the child and family. It may also be argued that providing assessment, diagnosis, treatment and access to other support is crucial in helping to avoid negative outcomes for children, their families and wider society and therefore the diagnosis may serve to protect individual rights and promote equality of opportunity (Brady, 2014). For example, L. J. Graham (2008) discusses that the labelling of children as having ADHD may enable teachers to gain access to additional resources and support from external professionals.

Despite this increased understanding, as previously discussed, diagnostic labelling can be associated with stigma, as is the case with the ADHD label. Research suggests that children with ADHD diagnoses are more negatively perceived than their non-diagnosed peers by both teachers and peers; Batzle, Weyandt, Janusis, and DeVietti (2010) demonstrated that, when presented with a description of a child with an ADHD label, teachers developed less favourable expectations of that child in terms of behaviour, academic and social skills when compared to control counterparts. Similarly, results of an online survey of 1318 American children, aged 8 to 18, suggested that children had more negative perceptions towards other children described as having ADHD or depression than children described as having asthma (Walker, Coleman, Lee, Squire, & Friesen, 2008). Furthermore, the diagnosis may also limit the collaboration between those who are engaged in supporting children with ADHD diagnoses, such as teachers, psychologists and parents (Angold, Erkanli, Egger, & Costello, 2000) due to the attributions associated with the assumed medical basis of ADHD.

In addition to the stigmatising effects of an ADHD diagnosis, Iudici et al. (2014) discuss that justifying the child's behaviour and not urging them to develop their own resources may begin a process of the reduction of opportunities for development and legitimise the notion of being different. This process may also be described as a self-fulfilling prophecy (R. Rosenthal & Jacobson, 1968). That is, after receiving the diagnosis, children may adopt an attitude of disengagement and irresponsibility for their own behaviours. Carpenter and Austin (2008) discuss that diagnosis may result in the child being in a position of justifying all their behaviours using their ADHD diagnosis. In the same way, Singh (2007) discusses that children who are diagnosed as having ADHD and take medication for this condition may credit all positive behaviour to their medications, which may impact upon their feelings of self-worth.

It may be summarised that there are both benefits and challenges associated with receiving a diagnosis of ADHD and these may differ between stakeholders involved.

3.1.3 Study Aims

Brady (2014) highlights that children's accounts of receiving a diagnosis may challenge dominant understandings and shed light on the ways that they use their agency to make decisions that are right for them, which may not necessarily be those that adults would make or agree with. Based on the findings of the Systematic Literature Review, my interaction with the available literature and my own epistemological stance, the research aimed to address two questions;

1. What does the label ADHD mean to a diagnosed child?
2. What does the diagnostic label ADHD mean to teachers/LSAs/parents who support a diagnosed child?

These questions led me to devise the title for my Empirical Research; what does the label ADHD mean to a diagnosed child, his parent and his school staff?

3.2 Method

3.2.1 Sample

As the aim of this empirical research was not to generate new theories but to illuminate differing perspectives within one context, I chose to utilise IPA to explore and interpret the perspectives of several individuals within one case of ADHD diagnosis. Whilst it may be

argued that the findings from this study are not generalisable, (Haug, 1987, p. 44) highlighted that 'if a given experience is possible, it is also subject to universalisation'. In the same way, Smith, Flowers and Larkin (2009) discuss that generalisability may be possible through the process of theoretical generalisability, 'where the reader of the report is able to assess the evidence in relation to their existing professional and experiential knowledge' (p. 4).

The sample for this empirical research was obtained from a medium-sized primary school in the North East of England. All names and identifiable information has been changed and replaced with pseudonyms to preserve their anonymity (see Chapter 2, p. 49) for further information). IPA recommends that participants are recruited on the basis that they can provide 'a particular perspective on the phenomenon under study' (J. A. Smith et al., 2009, p. 49). Therefore, I aimed to recruit a child (and their supporting adults) who was of primary age, had received a diagnosis of ADHD and who had no co-morbid diagnosis. However, factors such as gender and/or having English as an additional language were not important given the study design. It was important, in terms of addressing power imbalances, that the child was someone who wanted to take part and share their experiences with a wider audience.

Approval was sought from the Head Teacher and SENCo of a school who suggested a child (Peter) and parent (Debbie) who might be interested in taking part. Peter was suggested as he was then in year six and had received a formal diagnosis of ADHD 18 months prior to the study, he had no co-morbid diagnosis and, being very articulate, was keen to share his views with a wider audience. I had already formed a positive relationship with both Peter and Debbie during some previous work focussing on transitions with Peter's peer group. Consequently, I contacted Debbie and discussed participation with her. Debbie indicated her interest and then discussed this with Peter, provided informed, written consent and granted me permission to speak to him. After this, informed, written consent was sought from Peter, Alison (Peter's Learning Support Assistant) and Laura (Peter's Teacher).

3.2.2 Procedure

K. Reid et al. (2005) stress that semi-structured interviews are the exemplary method for IPA as they allow for flexibility and depth of exploration. Thus, a semi-structured interview guide (See Chapter 2: Tables 9 and 10) was designed in consideration of the Systematic Literature Review findings, available literature and guidance provided by (J. A. Smith et al., 2009). Throughout the interviews I tried to use 'funneling' (J. A. Smith et al., 2009) which involves asking broad questions and using follow-up questions to deepen the discussion and focus on specific points that participants made. The interviews were recorded using a Dictaphone and transcribed verbatim by a transcriber.

<u>3.2.3 Analysis</u>

My ontological stance can be classed as objectivist, meaning that I believe that social phenomena and their meanings exist independently of social actors (Bryman, 2012). My objectivist ontological stance echoes my critical realist epistemological stance. Critical realism assumes that all knowledge is fallible and that it is not possible to reveal the exact nature of the social world due to researchers describing it from a third person perspective (Scott, 2005). My critical realist epistemological stance is reflected by my use of Interpretative Phenomenological Analysis (IPA) (See Chapter 2, p. 43 for further discussion of ontology/epistemology). J. A. Smith et al. (2009) also note that IPA does not provide a prescriptive analysis procedure but provides some guidelines for researchers to follow:

I read each transcript several times, as the first stage of J. A. Smith et al. (2009) guidelines suggests rereading each transcript to become familiar with the data before moving onto stage two, which involved making initial annotations and comments on each of the transcripts, known as coding. The semantic context and use of language in the data were highlighted at an exploratory level. This helped me to begin to make sense of how the participants understood the questions.

The third stage of analysis involves identifying emergent themes for each transcript based on the initial notations and comments that I made in stage two (see Appendix C, p. 88 for a coded transcription extract). IPA acknowledges the role of the researcher in discovering themes and analysis whilst emphasising that it is vital that all interpretations of the data should 'arise from attending to the participant's words' (J. A. Smith et al., 2009, p. 90). After this I identified superordinate themes for each transcript by identifying commonalities across emergent themes, acknowledging the double hermeneutic process (J. A. Smith et al., 2009) (see Appendix D, p. 89 for Tables of superordinate themes). These higher order themes reflect my most salient interpretation of each participant's accounts of their lived experience. I then checked that themes linked to the original transcripts to enhance the rigour and trustworthiness. This helped me to preserve the 'voice' of the participant in the analysis (J. A. Smith et al., 2009).

After I had produced four sets of emergent and superordinate themes I began the fifth stage of the analysis. This stage involves the development of patterns across the transcripts. I was able to identify relationships between the superordinate themes through a process of relabelling and reconfiguring original themes. This stage of the analysis produced three master group themes (see Appendix E, p. 93 for master group themes). These master group themes were checked against the original data in order to ensure the participants' described

experience had not been lost through the interpretative process. The master group themes are discussed in consideration of the findings of the systematic literature review, quotes from the participants' accounts of their lived experience and my interpretation.

3.3 Findings and Discussion

I have merged the findings section with the discussion, following J. A. Smith et al. (2009) precedent, enabling triangulation of the raw data, my interpretation of the participants' described experiences and existing literature in the field. The finalized superordinate and master group themes are showed in Table 11.

Table 11: Master Grouped Themes and Associated Superordinate Themes.

Master Group Themes and Associated Superordinate Themes
Blame *Defining Difficulties from a Medical Perspective* *Not Just a 'Naughty Boy' - Changing Perspectives* *Increased Understanding - Avoiding Exclusion and the 'Wrong Path'*
Fear *Reluctance to Accept Label* *ADHD as Uncontrollable and Scary*
Support *Access to Resources* *Medication* *Relationships as a Protective Factor*

I suggest a relational link between the identified themes (Figure 1). The findings indicate that the label ADHD provides a medical context for behaviour and shifts blame away from individuals towards the label itself. The implications of this appear to be two-fold; firstly, the label may elicit feelings of fear relating to its apparent uncontrollability and associated social

stigma. Secondly, the label may also promote access to resources and medication, relationships were also highlighted as a protective factor and source of support.
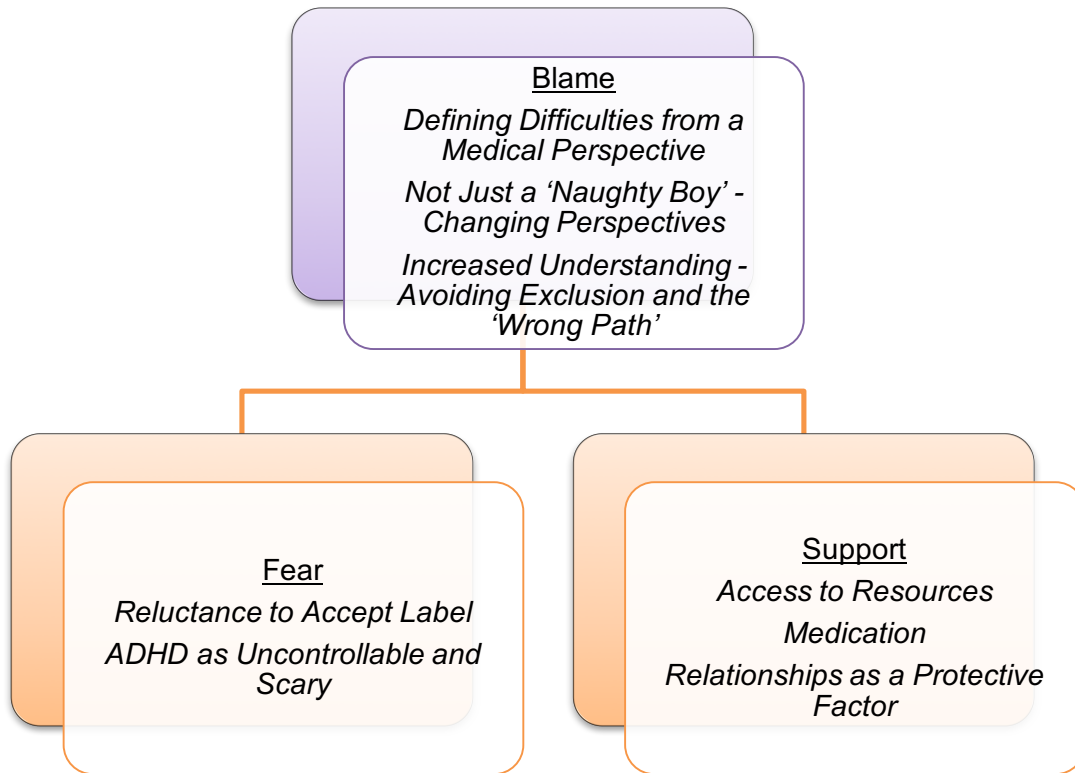

Figure 1: Model of Findings

The next section discusses each of the master group themes alongside the superordinate themes relating to each participant's described experience.

3.3.1 Master Group Theme 1: Blame

Superordinate Theme 1: Defining Difficulties from a Medical Perspective

The participants discussed their interpretations of the challenges faced by children who have ADHD diagnoses. However, these interpretations differed between the participants. Some felt as though the ADHD diagnosis explained Peter's behavioural difficulties, whilst others disagreed with this idea.

Alison: *'If he's got behaviour issues, that's separate to ADHD… if he's got behaviour issues, he had them behaviour issues before he had ADHD'.*

Laura: '*When I was told about Peter having ADHD, for me I thought I had a very hyperactive child on my hands. Somebody who couldn't settle. Erm – negative*

behaviour didn't come into it for me before I met him. Like, I didn't – that didn't occur to me.'

This ambiguity may represent the real-life impact of the disparity and conflicting discourses that surround the diagnosis ADHD (Visser & Jehan, 2009).

This superordinate theme also related to participants' conceptualisation of ADHD as a distinct medical disorder.

> Debbie: *'It is, like, a meaning to what he's- why he's doing it…'cause it's like a chemical imbalance in his brain.'*

> Debbie: *'He's not just a normal boy. 'Cause they get labelled 'the naughty kid', don't they?... But it's not. It's because he's got a medical condition.'*

Peter also explained that the word 'disorder' was the only word that he remembered from the acronym ADHD. Similarly, Laura's use of the term 'suffering from' is indicative of the medical conceptualisation of ADHD.

These findings echo the widely accepted medical understanding of ADHD and the impact that this view may have on promoting equality and understanding for children (Brady, 2014). Prosser, Reid, Shute and Atkinson discuss that the medical perspective of ADHD may promote to school staff that ADHD as 'strictly biological and outside their expertise' (2002, p. 587). My interpretation is that this theme links to attribution theory (Heider, 1958). 'Attribution theory is the process of deriving causal explanations for events and behaviour' (Maio & Augoustinos, 2005, p. 362). It is possible that the label ADHD contributes to external attribution – that is assigning the cause of behaviour to some situation or event outside a person's control. This theme also links to the notion of ADHD being a 'label of forgiveness' that is, when ADHD is conceptualised as a neuro-biological condition it becomes a 'no fault label' whereby no one is responsible for the behaviours associated with ADHD (R. Reid & Maag, 1997, p. 15)

Superordinate Theme 2: Not Just a 'Naughty Boy' - Changing Perspectives

The participants discussed that the ADHD diagnosis had led to changed perspectives of ADHD and a move away from the 'naughty boy' reputation that Peter had begun to develop.

> Debbie: *'When they says there was a thing called ADHD, it was like a peace of mind for me 'cause I thought oh well he's not just a naughty boy doing these horrible things'.*

>Alison: *'[The diagnosis] gave a bit more reassurance that maybe some of these things were out of his remit'.*

>Laura: *'[When we got the diagnosis] I felt it was a little bit of relief, not just for me but for him. When he got his, erm, diagnosis, I think it was a complete relief because it was actually, yes this is what's wrong'.*

>Laura: '*I think for him it was a relief that now he's got an answer and now we've got- he had somewhere to go with that.'*

Peter discussed another side to this in that he now sometimes feels as though he cannot be himself due to his diagnosis.

>Peter: *'I was just being myself. Like, hyper and angry all the time. And then, er, that- it's like when there's school, like, complained and, like, they were, like, complaining to my mam. I was getting sent home and stuff.'*

The shifting of perspectives discussed may be seen as positive as it moves away from a culture of blame. Hill and Turner (2016) highlighted that having an ADHD diagnosis may be desirable because people believe it reduces stigma associated with 'naughty children' and reduces blame. However, this may also create a narrative of uncontrollability and permanence of behaviours and does not allow for personality, as Peter highlights. Indeed, Boyle (2013) discusses that overuse of labels can lead to depersonalisation of individuality. This also reflects the move away from the term 'behaviour' to 'Social Emotional and Mental Health' in the Code of Practice (Department for Education, 2015). This can be seen as a positive step and recognition that various factors can contribute to children's behaviour. Furthermore, it is possible the removal of the term behaviour is related to the often-negative connotations associated with the term in educational contexts. However, classing behaviour as a mental health issue could also have implications for the inclusion of some children. It can be argued that this terminology promotes behavioural issues as within-child deficits rather than recognising the effect that external factors can have on behaviour. It is my interpretation that the participants seem to conceptualise ADHD in a reductionist way as opposed to taking an ecological perspective.

Superordinate Theme 3: Increased Understanding - Avoiding Exclusion and the 'Wrong Path'

All participants discussed that having an ADHD diagnosis had enabled Peter to be able to stay in mainstream education and avoided being moved to a specialist behavioural provision.

> Alison: *'I knew he wouldn't stay in the educational system if he didn't get some help.'*

> Laura: '*I think it would be really sad. I rea- I think we'd have a totally different story on our hand. I don't think he would still be in this school*'

> Debbie: *'He wouldn't have been in that school. He would have been in [a school], like, for naughty boys.'*

> Peter: *'I used to be getting, like, excluded, like, every week and stuff.'*

> Peter: *'cause if I wasn't told, I wouldn't have been put on the tablets. And if I wasn't put on the tablets, I wouldn't be in school.'*

Alison highlighted that they believe staying in mainstream education will lead to Peter achieving his academic potential and ultimately achieving better outcomes in life.

> Alison: '*I don't think he would've turned out the person I think he's gonna turn out to be… if he went to behaviour unit and he wasn't diagnosed, I don't know whether he would go down another path.'*

This theme may provide a distinct insight into the label ADHD. Boyle (2013) discusses that, due to the size of the bureaucratic systems involved, often diagnostic labels are sought as a means of gaining access to specialist provision. In Peter's case the opposite occurred and the label ADHD seems to have enabled him to remain in the mainstream setting. This raises questions relating to equality and social justice in that children who are not able to secure an ADHD diagnosis may be placed in behavioural provisions rather than being supported to remain in the mainstream setting. This issue is echoed by Norwich (1999) who suggests that by not applying a label then some children with special needs will not be provided with the necessary support, consequently being disadvantaged by the absence of a label.

3.3.2 Master Group Theme 2: Fear

Superordinate Theme 1: Reluctance to Accept Label

Debbie and Peter discussed their apprehension and reluctance to accept a formal ADHD diagnosis for Peter.

> Debbie: '*Because the school were keep saying, well, 'd'you want to make an appointment at the doctors and see if there's something medically wrong with Peter?'*

And I was like, I never have I believed it. I thought there was nothing medically wrong with him.'

Debbie: *'Well – I felt horrible 'cause I thought there was – er, oh it's really hard to explain. I thought – I didn't want anything to be wrong with him.'*

Peter: *'I didn't tell anyone 'cause I thought if I was telling anyone, they would be like 'what's this? What's this?' And they would, like, tell people and I didn't want anyone to know really.'*

My interpretation is that Debbie felt pressured to accept a diagnosis due to general expectations of what constitutes 'normal' behaviour and the judgment associated with not adhering to these socially accepted norms. It became apparent that Debbie felt torn in the situation, she did not want to believe anything was 'wrong' with Peter whilst wanting to avoid feeling embarrassed by others' perceptions of his behaviour. Peter voiced his initial concerns over the social stigma (Goffman, 1963) attached to receiving an ADHD diagnosis, especially in relation to his transition to secondary school. Specifically, Peter was upset that children with ADHD diagnoses were grouped with children with varying diagnoses of special educational needs. This echoes the findings of Batzle et al. (2010) and Walker et al. (2008) who demonstrated the stigmatising effects of an ADHD diagnosis. I believe that this theme links to Tajfel's (1982) social identity theory which posits that social identity is a person's sense of who they are based on their group membership.

Superordinate Theme 2: ADHD as Uncontrollable and Scary

Participants discussed that ADHD can seem scary and overwhelming due to the belief that it refers to extreme and uncontrollable behaviours which impact upon the diagnosed person and those around them.

Laura: *'As a new teacher and you've got a child in your class who can- you know, who does have huge episodes, sometimes it did feel like you were picking your battles and walking on eggshells.'*

Peter: *'I think a bit cautious of what it, like, was or something…Like, careful, like, that it was gonna, like, affect us, like, in school and stuff. I dunno, worried as well. 'Cause I didn't know if it was, like, gonna affect me in- like, for me SATs coming up … '.*

It is my interpretation that the uncontrollability associated with the diagnosis ADHD may impact upon the self-efficacy of Peter's supporting adults. Teachers' self-efficacy (Bandura, 1993) refers to the strength of the beliefs that teachers have that they can positively influence

aspects of children's educational development. In relation to unmotivated and challenging pupils, teachers' self-efficacy involves judgements of their capabilities in bringing about positive outcomes in student engagement and learning (Bandura, 1997). A study conducted by Gibbs and Gardiner (2008) highlights that some teachers believe that causes of children's challenging behaviour lie outside of the teacher's responsibility or control. Furthermore, previous research has suggested that teachers express low confidence in their ability to support children labelled as having ADHD (Ohan et al., 2011).

I believe this theme also demonstrates the impact that receiving a diagnosis of ADHD can have on children's self-concepts, as previously evidenced by Houck et al. (2011) and Bussing et al. (2000) who suggest that children with ADHD diagnoses reported significantly lower overall self-concept than children without ADHD diagnoses.

3.3.3 Master Group Theme 3: Support

Superordinate Theme 1: Access to Resources

The participants discussed that obtaining an ADHD diagnosis for Peter enabled them to access additional information from medical services as well as additional funding and support.

> Laura: *'Now I know what it is, there- there should be lots of help out there … And there was. Like, well you know, we- we were given lots of, erm- lots of documents to read'.*

The participants also discussed that these things led to the development of strategies to support not only Peter but other children in school who experience similar difficulties to him.

> Debbie: '*And the teachers know how to manage Peter now because they did used to shout at him and that just escalated things out of proportion. Now they just talk calmly to them.*'

> Laura: '*So I could have a conversation with Peter. Peter – you could talk to Peter and he- about his behaviour and he would be able to tell you the consequences of his behaviour personally and how it affected other people… So for me I think it's more of s-stop giving children such strict instructions. You need to talk to them… So for me I've had a lot of dialogue with children in my class*'.

> Peter: *'Teachers don't really tell us off as much anymore because, like, they don't shout at us'.*

These findings echo findings by Hill and Turner (2016) who proposed that the label ADHD may increase understanding by providing an explanation of difficulties and open up opportunities for extra support in school and for families. Boyle (2013) also discusses that it is necessary for the education system to provide schools with a mechanism to acquire additional funding so that they can follow the principles of supporting the range of needs in the education establishment. However, I wondered if a formal diagnosis for Peter had actually been necessary to obtain these specific support services.

Superordinate Theme 2: Medication

The participants discussed that obtaining the ADHD diagnosis was crucial to obtaining medication to alter Peter's behaviour. Peter highlighted the impact that having to take this medication has upon his life and peer relationships, whilst Debbie raised concerns regarding whether the medication had caused school staff to have an unrealistic expectation of Peter's behaviour.

> Alison: *'Medication assists him to access his work or concentrate on something for a longer period of time.'*

> Debbie: '*Hyper. But his meds do help with that.'*

> Laura: '*As soon as he had that diagnosis and he- you know, he had that medication but also he was talked to a lot more.'*

> Peter: '*And then I ended up being, like, put on tablets. And that, like, just helped us, like, a lot. Yeah.'*

This theme links research which indicates that there is rapid growth in the use of Methylphenidate to treat ADHD (Sparks & Duncan, 2008). Batzle et al. (2010) has also raised concerns that ADHD creates a self-fulfilling prophecy which can only be treated with medication and tells parents/teachers and society there is nothing they can do to support these children. It has been suggested that psychological interventions are more effective than using psychotropic drugs (Fabiano et al., 2009) and official guidance provided by the (National Institute for Health and Clinical Excellence, 2008) states that medication should only be considered after the implementation of behavioural interventions has failed. However, in Peter's case medication was discussed as the only intervention put in place. There are ethical implications associated when considering the vast amount of side effects associated with stimulant medication (J. Graham et al., 2011).

Superordinate Theme 3: Relationships as a Protective Factor

The participants discussed the importance of relationships as a protective factor for Peter in receiving his diagnosis. Participants discussed the importance of having a strong relationship with Peter and seeing him as an individual, not as a label.

> Alison: '*We have a very good relationship with anything, me and Peter. We're very good at understanding one another. Erm – but it [the ADHD diagnosis] doesn't change how I look at him.*'

> Laura: '*I just think it's lif- it's like autism. It's such a big spectrum and you have to tailor it to such a child. That the same for me is ADHD.*'

> Laura: '*And I think it's completely different for every child… But it gives you a good grounding on where to build on. Erm, but I think what works for one child isn't going to work for another.*'

They also discussed other interacting factors, such as strong parenting and Peter's high academic abilities, articulation and maturity, which helped to ensure things continued to go well for Peter in school.

> Alison: '*He had a very good teacher in year six, in year five.*'

> Laura: '*I think I struck lucky with Peter because he is so articulate.*'

Each participant discussed the importance of having strong relationships and it was clear that Peter is greatly valued and admired by his school staff. This theme highlighted to me the importance that valuing individuality and maintaining strong relationships, had had on Peter's primary school experience. I wondered if Peter's experience of receiving a diagnosis would have been as successful without the dedication and care of the adults around him and the commitment that they had made to seeing Peter for who he is rather than focusing on his diagnosis. Blum and Bakken (2010) warn against the potential negativity attached to deficit oriented labelling in education. However, Boyle (2013) suggests many teachers can and do understand the limitations of negative labelling and will already be aware of students' strengths due to the intensive nature of classroom teaching. Boyle (2013) discusses that consequently school staff are best placed to focus on the strengths of their students and thus develop individual programmes which accentuate these strengths, irrespective of a label.

3.3.4 Implications for Educational Psychologists

Firstly, this empirical research highlights the generally accepted medical model of the label ADHD (Brady, 2014; Prosser et al., 2002). This echoes comments by Hill and Turner (2016) who voiced concerns about the lack of consideration given to contextual factors with regard to an ADHD diagnosis and how health authorities often choose the intervention. Educational psychologists could work collaboratively to promote a more ecological perspective. Consequently, promoting equality and understanding for children.

Secondly, this empirical research highlights the focus of all participants on medication being the answer. There is growing concern regarding escalating rates of diagnosis of mental health disorders and the associated prescribing of psychotropic medication in children (Hill & Turner, 2016; Sparks & Duncan, 2008). It has been suggested that psychological interventions are more effective than using psychotropic drugs (Fabiano et al., 2009) for these children. However, given governmental reductions in funding for services such as children's mental health services, it is likely that medication is a cheaper option. This may echo findings of Atkinson, Squires, Bragg, Muscutt, and Wasilewski (2014) who demonstrated that, whilst educational psychologists were often well skilled and situated to deliver therapeutic interventions in schools, school staff were often not aware that they were able to do so. It is recognised that in the current economic climate of traded services educational psychologists delivering individual therapeutic work may prove problematic, thus educational psychologists could work systemically to assist school staff in developing and implementing programs of support for these children. This echoes the findings of Atkinson, Corban, and Templeton (2011) who used a case study approach to demonstrate that educational psychologists may use a wide range of therapeutic interventions at different levels in schools; including individually and systemically through consultation and training.

Finally, this empirical research indicated that the child's own response to the diagnosis contrasted to how the adults thought the child perceived the diagnosis. Hill and Turner (2016) assert that children's participation is crucial to the efficacy of interventions for children with ADHD diagnoses. Harding and Atkinson (2009) discuss that it is often the EP who works collaboratively with schools, parents and others to ensure the distinctive 'voice' of the child is heard. Thus, educational psychologists may be suitably skilled and well placed to support and promote the voice of children regarding diagnosis/interventions.

3.4 Limitations

This study provides an interpretation of the accounts of differing individuals with regards to the diagnostic label ADHD. I aimed to provide an insiders' account, however, I recognise that in interpreting interview transcripts, I interpreted accounts from my perspective, as recognised by IPA. This section seeks to discuss some limitations of this study.

Some of the limitations that have occurred to me at this point include: Peter being under the influence of medication for his ADHD. Whilst Peter was interviewed at the point where his medication had started to wear off from the morning, it is likely his responses were still influenced by being under the influence of his medication. However, this is a daily reality for Peter and it would have been a misrepresentation to withhold his medication for the interviews.

Furthermore, others undertaking the interviews or reading the transcripts may have interpreted it differently. Likewise, each new reading of the transcripts will generate new interpretations of them. My practitioner-researcher role and existing relationships with the participants will have shaped both the participants' responses, my interpretations and the conclusions reached. These aspects had significant bearings on the findings and are an accepted aspect of undertaking IPA (J. A. Smith et al., 2009) .

3.5 Conclusions

This research has highlighted the different perspectives that may be held by several stakeholders in one case of a child receiving an ADHD diagnosis. The findings indicate that the label ADHD may provide a medical context for behaviour and shift blame away from individuals towards the label itself. The implications of this appear to be two-fold; firstly, the label may elicit feelings of fear relating to its apparent uncontrollability and associated social stigma. Secondly, the label may also promote access to resources, although in this case this was limited to medication. Finally, the perspectives shared demonstrate the importance of valuing children's individuality rather than focussing solely on the ADHD label. Consequently, it may be suggested that there is a role for educational psychologists in terms of promoting an ecological perspective, supporting school staff and acting as advocates to promote the voice of children regarding diagnosis/interventions of ADHD. It is hoped that this empirical research has generated a richness of data to attract further exploration to this area.

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PARTICIPANT INFORMATION

PARTICIPANT NUMBER _____

NAME OF RESEARCHER	Honor Parker
PROJECT SUPERVISOR	David Lumsdon
PROJECT TITLE	**What does the label 'ADHD' mean to a diagnosed child, his parent and his school staff?**

You are being invited to consider giving your consent to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information.

1. What is the purpose of the project?

The purpose of this project is to find out the views of children/young people, their parents/carers and their school staff regarding what it means to have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). My aim is to find out about how people understand this diagnosis and how they feel it has impacted upon children/young people.

2. Why have I been selected to take part and is there any reason why I shouldn't take part?

Participants must have a diagnosis of ADHD or be the parent/carer/school staff of a child who has a diagnosis of ADHD. Participants should be able to speak English.

3. What will I have to do?

Children/young people and their parents/teachers will be asked to take part in an informal 1:1 interview, in person, which will last 30-45 minutes. The interview will be recorded using a dictaphone and transcribed word-for-word. The recording will be destroyed 6 months after completion of the project.

4. Will my participation involve any physical discomfort?

No.

5. Will my participation involve any psychological discomfort or embarrassment?

The interview questions will focus on the impact of the child's/young person's diagnosis of ADHD.

6. How will confidentiality be assured?

A pseudonym will be given to all participants and anyone/anywhere mentioned during the interview. Only the researcher, project supervisors and transcriber will have access to the interview recordings. You will also be given an individual participant number (above) so that only you can identify the information that you provided.

7. Will I receive any financial rewards / travel expenses for taking part?

No.

8. How can I withdraw from the project?

You can withdraw from the project at any time before completion by contacting the researcher or project supervisor and quoting your participant number (above). After the project has been completed it is not possible for you to withdraw.

You can withdraw by contacting me at;

Honor Parker – h.l.parker@newcastle.ac.uk

Or by contacting the project supervisor at;

David Lumsdon – david.lumsdon@newcastle.ac.uk

9. If I require further information who should I contact and how?

For more information please contact me at h.l.parker@newcastle.ac.uk.

If you would like to discuss this study with someone independent of the project please contact:
Simon Gibbs – simon.gibbs@newcastle.ac.uk

If you wish to make a complaint about the project please contact:
Simon Gibbs – simon.gibbs@newcastle.ac.uk

If you are a parent/carer and you deem this project to be suitable for your child/young person I have included a child/young person participant information sheet on the next page.

Thank you for taking the time to read this information sheet,

Honor Parker

Information Sheet for Young People

Hi,

I'm a student at Newcastle University and I'm writing to you to invite you to have a think about taking part in my project.

Before you decide if you want to take part it is important that you read this letter and talk to your parents/carers about it.

I am doing this project because I want to find out what having ADHD means to you. I also want to find out about what your parents and teachers think about it.

To take part you will be asked to have a talk with me about ADHD. This will last about 30 minutes and I will record it using a sound recorder. Later, I will also have a talk with your parent/carers and your teacher too.

Nobody who reads my project will be able to tell who you are or your family members are because I will give you all fake names.

If you decide to take part in my project, you can change your mind and pull out any time before it's finished. Just ask your parents/carers to email me to let me know.

Honor Parker

INFORMED CONSENT - PARENT

Participant Number	

PROJECT TITLE **: What does the label 'ADHD' mean to a diagnosed child, his parent and his school staff?**

Please read the following statements
If you *agree* with them please *write your initials* in the box next to each statement
If you do not agree, please speak to the researcher

I have read and understood the information sheet

I have had an opportunity to ask questions and discuss the project and I am satisfied with the answers I have received

I understand that my/my child's participation is voluntary and I am free to withdraw at any time up until completion without explanation or consequence

I would like to receive feedback on the overall results of this project at the email address given below

Email address: _____

I agree with all points detailed above. I agree to take part in the project and give permission for my child to take part in the project.

Participant:

**Name
(Please Print)** _____ Date _____

Child's Name _____ Date _____

Signed _____ Date _____

Researcher:

**Name
(Please Print)** _____ Date _____

Signed _____ Date _____

If you are a parent/carer and have provided consent for your child/young person to take part I have included a child/young person consent for your child to complete separately.

Participant Number	

PROJECT TITLE: **What does the label 'ADHD' mean to a diagnosed child, his parent and his school staff?**

Please read the sentences.

If you *agree* with them then *write your name* in the box
next to each sentence.

I read and understood the information
sheet

I have asked any questions that I want
to ask

I know that I can change my mind about
taking part if I want to

I agree to take part in the project.

Participant

Name _____

Signed _____   Date _____

Researcher

Name _____

Signed _____   Date _____

INFORMED CONSENT - STAFF

Participant Number	

PROJECT TITLE **: What does the label 'ADHD' mean to a diagnosed child, his parent and his school staff?**

Please read the following statements
If you *agree* with them please *write your initials* in the box next to each statement
If you do not agree, please speak to the researcher

I have read and understood the information sheet ☐

I have had an opportunity to ask questions and discuss the project and I am satisfied with the answers I have received ☐

I understand that my participation is voluntary and I am free to withdraw at any time up until completion without explanation or consequence ☐

I would like to receive feedback on the overall results of this project at the email address given below ☐

Email address: _____

I agree with all points detailed above. I agree to take part in the project.

Participant:

**Name
(Please Print)** _____ **Date** _____

Signed _____ **Date** _____

Researcher:

**Name
(Please Print)** _____ **Date** _____

Signed _____ **Date** _____

Table 12: Extract from Laura's Interview Transcript

I/R	Speech	Initial Notations	Emergent Themes
Respondent	I felt it was a little bit of relief, not just for me but for him.	Relief for Laura Relief for Peter	Relief
Interviewer	Hmm-hmm.		
Respondent	Because you could see – I could see, like – er, I think he must've got his diagnosis around Christmas time and I could see Peter desperate to socialise, desperate to dance – 'cause we used to have, like – you know, we had, like, Christmas parties.	Peter wanted to join in and be part of the group but couldn't until after his diagnosis *Why? Others perceptions of him?*	Self-awareness
Interviewer	Yeah, yeah.		
Respondent	And you could see, like, he just – he was edging. He wanted to get in but he was holding himself back and instead like of – instead of u- like, using that energy in a positive way to go and play with his friends, he wouldn't. He would use it in a negative way. Instead of going to, erm, dance, which you could see he wanted to do, he would- he would just kick a wall.	Prior to diagnosis Peter was channelling his energy in a negative way	Distinct difficulties Self-awareness

8 Appendix D: Superordinate Themes Linked to Example Extracts

Table 13: Superordinate Themes - Peter

Superordinate Themes (Bold) and Emergent Themes (Italics)	Example Extracts
Reluctance to Accept Label *Embarrassed* *Scared* *Confused* *Not identifying as SEN*	*'I just kept it to meself really. I didn't tell anyone 'cause I thought if I was telling anyone, they would be like 'what's this? What's this?' And they would, like, tell people and I didn't want anyone to know really'* p.12 *'I didn't want to because I wanted to, like, make, like, friends with, like, other people along, like, people without, like, ADHD and stuff.'* p.24 *'Because if I had, like, went with them, I'll be like – I wouldn't want to be known as, like, the per- like, the person with ADHD and I didn't want that'.* p.24/25 *'Like, careful, like, that it was gonna, like, affect us, like, in school and stuff.'* p.11 *'I didn't want to because I wanted to, like, make, like, friends with, like, other people along, like, people without, like, ADHD and stuff.'* p.24
Medical Perspective *Distinct difficulties* *Disorder*	*'Fidgety. That's the main thing.'* p.6 *'I knew it was 'disorder' at the end'.* p.8
Access to Resources *Access to support* *Medication*	*'And then I ended up being, like, put on tablets. And that, like, just helped us, like, a lot.'* p.15 *'Like, everyone else can work in, like, a loud and, like – I can't. I need to, like, be in, like, a quiet room on me own to, like, work, like, on me own…'* p.17 *'Like, when we had the SATs, erm, Miss, she worked with us… To, erm, help us concentrate and things.'* P.21
Increased Understanding *Better understanding* *Avoiding exclusion*	*'Cause I used to be getting, like, excluded, like, every week and stuff'.* p.15 *'I don't get, like, tell off 'cause miss knows I need, like- I'll start needing me, like- like, me tablets wear off…'* p.16. *'Oh, erm – teachers don't really tell us off as much anymore because, like, they don't shout at us.* p.21 *'I think I wouldn't even be in school if I- I wasn't told. If I – and 'cause if I wasn't told, I wouldn't have been put on the tablets. And if I wasn't put on the tablets, I wouldn't be in school.'* p.22
Individuality *Peter's character*	*'I was just being myself. Like, hyper and angry all the time. And then, er, that- it's like when there's school, like, complained and, like, they were, like, complaining to my mam. I was getting sent home and stuff.'* p.18. *'I'm just a bit hyper. But she says well that boys are going to be hyper, aren't they?'* p.19

Table 14: Superordinate Themes - Laura

Superordinate Themes (Bold) and Emergent Themes (Italics)	Extracts
ADHD as Uncontrollable *Overwhelmed* *Uncontrollable* *Impact on other students*	'as a new teacher as well totally finding my feet because I was an NQT … Erm – I kinda felt for a while, maybe for like a week or so, I was just observing him… Completely observing him. And it was more of, erm, crowd controlling.' p. 14 'But, er- er – but it was, it was an absolute – I think it was probably a shock to the system.' p.15 'Because I wasn't- I wasn't on edge. You do, like, c- as a new teacher and you've got a child in your class who can- you know, who does have huge episodes, sometimes it did feel like you were picking your battles and walking on eggshells.' p.25
Medical Perspective *Distinct difficulties*	'Negative behaviour didn't come into it for me before I met him. Like, I didn't – that didn't occur to me.' p.7 'it was just for me somebody who couldn't concentrate, who couldn't stay still, who might be out of their seat all of the time.' p.7 '… they find it very hard to settle themself. It's not so much that they can't follow instruction, it's that they find it really difficult to – and I think some of them might be really aware of it. 'Cause I do think Peter was.' p.8 'I think there's quite a few children …who could be suffering from this.' p.19
Changing Perspectives *Blame* *Relief* *Changing Perspectives*	'I felt it was a little bit of relief, not just for me but for him.' p.16 'I think he felt so – when he- when he got his, erm, diagnosis, I think it was a complete relief because it was actually, yes this is what's wrong. Because, like I say, Peter's very articulate.' p.17 'And I think for him it was a relief that now he's got an answer and now we've got- he had somewhere to go with that.' p.17
Access to Resources *Access to Resources* *Increased support* *Medication*	'Because before his medication, he couldn't concentrate. He was constantly looking to distract somebody.' p.11 '…we were given lots of, erm- lots of documents to read. And then he was obviously put on his medication.' p.18 'I think for me I- I then knew – right, now I know what it is, there- there should be lots of help out there …' p.18 'Erm – but with Peter, it was- it was almost like we were tailoring the behaviour policy to him and changing it every week.' p.28
Increased Understanding *Increased Understanding* *Avoiding exclusion* *Increasing Peter's self-awareness* *Increasing understanding of other students*	'I think for me i-it makes me a lot more understanding of children and children's development. And actually that Peter is a very extreme case. A very extreme case.' p.18 'So I just think for me it's just made me a lot – it- it's given me a- a better understanding of how to deal with children in a classroom and how it helped them learn.' p.22 'So that works with other children. Like I- I wouldn't have necessarily done that with any other children before I had Peter.' p.22 '…our relationship's developed, I think, because I've got a deeper understanding of what he's going through and because we talk about it.' p.26
Relationships *Peter's character* *Peter's potential* *Strong relationships*	'So for me it wasn't so much that information about ADHD was forthcoming, it was more about Peter's character.' p.9 'And it was more about who Peter is and what his character traits were.' p.9 'I just think it's lif- it's like autism. It's such a big spectrum and you have to tailor it to such a child. That the same for me is ADHD'. p.33

Table 15: Superordinate Themes - Debbie

Superordinate Themes (Bold) and Emergent Themes (Italics)	Extracts
Reluctance to Accept Label *Reluctance and pressure to accept diagnosis* *Sadness* *Overwhelmed* *Scared* *Embarrassed*	*'It was all the school. I didn't know anything about it.'* p.7 *'Because the school were keep saying, well, 'd'you want to make an appointment at the doctors and see if there's something medically wrong with Paul?' And I was like, I never have I believed it. I thought there was nothing medically wrong with him.'* p.8 *'I felt horrible 'cause I thought there was – er, oh it's really hard to explain. I thought – I didn't want anything to be wrong with him.'* p.9 *'They were saying they might be considering the hub. But he had only been bad for four days and I thought – like, four times. And I thought he's being good for ages, d'you know what I mean?'* p.14 *'Because sometimes, like if we're out shopping and stuff and he, like, you know, the meats on the counters?... He, like, run, punching them and stuff… And it's emba- like, it's embarrassing. And sometimes people are, like, looking.'* p.11
Medical Perspective *Distinct difficulties* *Extreme behaviours*	*'Cause it's like a chemical imbalance in his brain, isn't it?'* p.6 *'It's because he's got a medical condition.'* p.10
Changing Perspectives *Blame* *Relief* *Not just naughty*	*'I just always thought he was a naughty boy… But when they says there was a thing called ADHD, it was like a peace of mind for me 'cause I thought oh well he's not just a naughty boy doing these horrible things.'* p.6 *'…now it feels like a good thing that I know it's ADHD … He's not just a normal boy. 'Cause they get labelled 'the naughty kid', don't they?'* p.9.
Access to Resources *Increased support* *Medication*	*'The medication's working good.'* p.13 *'But 'cause he got diagnosed with ADHD and he's got started on his meds, it's just calmed him down.'* p.16 *'And the teachers know how to manage Paul now because they did used to shout at him and that just escalated things out of proportion… Now they just talk calmly to them.'* p.18
Increased Understanding *Better understanding* *Avoiding exclusion* *Increasing Peter's self-awareness* *Label as intervention*	*'It is, like, a meaning to what he's- why he's doing it.'* p.6 *'Just an understanding on- er, why he goes on like that.'* p.12 *'But now I think uh-huh, it's better for him as well 'cause he knows that ADH- like, it's 'cause ADHD, isn't it? That's what it is.'* p.13 *'He wouldn't have been in that school. He would have been in, like, for naughty boys.'* p.15
Relationships *Peter's character*	*'Nothing's changed. Everything's still the same just he's got ADHD.'* p.12

Table 16: Superordinate Themes - Alison

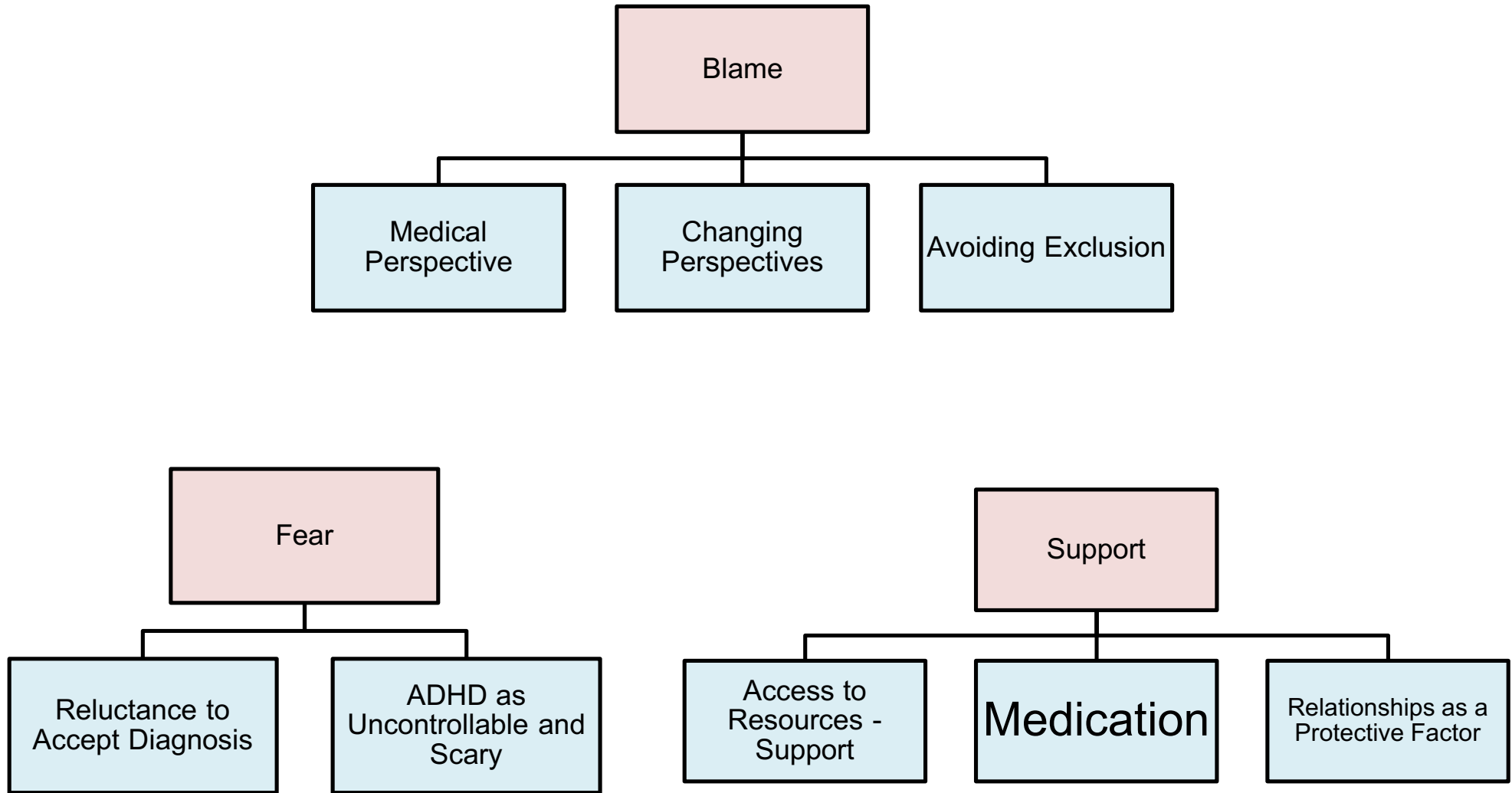| Superordinate Themes (Bold) and Emergent Themes (Italics)	Extracts
ADHD as Scary *Uncontrollable* *Overwhelmed* *Ashamed of diagnosis*	*'I suppose like everything in the world, if you put – his diagnosis probably helped in, well, 'I have got something. It's not me. It is me but it's not me. I can't control how I am.'* p.18 *'Probably give him a, erm- a sort – a bit- a bit more reassurance that maybe some of these things were out of his remit.'* p.18 *'Well pre-medication he would, er- er, he would be very, very challenging.'* p.4
Medical Perspective *Distinct difficulties*	*'I went to a clinical psychologist meeting with him when we suspected he did have ADHD.'* p.3
Changing Perspectives *Blame* *Relief* *Not just naughty*	*'I think it was good for him more than anything. Like, you know, he never, ever really discussed it with me as such, like, but I think probably for him it was probably a blessing in disguise. Because, like, it wasn't him. He wasn't this… naughty, horrible little boy.'* p.17 *'I think he was probably getting labelled as a very, very challenging child.'* p.18 *'I suppose like everything in the world, if you put – his diagnosis probably helped in, well, 'I have got something. It's not me. It is me but it's not me. I can't control how I am.'* p.18
Access to Resources *Increased support* *Medication*	*'And it was to see if we could get the medication to assist him with his learning.'* p.3 *'Medication assists him to access his work or concentrate on something for a longer period of time.'* p.8 *'I just went to the… clinical psychologist where it was being decided whether he's- was gonna take that leap to the medication.'* p.14
Increased Understanding *Increasing Peter's self-awareness* *Avoiding exclusion* *Label as intervention*	*'I knew he wouldn't stay in the educational system if he didn't get some help.'* p.15 *'…for him it probably identified that 'oh I have got something. I'll deal with it and I might not be the same- same as I was before.'* p.18 *'…we have a very good relationship with anything, me and Peter. We're very good at understanding one another.'* p.19 *'…if he went to behaviour unit and he wasn't diagnosed, I don't know whether he would go down another path.'* p.26
Relationships *Focus on Peter* *Interacting factors* *Limitations of diagnosis* *Strong relationships*	*'…he's just lovely. I just – I think he's qu- I think he's quite unique.'* p.7 *'…well my understanding of it is that it doesn't resolve everything… he's got Attention Deficit – and he- he clearly did… It's not gonna resolve – if he's got behaviour issues, it- that's separate to ADHD.'* p.8/9 *'I don't look at Peter and think 'ADHD'. I just see Peter for who he is.'* p.24

Figure 2: Master Group Themes Linked to Superordinate Themes