Investigating Familiarity with and Attitudes to 

Attention Deficit/Hyperactivity Disorder

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Abstract

Attention Deficit/Hyperactivity Disorder (ADHD) is a commonly diagnosed psychiatric disorder however concerns exist about validly of the disorder. This mixed methods study investigated familiarity and attitudes to ADHD and perceived stigma and discrimination related to mental illness. Method: Participants responses were collected through a snowball and purposeful sample (n=201) using an online questionnaire. Parents experiences were collected through a semi-structured personal interviews (n=3). Results: No significant difference was found in perceived discrimination between those who know/don’t know someone with a mental illness (p = .938). Negative self-image was found to significantly predict disclosure concerns of ADHD (p < .001). Parents of ADHD affected children did not perceive any negative attitudes follow disclosure. Conclusions: Results did not support contact as a stigma reducing strategy. Help-seeking behaviour and disclosure to school, family and friends provide parents with a support network and explanation for their child’s impulsivity and hyperactive behaviour.

1. Introduction
Attention Deficit/Hyperactivity Disorder (ADHD) is a commonly diagnosed psychiatric disorder however concerns exist about validly of the disorder. Additionally the stigmatising effects of a “mental illness” diagnosis can have significant implications for the well-being of the individual and their family. The 2015 release of the International Statistical Classification of Diseases (ICD-10) categories’ Attention Deficit/Hyperactivity (ADHD) among a group of conditions collectively called Hyperkinetic disorders involving inattention, increased hyperactivity and impulsivity which usually develop within the first five years of life characterised by deficits in cogitative activities (ICD-10, 2015, F90.9). Considered a neurological developmental disorder ADHD is estimated to affect over 5% of children/adolescents and 2.5% of adults worldwide, with widespread public scepticism of the condition as a valid psychiatric disorder (Thome, Fallgatter, Krauel, Lange, Riederer, Romanos,…Manfred, 2012, p. 379).

Stigmatizing attitudes relating to responsibility and dangerousness undermine opportunities for a person with serious mental illness with individuals internalising these negative belief expecting to be rejected by others (Park, Bennett, Couture & Blanchard, 2102, p. 43). Stigma associated with ADHD affects an individual’s decisions to engage in help seeking behaviour with significant impact on their life satisfaction and mental well-being (Mueller, Fuermaier, Koerts, & Tucha, 2012, p. 101).

Consequently, this study aims to investigate whether familiarity with an individual suffering from a mental illness influences discriminatory attitudes towards mental illness in general. Societal perceptions of ADHD as a disorder are collected from the general public and members of the ADHD Society of Ireland (HADD). Perceived stigma influences on a parent’s help-seeking behaviour and decisions to disclose their child’s ADHD condition to friends, family and teaching professionals are explored through qualitative analysis.

1.1. What is ADHD?
ADHD is one of the most commonly diagnosed psychiatric conditions estimated to affect 1 in 20 children in the US alone (Faraone, Sergeant, Gillberg, & Biederman, 2003, p.104). According to the HADD, an acronym for the ADHD Society of Ireland, Attention Deficit/Hyperactivity Disorder is a medical/neurobiological condition where the brain’s neurotransmitter chemicals, noradrelin and dopamine malfunction (HADD, 2018, para. 1). ADHD is a long-term condition which affects learning and behaviour throughout childhood particularly impacting school years and in some cases continuing into adulthood. Furthermore comorbidity with learning, anxiety and mood disorders can coexist in both adults and children including dyslexia, autism, dyspraxia, conduct and oppositional defiance disorders (HADD, 2018, para. 3). Without identification and treatment the condition can have serious implications on life satisfaction with long lasting consequences for the affected individuals, however, importantly, ADHD is a very treatable condition and individuals can lead happy and successful lives (HADD, 2018, para. 4). The ICD-10 categories ADHD among a group of conditions collectively called Hyperkinetic disorders which usually develop within the first five years of life and characterised by a lack of persistence in cogitative activities with a tendency to move from one task to another without completing any one individual activity. Hyperkinetic children exhibit reckless and impulsive behaviour are accident prone, often facing disciplinary problems for unwitting “rule breaking” rather than any deliberate defiance on their behalf. Children with ADHD tend to be unpopular and may become socially isolated. As a result secondary complications may also include dissocial behaviour and low self-esteem (ICD-10, 2015, F90). Spencer, Biederman, Wilens, Faraone, (1994) suggest evidence has shown a high level of conduct, mood, and anxiety disorders in children and adolescents with little known about the aetiology of other comorbid conditions which often present in ADHD patients (Hermann, Jones, Dabbs, Allen, Sheth, Fine,…Seidenberg, 2007, p. 3135).

1.2. Concerns around validity of ADHD
Concerns have been raised whether ADHD is a valid disorder due to a lack of biological markers with high comorbidity rates making it difficult to differentiate between normal and pathological symptoms (Moncrieff & Timimi, 2014, p. 1). Furthermore Milich, Balentine and Lynam (2003) suggest the changing criterion from the Diagnostics and Statistical Manual of Mental Disorders (DSM) result in an ever continuing debate over what are the primary symptoms of ADHD. Moncrieff and Timimi (2014, p. 1) argue that adult ADHD is little more than aggressive marketing by drug companies who promote common behaviours such as forgetting car keys as symptoms with many adults diagnosed who were never diagnosed as children. However Mörstedt, Corbisiero, Bitto, and Stieglitz (2015, p. 2) suggest ADHD is a neuro-developmental disorder characterised by inattention, hyperactivity and impulsivity with deficits in social communication leading to problems in family life, education and work. Thorne et al. (2012, p 379) propose that public scepticism of ADHD as a valid psychiatric disorder is widespread however research implicates genetic factors within brain functions while Klob and Wilshire (2014, p. 241) posit ADHD as “a dysfunction of noradrenergic and dopaminergic activating systems particularly in the frontal basal ganglia”, its prevalence throughout the world indicating a neurobiological rather than a cultural basis. In analysis of 13 studies, 4 from US and 9 non-US, Faraone, Sergeant, Gillberg and Biederman (2003, p. 110) found that prevalence rates of ADHD/ADD are at least as high in non US children as in US children. Furthermore longitudinal studies demonstrate that childhood symptoms continue to be expressed into adulthood supporting “the descriptive validity of adult ADHD” (Spencer, et al., 1994, p. 328). While McGough, and Barkley (2004, p. 1948) propose that adult ADHD should remain a clinical diagnosis however clinicians should use flexibility in applying criteria adding that further research is required.

1.3. What Determines Validity?
Differing opinions among practitioners coupled with wide classifications of mental disorders within the DSM and ICD-10 highlight several challenges for a clinical practice. According to Wakefield (2007), the concept of a disorder can range from a socio-political concept for social control to a more scientific factual concept, raising the question “is a mental condition a mental disorder”? Or is it based on problems encountered from normal living, issues that cause individual suffering from events in everyday life? He suggests that within the DSM-IV and ICD-10 there is no consensus on the meaning of a “mental disorder” which fully clarifies the conceptual issues raised through classification in order to improve the validity of psychiatric diagnosis. The fundamental question at the heart of Wakefield argument is whether disease and illness are based on value judgements or whether they are “value free in scientific terms” (Wakefield, 2007), in other words in “biomedical terms” or “socio-political terms”. To overcome these conceptual issues he proposes a hybrid concept of a mental disorder as “harmful dysfunction” (HD) where “harmful” refers to judgements made by sociocultural norms and “dysfunction” a scientific factual term referring to the breakdown of internal biological systems (Wakefield, 2007, p. 149). For example, illiteracy is seen as harmful in western society which may result from a multiple of interpersonal factors, access to education or economic factors, but is not in itself considered a disorder. However a lack of ability to learn to read due to an internal neurological anomaly is considered a disorder. Many negative conditions that are not disorders exist, for example grief following bereavement which contain symptoms that are clinically significant (depression). Grief is considered part of the normal human condition whereas individuals encountering intense sadness without any conspicuous signs of real loss are seen as disordered. Therefore a pure value account of “disorder” fails to explain the differences between disorders and non-disorders and seem to depend on a further criterion (Wakefield, 2007, p. 151).
The factual component of Wakefield’s HD concept is called “dysfunction” which suggests a failure of some biological mechanism within an organism to perform a normal function. This function is explained as how the mechanism affects the individual, for example perceptual stimuli provide an organism with information about their immediate environment. Cognitive mechanisms provide the capacity for rational deductive and inductive processing allowing for “means-end reasoning”. When assessing ADHD using the HD concept of mental disorder both components are in operation. For patients diagnosed with ADHD there is a high risk they will encounter stigma, prejudices, and discrimination negatively impacting social functioning and the quality of life for affected individuals (Mueller et al., 2012, p. 101).

Evidence for the existence of the factual “dysfunctional” component emerges through multiple studies implicating neurological mechanisms in the aetiology of the disorder (Thorne et al., 2012; Mörstedt, et al., 2015; Klob & Wilshire, 2014; Spencer, et al., 1994). Therefore a body of evidence exists to support the “harmful dysfunction” analogy indicating further support for the validity of ADHD putting it in the realm of a “mental illness” and “mental disorder”.

Conflicting evidence exists on the validity of ADHD as a mental disorder. Moncrieff and Timimi (2014, p. 1) dispute the validity of adult ADHD due to difficulty in differentiating normal symptoms from pathological ones. While Spencer, et al. (1994, p. 330) found adults who are impulsive, inattentive, and restless, display the same clinical "look and feel" of children who have ADHD. Furthermore (Kessler, Alder, Ames, Demler, Faraone, Hiripi,…& Walters, 2004, p. 246) reported that ADHD is probably ‘the most common chronic undiagnosed psychiatric disorder in adults’. Therefore the present study can be justified on the grounds that it investigates ADHD from the perspectives of individuals who are directly impacted by the disorder and those who are not.

1.4. Assessment, Diagnosis and Treatment
According to the ADHD institute, (2018, p. 3) formal diagnosis of ADHD typically utilises DSM-5 or ICD-10 involving clinical examination and assessment of data gathered in rating scales, the ADHD-RS-IV for children and the Adult Self-Report Scale (ASRS) for adults. The ADHD-RS-IV is home screening tool competed by a guardian to rate a child’s behaviour on an 18 item, 4 point rating scale with 9 items each for both hyperactivity-impulsivity and inattention symptoms (see appendix 6). The tool is scored by a healthcare provider and used in conjunction with parental interview and observer reports to provide a diagnosis (ADHD Institute, 2018, para. 1). Treatments range from nonpharmacological, dietary and Cognitive Behavioral Therapy (CBT) to pharmacological interventions involving drugs. Childress (2016, p. 20) suggests a wealth of data exists showing that ADHD symptoms respond well to pharmacological intervention and these are highly effective in treatment (Savill, Buitelaar, Anand, Day, Treuer, Upadhyaya, & Coghill, 2015, p.132; Mörstedt, et al., 2015, p. 2; Childress, 2016, p. 20).

Meta-analysis conducted by Spencer, et al., (1994) found evidence of descriptive, predictive, and concurrent validity of the disorder demonstrating that the condition can be reliably diagnosed in adults with evidence implicating genetic transmission factors with abnormalities in brain structure and function in affected individuals. The strongest evidence for improvement of ADHD symptoms is through prescription medications which are effective for approximately 80% of cases supporting the view that genetic factors within brain functions are responsible particularly: “in the basal ganglia thalamocortical neurocircuitries” (Thome, et al., 2012, p. 379). The relief of ADHD symptoms through the use of drugs are greater in population studies than are reported in drug trials for conditions like depression (Asherson, Adamou, Bolea, Muller, & Moura, 2010, para. 9).

1.5. Stigma
Stigma is an overarching term referring to stereotypes, prejudice and discriminatory behaviour towards people with mental illness (Hinshaw & Stier, 2008, p. 367). The Oxford English dictionaries (2018, para. 1) definition of stigma is “a mark of disgrace associated with a particular circumstance, quality, or person” implying something that takes away from one’s character or reputation. According to Mueller, et al., (2012, p. 101) stigma is a set of behaviours expressed as “a discrediting stereotype from falsely assumed associations between a group of people and unfavourable characteristics attributes, and/or behaviours”. Stigma involves stereotyping members of a devalued group in terms of prejudice emerging as discriminatory behaviour limiting the rights and life opportunities for those being degraded. The stigmatised group experiences increased internal shame and degradation coupled with dysfunctional social relationships involving anxiety, hostility, and rejection (Hinshaw & Stier, 2008, p. 368). Perception of discrimination in adolescence is likely to affect the individuals' identity their peer relationships and academic achievement as well as their mental and physical well-being (Brown & Bigler, 2005, p 533). Stereotypes are efficient social structures learned by members of an in-group, “social” in that they are collectively accepted by members of the group and “efficient” as they provide impressions and expectations of individuals who belong to the stereotyped out-group leading to prejudice (Hogg & Vaughan, 2010, p. 34). At an interpersonal level social contexts shape individual responses to individual outgroup members (Fiske, 2000, p. 303). The affective cognitive response of the in-group is often exhibited through hostility and discriminatory behaviour imposing social ostracism in order to intentionally exclude a devalued member or group (Hogg & Vaughan, 2010, p. 171).

Erving Goffman (1963) described three different types of stigma, firstly there are the physical deformities occurring in individuals through accident or birth deformities, secondly there are the perceived blemishes of an individual’s character such as weakness, domineering, treacherous or dishonesty deduced from a person’s background such as a history of mental
disorder, addiction, homosexuality or unemployment (Davis, 2006). Finally there is the stigma inferred through membership of a particular of race, nation, or religion inherited by all members of that group. Goffman proposed that is “all instances the same sociological features are found”, an individual who could easily integrate in social interactions among individuals or groups possesses unwelcome traits that becomes a focus for attention turning the people they meet away while masking an individual’s positive attributes in the process (Davis, 2006, p. 132).

Mental illness is one of the most stigmatized conditions in western society with mental illnesses sufferers stereotyped as unpredictable and dangerous (Alexander & Link, 2003, p. 272). Stereotypes about mental illness are generally held beliefs which incorrectly label people, for example “the mentally ill are dangerous”, lacking in moral character and incapable of real work (Corrigan & Shapiro, 2010, p. 4). According to Corrigan and Watson (2002, p. 16) an individual experiences stigma along two dimensions, Public stigma and Self-stigma. Public stigma involves negative reactions the general public exhibits towards members of a group (Corrigan & Watson, 2002, p. 16). Public stigma about mental illness is widespread in the United States and many countries in the western world with stigmatising attitudes are not just limited to the uneducated members of the general public, even well-educated trained professionals from mental health disciplines subscribe to stereotypical views about mental illness (Corrigan & Watson (2002, p. 16). However stigma appears less evident in Asian and African countries whether there is a cultural dimension which does not emphasise stigma however due to a lack of research the exact reasons are unclear (Corrigan & Watson (2002, p. 16).

Self-stigma occurs where public stigma and prejudice are turned inwards by an individual with mental illness by accepting the stereotyped societal attitude (Corrigan & Shapiro, 2010, p. 4). According to van Zelst (2009, p. 295) stigma can lead to negative psychological outcomes for
the mentally ill including lower self-esteem diminished self-efficacy and the occurrence of more depressive symptoms.

A third dimension of stigma, Courtesy Stigma occurs where family members or close associates of a stigmatised person are negatively judged because of their relationship with the affected individual (Mueller, et al., 2012, p. 102; Birenbaum, A. 1970, p. 196). It’s not the person with a disorder that’s affected but their family and friends also experience the manifestation of stigmatising identity marks (Ljungberg & Bussing, 2009, p. 1177). For Mothers of children with ADHD stress induced by their child’s behaviour can leave them at an increased risk of depression, anxiety, and social isolation and feel stigmatized by their children's diagnosis (Norvilitis, Scime, & Lee, 2002, p. 61). Social isolation through mental illness deprives of life opportunities including employment opportunities preventing achievement of important personal goals in employment, housing and relationships. While societal anger may result in withholding of healthcare and other services causing greater distress acting as major barriers to recovery (Hatzenbuehler, Phelan, & Link, 2013, para. 6).

For those suffering with ADHD taking prescribed medication also has the potential to increase stigma. According to Childress (2016, p. 27), amphetamine-based psychostimulant methylphenidate are the standard pharmacological ADHD treatment for over 50 years and while highly effective in the majority of patients, concerns about abuse, tolerability and potential for addiction limit their use. Perceptions of an individual being under the control of a medication with the potential for addiction can illicit public, self and courtesy stigma with negative consequences for quality of life and self-esteem (Mueller, et al. 2012, p. 103).

1.6. Strategies to reduce stigma

The World Health Organisation (WHO) recognises stigma, as the “single most important barrier” facing those with mental health and behavioural problems with approximately 10% of
the World’s adult population experiences a mental health disorder at any one point in time (Datta, & Frewen, 2010, para. 1). The challenge from serious mental illness is daunting without the additional problems of managing societal stereotyping and prejudice resulting from public misconceptions towards mental illness (Corrigan, & Watson, 2002, p. 16). The UK Mental Health Foundation identified fear of discrimination as a major inhibitory factor for those in choosing to disclose a Mental Health issue to an employer with just 58% of respondents disclosing their condition within the previous 5 years (Mental Health Foundation U.K., 2016, p. 11). To address the widespread nature and impact of stigma researchers have proposed three key strategies for countering its negative effects, education, protest (Corrigan & Watson (2002, p. 17) and contact (Alexander & Link, 2003, p. 273).

Education is targeted at replacing misinformation and myths about mental illnesses within society. Holmes, Corrigan, Williams, Conor, and Kubiak (1999, p. 454) failed to show significance on the main effects of education among a group nursing students attending a pre-education course on Severe Mental Illness. Suggesting the impact of education may depend on the group adding that pre-education attitudes of nursing students differ from attitudes of the general public. The long term effect of stereotype prejudice offers another significant challenge to education as a single strategy due to consequences of a long history of activation, implying stereotypes and more accessible to the individual than are personal beliefs (Devine (1989, p. 6).

Protest is individual actions designed to challenge and suppress discriminatory attitudes in an attempts to diminish negative attitudes (Case Consulting Ltd, 2005, p. 6). Protest strategies are exhibited to highlight the injustices of stigma and admonish perpetrators for their stereotypical and discrimination behaviour. There is anecdotal evidence that suggests protest can counter the harmful influence of discriminatory behaviour (Corrigan & Shapiro, 2010, p.
4). However protest fails to promote the more positive attitudes towards mental illness suffers (Corrigan and Watson, 2002).

1.7. The Contact Hypothesis

In 1954 Gordon Allport hypothesised that interaction and interpersonal contact with different out-groups result in changed attitudes and beliefs resulting in lower levels of associated stigma (Hill Hackler, 2011, p. 1). The contact hypothesis is recognised as an important strategy in reducing stigma and the associated prejudice and discrimination with evidence suggesting informed individuals are less stigmatising than uninformed people (Corrigan & Watson, 2002, p. 17). Kane (1990, p. 172) suggests that experience with an “attitude object” is significant for changing even deeply-rooted and long-standing attitudes based on a lack of information and misconceptions. Retrospective studies on personal contact have revealed more positive emotional responses towards people with mental health issues and a desire for less social distance. Furthermore indirect contact through videos is also effective while enabling the targeting of large groups with minimal resources (Reinke, Corrigan, Leonhard, Lundin, & Kubiak, 2004, p. 378). However Corrigan and Shapiro (2010, p. 5) suggest not all contact is effective, suggesting that health service providers such as psychologists, psychiatrists, social workers, and nurses who have a great deal of contact with mental illness suffers are among the groups who hold the most stigmatising attitudes.

According to Driscoll, Heary, Hennessy and McKeague (2012) children and adolescents with mental health issues have problems with peer relationships suggesting that little is known about the nature of peer stigmatization. Furthermore, Kellison, Bussing, Bell and Garvan (2010) reported a desire for social distance and aversion among adolescents and college undergraduates towards peers with mental illnesses such as ADHD.
Peer groups by definition suggest a group of people with similar attributes and social status with which a person associates, implying contact as self-evident. Their population-based review suggests that research into mental health has focused on depression, schizophrenia, and bipolar disorder while other conditions such as ADHD have been under researched, raising questions as to the reliability of the contact as a strategy to reduce ADHD associated stigma.

Despite the prevalence of stigma among ADHD sufferers Kellison, et al. (2010, p. 2) reported the lack of specific assessment instruments to evaluate stigma associated with ADHD. Their study involved assessment and design of an ADHD Stigma Questionnaire (ASQ) adapted from an instrument originally designed to assess stigma associated with Human Immunodeficiency Virus (HIV) on three subscales, disclosure concerns, negative self-image and public perceptions towards affected persons. Their results support the ASQ as a satisfactory instrument demonstrating internal consistency, item selection and test-retest reliability (p. 8).

1.8. Rationale

Empirical research suggests that ADHD is a medical/neurobiological condition that may have lifelong consequences for affected individuals including the potential for stigma and discrimination. However conflicting evidence challenges the validity of ADHD as disorder. Fear of stigma and discrimination prevents people with mental illness from engaging in help-seeking behaviour which significantly impacts their mental well-being while denying them opportunities to achieve their life goals.

The present study investigates familiarity with and attitudes to mental illness to investigate perceived discriminatory attitudes through both quantitative and qualitative research methods. Firstly, Alexander and Link (2003) suggest contact is an effective strategy in reducing stigma therefore hypothesis 1 with examine whether contact with someone with a mental illness is reduces discriminatory attitudes. While hypothesis 2 explores whether
negative self-image predicts concerns with public disclosure for those suffering with ADHD. Secondly personal interviews with parents of children diagnosed with ADHD will investigate whether they perceive themselves or their children as stigmatised or discriminated against following their child’s diagnosis.

**Hypothesis 1:** There will be a significant between group’s difference among those who had personal contact and no contact with someone suffering from Mental Illness.

**Hypothesis 2:** Negative self-image is a significant predictor of an individual’s concerns with public disclosure of ADHD

**Research Question**

Do parents of children with ADHD perceive their children as being stigmatised by the general population and teaching professionals following diagnosis?

Do parents of children with ADHD perceive themselves as being stigmatised by the general population and teaching professionals following diagnosis?

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2. **Methodology**

2.1. **Participants:**
This quantitative study recruited a total of 201 participants (male, n= 40, female, n = 161) with a mean age of 41.3 years. Volunteers were sought from Dublin Business School Psychology students and the researcher’s network of contacts through Facebook, Linked-in and WhatsApp. Participants were also recruited through HADD’s website and electronic newsletter. Three participants were recruited for the qualitative study. The requirement for participation was having a child clinically diagnosed with ADHD while attending either primary or secondary level education A request for volunteers was made through HADD however no participants were successfully recruited The researcher directly approached parents who met the study requirements and asked them to participate.

2.2. Design

The study is a mixed methods design using both quantitative and qualitative analysis. The Quantitative study is Cross Sectional design through convenience snowball and purposeful sampling incorporating correlational analysis. The independent variable used to test the hypothesis 1, is “Do you know someone suffering with a Mental Illness” on the Perceived Devaluation Discrimination Scale, Dependent Variable (IV).

For the correlational design two factors within the ADHD stigma questionnaire, Negative Self Image, Predictor Variable (PV) and Disclosure Concerns, Criterion Variable (CV) were used to test hypothesis 2.

Qualitative semi-structured interview methods were used to explore parent’s perceptions of perceived stigma and discrimination following their child’s diagnosis among friends, family and teachers. Interviews were conducted in the participants’ home. Purposive sampling was employed to recruit parents who had a child clinically diagnosed with ADHD while they attended either primary or secondary level education. Interviews lasted between eight and nineteen minutes and were digitally recorded. Thematic analysis as explained by Braun &
Clarke, (2006) was used to highlight essential themes identified within the interview transcripts.

2.3. Materials

Online resources: Facebook, Linked-In, WhatsApp and Google forms.

Materials: Sony Laptop Computer software packages Microsoft Excel, SPSS and NVivo.

Equipment: The psychological instruments Perceived Devaluation Discrimination Scale (Link, 1987) and The 26 item ADHD Stigma Questionnaire (Kellison, Bussing, Bell, and Garvan, 2010).

Both scales were modified from a 4-point to a 5-point Likert scale with the addition of a neither agree nor disagree option. This option avoided the problem of individuals having to choose between agree or disagree if they held a neutral opinion on any question asked.

Discriminatory attitudes towards mental illness were measured using the 12 item Perceived Devaluation and Discrimination (See appendix 1) (Link, 1987). Participants were requested to tick the box that best reflects their opinion for each item in the scale. Scoring; Strongly Disagree, 0, Disagree, 1, Neither Agree or Disagree 2, Agree 3 Strongly Agree 4, Questions 1, 3, 7, 8 & 11 are reversed scored. Higher scores indicate higher levels of perceived stigma. The measure has good internal consistency with an alpha coefficient of .79 (Link, 1987, P. 1). Example of Question 1: “Most people would accept a person who has a mental illness”

Levels of stigma towards ADHD were measured using the 26 item ADHD Stigma Questionnaire with three Factor Subscales (See appendix 2) (Kellison, et al., 2010, p. 18) Disclosure Concerns (7 items): questions 3, 5, 13, 17, 18, 19 & 23

Negative Self Image (6 items): questions 1, 2, 6, 8, 9 & 11
Concern with Public Attitudes (13 items): questions 4, 7, 10, 12, 14, 15, 16, 20, 21, 22, 24, 25 & 26. Participants were requested to tick the box that best reflects their opinion for each item in the scale. Scoring; Strongly Disagree, 0, Disagree, 1, Neither Agree nor Disagree 2, Agree 3, Strongly Agree 4. The scale is scored by adding scores for each item in the scale. Higher scores indicate higher levels of stigma perception for each subscale and overall scale.

The 26 item measure has good internal consistency, two week test retest reliability .71 Disclosure Concern $\alpha$ 0.83; Negative Self Image $\alpha$ 0.81; Concern with Public Attitudes $\alpha$ 0.87; 26 items $\alpha$ 0.93 (Kellison, et al., 2010, p. 19)

Qualitative Study

Materials: Consent sheet (See Appendix 5), Information sheet (See Appendix 4) and Debrief sheet (See appendix 6). Semi structured questionnaire (See Appendix 3). The interview schedule contained a total of twelve questions with additional prompts used to clarify a question if a participant appeared confused to draw out the participant’s response. For example, Question 4 asked participants what are the perceived barriers to parents seeking help for their child and then prompted is it a fear of rejection, stigmatisation, looked down on or excluded.


2.4. Procedure

Quantitative data was collected through a specifically designed questionnaire (See appendix 10) and hosted using Google forms. A link to the study was posted on the researchers Facebook page inviting friends to participate and encouraging likes and sharing of the page. A
link was posted on LinkedIn to engage professional connections while the questionnaire link was also posted on two WhatsApp groups DBS Award stage part-time psychology students and private family groups. All social media platforms contained a brief message explaining the study with a link to the questionnaires asking contacts to share with their networks. The study was also supported by HADD, study details together with a link on their website and their weekly electronic mailshot (See appendix 8).

Following collection the data was downloaded to a .csv file format from Google forms, and imported into an Excel spreadsheet. The data was coded into the required format and uploaded directly into IBM's SPSS Statistics software for data analysis. Linear Regression and an Independent Samples t-Test were conducted within SPSS to test the research hypothesis.

Qualitative Study: All interviews were conducted in the participant’s home. Before commencement, the researcher reassured participants they were not obliged to participate or answer any questions which made them feel uncomfortable and they could end the interview at any time. Participants were given an information sheet and asked to sign a consent form giving permission for data were collected. On completion of the interview, each participant was given a debrief sheet which provided information on support services available if a participant felt any discomfort during or after the interview. Each interview was recorded on a Sony Voice recorder. Following the interview the data was transferred to a password protected computer transcribed into Microsoft Word and imported into NVivo 11 computer software for qualitative data analysis. Interviews were transcribed verbatim with names and personal information anonymised during transcription through assigning either “he” or “him” to anyone named during recording. The procedure used for data analysis is explained by Braun & Clarke, (2006) when identifying themes from a dataset. Following familiarisation with the data, an inductive approach was followed where the data would "speak for themselves" (Welsh, 2002, para. 4). The themes identified emerged directly from the data. Significant quotes were
highlighted and sorted into 107 initial codes with 157 references. Following initial coding further recoding produced 16 potential sub themes. All themes were reread to ensure the coded data was correctly placed. The subthemes were then grouped together to form three master themes.

2. 5. Ethical Considerations

The study was conducted in accordance with Dublin Business School’s ethical guidelines for research with human participants. Information and consent sheets were provided to all participants in advance of the online survey and the semi-structured interview (see appendices 4&5). Participants were informed they had the right to withdraw at any time and they did not have to respond to any questions asked during the personal interviews. A debrief sheet was provided to all participants following the surveys (see appendix 6).

Ethical approval for this study was obtained and research conducted

3. Quantitative Results

Descriptive and inferential statistics are outlined below. No significant result was reported for hypotheses one that contact with an individual with a mental illness reduces perceived discrimination when compared to someone who has no contact. However for hypotheses two, negative self-Image was found to significantly predict disclosure concerns about ADHD. The
results did reveal that opinions on what ADHD is vary between exposure levels to the disorder. A majority of respondents believe ADHD is a Behavioural Disorder, (Figure 1) however of the fifteen people who have ADHD ten describe it as Psychological Disorder/Mental illness with no one calling it a Behavioural Disorder (Table 3). Two participants did not know what ADHD is (Table 4).

3.1. Descriptive Statistics

A summary of the participant descriptive statistics are contained in Table 1 below. Of the total sample (n=201) 80% were Female and 20% male with a mean age of 41.3 years. Fifty one participants (25.4%) had suffered from a mental illness and 176 (87.6%) know someone with a mental disorder. ADHD is considered a behavioural disorder by 94 people (41%), a psychological disorder by 61 (30%) and a mental illness by 22 (11%), (Figure 1).

Table 1: Participant demographic profile

<table>
<thead>
<tr>
<th>Number</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>40</td>
<td>161</td>
<td>201</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>44.1</td>
<td>40.6</td>
<td>41.3</td>
</tr>
<tr>
<td>Min</td>
<td>20</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>Max</td>
<td>68</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>SD</td>
<td>12.80</td>
<td>10.70</td>
<td>11.20</td>
</tr>
<tr>
<td>Do you work in Healthcare</td>
<td>2</td>
<td>29</td>
<td>31</td>
</tr>
<tr>
<td>Suffered from a Mental illness</td>
<td>10</td>
<td>41</td>
<td>51</td>
</tr>
<tr>
<td>Know someone with a Mental Illness</td>
<td>34</td>
<td>142</td>
<td>176</td>
</tr>
</tbody>
</table>
Figure 1: What would you call ADHD?

Table 2 below contains descriptive statistics for those with direct exposure to ADHD.

22.9% of respondents live with someone with ADHD with 7.5% having ADHD with both groups representing 30.4% of the total sample.

Table 2: Participants direct exposure to ADHD

<table>
<thead>
<tr>
<th>Have ADHD</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>4</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Mean Age</td>
<td>39.5</td>
<td>39</td>
<td>39.3</td>
</tr>
<tr>
<td>What is ADHD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Psychological Condition</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Social Dysfunction</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Live with someone with ADHD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>4</td>
<td>42</td>
<td>46</td>
</tr>
<tr>
<td>Mean Age</td>
<td>52.3</td>
<td>45.6</td>
<td>46.4</td>
</tr>
<tr>
<td>What is ADHD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Psychological Condition</td>
<td>3</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>Behavioural Disorder</td>
<td>1</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Social Dysfunction</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Don't Know</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Descriptive statistics and reliability test results for the variables used are contained in Table 3 below. Results confirm good to high reliability for the three factors of the ADHD scale. However Shapiro Wilk test showed that Negative Self Image, $p = .026$, and Concerns with Public Attitudes, $p = .003$, data was not normally distributed, (See Figure 2 & 3). As there is no non-parametric test available for regression analysis, simple linear regression is used. Therefore results should be interpreted with caution. Shapiro Wilks test on Perceived Discrimination Devaluation was not significant $p = .582$ (See Figure 3), other normality tests revealed assumptions were not broken.

| Table 3: Variables Statistics and Reliability tests |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|
| Variables                       | Negative Self Image | Disclosure Concerns | ADHD Stigma Total | PDDS Total |
| Mean                            | 14.18            | 16.74            | 56.9             | 24.61        |
| Median                          | 14               | 17               | 58               | 25            |
| Max                             | 24               | 28               | 102              | 43            |
| Min                             | 1                | 0                | 5                | 4             |
| Variance                        | 21.39            | 5.05             | 299.89           | 55.48        |
| SD                              | 4.63             | 9.33             | 17.32            | 7.45          |
| Skewness                        | -.302            | -.641            | -.412            | -.030         |
| Kurtosis                        | .031             | .914             | .493             | -.335         |
| Cronbach $\alpha$               | .79              | .92              | .95              | .82           |

### 3.2. Inferential Statistics

An independent tTest was used to test hypothesis 1 that there will be a significant difference between those who know or don’t know a person suffering from a mental illness.

Participants who do not know someone suffering with a mental illness ($\text{mean} = 24.72, \text{SD} = 7.53$) were not found to have higher levels of Perceived Discrimination than those who know someone ($\text{mean} = 24.60, \text{SD} = 7.48$) ($t(199) = -0.77, p = .938$, [95% CI -3.27 and 3.02]). Therefore the null can be accepted.
Linear regression was used to test hypothesis 2 that Negative self-Image is a significant predictor of Disclosures Concerns. Using simple regression, it was found that Negative Self Image significantly predicted Disclosure Concerns \( F (1,199) = 236.81, p < .001, R^2 = .54 \) (Negative Self Image beta = .737, p < .001, CI (95%).702 -> .908).

Therefore the null hypothesis is rejected.

**Table 4**: Exposure to ADHD

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have ADHD</td>
<td>4</td>
<td>11</td>
<td>15</td>
<td>7.50%</td>
</tr>
<tr>
<td>I have observed, a person I believe may have had ADHD</td>
<td>9</td>
<td>20</td>
<td>29</td>
<td>14.40%</td>
</tr>
<tr>
<td>I have observed persons with ADHD on a frequent basis</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>4.50%</td>
</tr>
<tr>
<td>I have worked with a person who had ADHD at my place of employment</td>
<td>4</td>
<td>11</td>
<td>15</td>
<td>7.50%</td>
</tr>
<tr>
<td>I have never observed a person that I was aware had ADHD</td>
<td>3</td>
<td>11</td>
<td>14</td>
<td>7.00%</td>
</tr>
<tr>
<td>A friend of the family has ADHD</td>
<td>2</td>
<td>19</td>
<td>21</td>
<td>10.40%</td>
</tr>
<tr>
<td>I have a relative who has ADHD</td>
<td>4</td>
<td>22</td>
<td>26</td>
<td>12.90%</td>
</tr>
<tr>
<td>I have watched a documentary on the television about ADHD</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>3.50%</td>
</tr>
<tr>
<td>I live with a person who has ADHD</td>
<td>4</td>
<td>42</td>
<td>46</td>
<td>22.90%</td>
</tr>
<tr>
<td>I have watched a movie or television show in which a character depicted a person with ADHD</td>
<td>0</td>
<td>8</td>
<td>8</td>
<td>4.00%</td>
</tr>
<tr>
<td>My job involves providing services/treatment for persons with ADHD</td>
<td>2</td>
<td>7</td>
<td>9</td>
<td>4.50%</td>
</tr>
<tr>
<td>I don't know what ADHD is</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1.00%</td>
</tr>
<tr>
<td></td>
<td>40</td>
<td>161</td>
<td>201</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
Figure 2: Distribution of Negative Self Image

Figure 3: Distribution of Disclosure Concerns

Figure 4: Perceived Discrimination and Devaluation Scale
4. Qualitative Results

A theme model was developed to reflect a role of disclosure on help-seeking behaviour for those effected by ADHD (Figure 5: Disclosure Model) through three master themes and subthemes discovered through thematic analysis. Disclosure is defined as actions taken by someone to seek information and communicate to their communities in order to engage a network of coping supports. Participant 1 stated, “I had never heard of it (ADHD) either until “he” was diagnosed so I wouldn’t have known, apart from that, that there just hyper”. A common underlying theme underpinned the importance of information sharing, “Yeah, definitely, well you get the support as well I suppose yourself you know, you’re not just keeping it for yourself and you know and then you get a bit more understanding as well”. Another stated that they would encourage other parent to seek help “Yes, they need to or the child would just be ignored or left to fend from himself, there has to be help for them and understanding” (Participant 3). In addition parents want others to understand that it’s not the fault of the child or their parenting style, “they are not being bold, doing it on purpose, he’s not bold or he’s not, he’s just as I would call it an active kid, it’s not his fault” (Participant 2).

Figure 5: Disclosure Model.
4.1. Theme 1 Information.

While the research question asks specifically do parents or their children feel stigmatised following diagnosis with ADHD, concerns about disclosure did not raise any significant issues among the parent sample. On the contrary information parents had gathered through their experience appears to have an enabling impact providing an opportunity to explain their child’s behaviour as “a disorder” where the child “involuntary” behaviour is beyond the child’s control. Trying to understanding ways to help involves different approaches. They know something is wrong “Well I always knew that there was something exactly what it was I didn’t know”. Parents will try homeopathy remedies first “You know we went through the oil tablets to you know they were saying that it’s good for the brain”

Subtheme; Help-seeking emerged a sub-theme however it was tempered with concerns their child will be labelled, “I was thinking is that going to stop him now to, you know, to be a normal child, like because he is going to be labelled”, however this idea was discounted “I mean I don’t want to be thinking that way”. The behaviour of a hyperactive child is very difficult to hide in a public and help-seeking brings benefits to both parent and child. One parent suggested “rather than just thinking, oh look at him again or look at her again or you know, so then they’ll understand that’s why there doing it”.

Subtheme Advice emerged through 8 references. All participants would advise other parents not to hide a child’s condition. “You’re not just keeping it for yourself and you know and then you get a bit more understanding”, “Yes, Yeah Yes I would, it’s easier, it’s easier on everybody.” The desire to seek help and disclose comes for the parent’s need for others to understand the child’s is not responsible for their behaviour, “I felt was at least we have something to say well that’s what his behaviour is down to”, “There trouble makers but there not really there just can’t sit still” (Participant 2), “again it’s one of those things he’s doing that for a reason, he’s not doing because you know he wants to” (Participant 1).
4.2. Theme 2. What is ADHD?

The question of what is ADHD is presented through two sub-themes Mental Illness and a Behavioural Disorder. The concept that ADHD is a mental illness was disconcerting for some participants. Subtheme: Mental Illness. None of the parents considered their child to have a mental illness although during diagnosis the term “Mental Illness” was used, “then you went to see the psychologist they all used that term”. “I thought he was just you know a really hyper child I didn’t think it was an illness as you know, a mental illness, you know, it was a bit scary for me”. “Oh, I don’t think it’s mental, (pause) inability to focus”. When asked, “would your family use the term Mental Illness” one parent said “No, don’t think so, no”, “overactive person, that’s what they would call it, yeah, overactive, yeah”. Responding to the same question another parent said “Possibly, yeah I would say they would yes”. One participant said she didn’t know what her family would call it “I wouldn’t imagine so Ummmhh, I don’t know really (laugh) you see I don’t, I don’t really use it” further adding “I don’t think many people know what exactly, like I never heard of it before”.

Subtheme: Behavioural Disorder emerged as how parents would explain ADHD to others. Again a consistent patter emerged from through all participant responses. “Hmm hyper a hyper and his head, if someone had their head is buzzing all the time, hmm, they can’t sit still” “Fidgeting all the time, that’s what I would call it”, parent 2 “I wouldn’t have known, apart from that that there just hyper there you know they can’t Ummmhh sit down still”, parent 1, “An inability to sit still, to concentrate, just jittery all the time, hard to focus” parent 3. No consistent explanation emerged suggested people don’t understand what ADHD is “people aren’t really educated in what it actually is”, another participant said “some people think it’s just bad behaviour”. While participant three said, “I don’t know the words you would put into it, how it would be described, hormonal, mental, well it’s definitely behavioural, what causes the behaviour”
4.3. Theme 3 Support Network.

Three Subthemes emerged around the support community, Family and Friends, Teachers and Schools. There was evidence among participants of non-stigmatising support provided through family and friends however opinions differed regarding support from Teachers and Schools which correlated with whether the child attended primary or secondary education.

Subtheme: Family and Friends revealed strong support for both parents and child among friends and family revealing the importance of their child’s long term friends in understanding and support them “yes there would be they would have known that person all their lives or as long as the friends would, so yes I think there would be more understanding for them” further adding “His friends were fine, I would say they accepted him without any difference; family would have been the same”. The other parents shared similar experiences “he still have the same I mean good few friends from no but there has never been any problems there2, ”Well in school it was great, friends Ummmhh, his friends and their mothers and fathers were ”

Subtheme: Teachers. ADHD can exist with other comorbid conditions including dyslexia suggesting support teachers have the skills to identify other conditions. One participant explained their child was already receiving support for dyslexia in primary school and described how a support teacher suggested they should have their child tested for ADHD, “because he has Ummmhh dyslexia as well, so he was with the support teacher”, “then he was saying to me you know that maybe you should go through this and that what do you feel about this so that’s how we started”. Primary school teachers emerged as very supportive in dealing with the disruptive behaviours of ADHD, “at the moment he seems really like the teacher was telling me that I mean, that he’s great and he puts his hand up for everything he’s not shy he’s you know”
One parent explained that her child was diagnosed in secondary school, when asked what support their child received she said “No, not really, no I don’t remember getting any extra support because of it”, further adding that it “really would depend on the teacher but I would say most teachers would support if they had the resources to support then yes they definitely would”.

Subtheme: Schools. The difference in support levels between primary and secondary school emerged as subtheme. While primary schools appear to be equipped to manage learning and behavioural disorders secondary schools emerged as lacking any identified support structures. Participant two explained the positive experience of primary school as “Well in school it was great” outlining the schools response following diagnosis “the school have been really good, like all the support teachers he had and everything through the years have been really, really good”. Secondary education appears as less personal and supportive of the needs of the individual, “well the amount of children they have in the class they can’t specifically give attention to one child over another child”. The feelings of frustration that the absence of support can lead to isolation for the child was articulated through the following comments “Yes, they need to or the child would just be ignored or left to fend from himself, there has to be help for them and understanding”. With proper resourcing and specialised educational programmes there could be long term and life changing benefits for a child with learning difficulties “could have a few children with special needs in the class so they need resources” “there may be an aid or somebody to help them out and pinpoint them or, a program for that child or children”.
5. Discussion

This study investigated the impact of familiarity on stigmatising attitudes towards those suffering with mental health problems. In doing so, it also examined people understanding of ADHD and the role of contact with a person suffering with a mental disorder in reducing stigmatising attitudes and discriminatory behaviour. The result found no significant difference between those who know someone with a mental illness and those who don’t (p = .938) therefore not supporting previous findings into contact as a stigma reducing strategy (Link & Cullen, 1986). A significant relationship was found between negative self-image and disclosure concerns p < .001. Beta values show that for every 1 point increase in negative self-image disclosure concerns increase by .737. These finding supports research that negative self-image influences perception of how other will view them. Seeing oneself as a target of discrimination is likely to affect individual identity formation significantly impact satisfaction with life (Brown, & Bigler, (2005, p. 533). Thematic analysis did not uncover any disclosure concerns among parents who engaged in help-seeking behaviour. In contrast parents were happy their protracted information search provided answers to explain their child’s behaviour offering reassurance that the challenging behaviour was not an intentional act by the child. This gives parents the confidence to disclose the condition to family friends and teachers.

ADHD is a problematic condition to diagnose due to the lack of consistent definitions through continually changing conceptions of the disorder (Jenson, Martin & Cantwell, 1996). This regularly leaves parents in a sort of information vacuum resulting in continual searching from differing information sources for an explanation, including trial and error approaches with homeopathic remedies. In Ireland typically people must first visit their local GP before a referral to a clinician for assessment. Even then not all clinician’s accept ADHD as a valid disorder, acceptance is important for a satisfactory diagnosed (Spencer, et al., 1994). Data from this study found almost half of all participants (n=94) consider ADHD to a “Behavioural
“Disorder” with just 22 participants using the term “Mental Illness” (see Figure 1). A further 61 participants used the term “Psychological Disorder” to describe the condition which poses a question, how an individual perceives the differences between a Mental and Psychological disorder? Furthermore none of the qualitative study participant’s use the term “Mental Illness” to describe their child’s condition preferring instead to use expressions of “over active child”, “hypert”, or “can’t sit still” to describe the behaviours. A limitation of the present study involving the data collection method prevented separate analysis from members of HADD and the snowball sample of the population. However responses from 15 participants with ADHD reveal inconsistencies with other respondents. Interestingly the term “Behavioural Disorder” was not used by any of these participants, the majority calling it either a “Psychological disorder” (8) or a Mental Illness (2), (see table 2). While this may confirm those suffering with ADHD view the condition as a valid mental disorder it does not explain why the majority of respondents describe the disorder as “behavioural”. This could reflect some general view of ADHD as a set of disruptive behaviours rather than a singular mental Illness.

The general population may not be familiar with the ICD-10 classifications of a mental illness however the Oxford English dictionary defines “psychological” as “arising in the mind; related to the mental and emotional state of a person” (Oxford English Dictionary, 2108), therefore a psychological disorder is a mental disorder. Anastasiou and Kauffman, (2013) suggest that people struggling with disabling conditions will experience the greatest benefit by recognising both the biological and the social dimensions of their condition. Modified labelling theory proposes that individuals develop negative conceptions of what it means to be a mental patient. This can result in stigmatising attitudes towards a patient when they enter treatment particularly for the first time (Link, Struening, Dohrenwend, Cullen, & Shrout, 1989, p. 419). Therefore it could be argued that labelling a condition includes a social dimension, calling a disorder “Behavioural” or “Psychological” could appear less stigmatising than “Mental Illness”
within society. Parents of ADHD affected children don’t use the term mental illness, one parent in particular found the term “scary”. This may suggest that the stereotypical idea of a person with a mental illness as “deranged and dangerous” may be embedded within society. This study found that disclosure concerns were a secondary consideration for parent’s decisions to engage in help-seeking behaviour. Their child’s hyperactivity is highly conspicuous affecting all aspects of the parent child relationship. A concern that others may perceive the child as bold while also questioning the integratory of their parenting style is at stake. Diagnosis and disclosure provides an explanation for their child’s behaviour described in Theme 1 “it’s not their fault”, “there’re not bold”. Future studies could investigate the perceptions of labelling ADHD as a “mental illness” and whether it impacts on help-seeking behaviours. Furthermore investigation is needed into a less conspicuous ADHD subtype “inattention”, the quiet child who looks out the window in class failing to engage with peers and class activity.

ADHD incorporates three different subtypes “attention deficit” “impulsivity” and “hyperactivity”. In a teaching environment hyperactivity is not difficult to recognise, the child who won’t sit still, always moving around. HADD recommend that teachers need to provide structure within the classroom and customise the learning experience into small interesting tasks (HADD, 2018, para. 2). At present, there is no mandatory training required for teachers working with students requiring Special Education Needs (SEN) in Ireland. The programme allocates special needs assistants to primary, post-primary and special schools to support students with an identified disability (National Council for Special Education, 2013, p. 16). While the Teaching Council guidelines for secondary school teaches focus on subject qualifications without any reference to special needs training (Teaching Council of Ireland, 2018). For students presenting with primarily “inattentive symptoms” there is an increased risk that teachers particularly in secondary education may mistake inattention for lack of interest. Adolescents with ADHD are more withdrawn and participate less in class, often reacting
impulsively to school tasks and homework (U.S. Department of Education, 2008, p. 1). According to Jussim, Eccles and Madon (1996, p. 282) teachers use stereotypes when developing their expectations for students particularly within stigmatised groups, and because of these inaccurate expectations they are also more likely to become a self-fulfilling prophecy.

The present study found differences in support levels between Primary and Secondary school. In primary school a child will generally have just one teacher for the school year. The single classroom structure facilitates monitoring of individual children enabling teachers to manage the environment more closely providing feedback to parents.

For a child entering secondary school the environment is radically altered with multiple subjects in different classrooms. Inattentive children may successfully negotiate primary school without many significant challenges however in secondary school they tend to disappear into the whole school structure and are often overlooked. In fact parents and teachers may not even notice that he or she has ADHD (Reynolds, 2013, para. 3). Mayes, Calhoun & Crowell (2000, p. 419) found one or more types of learning disabilities in 69.8% of participants in a study of 119 children with ADHD with ages ranging from 8 to 16 years. Further research could investigate firstly how the secondary school programme in Ireland identifies adolescent children with ADHD and its subtypes and secondly what strategies are in place to cater for the special learning requirements for this cohort. The Association of Secondary Teachers Ireland (ASTI) website provides guidelines for maximum class sizes for most subjects of 24 (ASTI, 2018, p. 1). Therefore given that a partial diagnosis of ADHD affects 6.6% of the population (Faraone, Biederman, & Mick, 2005, p. 384) a teacher could expect to have 1 to 2 students with ADHD in a classroom at any one time. Another hypothesis could investigate whether teachers do in fact have stereotypical expectations for their students. Limitations of this study include a lack of any verified data on school resourcing for the selected sample and population validity of the sample size used within the research methods.
Contact is a widely accepted strategy in reducing stigmatising attitudes towards those suffering with mental illness. Couture & Penn (2003) identified limitations to research in that important factors for attitudinal change are not considered within a contact situation. Furthermore they found several studies that don’t support “contact” in reducing stigma in employment settings (p. 296). Results into the contact hypothesis did not find any significant difference between contact and no contact groups within this study. This may be partly explained through the participant’s dynamics, 176 participants knew someone with a mental illness while 52 have suffered with a mental illness themselves. Pettigrew & Tropp (2006, p 766) found compelling evidence that intergroup contact reduces intergroup prejudice, however an increase in knowledge does not necessarily improve discriminatory attitudes or behaviour towards individual’s people with mental illness (Thornicrof, Rose, Kassam & Sartorius, 2007). Satisfactory peer relationships are an important part of a child’s socialisation however children with behavioural problems are more likely to be excluded from their peer group (Deater-Deckard, 2001). Children with psychological problems such as ADHD experience a double disadvantage firstly in their disorder and secondly the impact of exclusion from their peer group on normal socialisation (Hennessy, Swords & Heary, 2008). O’Driscoll, et al., (2012, p. 17) suggest that children stigmatising peers with ADHD more than depression which is influenced by the age and gender. While this study did not specifically investigate peer groups qualitative data did not reveal any stigma related problems with peers and friends of ADHD affected children either in primary or secondary school.

In conclusion, the investigation into familiarity with and attitudes to ADHD found no significant evidence that parents of children with ADHD or their children perceived any stigmatisation from teachers, family or friends following diagnosis. Furthermore investigation into the contact hypothesis found no significant results between contact and no contact groups, while perceptions about the description of what ADHD is varied across the different groups.
sampled. A limitation of the study is the small sample size used in qualitative analysis and not necessarily representative of the population. Furthermore quantitative data was only collected for gender and age, ethnicity was not considered with the study’s methodology. A second limitation is participants were almost 80% female with the mean age of the sample 41.3 years. According to the Central Statistics Office census data for 2017, 50% of the population are male with 34% of the population under the age of 25 years of age and a further 29% between the ages of 25 and 44 years of age (CSO, 2017). Finally the data collection method did not segment responses between the snowball and purposeful samples. Both samples were compiled within a single online tool. Separate samples would have facilitated between group comparisons on what ADHD is while also allowing for between group differences to be analysed on the two psychological instruments employed within the study.

References


Reynolds, L. (2013). Teaching Children With ADHD: Classroom Strategies To

Coghill, D. (2015). The Efficacy of Atomoxetine for the Treatment of Children and
Adolescents with Attention-Deficit/Hyperactivity Disorder: A Comprehensive Review of
Over a Decade of Clinical Research. CNS Drugs 29, 131–151, DOI 10.1007/s40263-014-
0224-9

Hyperactivity Disorder in Adults a Valid Disorder? Harvard Review of Psychiatry, 1 (6),
326-335. http://dx.doi.org/10.3109/10673229409017099

Thome, J., Ehlis, A. Fallgatter, A. J., Krauel, K., Lange, K. W., Riederer, P., Romanos,
M., Taurines, R., Tucha, O., Uzbekov, M., & Manfred, G. (2012). Biomarkers for attention-
deficit/hyperactivity disorder (ADHD). A consensus report of the WFSBP task force on
biological markers and the World Federation of ADHD. The World Journal of Biological

DOI:10.1192/bjp.bp.106.025791


## Appendices

**Appendix 1**
### Perceived Devaluation Discrimination Scale including percentage distribution of scoring

<table>
<thead>
<tr>
<th>Perceived Devaluation Discrimination Scale (Link, 1987)</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or Disagree</th>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Most people would accept a person who has a mental illness as a close friend. (R)</td>
<td>8.5%</td>
<td>35.3%</td>
<td>19.9%</td>
<td>27.4%</td>
<td>9.0%</td>
</tr>
<tr>
<td>2. Most people believe that someone who has a mental illness is dangerous.</td>
<td>14.4%</td>
<td>42.3%</td>
<td>15.9%</td>
<td>25.9%</td>
<td>1.5%</td>
</tr>
<tr>
<td>3. Most people believe that a person with a mental illness is just as trustworthy as the average citizen. (R)</td>
<td>3.5%</td>
<td>27.9%</td>
<td>23.9%</td>
<td>36.3%</td>
<td>8.5%</td>
</tr>
<tr>
<td>4. Most people would accept a person who has fully recovered from mental illness as a teacher of young children in a public school. (R)</td>
<td>3.5%</td>
<td>25.4%</td>
<td>23.4%</td>
<td>39.3%</td>
<td>8.5%</td>
</tr>
<tr>
<td>5. Most employers will not hire a person who has been hospitalised for mental illness</td>
<td>5.0%</td>
<td>32.8%</td>
<td>23.9%</td>
<td>32.3%</td>
<td>6.0%</td>
</tr>
<tr>
<td>6. Most people think less of a person after he/she has been diagnosed with a mental illness.</td>
<td>7.0%</td>
<td>30.8%</td>
<td>25.9%</td>
<td>29.4%</td>
<td>7.0%</td>
</tr>
<tr>
<td>7. Most people would be willing to marry someone who has been diagnosed with a mental illness. (R)</td>
<td>5.0%</td>
<td>22.9%</td>
<td>34.8%</td>
<td>29.4%</td>
<td>8.0%</td>
</tr>
<tr>
<td>8. Most employers will hire a person who has been diagnosed with a mental illness if he or she is qualified for the job. (R)</td>
<td>4.5%</td>
<td>27.4%</td>
<td>28.4%</td>
<td>33.3%</td>
<td>6.5%</td>
</tr>
<tr>
<td>9. Most people believe that entering a psychiatric hospital is a sign of personal failure.</td>
<td>19.9%</td>
<td>22.4%</td>
<td>22.4%</td>
<td>31.3%</td>
<td>4.0%</td>
</tr>
<tr>
<td>10. Most people will not hire a person who has been diagnosed with a serious mental illness to take care of their children, even if he or she had been well for some time.</td>
<td>6.5%</td>
<td>13.4%</td>
<td>20.9%</td>
<td>40.3%</td>
<td>18.9%</td>
</tr>
<tr>
<td>11. Most people in my community would treat a person who has been diagnosed with a mental illness just as they would treat anyone. (R)</td>
<td>6.5%</td>
<td>29.9%</td>
<td>25.4%</td>
<td>31.8%</td>
<td>6.5%</td>
</tr>
<tr>
<td>12. Most young people would be reluctant to date someone who has a serious mental illness.</td>
<td>7.0%</td>
<td>19.9%</td>
<td>30.3%</td>
<td>36.8%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

---

### Appendix 2

**ADHD Questionnaire including percentage distribution of scoring**
<table>
<thead>
<tr>
<th>ADHD Stigma Questionnaire</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree or Disagree</th>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kellisona, Bussinga, Bella, &amp; Garvanb, (2010)</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neither Agree or Disagree</td>
<td>Strongly Agree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>1. People who have ADHD feel guilty about it.</td>
<td>6.4%</td>
<td>22.3%</td>
<td>43.1%</td>
<td>20.8%</td>
<td>7.4%</td>
</tr>
<tr>
<td>2. People’s attitudes about ADHD may make persons with ADHD feel worse about themselves.</td>
<td>2.0%</td>
<td>9.4%</td>
<td>9.4%</td>
<td>58.4%</td>
<td>20.8%</td>
</tr>
<tr>
<td>3. Someone who has ADHD would think it’s risky to tell others about it.</td>
<td>2.5%</td>
<td>12.4%</td>
<td>21.3%</td>
<td>50.0%</td>
<td>13.8%</td>
</tr>
<tr>
<td>4. People with ADHD lose their jobs when their employers find out.</td>
<td>14.8%</td>
<td>33.2%</td>
<td>43.6%</td>
<td>6.4%</td>
<td>2.0%</td>
</tr>
<tr>
<td>5. People with ADHD work hard to keep it a secret.</td>
<td>4.5%</td>
<td>15.8%</td>
<td>39.6%</td>
<td>30.2%</td>
<td>9.9%</td>
</tr>
<tr>
<td>6. Someone with ADHD feel they aren’t as good a person as others because they have ADHD.</td>
<td>5.4%</td>
<td>17.8%</td>
<td>31.2%</td>
<td>34.2%</td>
<td>11.4%</td>
</tr>
<tr>
<td>7. People with ADHD are treated like outcasts.</td>
<td>11.4%</td>
<td>34.2%</td>
<td>33.2%</td>
<td>15.3%</td>
<td>5.9%</td>
</tr>
<tr>
<td>8. People with ADHD feel damaged because of it.</td>
<td>3.5%</td>
<td>14.9%</td>
<td>32.7%</td>
<td>38.6%</td>
<td>10.4%</td>
</tr>
<tr>
<td>9. After learning they have ADHD, a person may feel set apart and isolated from the rest of the world.</td>
<td>4.0%</td>
<td>8.9%</td>
<td>20.3%</td>
<td>53.5%</td>
<td>13.3%</td>
</tr>
<tr>
<td>10. Most people think that a person with ADHD is damaged.</td>
<td>4.5%</td>
<td>27.2%</td>
<td>30.7%</td>
<td>29.7%</td>
<td>7.9%</td>
</tr>
<tr>
<td>11. A person with ADHD feels that they are bad because of it.</td>
<td>4.5%</td>
<td>25.7%</td>
<td>39.1%</td>
<td>21.8%</td>
<td>8.9%</td>
</tr>
<tr>
<td>12. Most people with ADHD are rejected when others find out.</td>
<td>9.8%</td>
<td>41.1%</td>
<td>32.7%</td>
<td>13.9%</td>
<td>2.5%</td>
</tr>
<tr>
<td>13. People who have ADHD are very careful about who they tell.</td>
<td>3.5%</td>
<td>11.8%</td>
<td>26.7%</td>
<td>44.1%</td>
<td>13.9%</td>
</tr>
<tr>
<td>14. Some people who learn of another person having ADHD grow distant.</td>
<td>5.9%</td>
<td>21.8%</td>
<td>40.6%</td>
<td>24.8%</td>
<td>6.9%</td>
</tr>
<tr>
<td>15. After learning they have ADHD, people worry about others discriminating against them.</td>
<td>3.0%</td>
<td>9.9%</td>
<td>25.2%</td>
<td>52.5%</td>
<td>9.4%</td>
</tr>
<tr>
<td>16. Most people are uncomfortable around someone with ADHD.</td>
<td>7.4%</td>
<td>30.2%</td>
<td>34.2%</td>
<td>24.8%</td>
<td>3.5%</td>
</tr>
<tr>
<td>17. People with ADHD worry that others may judge them when they learn that they have ADHD.</td>
<td>3.0%</td>
<td>11.4%</td>
<td>19.8%</td>
<td>52.5%</td>
<td>13.3%</td>
</tr>
<tr>
<td>18. People with ADHD regret having told some people that they have ADHD.</td>
<td>3.5%</td>
<td>12.9%</td>
<td>40.1%</td>
<td>34.2%</td>
<td>9.3%</td>
</tr>
<tr>
<td>19. As a rule, People with ADHD feel that telling others that they have ADHD was a mistake.</td>
<td>3.5%</td>
<td>19.8%</td>
<td>46.0%</td>
<td>26.2%</td>
<td>4.5%</td>
</tr>
<tr>
<td>20. People don’t want someone with ADHD around their children once they know that person has ADHD</td>
<td>10.4%</td>
<td>30.2%</td>
<td>36.1%</td>
<td>20.3%</td>
<td>3.0%</td>
</tr>
<tr>
<td>21. Some people act as though it’s the person’s fault that they have ADHD.</td>
<td>10.4%</td>
<td>18.3%</td>
<td>24.3%</td>
<td>34.2%</td>
<td>12.8%</td>
</tr>
<tr>
<td>22. People with ADHD have lost friends by telling them they have ADHD.</td>
<td>5.9%</td>
<td>17.8%</td>
<td>44.6%</td>
<td>27.7%</td>
<td>4.0%</td>
</tr>
</tbody>
</table>
23. People with ADHD have told others close to them to keep the fact that they have ADHD a secret. | 4.0% | 11.4% | 36.1% | 37.6% | 10.9%
---
24. The good points of people with ADHD tend to be ignored. | 4.5% | 15.3% | 14.9% | 40.6% | 24.7%
---
25. People seem afraid of a person with ADHD once they learn they have ADHD. | 8.9% | 29.7% | 30.2% | 26.2% | 5.0%
---
26. When people learn that someone has ADHD, they look for flaws in their character. | 8.9% | 15.3% | 27.7% | 33.7% | 14.4%

**Appendix 3**

**Research Questions**, “Do parents of children with ADHD perceive themselves as being stigmatized by the general population and teaching professionals following diagnosis?”

"Do parents of children with ADHD perceive their children as being stigmatized by the general population and teaching professionals following diagnosis?"

**Interview schedule**

Q1. How would you describe ADHD to someone who never heard of the condition?

Q2. If I asked your friends/family to explain what ADHD is to someone who had never heard it, what do you think they would say?

Q3. Do your friends and family use the term “mental illness” to describe ADHD?

Q4. What are the perceived barriers to parents seeking help for their child?

Q5. When your child was first diagnosed with ADHD how was it delivered? How did you feel about it? And did you wait a while before you told your friends?

Q6. Did you wait a while before you told your friends and family?

Q7. Did you tell the school year head/principal and how confident were you that your child would get the support they needed from the teachers and their class mates?

Q8. What did your friends think when you told them?

Q9. How would rate this statement: Overall the support my child received from their friends extended family and school teachers while excellent while dealing with ADHD and greatly helped in their education and personal development
Q10. Would you encourage your child to disclose their diagnosis to future employers?

Q11. Would you encourage your child to disclose their diagnosis if applying to further or higher education/ training courses

Q12. From your experiences, if you were asked for advice, would you encourage other parents to disclose their child’s ADHD to friends, family and teachers

Appendix 4

Investigating familiarity with and attitudes to Attention Deficit/Hyperactivity Disorder

My name is David McDonagh and I am conducting research in the Department of Psychology that explores attitudes and stigma towards those suffering with Attention Deficit/Hyperactivity Disorder. This research is being conducted as part of my studies and will be submitted for examination.

You have been asked to participate because you are a parent of an Adolescent/Child diagnosed with ADHD. Participation is completely voluntary and so you are not obliged to take part. While the survey asks some questions that might cause some minor negative feelings, this method is used widely in research. If any of the questions raise difficult feelings you have the right to decline to answer. Contact information for support services will be provided at the end of the interview.

Participation is confidential however your responses will be recorded using an Audio Voice recorder with the potential to attribute comments to any one participant. For this reason, dissemination of the Audio recorder data will not be conducted. Recorded data will be used for transcription purposes only with written transcriptions stored without any personal identification.

It is anticipated that transcription will take place 7 days after recording and you have the right to withdraw your responses any time within this 7 day period. The questionnaires data will be stored securely in electronic format on a password
protected computer and retained for 12 months.

Should you require any further information about the research, please contact Dave McDonagh via email [REDACTED] or Phone [REDACTED].

Thank you for taking the time to participate in the study.

Appendix 5

Consent Form

Investigating familiarity with and attitudes to Attention Deficit/Hyperactivity Disorder

I have read and understood the attached Information Leaflet regarding this study. I have had the opportunity to ask questions and discuss the study with the researcher and I have received satisfactory answers to all my questions. I understand that I am free to withdraw from the study at any time without giving a reason and I agree to take part in the study.

I understand that any discussions which take place during focus group meetings including responses from other individuals are confidential and agree not to disclose any information outside the focus group interview.

Participant’s Signature: ______________________________ Date: _________

Participant’s Name (Print): ______________________________

Researcher Name (Print): ______________________________

Researcher’s Signature: ______________________________ Date: _________

Appendix 6
Debrief Sheet

Thank you for taking the time to participate in this study. If any issues emerged as a result of completing this questionnaire, below are contact details of support groups which can help.

AWARE: 01 661 7211, www.aware.ie

The Samaritans 24-hour helpline 116123, www.samaritans.org

ADHD Society of Ireland Phone 01 8748349, www.hadd.ie

Appendix 7

ADHD Rating Scale-IV: Home Version

Child’s Name:_______________________ Sex: ■ M ■ F Age:______ Grade:______

Completed by: ■ Mother ■ Father ■ Guardian ■ Grandparent

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Never or Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Fails to give close attention to details or makes careless mistakes in schoolwork.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Fidgets with hands or feet or squirms in seat.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Has difficulty sustaining attention in tasks or play activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Leaves seat in classroom or in other situations in which remaining seated is expected.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>Does not seem to listen when spoken to directly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Runs about or climbs excessively in situations in which it is inappropriate.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>Does not follow through on instructions and fails to finish work.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Has difficulty playing or engaging in leisure activities quietly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Has difficulty organizing tasks and activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Is “on the go” or acts as if “driven by a motor.”</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Avoids tasks (eg, schoolwork, homework) that require sustained mental effort.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Talks excessively.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13</td>
<td>Loses things necessary for tasks or activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14</td>
<td>Blurs out answers before questions have been completed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15</td>
<td>Is easily distracted.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16</td>
<td>Has difficulty awaiting turn.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17</td>
<td>Is forgetful in daily activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18</td>
<td>Interrupts or intrudes on others.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

How to score: A diagnosis of ADHD depends on the type and number of symptoms your child is having and how those symptoms are affecting him or her. This screening tool is scored by a healthcare provider and is used in the process of making a diagnosis. The tables on the back of this screening tool are for use by your child’s healthcare provider. If you feel that your child may be showing signs of ADHD please complete this questionnaire and share the results with your healthcare provider.

### Appendix 8

HADD Ireland info@hadd.ie via vzcloic64owu0ipg.xk9cyrw.2-z6xeae.eu7.bnc.salesforce.com

12/12/2017

### Parents Support Group

Our next Parents Support Group is scheduled for the 19th Dec 7.00pm -9.00pm here in the Carmichael Centre. We have a special Christmas treat for you in that Dr Kate Carr Fanning (Board member HADD-ADHD Ireland), will be giving a presentation on ADHD and an introduction to a strengths based approach (if you have already seen Kate at our seminar in September, you will know this is not to be missed!). Mince pies will also be provided! We very much you hope can make it along, if you would like to register your interest for this event please email info@hadd.ie or call the office on01-874 8349. We look forward to hearing from you.

### Adults Support Group

The next meeting of the Adult Support Group will take place on the 4th January 7.00pm – 9.00pm here in the Carmichael Centre. Cormac Lynch is going to come along and give a talk on Mindfulness (Cormac recently ran our mindfulness course for parents, so we know he is very good!).
We very much you hope can make it along, if you would like to register your interest for this event please email info@hadd.ie or call the office on 01-874 8349. We look forward to hearing from you.

Research Call
As part of his 3rd level studies Dave McDonagh is conducting a survey on ‘Investigating familiarity with and attitudes to Attention Deficit/Hyperactivity Disorder’ this is a short survey that will take you 10 minutes, if you would like to take the survey please click on the link below:
https://goo.gl/forms/1qsE1uq4q8d6PnWt2

Appendix 9

Participant 1

Interview time 18 minutes 10 seconds

Researcher How would you describe ADHD to someone who never heard of the condition?
Participant Like Ummmhh, I had never heard of it either until you know “?????” was diagnosed with it so I wouldn’t have known, apart from that that there just hyper there you know they can’t Ummmhh sit down still but that’s my own you know, that I suppose, they don’t (pause) they don’t want to do things like that but they don’t think and they (pause) But (just hyperactive) Yeah, Yeah (it’s not their fault) no well exactly, there not, that’s when people ask me you know, like oh and I suppose and that’s why I always explain but he doesn’t want to do that or he doesn’t want to say that it’s just the way that obviously he is, you know but I wouldn’t imagine that it’s just people trying to do it on purpose it’s just the way that their mind works and how, you know. Like I know on “????”, you know most of the time where he doesn’t think and he will be I didn’t mean to say that but it’s just a quick, you know (reaction) yeah exactly, you know.

Researcher If I asked your friends/family to explain what ADHD is to someone who had never heard it, what do you think they would say?
Participant I say the same, like I don’t; I don’t think many people know what exactly, like I never heard of it before like you heard of the mental illness depression this, but you know I though he was just you know a really hyper child I didn’t think it was an illness as you know a mental illness you know it was a bit scary for me to even bring him to a psychologist and all that because I was thinking like when you look at him there is nothing really wrong with him as, but obviously there is just that way, that you know that he really hyper and he can’t stay still and he’s you know, but I wouldn’t thing, I have never imagined that it was just, that there putting it as a mental illness, and I don’t a, I don’t know, I don’t think, like my sister now she is checking her son because its only by talking to me and going through it, like I think it’s the same thing so there going through but again she had never heard of it (this is in Spain) yeah, yeah
Researcher: *Do your friends and family use the term “mental illness” to describe ADHD?*

Participant: Ummmhh, I wouldn’t imagine so Ummmhh, I don’t know really (laugh) you see I don’t I don’t really use it it’s just like you know, I know when you know when we went through everything all the papers all the paper work and we then you went to see the psychologist they all used that term but I have never you know think that there was, you know (you would that term) no, no (What term do you think your friends and family would use to describe it?) just hyper you know hyper (activity) yeah, yeah.

Researcher: *What are the perceived barriers to parents seeking help for their child?*

Participant: Like put him in Ummmhh, (pausing) (Like in terms of the fear of rejection, stigmatisation maybe they could be looked down on or they could be excluded) Well yeah I suppose I thought that at the beginning going when we were going through the whole thing I was thinking is that going to stop him now to, you know, to be a normal child, like because he is going to be labelled to, he has this and he has to be, but I suppose, you know, he is growing you can see the difference now in a years’ time that he is, so no, I mean I don’t want to be thinking that way I don’t want to thing that is going to be treated differently or people are going to be looking at him, you know in a different way because he is just like I say I wouldn’t even use the term mental illness, I just, I just have always though he is hyper you know that’s the way that I see it, you no he’s just hyper You know (so for you it was not a barrier to seek help) no absolutely, no and if anybody asked I would you know say he have been diagnosed with ADHD, you know, that’s the way he is you know like we have to learn to live with it everybody else has to, you know, but yeah but it was just for his own sake in the school because he was really hyper or whatever, that’s why we went through the whole you know, like it’s well he have to be looked at it I mean we went through maybe trying to use Ummmhh, you know we went through the oil tablets to you know they were saying that it’s good for the brain and we tried all the you know before we went into the actual medicine you know tablets and all that but look it didn’t work, didn’t work and that’s what we’re saying I didn’t want him to be on tablets but Ummmhh (sorry, before you tried the ADHD medication you tried different medication) yeah we tried the tablets like you know he had all these smoothies, they were like you know they were called cod Ummmhh, (Cod Liver Oil tablets) yeah and Ummmhh (vitamins tablets) yeah, yeah to see if they would calm him down a bit you know, and obviously you know the other thing came and I wasn’t too happy about it but anything that would help him to go through it and especially school, you know, we can only try and see.

Researcher: *When your child was first diagnosed with ADHD how was it delivered? How did you feel about it? And did you wait a while before you told your friends?*

Participant: Well I always knew that there was something exactly what is was I didn’t know but I knew you know Ummmhh so we had an idea so went through so many interviews and tests and all that Ummmhh and pretty much as we were going it was showing that it was going to happen so we were not surprised
when it came you know I know that there is a few degrees “???” is not on the high degrees but we pretty much knew that there was something there anyway you know by talking to the Psych because they did tests on him and they were telling us the points that they thought so you know, yeah (was it delivered as a kind of a mental illness or was it delivered as any term at the time other than ADHD?) No ADHD yeah, ADHD yeah

Researcher
Did you wait a while before you told your friends and family?
Participant
Well Ummhh, No, obviously my closest friends and family we told them straight away they knew we were going through the whole, you know, so you know, no pretty much straight away but for me it was that they could understand that if he ever did say anything, or did anything that they would understand that it wasn’t himself doing it, you know on purpose there was just that’s the way he is, that’s the way you know, so they wouldn’t think oh my goodness look at him, you know, you know just to, just to, well, that’s you know, Ummhh and then I was a bit like but I suppose that after talking to the teachers it became a bit more yeah if anybody ever I’d say yeah, I wouldn’t hide it you know.

Researcher
Did you tell the school year head/principal and how confident were you that your child would get the support they needed from the teachers and their class mates?
Participant
Do you see he had he was on support before we went through the whole thing, because he has Ummhh dyslexia as well, so he was with the support reading and all that before and then it’s basically by the teacher, the support teacher that we started to talk and then we was saying to me you know that maybe you should go through this and that what do you feel about this so that’s how we started now the school have been really good, like all the support teachers he had and everything through the years have been really, really good and I remember going through the paperwork and you know all the forms you have to sign and then you have to bring the same forms to school and they’ll have to do them as well, they were always really, really good up to now and every so often for camps we have to fill up the forms and we have ones and we have to bring one to school and they will fill it up as well you know, and they used to, no the school I mean the school is yeah so it was pretty much the school as well they were a bit you know (long pause)

Researcher
What did your friends think when you told them?
Participant
(Next question, you probably answered this already did you tell your friends) Yeah, yeah, (Researcher asks Question) No, nothing (speaking softly), well a friend of mine she said to me, she would be the one we would talk the most because her son, now he’s only starting now he’s only, Ummhh (pausing) he’s only 9 they are only starting to do everything but again she was always all through the years that something definitely you know, but they were telling her that he was too young yet to be diagnosed and all that so I was actually talking to her the other day and saying that he been admitted now and he is starting to, you know, so we would talk the most but no they all ah they all understand I suppose (they are all very good) yeah, yeah
Researcher: How would rate this statement: Overall the support my child received from their friends, extended family and school teachers while excellent while dealing with ADHD and greatly helped in their education and personal development

Participant: (How would rate that statement) Ummmhh well on my own, on my personal thing yes I think I mean I could you know relate to that, I mean they have been really good at Ummmhh I have never had anybody coming and saying oh you know your child is this or your child has, ah I never had any problems so far (you haven’t felt they were excluded in any way) No, no, you know see he still has, he still have the same I mean good few friends from no but there has never been any problems there and he will now say, but he doesn’t really know, I told him look don’t be telling anything about the, he will ask about the tablets, I don’t think he understands the whole thing of the tablets but all I said to him was there just helping you in the school to concentrate a bit more and you know ah, so I haven’t really, we haven’t really discussed it with him because I know of the meetings in camps they were saying have you explained to him and I said I don’t really want him to know cause I don’t see the big issue about it just yet and he’s too young to start to explain to him about all that because he doesn’t understand that I mean I am finding it hard to understand it myself most of the times when I go to the meetings and all that (he is 9 is he?) no he’s 11 (11) yeah so I think you know, keep it, you know, he knows he’s dyslexic and you know and he try to use that every so often but no I got to, you know I don’t know if it’s wrong or right but I just think as less that he knows at the moment about it, he takes the tablets yeah but that’s just for concentration like you used to take the oil when we used to give to you, you know a few years ago whatever, but I don’t, I don’t think he needs it yet to go through the whole, you know, (pause) no because I don’t want him to feel then that he’s different as well (yeah, yeah) that he has this and him thinking then at the moment he seems rally like the teacher was telling me that I mean, that he’s great and he puts his hand up for everything he’s not shy he’s you know, so that’s the way that I like him to be regardless he has that, you know that he doesn’t but yeah I don’t think he, at the moment no, maybe in a few years yeah, yeah, I don’t think he need to know it yet actually the whole extent of the whole thing, you know.

Researcher: Would you encourage your child to disclose their diagnosis to future employers?

Participant: Well I am hoping that he’ll grow out of it (laughing softly) Ummmhh well I suppose, I don’t know actually I never thought about it Ummmhh I was hoping that he’d go through it and he doesn’t have to explain too much about it, but it depends how, in a few years he feels himself ah, see again like the form we were filling today Ummmhh yeah, will they put it as a point and then he’ll probably won’t get the job because he has, so, I don’t know (laughs) I don’t know what Ummmhh I couldn’t tell you (pause) (he is 11 I suppose its long term) yeah I mean we have talked to the guys in camp they have said to us in a few years he will learn to live with that, that way so it will become more, you know, natural to him, you know so he’s not going to be thinking, I mean (pause) yeah I have never thought about what is going to happen in the future I’m just hoping that he goes along, you know (yeah)
Researcher Would you encourage your child to disclose their diagnosis if applying to further or higher education/training courses

Participant (Researcher the next question is very similar; Question) Well I suppose school wise and courses Yes, because I suppose that’s when they understand that OK, again it’s one of those things he’s doing that for a reason, he’s not doing because you know he wants to do it, that’s the way and (do you feel there is better supports in education for understanding, than there would be from an employer) yes, but you see an employer is a different thing, isn’t it, than college I mean they are just going to point to whoever they think that has the best, you know when education is where everybody is going to go through it and they will have to, you know (pause) (very true)

Researcher From your experiences, if you were asked for advice, would you encourage other parents to disclose their child’s ADHD to friends, family and teachers

Participant Yeah, definitely, well you get the support as well I suppose yourself you know, you’re not just keeping it for yourself and you know and then you get a bit more understanding as well of, if the little one does something or says something that’s wrong, you know that people understand OK you know that’s the way there thinking or you know rather than just thinking oh look at him again or look at her again or you know, so then they’ll understand that’s why there doing it, but then again does many people understand what ADHD you know what it is, but what, I don’t know you know so it depends on that person what, (long pause) (probably just the question is to understand from your experiences which seem to have been positive just disclosing early to friends and family not holding back seem to have helped you quite a lot) Yeah, yeah well it’s like everything else, isn’t it Ummmhh any other type of illness or whatever or depression this or that it’s nice for the family at least you know if you talk about it, like I don’t have any problem if “???” you know talks about it and whatever, I don’t have any problem him Ummmhh telling his closest friends or whatever you know so they can understand it a bit better about it as well you know I don’t it has to be, we better not say anything about just it in case they think this or you know.

Participant 2

Interview time 7 minutes 19 seconds

Researcher How would you describe ADHD to someone who never heard of the condition?

Participant Hmm hyper a hyper and his head if someone had their head is buzzing all the time, Hmm, they can’t sit still, and there, they seem to be in Hmm trouble all the time there not in trouble they just can’t sit still, fidgeting all the time, that’s what I would call it

Researcher If I asked your friends/family to explain what ADHD is to someone who had never heard it, what do you think they would say?
Participant: Hmm, overactive, he overactive and ah that’s probably what would be over it, he’d be, he’s just full of energy and he’s overactive that would be about it.

Researcher: Do your friends and family use the term “mental illness” to describe ADHD?

Participant: No, don’t think so no. (Prompt, What term do you think they would use) Hmm, how would they Ummmhh Overactive person, that’s what they would call it, yeah, overactive, yeah.

Researcher: What are the perceived barriers to parents seeking help for their child?

Participant: Ummmhh what’s stopping them? (prompt, The barriers would be the fear of their rejection or the child’s rejection, could be stigmatisation by family or friends, teachers or that they could be looked down either the family or) Yeah, they look down, there trouble makers basically, they look down, there trouble makers but there not really there just can’t sit still that’s what would be (prompt, would you think that’s a barrier to a parent seeking help for their child? Just not to disclose it, just to keep it under raps? No nor really, no it would not be a big thing because we know what he is like so we are used to it, it’s about getting help and understanding it for ourselves and you can control it.

Researcher: When your child was first diagnosed with ADHD how was it delivered? How did you feel about it? And did you wait a while before you told your friends?

Participant: Hmm, we went to a couple of meetings and in the local place up the road there, can’t think of the name of it and he just said yeah we have done this test and he has ADHD and that was that (prompt, And How did you feel about it) Hmm, well he could grow out of it so it’s like that’s the way he is that’s the way it is so at least he can, we know what it is, he’s not bold or he’s not, he’s just as I would call it an active kid, (Prompt it’s not his fault) It’s not his fault no.

Researcher: Did you wait a while before you told your friends?

Participant: Hmm, well I told my mum and dad first and we left it be and slowly told the rest of the family, just to, yeah, that would be it (Prompt, you told me recently as well), yeah so yeah, I think I left my sisters a little while it wasn’t too long but, I think it was (prompt, any particular reason?) Ummmhh No it just that, that’s the way it was, we said, we told them and then we went through it yeah.

Researcher: Did you tell the school year head/principal and how confident were you that your child would get the support they needed from the teachers and their class mates?

Participant: Yeah, we told the school straight away, Ummmhh, teacher, they were all good about it, so yeah there was no problem there.

Researcher: What did your friends think when you told them?

Participant: No, no mad reaction, no, no, not that I can remember anyway, no (laughs)
Researcher: How would you rate this statement: Overall the support my child received from their friends and school teachers was excellent while dealing with ADHD and greatly helped in their education and personal development.

Participant: Well in school it was great, friends mmm, his friends and their mothers and fathers were, they were, some of them, there was one, none of them, there was his two best friends say their parents were very understandable Ummmm, yeah mmm, no negative about it, they are pretty good when you tell people about it, there is no, there is no problem, no (prompt, there is good understanding) good understanding yeah would be yeah (prompt and no negative impact since you told them) no

Researcher: Would you encourage your child to disclose their diagnosis to future employers?

Participant: Ummmmh, I would have no problem with that, would say it’s up to him, if he wanted it it’s his but like that he could grow out of it we don’t know but yeah I have no problem with that it’s up to him, I’d leave it up to him, yeah

Researcher: Would you encourage your child to disclose their diagnosis if applying to further or higher education/training courses

Participant: Yeah I would, it would be easier if he did that I’d say (prompt be easier) yeah (prompt because the supports are probably there, but maybe an employer it’s down to how he feels himself?) yeah and kinda what job he is in, like if is sitting down at a desk he probably would but if he is working with his hands he probably wouldn’t need to, no, mmm, depends what, you know, if he is a builder and he’s out with lads here there all, (laughs) they would probable just fit in so (laughs) you know

Researcher: From your experiences, if you were asked for advice, would you encourage other parents to disclose their child’s ADHD to friends, family and teachers

Participant: Yes, Yeah Yes I would, it’s easier, it’s easier on everybody.

Participant 3

Interview time 10 minutes 35 seconds

Researcher: How would you describe ADHD to someone who never heard of the condition?

Participant: An inability to sit still, to concentrate, just jittery all the time, hard to focus

Researcher: If I asked your friends/family to explain what ADHD is to someone who had never heard it, what do you think they would say?

Participant: I don’t know if the never heard of it, I would say it was Ummmmh, some people think its bad behaviour; don’t know if they know the actual diagnosis of it, what it actually involves and entails
**Researcher**  Do your friends and family use the term “mental illness” to describe ADHD?

**Participant**  Possibly, yeah I would say they would yes, *(why)* people aren’t really educated in what it actually is *(long pause)*, *(prompt, is ADHD a mental illness)*, No, *(prompt, what do you think it is)* Oh, I don’t think it’s mental, *(pause)* inability to focus, I don’t know the words you would put into it, how would it be described, hormonal, mental *(behavioural)* well it’s definitely behavioural, what cause the behaviour

**Researcher**  What are the perceived barriers to parents seeking help for their child?

**Participant**  Diagnosis is the one thing, trying to get people to diagnose them, getting the right help for them, some people think it’s just bad behaviour, other people think it’s a mental illness, it’s you don’t really know, it’s difficult finding the actual help

**Researcher**  When your child was first diagnosed with ADHD how was it delivered? How did you feel about it? And did you wait a while before you told your friends?

**Participant**  Kind of, when he was diagnosed with it we kind of suspected it for a while because he couldn’t focus couldn’t concentrate and I felt was at least we have something to say well that’s what his behaviour is down to, it wasn’t just him being bad behaviour, as for telling other people I had no problem telling other people and my family that he had ADHD

**Researcher**  Did you wait a while before you told your friends and family?

**Participant**  Don’t know if I actually waited if it came in conversation I would just come out straight and say he had ADHD, as for hiding it no we were different ours was an adolescent ours wasn’t a child so those conversations didn’t really come up with family.

**Researcher**  Did you tell the school year head/principal and how confident were you that your child would get the support they needed from the teachers and their class mates?

**Participant**  He wasn’t diagnosed in school as I said he was an adolescent and going on to third level when he was or less diagnosed it was never picked up in school, *(pause)* *(Prompt could you expand on that, was he actually in secondary school or was he in third level when)* He was late secondary school he was more of less coming to the end of secondary school it was his last two years after he done, what year was it, I’m trying to figure out the years, it would have been leaving cert *(pause)* *(prompt did you tell the year head)* yes *(prompt and did you get the support they needed from their teachers and their class mates)* No, not really, no I don’t remember getting any extra support because of it

**Researcher**  What did your friends think when you told them?

**Participant**  They didn’t think anything to be honest but *(pause)* most people have heard of ADHD now so I don’t think they look on it as anything untoward, there accepting
Researcher: How would you rate this statement: Overall the support my child received from their friends extended family and school teachers while excellent while dealing with ADHD and greatly helped in their education and personal development.

Participant: His friends were fine, I would say they accepted him without any difference; family would have been the same as for the schools I don’t think they put any support into it for him; he was just kinda left ah yeah right that’s grand get on with it, so support from the school No.

Researcher: Would you encourage your child to disclose their diagnosis to future employers?

Participant: If he felt comfortable doing it himself then yes, but that would have to be his decision.

Researcher: Would you encourage your child to disclose their diagnosis if applying to further or higher education/training courses?

Participant: Yes, because he ah hands on practical he has absolutely no problem but as for trying to concentrate and leaning and written stuff he would have problems so therefore they may be able to help him with it (pause) or understand it.

Researcher: From your experiences, if you were asked for advice, would you encourage other parents to disclose their child’s ADHD to friends, family and teachers?

Participant: Yes, they need to or the child would just be ignored or left to fend from himself, there has to be help for them and understanding (pause) (prompt: do you think there is more understanding from friends and family if they are aware of the problem) yes there would be they would have known that person all their lives or as long as the friends would, so yes I think there would be more understanding for them (prompt: and teachers) really would depend on the teacher but I would say most teachers would support if they had the resources to support then yes they definitely would (prompt: do you believe teachers don’t have enough resources to deal with it) I don’t think they do, I don’t think the school system does (prompt: could you expand on that please) well the amount of children they have in the class they can’t specifically give attention to one child over another child, they could have a few children with special needs in the class so they need resources there may be an aid or somebody to help them out and pinpoint them or, a program for that child or children.

Appendix 10

Investigating familiarity with and attitudes to Attention Deficit/Hyperactivity Disorder

My name is David McDonagh and I am conducting research towards a BA Hons in Psychology at Dublin Business School. The aim is to explore attitudes towards Attention
Deficit/Hyperactivity Disorder. This research is being conducted as part of my studies and will be submitted for examination. You are invited to take part in this study and participation involves completing an anonymous online survey. While the survey asks some questions that might cause some minor negative feelings, it has been used widely in research. If any of the questions do raise difficult feelings for you, contact information for support services are included below, and on the final page. Participation is completely voluntary and so you are not obliged to take part. Participation is anonymous and confidential, so responses cannot be attributed to any one participant. For this reason, it will not be possible to withdraw from participation after the questionnaire has been submitted. The questionnaire data will be securely stored in electronic format on a password protected computer and retained for 12 months. It is important that you understand that by completing and submitting the questionnaire that you are consenting to participate in the study. Should you require any further information about the research, please contact Dave McDonagh via

Email: [红acted] or Phone [红acted]

Thank you for taking the time to complete this survey.

AWARE: 01 661 7211, www.aware.ie

The Samaritans 24-hour helpline 116123, www.samaritans.org

ADHD Society of Ireland Phone 01 8748349, www.hadd.ie

*Required

Q 1: Consent to Participate in the Study

I am over 18 and agree to take part in the Study

Q 2: Gender *

Male
Female
Other

*Required

Q 3: What Age are you in Years *  

Q 4: Do you work in Healthcare related to Mental illness *

Yes
No

Q 5: Have you ever suffered from a Mental illness or Psychological Disorder *

Yes
Q 6: Do you know someone suffering with Mental illness or disorder *
Yes
No

Q 7: Please read each of the following statements carefully. After you have read all the statements below, place a check by the statements that best depict your exposure to persons with ADHD Choose one option *
A friend of the family has ADHD
I have a relative who has ADHD
I have watched a documentary on the television about ADHD
I live with a person who has ADHD
I have observed, a person I believe may have had ADHD
I have worked with a person who had ADHD at my place of employment
I have never observed a person that I was aware had ADHD
I have observed persons with ADHD on a frequent basis
My job involves providing services/treatment for persons with ADHD
I don't know what ADHD is
I have ADHD
I have watched a movie or television show in which a character depicted a person with ADHD

Q 8: Which of the following phrase or phrases best describes ADHD Choose one option *
Mental Illness
Psychological Condition
Behavioural Disorder
Learning Disability
Social Dysfunction
Don' Know

Q 9: Please indicate to what level you either Agree or Disagree with the following statements. Select just one option of 5 possible options per question. If using a mobile device please scroll across to view all 5 possible responses
1. Most people would accept a person who has a mental illness as a close friend
2. Most people believe that someone who has a mental illness is dangerous
3. Most people believe that a person with a mental illness is just as trustworthy as the average citizen
4. Most people would accept a person who has fully recovered from mental illness as a teacher of young children in a public school
5. Most employers will not hire a person who has been hospitalised for mental illness
6. Most people think less of a person after he/she has been diagnosed with a mental illness
7. Most people would be willing to marry someone who has been diagnosed with a mental illness
8. Most employers will hire a person who has been diagnosed with a mental illness if he or she is qualified for the job
9. Most people believe that entering a psychiatric hospital is a sign of personal failure
10. Most people will not hire a person who has been diagnosed with a serious mental illness to take care of their children, even if he or she had been well for some time
11. Most people in my community would treat a person who has been diagnosed with a mental illness just as they would treat anyone
12. Most young people would be reluctant to date someone who has a serious mental illness

Q 10: Please indicate to what level you either Agree or Disagree with the following statements. Select just one option of 5 possible options per question. If using a mobile device please scroll across to view all 5 possible responses

Strongly Disagree; Disagree; neither Agree nor Disagree; Agree; Strongly Agree

1. People who have ADHD feel guilty about it.
2. People’s attitudes about ADHD may make persons with ADHD feel worse about themselves.
3. Someone who has ADHD would think it’s risky to tell others about it.
4. People with ADHD lose their jobs when their employers find out.
5. People with ADHD work hard to keep it a secret.
6. Someone with ADHD feel they aren’t as good a person as others because they have ADHD.
7. People with ADHD are treated like outcasts.
8. People with ADHD feel damaged because of it.
9. After learning they have ADHD, a person may feel set apart and isolated from the rest of the world.

10. Most people think that a person with ADHD is damaged.

11. A person with ADHD feels that they are bad because of it.

12. Most people with ADHD are rejected when others find out.

13. People who have ADHD are very careful about who they tell.


15. After learning they have ADHD, people worry about others discriminating against them.

16. Most people are uncomfortable around someone with ADHD.

17. People with ADHD worry that others may judge them when they learn that they have ADHD.

18. People with ADHD regret having told some people that they have ADHD.

19. As a rule, People with ADHD feel that telling others that they have ADHD was a mistake.

20. People don’t want someone with ADHD around their children once they know that person has ADHD.

21. Some people act as though it’s the person’s fault that they have ADHD.

22. People with ADHD have lost friends by telling them they have ADHD.

23. People with ADHD have told others close to them to keep the fact that they have ADHD a secret.

24. The good points of people with ADHD tend to be ignored.

25. People seem afraid of a person with ADHD once they learn they have ADHD.

26. When people learn that someone has ADHD, they look for flaws in their character.

Thank you for taking the time to participate in this study. If any issues emerged as a result of completing this questionnaire, below are contact details of support groups which can help.

AWARE: 01 661 7211, www.aware.ie

The Samaritans 24-hour helpline 116123, www.samaritans.org

ADHD Society of Ireland Phone 01 8748349, www.hadd.ie

Link to online questionnaire https://goo.gl/forms/eWd72eOycOzPQS1t2