

**THE EXPERIENCES OF PRIMARY SCHOOL TEACHERS WHO HAVE CHILDREN
DIAGNOSED WITH ADHD IN THEIR CLASSROOMS**

By

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DECLARATION OF OWN WORK

“I herewith declare that **THE EXPERIENCES OF PRIMARY SCHOOL TEACHERS WHO HAVE CHILDREN DIAGNOSED WITH ADHD IN THEIR CLASSROOMS** is my own authentic work and that all the resources that I have used and quoted have been indicated and acknowledged by means of complete references”.

Janine Kendall

Date

ABSTRACT

As children with ADHD are typically diagnosed at school entry level, when problems with especially reading and writing occur, primary school teachers are directly affected by a pressing need to become more educated on the subject of ADHD. The responsibility to teach these young children effectively, and help them to successfully cope with their struggles in an academic environment also rests with the primary school teacher. The purpose of this study was to gain an understanding of the experiences of primary school teachers who have children diagnosed with ADHD in their classrooms. The phenomenological approach was used as a lens for collecting and interpreting data. Four participants from a private school were interviewed and transcripts were analysed and interpreted using the Interpretive Phenomenological Approach. The research findings were that the teachers experiences of having children with ADHD in their classrooms were both positive and negative and were affected by several factors including the number of diagnosed children in the classroom, the degree of severity of ADHD, support received from others, medication for ADHD and knowledge of ADHD.

Key terms: Attention Deficit Hyperactivity Disorder (ADHD), primary school teacher, private school, special education, phenomenology, Interpretive Phenomenological Analysis, and qualitative research.

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CHAPTER ONE

PREFACE

“You are the way you are,
Because I made you that way”

- Lucado (2003, p. 23)

1.1 INTRODUCTION

For decades, Attention Deficit Hyperactivity Disorder (ADHD) has been a controversial subject among health care professionals, researchers, parents, and teachers. As a result of difficulties with inattention, impulsivity and increased motor activity, children with ADHD find it challenging to adapt and cope in a school environment where they are expected to conform to rules and behave in a socially appropriate manner. Consequently their academic performance and achievement is hindered and they are referred for treatment. When regarding South African statistics of ADHD, approximately 3 - 6% of the general child population meets the criteria for some type of ADHD diagnosis (Venter, 2006), which means that it is probable that a teacher may have at least one child diagnosed with ADHD in his/her classroom. This study endeavours to explore specifically primary school teachers' experiences of having children diagnosed with ADHD in their classrooms. Similarities and/or differences in their personal experiences are explored.

This chapter provides the introduction to the study and describes the research design. The aim and rationale of the study is explained, as well as key concepts relevant to the study. This chapter further explains the autobiographical context of the researcher as well as the value of the study.

1.2 DEFINITION OF TERMS

The following terms are defined as they are relevant to this study:

1.2.1 Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is a developmental disorder and is defined as “a mental disorder of childhood” (Coleman, 2006, p. 63) that is characterized by a pervasive pattern of inattention and/or hyperactivity that is more frequently displayed and more severe than is typically seen in individuals at an equivalent level of development (American Psychological Association (APA), 2000). A detailed discussion of various aspects of ADHD is presented in chapter 2.

1.2.2 Primary school teachers

In this study, primary school teachers refer to teachers who have a tertiary qualification in education and are involved in the education of children between the ages of 6 and 13 years. A tertiary qualification implies the context for exploring preparation of teachers to deal with children with learning difficulties such as ADHD.

1.2.3 Private School

A private school is referred to as ‘independent’, according to the Gauteng School Education Act 6 of 1995 and is defined as a school other than a public school (DoE, 1995). A private school is privately established, owned, managed and funded by stakeholders other than the state (du Toit, 2004).

1.2.4 Special Education

Special education refers to teaching methods, exercises, assignments and subject content that are designed for learners with disabilities and impairments (DoE, 2001). These learners include those with mild to severe learning difficulties whose educational needs cannot be met in a mainstream school (DoE, 2001).

1.3 AIM OF THE STUDY

The research question for this study is: What are the experiences of primary school teachers who have children diagnosed with ADHD in their classrooms?

The aim of this study is to explore the shared and differing experiences of primary school teachers who have children diagnosed with ADHD in their classrooms. In chapter 2 a review of the literature indicated that there is no recent research conducted on this topic using the qualitative research design engaged in this study. Although some studies have considered the experience of teachers in dealing with ADHD (Durbach, 2002; Kleynhans, 2005), from the literature review it became apparent that teachers experiences have only recently been deemed important and research on this topic is still needed.

1.4 VALUE OF THE STUDY

This study is relevant in that there are few studies to date considering the experiences of teachers working with ADHD on a daily basis. The research findings may assist teachers in recognizing and appreciating shared and differing experiences regarding teaching children with ADHD. They may consequently gain more insight into the disorder and their own experiences. Better insight into the disorder may contribute to an understanding of, and empathy with these children as well as aid in the prevention of a negative or stereotypical view of them. Parents may find the research findings valuable in gaining a better understanding of what it is like for teachers to deal with a diverse group of learners every day. Better understanding may lead parents to be even more involved and supportive of teachers regarding their child with ADHD.

Therapists and mental health practitioners may find the research findings significant in that it may illuminate their understanding of ADHD and the effects it has on teachers. New knowledge will be contributed to the field of psychology and education in that this study is one of the first to explore the meanings of the experience of teachers having children with ADHD in their classrooms, particularly in the South African context. The researcher will gain more knowledge and understanding of ADHD and the experiences of teachers in dealing with these children on a daily basis.

1.5 RESEARCH DESIGN

The research design of this study is described in chapter 4. This is a qualitative study drawing on the phenomenological approach. Participants in this study were selected by using both purposive and snowball sampling techniques. Data was collected by conducting in-depth, semi-structured interviews with the participants and data was analyzed by means of the Interpretive Phenomenological Approach.

1.6 AUTOBIOGRAPHICAL CONTEXT OF THE RESEARCHER

The researcher has a family member who was diagnosed with ADHD several years ago. The researcher has since been curious and interested in the disorder. As the researcher became a post-graduate student in the field of psychology at the time of the diagnosis, she had the opportunity to gain extensive knowledge and insight about the disorder. Over the years, the researcher has witnessed the difficulties and challenges faced by this family member. She became increasingly affected by the disorder and its symptoms when for a short time she shared a residence with this family member. The researcher felt helpless in that she could not help the family member to cope better with the symptoms of ADHD, as her attempts to help were frowned upon by the rest of the family. The researcher saw no other choice but to withdraw from the situation and has ever since felt a need to do research in the area of ADHD. It was from this time that the researcher's interest in this specific topic of research was fuelled.

The research findings were interpreted from the researcher's subjective point of view and experience of having a family member with ADHD. As a result of the researcher's close encounter with ADHD she has outlined her biases, beliefs, values and assumptions about ADHD in Chapter 4. The researcher was aware of these personal aspects before embarking on the research and bracketed her biases, beliefs, values and assumptions throughout the research process. How the potential influence of the subjective stance of the researcher on the data was dealt with will be discussed in Chapter 4 in the section on the validity and reliability of the study as well as the section on the role of the researcher.

1.7 LAYOUT OF CHAPTERS

Chapter 2 will provide general information on past and present literature regarding ADHD including literature on diagnosis, symptoms, etiology, treatment, and stigma and stereotyping. This chapter will also explore current studies on the subject of ADHD and teachers' experiences thereof.

Chapter 3 will explain and discuss the theoretical approach used in this study. The development of phenomenology is explored as well as how it is suited to the qualitative research framework. The chapter also describes the phenomenological approach to interpretation of research findings.

Chapter 4 will outline the research methodology and design used in this study. The research methodology will be explained in detail with regards to participant selection, method of data collection, method of data analysis and ethical procedures followed. This chapter will also explore the role of the researcher in the research process.

Chapter 5 will present the research findings. This chapter will present the themes and sub-themes as they emerged from the transcripts during the analysis process. Direct quotations from participants are used to substantiate identified themes.

Chapter 6 is the concluding chapter and will discuss the identified themes by connecting findings to literature and phenomenological theory. This chapter will also present the limitations of the study as well as recommendations for future research.

1.8 CONCLUSION

This study allows teachers to share their experiences so that a better understanding of their situation is generated. This chapter was the introductory chapter to the study outlining the design of the research. The following chapter will explore current and past literature on ADHD and identify a lack of research on how primary school teachers experience children with ADHD in their classrooms. Chapter 2 will form the underpinning of the research.

CHAPTER TWO

LITERATURE REVIEW

“See the naughty, restless child
Growing still more rude and wild...”

“He wriggled
And giggled,
And then, I declare,
Swung backward and forward
And tilted his chair...”

- Hans Hoffman
(as cited in Papazian, 1995, p. 188)

2.1 INTRODUCTION

When Hans Hoffman wrote the story about *Fidgety Philip* in 1845 for his son as part of a children’s book, few could have predicted that 150 years later this satire would define the clinical characteristics of what has become known as ADHD (Teeter, 1998). This chapter is aimed at examining relevant literature regarding the diagnosis, symptoms, prognosis, etiology, treatment, and stereotyping of ADHD. The primary symptoms of ADHD are described as well as secondary behaviour that typically accompanies the disorder. Literature presented in this chapter is important to the overall understanding of the child with ADHD and is necessary to fully comprehend the encompassing experience of teachers who educate these children on a daily basis. The literature review also provides the underpinning for the research question.

2.2 DIAGNOSIS AND SYMPTOMS

ADHD is one of the most common reasons why children are referred to mental health services (Holz & Lessing, 2002; Teeter, 1998; Venter, 2006). According to Sadock and Sadock (2003), ADHD is more frequently diagnosed, and therefore requires greater attention and study.

ADHD was first recognized in the 1940s (Woods, 1997) and has over the years been described by many terms such as *hyperactive syndrome* which referred to impulsive, disinhibited, and hyperactive children (Sadock & Sadock, 2003). Children with this syndrome were believed to have some neurological damage caused by the encephalitis epidemic in 1918 (Hersen & Ammerman, 2000). It was during the 1950s and 1960s that hyperactivity in children was seen as a common behaviour problem (Diller, 1999). In the late 1950s to mid 1960s (Hersen & Ammerman, 2000) children displaying symptoms of poor coordination, learning disabilities, and emotional lability, without specific neurological damage, were identified as having *minimal brain damage* (Sadock, & Sadock, 2003). Minimal brain damage referred to a condition caused by an unknown brain injury which was difficult to identify (Wodrich, 1994), and the term was later modified to *minimal brain dysfunction* (Diller, 1999). In the 1970s children with ADHD were often referred to as 'hyperkinetic' or 'hyperactive' following the publication of the American Psychological Association's Diagnostic and Statistical Manual for Mental Disorders (DSM) in 1968 (Wodrich, 1994).

With the DSM-III published in 1980, *Attention Deficit Disorder (ADD)* became the preferred term when researchers identified inattention as the most important symptom of the disorder (Wodrich, 1994). Today, the inclusive term *Attention Deficit and Hyperactivity Disorder (ADHD)* is used and a diagnosis of ADHD is specified by primary symptoms – ADHD predominantly inattentive type, ADHD predominantly hyperactive-impulsive type, and ADHD combined type (Sadock & Sadock, 2003). ADHD is a developmental disorder that consists of a persistent pattern of inattention and/or hyperactive and impulsive behaviour that is often present at the age of 3 years (Holz & Lessing, 2002; Sadock & Sadock, 2003). A diagnosis is however generally made when the child is in a structured school setting and problems such as reading and writing occur, and where teachers are able to compare the attention and impulsivity of the child with other children of the same age (Hersen & Ammerman, 2000).

The primary clinical characteristics or symptoms of ADHD are developmentally inappropriate degrees of inattention, hyperactivity and impulsivity (Holz & Lessing, 2002; Sadock & Sadock, 2003; Venter 2006). Diagnosis for ADHD according to the DSM-IV-TR (APA, 2000) differentiates two groups of symptoms. The first identified group includes symptoms of inattention, which refers to the inability of the child to give close attention to details which results

in careless mistakes made in schoolwork and other activities. Necessary tools such as stationery, books or school assignments are often lost and these children are generally forgetful in daily activities such as brushing their teeth, and need to be constantly reminded. The second group of symptoms includes hyperactivity and impulsivity. Hyperactivity refers to behaviour such as fidgeting with hands or feet, difficulty in sitting still for extended periods of time, and talking excessively. Impulsivity includes behaviour such as blurting out answers before questions have been completed, interrupting others, and difficulty in waiting a turn. From these characteristic symptoms of ADHD, the challenge in managing a classroom with both children with ADHD and children with no learning difficulties is imaginable.

According to the diagnostic criteria for ADHD, as stipulated by the DSM-IV-TR (APA, 2000), six or more symptoms of inattention are required, which have persisted for at least six months, and to a degree that is considered developmentally inappropriate (Holz & Lessing, 2002; Sadock & Sadock, 2003). The diagnosis of ADHD requires “persistent, impairing symptoms of either hyperactivity/impulsivity or inattention that cause impairment in at least two different settings” (Sadock & Sadock, 2003, p. 1224). The formal diagnostic criteria for ADHD according to the DSM-IV-TR (APA, 2000) are as follows:

A. Either (1) or (2):

(1) Six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

- (a) Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities.
- (b) Often has difficulty sustaining attention in tasks or play activities.
- (c) Often does not seem to listen when spoken to directly.
- (d) Often does not follow through on instructions and fails to finish schoolwork, chores or duties at the workplace (not due to oppositional behaviour or failure to understand instructions).
- (e) Often has difficulty organizing tasks and activities.

- (f) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).
 - (g) Often loses things necessary for tasks and activities (such as toys, school assignments, pencils, books or tools).
 - (h) Is often easily distractible by extraneous stimuli.
 - (i) Is often forgetful in daily activities.
- (2) Six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

- (a) Often fidgets with hands or feet or squirms in seat.
- (b) Often leaves seat in classroom or in other situations in which remaining in your seat is expected.
- (c) Often runs about or climbs in situations in which it is inappropriate (in adolescents or adults may be limited to subjective feelings of restlessness).
- (d) Often has difficulty playing or engaging in leisure activities quietly.
- (e) Is often “on the go” or often acts as if “driven by a motor”.
- (f) Often talks excessively.

Impulsivity

- (g) Often blurts out answers before questions have been completed.
 - (h) Often has difficulty waiting turn.
 - (i) Often interrupts or intrudes on others (such as butting into conversations or games).
- B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before 7 years.
- C. Some impairment from the symptoms is present in two or more settings (example at school, work or home).
- D. There must be clear evidence of clinically significant impairment in social, academic or occupational functioning.

- E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder such as Mood Disorder, Anxiety Disorder, Dissociative Disorder or a Personality Disorder.

Code based on type:

Attention-deficit/hyperactivity disorder, combined type: if both Criteria A1 and A2 are met for the past 6 months.

Attention-deficit/hyperactivity disorder, predominantly inattentive type: if Criteria A1 is met but Criteria A2 is not met for the past 6 months.

Attention-deficit/hyperactivity disorder, predominantly hyperactive-impulsive type: if Criteria A2 is met but Criteria A1 is not met for the past 6 months.

According to Accardo, Blondis, Whitman and Steyn (2000), it is not only the presence of these symptoms, but their intensity as well as their course, that compel a diagnosis of ADHD. Also, their marked negative impact on other areas of behaviour and functioning contributes to the diagnosis of ADHD (Accardo et al., 2000; Sadock & Sadock, 2003).

ADHD symptoms vary in degrees of severity of mild, moderate, and severe and the level of severity is usually an indication of prognosis (Hersen & Ammerman, 2000). According to Hersen and Ammerman (2000), a mild degree of ADHD refers to behavioural symptoms that meet the diagnostic criteria for ADHD but show only mild dysfunction in school and social relationships. Moderate symptoms indicate considerable problems at school, home, and with peers where coexisting problems such as learning disabilities and oppositional defiant disorder may be present. These children usually show disruptive behaviour and have low self-esteem. Children with severe symptoms of ADHD experience significant difficulties at home, school, and with social relationships. Coexisting problems of learning disabilities and oppositional defiant disorder is almost always present (Holz & Lessing, 2002). However, not every child that presents with symptoms of ADHD can be formally diagnosed with ADHD (Venter, 2006). In some children it may be a common effect of a health condition or an affective disorder (mood disorder) (Venter, 2006). Also, according to Venter (2006), “ADHD-like symptoms may be secondary to learning disabilities, limited sensory abilities or below average cognitive potential” (p. 144).

Sadock and Sadock (2003) state that for the purposes of an accurate diagnosis, the child's relationships with siblings, peers, and adults in structured and unstructured environments need to be observed and evaluated as it may give valuable insight into the occurrence and complications of ADHD. A detailed prenatal history of the child's early development patterns as well as direct observations of the child in situations such as in the classroom or at home, are necessary (Sadock & Sadock, 2003). School history and teacher's reports are essential in assessing whether a child's learning difficulties and inappropriate behaviour is due primarily to maturational problems, or poor self-image as a result of felt inadequacies (Holz & Lessing, 2002; Sadock & Sadock, 2003).

A neurological examination may be necessary for the diagnosis of ADHD as it may reveal visual, motor, perceptual, or auditory discriminatory impairments without explicit signs of visual or auditory perception disorders (Sadock & Sadock, 2003). Children with ADHD are more likely to display signs of soft neurological damage such as problems with motor coordination and right-left discrimination (Holz & Lessing, 2002; Sadock & Sadock, 2003) and midline-crossing. Therefore, an accurate diagnosis of ADHD cannot be made without an adequate developmental and medical history and collateral information from different sources such as teachers and parents (Venter, 2006). Correctly diagnosing ADHD requires the stipulated diagnostic criteria to be met, as well as a neurological examination which may further clarify certain experienced symptoms.

2.2.1 SECONDARY SYMPTOMS

Children diagnosed with ADHD often present with secondary symptoms which refer to behaviours and difficulties that accompany the disorder, but is not sufficient or necessary for the diagnosis of ADHD (Hersen & Ammerman, 2000). Children with ADHD face many challenges in various important developmental areas (Hinshaw, 1994). They often experience academic underachievement and frequently display unwanted behaviours such as defiance, aggression, and antisocial behaviour. This usually causes rejection from peers (Hinshaw, 1994; Holz & Lessing, 2002). Children with ADHD also experience difficulty with social interaction, low self-esteem, depressed mood, and behaviour problems (Hersen & Ammerman, 2000; Sadock & Sadock, 2003). Secondary features impede optimal development in children with ADHD as it greatly affects their relationships, behaviour and self-esteem.

2.2.2 ADHD IN THE CLASSROOM

Children spend most of their time in classrooms and other school settings where, especially at primary school level, they are expected to follow instructions and participate in organized and complex activities in socially appropriate ways (Kleynhans, 2005). The demand on the teacher becomes more pressing when dealing with children with ADHD (Holz & Lessing, 2002; Kleynhans, 2005) as their difficulty with inattention, impulse control, and hyperactivity regularly interfere with activities in the classroom as well as with peer relations (DuPaul & Stoner, 2003).

In the school setting, children with ADHD may approach a test adamantly, but may only be able to answer the first few questions due mostly to their distractibility and inattentiveness (Sadock & Sadock, 2003) and in class, they may be unable to wait their turn in answering questions and may respond hastily and incorrectly. In general, children with ADHD are irritable and explosive and may be apt to aggressive and uncontrollable outbursts (Sadock & Sadock, 2003) which greatly challenge teachers in terms of discipline and general organization of classroom activities. A further challenge for teachers is that children with ADHD are often emotional labile and their emotions may range from tears to laughter in a short time which makes their mood and actions unpredictable (Sadock & Sadock, 2003). For primary school teachers not trained in special education, children with ADHD pose a great challenge, not only regarding discipline, but also in terms of divided attention, a challenge which can be expected to increase with the size of the class and the number of children diagnosed with ADHD (Holz & Lessing, 2002). School difficulties mainly occur as a result of the child's inattention and distractibility, which hampers the acquisition, retention, and presentation of knowledge (Sadock & Sadock, 2003).

Children with ADHD often develop a negative self-image as they recognize that they are different from their peers and as a result may react with hostility towards peers and adults (Sadock & Sadock, 2003). According to Sadock and Sadock (2003), combinations of primary and secondary symptoms cause scholastic problems as well as difficulties with social relations, which make these children generally difficult to manage, inside and outside of the classroom. Teachers with no training in special education are therefore expected to be greatly challenged by having children with ADHD in their classrooms.

2.2.3 DIFFERENTIAL DIAGNOSIS AND COMORBIDITY

Comorbidity refers to the presence of more than one disorder within the same individual (Hersen & Ammerman, 2000). ADHD exists among a variety of other childhood developmental disorders and it is important to determine comorbid conditions in order to aid best possible treatment (Snyder & Nussbaum, 2000). Children who display a high activity level and short attention span, which is in the normal range for that particular age or developmental level, should firstly be considered as developmentally appropriate before making a diagnosis of ADHD (Sadock & Sadock, 2003). A two-year-old child, for example, who cannot sit still for extended periods of time and gets easily distracted by noise and stimuli, should be considered as reacting and behaving age appropriately. Differentiating the symptoms of ADHD with normal temperament styles is challenging and not viable before the age of three years as young children have “normally immature nervous systems” (Sadock & Sadock, 2003, p. 1226).

Anxiety should be evaluated in children displaying symptoms of ADHD as anxiety may accompany the disorder and may manifest as excessive activity, distractibility or inattention (Sadock & Sadock, 2003). Children with ADHD may develop secondary depression in reaction to their continuing frustration over their failure to learn as well as their resulting low self-esteem (Sadock & Sadock, 2003). ADHD also shares common features with mania such as excessive talking, motor hyperactivity, and distractibility (Sadock & Sadock, 2003) and may imitate symptoms of bipolar disorder (Snyder & Nussbaum, 2000). Sadock and Sadock (2003) explain that mania and ADHD can coexist. However, in children with bipolar I disorder, symptoms tend to wax and wane, whereas symptoms of ADHD remain constant. Conduct disorder (CD) and oppositional defiant disorder (ODD) may also coexist with ADHD (Hinshaw, 1994) as well as various learning disorders (Sadock & Sadock, 2003), such as disorders involving reading, writing, arithmetic, language, and coordination. Specific learning disorders need to be considered as to whether they are as a result of ADHD or a separate diagnosable disorder (Sadock & Sadock, 2003) such as dyscalculia which refers to difficulty in learning or comprehending mathematics (Coleman, 2006). Children with ADHD may present a range of symptoms which could indicate comorbid conditions or differential diagnosis. Comorbid conditions in ADHD should be distinguished for the purposes of optimal management and treatment.

2.2.4 COURSE AND PROGNOSIS

Earlier literature suggests that ADHD has a favourable prognosis if diagnosed in early childhood, but indicates that aggressive behaviour tends to remain stable across development (Hinshaw, 1994). However, according to more recent literature (Sadock and Sadock, 2003), the course of ADHD tends to be variable, as symptoms may persist into adolescent or adult life or remit at puberty. Hyperactive symptoms may disappear but distractibility and impulsivity may continue into adulthood (Sadock & Sadock, 2003). Research abroad has shown that after a four-year follow up study, ADHD has been found to be generally persistent into adolescence and adulthood (Sadock & Sadock, 2003). Follow-up studies of clinical samples in South Africa suggest that children with ADHD are far more likely to drop out of school than the general population, with an estimated 32-40% drop-out rate (Venter, 2006). A further estimated 50-70% of children with ADHD are more likely to have few or no friends, and 40-50% are likely to engage in anti-social activities and use tobacco and drugs (Venter, 2006).

Sadock and Sadock (2003) state that remission of ADHD symptoms occurs rarely before the age of 12 but symptoms usually decrease between 12 and 20 years of age. Remission may lead to a productive adult life, but in cases of partial remission, the disorder is often accompanied by antisocial behaviour, conduct disorder, substance use disorders, and affective disorders (Sadock & Sadock, 2003). Learning difficulties generally persist throughout life (Sadock & Sadock, 2003). According to Hersen and Ammerman (2000), during middle childhood (6 to 12 years) children with ADHD experience increased difficulty with attention, impulsivity, and hyperactivity “as the classroom environment requires compliance, paying attention, and the engagement in structured activities” (p. 363).

The overall prognosis of ADHD in childhood appears to be related to the persistence and pervasiveness of comorbid conditions, especially conduct disorder, difficulty with interpersonal relationships, and a disordered family environment (Sadock & Sadock, 2003). Good prognosis is promoted by developing children’s social functioning, diminishing aggressiveness, and improving family situations as early as possible by means of therapeutic interventions (Sadock & Sadock, 2003).

2.3 ETIOLOGY OF ADHD

The etiology of ADHD as well as the treatment thereof remains a contentious subject among health care professionals. Since the 1960s classification of minimal brain damage, many hypotheses have been provided to attempt to explain the cause of ADHD as it is referred to today (Sadock & Sadock, 2003). At present, no single factor is believed to cause ADHD, rather a combination of environmental and biological factors are considered as essentially contributory (Sadock & Sadock, 2003). Speculations concerning the possible causes of ADHD are largely controversial and definite answers still remain ambiguous. However, at present there is consensus among health practitioners and researchers regarding certain possible factors related to the etiology of ADHD, such as a genetic component, developmental factors, neurophysiological factors, as well as neurochemical factors (Holz & Lessing, 2002; Sadock & Sadock, 2003; Venter, 2006).

2.3.1 GENETIC FACTORS

According to Venter (2006) in more than 80% of South African cases, genetic factors are identified as contributory in the development of ADHD. This recent statistic is contradictory to earlier belief that ADHD is only moderately influenced by heritable factors (Hinshaw, 1994). The identified genes believed to be the cause of ADHD, together with certain environmental factors, ultimately cause the disorder (Holz & Lessing, 2002; Venter, 2006). It appears that a genetic component in the development of ADHD as a definite causative factor is no longer disputed among researchers as biological parents of children with ADHD have a higher risk of having the disorder themselves than adoptive parents (Sadock & Sadock, 2003). Also, siblings of children with ADHD are at a higher risk of inattention and hyperactive symptoms than the general population (Holz & Lessing, 2002; Sadock & Sadock, 2003), which clearly supports a genetic correlation.

2.3.2 DEVELOPMENTAL FACTORS

It has been speculated that some children with ADHD suffered subtle damage to the central nervous system (CNS) and brain development during foetal development: “the hypothesized brain damage may potentially be associated with circulatory, toxic, metabolic, mechanical, or physical

insult to the brain during early infection, inflammation, and trauma” (Sadock & Sadock, 2003, p. 1224). As ADHD is believed to involve specific neurological damage, research has shown that areas of the right brain hemisphere may be malfunctioning and that frontal lobe development and performance may be anomalous (Riccio, Hynd, Cohen, & Gonzalez, 1993). However, most children with CNS damage and/or neurological disorders caused by brain injuries display no symptoms of attention deficit or hyperactivity, and therefore neurological damage *per se* as causative is strongly contested (Sadock & Sadock, 2003). Suggested contributory factors to the development of ADHD include prenatal toxic exposures, prematurity, and prenatal damage to the foetal nervous system (Sadock & Sadock, 2003), as well as low birth weight and diseases in formative years (Hinshaw, 1994).

2.3.3 NEUROCHEMICAL FACTORS

Neurochemical factors have been believed to be contributory to the development of ADHD from the 1970s and research in this area found specifically the lack of the neurotransmitter dopamine as causal (Woods & Ploof, 1997). According to Sadock and Sadock (2003) many neurotransmitters are associated with the symptoms of ADHD. Hypotheses about the neurochemistry of the disorder have mainly arisen from the impact of medications on symptoms of attention and hyperactivity (Sadock & Sadock, 2003; Venter, 2006). Studies have suggested possible dysfunction in the production of sufficient dopamine and norepinephrine neurotransmitters (Sadock & Sadock, 2003), hence the prescription of drugs such as Ritalin for the management of neurotransmitter production (Diller, 1999).

Sadock and Sadock (2003) state that no evidence exists for a single neurotransmitter involved in the production of inattention and hyperactive behaviour, rather numerous neurotransmitters may be involved in the development of ADHD. In South African studies it appears that children with ADHD have a deficient production of dopamine in the synapses of localized areas in the brain (Venter, 2006). As a result, children with ADHD exhibit attention, concentration, and higher cognitive functioning difficulties which are regulated by the production of dopamine (Venter, 2006). Recently it has been found that the norepinephrine pathways are also relevant for attention, concentration and cognitive function, emotions, energy and agitation (Venter, 2006).

According to Sadock and Sadock (2003) and Venter (2006), treatment and management of ADHD usually involves some process to increase dopamine and/or norepinephrine in the synapses of the related neuronal pathways in the brain. The researcher is aware that literature is ambiguous on whether symptoms of ADHD are caused by neurochemical factors or whether neurochemical changes occur as a result of the disorder. This is an area for further research.

2.3.4 NEUROPHYSIOLOGICAL FACTORS

As early as the 1960s, researchers have speculated about a neurophysiological basis for ADHD (Woods & Ploof, 1997). Today, neurophysiological factors are believed to play an integral part in the development of ADHD (Holz & Lessing, 2002). According to literature (Sadock & Sadock, 2003), the human brain undergoes a number of rapid growth periods at several ages: 3 to 10 months, 2 to 4 years, 6 to 8 years, 10 to 12 years, and 14 to 16 years, in contrast to the single identified 7 to 8 years growth period (Woods & Ploof, 1997). It is suggested that some children have a maturational delay in these periods of development and symptoms of ADHD may manifest as a result (Sadock & Sadock, 2003).

Regarding brain function, earlier literature suggests that the frontal cortex is affected in children with ADHD (Woods & Ploof, 1997), which produces symptoms of inattention, disinhibition, and impulsivity. Several studies indicate no consistent findings regarding computed tomographic (CT) head scans of children with ADHD. However, studies using positron emission tomography (PET) indicate a lower cerebral blood flow and metabolic rates in the frontal lobe areas of children with ADHD than in control groups (Sadock & Sadock, 2003). Sadock and Sadock further maintain that these findings are supported and explained by the supposed theory of inadequately performing frontal lobes regarding inhibitory mechanisms of children with ADHD, leading to disinhibition in these children. Recent studies using PET scans have shown that in children with ADHD three areas of the brain are involved namely: the frontal lobe, its connection to the basal ganglia and its relationship to the central aspects of the cerebellum (Venter, 2006). Venter also explains that these areas show less activity and may be comparatively smaller.

2.3.5 ENVIRONMENTAL AND NUTRITIONAL FACTORS

Food additives, preservatives, and excessive sugar have been proposed by earlier literature as possible causes of hyperactive behaviour (Hersen & Ammerman, 2000). However no scientific evidence up to date exists to fully support these assumptions (Sadock & Sadock, 2003). Several environmental factors have been identified as possible causes of ADHD (Hersen & Ammerman, 2000; Holz & Lessing, 2002) which include elevated blood levels, birth complications, maternal smoking, and the consumption of high quantities of food additives, preservatives, and sugar (Riccio et al., 1993). Nicotine and alcohol exposure in the mother's womb have been shown to increase the chances of the development of ADHD by up to 50% (Milberger, Biederman, Faraone & Jones, 1998).

2.3.6 PSYCHOSOCIAL FACTORS

Several factors have been identified as contributing to the initiation and continuation of ADHD symptoms such as stressful emotional events including violence, neglect, and divorce; disruption of family equilibrium; and other anxiety-inducing factors (Sadock & Sadock, 2003). Studies have indicated that children in institutions such as safe houses or orphanages frequently display over-active behaviour as well as poor attention spans (Sadock & Sadock, 2003). The behaviour or symptoms may be attributed to prolonged emotional withdrawal, and usually dissolve when deprivational factors are taken away by means of adoption or foster placement (Sadock & Sadock, 2003). Predisposing factors that may yield a child vulnerable include temperament and attachment styles, genetic-familial factors (Holz & Lessing, 2002), as well as societal demands regarding behaviour and performance (Sadock & Sadock, 2003). There appears to be no relation to socio-economic status as a predisposing factor in causing ADHD (Sadock & Sadock, 2003), however more research in this area is indicated.

Conclusively, regardless of the etiology of ADHD, the existence of the disorder is no longer disputed among researchers and health care professionals. Whether from a neurological or psychological perspective, ADHD is perceived as a real and existent condition that, without intervention and treatment, will hamper the child's development and maturation on many different levels.

2.4 EPIDEMIOLOGY OF ADHD

Epidemiology refers to “the study of patterns of disease in human populations and of the factors that influence these patterns” (Hersen & Ammerman, 2000, p. 37). In the United States of America, ADHD is reported in 3–7% of primary school children and in the United Kingdom, less than 1% of children are reported to have ADHD (Holz & Lessing, 2002; Sadock & Sadock, 2003). Approximately 5% of South African children meet the diagnostic criteria for ADHD and early statistics indicate that it is the most prevalent psychiatric disorder among South African children (Meyer, 1998). More recent South African statistics on the prevalence of ADHD (Venter, 2006) indicate that an estimated 8% of the population’s children have ADHD. An estimated 85% of children with ADHD will display symptoms persisting into adolescence and 31% will display persisting symptoms and behaviours into adulthood. From this it is assumed that there might be at least one child with ADHD in a classroom (Kleynhans, 2005).

In the United States ADHD is more prevalent in boys than in girls, with a ratio ranging from 2 to 1 to as much as 9 to 1 (Sadock & Sadock, 2003). In South Africa, boys are also reported to be more affected than girls, with an estimated ratio of 3 to 1, although girls outnumber boys in the occurrence of ADHD predominantly inattentive type (Venter, 2006).

2.5 TREATMENT FOR ADHD

Children who display symptoms of hyperactivity as a predominant feature are more likely to be referred for treatment than children with attention deficits as primary symptom (Sadock & Sadock, 2003), presumably as over active behaviour is more disruptive in the school and home setting. Children with the primarily hyperactive-impulsive type are more likely to have a stable diagnosis over time concurrent with conduct disorder, than children with the inattentive type without hyperactivity (Sadock & Sadock, 2003). Several treatment options are available for children with ADHD with pharmacotherapy being the treatment of choice (Venter, 2006). Other treatment options include psychotherapy such as behaviour management therapy and cognitive control therapy.

2.5.1 PHARMACOTHERAPY

According to Venter (2006) the treatment of ADHD requires a “multi-modal approach, as a single intervention is rarely effective” (p. 144). The main identified intervention or treatment modalities are medical, educational, psychosocial (behaviour modification), diet and nutritional supplements (Venter, 2006). All of the modalities will not be addressed in this chapter as its scope is far greater than is relevant to the purpose of this study.

When treatment is considered for a child diagnosed with ADHD, the drug Ritalin, is probably most commonly prescribed (Richards, 2001). Psycho-stimulants were first used to treat disruptive behaviour in children in 1937 in the USA and have ever since been the basis of the medical management of children with ADHD (Venter, 2006). Ritalin has been used for over 50 years and has been found to be helpful in about 70% of children with ADHD (Venter, 2006). Stimulants are used to treat the three core symptoms of ADHD – inattention, impulsivity and hyperactivity. Several other effective drugs are also available for the treatment of ADHD such as Aderall, Dexedrine Spansule, and Concerta (Sadock & Sadock, 2003). Most commonly used drugs in the treatment of ADHD are grouped in two categories namely methylphenidate and dextroamphetamine (Sadock & Sadock, 2003).

The Food and Drug Administration (FDA) in the USA approves the use of dextroamphetamine in children 3 years old and older and methylphenidate in children 6 years old and older (Sadock & Sadock, 2003). Ritalin forms part of the methylphenidate category. Methylphenidate has been shown to be highly effective in treating children with ADHD with relatively few adverse effects (Sadock & Sadock, 2003; Venter, 2006). Methylphenidate is a short-acting medication that is generally used during school hours as it is effective in aiding children with ADHD to attend to tasks in the classroom by significantly improving their ability to concentrate (Sadock & Sadock, 2003). Common side effects include headaches, nausea, abdominal pain, and insomnia or disrupted sleep (Sadock & Sadock, 2003). According to Diller (1999), other common side-effects include loss of appetite, nervousness, and diminished cognitive creativity. Other reactions such as hypersensitivity (including skin rash), fever, dizziness, heart palpitations, dyskinesia (involuntary repetitive bodily movements), drowsiness, blood pressure and pulse changes and weight loss during prolonged therapy have also been reported. Allergic reactions may include skin rashes,

hives, joint pains, and dizziness (Diller, 1999). When methylphenidate is not effective, dextroamphetamine is usually the second choice of treatment (Sadock & Sadock, 2003). It has been suggested that Ritalin is indicated when a child's measured IQ (Intelligence Quotient) is significantly higher than academic achievement (Diller, 1999). According to Diller (1999), Ritalin improves concentration in the short term, and decreases impulsivity and motor activity. It also is inclined to temporarily increase compliance.

One advantage of the sustained-release of Ritalin and other drugs prescribed for ADHD is that one dose in the morning will sustain the effects all day (Sadock & Sadock, 2003). Sustained-release medication also helps avoid periods of irritability as an even level is maintained throughout the day. According to Sadock and Sadock (2003), Ritalin-SR (slow release) has a sustained duration of approximately 8 hours (as does Dexedrine Spansule), Concerta has a sustained effect of 12 hours, and Aderall lasts about 4 to 6 hours. Ritalin, however, does not improve multifaceted and complex skills such as reading, writing, and social behaviour, and cannot correct a learning disability, or improve emotional problems the child may be facing (Richards, 2001).

Alternatively to stimulants, non-stimulant drugs are recommended as findings indicate that 20-30% of children with ADHD may not respond to stimulants or have adverse side effects that are difficult to cope with (Venter, 2006). As a result there has recently been a growing interest in developing non-stimulant medication for ADHD (Venter, 2006). Non-stimulants are still considered second-line medications in the management of ADHD, because they do not always improve all three core symptoms of ADHD (Venter, 2006). Potential advantages of non-stimulants include a longer duration of action, the treatment of co-morbidity such as anxiety and a minimal risk of abuse (Venter, 2006). Examples of non-stimulants are Atomoxetine (better known as Strattera), antidepressants, and Clonidine (Dixarit). According to Venter (2006) Atomoxetine has shown no abuse potential and is an alternative for parents seeking non-stimulants for their children. It is also particularly useful in children with co-morbid anxiety. Antidepressants cause fewer disruptions of sleep, appetite and growth patterns (Venter, 2006). Clonidine treatment has yielded behavioural improvements (decreased hyperactivity and disinhibition) (Venter, 2006).

It is apparent that according to research (Richards, 2001; Sadock & Sadock, 2003; Venter, 2006), ADHD responds well to pharmacological intervention and is this usually the treatment option of

choice. Research also indicates that stimulants may be replaced by non-stimulants which are beneficial in the treatment of ADHD (Venter, 2006).

2.5.2 PSYCHOSOCIAL INTERVENTIONS - PSYCHOTHERAPY

Drug treatment is only one facet of the multidimensional treatment and management of ADHD. Alternative treatment approaches may be used in conjunction with medication such as behaviour management therapy (Sadock & Sadock, 2003) and cognitive control therapy (Santostefano, 1995) for optimal outcome. These treatment approaches are usually indicated when symptoms are less severe or when side effects from prescribed drugs prevent the child from functioning normally (Diller, 1999).

Behavioural therapy works by rewarding desired behaviour with privileges or rewards while discouraging bad behaviour with removal of privileges (Diller, 1999). The goal of behaviour therapy is to increase desirable behaviour by increasing the child's interest in pleasing parents and by providing positive consequences when the child behaves appropriately. Inappropriate behaviour is reduced by consistently providing negative consequences when such behaviour occurs. Disciplinary strategies used in reducing negative behaviour include taking away privileges such as watching TV or playing computer games. Several behaviours can be targeted using this treatment approach such as not completing tasks, interrupting others or talking out of turn, as well as disobedience or aggressive behaviour (Diller, 1999). Behaviour management therapy is indicated especially for children with ADHD who display unwanted behavioural problems.

Cognitive control therapy aims at altering the child's style of mental organization or management (Santostefano, 1995). After an evaluation of the child with ADHD, "the identified cognitive functions considered as developmentally lagging become the target for treatment" (Santostefano, 1995, p. xxii). Cognitive control therapy is indicated for children whose cognitive dysfunctions are the primary cause for academic failure and maladaptive functioning (Santostefano, 1995). It is suggested that behavioural therapy and cognitive control therapy are used in conjunction with pharmacotherapy to increase effectiveness (Sadock & Sadock, 2003). Other beneficial approaches to the management of ADHD include group social skills training and parent training of children with ADHD (Sadock & Sadock, 2003).

An important aspect in the treatment of ADHD is education about ADHD. Children need to be informed about the purpose of the medication and the effects or side effects that can be expected (Sadock & Sadock, 2003). This is useful in dispelling misconceptions about taking medication and allowing the child a sense of control. According to Sadock and Sadock (2003), when children are helped in structuring their environments, their anxieties usually diminish: “It is often beneficial for parents and teachers to work together to develop a concrete set of expectations for the child and a system of rewards for the child when expectations are met” (p. 1229).

Sadock and Sadock (2003), state that a fundamental part of intervention is parental training. Parents need to understand that even though children with ADHD may not voluntarily exhibit symptoms such as hyperactivity and inattention, they still face normal developmental tasks and maturation such as building self-esteem and skills needed in social interactions. Sadock and Sadock (2003) further maintain that children do not benefit from being excused from the requirements applicable to other children of the same age and should be treated as ‘normally’ as possible. Another beneficial intervention strategy is group social training which is targeted at increasing social skills, a sense of achievement, and self-esteem (Sadock & Sadock, 2003), which may be especially beneficial for children who experience difficulty in social settings and interpersonal relationships.

2.6 STIGMA AND STEREOTYPING

According to Diller (1999), the tendency to emphasize biological causes has been embraced by parents, teachers, health professionals, and children with ADHD themselves. Diller (1999) states that “the effect of this has been implicitly to diminish the significance of learning disabilities and emotional problems, family dynamics, classroom size, and economic and cultural issues that may be relevant to ADHD in favour of genetic and neurochemical factors” (p. 103). From this statement it can be presumed that as a result of the emphasis on biological origins, and perceiving ADHD as being primarily a neurological and/or hereditary condition, less stereotyping is attached to a medical or neurological condition than to a psychiatric one (Diller, 1999). Biological or neurological causes are, however, only one dimension of the ADHD syndrome. The negative stigma attached to any diagnosed disorder remains a reality, regardless of etiology or severity (Richards, 2001). Children from a very young age usually know that they are ‘ADHD’ when

diagnosed and have a ‘problem’, and usually know that their medication helps them to ‘behave’ or ‘calm down’. Parents’ and teachers’ well-intended conversations usually include the diagnostic label of ADHD which remains with a child throughout his/her life.

In primary school, ADHD is usually diagnosed when difficulties with reading and writing present. The diagnostic label ‘sticks’ and soon the child’s peers become aware of the ‘problem’ (Richards, 2001) as ADHD children are perceived and described as difficult to manage, and generally disruptive. Secondary problems may arise such as difficulties in social relations and teachers are challenged further to balance a classroom with children with ADHD and children not facing learning problems. Stereotyping regarding ADHD is considered relevant for the purpose of this study, as it is likely to affect teachers’ experiences of these children.

2.7 PREVIOUS RESEARCH ON TEACHERS’ EXPERIENCES

As health care professionals and researchers increasingly recognized the long-term difficulties faced by children with ADHD, research efforts on ADHD have dramatically escalated over the last decade and although abundant information is currently available, more research is still needed in certain areas. The majority of literature and research up to date focuses mainly on the assessment (Carey 1999), etiology and epidemiology (Diller, 1999; Richards, 2001), and the diagnosis, management and treatment of ADHD (Fabiano & Pelham, 2003). The impact of ADHD on parents and the child have been thoroughly researched over the years. Practical guidelines and manuals for parents and teachers on how to effectively manage children with ADHD have been provided (Barkley, 2000; Flick, 1996; Rief, 1993).

Some literature considers the subjective experiences of parents of children with ADHD, especially mothers (Burke, 2004) and explores parents’ coping styles and parent-child interactions before and after treatment for children with ADHD (McKee, Harvey, Danforth, Ulaszek & Mauren, 2004). Parents’ beliefs about ADHD and treatment experiences have also recently been explored (Johnston, Seipp, Hommerson, Hoza & Fine, 2005) and some literature considers service professionals’ experiences in assessing and treating children with ADHD (Hazelwood, Bovingdon & Tiemens, 2002). Recent South African context literature that focuses on the subjective experience of specifically teachers who deal with ADHD, is limited.

From an educational perspective Durbach (2002) researched how teachers can deal with ‘scattered minds’, as well as their perspectives on attention deficit hyperactivity disorder (ADHD) in the classroom. Another study by Kleynhans (2005) specifically considered primary school teachers’ knowledge and misperceptions of ADHD. This study used a quantitative methodology to explore how teachers perceive children with ADHD and what insight and misconceptions they have regarding the disorder. Considering available literature, it can be concluded that the teacher’s experience of dealing with ADHD in an educational setting has only recently been deemed as important and relevant in understanding the dynamics involved in ADHD, and has not yet been thoroughly researched. No studies on primary school teachers’ experiences of dealing with children diagnosed with ADHD using a qualitative methodology were found. This study therefore particularly endeavours to address the gap in the body of knowledge about primary school teachers’ experiences of having children with ADHD in their classrooms.

2.8 CONCLUSION

This chapter examined past and present literature on ADHD as well as current research on the experiences of teachers. There is an abundance of information in the literature on ADHD regarding diagnosis, treatment, and etiology. From examining the literature, there appears to be a shortage of research on the experiences of teachers dealing with ADHD in their classrooms. The next chapter presents the theoretical approach that underpins the study.

CHAPTER THREE

THE PHENOMENOLOGICAL APPROACH

“We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.”

- T. S. Eliot
(as cited in Zaner, 1970, p. 205)

3.1 INTRODUCTION

The phenomenological approach is used as the theoretical framework for this study and as a lens for interpreting collected data. Defining phenomenology is not an easy task and has been debated among phenomenologists and other philosophers over centuries. Phenomenology as a philosophical approach has evolved since its first appearance in the works of Plato and Aristotle (Spiegelberg, 1982), and several descriptions have since developed. In this chapter some of the descriptions will be explored and an appropriate method for approaching and interpreting data will be chosen for this study. Phenomenology essentially aims to explore and understand the meaning of human experience as it is lived (Wagner, 1983). The focus is therefore on how the phenomenon being explored is experienced by the individual. From this phenomenological perspective, the study endeavours to explore primary school teachers' experiences of having children diagnosed with ADHD in their classrooms, as this approach is essentially concerned with human awareness and specifically the awareness of human experience (Wagner, 1983). Phenomenology further explores the commonalities and distinctiveness of individual experience with emphasis on the descriptions of experiences (Cerbone, 2006) and therefore, in this study, teachers' shared and differing experiences are explored.

3.2 THE PHENOMENOLOGICAL APPROACH

3.2.1 THE DEVELOPMENT OF PHENOMENOLOGY

The history and development of phenomenology is intricate and elaborate and its understanding is pertinent to the appreciation of this philosophical approach. A brief overview of the development of phenomenology is presented. Phenomenology is one of several strong currents in philosophy prominent at the outset of the twentieth century alongside other dominant streams such as idealism, hermeneutics, positivism, and pragmatism (Moran, 2000). Phenomenology dates as far back as 1875 and is believed to have originated with the work of German philosopher-psychologist Franz Brentano who is considered the forerunner of the phenomenological movement (Spiegelberg, 1982). However, traces of phenomenological thinking are found in works of Plato, Aristotle (Spiegelberg, 1982) and Descartes (Wagner, 1983).

The term ‘phenomenology’ occurred in several of Brentano’s unpublished notes, but it was Edmund Husserl (1859 – 1938), a German mathematician, who wrote extensively on the subject of phenomenology (Spiegelberg, 1982) and became known as the protagonist of modern phenomenology (Wagner, 1983). Husserl was, however, not the first to formally introduce the term ‘phenomenology’. In the eighteenth century others such as Kant, Hegel, and Lambert had already employed the term ‘phenomenology’ in their writings (Moran, 2000). In 1900–1901, Husserl essentially announced phenomenology as a radically new way of doing philosophy in an attempt to bring philosophy back from abstract metaphysical theory (Moran, 2000). Husserl carried phenomenology into the twentieth century, bringing it to full development. It was, however, Dewey and Mead whose work first displayed phenomenological-psychological tendencies where phenomenology is described as a psychological undertaking, as it considers ‘consciousness’ – a psychological concern (Wagner, 1983).

3.2.2 WHAT IS PHENOMENOLOGY?

An all encompassing description and analysis of phenomenology is beyond the scope and purpose of this chapter and only a concise summary of the essential elements is presented, as applied in the study. Phenomenology explores mental phenomena which refer to the way in which objects are

experienced and the meanings objects have in experience (Lyotard, 1991). It studies “*that* which appears to consciousness, *that* which is given” (p. 32) and does not aim to describe or investigate relationships or connections ‘outside’ of the phenomena (Lyotard, 1991). Phenomena refer to what is observed or perceived – that which is sought to be explained or explored (Wagner, 1983).

Phenomena are objects as they appear to the consciousness, whether through thought, perception, or imagination (Spiegelberg, 1982). “Phenomenology deals with the world in structural, not factual, terms” (Hamrick, 1985, p. 32), which means that phenomenology does not endeavour to explore whether objects or experiences are real or not, but aims to understand the essence and deeper meaning of the experience (Zaner, 1970). According to Husserl “phenomenology is based on the intuitive and faithful description of the phenomena within the context of the world of our lived experience” (Spiegelberg, 1982, p. 52). Phenomenology aims “to remain as faithful as possible to the phenomenon and to the context in which it appears in the world” (Smith, 2003, p. 26). Phenomenology is interested in the personal experiences of individuals regarding situations in their lives and the aim is to “capture as closely as possible the way in which the phenomenon is experienced within the context in which the experience takes place” (Smith, 2003, p. 27). The purpose of this study is to explore teachers’ experiences of having children diagnosed with ADHD in their classrooms as phenomenology is aimed at exploring the phenomena as it is experienced and not at affirming or denying facts or beliefs (Zaner, 1970).

Phenomenologists across the centuries have developed their own descriptions of what phenomenology essentially entails. According to Hegel, phenomenology is “science of consciousness” and this science is the “experience had by consciousness” (Lyotard, 1991, p. 65). Phenomenology, according to Husserl, is described as a fundamental way of doing philosophy, “a practice rather than a system” (Moron, 2000, p. 4). Husserl explains: “Phenomenology is best understood as a radical, anti-traditional style of philosophizing, which emphasizes the attempt to get to the truth of matters, to describe phenomena, in the broadest sense as it manifests itself to consciousness, to the experiencer” (p. 4). For Husserl, phenomenology should “carefully describe things as they appear to consciousness” (Moron, 2000, p. 16). In this study the Husserlian understanding of phenomenology is prescribed to. Husserl’s phenomenological approach will be utilized to explore and describe the underlying structure or essence of teachers’ experiences, and to gain an understanding of the essential nature of their experiences.

Husserl wrote extensively on phenomenology throughout his life. He defined phenomenology as the knowledge of the essence, or real meaning of consciousness, centred on intentionality and approached from the first person perspective (Husserl, 1913/1963). According to Husserl, consciousness is an intentional process that comprises several factors such as feeling, thinking, perceiving, remembering, imagining, and anticipating directed towards realities experienced (Spiegelberg, 1982). Husserl further explains that phenomenology explores the structures of consciousness or experiences from a first-person perspective. These conscious experiences are studied by reflecting on experiences as they were experienced by the individual self (Spiegelberg, 1982).

Husserl describes experience as intentional as it is directed towards a specific object or situation (Husserl, 1913/1963). This experience is subjective and interpreted by the individual or the 'experiencer' self. Husserl's idea of intentionality was developed based on William James' theory of consciousness (Edie, 1987). The psychologist and philosopher William James proposed that all consciousness is world-directed (Edie, 1987). Husserl took this idea further to explain that "all experiences are intentional experiences" (Kockelmans, 1994, p. 80). Experience involves more than just sensory perception such as hearing or seeing. It also involves meaning, association, memory, emotion, time, social and cultural movement, and the awareness of others and the self, which ultimately refers to the experienced 'life-world' (Lyotard, 1991). These experiences are intentional as they are directed towards objects of the outside world and these experiences also represent the meaning attached to experiences (Husserl, 1913/1963). Intentionality refers to "consciousness, to the internal experiences of being conscious of something; thus the act of consciousness and the object of consciousness are intentionally related" (Moustakas, 1994, p. 28). Phenomenology explores different types of experience. One type of experience, as described by Husserl and Merleau-Ponty, considers experience as it is lived (first-person point of view) and analyses this experience to draw conclusions (Wagner, 1983).

The aim of this study is therefore to explore the experiences of teachers who have children diagnosed with ADHD in their classrooms from a first-person point of view, and to essentially understand these experiences and their meaning as they are lived. Phenomenology attempts to understand consciousness "from within, beginning with reflection" on experiences as they were lived (Wagner, 1983, p. 11). Ultimately, phenomenology aims to "gain access to the outer world

from the inside of human experience” (p. 19). According to Zaner (1970), the phenomenological perspective proposes that there are different ways of experiencing the same thing, including sense perception and mental processes, and experience is therefore viewed as extensive and intricate. For the purpose of this study, teachers were interviewed to explore specifically the similarities and differences regarding their experiences of dealing with children with ADHD in their classrooms. Their experiences may be formed by personal history, education, as well as available resources.

According to Wagner (1983), “phenomenology is a way of viewing ourselves, of viewing others, and of viewing all else that comes in contact with our lives” (p. 8). Wagner further explains that phenomenology “is a system of interpretation that helps us perceive and conceive ourselves, our contacts and interchanges with others and everything else within the realm of our experiences” (p. 8). Zaner (1970) states that phenomenology, as a philosophical approach, gave rise to awareness of historicity and sociality. Wilhelm Dilthey described the term ‘historical consciousness’ as awareness in each individual allowing the person to actively experience the world, objects, and the self (Zaner, 1970). Dilthey maintained that nothing can be interpreted without reference to history (Zaner, 1970). Also, interpretations are influenced by individual values, and socio-cultural background and “as social beings, deeply informed and determined by our own nexus of social values, concepts, and the like, our interpretations of other cultures seems to disclose the nature of our own being as much as that of other cultures” (Zaner, 1970, p. 21). From this it can be supposed that teachers’ experiences of children with ADHD in their classrooms will draw on personal history, previous educational experiences, as well as their own culture, values and beliefs.

3.3 QUALITATIVE RESEARCH AND PHENOMENOLOGY

Qualitative research focuses on human experience (Valle & Halling, 1997), as does the phenomenological approach. Phenomenology is considered a philosophical perspective, as described in the section above, as well as an approach to qualitative methodology that emphasizes a focus on people’s subjective experiences and meanings of the world (Burke, 2004). Phenomenological research entails “illuminating intersubjective human experiences by describing the essence of the subjective experience” (Tesch, 1990, p. 51). According to Patton (2002), qualitative research’s approach to knowledge production is centred on the idea of people’s experiences and interpretations. A qualitative perspective focuses on human experience and the

meanings ascribed to those experiences (Burke, 2004). This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people ascribe to them (Patton, 2002). Phenomenology as a paradigm is parallel to the qualitative research design, as both view information gathering as unique to human experience and allows for human interpretation and meaning that are not based on statistics or scientifically verifiable facts.

3.4 PHENOMENOLOGICAL INTERPRETATION

Maurice Merleau-Ponty (1908–1961) made significant contributions to post-Husserlian phenomenology (Moran, 2000), and describes true objectivity as turning to “things themselves” (p. 391), describing them accurately, and drawing from this description an “interpretation of their meaning” (Lyotard, 1991, p. 98). Meaning can only be derived once the phenomenon is understood. Lyotard clarifies: “to really explain in the human sciences is to understand” (p. 99). Interviews with teachers will therefore include the explanation of classroom situations from which teachers draw experience, so that the meaning of their experiences may be better understood.

According to Hamrick (1985), for Husserl, phenomenological interpretation requires the “adoption of a special type of attitude or standpoint toward one’s own life or experience which makes explicit certain ‘anonymous’ or normally hidden aspects of that life or experience” (p. 55). According to Husserl, data refers to “phenomena of and in consciousness whether they be called objects, feelings, ideas, or images” (Wagner, 1983, p. 46). Husserl further explains that “interpreting data, drawing from observations, and making conclusions yield what amounts to phenomenological theory” (p. 46). Phenomenology seeks “to avoid all misconstructions and impositions placed on experience in advance, whether these are drawn from religious or cultural traditions...” (Moran, 2000, p. 4). Moran maintains that explanations cannot be imposed “before the phenomena have been understood from within” (p. 4). Therefore, for the purpose of this study, themes emerging from the transcripts will do so spontaneously and will not be predetermined.

Husserl proposed the method of interpreting phenomena as ‘phenomenological reduction’. The aim of this method is to “reduce the observed phenomena to its own features, instead of observing it in the light of preconceived interpretations and evaluations” (Wagner, 1983, p. 42). Husserl

proposed that the phenomena be subjected to a second reduction, which he referred to as ‘eidetic’. This eidetic reduction would yield the “essence of universal validity” (p. 42) in contrast to individual described features. Data collected will be reduced to themes or ideas that are found to be universal or similar between the transcripts.

Husserl proposed a third reduction called the “transcendental” (Wagner, 1983, p. 44). The aim of this further reduction is to reduce “the eidos of objects of consciousness and finding its universal centre in the ‘transcendental ego’ – a kind of pure essence of subjectivity” (p. 44). According to Husserl, ideas derived from the third reduction are not derived from experience but in the conscious and would therefore be able to be classified as universal. Phenomenology includes several factors that play a role in the experience or description of a certain phenomenon. According to Wagner (1983) essential influential factors include perception, experience, attention, interest, and motivation, a definition of the situation, vantage point, horizons, and relevance. These factors may shape teachers’ experiences with ADHD, and may become apparent in their conversations with the researcher.

Phenomenological interpretation aims to understand how the self is experienced, and how things outside the self are experienced (Wagner, 1983). For the purpose of the study, the phenomenological method of ‘bracketing’ will be used. This method involves the researcher identifying themes or ‘items’ that are detached from their meaning context when the researcher suspends his or her judgments and predispositions (Bentz, 1995). Preconceptions, biases, and prejudices should be bracketed so that the researcher’s interaction with collected data remains objective (Bentz, 1995). The researcher in this study identified her biases, beliefs, values and assumptions before the commencement of the study, as will be described in Chapter 4. Throughout the study the researcher was aware of her own subjectivity and bracketed her assumptions and beliefs so as to become immersed in the collected data and uncover the fundamental deeper meaning of the participants’ experience (Burke, 2004).

A further phenomenological interpretation technique is described by James as introspection and refers to a method for accessing inner experience by means of self-examination (Wagner, 1983). By using this technique, the inner “stream of consciousness” (p. 33) can be explored. In James’ study of introspection he warned of the “psychologist’s fallacy” (Wagner, 1982, p. 39) which

refers to the psychologist's own values, personal bias, standards, and preconceived theories that may influence the true nature of the revealed consciousness. Data collected may become tainted and inaccurate, as it is no longer the real description of the participant's consciousness or experience (Wagner, 1983).

The researcher made her role in this study explicit in Chapter 4 as well as her beliefs, assumptions and biases of ADHD. From a phenomenological perspective, true objectivity is neither attainable nor desirable; however, the researcher has to be aware of her subjectivity and attempt to accurately present the participants' experiences and meanings of their personal life-world.

3.5 CONCLUSION

From the phenomenological perspective described in this chapter, the study aims to explore the true experiences of primary school teachers who have children diagnosed with ADHD in their classrooms. These experiences are described from a first-person perspective to highlight subjectivity and inner experience as described by Husserl and by Merleau-Ponty (Lyotard, 1991). Interpretation and understanding of data will draw on James' concept of introspection (Wagner, 1983) as well as Dilthey's concept of historical consciousness (Zaner, 1970). In the following chapter the research methodology for the study will be explained.

CHAPTER FOUR

RESEARCH METHODOLOGY

“He lit a lamp in broad daylight and said as he went about,
‘I am looking for a man’”.

- Sayre (1938, p. 99)

4.1 INTRODUCTION

The Greek philosopher Diogenes was said to have walked through the city with a lit lamp in daytime looking for a man (Sayre, 1938). When asked what he was doing, Diogenes replied that even with a lamp in broad daylight he cannot find a real human being (Zambo, 2004). This tale of Diogenes illustrates the researcher’s rationale for a qualitative study in that the lamp of quantitative methodology is not conducive to the understanding of personal experiences (Zambo, 2004) such as those of teachers dealing with children with ADHD in their classrooms. For the purpose of this study, qualitative methods are therefore used to explore and gain an in-depth understanding of the experiences of primary school teachers who have children diagnosed with ADHD in their classrooms.

This study aims to explore teachers’ shared and differing experiences in dealing with children with ADHD on a daily basis. As referred to in the literature review, the experiences of teachers educating children with ADHD have only recently been studied and there is a definite need for further research in this area, especially regarding the context of primary schools as this is where children are typically first diagnosed. The chapter begins with a rationale for using a qualitative research design and its suitability for a phenomenology paradigm. It describes the participant selection process as well as how data was collected, analysed and interpreted. The chapter also describes the validity and reliability of the study.

4.2 QUALITATIVE RESEARCH

Qualitative research refers to the exploration and interpretation of human phenomena (Heath, 1997). It is descriptive and interpretive (Tesch, 1990), and is mainly concerned with the nature of explored phenomena (Labuschagne, 2003). The purpose of qualitative research, according to Morrow (2007), is to gather information that is rich and descriptive in nature which illustrates the phenomenon being studied. Qualitative research aims at understanding the meaning that individuals attach to certain situations or behaviour (Tutty, Rothery & Grinnell, 1996). The word *qualitative* implies an emphasis on “processes and meanings that are not experimentally examined or measured” (Denzin & Lincoln, 2000, p. 8) in terms of magnitude or incidence. Qualitative research is mainly concerned with the lived experience and meanings of explored phenomena. There is an emphasis on understanding the social world (Labuschagne, 2003) from the first-person point of view, as described by Husserl and Merleau-Ponty’s phenomenology (Lyotard, 1991). According to Labuschagne (2003), qualitative research methods characteristically generate in-depth and detailed data of a small number of people and cases, by emphasizing processes and meanings rather than using numerical data.

This study was compiled with the aid of a comprehensive literature review to express the underlying assumptions behind the research question and to demonstrate the need for the study, as well as in-depth interviews which aim at understanding the participants’ meanings and experiences of having children with ADHD in their classrooms. The study was exploratory in nature and interviews aimed at generating rich, detailed and descriptive data.

4.3 QUALITATIVE RESEARCH AND PHENOMENOLOGY

For the purpose of this study, the phenomenological approach to qualitative research was used to explore and understand collected data. According to Tesch (1990), “phenomenological researchers study the ordinary ‘life-world’: they are interested in the way people experience their world, what it is like for them...” (p. 68). Phenomenology is a qualitative research methodology that can be used to discover and understand meaning and lived experiences (Fochtman, 2008). Phenomenological studies describe the meaning for individuals of their “lived experiences of a concept or a phenomenon” (Creswell, 2007, p. 57). Creswell (2007) further explains that

phenomenological research focuses on describing shared experiences of participants. This study is aimed at exploring the lived experiences of teachers in dealing with children with ADHD in their classrooms. According to Moustakas (1994) phenomenology's approach to research is to understand "meaningful concrete relations implicit in the original description of experience in the context of a particular situation" (p. 14), which is the main objective of phenomenological information and understanding. Phenomenology is also described as the study of the collective meaning of experience of a phenomenon for several persons (McCaslin & Scott, 2003) and "the aim is to determine what an experience means for the persons who have had the experience" (Moustakas, 1994, p. 13).

Teachers were interviewed to gain an understanding of what it is like for them to have children with ADHD in their classrooms. Phenomenology, as a research design, depends primarily on interview-data (Morrow, 2007), and the study used in-depth interviews as the method of data collection. From the individual descriptions, general or universal meanings were derived that represents the essence or structures of the experience (Moustakas, 1994). Data obtained from interviews were analyzed using interpretative phenomenological analysis (hereafter IPA) which will be explained further on.

4.4 SELECTION OF PARTICIPANTS

Signs and symptoms of ADHD vary in degrees of severity from child to child. Many children are considered to have ADHD as they display several traits of the disorder, but cannot be formally diagnosed as the symptoms are not developmentally inappropriate or do not significantly impair their functioning (Sadock & Sadock, 2003). A formal diagnosis of ADHD by a qualified medical or mental health care practitioner (such as a psychologist) is necessary and a prerequisite for the study. For the purpose of this study, primary school teachers were selected who have one or more formally diagnosed children with ADHD in their classrooms. Four teachers from one private primary school were interviewed. One school was selected as the study was in-depth in nature and aimed at generating data rich and descriptive in nature. The age and gender of teachers selected were of no significance for this study. However, a necessary stipulation was that the children that inform their experiences are formally diagnosed with ADHD, and are not pending a diagnosis, or only show traits of ADHD.

4.4.1 CRITERIA FOR PARTICIPANT SELECTION

The importance and relevance of a criteria framework is that it allows the researcher to include appropriate participants in the study for the purpose of generating specific data relevant to the goal of the study. Participants were selected on grounds of the following pre-determined criteria (refer also to Appendix B):

- The participant should have one or more children who have been formally diagnosed with ADHD (by a qualified medical or mental health care practitioner) in his/her classroom; and
- The child/children that form the participant's experience should be formally diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and not any other developmental disorder or learning disability.

If participants met the stipulated criteria, they were subsequently selected based on the availability of children with ADHD in the classrooms. In other words, classrooms with more than one child with ADHD were preferred to classrooms with only one child with ADHD, with the intention that experiences of participants are not child specific, but specific regarding ADHD.

4.4.2 PURPOSIVE SAMPLING OF PARTICIPANTS

Participants were selected based on the stipulated criteria, as discussed in the previous section, as well as availability of suitable participants. In this study, both purposive and snowball sampling techniques were utilized to select suitable participants. Purposive sampling refers to when particular participants are chosen because they “illustrate some feature or process that is of interest to the particular study” (de Vos, Strydom, Fouché, & Delpont, 2002, p. 334). According to Morrow (2007), purposively choosing participants and sources of data is associated with the qualitative framework. Creswell (2007) describes purposeful sampling as a means that is used to select participants for the study “because they can purposefully inform an understanding of the research problem and central phenomenon in the study” (p. 125). Purposive sampling as a method of selecting participants was chosen because it is based on the subjective judgment of the researcher regarding the characteristics of the representative sample, with a specific purpose in mind (Neuman, 2006). In this way, the researcher had control over who was included in the study and who was not.

4.4.3 SNOWBALL SAMPLING OF PARTICIPANTS

Snowball sampling, or network chain referral, refers to the researcher choosing one participant and locating others by using the information supplied by the first (de Vos et al., 2002). The underlying principle is that “each person or unit is connected with another through a direct or indirect linkage” (Neuman, 2006, p. 223). Neuman defines snowball sampling as “a non-random sample in which the researcher begins with one case, and then based on the information about interrelationships from that case, identifies other cases” (p. 223). The researcher is acquainted with a primary school teacher who is aware of children diagnosed with ADHD in other teachers’ classrooms within the school. This teacher referred the researcher to these teachers who in turn referred the researcher to other teachers, and in such a way the researcher gained information about similar potential participants.

Both purposive and snowballing as techniques for selecting suitable participants were utilized in this study in that the researcher chose initial participants that fulfilled the requirements for the study, and as information was provided about other possible participants, the researcher determined their suitability according to the established criteria. The researcher was therefore in control of the selection of the participants. The rationale for this is that the study stipulates certain specific requirements regarding the diagnosis of ADHD in children as well as participating teachers which will be subsequently explained.

The researcher contacted the Head of Department of the Foundation Phase of the school to discuss suitable participants. The stipulated criteria as well the availability of the participants had to be considered. The Head of the Department approached the several teachers to assess their willingness to participate in the study. Four participants were selected according to the stipulated criteria.

4.4.4 SAMPLE SIZE

According to Patton (2002), the number of participants in a qualitative study should be relevant to the purpose and goals of the study: “sample size depends on what you want to know, the purpose of the inquiry, what’s at stake, what will be useful, what will have credibility, and what can be

done with available time and resources” (p. 244). For the purpose of this study at least four participants at the school met the stipulated criteria. As this study was exploratory it was not necessary to select a larger sample. The data also reached saturation for the purposes and scope of the study once the four interviews were completed and the researcher decided not to interview any further potential participants at the school. Saturation refers to the “condition of an interpretive account where the account is richly fed by the material that has been collected” (Terre Blanche & Durrheim, 1999, p. 422). This means that in this study the researcher was able to acquire a sense of satisfaction with the data collected in that she has thoroughly explored the phenomenon (Terre Blanche & Durrheim, 1999).

4.5 DATA COLLECTION METHOD - THE SEMI-STRUCTURED INTERVIEW AND INTERVIEW GUIDE

4.5.1 SEMI-STRUCTURED INTERVIEW

For the purpose of the study, semi-structured interviews were used to collect information about the teachers’ experiences of having children diagnosed with ADHD in their classrooms. The rationale for conducting semi-structured interviews is that they guide the researcher, but are not restrictive as they allow the researcher to explore interesting areas that arise and can follow the participant’s ideas, interests or concerns more closely (Smith, 2003). This approach to interviewing can provide a “greater breadth of data” because of its “qualitative nature” (Denzin & Lincoln, 2000, p. 652). The interview guide (refer to Appendix A) was developed by the researcher as a means of collecting data, as it provides some structure while still maintaining flexibility.

According to Smith (2003), the semi-structured interview has several advantages including providing a means of facilitating rapport, allowing for flexibility of coverage as it allows the interview to explore new areas of interest, and as a result, tends to produce richer, more detailed data than a structured interview. Smith (2003) also proposes some disadvantages to semi-structured interviews such as reducing the control the researcher has over the situation, and it being more time consuming to carry out and harder to analyze.

Interviews with the participants were allowed to progress spontaneously and they could introduce their own ideas and concerns that the researcher had not considered previously as they were perceived as the “experiential expert on the subject and should therefore be allowed maximum opportunity to tell their own story” (Smith, 2003, p. 57). The interview guide was developed in advance by the researcher considering available literature on ADHD for the purpose of eliciting participants’ experiences, perceptions and emotions regarding having children with ADHD in their classrooms. This allowed the researcher to think explicitly about what would or should be covered in the interview as well as to consider possible difficulties or hurdles that might be encountered (Smith, 2003). This process allowed the researcher to be more focused on what the participant was sharing at that moment. The interview guide was aimed at exploring teachers’ experiences and emotions of teaching children with ADHD. The interview guide further explored teachers’ knowledge about ADHD, including diagnosis and stereotyping, as well as their training in dealing with children with learning difficulties.

4.5.2 DATA COLLECTION PROCEDURE

Appointments for the interviews were set up by the researcher by consulting with the Head of Department of the Foundation Phase of the school regarding the teachers’ schedules. She was the gatekeeper to these participants as the researcher needed her, in addition to the principal’s permission, to approach the teachers as stipulated by the school’s governing body. One hour per interview was allocated, but teachers were informed that they were welcome to extend the interview time if desired. Before the commencement of the interview, the researcher allocated some time to establish rapport with the participant with an informal conversation without audio taping the conversation, and thus created a relaxed atmosphere. The researcher then briefly explained the research and its goals as well as why the specific school was chosen and how research results would be disseminated. Interviews were audio taped with the written permission of the teachers. Participants were reminded, before the commencement of the interview, to not disclose any identifying information about any children. The recording of each interview was then transcribed verbatim by the researcher.

4.5.3 ETHICAL PROCEDURES

Approval from the Research and Ethics Committee of the Humanities Faculty at the University of Pretoria was obtained before the research commenced. The following ethical guidelines and procedures, according to the Ethical Guidelines for research of the University of Pretoria, were applied in this study:

- Participants were not pressurized or coerced into participating in the study. Participation was voluntary and participants could withdraw from the study at any time without negative consequences to themselves or the school;
- The stipulated criteria for the selection of participants did not discriminate against any potential participant based on the grounds of race, gender, sex, pregnancy, marital status, family status, ethnic or social origin, colour, sexual orientation, disability or medical condition, religion, conscience or beliefs, and culture;
- No physical or psychological risks or discomforts were expected to result from the study. However, if participants indicated some anxiety when recollecting events, an appropriate referral system was in place for further management;
- All information collected was treated as confidential, and anonymity of participants was assured, including that of the school. No identifying information is made public without the written consent of the participant. The children who form the participants' experiences remain anonymous as no identifying information was provided to the researcher;
- Participants were informed about the nature and purpose of the study by means of a Participation Information Sheet (refer to Appendix B), and were therefore able to make an informed and knowledgeable decision about participating in the study; and
- Written consent was obtained from each participant to take part voluntarily in the study as well as to be audio-taped during interviews.

4.6 PHENOMENOLOGICAL DATA ANALYSIS

Once data has been collected and transcribed the researcher analysed the accounts of the participants. From the phenomenological perspective, a composite description is developed of the essence of the experience for the participants (Creswell, 2007). This description consists of 'what' they experienced and 'how' they experienced it (Creswell, 2007; Moustakas, 1994). The aim is to

explore lived experience rather than to attain theoretical explanations (Creswell, 2007). Interviews focused on the experiences of the primary school teachers regarding having children with ADHD in their classrooms. The meanings of central themes or patterns arising through the interviews were interpreted using the IPA approach. According to Smith (2003) the aim of IPA is to “explore in detail how participants are making sense of their personal and social world” (p. 51) and meaning of experiences is of particular importance. The approach is phenomenological in nature as it entails the exploration of the participant’s life world (Smith, 2003).

Marshall and Rossman (1995) state that “through questioning the data and reflecting on the conceptual framework, the researcher engages the ideas and the data in significant intellectual work” (p. 114). Data analysis includes identifying salient themes, recurring ideas or language, and patterns of beliefs that link teachers and their contexts. According to Patton (1980), “inductive analysis means that patterns, themes, and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis” (p. 306). The analysis of the interview transcripts was based on this inductive approach aimed at identifying salient themes.

According to Smith (2003), IPA is well suited to qualitative studies that utilize small sample sizes and thus the IPA method was chosen as an appropriate method for data analysis for this study. As the aim of this study is to explore the experiences of teachers by gaining an understanding of their perceptions and emotions which is particular to the selected sample generalizations cannot be made. IPA generally makes use of purposive sampling to identify appropriate participants, and uses semi-structured interviews to collect data (Smith, 2003), as does this study. For the purpose of this research, semi-structured interviews are used as the only data collection method.

4.6.1 INTERPRETIVE PHENOMENOLOGICAL ANALYSIS

IPA is a qualitative approach and attempts to explore personal experience and emphasizes the individual’s personal account of the phenomenon being studied (Smith, 2003). IPA aims at gaining an insider’s view of the participants’ experience of a situation (Mulveen & Hepworth, 2006). Collins and Nicolson (2002) describe IPA as a method for representing participants’ subjective experiences and the meaning that such experiences hold for them. IPA also entails

determining salient messages or cues, whether verbal or non-verbal, provided by the participants that they are usually unaware of, such as perceptions, prejudices, values and core beliefs. The researcher must interpret participants' mental and emotional state from what they say, especially when they find it difficult to discuss feelings and emotions or to self-disclose (Smith, 2003). IPA is about exploration of meaning and sense-making of experiences and there is no attempt by the researcher to test a predetermined hypothesis. Phenomena are explored in detail so as to reveal the participant's life world by exploring his/her viewpoint (Smith, 2003).

According to Terre Blanche and Durrheim (1999), data analysis involves reading through collected data repeatedly, becoming acquainted with the data and engaging in activities of "breaking the data down (thematizing and categorizing) and building it up again in novel ways (elaborating and interpreting)" (p. 140). For the purpose of this research, IPA is used to analyze and understand data collected from the interviews with participants. Several steps are proposed when making use of IPA, but these steps are viewed as guidelines to the analyzing process and the researcher may alter these to suit the context and nature of data.

According to Terre Blanche and Durrheim (1999), the first step in IPA is the familiarization with data content and the immersion of the researcher with the collected data. Familiarization occurs by reading and rereading the data so that content is well-known to the researcher (Tesch, 1990). At this stage the researcher develops an idea of initial interpretations that can be supported by the data. The second stage involves identifying themes. This is seen as a 'bottom-up approach' (Terre Blanche & Durrheim, 1999) where data is viewed in the light of principles that "naturally underlie the material" (p. 141). In other words, initial themes arise from the data and are not predetermined beforehand (Patton, 1980; Tesch, 1990). Identified themes are produced in the language of the participants as they arise naturally from the data. The researcher reflects on the identified themes and comes up with the essence or the core of that experience for the participant (Moustakas, 1994).

According to McCaslin and Scott (2003), the researcher reduces collected information to a central theme or meaning which is referred to as the 'essence' of the experience. The third stage involves the coding process where not only themes are identified, but data is also coded according to relevance to the identified themes.

The fourth step entails the elaboration process where the sequence of themes arising from the data is broken up to provide a fresh look at the data. The purpose is to “capture the finer nuances of meaning” (p. 144) not apparent in the initial coding system. At this stage new insights may emerge from the data. The last step as described by Terre Blanche and Durrheim (1999), involves interpretation and checking of interpreted data. This entails going through interpretations with a fine-tooth comb ensuring that the interpretations are accurate as well as identifying the researcher’s reflection and own involvement in collecting the data and creating the interpretation.

The analysis process, based on the IPA method, commenced with the researcher transcribing the interviews verbatim and engaging with the text by familiarizing herself with its content. This process already started with interviewing the teachers and continued when the interviews were transcribed (Tesch, 1990; Terre Blanche & Durrheim, 1999). Thereafter, the transcription was read several times. In the left-hand margin, the researcher made notes on what was thought to be interesting or significant about what the participant said (Smith, 2003). With each reading, the researcher enhanced her understanding of the accounts and discovered new insights. The researcher freely commented on what she felt was noteworthy without any restrictions. Some parts of the transcripts were richer than others, with more ideas and thoughts, and so warranted more annotations. As Smith (2003) indicated “some of the comments are attempts at summarizing or paraphrasing, some will be associations or connections that come to mind, and others may be preliminary interpretations” (p. 67). Comments made include use of language, how the person comes across, similarities and differences, repetitions, amplifications and contradictions in what was said by the participant.

Once this process was completed, the researcher moved back to the beginning of the transcript and used the right-hand margin to document emerging themes. Here the “initial notes are transformed into concise phrases which aim to capture the essential quality of what was found in the text” (Smith, 2003, p. 68). The emerging themes had bearing on the research question (Tesch, 1990; Terre Blanche & Durrheim, 1999). This process is also referred to as coding and according to Terre Blanche and Durrheim (1999), entails “making different sections of the data as being instances of, or relevant to, one or more of the themes” (p. 143). This process allows the transcript to be broken down into significant pieces that are labelled and then grouped together under code headings (Terre Blanche & Durrheim, 1999). The themes became more abstract and it was found

that the same theme title was repeated. At this stage the entire transcript was treated as data, as no part was omitted and no part was selected for particular consideration (Smith, 2003). Some passages generated more themes than others, which gave an indication of the richness of the text (Smith, 2003). The initial themes were then listed in chronological order as they appeared in the transcriptions and connections between the themes were looked for.

The next stage entailed more analytical and theoretical ordering (Smith, 2003) as the researcher attempted to understand the connections between the identified themes. As the clustering of themes emerged, it was checked in the transcript to make sure the connections worked and was in the actual words of the participant. The participants' actual phrases (direct quotes) were used to support the identification of these themes. Some themes clustered together and superordinate concepts emerged (Smith, 2003), and were no longer in the direct language of the participants. Themes were paraphrased by summarizing it into academic language (Tesch, 1990).

The next step was to construct a table of the themes ordered logically. The clusters were given names and represented the superordinate themes (Smith, 2003). The table listed the themes which match each superordinate theme, and an identifier was added to each illustration to aid the organization of the analysis and facilitate finding the original source afterward (Smith, 2003). The identifier "indicates where in the transcript instances of each theme can be found by giving key words from the particular extract plus the page number of the transcript" (Smith, 2003, p. 72). According to Terre Blanche and Durrheim (1999), elaboration and exploring themes more closely occurs when themes and coding allows the order of the data to be broken up providing the researcher with a new observation of the data. It is at this stage that the researcher kept on "coding, elaborating and recoding, until no further significant new insights" (p. 144) appeared to emerge. It was also during this process that some themes were discarded if found to not be supported enough in the transcript. This process was repeated with each interview transcript. Previously identified themes in other transcripts were not used as a guideline in analyzing the next. Each transcript was approached in this manner. Once all four transcripts were analyzed according to this process, a final table of superordinate themes was constructed: "deciding which themes should be focused on requires the researcher to prioritize the data and begin to reduce them" (Smith, 2003, p. 76). The researcher also reviewed previous transcripts as soon as new themes emerged during the analysis process.

After the analysis process, the researcher outlined the “meanings inherent in the participants’ experience” by “translating themes into a narrative account” (Smith, 2003, p. 76). At this stage themes were explained, developed, amplified and nuanced. Direct quotations were used to support themes which form the basis for the account of the participants’ responses (Smith, 2003). A distinction was made between the actual accounts of the participants and the researcher’s interpretations of those accounts. After the analysis process, the interpretations were checked to determine whether the researcher over-interpreted the data or merely summarized the findings (Terre Blanche & Durrheim, 1999). The researcher also explained how her role impacted the study and may have influenced the way data was collected and analyzed (Terre Blanche & Durrheim, 1999). The analysis process ended as the data no longer generated new insights or ideas, in other words the process ‘exhausted’ the collected data (Tesch, 1990).

4.7 VALIDITY AND RELIABILITY IN THE QUALITATIVE CONTEXT

4.7.1 RELIABILITY

Reliability refers to dependability or consistency (Neuman, 2006) and is “the degree to which the results are repeatable” (Terre Blanche & Durrheim, 1999, p. 63) which applies to both participants’ scores and responses on measures and to the outcomes of the study as a whole. Within the qualitative framework, social phenomena are, however, context-dependent and the meanings individuals ascribe depend on the situation in which the individuals exist (Terre Blanche & Durrheim, 1999). For the purpose of this research, semi-structured interviews were used to collect information from participants. Other researchers exploring the same phenomena, using different data collection methods, may obtain distinctive results (Neuman, 2006). Neuman explains that this occurrence is because “data collection is an interactive process in which particular researchers operate in an evolving setting and the setting’s context dictates, using a unique mix of measures that cannot be repeated” (p. 196). The study does not take place in an unchanging and stable reality as “individuals, groups and organizations will behave differently and express different opinions in changing contexts” (p. 64). Therefore the study cannot be expected to necessarily yield the same results when repeated.

In place of reliability, Terre Blanche and Durrheim (1999) propose that findings should be *dependable* which is defined as “the degree to which the reader can be convinced that the findings did indeed occur as the researcher says it did” (p. 64). According to Creswell (2007), dependability can be enhanced by employing audio tape recordings and by transcribing the tapes. In this study a good quality digital tape recorder was employed to record the interviews and was transcribed by the researcher herself. Terre Blanche and Durrheim (1999) state that “dependability is achieved through rich and detailed descriptions that show how certain actions and opinions are rooted in and develop out of contextual interaction” (p. 64). The analysis of the data collected by means of interviews, produced rich, detailed and descriptive data pertaining to the research question, within the context of the study, which supports the dependability of the study. This connects to the phenomenological approach of the study in that it aims at exploring and understanding personal meaning of experiences of participants and not at generating data to test or prove hypotheses.

4.7.2 VALIDITY

According to Neuman (2006, p. 196) “validity means truthful” and qualitative research aims at portraying authenticity of participants’ accounts. Authenticity means “giving a fair, honest, and balanced account of social life from the viewpoint of someone else who lives it every day” (Neuman, 2006, p. 196). Creswell (2007) explains validity as an attempt to assess the accuracy and credibility of research findings. In other words, validity refers to whether the explanation fits the description (Denzin & Lincoln, 2000).

From a qualitative perspective, there is no one way of interpreting phenomena. There is no one ‘correct’ interpretation, but rather an accurate description or account of the phenomenon (Denzin & Lincoln, 2000). According to Terre Blanche and Durrheim (1999), validity in qualitative research refers to “the degree to which the research conclusions are sound” (p. 61) which means that interpretive validity becomes important in qualitative research. Interpretive validity means “the extent to which the appropriate conclusions are drawn from the study” (Terre Blanche & Durrheim, 1999, p. 62).

Validity in this study was achieved by ensuring that the thoughts, ideas, meanings, perceptions, emotions and experiences expressed by the participants were accurately portrayed and in this way

connects with the phenomenological approach of the study. This research endeavours to give a true and candid description of teachers' experiences of having children with ADHD in their classrooms, from the teachers' perspectives. To further increase the validity (or credibility) of the study, the researcher took note of possible impacting factors on the research and these were explained (Terre Blanche & Durrheim, 1999). Impacting factors identified include the role of the researcher in collecting and interpreting data, the particulars of the participants selected, as well as the context in which the study took place. These will be explained further on.

As stated earlier, results or conclusions are not always generalizable to the broader population in qualitative research as they usually draw on small samples (Terre Blanche & Durrheim, 1999). However, conclusions are transferable which is achieved by producing detailed and rich descriptions of contexts, which

“give readers detailed accounts of the structures of meaning which develop in a specific context. These understandings can then be transferred to new contexts in other studies to provide a framework with which to reflect on the arrangements of meaning and action that occur in these new contexts” (Terre Blanche & Durrheim, 1999, p. 63).

For the purpose of this research, one school, from which four participants took part, was included in the study. The small sample offered rich, in-depth, descriptive accounts of the experiences of dealing with children with ADHD, and the conclusions drawn from this study can be transferred to contexts and areas of possible further research.

When assessing the quality of qualitative research, Smith (2003) puts forth broad principles to be considered. The first principle is sensitivity to context which means that the study should “demonstrate sensitivity to the context in which the study is situated” (p. 232). This research demonstrated sensitivity to its context by indicating an awareness of the current literature on ADHD which formed the underpinning for the research as well as explaining key principles of the phenomenological approach which forms the theoretical conceptualization of the study. The study further indicates sensitivity to contexts by providing direct quotes or extracts from participants' responses to present evidence for the interpretations offered. Both the role of the researcher in the research process is explained as well as the socio-cultural milieu in which the study takes place,

which may have influenced the study's implementation and its outcomes. The second principle proposed by Smith (2003) is transparency and coherence which refer to "how clearly the stages of the research process are outlined in the write-up of the study" (p. 233).

Chapter 4 presents detailed information on participant selection, the construction and rationale of the interview guide as well as data analysis. In this study, the Interpretive Phenomenological Analysis (IPA) method is used to analyze and make sense of collected data. The process is explained in detail and conclusions are presented with supporting evidence from direct responses of participants. The third principle specified by Smith (2003) is impact and importance which refers to the validity of the research and "whether it actually tells us anything useful or important or makes any difference" (p. 234). This is indicated in the conclusions drawn from the study and will be explained further on.

Angen (2000) suggested that validity is "a judgment of the trustworthiness or goodness of a piece of research" (p. 387). In this study, dependability and trustworthiness were achieved by the researcher disclosing her role and orientation (Morrow, 2005; Stiles, 1993) with regards to the research. The researcher explained her biases, assumptions and own meanings ascribed to the topic (Creswell, 2007). She also explained her social and cultural context as well as those of the participants. The researcher further established an in-depth engagement with the collected data by familiarizing herself with the data and establishing a subjective stance towards the participants and the data (Stiles, 1993).

4.7.3 THE CONNECTION BETWEEN DEPENDABILITY AND CREDIBILITY

According to Stiles (1993), both validity and reliability entail trustworthiness. Validity refers to the trustworthiness of interpretations and understanding, and reliability refers to the trustworthiness of observations or data. In order for the research to increase its validity (credibility and transferability) and reliability (dependability), the semi-structured interview guide was developed to ask specific and particular questions with regard to ADHD and teachers' experiences of having children with ADHD in their classrooms. The interview guide was unstructured enough to allow for flexibility of participant responses, subsequently increasing the validity of the measure. Responses of participants were plausible which means that statements and descriptions

about their experiences in the classroom were not exclusive or limited: “they are not the only possible claims, nor are they exact accounts of the one truth in the world” (Neuman, 2006, p. 197). From this it can be expected that the same study may have yielded different conclusions when interpreted by different researchers, each with their own biases, assumptions, beliefs, and experiences.

Validity, according to Neuman (2006), is increased as connections between the data obtained from the interviews are considered: validity “grows with the creation of a web of dynamic connections across diverse realms and not only with the number of specifics that are connected” (p. 197). As the researcher engaged with the collected data, a rich description of the account of teachers’ experiences in the classroom emerged, indicating several similarities and some differences in their experiences of ADHD. The descriptions were accurately and truthfully portrayed by the researcher.

4.8 THE ROLE OF THE RESEARCHER

Morrow (2005) maintains the essentiality of understanding the researcher in relation to the study as to provide “sufficient information on which to base a full understanding of the context of the study” (p. 215). According to Denzin and Lincoln (2000), it is important that the researcher describes his/her role in the research process as the researcher “speaks from a particular class, gender, racial, cultural, and ethnic community perspective” (p. 18). Morrow (2007) states that when researchers “make public their own stances, motivations, assumptions, and biases, the research gains a level of honesty that contributes to the trustworthiness (rigor) of the study” (p. 216). Smith (2003) maintains that the researcher’s biases, prejudices and preconceptions may inaccurately influence the description of the experiences of the participants and that these need to be identified and described in order to obtain the most truthful and accurate information from the accounts of the participants. Stiles (1993) states that in qualitative research, the researcher develops close relationships with participants and is purposely subjective, but the researcher’s role, biases and beliefs need to be made explicit. The researcher therefore made her biases, values and assumptions explicit so as to ‘bracket’ these when collecting, analysing and interpreting the data.

The researcher has a family member diagnosed with ADHD and as a result holds certain beliefs and assumptions about ADHD regarding diagnosis and treatment. The researcher believes that ADHD is a developmental disorder that the child must learn to cope with and manage effectively with the assistance of parents and teachers. ADHD should also be diagnosed carefully taking into consideration all possible influencing factors and differential diagnoses. A diagnosis of ADHD is imperative as it allows for the correct treatment and intervention strategies to be formulated for the specific child and his/her environment. As a child does not outgrow ADHD, it is the task of parents and teachers, and any other primary caregivers, to assist and support the child in learning ways to cope academically and socially.

Children with ADHD need constant individual attention at home and at school if they are to cope effectively with the disorder. The researcher believes that medication alone is not sufficient to deal with ADHD, but that a multidisciplinary approach is the best avenue of intervention and treatment. This team should include doctors, psychologists, occupational therapists, dieticians, teachers and parents, and whoever else is needed to address the specific needs of the child.

The researcher's motivation for choosing this particular subject mainly originates with her experience of ADHD in her immediate context and her postgraduate training in learning difficulties. The researcher was drawn to a qualitative inquiry and phenomenology as the aim of the study is to get an insider's point of view of the experiences of teachers. From experience, the researcher assumed that dealing with ADHD would be demanding, exhausting, and strenuous on teachers. During the interviews the researcher had to be cautious not to impose her own assumptions of ADHD onto the teachers. The researcher allowed the participants to freely tell their stories and express their experiences regarding dealing with children with ADHD.

During the analysis of the information, the researcher drew on her own experiences and beliefs about ADHD to understand the information collected, but she was also constantly aware of her biases, assumptions, beliefs and values regarding ADHD and attempted to consistently apply the validity and reliability guidelines discussed previously in this chapter.

4.9 CONCLUSION

This chapter provided a detailed description of the research methodology of this study including the method of data collection, the selection of participants and the ethical principles followed by the researcher. The IPA process that was followed by the researcher to obtain the results of the study was described. The chapter also considered reliability and validity within a qualitative framework of this study. A reflection on the researcher's own beliefs and assumptions of ADHD that may influence the development and results of the study, is provided. The next chapter presents the research findings of this study in the format of themes and sub-themes identified by the researcher during the analysis process.

CHAPTER FIVE

RESEARCH FINDINGS

5.1 INTRODUCTION

This chapter will present the research findings of the study. Themes and sub-themes were identified and formed during the analysis process and revealed the underlying meaning of the accounts of the participants. Themes were not predetermined and were allowed to unfold as the researcher engaged with the transcripts. The emergent themes are described and direct quotations from the participants are provided to support the themes. Only themes and sub-themes that have bearing on the research question are presented. The chapter starts with a description of the participants explaining their personal milieu. This information is essential as it provides an understanding of the context in which the teachers' experiences were formed. Information is provided with regards to the participants' training in special education, the number of children diagnosed with ADHD per classroom and medication management. This information was elicited during the interviews and is considered as significant in that it provides a further understanding of the participants' context from which their accounts were formed.

5.2 DESCRIPTION OF THE PARTICIPANTS

Four participants from one private school were selected for this study. The school is set in an affluent Eastern suburb of Pretoria. The participants are all white females with at least 10 years teaching experience each. Three participants teach Grade 2 (children age 8) and one participant teaches Grade 4 (children age 10). The participants were selected as described in Chapter 4. More teachers from Grade 2 classes were available as potential participants as children are typically diagnosed at this age. Grade 1 classes had few children who have already been diagnosed with ADHD as most of them are still in the process of being assessed, and were therefore teachers from these classes could not be considered for inclusion in the study. The Grade 4 teacher was included as she has several children in her classroom who are diagnosed with ADHD.

Interviewing the participants in the comfort and familiarity of their own classrooms provided for a relaxed atmosphere. All four participants had no formal training in special education and had not specialized in learning difficulties. They have, however, received some remedial training as part of their teaching qualification.

All children informing their experiences have been formally diagnosed with ADHD by a qualified medical practitioner. The children's diagnostic status was crosschecked by the researcher with the Head of Department without her revealing the identities of the children to the researcher. Most of these children are currently on medication – either Concerta or Ritalin – and receive their medication at home. Two teachers administer a small dose of medication to certain children during school hours as well. There are no more than 24 learners per teacher's classroom of which an average of two are diagnosed with ADHD per classroom. The researcher experienced the teachers as kind and caring with a real enthusiasm and passion for teaching. The participants were all exceptionally willing to share their experiences with the researcher.

5.3 EMERGING THEMES

Themes and sub-themes that emerged from the transcripts are presented in the sections that follow. Verbatim quotations are provided with the number of the participant that made the statement. The three Grade 2 teachers are referred to as participant 1, participant 2 and participant 4. The Grade 4 teacher is referred to as participant 3. This allocation was made by the researcher with regards to the sequence of interviews. The following themes and sub-themes were identified from analyzing the transcripts which were supported by the accounts of the participants:

5.3.1 **THEME 1: KNOWLEDGE OF ADHD PROVIDES UNDERSTANDING**

The participants explain that as a teacher you need to have knowledge of ADHD because that gives you understanding of the child with ADHD. With understanding of ADHD comes patience with the child: “knowledge gives you understanding, and when you've got understanding, you've got patience, then you can deal with the situation” (Participant 1).

They also believe that with knowledge and understanding they can better cope with these children in the classroom: “It definitely makes it easier to deal with. You understand the way they react towards things. Why they don’t work the one day and work the next day, the way they leave their homework at school everyday” (Participant 2). The participants stated that with knowledge of ADHD they have more empathy with the child and feel they can change their interventions in the class to suit the child: “Knowing also gives you an empathy with the child - I know this child now, or have an idea now, so I need to change my ways, or my strategy for the child” (Participant 4).

The participants also said that knowledge of ADHD changes the way they approach and manage the child in the classroom: “I think it helps you to understand a little bit better...you definitely change your way of dealing with that child” (Participant 3); “I think any teacher, the more you get to know about it, the better. The more background you have, the more able you are to assist the child, most definitely” (Participant 2). The participants believe that without knowledge of ADHD they lose understanding and patience to deal with the situation and then they tend to focus only on the symptoms of ADHD: “But if you’ve got no knowledge you just look at the symptoms and they drive you crazy” (Participant 1).

The participants said that by attending courses and workshops on ADHD they can increase their knowledge and with more knowledge they are better able to deal with these children in the classroom: “And throughout the years I went to a few courses and that has helped a lot” (Participant 2); “So I struggled with that first little boy very much to handle it... I had no knowledge...and then I went to a symposium on ADHD...and that helped a lot” (Participant 1). It became apparent from the participants’ accounts that knowledge of ADHD does not only increase their understanding and empathy for the child, but also their strategies of managing these children in the classroom.

The participants said that they have gained most of their knowledge of dealing with children with learning difficulties such as ADHD by teaching over the years: “And I really learnt a lot there of how to pick up problems and how to help children with ADHD or other problems. Until then I had no idea. I hadn’t even realized children had these problems - so that helped a lot” (Participant 3); “I would say experience, lots of experience made me know more” (Participant 1).

5.3.1.1 SUB-THEME 1: EXPERIENCES OF NOT HAVING ENOUGH KNOWLEDGE OF ADHD

The participants shared with the researcher their experiences of teaching where they felt that they did not have enough knowledge of ADHD to handle classroom situations, for example: “The first time I had a little boy with ADHD, it was my second year of teaching and I went nuts, I really did. I didn’t know how to handle this child” (Participant 1). The participant refers to her teaching experience when she qualified as a teacher when she did not have enough knowledge of ADHD. The participants’ lack of knowledge makes them feel helpless and ill-equipped to help these children “...and I just feel I can’t. I can’t help them because I’m not qualified”. “And I felt ill-equipped. I don’t have the qualification. I don’t have the knowledge” (Participant 3).

5.3.1.2 SUB-THEME 2: ADHD IS INNATE

The participants explained that part of understanding ADHD is realizing that children with ADHD are the way they are because they cannot help it. ADHD is innate or inborn to the child. As a teacher it seems that realizing that these children are not being difficult or naughty on purpose, makes it easier to understand them, have patience with them, and deal with them more constructively in classroom situations more: “this child is not just running around to be funny, or this child is not just constantly losing his stuff because he’s trying to be difficult or is constantly asking you the same question, after you’ve explained twenty times, its not that he is just difficult. It’s just because he can’t help it” (Participant 1); “It’s not because he is just plain naughty” (Participant 2). It appears that understanding that ADHD is inherent allows the teacher to collect her thoughts and emotions to be better able to deal with the situation: “you just stand outside the door and take a deep breath because you have to constantly remind yourself they can’t help it” (Participant 2).

5.3.2 THEME 2: EXPERIENCE OF THE VALUE OF MEDICATION FOR ADHD

The participants spoke ardently about the value of medication for children with ADHD. They said that children who are on medication tend to do better in class as they are able to follow instructions: “Such a big difference is if you see children that’s on medication...how it changes

when neurologically he is able to follow that instruction, able to follow it through on what he tried or started” (Participant 1).

The participants believe that children with ADHD receiving medication tend to perform better, academically and socially: “We usually call this medication ‘turn the page’ medicine, because you cannot believe the difference between one page and the next page” (Participant 2); “An amazing turnabout...he’s producing, even in mathematics, the most stunning work. He’s neat” (Participant 3); “It actually has made a huge difference to neatness, his handwriting...just being more focused” (Participant 4).

The participants also experience an improvement in the children’s ability to cope with relationships, including their ability to socialize with peers: “And since he has been diagnosed and he has been taking medication, he had integrated into a group of boys that actually is quite a calm group of boys” (Participant 4). The participants also noticed a difference in the children’s overall ability to cope in the classroom “he copes very well, especially with concentration now that he is on something to help him” (Participant 3). The participants also felt that with medication, children with ADHD are likely to be more confident and less frustrated: “the change in this child is incredible. To me the most important thing was the confidence he found in himself, more than anything. The drop in frustration levels with them, and just the confidence. He’s a different child” (Participant 2).

5.3.2.1 SUB-THEME 1: EXPERIENCES OF WHEN A CHILD WITH ADHD IS NOT RECEIVING MEDICATION

The participants seem to be greatly affected when children are not on medication for ADHD as it becomes increasingly difficult to deal with them in the classroom: “It’s impossible if you have three or more kids in your class with ADHD that’s not on medication...people have no idea how difficult it is” (Participant 2); “some are not taking anything, that makes it very hard” (Participant 4). The participants feel that without medication, children with ADHD lag behind and miss out on the basic concepts needed to progress academically: “...they do fall behind, they miss out, especially in foundation phase are all those concepts that need to be put in place” (Participant 2); “Sometimes I feel he might as well not even have been here, cause he hasn’t benefited. It’s hard.

And the thing is those gaps are going to be there next year” (Participant 3). The participants also expressed certain emotions in dealing with children with ADHD that are not receiving medication: “you feel a failure...you can’t get to everything” (Participant 2). Further, the participants stated that without medication, children with ADHD disrupt the classroom: “He wasn’t on and he would run around the classroom and roll on the carpet. Very disruptive” (Participant 1).

5.3.2.2 SUB-THEME 2: EXPERIENCE OF RELUCTANCE OF PARENTS TO GIVE MEDICATION FOR ADHD

It appears that for the participants it is particularly hard if parents are unwilling or hesitant to consider medication for ADHD, as this affects not only them, but the child as well: “It’s not about me as a teacher, its not about the other children, it’s about your child and your child’s emotions and development... I wish parents would just realize that we are not out to drug the children, this is for the children’s sake” (Participant 2). “Therapists say ‘needs medication’, parents say ‘no’. It’s kind of a dead end in a way. (Participant 3); “...they were very hesitant to put him on medication” (Participant 2); “It was a very long process, trying to get him on...” (Participant1).

By analyzing the transcripts it became apparent that the participants felt strongly about the need and significance of medication for children with ADHD. The participants believe that when children with ADHD are on medication the participants are better able to cope in the classroom and they feel more at ease and better able to manage the class as a whole.

5.3.3 THEME 3: EXPERIENCES OF ADHD IN THE CLASSROOM AFFECTS PERSONAL LIFE

The participants shared with the researcher what it means to them having children with ADHD in their classroom and how it affects their personal life. It appears that it is difficult for them to spend quality time with their own families and children as they are emotionally drained and exhausted at the end of a school day. The stress of having children with ADHD in their classrooms also places stress on their personal relationships: “I find that I tend to be quite exhausted and then I’m reluctant to spend time with them so I feel that I do neglect my own children” (Participant 4); “Oh my children definitely come second. The children in my class, especially those with ADHD, get

everything out of me, but that's unfortunately...teachers, their kids don't get the same" (Participant 2); "Emotionally you do take it home (referring to dealing with children with ADHD) and you then perhaps more impatient with your own children understandably, and in the end its stress on your own relationships" (Participant 4).

The participants also shared their experience of losing patience with their own families as a result of giving everything to their class: "They always say that you're so patient with your class and then when you get home with your family and your own kids, the patience is so slim. You know I will never yell at my class, but my kids - they're the quickest to land into trouble when I'm tired" (Participant 3); "It definitely affects people in your life. Unfortunately it is either your children or your husband or the dog or the cat that gets it...whoever is in your way" (Participant 2). In these statements, the participants referred to specifically to children with ADHD in their classrooms as being physically and emotionally draining.

The effect that teaching children with ADHD have on the participants' personal lives seemed to be of great importance, as one participant had to seek treatment for not being able to cope "for the first time in my life I really felt this year that I wasn't going cope where I eventually had to go and see the doctor and he gave me something. I was becoming emotional at school. I was becoming tearful where I just, I felt...where I would have sort of like an outburst with the children as well. So I've been taking something, and I've been feeling better" (Participant 4). This participant shared her experience in the context of dealing with children with special needs, such as ADHD and Asperger's disorder on a daily basis.

5.3.3.1 SUB-THEME 1: EXPERIENCE OF LACK OF UNDERSTANDING FROM OWN FAMILY

From the participants' accounts of their experiences there seems to be a lack of understanding from their own families regarding what it is like for them to teach a diverse group of children every day: "They have no idea what it is like working with twenty different children in front of you, and each with their own demands...your family don't understand it. I've got kids that need my attention when I get home, and my 15 year old says to me 'how can you be tired, you only went to school and taught today?'" (Participant 2); "they don't know how much it takes out of

you” (Participant 4). This lack of understanding seems to place more stress on the participants “it is just very difficult. They don’t know what it is like and no one can explain it to them” (Participant 1).

5.3.4 THEME 4: EXPERIENCE OF SUPPORT FROM PARENTS

It appears that support from parents is essential in dealing with children with ADHD. The participants believe that they are better able to deal with children with ADHD in their classrooms if certain support from parents is available to them: “It’s very important that the parents are on board. With their support, we can help the child with that academic backlog” (Participant 3); “I can handle it much better, because first of all, we’ve got the support of the parents. So you work in a partnership...So in that way it helps really, it’s much easier to handle it, although it’s still challenging” (Participant 1); “And especially when a child is diagnosed, parents should stay in close contact with the teacher and work closely together” (Participant 2).

The participants also believe that without the support from parents of children with ADHD it becomes a battle faced by the teacher alone: “Without the parents’ support, you’re fighting a losing battle” (Participant 3). The participants said that without the support from parents they feel that they are on their own and have to deal with symptoms on a daily basis without assistance from the parents to enforce routine at home as well: “You just have to deal with the situation but there’s no extra help. There’s no involvement from the parents or, you know, to get help for this child, so you just deal with the symptoms daily” (Participant 1).

5.3.5 THEME 5: EXPERIENCE OF SUPPORT FROM THE SCHOOL

The participants stated that there is support available to them from the school if needed. This support is in the form of available therapists - such as speech therapists, occupational therapists and educational psychologists - pastoral care and the assistance from the principal and the Head of Department of the Foundation phase: “Within the school we also have pastoral care specifically and the therapists would assist...” (Participant 3); “The head of department is wonderful...she sometimes takes the children and also works with them” (Participant 2); “With our head of department, when she can, she works with the children...” (Participant 4).

Other support available to them is in the form of opportunity for personal growth in terms of being able to attend workshops as the school's expense: "If there is a course or workshop that is coming up, they are supportive. In our budget there is money for personal and staff development" (Participant 1). However, they did mention that there are certain support structures they would like to have in place, such as assistant teachers as they believe this would help them teach more efficiently, especially regarding children with ADHD: "The school should really consider having classroom assistants to help the teacher deal with children needing help more on a one-on-one basis" (Participant 4); "The greatest thing for me would be classroom assistants" (Participant 1).

5.3.6 THEME 6: EXPERIENCE OF SUPPORT FROM COLLEAGUES

The participants said they receive support from their colleagues at the school and that they share knowledge of ADHD with each other and in so doing gain better understanding of which interventions are successful: "And you learn from your colleagues, what works here, and what works with that child. Sometimes you try something and it does not work at all and you share that" (Participant 1); "We share whatever we learn, we help each other. We constantly talk to each other" (Participant 2); "as colleagues we are able to talk" (Participant 4).

5.3.7 THEME 7: EXPERIENCE REGARDING CLASSROOM MANAGEMENT

The participants shared a great deal about their experiences in the classroom regarding children with ADHD. They spoke about their experiences of how each child differs and how the same strategy does not apply to every child. They also shared their experiences regarding classroom management involving discipline and lesson-planning. The participants spoke about their challenges in the classroom as well as how peers respond to children with ADHD in the classroom. They further shared their experiences of the impact of the degree of severity of ADHD and the number of children diagnosed in their class.

5.3.7.1 SUB-THEME 1: DIFFERENT STRATEGIES FOR DIFFERENT CHILDREN

The participants believe that all children are unique and individual and therefore need different strategies and interventions: "Every child is so individual and every child has got a different need

and a different way in why he does it. There are some symptoms I think that's the same, but how a child will respond to you, your intervention will differ. The one will rebel and the other one will accept it and the other one will try to be even funnier" (Participant 1); "But not everything works for all of them" (Participant 2). The participants believe that because each child is unique, each has his/her own needs which the teacher must cater for in the classroom: "Because each one is different – you can't just say 'this is the recipe for an ADHD child, use it. Every child is so individual and every child has got a different need" (Participant 1).

The participants also shared their experiences of having to constantly integrate children with ADHD into the rest of the class as it is very easy to exclude them because of their differences: "...to cater for this child's needs, but not to exclude him from how things must operate and go in the class, and that's when to have a constant integration" (Participant 1); "I find that's the most difficult challenge to keep him part of the class, but also give attention to his special needs" (Participant 1).

5.3.7.2 SUB-THEME 2: EXPERIENCES REGARDING DISCIPLINE

The participants shared their experiences regarding managing discipline in the classroom. They said they find they have to change strategies all the time: "I try not to stick to one discipline strategy the whole time - I find the reward-system works" (Participant 4). The participants find handling discipline in the classroom as particularly challenging: "And if you're constantly just handling discipline problems, then I feel I've become a witch, I just started to be somebody I am not in my being" (Participant 1); "That's the difficult thing, you have to handle the class but you have to intervene quickly here, because it can escalate so quickly. If we start throwing things around you can't just leave it, if we are running out of the class, you can't just leave it. It disrupts everything" (Participant 1).

5.3.7.3 SUB-THEME 3: EXPERIENCES REGARDING LESSON PLANNING

The participants said that it is difficult to adapt lessons to suit all the children's needs in the classroom and they have to be constantly creative to include those children with ADHD: "You have to be creative...any creative activities. You have to look at your lesson plan and see like if

there is time for movement or drawing...” (Participant 1); “I try to be creative” (Participant 4). The participants also find they have to constantly negotiate with children with ADHD as they are quick to lose focus: “You have to negotiate – let’s write a sentence and then we can draw...” (Participant 1).

The participants also shared that it is particularly challenging for them planning lessons because they have to consider where each child is academically and try to aid academic development of the whole class: “We have to have differentiated work in the lesson-plan, because they lose basic concepts that need to be put in place. So you have to have differentiated lessons for them and they definitely need individual assistance, otherwise they fall behind” (Participant 2); “I struggle to have three kids still busy with maths and then start with something else with four others. Especially if it’s something you have to teach. You have to wait and keep the others busy for those to finish up” (Participant 2).

5.3.7.4 SUB-THEME 4: EXPERIENCE OF THE DEGREE OF SEVERITY OF ADHD

The participants believe that managing the child with ADHD becomes increasingly difficult with the degree of severity of the ADHD. They find less severe ‘cases’ easier to deal with than severe cases: “It was easier for me to handle him, because he was, how will I say it diplomatically, the second most severe child..., you know, case that I’ve dealt with” (Participant 1). It seems that the degree of severity also challenges the participants in that the more severe the ADHD, the more one-on-one attention the child needs: “The degree of their ADHD, how severe it is...they can take up the attention of two, three, four kids at a time. Cause they need constant assistance” (Participant 2).

5.3.7.5 SUB-THEME 5: EXPERIENCE OF THE NUMBER OF CHILDREN WITH ADHD IN THE CLASSROOM

Participants point out that the more children diagnosed with ADHD they have in the classroom, the more difficult it becomes to handle and manage the class as they all need individual attention – both the children with ADHD and the children without: “It’s very challenging especially if you’ve got more than one child – I’ve got two now, and last year I had four children that were diagnosed,

and then it becomes challenging” (Participant 1); “The more diagnosed children you have, it’s hard - it just multiplies everything” (Participant 1); “It’s difficult when you have a class where two or three of them ADHD and you try to teach” (Participant 2).

5.3.7.6 SUB-THEME 6: EXPERIENCES OF RESPONSES FROM PEERS

From the accounts of the participants it seems that children without ADHD in the classroom tend to feel that rules do not apply to everyone equally, which creates tension in the classroom: “Because if one breaks the rule, why can he do it and I cannot...The rest of the class may feel this child is treated differently and have other privileges” (Participant 1).

The participants spoke about how the class in general reacts to the behaviour of children with ADHD: “The whole class would think he’s the clown, or get irritated with him and push him out. Children are quick to exclude somebody that is not like them, somebody who does not fit the mould...” (Participant 1). The participants also feel that the responses of peers in the classroom make it more difficult to handle classroom situations, as these children may imitate the child with ADHD’s behaviour: “Because they are so quick to pick up on each other’s mannerisms...and that’s difficult for me to handle” (Participant 1); “Then somewhere along the line then they pick up on that, and that is when they get a bit out of hand” (Participant 2).

5.3.7.7 SUB-THEME 7: TEACHERS’ RESPONSES IN THE CLASSROOM

The participants shared that they respond in certain ways to children with ADHD and that they often have to keep their own behaviour in check: “So that’s for me the first thing, to always keep calm, stay steady” (Participant 1); “I’m have to be very calm and patient with kids in my classroom” (Participant 2); “I try to never lose my cool or get frustrated and just be consistent, always smiling” (Participant 3). The participants also believe that they need to respond with patience to children with ADHD: “So it is about patience. Because you have to repeat lots of instruction” (Participant 1); “You have to re-explain to those individual individually – it’s very time consuming. So you have to be patient” (Participant 4).

There is also a sense of responsibility with having children with ADHD in their classrooms: “And those children can be damaged emotionally, especially if you as teacher don’t handle it correctly, those children can feel excluded...” (Participant 1); “You have to be so careful that the child doesn’t feel you’re picking on him” (Participant 2). The participants’ experience of having children with ADHD in their classrooms affects nearly all aspects in the classroom: “You have to sort their books out for them, you have to sort out their desks out for them...you need to put them in a routine” (Participant 2); “It affects my seating arrangements; it affects my group-work – the classroom management definitely” (Participant 3). The participants share that it is difficult for them to manage the class and that they find having children with ADHD in the classroom tends to disrupt the flow of the class: “Lets face it; it is difficult on the teacher. And everybody can be very heroic about it, but it’s difficult” (Participant 2); “I find it very difficult. It is disruptive in a classroom environment” (Participant 3).

It became apparent that the participants tend to spend more time and energy on the children with ADHD as they need individual attention: “with these children I tend to spend much more time than with your average kid in class that can cope with everything” (Participant 2); “You become so tuned to try and help those children, so it’s actually difficult to move away from them and give the other children attention” (Participant 4).

5.3.8 THEME 8: EXPERIENCES REGARDING STIGMA AND STEREOTYPING OF ADHD

The participants believe that there is a general stigma and stereotyping regarding ADHD, but that in their school, stigmatism is not prevalent: “I think there is a general...stigma concerning these children, I would think so” (Participant 1); “I know in the broader sense in other schools and with colleagues I’ve got in other schools, they’re very – ‘oh just leave him he’s hyper’ or ‘just leave him he’s ADHD’” (Participant 1); “From our school’s perspective there’s no labelling” (Participant 2). The participants also explained that even though stereotyping and stigma are not prominent in the school, it is a constant challenge to ensure children with ADHD are not excluded because of their behaviour, especially in the classroom: “Stigma is not publicly...but others are aware of it, and children pick up on that” (Participant 3); “No labelling or seen as different. You do not try and make them different, especially among their friends” (Participant 3).

Participants shared their experiences of stigma specifically with parents of children that do not have ADHD: “I had a mom who came to me and said she refuses to have him come and play at her house, because he’s the naughtiest child she’s ever met” (Participant 4); “But there is that stigma, this little boy...the parents got their back up and don’t want their children in the same class as him” (Participant 4). The participants also said that they are inclined to stereotype children with ADHD when observing a child in another teacher’s class displaying traits of ADHD: “There is a stigma perhaps walking into someone’s class and saying ‘that one is rolling around on the carpet’, and then they land up being in your class and you think ‘how am I going to handle this child?’” (Participant 4); “It is difficult, because even the teacher starts playing into this thing of ‘this one is difficult’” (Participant 2).

5.3.9 THEME 9: EXPERIENCE OF EMOTIONS IN DEALING WITH CHILDREN WITH ADHD

The researcher probed the participants to elaborate on their experiences of emotions in dealing with children with ADHD. However, the participants did not describe their emotions in much detail. The shared negative emotions mentioned include: exhaustion: “absolutely exhausting” (Participant 2); “I tend to be quite exhausted” (Participant 4); “I find it very tiring – total emotional fatigue” (Participant 4) challenging: “its really, really difficult” (Participant 3); “I find it quite difficult” (Participant 4), worry: “and you worry about them” (Participant 1), sympathy: “your heart bleeds for them” (Participant 1); “poor child” (Participant 2), frustration: “its very frustrating” (Participant 3), sense of failure: “you feel a failure, cause you can’t get to everything” (Participant 2); “I just feel I can’t help them” (Participant 3); “I didn’t achieve because he didn’t achieve” (Participant 3); “I was a failure” (Participant 4), disappointment: “there is some disappointment if they don’t achieve” (Participant 3), helplessness: “What more could I have done? And you just feel helpless” (Participant 3) and irritation: “you have your off days where they irritate you more than other days” (Participant 2).

Positive emotions experienced include: empathy, sense of accomplishment: “feeling of accomplishment by the end of the year” (Participant 4) , happiness, rewarding: “so rewarding when child achieves” (Participant 1); “just to be able to see a change in that child” (Participant 2), encouraging: “and to see that they have the ability, that’s encouraging” (Participant 3) satisfaction

and pride: “Wow, I could help this child” (Participant 1); “knowing that you could make a difference in that child’s life” (Participant 4).

5.3.10 THEME 10: EXPERIENCE OF PRIMARY AND SECONDARY SYMPTOMS OF ADHD IN THE CLASSROOM

The participants had different ideas about what they perceived as “difficult” and “less difficult” ADHD behaviour to deal with in the classroom. Participant 1 felt strongly about impulsivity being the most difficult and challenging behaviour for her to deal with: “the spontaneity of screaming out - ‘can’t wait for my turn’. ‘I want to say it now and I want to scream it out now’”. She also expressed a sense of helplessness: “that impulsivity, there’s nothing I can do as a teacher to control it, or to help the child to control it”. This participant further felt that hyperactivity was less difficult to deal with in her experience: “I can still handle the busy body...I feel we can still make a plan, I can still relieve you of your energy”. The participant also mentioned that she struggles with scholastic underachievement in children with ADHD as well as with their difficulty in socializing with peers.

Participant 2 felt that children with ADHD tend to be disorganized and she found this the most difficult to cope with: “complete disorganization – when things are all over” (Participant 2). The participant expressed that lack of self-motivation in children with ADHD was less difficult for her to deal with: “That’s not a difficulty. That’s a driving force behind having to help this child”. The participant further mentioned that she struggles to manage low self-esteem, low self-confidence, and high levels in frustration in children with ADHD. She also stated that conduct problems are difficult to deal with in children with ADHD as this disrupts the class. The participant mentioned that children with ADHD, according to her experience, also tend to struggle with depressive moods: “they seem withdrawn some days and teary, they often seem depressed” and aggressive behaviour towards others: “they are highly-strung, and sometimes become out of control - will fight and be aggressive”. Participant 2 states that this may be because of their low emotional intelligence in that they find it difficult to express themselves in a socially acceptable manner.

Participant 3 said that movement and focus is the most difficult for her to manage. She feels that this obstructs their academic development: “he might as well not even have been here, because he

hasn't benefited...and those gaps are going to be there next year". The participant states that she finds their impulsivity less difficult to deal with as she perceives it as creativity: "more a creative thing, they are the ones that come up with really interesting stuff". She mentions that she finds the movement, inattention and concentration problems most difficult to cope with. As she finds that children with ADHD rush through their work: "the neatness and the rushing through their work is a problem".

Participant 4 also feels that hyperactivity in children with ADHD is the most difficult for her to manage: "the moving around, the being off the chair the whole time". She also mentions that she struggles with encouraging them to work neatly all the time. She further states that their impulsive behaviour is also a problem in the classroom and that it is very difficult to cope with. With this she mentions that children with ADHD tend to not complete their tasks and that she finds it especially difficult to evaluate their work. She found no symptoms of ADHD less difficult to deal with, as she considers all as equally disruptive. She constantly has to encourage children with ADHD to work and do their best and to build self-esteem: "I think they really need a lot of encouragement".

5.4 CONCLUSION

In this chapter research findings were presented in the format of themes and sub-themes identified by the researcher. Emerging themes which were relevant to the research question were supported by the participants' accounts. The participants appeared to have shared their experiences honestly with the researcher. The following chapter will provide interpretation and understanding of themes with regard to relevant theory and the literature review and will highlight differences and similarities of the participants' experiences.

CHAPTER SIX

DISCUSSION AND CONCLUSION

“Cut from the grandest forest, carved from the strongest tree,
Full of sap – only the purest – she’s of the highest pedi-tree
So welcome, ye Wemmicks, to your village so small,
The noblest grain from the finest lumber –
She is Bess Stovall!”

- Lucado (2003, p. 7)

6.1 INTRODUCTION

This is the concluding chapter and aims at elaborating on identified themes by connecting them to the phenomenological approach and literature as discussed in the literature review (chapter 2). The researcher interprets the identified themes and sub-themes with the aim of gaining a deep understanding of the life-world and experiences of the teachers who have children diagnosed with ADHD in their classrooms. The essence of their experiences is presented in this chapter. This chapter also discusses the limitations of the study and provides recommendations for future research.

6.2 DISCUSSION OF THEMES AND SUB-THEMES

According to Creswell (2007), the researcher interprets information and provides textural and structural descriptions of the phenomenon. Textural descriptions refer to ‘what happened’, or ‘what’ was experienced and structural descriptions refer to ‘how’ the phenomenon was experienced. These descriptions will include the interpretations of the researcher and will follow the themes and sub-themes as identified during the analysis process.

6.2.1 KNOWLEDGE OF ADHD

The teachers have obtained knowledge of ADHD throughout their years of teaching, which includes practical interventions for use in the classroom as well as knowledge of the symptoms and difficulties faced by these children. The teachers' knowledge of ADHD is further enhanced by attending workshops and symposiums regarding learning difficulties such as ADHD where they gain an understanding of symptoms and interventions to deal with them. They find the knowledge they gain by attending these workshops invaluable in helping them deal effectively with children with ADHD. The teachers indicated that some of their knowledge of ADHD also comes from the school's occupational therapist and educational psychologist in that the therapists would prescribe certain interventions the teacher can use in the classroom for children with ADHD. Gaining knowledge of ADHD, as the literature suggests in Chapter 2, is important for teachers as the demand on the teacher becomes more pressing when dealing with children facing learning difficulties such as ADHD (Holz & Lessing, 2002; Kleynhans, 2005).

Knowledge of ADHD, as indicated by the teachers themselves, leads to an understanding of and empathy with these children. The teachers feel that when they are equipped with knowledge they are able to understand children with ADHD. This understanding allows the teachers to act compassionately towards these children and respond with patience. Knowledge of ADHD also brings a sense of control and power for the teachers as they feel better equipped to deal with these children in classroom situations. Teachers tend to feel more confident when they are able to deal efficiently with children with ADHD. It became clear through the accounts of the teachers that they gained more understanding and patience with children with ADHD as their knowledge of ADHD increased. There appears to be a relationship between knowledge of ADHD and being able to cope better with children with ADHD in the classroom. The teachers also feel that with more knowledge of symptoms and the nature of ADHD, they are better able to handle classroom situations in that they are able to change and adapt their interventions according to the child's specific and individual needs.

Although the teachers regard themselves as being relatively knowledgeable of ADHD, they express a definite need to further their knowledge. The teachers express a desire to specifically gain more knowledge regarding symptoms of ADHD and how to effectively manage these

symptoms in the classroom. Without adequate knowledge of ADHD, the teachers experience classroom situations as being more challenging and difficult to manage. Their lack of knowledge leaves them feeling ill-equipped, unskilled and helpless as they feel unable to assist children with ADHD effectively. The teachers experience their deficient knowledge of ADHD as debilitating and feel disappointed in themselves for not having the knowledge to assist the child with ADHD. Without sufficient knowledge of ADHD, the teachers tend to become overwhelmed as they are only able to focus on the symptoms of ADHD.

Knowledge of ADHD, regarding symptoms and behaviour, does not only provide teachers with an understanding of academic needs but also allows them to become more sensitive and responsive to the child's social and emotional needs. The teachers' feeling of being largely unprepared to deal with children with ADHD also stems from the nature of their tertiary teaching qualifications, as it does not include sufficient training on the subject of learning difficulties. The teachers' lack of formal qualifications in dealing with ADHD, made them experience classroom situations as even more helpless.

Knowledge of ADHD also includes an understanding that ADHD is innate to the child. The participants in this study recognize that ADHD is not something the child can control or willingly access in certain situations; it is fundamentally a part of them. The participants believe that children with ADHD are not naughty on purpose or do not try to irritate them intentionally, they just behave the way they do because they cannot help it. It appears that this realization brings understanding as well as empathy and sympathy for the child with ADHD. This understanding also enables the teachers in this study to be able to better manage the child with ADHD and the classroom as a whole when they are able to understand why they behave the way they do. The participants feel that without knowledge of the nature of ADHD, they are not able to fully understand why children with ADHD behave the way they do and consequently find it difficult to manage them with patience and empathy in the classroom.

6.2.2 MEDICATION FOR ADHD

It became apparent from the teachers' experiences that medication for ADHD is not only valuable, but necessary for the child with ADHD. Medication such as Ritalin has been used for over 50

years and has been found to be helpful in about 70% of children with ADHD (Venter, 2006). In the participants' opinion a children with ADHD receiving medication tend to achieve better academically and are able to socialize more appropriately with peers. One of their experiences includes children with ADHD being able to integrate with a group of children after receiving medication. Before then, the child was finding it difficult to interact with peers. For the teachers, children with ADHD who are able to socialize with their peers, allow them to deal with these children in the classroom more effectively as they are less disruptive. This is important as children with ADHD often display unwanted behaviours such as defiance, aggression, and antisocial behaviour which usually result in rejection from peers (Hinshaw, 1994; Holz & Lessing, 2002). The teachers believe that medication helps to manage these unwanted behaviours in children with ADHD.

The participants experience a noticeable physical and neurological response to medication in the children with ADHD. Research indicates that many neurotransmitters are associated with the symptoms of ADHD and the impact of medication on the symptoms of attention and hyperactivity has been well documented (Sadock & Sadock, 2003; Venter, 2006). It is the experience of the participants that medication gives the child with ADHD the ability to concentrate better and, as a result, teachers find managing them in the classroom easier and less taxing. When the child with ADHD is able to concentrate for extended periods of time, the teacher can attend to the other children in the class and in this way promote the academic development of the whole class. The teachers' meaning of medication for ADHD is that it provides the child not only with the ability to better cope in terms of concentration, but also give them self-confidence in peer relations and a sense of achievement. When the child with ADHD feels more confident in his/her abilities, the teacher is more able to encourage the child, yielding more favourable outcomes.

The teachers experience children with ADHD, who do not receive medication, as generally disruptive and difficult to manage in the classroom. The teachers experience this classroom situation as tiring and challenging. They feel as though they are constantly dealing with the symptoms of ADHD and this prohibits the teacher from attending to all the needs of the children in the class, those with and those without ADHD. Therefore, the teachers believe they are negatively affected when children with ADHD do not receive medication as they find it almost impossible to handle the child and the classroom as a whole. The teachers believe that without

medication, children with ADHD lag behind in important developmental areas such as academic development and peer relations. According to Diller (1999), Ritalin improves concentration in the short term, and decreases impulsivity and motor activity. It also is inclined to temporarily increase compliance. It is the participants' opinion that children with ADHD find it difficult to concentrate, and without medication they miss out on important concepts, and in this way they lag behind the rest of the class. In peer relations, children with ADHD tend to be rejected by peers because of their disruptive and anti-social behaviour (Hinshaw, 1994; Holz & Lessing, 2002). With medication, the participants experience children with ADHD as able to interact socially with peers in an appropriate manner as aggressive behaviour is diminished.

The participants experience that some parents are reluctant to allow their children with ADHD to receive medication. They experience the parents as not understanding the value and importance of medication for ADHD for the child's academic development. It appears to be particularly difficult for the teachers if parents are unwilling or hesitant to allow their child with ADHD to receive medication as it does not only affect them as teachers but the child as well. They also feel helpless and they feel as though they are fighting a losing battle. The teachers feel that there is only so much they can do in the classroom to try and assist the child with ADHD, but without the added help that medication offers. They are not able to do much more. The teachers experience medication for ADHD as significant and valuable but also as necessary in managing the disorder effectively. Teachers are better able to cope in the classroom as a result of children with ADHD receiving medication.

6.2.3 EFFECT ON PERSONAL LIFE

The teachers experience their personal lives as being effected by having children with ADHD in their classrooms. They feel as though their families and own children come second as their class demands all their attention, effort and energy. The teachers find it difficult to spend quality time with their own families and children as they find themselves physically and emotionally drained at the end of the day. Dealing with children with ADHD on a daily basis leaves the teachers feeling exhausted and this places stress on their personal relationships. The teachers feel their personal relationships tend to suffer and their own children's needs are placed second to the needs of the children in their classroom.

It seems that the participants experience a sense of guilt as they feel unable to give their families the attention they need and deserve. They, however, feel that this personal difficulty and stress put on their families comes with the territory of being a teacher and that it is out of their control. The teachers feel that it is a career they have chosen and that they have to accept the difficulties that accompany it. The participants experience their families as having a lack of understanding of what it is like to teach a diverse group of learners. It seems to become even more difficult for the teachers to deal with children with ADHD in their classrooms when their own family does not seem to understand their experiences. This lack of understanding from their families places more stress on them as they feel they cannot explain their experiences to them. The participants are left feeling isolated and alone in dealing with their experiences and emotions of teaching children with ADHD.

6.2.4 SUPPORT FROM OTHERS

The participants who receive support from parents of children with ADHD tend to cope better in the classroom than those who receive no support from parents. This support from parents is in the form of involvement, shared responsibility and following through on routine and structure at home. When teachers receive support from parents, there is a sense of teamwork and collaboration. This support allows the teacher to feel more confident and more in control of classroom situations. For example, when a child with ADHD receives support at home regarding home work, it allows the teacher to tend to other children in the classroom, and not only focus on the child with ADHD. Also, when a child with ADHD is on a specific diet, as prescribed by a medical professional, the parents at home and the teacher at school can work together to enforce the child's eating habits.

Teachers who do not receive support from parents of children with ADHD feel as if they are fighting a losing battle. It appears that support from parents is very important and valuable for teachers in dealing with children with ADHD. Teachers are able to cope better with children with ADHD when parents support the teachers, although they still experience it as challenging. A lack of support from parents of children with ADHD leaves the teacher feeling alone and helpless.

The participants experience support from the school in terms of dealing with diverse learners in their classrooms. There are therapists available on the grounds such as a speech therapist, an

occupational therapist, and an educational psychologist. The participants are able to refer children for assessment, with the support of the parents, if they feel the child may benefit. The Head of Department also supports the teachers in that she from time to time takes those children needing extra individual attention for lessons. This lightens the burden on the teachers and they are able to attend to all the children in the class, not only those with ADHD. Support from the school is also apparent in the opportunities allowed for personal growth and staff development in the form of attending informative courses and workshops on learning difficulties sponsored by the school.

The support from the school is experienced by the participants as extremely valuable and advantageous in dealing with children with ADHD. The participants do however feel that they would benefit from having teacher assistants in the classrooms. They feel that teacher assistants will aid them to teach more effectively in that the assistant can attend to those children with ADHD needing individual attention. This will allow the teachers to focus on their lessons and promote the academic development of all the children in the class.

The participants also experience support from their colleagues of the school. This support includes the sharing of knowledge and techniques in dealing with children with ADHD. This sharing of knowledge among colleagues creates a better understanding of ADHD in terms of which interventions are successful and which are less effective. It appears that the teachers find it easy to share information with each other as they have a common interest in helping and assisting the child with ADHD to the best of their ability. This support from colleagues also becomes more essential when the teachers feel that the parents of children with ADHD are not involved and supportive. The teachers seem greatly dependent on the support from their colleagues and deem it extremely valuable. This support makes them feel more in control, more confident in their abilities, and in essence, better equipped with practical skills to deal with children with ADHD.

6.2.5 CLASSROOM MANAGEMENT

Children spend most of their time in classrooms and other school settings where, especially at primary school level, they are expected to follow instructions and participate in organized and complex activities in socially appropriate ways (Kleynhans, 2005). The demand on the teacher becomes more pressing when dealing with children facing learning difficulties such as ADHD

(Holz & Lessing, 2002; Kleynhans, 2005) as their difficulty with inattention, impulse control, and hyperactivity regularly interfere with activities in the classroom as well as with peer relations (DuPaul & Stoner, 2003). The participants find it extremely difficult and challenging to manage their classes consisting of children with ADHD and children without ADHD.

The participants find it difficult to achieve the correct balance between equal treatment for all and giving attention to special individual needs. They reported that it is one of the most difficult tasks they are faced with every day. The teachers believe that because each child is unique and different, no one strategy or intervention will apply to all. According to the participants, classroom management includes discipline, lesson planning, and time management. Classroom management becomes even more challenging when certain factors come into play such as the number of children diagnosed with ADHD, the degree of severity of the disorder, and how peers respond to the child with ADHD in the classroom. Peers tend to pick up on the mannerisms of children with ADHD. The teacher needs to constantly be wary of peers' reactions towards children with ADHD as this result in disrupting the classroom and this places added stress on the teacher.

The participants experience children as unique and different both in terms of their development and needs. This difference and uniqueness becomes even more apparent in children facing learning difficulties such as ADHD. The uniqueness of the child with ADHD requires the teacher to adapt and change strategies and interventions to suit the child's specific needs. This is taxing and tiring for the teacher as it involves a constant evaluation of the child's needs and development. The responses of the child to that strategy or intervention also differ from child to child. According to the participants, children with ADHD tend to either reject the intervention, or act even more disruptively in the classroom. This constant need for adaptation and change leaves the teacher feeling confused and in desperate need of more knowledge and guidance regarding dealing with children with ADHD.

Children with ADHD need different strategies, but other children in the class may not fully understand this. This becomes a constant battle for the teacher – to create and maintain a balance between adapting discipline strategies, and at the same time promote the same treatment for all. The participants experience children with ADHD as quick to be excluded by their peers as they are experienced as different. The teachers feel that it is their responsibility to integrate these children

in the classroom. This constant negotiation of integration of children with ADHD into the rest of the class is experienced by the teachers as demanding and strenuous.

In general, children with ADHD are irritable and explosive and may be apt to aggressive and uncontrollable outbursts (Sadock & Sadock, 2003) which greatly challenge teachers in terms of discipline and general organization of classroom activities. The participants experience the management of discipline in the classroom as challenging and demanding. They have to constantly change between discipline strategies to fit the situation and the child. Discipline as described by the participants refers to getting children to listen to the teacher, to sit still in their chairs, to complete their tasks and homework and to interact appropriately with classmates. The participants experience discipline problems as something that needs to be addressed and dealt with immediately. They find that it can escalate into an uncontrollable chaotic situation. The participants feel that they need to be constantly in control to avoid chaotic situations in the classroom. They also feel that they become unkind in dealing with discipline situations when they feel they are unable to control and manage children with ADHD: “I feel I have become a witch” (Participant 1).

The participants experience planning lessons for their classroom as difficult. Children with ADHD struggle to concentrate and teachers have to obtain and retain the attention of the child by being creative in their lesson planning as they find that children with ADHD respond to creative activities. The participants try to integrate this in their lessons by playing the guitar, drawing pictures, singing and incorporating movement. They find that they also need to negotiate constantly with children with ADHD as they are quick to lose focus and concentration during the lesson. This negotiation takes the form of finishing a part of the lesson and then allowing the children with ADHD to do something they find interesting such as drawing and then continuing with the lesson. This poses further problems in the classroom as other children want the same privileges as the children with ADHD.

According to Hersen and Ammerman (2000), during middle childhood (6 to 12 years) children with ADHD experience increased difficulty with attention, impulsivity, and hyperactivity “as the classroom environment requires compliance, paying attention, and the engagement in structured activities” (p. 363). Another experienced challenge in classroom management is lesson planning

for a diversity of learners. The teachers find that they need to be aware of and consider each child's level of academic development when planning their lessons. This is particularly strenuous for the teacher as it creates pressure in the classroom when the teacher needs to continue with a lesson and children with ADHD are still busy with the previous lesson. It seems to be challenging for the teachers to create lessons for the class as a whole and differentiate lessons to suit each individual child, especially children with ADHD.

The primary clinical characteristics or symptoms of ADHD include developmentally inappropriate degrees of inattention, hyperactivity and impulsivity (Holz & Lessing, 2002; Venter 2006). The participants had different ideas on what they perceived as 'difficult' and 'less difficult' ADHD behaviour to deal with in the classroom. Two teachers felt that impulsivity is the most challenging behaviour to manage in their classrooms. The teachers experience a sense of helplessness when dealing with impulsive behaviour as they feel that there is nothing they can do to control it or to help the child to control this behaviour. Two participants felt that hyperactivity and inattention are the most difficult symptoms to manage in the classroom. All the participants experience children with ADHD as not completing their tasks and they find it difficult to evaluate their work. The participants believe that this behaviour obstructs the child with ADHD's academic development and that they miss out on the basic concepts, creating developmental lags.

One participant found hyperactivity less difficult to deal with in her classroom as she felt that, in her experience, she was able to relieve the children with ADHD of their energy by sending them on errands or allowing them to move around the class for a while. Two participants experienced impulsivity as less difficult to manage as they perceive it as spontaneity and creativity in the child with ADHD. One participant experienced no symptoms or behaviour as less difficult to manage as she considers all the symptoms of ADHD as equally disruptive.

Aside from the primary symptoms of ADHD, children can present with secondary symptoms as discussed in the literature chapter. The participants experience secondary symptoms as particularly difficult to deal with and manage in their classrooms as this behaviour tends to affect the child with ADHD on a more personal level. It is the experience of the participants in this study that children with ADHD tend to need constant encouragement to complete their work. They rush through their work without much attention to detail. The teachers feel that they are continually

trying to encourage and build the self-esteem of children with ADHD as they struggle with academic underachievement and lack of self-motivation.

Children with ADHD also struggle with low self-esteem and low self-confidence which becomes a daily struggle for teachers to deal with. Children with ADHD often develop a negative self-image as they recognize that they are different from their peers and as a result may react with hostility towards peers and adults (Sadock & Sadock, 2003). The participants also find that children with ADHD display high levels of frustration in themselves and with others, which usually causes disruptive and aggressive behaviour in the classroom and towards peers.

Children with ADHD are inclined to experience difficulty in socializing with peers which is challenging for the teacher to manage in the classroom as these children may be excluded by peers. Conduct problems tend to be associated with children with ADHD which the participants find particularly hard to deal with as it disrupts the classroom. A further challenge for teachers is that children with ADHD are often emotionally labile and their emotions may range from tears to laughter in a short time which makes their mood and actions unpredictable (Sadock & Sadock, 2003). The teachers experience children with ADHD as at times struggling with emotional lability such as a depressed mood where they may become teary, withdrawn and irritable. According to Sadock and Sadock (2003), combinations of primary and secondary symptoms cause scholastic problems as well as difficulties with social relations, which make these children generally difficult to manage, inside and outside of the classroom.

ADHD symptoms vary in degrees of severity of mild, moderate, and severe (Hersen & Ammerman, 2000). It is the participants' experience that the degree of severity of ADHD has a direct relationship to the difficulty experienced in managing the classroom. Children with severe symptoms of ADHD experience significant difficulties at home, school, and with social relationships. Coexisting problems of learning disabilities and oppositional defiant disorder are almost always present (Holz & Lessing, 2002). The more severe the case of ADHD, the more attention and management is required for that child. Participants experience the children with severe ADHD as needing constant attention and for them this is time-consuming and physically and emotionally draining. They also experience these children with severe ADHD as especially demanding as they can take up the attention equivalent to two or three children at a time.

It is the experience of the participants that the more children with ADHD per classroom, the more difficult classroom management becomes. The increased number of children with ADHD amplifies the felt effects of disruptive behaviour, inattention and hyperactivity. The more children with ADHD in the classroom, the more individual attention is required from the teacher. This makes the teachers feel exhausted and drained.

The participants experience their own responses to children with ADHD as something they have to constantly be aware of and keep in check. They expect themselves to stay calm and patient in challenging situations and to remain collected and in control. The participants try as far as possible to respond with patience and understanding towards children with ADHD. Their patience is tested as they have to repeat instructions over and over and that they are required to re-explain lessons individually, which they experience as time-consuming. The participants also experience a sense of responsibility with having children with ADHD in their classrooms as these children are considered emotionally fragile and that they should not feel excluded or picked on. They feel that it becomes particularly difficult to manage the class as children with ADHD tend to disrupt the flow of the class.

The participants tend to empathize and sympathize with children with ADHD having to deal with this array of symptoms on a daily basis. Teachers find that they tend to spend more time with children requiring individual attention than those children who are able to cope at their own pace. It becomes a balancing act between creating a fair and equal classroom environment and attending to the individual needs of children with ADHD.

6.2.6 STIGMA AND STEREOTYPING

In the participants' opinion there is a general stigma and stereotyping of ADHD in other schools and in the broader community. However, according to the participants, stigma and stereotyping are not very prevalent in their school. In their school, all children are perceived as unique but not labelled as different. It is the opinions of the participants that they are, however, constantly challenged in their classrooms to ensure children with ADHD are not excluded by peers because of their behaviour. It is the opinion of the participants that children with ADHD are seen as different by children without ADHD as their behaviour singles them out as disruptive and difficult

to manage. This becomes challenging for the teacher in the classroom when endeavouring to advocate the same treatment for all but still pay attention to the special needs of children with ADHD.

The participants experience some stigma and stereotyping regarding ADHD when reflecting on their encounters with parents of children who do not have ADHD. Some parents do not allow children with ADHD to socialize with their children who have not been diagnosed with ADHD as they are experienced as disruptive and naughty. Some parents even verbalize to the teacher that they do not want a child with ADHD in the same class as their child as this will impede their child's learning experience. The participants also experience that they at times tend to stereotype children with ADHD. For example, when a teacher realizes that the 'difficult' child from their colleague's class will be in their class next year, they start to wonder how they will handle this child. From the accounts of the participants it became apparent that they experience stigma and stereotyping within their classrooms from children without ADHD and from parents of children without ADHD. Stigma and stereotyping are also experienced by the participants as resulting from other teachers in their school.

6.2.7 EMOTIONS EXPERIENCED BY THE PARTICIPANTS

The participants' experiences of having children with ADHD in their classrooms gave rise to certain negative and positive emotions. During the interviews it seemed that the participants found it particularly hard to share their emotions with the researcher, not because of the nature of the emotions, but seemingly as their experienced emotions of dealing with children with ADHD have never been deemed as important or relevant.

In dealing with children with ADHD on a daily basis, participants felt mainly exhausted and physically and emotionally drained describing their experience as "total emotional fatigue" (Participant 4). Teachers tend to worry about the well-being of children with ADHD regarding academic, emotional and social development. The teachers feel sympathy and empathy for these children as they believe that having ADHD is something that the child cannot control. The participants expressed a sense of frustration and irritation with children with ADHD as they find general classroom management as taxing and demanding. They also experience a sense of failure

when they were unable to attend to the individual needs of child with ADHD: “you feel a failure, because you can’t get to everything” (Participant 2). The participants felt powerless and helpless because they experienced their situation as out of their control. There is also a feeling of disappointment in themselves when they were unable to help the child with ADHD: “I didn’t achieve because he didn’t achieve” (Participant 3).

The participants experience some positive emotions in dealing with children with ADHD in their classrooms. They experienced a sense of accomplishment when they were able to help the child with ADHD and see a difference in that child. The participants also felt encouraged and more confident in their abilities as a teacher when they were able to help the child with ADHD achieve academically and socially. Satisfaction and pride is experienced by the teachers when the child with ADHD achieves according to his/her ability and the teacher feels that she has made a positive contribution to the child’s life.

6.3 THE ESSENCE OF THE EXPERIENCE OF TEACHERS WHO HAVE CHILDREN WITH ADHD IN THEIR CLASSROOMS

Phenomenology is interested in the first-hand experiences of individuals regarding situations in their lives and the aim is to “capture as closely as possible the way in which the phenomenon is experienced within the context in which the experience takes place” (Smith, 2003, p. 27). This study explained the socio-cultural context of the participants in order that research findings could be understood within this context. The participants’ experiences of having children with ADHD in their classrooms were presented from their first person perspectives (Husserl, 1913/1963) in order to gain an in-depth understanding of their life-worlds (Lyotard, 1991). Husserl defined phenomenology as the knowledge of the essence, or real meaning of consciousness, centred on intentionality and approached from the first person perspective (Husserl, 1913/1963). This study drew on Husserl’s approach and described the underlying structure or essence of teachers’ experiences, and gained an understanding of the essential nature of their experiences.

The essence of the experience of the participants is that having children with ADHD in their classrooms is both challenging and fulfilling. Their experiences may be positive or negative depending on certain factors such as:

- Support from own family, the parents, school and colleagues;
- The teachers' knowledge of ADHD;
- Medication for ADHD;
- Severity of ADHD; and
- Number of children with ADHD per classroom.

Some experiences regarding having children with ADHD in their classrooms were shared and others differed from participant to participant. The shared experiences are experiences of support from the school and colleagues. All the participants experienced the school environment as being supportive and as a result felt empowered and better able to cope with children with ADHD in their classrooms. The participants shared the experience of the value of medication for ADHD. All the participants' experiences regarding medication for ADHD are that it is not only beneficial for the child with ADHD but necessary to prevent academic lags. A need for more knowledge of ADHD was shared by the participants. There appears to be a need for knowledge regarding symptoms of ADHD and practical interventions the teachers can use in their classrooms. The participants also shared experiences of stigma and stereotyping of ADHD. They experience stigma as not prevalent in their school. However, the participants experience stigma and stereotyping of ADHD among parents of children without ADHD as well as among the teachers of the school. All the participants experienced classroom management as a whole as challenging regarding having children with ADHD in their class. They experienced difficulty with discipline and lesson planning.

The participants had differing experiences of dealing with children with ADHD which are the effect children with ADHD have on their personal lives. Three participants experienced having children with ADHD in their classrooms as having a negative impact on their personal lives. One participant experienced no significant influence on her personal life regarding having children with ADHD in her classroom. The participants also had differing experiences of the level of difficulty in dealing with primary and secondary symptoms of ADHD. One participant experienced all the symptoms of ADHD as equally disruptive and difficult to manage. The participants experienced differing emotions in dealing with children with ADHD in their classrooms.

6.4 RECOMMENDATIONS FOR IMPROVING TEACHERS' EXPERIENCES OF ADHD IN THE CLASSROOM

Although the sample size is small and non-random and the findings cannot be generalized to the experiences of all teachers, some suggestions for improving teachers' experiences of having children with ADHD in their classrooms can be made:

- The addition of more content in education training on learning difficulties particularly in the context of inclusive education. This is based on the assumption that if teachers are better prepared during their training, they would feel more confident and equipped to deal with learners with special education needs such as ADHD;
- A forum for increased co-operation between teachers, school therapists and parents to consider medication for ADHD is recommended. It is the participants' experience that medication assists the child in preventing academic lags;
- Even though stigma is not experienced as prevalent within the school, stigma and stereotyping of ADHD is still a reality and is developed and enhanced by parents and teachers alike. A forum for discussing the negative effects of stigmatizing and stereotyping ADHD and ways to reduce stigma in classrooms, among teachers and parents is recommended.
- Teachers sharing their experiences of having children with ADHD in their classrooms with colleagues and the teachers' families may create a better understanding and perception of the situation.

6.5 LIMITATIONS OF THE STUDY

The study presents certain weaknesses that are subsequently discussed. The weaknesses of the study include:

- Only one private school was used in this study. Findings might be unique to the school and the private school is possibly better resourced than government schools;
- The study includes a small sample size of only four participants. Although sufficient saturation of the data, for the purposes of this study, was reached, more participants may have provided more information on teachers' experiences;

- The study uses purposive sampling and snowball sampling as methods for selecting participants which raises uncertainty of whether or not the sample represents the population (Neuman, 2006) as results are also not generalizable from a non-random sample;
- The sample in this study was homogenous and research findings are specific to the participants. More diverse participants may provide more information on the experiences of teachers in dealing with children with ADHD;
- The Head of Department of the school functioned as the gatekeeper to the participants and assisted the researcher to set up interviews with them. As a result participants may have felt obliged to portray a more 'positive' depiction of children with ADHD than they would have if they were contacted directly by the researcher and their identities were not known to anyone of the school;

6.6 RECOMMENDATIONS FOR FUTURE RESEARCH

Further research in this area is greatly needed as teachers' experiences have only recently been published in the literature. Future research endeavours may include:

- Increasing the sample size to include more participants with the purpose of obtaining more information about the experiences regarding the phenomenon;
- Including a diversity of teachers in the sample (representative of South Africa's population dynamics) to obtain a range of perspectives on dealing with children with ADHD;
- Research with 'new' teachers who have recently qualified are recommended as their experiences of children with ADHD may differ from teachers who have many years of teaching experience;
- Including more schools in the study to ensure that results are not school specific. Public schools should also be selected to gather experiences of teachers in different educational contexts;
- More research is needed to illuminate the experiences of teachers in dealing with ADHD at high school level, as these may differ considerably from primary school teachers. According to the literature in Chapter 2, the course of ADHD tends to be variable, as symptoms may persist into adolescent or adult life or remit at puberty. Hyperactive symptoms may disappear but distractibility and impulsivity may continue into adulthood (Sadock & Sadock, 2003).

- From the findings of this study there appears to be a relationship between knowledge of ADHD and being able to cope better with children with ADHD in the classroom. Further research is needed to statistically verify if there is such a relationship.

6.6 CONCLUSION

This study provided valuable information concerning how primary school teachers experience ADHD in their classrooms. The information provided by this study highlighted research that has already been done on teachers' experiences. This study may contribute more to the understanding of the experiences of teachers dealing with children with ADHD on a daily basis. In this chapter a discussion of the identified themes was provided along with suggestions, based on the research findings, to improve teachers' experiences of having children with ADHD in their classrooms. Limitations of the study were explored as well as recommendations for future research.

In planning and conducting this study, the researcher was introduced to the story *Best of All* (Lucado, 2003). The story fits well with the topic of the research regarding the nature of ADHD and how teachers experience it in their classrooms. In Wemmicksville, the townspeople are crafted from different types of wood - maple, willow and oak. The people crafted from maple were perceived by the town as 'superior' as this type of wood is unsurpassed by any other type. Willow wood was looked down upon as it is a soft wood that can easily bend, not hard and sturdy as maple wood. But when Miss Bess Stovall – crafted from superior maple wood – falls into the river and nearly drowns, she is saved by a little boy crafted from Willow wood as he was able to bend over the bridge when no other wood could. The townspeople of Wemmicksville soon realized that every type of wood is special and has a purpose. This story reminded the researcher that children with ADHD are just as special as any other child. They might have different characteristics and needs and face different challenges but they are just as exceptional as all children are.

We are the way we are, because we were made that way.

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APPENDIX A – THE SEMI-STRUCTURED INTERVIEW GUIDE

1. How many children in your class have been diagnosed with ADHD? How many are boys and how many are girls?
(They might mention that there are other children they suspect of having ADHD in their classroom – it might be necessary to remind them that a formal diagnosis is necessary when they refer to experiences in the classroom).
2. How and when have they been diagnosed? By whom were they diagnosed?
 - Were you informed of the diagnosis? By whom?
 - How is medication managed? (Any information about how diagnostic information is relayed and discussed is relevant here).
3. What is your understanding of ADHD? What knowledge do you have of ADHD? (This is to explore their perceptions and understanding about ADHD, whether accurate or inaccurate).
4. Do you have any training in special education or dealing with children with learning difficulties?
 - If yes, explain the nature and duration of your training.
 - If no, from where does your knowledge about children with special education needs or learning difficulties originate?
 - Do you have opportunities to further your knowledge, and if so, how?
 - How do you think your knowledge of ADHD influences your experiences in dealing with children with ADHD?
5. Do you experience any stigma or stereotyping regarding children with ADHD in the school or in your classroom? (If they ask from whom the stigma arises, leave the answer open to their interpretation)
 - If yes, explain further – what do you think contributes to stereotyping?
 - If no, explain why you think stereotyping is not prevalent.

6. What is it like for you to have children with ADHD in your classroom? What is it like for you to teach children with ADHD?
7. Which symptoms of ADHD, if any, do you struggle the most to deal with and manage? How do you manage these symptoms?
8. Which symptoms of ADHD, if any, do you find less difficult to deal with? Why?
9. Does the handling and management of certain symptoms (whether difficult or less difficult) vary according to the gender of the child?
 - If yes, in what way?
 - If no, what is your explanation of this?
10. What secondary behaviour or symptoms do you deal with on a daily basis? (Primary symptoms: inattention, hyperactivity, impulsivity. Secondary symptoms refer to behaviours and difficulties that accompany the disorder but are not sufficient or necessary for the diagnosis of ADHD such as: general difficulty with social interaction, academic underachievement, school failure, low self-esteem, depressed mood, and conduct problems).
11. What are your experiences of these secondary behaviours? (More prominent or less prominent than primary symptoms? Easier or more difficult to deal with?).
12. Is there any support available to you in dealing with children with learning difficulties, especially ADHD?
 - If yes, what kind of support?
 - If no, what kind of support would you like to receive?
13. In what way, if any, has the diagnosis of ADHD changed your experience of the child? (Encourage the participant to be honest as anonymity is assured).

14. What struggles or challenges do you face on a daily basis regarding having children with ADHD in your classroom? -
 - Discipline?
 - Lesson planning?
 - Size of class?
 - Time management?
 - Assistance or support?
 - Other?
15. How are you impacted, personally and/or otherwise, having children diagnosed with ADHD in your classroom?
16. What emotions do you experience on a daily basis as a result of managing children with ADHD in your classroom?

When describing specific experiences:

1. When you think about these experiences, what stands out for you?
2. How did the experience affect you? What changes do you associate with the experience (intrinsic and/or extrinsic)?
3. How do your experiences in the classroom affect others in your life?
4. What feelings were generated by the experience?
5. What thoughts stood out for you?
6. Did you experience any bodily changes or conditions that you were aware of when in that situation?

APPENDIX B – PARTICIPANT INFORMATION SHEET AND INFORMED CONSENT FORM



FACULTY OF HUMANITIES
DEPARTMENT OF PSYCHOLOGY

Research Title:

The experiences of primary school teachers who have children diagnosed with ADHD in their classrooms

Purpose of the study:

The study endeavours to explore your experiences of having children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) in your classroom. These experiences may include insight about these children, as well as your experiences of teaching them.

Procedures:

The study will include in-depth individual interviews with each selected participant (teacher). Participants are selected on grounds of certain stipulated criteria:

- You should have one or more children who have been formally diagnosed with ADHD (by a qualified medical practitioner) in your classroom;
- The child/children who forms your experience should be formally diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and not any other developmental disorder or learning disability;
- Your gender, age, and ethnicity will not play a role in the selection process as it is not relevant to the purpose of the study; and

- You will be selected based on availability of children diagnosed with ADHD in classrooms.

Interviews will be conducted at the school, after school hours. Interviews will range in time depending on each participant. Interviews will be audio taped and participants will voluntarily consent to being recorded.

Risks and Rights:

No physical or psychological risks or discomforts are expected to result from the study. However, if stress or anxiety is experienced when recollecting events, you will be referred to a registered counselling psychologist for further management. You participate voluntarily and provide written consent once comfortable with the information provided by the researcher. You may withdraw from participation at any time without any negative consequences to you or the school.

Benefits:

The study will not provide financial gain or benefit for you as participant, the school, the researcher, or the University of Pretoria. You may personally gain insight and understanding from research findings and may as a result better understand your own and others experience of teaching children with ADHD.

Confidentiality:

All information will be treated as confidential and anonymity of all participants is assured, including that of the school. The children who form your experiences will remain anonymous as no identifying information will be provided to the researcher at any time. All information gathered will be destroyed should you as participant decide to withdraw from the study. Research data and information collected will be made available to the researcher's supervisor as well as in published format. The research will remain the property of the University of Pretoria and will be published by the University.



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CONSENT FOR PARTICIPATION IN THE RESEARCH PROJECT

Title of the study:

The experiences of primary school teachers who have children diagnosed with ADHD in their classrooms

Consent for participation:

I _____ voluntarily agree, without being coerced or pressured, to participate in the study and feel comfortable to share my experiences with the researcher. I understand that the information that I will provide for this study will be disseminated and shared with other researchers and that my identity will not, under any circumstances, be disclosed during publication without my prior written consent. I also consent to being audio taped during the interview.

Name of participant

Signature of participant

Participants are welcome to contact the researcher or supervisor for any queries regarding the study.

Signature of researcher
Janine Kendall