

**FRAMING THE ADHD CHILD:
HISTORY, DISCOURSE AND EVERYDAY EXPERIENCE**

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Abstract

Through employing a two-faceted approach to the sociological study of Attention Deficit-Hyperactivity Disorder (ADHD), this thesis seeks to further the study of this mental illness and also to elucidate new methodological directions for the sociology of similar phenomena. Past approaches in the sociology of mental disorder have considerable merit, but may also be limited in the type of analyses they offer. One particular limitation concerns sociological accounts of mental illness that portray the meaning of such illnesses as unified and that this unification results from the collusion of special interests. Sociologists who address mental illnesses as social problems, for example, appear wont to portray such illnesses as social constructions which arise from specific agents of labeling. With regard to ADHD, previous sociological accounts often make a case for the rhetorical and political power of government agencies, medical practitioners, and pharmaceutical companies. Though such agents are certainly influential in shaping public conceptions of ADHD, this thesis demonstrates that ADHD is interpreted in various ways. These assertions are supported through the analysis of two different data sources: 1) textual data; and 2) interview data.

The textual data for the first part of the thesis comprises the subject matter for a genealogy of ADHD. Through examining past and contemporary texts that frame this disorder, including medical journal articles, medical manuals, popular writings, and parental guidebooks, the author argues that the historical and current discussions of ADHD are replete with differing interpretations of the causes and treatments for ADHD. These ADHD discourses, as they are seen through written accounts, offer a variety of perspectives towards the disorder, drawing from many opposing schools of thought. Most notable in this regard are psychodynamic and neurological approaches to ADHD. I argue that even though the neurological perspective towards ADHD appears to be the most dominant in diagnosing and treating the disorder, it is far from monolithic.

The second part of the thesis draws upon interview data from sixty-two respondents associated with cases of ADHD: twenty clinicians, twenty parents, and twenty-two teachers.

Each of these groups of respondents were asked questions designed to solicit their subjective experiences with the disorder, including how they perceived ADHD children and their sources of ADHD knowledge. The analysis of such data is placed against the backdrop of the genealogical part of the thesis. Responses from participants are examined as reflecting ADHD discourses. Some respondents, for example, demonstrate a commitment to neurological perspectives towards ADHD, while others gravitate towards psychodynamic or combined understandings of the disorder.

Through combining these two data sources, this thesis analyzes ADHD discourses that give rise to conceptions of the disorder and shows how these discourses influence attitudes and actions towards ADHD. By giving less salience to the collusive relationships between government agencies; medical practitioners, and pharmaceutical companies, and by putting more focus on the relationship between the three major groupings directly involved in the ADHD experience--clinicians, teachers, and parents--this thesis furthers the sociological study of ADHD.

Table of Contents

Abstract	ii
Table of Contents	iv
List of Tables	xv
Acknowledgements	xviii
Part I: Past and Current ADHD Discourses	1
Introduction	1
Chapter 1: Critiquing Social Constructionism: Introduction to the Genealogical	
Method	11
Addressing social constructionism	11
Focusing on ADHD	14
Previous ADHD nomenclature	14
Problematic epidemiology	15
Addressing Peter Conrad	15
Reflexivity and Foucault.....	20
Introducing the genealogical method	20
Genealogy and Foucault's dependencies	23
Chapter 2: Linking Immorality to the Disordered Brain	30
Idiocy vs. imbecility.....	32
Examining the work of George F. Still.....	37
Encephalitis lethargica as explanation of childhood immorality.....	40
Chapter 3: Psychodynamic and Neurological Perspectives on ADHD: Exploring	
Strategies for Defining a Phenomenon	48

Psychodynamic perspectives.....	50
Psychoanalytic perspectives: Anna Freud and Melanie Klein	50
Compulsion neuroses	52
Psychological perspectives.....	54
The dominance of neurology	58
Neurology's response to the psychodynamic perspective	59
Charles Bradley and Benzedrine	65
Paradoxically speaking	67
Neurological discourse today.....	77
Antagonism and the absent center of ADHD.....	86
Laclau and the irony of the 'undecidables'	90
Chapter 4: ADHD Discourse in the Domestic Realm: Parental Guidebooks and the	
Disciplining of Domesticity.....	94
Examining the ADHD parental guidebook.....	95
Articulating experience and credibility.....	98
Framing the ADHD child.....	100
ADHD children and the disciplinary moment	101
Volatile children.....	102
The narrative of domestic management	104
Negotiation and contract	107
Token economies and points systems	109
Alternative explanatory frames for ADHD	113
Diet.....	113

Television and video games.....	117
Guidebooks and the disciplined ADHD body.....	121
Part II: The Everyday Framing of ADHD.....	123
Chapter 5: Methodology and Profile of Interview Respondents.....	123
Respondent recruitment.....	125
Respondent Profile.....	129
Parents.....	129
Teachers.....	131
Clinicians.....	132
Interviewing.....	132
Procedure.....	135
Staying on task.....	136
Analysis.....	137
Coding.....	139
Chapter 6: Clinician Frames for ADHD Children.....	144
Addressing the length of time clinicians had become familiar with ADHD.....	147
Suspecting parties and referral sources.....	148
School counselors and teachers.....	149
Parents.....	151
Factors in providing diagnoses for ADHD.....	153
Diagnosis time depends on the complexity of the case.....	153
Clinicians who report a regimented time for providing ADHD diagnoses.....	155
Clinicians who report that they are not diagnosing, just collecting information ...	157

Clinician opinions on <i>DSM IV</i>	158
Clinicians who use <i>DSM IV</i> , but find it inadequate to entirely describe the ADHD condition	159
Clinicians who have reservations about specific <i>DSM IV</i> nomenclature.....	160
Unquestioning use of <i>DSM IV</i>	161
Clinicians who do not use <i>DSM IV</i>	161
Discussion of treatment methods for ADHD.....	163
Behavior modification	165
Combining behavior modification and medication.....	168
Medication therapy	169
Clinicians' perceived acceptance of their treatment methods	171
Perception that treatment methods have a tentative or conditional acceptance.....	172
Clinicians who state that their methods of treatment are not accepted.....	174
Reservations about medication	174
Stimulant medications are overprescribed/the ADHD diagnosis is inadequate.....	175
Concerns about side effects.....	177
Concerns that the medication removes internal locus of control.....	178
Concerns over chemical dependency in later life.....	180
Clinicians with no reservations about prescribing stimulant medication	181
Addressing the issues of the duration of medication treatment	182
Medication duration depends on severity and complexity of ADHD condition.....	183
Clinicians who state that it is impossible to function without meds.....	184
Clinician perspectives on the temporary cessation of medication	185

Temporary cessation from medication is always recommended.....	186
Cessation whenever there is tolerance	189
The question of ADHD eradication	189
ADHD can be eradicated if managed effectively.....	191
ADHD cannot be eradicated if it is truly neurological.....	193
Clinician opinions on the role of educators in ADHD.....	194
Teachers need to recognize that ADHD is real and learn more about the disorder	195
Teachers need to modify curricula to suit ADHD children	197
Teachers are not qualified to provide diagnoses of ADHD and should stay within their field.....	199
Clinician opinion on the role of parents in relation to their ADHD children	200
Parents must keep a disability perspective when dealing with their child's behavior.....	201
Parents must involve themselves in the treatment process	203
Parents must learn to empower themselves	205
Clinician descriptions of the physiological process of ADHD	205
Clinicians who felt they could not adequately describe the physiology of ADHD.	206
Clinicians describing dopamine dysregulation/brain underactivation as a cause of ADHD.....	207
Concluding remarks	209
Chapter 7: Educator Frames for ADHD Children	212
Conceptualizing ADHD children.....	216

ADHD children differ in their on-task behavior and general ability to focus.....	217
ADHD children have an excess of mental activity	219
ADHD Children have specific social problems	220
Teacher discussion of ADHD children's disciplinary problems	222
Teachers who stated that ADHD children disturb others, especially in the process of learning	222
Teachers who stated that ADHD children engaged in anti-social behavior, especially fighting	223
Connecting behavioral and academic troubles.....	225
Teachers who explain ADHD children's problems as a combination of academic and behavioral difficulties	225
Neurology or will: teacher perceptions of what motivates ADHD	227
ADHD children can control themselves to some degree	227
It is impossible for ADHD children to control themselves.....	229
ADHD children eventually outgrow the behavior	230
Teachers and other social actors surrounding a suspected case of ADHD	231
School-based team	232
Speaking directly with parents	235
Discussion of teaching techniques for ADHD children.....	235
Teachers who modify assignment structure to suit ADHD children's needs	236
Teachers who employ a general effective method of teaching	238
Teachers who advocate building self-esteem and self-awareness	239
Classroom restructuring	240

Teachers who state that they do not implement structural changes to the classroom for ADHD children	241
Change proximity of the ADHD children to the teacher and other students	242
Particular teaching environment already accommodates children with ADHD and other disabilities	243
Teacher discussion of <i>DSM IV</i>	245
Teachers who never heard of <i>DSM IV</i>	246
Teachers who have heard of <i>DSM IV</i> and utilize these criteria in suspecting children of having ADHD.....	246
Teachers who have heard of <i>DSM IV</i> , but do not use it.....	248
Teacher perceptions of school consensus regarding ADHD.....	248
Teachers who feel there is no consensus in their school about how to deal with ADHD.....	249
Teachers who feel there is some degree of consensus about how to deal with ADHD children.....	252
Teacher discussion of the process of labeling kids "ADHD"	253
Teacher concerns about labeling children as ADHD.....	254
Teachers who stated that they had no major concerns about the ADHD label.....	258
Teacher concerns about the effects of failing to treat ADHD.....	260
Teachers who stated that untreated ADHD may lead to academic failure.....	261
Discussing ADHD and gender.....	263
Teachers who stated that the children with ADHD in their classrooms were predominantly boys.....	264

Concluding remarks	266
Chapter 8: Parental Frames for ADHD Children	270
Parent impressions of their ADHD children's social and academic competence.....	272
Parents who described their child's academic performance as poor in comparison to kids from the same age group	273
Parents who stated that their children had considerable gaps in their learning	276
Parents who described their child as academically superior to others from the same age group.....	277
Parents who described considerable immaturity in their child's social interactions	279
Parents who describe that their ADHD child demonstrated aggressive behavior in social situations.....	280
Parents who stated that their ADHD child's social development was normal in comparison to other kids.....	281
Parent discussion of whether or not their ADHD children expressed resentment at going to school	281
Parents who stated that their child expressed resentment towards school.....	282
Parents who stated that their child did not express any resentment towards school	284
Precipitating incidents leading to the suspicion of ADHD and their location.....	285
Parents who stated that their child showed signs of academic failure	286
Parents who stated that their child demonstrated specific anti-social behavior.....	288
Parents who stated that their child was generally disruptive during class time	291
The dominance of the school as the primary context in which incidents	

precipitating the suspicion of ADHD occur.....	292
Addressing the absence of incidents outside of school.....	293
Discussing the first formal suggestions of ADHD.....	294
Instances where the suggestion of ADHD was made by a teacher, or some other school representative.....	296
Instances where the suggestion of ADHD was made by the parent.....	297
Instances where the suggestion of ADHD was made by a clinician.....	298
Sources of knowledge about ADHD symptoms.....	299
The connection between suggesting party and ADHD knowledge acquisition.....	300
Parental pursuit of literature.....	301
Finding out.....	303
Feelings of relief.....	304
Feelings of shock/devastation.....	305
Mixed emotions: being "scared for him".....	307
Nipping the illness in the bud.....	308
Parents' discussion of alternative diagnoses and treatment.....	310
Parents who conveyed that they did not seek any alternative diagnoses to their children's ADHD condition.....	311
Parents who conveyed that they did seek alternative diagnoses to their children's ADHD condition.....	312
Breakdown of treatment methods.....	315
Parents who do not use any behavior modification techniques.....	316
Parents who use behavior modification.....	317

Parents' theories about the nature of ADHD.....	317
Parents who claimed that ADHD was an unspecified genetic condition.....	318
Parents who claimed that ADHD was a result of physiological processes.....	320
Parents who claimed that ADHD was a result of trauma	322
Concluding remarks	323
Chapter 9: Analyzing the Interaction between Respondents: Suspicion, Social Role	
Acknowledgement and ADHD Discourse.....	326
Discourse and group identity	327
Exploring cases of respondent interaction	330
Smooth transitions from suspicion to treatment: case #1	331
Experiencing formal intervention, semi-formal suspicion: case #2.....	336
Resistance at the point of pharmacological treatment: case #3.....	343
A psychodynamic interpretation and treatment for ADHD: case #4	349
Concluding remarks	354
Chapter 10: Conclusions	357
Revisiting social constructionism	359
The articulation of colluding forces.....	359
The dichotomy between the experts and the non-experts	360
Discounting discourse.....	361
Supplementing social constructionism: towards a synthetic methodology.....	362
Discourse analyses and interview schedules as mutually-influential.....	363
Inclusion of discourse in the analysis of interview data.....	364
Clarifying some key findings of this thesis in relation to the specific phenomenon	

of ADHD.....	366
The contested nature of ADHD	366
The processes of ADHD suspicion and the framing of ADHD children.....	368
Suggestions for further research.....	370
The need for longitudinal analyses	371
The potential for in-depth empirical analyses of the transfer of knowledge.....	371
The empirical study of mechanisms of suspicion	373
Studying children	374
Final remarks	374
Bibliography	376
Appendix I: Introductory Letter for Respondents	394
Appendix II: Respondent Consent Form	395
Appendix III: Interview Questions for Parents of ADHD Children	397
Appendix IV: Interview Questions for Educators	398
Appendix V: Interview Questions for Clinicians	399

List of Tables

Table 6-1. Length of time clinicians reported familiarity with ADHD 147

Table 6-2. Most common referral sources as reported by clinicians 148

Table 6-3. Breakdown of clinician opinions on the utility of *DSM IV* 159

Table 6-4. Breakdown of clinicians' treatment methods for ADHD 165

Table 6-5. Perceived conventionality of treatment measures by clinicians..... 172

Table 6-6. Breakdown of clinicians' reservations about prescribing medication
for ADHD 175

Table 6-7. Length of time clinicians feel a child should take medication for ADHD. 183

Table 6-8. Perspectives on the temporary cessation of medication 186

Table 6-9. Clinicians' perspectives towards the possibility of treatment that would
eradicate ADHD..... 190

Table 6-10. Clinician opinions on the role of educators in relation to ADHD
children 195

Table 6-11. Clinician opinions on the role of parents in relation to ADHD children..... 201

Table 6-12. Clinician descriptions of the physiological nature of ADHD. 206

Table 7-1. Teacher descriptions of how ADHD children differ from normal children.. 217

Table 7-2. Teacher perceptions of disciplinary problems with ADHD children..... 222

Table 7-3. Teacher description of children's problems as academic, behavioral,
or a combination of the two. 225

Table 7-4. Teacher opinions on whether or not ADHD children can control their
own behavior..... 227

Table 7-5. Teacher descriptions of the parties they initially contact when they

suspect a child may have ADHD	232
Table 7-6. Teacher description of teaching techniques employed for ADHD children .	236
Table 7-7. Teacher response to question concerning restructuring the classroom for ADHD children	241
Table 7-8. Teacher description of knowledge and/or relevance of <i>DSM IV</i>	245
Table 7-9. Teacher opinions on the level of consensus in their school about how to deal with ADHD children	249
Table 7-10. Teacher responses on whether or not they are concerned about labeling children "ADHD"	253
Table 7-11. Teacher concerns about untreated ADHD	260
Table 7-12. Teacher description of the gender of ADHD children in their class	264
Table 8-1. Parent description of their ADHD child's academic performance in comparison to their child's peers.....	273
Table 8-2. Parent description of their ADHD child's social skills in comparison to their child's peers	279
Table 8-3. Parent discussion of child resentment towards school	282
Table 8-4. Parent discussion of specific incidents that led to suspicions that their child may have ADHD.....	285
Table 8-5. Location of incidents that precipitated parental suspicion of ADHD	292
Table 8-6. Parent description of parties who made the first suggestion that their child may have ADHD.....	296
Table 8-7. Parent responses when asked whether or not they sought alternative diagnoses for their children's condition	310

Table 8-8. Parents' responses to whether or not they used behavior modification techniques to treat their children's ADHD 316

Table 8-9. Breakdown of parent's opinions on the origins of ADHD 318

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Part I: Past and Current ADHD Discourses

Introduction

In his book, *Ritalin Nation* (1999), Richard DeGrandpre claims that the prevalence of attention deficit hyperactivity disorder (ADHD)¹ is symbolic of modernity. We live, according to DeGrandpre, a contradictory life, as we are forced into intensified "on-task" behavior in work and school, and simultaneously, with an addict-like willingness, we are bombarded by the technicolor onslaught of modern society's digitized, shifty, and distracting images. ADHD, according to DeGrandpre, is a product of this social environment--an environment that defines success as having the ability to gracefully respond to markedly contradictory demands. To internalize and regard as a kind of reality rapidly shifting media images, and to be able to separate these virtual experiences from the actual world, is to be successful. ADHD, according to this argument, is a moniker for those who lack this success, that is, ADHD is a way of pathologizing those who do not live up to the difficult standards modern society mandates. Ritalin, the perennial treatment for ADHD, serves as a great equalizer, consumed *en masse* by a society that fails to see its own role in creating ADHD.

According to DeGrandpre, rather than addressing the inhuman and perhaps inhumane effects of what he terms "rapid fire culture," we engage in a kind of self-serving groupthink, in which we pat ourselves on the back for discovering ADHD, and regard the discussion of the disorder as one amongst many in modern medicine. Instead of looking at contemporary culture as potentially harmful to children and adults alike, we take solace in modern psychiatry and its ability to continuously elucidate those mental aberrations that impede productivity and lower the quality of life. Rapid fire culture fails to ponder ADHD in any critical way because it lacks the time.

¹It is estimated that diagnoses of ADHD and prescriptions for stimulant medications have increased 7-fold since 1990. See Diller (1998).

DeGrandpre's and numerous other books (most of which will be addressed in this thesis) define ADHD as a cultural problem, cast in myriad ways. Amongst these, ADHD is argued to be cultivated through flaws in parenting, that is, by parents who are so wrapped up in the demands of modern life that they decide it is easier to "drug" their children than to deal with their children's deeper emotional and intellectual needs. At other moments it is argued that ADHD reflects the state of public education, in which bloated classrooms and stressed-out teachers foster an intolerance towards children who cannot sit still. ADHD is also perceived to reflect medical perspectives in which children are equated to a mechanical device easily subdued through appropriate chemical intervention. With these and many other perspectives on the nature of ADHD, an accusing finger is wagged: rapid fire culture, it is implied, may succeed in entertaining children--it successfully gets them in front of the TV until mom or dad come home--but it fails to care for them. For children who cannot successfully negotiate the experience of rapid fire culture, the care they receive is pharmacological.

As important and relevant as such cultural commentaries are for the discussion of ADHD, they paint a picture of modern life which is as bleak as it is one-sided. Through varying degrees of rhetorical mastery, such perspectives portray us as the perpetual victim of our culture, and therefore of ourselves. Such self-victimization continuously prevents our own critical reflection. Our knowledge about ADHD, for example, is only that which has been spoon-fed to us by the same culture that invented ADHD. In addition, such perspectives provide a limited view on the nature of ADHD and implicitly discount other perspectives towards the disorder. Through an "Us vs. Them" sentiment, we are implored to choose a position regarding ADHD. The discussion of ADHD becomes confined to an allegiance to one of two camps: ADHD is either a bona fide neurological reality, or ADHD is a falsehood.

The discussion of ADHD need not be this simplistic. Given the prevalence of the disorder (more than 4 million school-age children are assumed to be diagnosed with ADHD in North America) it is imperative that ADHD be examined in multifarious ways. Through examining

historical and contemporary ADHD discourses, combined with a qualitative analysis of people's everyday experiences, this thesis offers a unique social perspective on the disorder. ADHD will be studied using two methodologies, one for elucidating the textual discursive framework of the disorder, the other for conveying the manner in which these discourses frame ADHD children in everyday life. The first section of this thesis utilizes a genealogical approach to ADHD, focusing on the textual discourses throughout the last 140 years that claim an understanding of the disorder. These discourses are mainly characterized by two different camps--one psychodynamic, the other neurological--which oppose each other in their discussion of what causes ADHD and how it should be remedied. The antagonism between these schools of thinking is based upon different members from each adopting and perpetuating a "master frame" (Snow and Benford, 1988; Carroll and Ratner, 1996) for ADHD. For the neurological approach this master frame regards ADHD as a strictly physiological phenomenon, whereas the master frame for ADHD from a psychodynamic perspective views ADHD as attributable to environmental conditions. This genealogical approach culminates with an analysis of contemporary texts that embody parenting discourses addressing the needs of ADHD children. The second part of the thesis which analyzes the everyday ways ADHD children are framed is based upon interview data from the adult authorities involved with ADHD suspicion, diagnosis and management. This set of respondents includes educators, parents and clinicians of ADHD children. The empirical emphasis upon these adult authorities is crucial to understanding how discourses influence the way ADHD children are perceived by adults in their lives and how these perceptions prompt various types of action in diagnostic and treatment capacities, but also in familial, nurturing ones.

Both the genealogical and everyday accounts of ADHD in this thesis analyze two related, yet different objects of knowledge. The textual discourses that examine the collection of symptoms believed to indicate ADHD give rise to ADHD as an object of knowledge. That is, the historical and contemporary discussion of ADHD examined in the first part of this thesis reveals how the phenomenon of ADHD is constituted. Etiological stances towards ADHD are crucial in this regard, and are contingent upon many different and often conflicting perspectives that have

sought the ownership of what causes the disorder and how it should be treated. The everyday accounts of the authorities in an ADHD child's life give rise to the ADHD child as object of knowledge. According to adult authorities, ADHD children are believed to have something fundamentally wrong with them, but the ways in which they are perceived appear to vary. Such frames for ADHD children stem largely from the base of past and present knowledge about ADHD, but are also influenced by other factors, such as the personality of the child, the circumstances under which the child is suspected of having ADHD, the specifics of their learning and social difficulties, and so on. Through everyday accounts of the adults who are associated with ADHD children we see the master framing of neurology and also the master framing of psychodynamic perspectives. Some respondents view ADHD as a strictly neurological phenomenon and hence, give accounts of the disorder that strongly resonate with neurological perspectives, whereas other respondents attribute ADHD symptoms to environment. The interview data also reveal points at which these different master frames appear to be hybridized, combining neurological and psychodynamic perspectives. In sum, the past and present textual discussions of ADHD view this disorder mechanically, as a type of solvable puzzle, whereas everyday accounts of the disorder, though clearly influenced by these discussions, are infused with certain subjective elements that contribute to a multifaceted framing of ADHD children. By uniting textual accounts with everyday accounts this thesis will demonstrate how discourses influence people's perception of ADHD children, and also how people negotiate between these bases of knowledge and the actual children they treat, teach and parent.

Chapter one provides an introduction to the genealogical method. Of primary importance in this chapter is the way a genealogical approach can effectively lay the groundwork for a qualitative analysis of respondent data. I argue that genealogical analyses, such as those employed by Hacking (1995) and Young (1995) are indispensable when analyzing the social vicissitudes of mental disorder. However, many genealogical analyses fall short of a practical application in that they do not present the "lay discourses" expressive of mental disorder, that is, the voices of those for whom the label of mental illness is highly consequential. This chapter

argues, therefore, that the genealogical perspective is a crucial and necessary component to a more penetrating analysis of ADHD, yet it does not suffice as a holistic way to address such social phenomena.

Beginning the genealogical analysis, chapter two provides an historical examination of the medical discourse that addressed the problem of childhood immorality, starting with the late 19th century discussion of imbecility and idiocy and culminating in the medical discussion of the psychological sequelae of the disease *encephalitis lethargica*, or "sleepy sickness." My contention in this chapter is that ADHD was not "discovered" in 1902 by George F. Still, as many publishing in the ADHD field have asserted. Instead, I argue that the early discussion of ADHD symptoms rested upon the medical concepts of idiocy and imbecility that predated Still's work by at least 24 years. In the same sense that we can say the contemporary discussion of ADHD was possible because of the work of Still and others, we can say that the moral shortcomings in children Still saw as problematic were not solely the result of his efforts. G.F. Still's "discovery" was being hammered out in British medicine even before he began to practice as a doctor.

The genealogical analysis continues in chapter three to include psychodynamic discussions of ADHD-like symptoms during the 1930's and 1940's. The term "psychodynamic" is divided into two categories: psychoanalytic and psychological. Psychoanalytic interpretations, it will be shown, sought little information for organic causes of childhood immorality or maladjustment. Such perspectives, epitomized by the work of Anna Freud and Melanie Klein, relied heavily upon the concepts of compulsion neuroses, ego demarcation, and the latency period in childhood development. Psychological perspectives also rejected the idea that immoral behavior was directly linked to a chemical condition, and framed such childhood behavioral problems as part of a coping strategy in the face of interpersonal or institutional failings. Psychologists argued that ADHD-like symptoms could be seen in pronounced types of personal difficulties, often signalled through scholastic shortcomings. This perspective is typified by the work of Laretta Bender and Phyllis Greenacre--two psychologists who argued that ADHD-like

symptoms could be alleviated through psychotherapeutic intervention. An emphasis on psychotherapy also characterizes the treatment stance towards ADHD-like symptoms adopted by psychoanalysts during that time. However, in contrast to psychoanalysis, psychological perspectives often affirmed that ADHD-like symptoms could be linked to organic trauma, such as those caused by head injuries.

The difference between psychological and psychoanalytic perspectives towards ADHD symptoms rested largely on a disagreement regarding the etiology of the disorder in the person exhibiting ADHD symptoms. For psychologists, it was the *response* to an organic trauma that manifested itself as a mental disorder, not an unconscious mechanism buried deep in the psyche, as psychoanalysts asserted. For psychoanalysis, the problem was addressed and treated through the discovery of an overdetermining cause deep within the mind. For psychology, remedy was sought by means of one of various techniques of behavioral modification.

Chapter three continues with an examination of the neurological discussion which has comprised the dominant etiological position towards ADHD. Beginning with an analysis of how neurology dismantled psychodynamic reasoning, this chapter describes how neurology came to dominate popular and academic perspectives on ADHD. Due to neurology's influence, ADHD is today considered largely to be a discernible organic phenomenon, more linked to brain chemistry than to an effect of one's social environment. Crucial to the neurological perspective is the subscription to medication as providing both confirmation of and treatment for a diagnosis. The "paradoxical effect"--stating that children with ADHD-like symptoms will be calmed by stimulants rather than "sped up" by them--is a case in point. I provide an examination of the many interpretations of the paradoxical effect, both from proponents and critics of stimulant use by children.

This dominance of the neurological perspective greatly deflated the claims of psychoanalysis as a bona fide cure for many mental illnesses, including ADHD. With the profusion of medications for the mentally ill beginning in the 1950's, the neurological discussion of minimal brain dysfunction (the medical term prior to "ADHD") in the 1970's had acquired a

considerable momentum. In conjunction with the expanding influence of psychopharmacology, neurological perspectives transformed the ADHD debate. The treatment of ADHD solely by psychotherapeutic or behavioristic methods was now seen as antiquated. ADHD was viewed as a physiological impairment, having a pharmacological cure.

This chapter closes with a brief discussion of some of the dissenting opinions in research and clinical circles against the dominant neurological perspectives. For example, the diagnosis of ADHD as formulated by the American Psychiatric Association has come under considerable scrutiny in recent years. Amongst the many criticisms of the diagnosis is the argument that there is no incontrovertible method for diagnosing ADHD, particularly since the diagnosis is arguably made according to cultural standards rather than physiological ones. Because of these diagnostic validity issues, many researchers have claimed that ADHD may be over-diagnosed in North America and that Ritalin and other stimulants are given too freely. This chapter concludes that although North American psychiatry has been instrumental in formulating the ADHD debate, it is not an exclusive source of ADHD knowledge.

The genealogical analysis culminates with the examination of texts that are geared for ADHD parents. In addressing the "ADHD parental guidebook," chapter four demonstrates how the various discourses (psychological, psychoanalytic, and neurological) find their way into manuals that help parents negotiate the experience of parenting an ADHD child. This can be seen in the way such guidebooks provide a frame for parents within which to understand or have special insights into the nature of their ADHD children. The domestic sphere, these guidebooks argue, is a crucial location for the employment of disciplinary techniques with ADHD children, including behavior modification, dietary intervention, and TV/video game regulation.

After the genealogical analysis of ADHD is presented in chapters one through four, I provide contemporary, "everyday" accounts of the disorder. The purpose of such accounts is to demonstrate how psychological, psychoanalytic, and neurological discussions of ADHD make their way into everyday life. In addition, the analysis of these interviews provides glimpses into the daily experience of people embroiled in a case of ADHD that are not registered in an analysis

of discourse. Chapter five offers a detailed explanation of the methods employed in interviewing the 20 clinicians, 22 teachers, and 20 ADHD parents.²

The voice of clinicians associated with ADHD, heard in their responses to interviews, forms the groundwork for chapter six. Various themes are explored in this chapter, including clinicians' attitude towards the efficacy of the ADHD diagnosis, their perspectives on the administration of medications, and their opinions on the so-called "alternative" methods for diagnosing and treating ADHD. Surprisingly, clinicians were the respondents most skeptical of the ADHD diagnosis. This skepticism demonstrates how the attitudes of clinicians reflect the ongoing ADHD debate within the lay, clinical and research communities. Though there was considerable variability, the majority felt that ADHD was a disorder still "in process." That is, they felt the disorder was slowly becoming understood by medical science, and that the visible drawbacks of medication treatment (through drugs like Ritalin, Cylert, and Adderall) were part of the process of mastering ADHD, its causes and treatments.

Chapter seven continues the analysis of interviews, this time focusing on teacher respondents. As they are perhaps the most significant actors in the process of labeling ADHD, teacher depictions of ADHD children and how they differ from others are crucial in displaying how psychological, psychoanalytic, and neurological perspectives on ADHD influence the way such children are conceptualized. I contend that teachers are "semi-formally" suspicious, representing a hybridized role between clinician and lay person. Teachers embody an awareness of ADHD symptoms and certainly convey this in their conception of ADHD students: their accounts of ADHD behavior mirror many of the things mentioned in clinical textbooks covering the disorder.³

²The specific profiles of respondents based upon gender, occupation, and race are not offered in chapter five for the purposes of preserving respondent anonymity. Moreover, in chapters six through nine, minimal information is provided about specific respondents. For clinicians, I only describe a respondent's profession, omitting their age and gender, for teachers I only describe the grade level at which they teach, and for parents, no specific information is offered.

³However, most of the teachers I interviewed had not heard of the APA's *DSM IV* criteria for ADHD. To supplement the discussion of teacher interviews, I have interspersed an analysis of literature that addresses some of the

Chapter eight concludes the interview analysis portion of the study with the examination of data from parent respondents. As they are the negotiators between their ADHD children and the institutional worlds that apply the diagnosis to them, parents provide the richest and most subjective account of the disorder. Similar to chapters six and seven, this chapter demonstrates how the lived experience of parents with ADHD children is influenced by the discourses that have comprised the history of ADHD. Some of the major themes from the interviews with parents included how they saw their children's social and academic competence in relation to their children's peers; who introduced them to knowledge about ADHD; what were some of their emotional experiences upon hearing about their child's diagnosis, and what they felt was the root cause of the disorder.

Chapter nine analyzes the interactions between respondent groups. Within this analysis is a discussion of how particular narratives for ADHD are revealed through the dynamics between clinicians, teachers, and parents. Crucial here is the extent to which neurological and/or psychodynamic perspectives towards ADHD provide definitions of the situation for such respondents, prompting the adoption of particular perspectives towards ADHD and the adoption of treatment strategies. Four cases of respondents are illustrated in this chapter which exemplify the most prevalent themes from the interviews. These cases typify the process of suspecting and ultimately diagnosing ADHD.

Chapter ten is the concluding chapter in which I discuss some of the contributions I feel were made by this thesis and where this type of research can continue. Through reiterating some of the shortcomings of traditional social constructionist accounts of mental disorder, this chapter highlights how the thesis has furthered the social study of ADHD. These contributions are comprised by: 1) the assertion that ADHD, though understood largely to be a neurological condition, is still a contested topic and consequently, has multiple interpretations in everyday life, 2) the argument that ADHD is largely suspected and diagnosed within specific institutional

educational issues with ADHD, including how teachers should suspect ADHD, through what channels to direct this suspicion once it is felt, and how they should tailor their classroom strategies for children with ADHD.

confines, namely the school, and 3) that the various discourses comprising the conceptual history of ADHD frame the experience of ADHD children in their everyday worlds. In examining the implications for further study, this chapter provides arguments for the analyses of ADHD respondent data over a longer period of time (perhaps over a five year period) that can show the changes in a respondent's relationship to ADHD, the empirical studies of how knowledge circulates amongst social actors, and the benefits of studying ADHD children themselves.

Chapter 1

Critiquing Social Constructionism: Introduction to the Genealogical Method

Addressing social constructionism

ADHD has had a limited discussion in sociology. With a notable exception or two, ADHD has been virtually ignored both as a topic of discourse and as a diagnosis with palpable consequences. Previous discussions of ADHD have invoked sociological accounts of mental deviance, especially those models which denote processes of "labeling" and of "medicalization." Influenced by the work of Goffman, Lemert, Becker, and the like, sociologists and social critics need merely "insert" the mental disorder of ADHD into an already established niche of the sociology of deviance lexicon. A study of hyperactivity, like the study of other mental disorders becomes a forum for an "empirical account" of previous sociological positions. The work of Peter Conrad (1975, 1976) in his study of hyperkinesis ("hyperkinesis" being part of the medical nomenclature which came before that of ADD and ADHD) stands as a strong example of this type of research. We are, then, left with a well-accepted structure with which to discuss ADHD, offer commentary and advocate awareness.

Much of the sociological interpretation of mental illness derives from the Symbolic Interactionist perspectives of George Herbert Mead and Charles Horton Cooley and has evolved into what is now called (perhaps aphoristically) "social constructionism".⁴ In a general discussion of deviant behavior, Jack Douglas (1970) provides a summary of some of the tenets of this perspective:

Human social order is necessarily problematic. Since we must have social order to exist, but cannot achieve it by simply living naturally, it becomes

⁴It is important to note that this thesis refers to the type of social constructionism that came to dominate deviance theory in sociology in the late 1950's and still serves as a perspective for current studies in the sociology of deviance. Such deviance theory needs to be distinguished from the poststructural strains of social constructionism that more generally characterize contemporary social theory or cultural studies. The former emphasizes that meanings are constructed by powerful agents and heavily influence the perspectives of lay people, while the former emphasizes a universal relativism.

a crucial problem of our existence which we must solve if we are to exist at all.

Man is also necessarily a symbolic animal, for it is only his capacity to create and work with symbols which he takes in some way to be real that allows him to solve the necessary problem of social order. Being unable to rely on shared instincts (or shared imprintings) to coordinate his interactions with his fellows, man must substitute a shared universe of (symbolic) meanings to achieve that coordination (p. vii).

Implied in this preface is the notion that human interaction is based upon a shared symbolic interpretation of the world. Humans act according to a symbolic order, constituting the stability of social life which sociologists can analyze on many different levels: interpersonal, institutional, and cultural.

These analyses examine the specific grammar of the symbolic order, that is, how the collectively interpreted symbolic matrix weaves its way into daily consciousness and prompts repeated, somewhat predictable, behavior. Social constructionists are often concerned with the mechanisms that are used to deploy a particular symbolic device. Peter Conrad's (1975) "content analysis" of hyperactivity, for example, measures the symbolic power of the pharmaceutical industry by counting the number of advertisements in medical journals such companies use to sway clinical belief. Attached to the analysis of the deployment of symbols is an examination of the power relations associated with them. More often than not, social constructionists place themselves in a position of advocacy for those who become objectified or dehumanized by the symbolic order.

This advocacy often prompts social constructionists to articulate (and critique) the "source" of symbolic power. Erving Goffman's *Asylums* (1961) and Thomas Scheff's *Being Mentally Ill* (1984) serve as two prominent examples. In both these works, and countless others, comprising the enterprise known as the "sociology of mental health", mental disorder is not

viewed as a "thing" to be studied and interpreted, but rather as a result of certain "possibilities" within social life.

Predominant theoretical positions in the sociology of mental deviance are characterized by a duality, which places the "informal" or everyday realm against the "formal" or medicalizing realm. Previous studies have asserted that medicalization shifts interpretations of deviant behavior from seeing such behavior as "bad" to seeing it as "sick" (Conrad and Schneider 1980). The informal realm constitutes "cultural scripts" for personal conduct, prescribing what is normal/abnormal behavior within a certain context. Thomas Scheff's (1984) famous application of Goffman's (1964) "residual rule breaking" exemplifies this conception. The formal realm, on the other hand, is often described institutionally, and is the basis of official mental disorder diagnoses. The formal realm has a profound interdependence with the informal. For example, Scheff contends that behaviors become formally described as states of mental illness when undefined or "residual" rules are consistently broken in the informal context. Violation of these rules is not defined as criminal or impolite, yet these violations represent something which "just isn't quite right" with the individual. It is argued that medical practices exploit these ambiguities in the informal realm and apply a label which offers a technical explanation for why "something wasn't quite right" with a particular person's behavior. From the perspective of the formal medical realm the informal label of "weirdo" represents a misunderstood phenomenon. He/she may not be "weird" at all, but perhaps "hebephrenic," "bi-polar," or "attention deficient."

From this perspective mental disorder is seen as a product of the interplay between formal and informal forces. Mental disorder, it is argued, is a phenomenon whose etiology can be discussed through an examination of cultural and institutional antecedents rather than psychological or physiological ones (Grosky and Pollner 1981). Hence, many sociological accounts of mental illness implicate an intolerant culture, or an out-of-control mental health industry, or profit-hungry pharmaceutical corporations, or any combination of these.

Focusing on ADHD

A more comprehensive examination of ADHD must provide a significant break from previous sociological accounts. Considerable effort will be expended in order to not point the finger at some party responsible for either creating ADHD or, conversely, not granting it enough clinical significance. ADHD will instead be discussed as a topic with a vast array of conflicting and converging interpretations, each of which might be better regarded as a specific "research narrative" (Young 1995). Because of these various interpretations this thesis will demonstrate that ADHD is far from being unified by an all-encompassing discourse. ADHD, in the clinical sense, is a nomenclature used to summarize a plethora of symptoms.

Previous ADHD nomenclature

Since the early 1900's these symptoms have included, but are certainly not limited to: 1) poor performance in school; 2) extreme extroversion; 3) outbursts of violent behavior; 4) inability to "stay on task"; 5) thievery; 6) disturbances in sleep patterns; 7) morality inconsistent with age; 8) forgetfulness. Some of these may not seem remotely related to today's conceptions of ADHD, and yet these symptoms are inextricably linked to today's clinical interpretations of this disorder.

All of these symptoms and many more have comprised a variety of diagnoses over the years, depending on historical period, and again, the system of logic underneath the discourse which provides the diagnosis. Some of these disease names include: 1) Encephalitis Lethargica (the sequelae thereof); 2) Minimal Brain Damage; 3) Minimal Cerebral Palsy; 4) Mild Retardation; 5) Minimal Brain Dysfunction; 6) Hyperkinesis; 7) Atypical Ego Development; 8) Attention Deficit Disorder (ADD); 9) Attention Deficit Hyperactivity Disorder (ADHD). These categories, in that they represent the historical antecedents of today's discussion of ADHD should not be considered interchangeable, however, they should be regarded as nomenclature addressing very similar problems of childhood that would ultimately crystallize into what the American Psychiatric Association currently calls ADHD. The fact that the collection of symptoms we today call ADHD have had so many different names over the years suggests that it may be reasonable

to expect that the nomenclature describing these childhood problems may change yet again in the future.

Problematic epidemiology

The epidemiological breakdown of ADHD in the United States and Canada is constantly changing, partially due to the fact that ADHD is nebulous and comprises so many symptoms, but also because the presentation of the data of those who are afflicted tends to serve the ideological interests of the researcher. The "anti-Ritalin" camp, for example, has estimated that between 10 and 12% of school-age children are diagnosed with ADHD and taking medications (Breggin 1998, Diller 1998), while proponents of Ritalin treatment estimate that only between 3 and 5% of school-age children are diagnosed with the disorder (Shaffer et al. 1996).

Controlling for gender, the epidemiological breakdown has an estimated male-female ratio of 5:1 (Arnold 1995, 1996), but the prevalence of the disorder in females remains unclear⁵ (Biederman et al. 1999). In addition, the difference in rates of ADHD is marked when clinic-referred data are compared with community samples, with male-female ratios of 10:1 and 3:1, respectively (Gaub and Carlson 1997). Controlled for race, recent studies argue that the cases of ADHD in African American children is proportional to the cases in the white population.⁶

Addressing Peter Conrad

The primary sociological text to date which examines hyperactivity from a sociological perspective is Peter Conrad's *Identifying Hyperactive Children* (Lexington Books, 1976). In this

⁵The gender discrepancy in ADHD cases is a major obstacle to a neurological etiology of this disorder. The fact that so many more boys than girls appear to have this disorder fails to be adequately explained by the neurological discourse which so readily contends ADHD is physiological. For example, no substantial study brings forth scientific evidence to demonstrate that the gender discrepancy in ADHD cases is related to differences in male and female endocrine systems. Furthermore, sociology and cultural anthropology have established that within the realm of gender we see discernible forms of social constructionism. With regard to boys being so much more afflicted by ADHD, we must inquire what role culture plays in making the disorder "possible" in Blum's (1970) words.

⁶ Data which describe the incidence of ADHD by other racial categories, such as Latino, Asian, and Native American could not be located. In addition, class-specific data were also unavailable.

text, which Conrad claims to be the "first empirical analysis of the process of medicalization" (p. 5) the author wishes to examine the process by which medical professionals construct a medical problem from deviant behavior. It exemplifies the informal/formal duality which has come to dominate previous discussions of mental disorder. Conrad's position rests upon an interest in the growing sphere of medical practice and its encroachment upon social life:

What is significant, however, is the expansion of the sphere where medicine now functions as an agent of social control. In the wake of a general humanitarian trend, the success and prestige of modern medicine, the increasing acceptance of deterministic social and medical concepts, the technological growth of the twentieth century and the diminution of religion as a viable institution of control, more and more deviant behavior has come into the province of medicine (pp. 4-5).

Conrad's work claims that the "discovery" of hyperactivity, or hyperkinesis can be attributed to the interplay of three social factors. These are "(1) the pharmaceutical revolution, (2) trends in the medical profession, and (3) government action" (pp. 12). Conrad's "pharmaceutical revolution" analysis points the finger at the party responsible for the synthesis and marketing of Ritalin, Ciba corporation (Ritalin is now produced and marketed by Novartis corporation), which in the 1960's, addressed a large-scale advertising campaign to the medical and educational sectors alike. His examination of medical trends⁷, though slightly unclear, generally refers to the increased interpretation of behavioral problems as biochemical or organic in origin. The "government action" side of Conrad's analysis directs attention towards government agencies, in this case the U.S. Public Health Service, who were responsible for formally labeling hyperkinesis as "minimal brain dysfunction." By discussing the role of this government agency, Conrad is

⁷In *Identifying Hyperactive Children*, Conrad asserts little about the specifics of trends in medical practice and even less about how they relate to the diagnosis of hyperactivity. For example, he presents no empirical evidence to establish that medical practices had in fact gone through some significant changes that would make the diagnosis of hyperactivity more prevalent.

clearly describing the power of a public institution to contribute to medicalization through decreeing a "unified" diagnosis.

This three-fold description of the agents which contribute to the discovery of the hyperkinesis phenomenon shows hyperkinesis as a specific project of a somewhat concerted effort on behalf of these agents. From Conrad's perspective, the three social factors reflect the sizable disparity in power between lay actors and formal organizations. ADHD, then, can be seen as a product of "expert control", in which lay actors have been removed from the debate. This system of experts use language which is obscure and inaccessible to lay actors. Conrad (1975) states: "By defining a problem as medical it is removed from the public realm where there can be discussion by ordinary people and put on a plane where only medical people can discuss it" (18).

In defining a problem as medical rather than "ordinary" in Conrad's terms, there is a profound separation between those who articulate hyperkinesis as a problem and their lay audience. It is not surprising that Conrad (1976) gives credence to Howard S. Becker's discussion of "moral entrepreneurs"--agents who further the medical cause by bringing attention to a problem:

There were, however, also agents outside the medical profession itself that were significant in "promoting" hyperkinesis as a disorder that was within the medical framework. These agents might be conceptualized in Howard S. Becker's terms, "moral entrepreneurs," those who crusade for creation and enforcement of the rules whose violation constitutes deviance. In this case the moral entrepreneurs were the pharmaceutical companies and the Association for Children with Learning Disabilities (p. 15).

Through describing a combination of the formal nomenclature of modern medicine and the passionate voice of moral entrepreneurs, Conrad sets the stage for an analysis of hyperactivity which stays within the confines of what has now become "classic" deviance theory.

Many of the assertions posited by Conrad and others tend to view knowledge systems as originating in one arena and disseminating to another. As one realm accumulates knowledge, it is

argued, this realm becomes a kind of resource for the segments of society which comparatively lack this type of knowledge. Within this asymmetrical knowledge relationship, many argue, is the potential for the abuse of power, perhaps through the literal fabrication of social problems. For example, the medical realm, according to Conrad, is a place where ADHD had effectively originated and is--through medicine's own invention--the location of the solution for ADHD. The medical realm, in this instance, invents a problem and then claims ownership to the most feasible rectifying measure. As the problem and solution become more known and legitimate this further maintains the asymmetry between medical and lay realms. The ultimate result of this is a kind of dependency in which the lay realm seeks out the medical to provide information and direct the most legitimate path for action.

With his perspective firmly rooted in the established sociology of deviance lexicon, Conrad then begins his specific empirical study of hyperactivity. This is done through qualitative analyses of interviews with parents of children being treated at the Hyperactivity-Learning Disabilities Clinic (HA-LD) in a Northeastern city. Throughout this interview process, using a grounded theory approach, Conrad describes the interactions between various social agents and how they ultimately label a child as being hyperactive. These primary agents are schools, parents, and to a lesser extent, physicians.

It is not my intention to review all of Conrad's research, its conclusions, and its implications for further analysis, but rather to highlight some of his theoretical positions and methodology. In bringing an awareness to the process by which hyperactivity is constructed as a medical phenomenon, Conrad has us in his debt. But, I believe there is much more to the story of what we today call ADHD. Conrad's analysis illustrates only a *segment* of how ADHD can be perceived through sociological inquiry.

Conrad's research demonstrates one side of a power struggle between social critique and institutional practice. In what is really one faction in a war of etiologies, Conrad's "social constructionism" perspective opposes the biological or naturalistic perspectives. As soon as clinicians deem a mental disorder to be a definite physical reality this position is debunked by

those who view this disorder as wholly contingent upon social dynamics. The work of the sociology of mental health, with its foundations in social constructionism, is often a reaction-formation against the clinical perspectives of mental health. The rather reactionary stance of social constructionism is epitomized in *Asylums* (1961), which was the first in-depth discussion of the mechanisms of "informal" and "formal" suspicion. *Asylums* is a treatise on how social processes can construct a deviant subject through formal apparatuses of control.

Social constructionist etiological stances, in that they are reactive towards clinical perspectives, commonly offer analyses which smack of conspiracy. We envision moral entrepreneurs plotting their manipulation of public belief and clinicians who give institutional legitimacy to the moral entrepreneurs' vision. For example, Conrad's (1976) study analyzes the prevalence of advertisement campaigns of pharmaceutical companies and the number of alarmist television programs which discuss hyperactivity. Mental disorders, like ADHD, are seen as a project for profit-making on behalf of pharmaceutical companies and a source of professional esteem for research-minded clinicians. ADHD is depicted as the result of a concerted and collusive effort, inviting sociological criticism.

This highly reactive stance has even been taken up by those within the medical profession. Peter Breggin's *Talking Back to Ritalin* (1998), Thomas Moore's *Prescription for Disaster* (1998) and Sydney Walker's *The Hyperactivity Hoax* (1998) serve as three recent examples. The position of these authors, if not denoted by their titles, can be summarized in a few points, not unfamiliar to social constructionists: 1) Attention disorders are a biological myth; 2) this myth is perpetuated and has served the interests of pharmaceutical companies which have grown enormously wealthy; 3) the American Psychiatric Association's *Diagnostic and Statistical Manual* (1994) is a blatant example of politics, cultural judgments and out-right quackery; and 4) the administration of Ritalin is tantamount to child abuse.

Reflexivity and Foucault

It is pertinent to examine the relationship between the realms of medicine and everyday life as reflexive. In invoking the term "reflexive" I mean that the relationship between the medical realm and the everyday realm is mutually influential. Taking this idea to its logical extension, reflexivity tends to blur the distinctions between the realms which many in sociology perceive to be distinct from each other.

A Foucauldian analysis of power/knowledge is highly relevant to a reflexive critique of ADHD. In Foucault's analysis, knowledge does not have a point of origination or a consistent source of production. The system of power/knowledge is entirely reflexive, and in a constant state of flux. To portray one group or collection of experts as "owning the power and therefore the knowledge" is an impossibility in this regard. Similarly, the knowledge that has been generated about ADHD is as much a function of medical practice and research as it is one of public legitimation. From Foucault's perspective, people embrace the medical apparatus, not because of some overpowering ideology, but because medicine has achieved a degree of legitimacy. Medicine has become a "validated" source of knowledge. In seeing the public subscription to the knowledge generated by modern medicine we have an insight into the *raison d'etre* of power (see Foucault 1978; 90-102), namely, that a moment of knowing is synonymous with a moment of power realizing its aim. These moments of knowing are highly visible, for example, when an "account" of mental illness is provided. As Dorothy Smith (1978) asserts in her essay, "K is Mentally Ill: An anatomy of A Factual Account," the way that an interpretation of a mental illness is provided is not as factual as it is political. Smith and Foucault both contend that the truth value of an assertion about mental illness is rooted in nomenclature that is an extension of power relations.

Introducing the Genealogical Method

A sociological perspective that avoids some of the theoretically subjective obscurity of recent works and at the same time avoids *ad hominum* attacks on the medical establishment

needs to employ alternative theoretical and methodological perspectives. Mental disorders must be discussed not only as effects of specific social agents, organizations, institutions, etc., but also as discursive formations. That is, mental disorders should be examined as a collection of historically-contingent concepts and statements, which do not necessarily adhere to one discipline or institutional context, and cannot be traceable to any specific social agent. As the "social product" of discursive formations, mental disorders should be discussed as in a state of flux, always contested and contestable. The contest between etiological stances needs no new addition (there has been enough debate for the time being, with no resolution point in sight); rather, the contest itself, its history, and its contemporary character need discussion.

In examining ADHD as a discursive phenomenon, the disorder can be viewed as a topic of contention, rather than a socially-constructed medical falsehood or, conversely, as a clinical reality. The conclusions from such a perspective might not be suitable for those determined to debunk clinicians or, conversely, those who wish to champion the cause of modern medicine. One of the goals of a discursive perspective is to step outside of the etiological debate and objectify the debate itself, or more specifically, to objectify *parts* of the debate. Instead of proposing an ontology of ADHD, it would be more pertinent to examine the discourse which has constituted ADHD as an object. This calls for an application of the genealogical method which characterized the later work of Michel Foucault.⁸ In Foucault's words genealogy "will cultivate the details and accidents that accompany every beginning; it will be scrupulously attentive to their petty malice; it will await their emergence, once unmasked, as the face of the other" (1984: 80). Genealogy, then, does not seek to force a continuity among historical events, rather, it sniffs out things like "accidents" and the dynamics of the petty malices which constitute the beginnings of a historical object. From Foucault's perspective, the discussion of any object of knowledge might begin by paying attention to the aggressive politics between differing perspectives towards that object.

⁸See especially *Discipline and Punish* and *the Birth of the Clinic* as examples of this method.

In addressing mental illness discourse, genealogy has proved to be a valuable methodology. Foucault's genealogical studies of institutions, such as the clinic, the hospital, and the prison provide the starting point for a critique of the knowledge bases and practices of such institutions. Foucault's writings on these institutions demonstrate that their influence is a result of the interplay between the infusion/generation of knowledge systems and how those make their way into institutional practice. As the categories of mental illnesses have become legitimated, they largely function as institutions. Hence, a genealogical perspective is particularly effective in analyzing mental illnesses. Ian Hacking's examination of Multiple Personality Disorder (MPD) in *Rewriting the Soul* (1995) and Allan Young's analysis of Post-Traumatic Stress Disorder (PTSD) in *the Harmony of Illusions* (1995) reflect Foucault's influence, but also represent a considerable advancement of genealogical methods, and new directions of study in mental health. In both *Harmony* and *Rewriting*, neither author makes an etiological or philosophical commitment to the mental illness in question. Instead, both authors elaborate a narrative of each of these mental illnesses, presenting historical and contemporary discourses. With each text, the reader is left well-informed on the etiological, symptomatic, and epidemiological discourses which comprise MPD and PTSD. Because neither author "takes sides," Hacking and Young are free to address all discussions of MPD and PTSD, rather than ignoring arguments which may invalidate their stance.

The work of Hacking and Young is a contemporary example of Foucault's work. Their methodological foundations stem from Foucault's analysis of the shape and dynamics of knowledge systems. In addressing discourse, Foucault studies the ways in which different disciplines or actors within the same discipline contest objects of knowledge, and at the level of the extradiscursive, how lay actors are affected by the manifestations of those disciplines. This position was a way for Foucault to offer an alternative to the concept of ideology which was such a deterministic force for his Marxist critics. Foucault states: "I would like to substitute this whole play of dependencies for the uniform, simple notion of assigning a causality; and by suspending the indefinitely suspended privilege of the cause, in order to render apparent the polymorphous

cluster of correlations" (in Michelle Barret *The Politics of Truth*, 130). Ideology, from a classic Marxist perspective, is dispensed unidirectionally from those in positions of economic power to the masses who internalize these belief systems and act in accordance with them. Sociological examinations of mental illness (Conrad's study of hyperactivity serving as our most relevant example) also discuss notions of mental illness as ideological. Corporate and medical realms, it is argued, control public perception, hence, the idea of a mental disorder is dispensed to a susceptible public.

Genealogy and Foucault's dependencies

There are three dependencies Foucault (1978) outlines: the *intradiscursive*, *interdiscursive*, and *extradiscursive*. The intradiscursive refers to the objects, systems of concepts, and methodologies within one discursive formation or discipline. The interdiscursive refers to interactions between different discursive formations, for example, the polarities taken between social constructionists and clinicians towards mental illness diagnoses. The extradiscursive refers to the relationship between discourse and everyday experience, for example, the way lay people are affected by the established disciplines' institutional manifestations, such as prisons, mental asylums, hospitals, schools, and so on.

These three dependencies are the basis of genealogical accounts and have proven to be particularly relevant to mental health. Mental disorders are peculiar cases of social phenomena because the nomenclature surrounding them seems to change according to political and social climates. They are a distinct representation of discursive formations which have established a sort of legitimacy in clinical and lay realms, and are manifested very strongly in everyday lived experience. Because mental disorders can be heavily analyzed on the discursive end, as well as within the less-discursive field of lived experience, the topic is a unique opportunity for a nexus between genealogy and ethnography.

Genealogical analyses of mental disorder can cultivate awareness of such phenomena which would prove difficult through other methods. There are at least two reasons for this, both of which separate genealogical accounts of mental disorder from other accounts.

First, genealogical accounts of mental disorder do not profess any etiology of mental illness, falling on neither side of the mental illness "validity question." Such studies are not concluded by stating that a specific mental disorder is a bona fide truth or falsehood. In lieu of the temptation to lay claim to a mental illness etiology, genealogical accounts instead provide elaborate discussion of the various statements which have strategized to lay claim to one etiology or another. In short, genealogical accounts avoid etiological arguments by "objectifying" the multitude of etiological positions. Genealogical studies stand on the outside of what has been labeled the "discursive field," discussing the players within this field, and these players' strategies to account for an object of knowledge.

Genealogists objectify the process through which statements are made about a mental illness, and, to a lesser degree, the methods which propel those statements. Hence, those who provide genealogical accounts of a mental disorder are inclined to discuss the phenomenon at hand as a result of "narratives" crafted by the warring factions in the discursive field.⁹ The use of the term "narrative," many argue, reduces a mental illness to a kind of story, rather than a lived social reality. I believe this is a point at which empirically-based sociology tends to withdraw support from genealogical methods, because the *experience* of mental disorder is not articulated. Genealogical studies become relegated to the amorphous category of "postmodern methodology," and are argued to be more suitable for literary criticism and cultural studies forums.

Second, genealogical accounts have a tremendous variability in the types of "data" with which they engage. This stems from the theoretical positions about the discursive field, specifically that this field is enormous--to the point of being impossible to quickly summarize in one study--and is comprised by extreme variability. Genealogists scrutinize the sets of statements

⁹Young, Allan. (1995) *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*. Princeton, NJ: Princeton University Press. (p. 270).

to be objectified at the admitted exclusion of others. There is a sort of faith that they will examine the discourses which appear the most dominant in a contemporary understanding of mental disorder (i.e. an examination of neurochemical discourses in relation to disorders such as ADHD, schizophrenia, and depression) and analyze such a disorder in terms which contemporary social actors can understand. But, there is simply no guarantee. This is an exciting methodological space. Genealogy is induction to an extreme, of sorts. It defies much of the ideas of research design, hypothesis creation/testing, theory generation, and so on, but frees a researcher to explore data sources which might otherwise be ignored.

The exploration of concepts and systems of statements inherent to the genealogical method would be wrongly equated to a "new social constructionism." Genealogical methods are divergent from social constructionist studies, mainly due to the source from which the construction stems. Social constructionists are commonly inclined to link the understanding of a mental disorder to specific political locations. For example, in Peter Conrad's article "the Discovery of Hyperkinesis," childhood hyperactivity is argued to be "medicalized" through the political dominance of certain institutions, primarily government agencies, and pharmaceutical corporations.¹⁰ Conrad leads the reader to a point of origination for hyperkinesis, using the term "discovery" in a disingenuous way. Hyperkinesis, from this perspective, was never discovered, but *fabricated* out of special, focused interest. It is a mental disorder rooted in conspiracy.

The perspective embodied in Conrad's work is nowhere to be found in the work of those doing genealogical studies. For example, Allan Young's *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (1995) uses the term "inventing" very differently than a social constructionist. Post-Traumatic Stress Disorder is not "invented" because of the efforts of particular agents, but rather, PTSD is an artifact of the discursive field. A contemporary understanding of PTSD is not the result of a selfish investment of a special interest group, but instead stems from multiple interests in the disorder. Such a claim reinvents the word "invention"

¹⁰ Conrad, Peter (1975) "The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behavior," *Social Problems* 23: 12-21.

and portrays an examination of PTSD as an eye gazing into a kaleidoscope, rather than a uni-directional, "telescopic" perspective.

Through focusing on a history of multiple discourses, genealogy promotes a "less-taken-for-granted" perspective on mental illness. Issues of validity become secondary to another analytical context in which discourses are placed within a political arena, portrayed as working within and against each other, always in motion, always propagating new sets of statements. Articulating the constant and seemingly arbitrary shifts in discursive motion, genealogy subverts notions of truth or even the notion of "progress" towards some semblance of truth. This has been interpreted as a "political aim" of genealogy, not because it seeks to invalidate a discourse as "self-serving," or "conspiratorial," but because such an analysis demystifies contemporary dominant discourses.

For sociologists who wish to undermine dominant narratives towards mental illness, this method is highly disconcerting. The reason for this feeling on behalf of sociologists is that their own discourses about a mental disorder--for example, ones which invoke a social constructionist nomenclature--are also subject to genealogy's inherent politics. The political normativity of social constructionism, or any "ism" for that matter, cannot reign within a genealogical framework. Because genealogy eliminates the efficacy of alternative discourses it is a methodology subject to considerable criticism. Hence, Nancy Fraser playfully calls Foucault's genealogy a great "lover" but terrible "husband,"¹¹ and Jurgen Habermas labels the method "cynical."¹²

After presenting the discourse-scape, genealogy bids us farewell, telling us to "do what we will" with the information which has been given to us. For sociologists who would much rather align themselves with a "critical realist" rather than "postmodernist" perspective, this is simply inadequate. Sociologists, myself included, find a continuous need to ground information

¹¹Nancy Fraser, Nancy. (1989). *Unruly Practices: Power, Discourse and Gender in Contemporary Social Theory* Minneapolis: Minnesota Press. (p. 64, 65).

¹² Habermas, Jurgen. (1984). *The Philosophical Discourse of Modernity: Twelve Lectures*. Cambridge, Mass: MIT Press (p. 253).

in some type of empirical account. If this is an impossibility, it is argued that the data either needs to be rethought or collected from a different methodological standpoint.

The first part of this thesis will address ADHD from a genealogical perspective in a style similar to both Hacking and Young. The reader should not be deceived into thinking that the genealogy of ADHD I will present is a comprehensive history of ADHD. Such a history, I believe, would be an impossibility. Instead, I have documented some examples of neurological, psychological, and psychoanalytic discourse which have relevance to contemporary understandings of ADHD. In addition, this thesis will examine the conflation of those discourses with those that lay actors internalize in the form of education manuals and parental guidebooks.

This thesis will be devoted to studying some of the "higher profile" discourses surrounding ADHD-like symptoms since the turn of the century. More appropriately labeled "textually mediated" discourses, these discourses will mainly be drawn from books and journal articles. The discursive depiction of ADHD will clearly demonstrate that ADHD is far from being uniformly understood.

Even as concerted and unified as the treatments for ADHD are, this disorder's etiology remains highly contested within the same discursive formation, for example, within the discourse of Western medicine in which similar concepts and methodologies are used as points of reference. This exemplifies Foucault's "intradiscursive dependency." Therefore, this study will examine the reactive, "anti-Ritalin" stances of researchers such as Peter Breggin and Sydney Walker as they contrast with the positions of researchers such as Russel Barkley and Barbara Fisher.

ADHD and ADHD-like symptoms, described in the past as hyperkinesis, minimal brain dysfunction, hyperactivity, etc., has also been highly contested between disciplines with markedly different points of reference, or, what Foucault would call the "interdiscursive" dependency. Obviously, the opposition between social constructionists and those in the field of medicine can be analyzed from an interdiscursive standpoint, but there are other, less polarized discourses which have contested the etiology of ADHD and have contributed to its contemporary

form. For example, the rift between neurological and psychodynamic perspectives towards ADHD will be given considerable regard.

The neurological perspective, I will argue, solidified its position through a physiological interpretation of childhood behavior problems. Initially, this interpretation was linked to the diagnosis of *encephalitis lethargica*, beginning in the 1920's. From the medical discussion of the psychiatric sequelae of encephalitis, the neurological camp constructed a nomenclature which eventually led to the sophisticated discourse influential in the discussion of ADHD today--a highly physiological, scientific stance providing the foundation for the current dominance of medicinal treatments for ADHD. Psychodynamic perspectives, on the other hand, did not link ADHD-like symptoms directly to brain chemistry, but instead saw them as behavioral responses to a personal incapacity to cope with life as "normal" people do. Because of an analysis which focused on behavior, psychodynamic practice and theory continue to argue for psychotherapy, rather than medicines, as treatment for ADHD.

The genealogical component of this thesis is meant to provide more than a simple "background" to the ADHD phenomenon. Rather, it is meant to be an examination of a cross-section of some of the many discourses which served to create the modern ideas of ADHD. Such a perspective is highly relevant to sociology for at least two reasons.

First, historical examinations of mental disorder often lead to conclusions which implicate well-known social institutions, such as the family, the economy, medicine, and government. Given the breadth of available literature which provides analyses of these and other institutions, a historical account of mental disorders like ADHD would engender a useful context to further such critique. It is my belief that the history of a mental disorder and the institutions with which it intertwines work together to give us the "current" discussion of both the disorder and those institutions. ADHD is an excellent example of this because it has been so closely tied to the institutions we have always perceived to be so valuable. In fact, the diagnosis of ADHD is in many ways synonymous with an individual failure in institutional contexts. The kids with ADHD are the kids we perceive to have "problems" with school, family, and everyday social life.

With a rich historical account we can separate ourselves from the apparent legitimacy of institutional demands and place ADHD (and the inability to function within the confines of conventional institutions) into a larger discursive context.

Second, a historical account of ADHD sheds light on the everyday discourse which can be seen in the discussions of social actors surrounding the disorder. The other half of this thesis, which analyzes interview data from a variety of respondents, including parents, teachers, and clinicians of ADHD children, is meant to provide an empirical account of the various academic discussions of ADHD. This complement to the historical account shows the importance of balancing interview data with its greater socio/historical context.

If the aim of this analysis is realized, the lineage of ADHD, or the discourses which have and continue to strategize for ownership of the term, will be shown as a history accented with contest and controversy. In this regard, a unified history of ADHD, that is, one that need merely serve as a monolithic background for some ideological discussion of the phenomenon, will be shown as a much more daunting task than previous authors have presented. The genealogical account of ADHD may be better served with a discussion of some of the conceptual antecedents that gave rise to the later discussion of ADHD, rather than through discussing a predictably linear sequence of events. This is the undertaking of chapter two, in which a discussion of the medical concepts of idiocy, imbecility and encephalitis lethargica are argued to have laid the groundwork for contemporary discussions of ADHD.

Chapter 2

Linking Immorality to the Disordered Brain

As common as a specific case of ADHD, is an opinion by someone who has "made up their mind" about the phenomenon. Virtually everyone I interview or casually discuss the topic with has some degree of conviction about this disorder, whether that conviction be about the "horrors of TV" or those "poor disabled children" or the "sham of psychiatry" or the "devastating effects of bad parenting" or the "pill-popping society." These generalizations, which are so readily available in the popular discussion of ADHD, seem to be made in haste. Few people I interviewed purported to have knowledge about the history of ADHD, and the same number were unaware of the current scientific narrative about the disorder. I must admit to a certain uneasiness in hearing this cross-section of opinions. ADHD, whether "real" or "constructed", is a disorder with tremendous educational and interpersonal implications, whose discursive history needs careful analysis. Failing such an analysis limits the potential depth at which the disorder may be understood.

ADHD is an acronym embedded in popular culture, yet its conceptual history is little discussed both in the popular realm and in academia. Brief histories of ADHD have been provided by researchers in the field (Kessler 1980; Barkley 1990, 1997) and also by those opposed to clinical discourse (Schrag and Divoky 1975; Conrad 1976). Schrag and Divoky (1975) for example, treat the history of ADHD as one of "child control"; Conrad (1975), taking a sociological analysis presents the history of ADHD as being directly linked to the exercise of institutional power, such as that found in schools and in government organizations. On the other hand, historical accounts by Kessler (1980) and Barkley (1990, 1991, 1997), discuss the history of ADHD as one characterizing the progress of modern clinical practice, slowly honing its nomenclature to greater levels of scientific validity and practical effectiveness. The medical concepts prior to ADHD, such histories imply, are stepping stones to increased knowledge and decreased human suffering.

There are two qualities which unify each of these historical accounts of ADHD. First, they are plainly ideological; each account appearing to serve the agenda of the authors' perspective on the legitimacy of ADHD as a disease category. Second, each of these accounts is all too brief, perhaps irresponsibly so. These histories are written as introductions to the aforementioned authors' books, serving as a "background" for their readership rather than as a significant topic of inquiry.

The most common starting point for historical accounts of ADHD are a series of lectures given by George Frederic Still in 1902. Both skeptics of ADHD validity (Shrag and Divoky 1975, Breggin 1998) and advocates (Barkley 1990, 1997) trace the lineage of the study of ADHD to these lectures. Though this chapter will address the work of G.F. Still, I will not begin a conceptual history of ADHD with this document. Instead, I will discuss the clinical distinction between two medical terms of the 19th century: idiocy and imbecility. It will be argued that the discourse of "imbecility" marked an early point of connection between marked and unmarked nervous disorders. Imbecility was part of the medical nomenclature which enabled medical science to begin inquiries into the mental health of persons who were not drastically maldeveloped or mentally handicapped. Medical discourse also began addressing the moral aspects of imbecility, eventually coining the term "moral imbecile" around the turn of the century. As will be shown, "imbecility" was a medical diagnosis which included persons who could not function within conventional institutional structures, and engaged in behaviors which were socially inappropriate, often criminal. This included, to a large extent, the behaviors of children--something in which G.F. Still took particular interest.

This chapter will examine the work of Still as a conglomeration of the many medical discourses surrounding imbecility and morality in the late 19th and early 20th century. After providing a description of the discourse of imbecility and idiocy, I will demonstrate how Still's work was significant for the particular medical study of child immorality. It will be argued that Still was the first to link notions of moral imbecility to children, even though he failed to provide an official diagnosis for this childhood behavior.

The latter half of this chapter will be devoted to an examination of the discourse surrounding *encephalitis lethargica* or "sleepy sickness" in children during the 1920's. According to Kessler (1980) and Barkley (1990, 1997), the medical discussion of this disease is crucial in understanding the formulation of the concept of ADHD. The psychological sequelae of this disease were supposed to be the root of a litany of childhood behavioral problems including many of the things we today associate with ADHD: inability to study, overactivity, impulsivity, etc. Hence, the nomenclature which addressed the residual effects of *encephalitis lethargica* realized much of Still's suspicions in 1902. What Still had suspected as an organic manifestation or lesion in the immoral child, those who studied *encephalitis lethargica* made into a clinical reality.

Idiocy vs. imbecility

Today both idiocy and imbecility are so popularized that their clinical meanings have all but been forgotten. Interestingly, those who wrote about idiocy and imbecility in the medical literature of the 1870's also struggled to keep its meaning within the confines of medical nomenclature (see Ireland, 1877). The idiot was a type of person who needed to be clarified and understood as a medical phenomenon, not jeered and mocked as a social misfit or catch-all typology for someone deemed socially inept. The discussion of imbecility was engaged in a partial effort to provide clarity to the diagnosis of idiocy, and later gave rise to imbecility owning its own clinical place in mental health nosology. William Ireland (1877) provides a distinction between the two terms:

Idiocy is mental deficiency or extreme stupidity, depending upon malnutrition or disease of the nervous centres, occurring before birth or before the evolution of the mental faculties in childhood.

The word imbecility is generally used to denote a less decided degree of mental incapacity. Thus, when a man distinguishes between an

idiot and an imbecile, he means that the mental capacity of the former is inferior to that of the latter (p. 1).

Imbecility here denotes a condition much less severe than that of idiocy but the extent of the difference between the two terms is unclear. The idiot is presented as someone who has an organic disorder of some kind, the onset of which occurs at the earliest phases of life. The imbecile is presented as someone with a lesser degree of the same symptoms as the idiot. The imbecile can certainly demonstrate "mental deficiency" or "stupidity," yet not as much as the idiot. What is missing in this rudimentary analysis by Ireland is some form of conceptual standard by which a more calculated distinction can be made between the idiot and the imbecile.

British physician Charles Mercier (1890) expands on the distinction between these two mental affectations. Lumping both idiocy and imbecility into the category of "congenital mental deficiency" or *dementia naturalis* (286), Mercier provides a more sophisticated analysis of the distinction between the two diagnoses. His analysis is one which rests upon the premises of mental development in the individual:

The first thing the child learns is to avoid physical danger--to keep from falling into the water, running against obstacles, burning and cutting itself, and all forms of physical injury. ...when the activities answering to this class of circumstances has been thoroughly acquired, then, and not till then, begins the acquisition of those activities by which the livelihood is to be earned. Then begins the formal process of education, which is the first step in fitting the individual to get his living. When this has been done, when sufficient time has been spent daily in the acquisition of these activities, then what remains over can be devoted to recreation and other purposes (p. 289, 290).

Mercier claims that the development of certain faculties throughout the early part of life will enable the individual to function at increasingly higher levels. The lowest level of functioning is denoted by the individual's ability to display minimal self preservation, therefore avoiding

physical injury. The higher levels of functioning include things like receiving an education and finding adequate employment.

Mercier claims that the idiot is a type of individual who demonstrated poor development at the most basic level of human existence. Idiots are to be watched and cared for; they are a danger to themselves because of their total lack of awareness of their surroundings. Imbeciles represent a slightly higher, though inadequate, level of development:

In idiocy the deficiency is still greater. The imbecile fails to adapt himself to his vital environment, he fails to complete the second step in his intellectual development; but he surmounts completely the first step, that which enables him to adapt himself to his *physical* environment (p. 290, emphasis in original).

Imbeciles could avoid dangerous moving objects, but could not be adequately educated to make a living. The imbecile personifies a failure to meet the demands of social and institutional expectations.

Imbecility as a category of mental defect became widely known in the medical community as a specific phenomenon not to be confused with the more obvious and impairing condition of idiocy. The definition of imbecility was decreed by the Royal College of Physicians in England (arguably the most esteemed collection of physicians in Europe during that time) in 1912. From the Royal College's official definition an imbecile "...is incapable from mental defect, existing from birth or from an early age, (a) of competing on equal terms with his normal fellows, or (b) of managing himself or his affairs with ordinary prudence" (Goddard 1915, p.12).

The ineptitudes described in the discussion of imbecility were eventually linked to an individual's inability to display moral restraint and lawful behavior. In what became known as "moral imbecility"¹³ medical practitioners conceptualized the acquisition of morality as a problem of human biological development. William Ireland (1900) provides a description:

¹³Charles Mercier (1917) has stated that it was he who coined the term "moral imbecility". The date of the inception of the term could not be found in my research. Due to no findings of another to stake claim of the origin of the term,

We now and then read of a "moral imbecility," a variety of the unhappy invention styled "moral insanity," originally intended to signify a total want of moral feelings as proved by reckless and shameless conduct without any intellectual impairment. ...The title "moral imbeciles," however, is so far correct that there are certain children who show from the beginning a proneness to evil, a callous selfishness, and a want of sympathy with other people, which is the most striking part of this disorder (p. 287).

This passage represents much of the literature which addressed moral imbecility around the turn of the century. Such writing presents a new direction of study for medical science. The inability to demonstrate moral behavior, in that it fell under the rubric of imbecility, could be understood as a medical problem. Ireland (1900) describes a case of moral imbecility--a boy, K.N., housed in a hospital dormitory:

The first symptom of insanity was his smashing of panes of glass in the passage and other places where he would not be readily noticed. When asked why he did so he said that he liked to see the glass fly. This went on for about six months. One day he took out of his pocket a knife which he had got hold of and deliberately made an incision in a boy's hand (p. 288).

The imbecile represents one more piece in the historical tapestry of discourse which has objectified the "nature" of the criminal, the uneducated, or the undisciplined. In *Discipline and Punish* (1977) Foucault discusses such processes of objectification as constructing the "modern soul". This modern soul represents the perceived essence of those who engaged in deviant behavior--an essence believed to be understandable and malleable only through the administration of scientific techniques. Foucault's work in *Discipline* is mainly credited with analyzing modern science's examination and objectification of the criminal (what Foucault calls

perhaps credit at this time, for placing "moral imbecility" into medical discourse, should be awarded to the late doctor.

homo criminalis), but this process of seeking the essence of the deviant through scientific study encompasses virtually anyone who has persistent troubles with conventional institutions. Within the discourse of imbecility during the later 19th and early 20th centuries, there is particular attention given to children. An examination of medicine's focus upon the moral propensity of children is crucial in drawing a bridge between this early discourse and the gradual unfolding of the discourse which has surrounded ADHD. The ADHD child, much like *homo criminalis*, represents an object of study who could not fit into the institutional frameworks of everyday life, and needed, in one way or another, to be molded to meet the demands of these institutions.

Moral imbecility evolved as a concept both medically and legally. It was formally inducted into the British Mental Deficiency Act of 1913 constituting a class of "Persons who from an early age display some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect" (Tredgold 1917, 43). The continued failure of reformative intentions of punishment, or the threat thereof, led many medical practitioners to believe that the moral imbecile represented a case of incorrigibility in the face of the disciplinary mechanisms of that time period. Hence, there was an increasing pressure on the medical establishment to conceptualize and re-conceptualize moral imbecility in an effort to apply more effective techniques of reform.

Part of the later conceptualization of the moral imbecile involved the discussion of this type of imbecile being, in many cases, of normal or even superior intelligence. The moral imbecile, physicians argued, was a more complex creature than physicians had initially thought. Physician Alfred Tredgold (1917) in an article on moral imbecility states: "Many undoubted moral imbeciles are so cunning, so plausible, and so seemingly intelligent, that mental defect, as normally understood, would appear to be, and in truth, is, quite out of the question" (43). Charles Mercier (1917) in an article covering the same topic two months later states: "...I would go farther than Dr. Tredgold, and say that some moral imbeciles are not only seemingly intelligent, but really intelligent. I have met more than one who have engaged me in a battle of wits, in which I did not win every round" (303). This discussion on behalf of medical practitioners is ironic

given the conceptual history of imbecility. The imbecile was generally defined as someone who functioned at a lower level than his/her peers, perhaps just a step or two above the idiot. The concept of the *moral* imbecile was able to abandon these "human development" presuppositions because it represented a specific type of ineptitude in which other human faculties--those of intelligence, emotion, and physical skill--could be regarded as normal.

Examining the work of George F. Still

The work of George F. Still needs to be understood within the context of the aforementioned discourse of imbecility and idiocy. His 1902 discussion of moral control in children as a medical problem rides the crest of the discussion of moral imbecility by his peers and no doubt reflects their influence. Because of this, Still's work should not be regarded as a point of origin in the discourse on ADHD children. It might be better understood as a product of the dominant medical literature of his time. Moreover, ADHD researcher Russell Barkley (1990) presents Still's research into immoral children as more meticulous than it was, making it seem novel, or avante garde. Still's work, I believe, represents a plea to the medical community rather than a breaking medical discovery.¹⁴

Still's plea begins in a series of lectures given before the Royal College of Physicians of London in March 1902, in which he proposes a new topic of medical examination:

Mr. President and gentlemen, -The particular psychical conditions with which I propose to deal in these lectures are those which are concerned with an abnormal defect of moral control in children. ...For some years past I have been collecting observations with a view to investigating the occurrence of defective moral control as a morbid condition in children, a

¹⁴Part of this misrepresentation by Barkley, I believe grossly distorts the experimental and conceptual history which has given us the legacy of ADHD. During the time period of Still's writing there was no hypothesizing about neurological structures and moral acquisition, and no large-scale study performed to ascertain the nature of this "ailment" (most of Still's limited number of subjects were part of an institutionalized population subjected to countless socially-influenced variables, all of which were ignored in his study).

subject I cannot but think calls urgently for scientific investigation (p. 1008).

In this address, Still tentatively hypothesizes the relationship between self control and the biological propensity for understanding the moral demands of one's environment. He states: "Moral control can only exist where there is a cognitive relation to environment" (1008). Individual morality is a developmental phenomenon, Still argues, which stemmed from organic functions of the brain. He contends that at a certain age there were biological standards for moral conduct, and to have less moral control than others in a particular age category constitutes the basis for suspecting a pathological condition.¹⁵

Still eliminates mental retardation as a variable affecting this immoral condition. His discussion separates "the idiot" from those with more particular moral difficulties:

The driveling idiot who recognizes no one, does not distinguish his food, and is little more than a mere automaton stands in little or no cognitive relation to his surroundings and *a fortiori* lacks that higher form of reasoning comparison which we call moral consciousness. Here, therefore, the absence of moral control is complete. Such cases are of interest chiefly as exemplifying one cause of failure of development of moral control; they have otherwise little bearing on the question before us and need not detain us further (p. 1009).

The child with inadequate control of his/her moral faculties, it is argued, should not be confused with the intellectually inferior. This line of reasoning resonates very well with the later literature which separated the morally inferior from the intellectually inferior. Like Mercier (1917) and Tredgold (1917) would later do, Still pleads to the medical community to not misunderstand immoral children as being less intelligent than children who demonstrated moral prowess. The immorality Still wishes to address is presented as significantly 'too advanced' for visibly deranged

¹⁵A standard of self-control as set by a particular age category is still a consistent diagnostic tool in the assessment of ADHD as well as other childhood mental disorders. See the APA's *DSM IV* criteria on ADHD for an example of this.

or mentally incapacitated children. Immorality in the normal child, at least the child who defied categories like "retarded", is argued to be symptomatic of some larger medical issue. Some of these symptoms include: "(1) passionateness, (2) spitefulness-cruelty; (3) jealousy; (4) lawlessness; (5) dishonesty; (6) wanton mischievousness-destructiveness;" (1009).¹⁶

For Still, these immoral behaviors are representative of some degree of personal agency on behalf of those children who display them. These are not children who, due to being too stupid to understand the moral codes of society, act out against those codes. These children, perhaps, have a clear understanding of the contents of the law, and willfully choose to disregard it. Nameless to modern medicine, these children are too intelligent to be categorized under the established nomenclature of idiocy, and too young to be understood as "criminal minds." For Still, as with those researchers who would follow in his footsteps, these are the "other children" who require a more specific understanding through medical examination. Still raises the question of whether or not these children represent an entirely new form of idiocy or imbecility: "Lastly, the question must be raised whether we can associate defect of moral control with any particular type or types of idiocy or imbecility--a question of considerable importance, for if it were possible to do so we might hope by a study of these types to find some anatomical basis for this abnormality of function" (1012).

In addition to the influential discourse of imbecility and idiocy, Still's lecture is given during a time when there are other discussions about the biological characteristics of immorality, more specifically, criminal behavior. Lombroso, and his infamous *L'Uomo Delinquente* (1876) is an unquestionable influence in the medical discussions of morality in Europe during this time period.¹⁷ Through examining the morphology of the criminal's skull, as well as other parts of the anatomy, Lombroso provides the scholarly community with a tangible form of the criminal.

¹⁶In his discussion of Still's work, Russell Barkley (1990) makes the comment that "Most of these children were impaired in attention and were quite overactive" (4). This is not documented in Still's address.

¹⁷Barkley (1990), in his commentary on Still's address, also discusses the influence of the work of people like Lombroso: "We must not forget, however, that in this Victorian era, medical scientists were frankly obsessed with head size and physical stigmata as reflecting defective intellect or morals..." (p 4).

Still's discussion, though obviously a product of its time, differs from Lombroso's. Even though, Still comments about the physicality of these children in an effort to make a distinction between them and those in the "normal" population, Still's analysis proposes a different focus of scientific study--an uncharted *neurological* one. There is an implicit assumption in his idea of the cognitive component of morality that the cause of these immoral behaviors lay hidden inside the mind of the child. The cause of this immorality is not as blatant as the slobbering idiot or the adult with criminal indentations on his head, rather, the cause is unknown and hidden. To understand the cognitive origins of moral pathology would imply a more methodical examination. Though he suspects a specific type of imbecility, Still offers no conclusions about the cause of these moral ineptitudes; his tone is one which seems to recognize the long, hard road ahead for modern medicine. As theoretically unsophisticated as it is, Still's work reflects a passion within medicine--beginning a process of inquiry and debate which today, has yet to be resolved.

Still's work is significant for the examination of the early discourse surrounding ADHD, and represents a break from the more general medical discussions of moral ineptitude, because he proposes that children be an object of study. Though ADHD is being increasingly diagnosed in adults, it remains a disorder perceived to almost exclusively afflict the young. Up to the point of Still's address, the elaboration of diagnostic categories--especially those like "moral imbecility"--are not understood in a direct relationship to children. Stemming from the discourse of idiocy and imbecility, Still provides the groundwork for a category of mental illness which is, in practicality, specific to delinquent youth.

Encephalitis lethargica as explanation of childhood immorality

The medical discussion of *encephalitis lethargica* in the 1920's is credited as an early point in the discussion of specific childhood symptoms which would later be attributable to ADHD (Stewart, 1970; Kessler 1980; Cantwell 1981; Barkley 1990). Encephalitis Lethargica or "sleepy sickness" reaches epidemic proportions towards the close of World War I. It is a disease

unknown to medicine at its outbreak, but quickly becomes a center-piece of medical attention. Isador Abrahamson (1920) provides a concise history of the spread of the illness:

News of this strange plague had scarcely escaped from the beleaguered Central Empires when the disease itself suddenly appeared in the outer world. An epidemic which was described by J.H. Mathewson and Oliver Latham, began in February, 1917, in the province of New South Wales, Australia; whence it spread to Queensland and to Victoria. It persisted till the following May. ... On February 11, 1918, the first recognized case occurred in England, and an outbreak followed which, with remissions, lasted until January, 1919. Then the disease appeared in Ireland. In 1918 the epidemic was reported as raging also in Uruguay and in Algeria, in Germany and in Greece...

So far as is known the first recognized case of this epidemic disease in America entered Mount Sinai Hospital, New York City, in September, 1918 (p. 17).

Encephalitis lethargica was an often fatal illness characterized by tremendous sluggishness, hallucinations and fever, sometimes bringing with it periods of remission--something doctors viewed as hopeful. These remissions were often short-lived and a full relapse of the illness was a common occurrence. Abrahamson (1920b) describes his experience: "The early optimism I enjoyed quickly perished, and I learned to dread this disease, so often fatal, not infrequently inflicting permanent damage on those who survived it, and sometimes bringing in its train progressive functional deterioration" (428).

What becomes as significant as the symptoms of the disease itself were the residual effects of encephalitis (This is what Stryker [1925] calls the "behavior residuals" of encephalitis; also see Paterson and Spence [1921] and Hohman [1922]). It was a disease thought to irreversibly damage many who suffered it, leaving people with extensive physical and mental

impairments. These physical and psychological sequelae came in so many forms that it was common for neurologists to refer to these sequelae as a syndrome.

In a brief history of minimal brain dysfunction Jane Kessler (1980) comments that *encephalitis lethargica*, had as many as 27 different symptoms, including: "sleep reversals, emotional instability, irritability, obstinacy, lying, thieving, impaired memory and attention, personal untidiness, tics, depression, poor motor control, and general hyperactivity" (18). Hardly an elegant diagnosis, *encephalitis lethargica* is significant because it marked a point where moral and scholastic difficulties were being discussed through somatic disease categories. The amorphous cluster of statements which constitute the discussion of idiocy and imbecility are no longer useful as a medical explanation. The discussion of *encephalitis lethargica* makes a strong break from that of idiocy and imbecility because it replaces moralizing and unscientific reasoning with inquiries that were rooted in physiology.

Franklin G. Ebaugh (1923) describes the sequelae of encephalitis as they are demonstrated through behavior patterns contrasting with those prior to the encephalitis affliction. The sequelae range anywhere from alterations in sleeping and eating patterns, to marked oppositional behavior:

Normal children who were well adjusted in school and home changed abruptly to a state of hyperkinesis, characterized by transient periods of talkativeness, tension states and emotional outbreaks often leading to general incorrigibility and inability to remain in school. ...One of the patients, a girl aged 10, was difficult to manage. She was noisy, abusive to other children and capriciously depressed. She was "bossy," quick tempered, and impulsive and showed little respect for authority. ...she gave evidence of definite sexual precocity. One boy had streaks of cruelty, and on one occasion stabbed a schoolmate with a knife. Another boy, who formerly had been quiet and orderly, became obscene and masturbated in public (p. 90).

To Ebaugh, these and other sequelae describe a "total change in the patient's character and disposition" (90) of what were at one time completely normal children--children who were well-adjusted, happily involved with conventions like school, family life, friendships, etc. After the onslaught of the formidable illness of encephalitis these children exhibit behaviors which not only fall outside the parameters of appropriate behavior within these contexts, but also, at times, go directly against them. These sequelae which exhibit an entirely new character and personality represent actions against accepted institutions, for example, the school:

In three of our patients marked hysterical phenomena were observed. One child developed spells of the functional variety, usually to escape from a difficult situation. The spells consisted of prolonged periods of rapid respirations, the child thus feigning illness in order to stay out of school (p. 91).

In a later discussion of the sequelae of encephalitis, Roger Kennedy (1924) formulates similar descriptions, citing numerous case studies, each organized according to a particular category of sequelae. Discussing the sequelae described as, "Change in Personality and Behavior" (169), he comments on the state of a 10 year old:

...a boy aged 10 years was brought to the clinic May 9, 1922, because of nervousness. In March, 1920, he had influenza followed by an acute attack of encephalitis which lasted eight days. ...He improved gradually and returned to school, but had to be taken out because he asked so many questions and removed books from other desks to his own.

In September, 1920, another attempt was made to have him attend school, but this was soon given up as he started to steal at random. He took a diamond ring belonging to his sister and disposed of it for an automobile ride (p. 170).

Kennedy's is one of the first accounts which attempts to create a case for these sequelae, especially the ones associated with defiance and oppositional behavior, to be understood as a

syndrome. He argues that the defiant behaviors and other symptoms in the post-encephalitic child are representative of a physiological mechanism. This position remains the dominant perspective of today's neurologically oriented ADHD researchers: ADHD is a syndrome comprising a variety of behaviors with a more basic neurological cause. Kennedy states: "This case illustrates the main features to be considered in dealing with children who are suffering from this syndrome. In the first place the absolutely different personality which they display is well exemplified. They are apparently acting in response to a most urgent stimulus, which they are powerless to resist" (170). This is the beginning of the discussion of the post-encephalitic child as not being responsible for his/her actions. These children, the medical literature demonstrates, were merely acting according to a neurological principle, the specifics of which remained a mystery.

Similar to Still's initial discussion of child immorality as a medical problem, Kennedy also wishes to exclude those who are retarded or have some kind of obvious mental defect:

Second, and perhaps of most importance, is the consideration of mental status. As has been indicated, there is no evidence to show that a considerable proportion of such patients are mentally retarded or deficient. ...they are moral rather than mental imbeciles. Some of them appear dull and drowsy, but in their antics and behavior they display a cunning that is not commensurate with greatly impaired mental faculties (p. 171).

The idea that a child could be "dull and drowsy" speaks not to an issue of intelligence, but to the dominant understanding of *encephalitis lethargica*. Again, this disorder was thought to be characterized by an untimely sluggishness in the child. This sluggishness apparently disappears when the child responds to the neurological stimulus in his/her brain and acts immorally. This is a different kind of mental impairment, distinct from retardation, where the afflicted child was described as cunning and calculating. This is little different from the description of the moral imbecile whom Mercier and others in the late 19th and early 20th centuries considered to be both a defective imbecile, and at the same time, owning a reasonable (sometimes high) intelligence.

Kennedy's perspective, depicting the immoral behavior of the post-encephalitic child as the result of neurological processes, is elaborated by Edward Strecker (1929). Strecker makes distinctions between two types of behavior exhibited by the post-encephalitic child: 1) "motor" behaviors; 2) "studied" types of conduct (137-138). Motor types of behavior refer to actions which are unintentional, outside the control of the child. Studied behaviors are those which result from a conscious effort. The author presents examples of each:

An example of some misconduct of the motor type is as follows: A boy, aged 10, who had acute encephalitis at the age of 7, is described as being overactive, constantly in motion, roaming about the streets at night, wandering about the house at night, whistling and singing; once he dashed up to an infant sister's crib and swung the baby about by the heels; ...In the severe studied type one witnesses such deviations as stealing, forgery, deliberate lying to gain an end, moral lapses and running away, carefully planned and with a definite objective (p. 137, 138).

Strecker paints two very distinct pictures of this type of child. On one hand, such children are clearly driven by impulses which fall outside of conscious thought or reason. They sleep poorly, and are markedly overactive. On the other hand, these children demonstrate a certain malice in the things they do. They steal, they commit forgery, all with the intent of some form of personal gain. They demonstrate a total self-centeredness in which careful plans are made and objectives sought.

The moral imbecile child portrayed by the medical discourse of the late 19th century is eclipsed by the much more elaborate analysis provided to describe the post-encephalitic child. In applying the diagnosis of *encephalitis lethargica* to immoral children, a medical understanding is provided that gives physiological explanation for immoral, anti-institutional behavior. The discourse on *encephalitis lethargica* is documented, however spuriously, by Kessler, Barkley, Stewart, and others as a place in the history of the gradual sophistication of medical practice, ultimately leading to the "teasing out" of the more correct diagnosis of ADHD. Barkley, for

example, claims that children with ADHD in the 1920's were mixed in with the population of those suffering from encephalitic trauma. Due to the rudimentary knowledge of neurology during that time period, *encephalitis lethargica*, Barkley argues, served as a catch-all, ad-hoc diagnosis. Such researchers look endearingly at their own discipline's history and claim that medicine had to start somewhere, and is gradually becoming more sophisticated and "correct."

The interpretation of past medical practice by Russell Barkley and others ignores some valuable points of analysis. Such perspectives assume that ADHD, though unnamed and anomalous in the past, is a real condition that has existed a long time. Only recently, they argue, has it become understood. Through the meeting of the neurological interest in childhood morality with the object of the post-encephalitic child, they argue we began a journey which is both humane and just. But the nexus of neurology and the post-encephalitic child is presented much too coincidentally, as if it were good fortune that the encephalitic and ADHD populations, which comprised the subjects of study, were mixed inside the institutions.

The problems of that coincidence are ignored in child psychology. Factors other than the progressive mind of science need to be addressed in interpreting the discourse on *encephalitis lethargica*. Variables that influenced the environment of the children under study and which undubitably affected behavior need to be addressed. In my fairly thorough examination of this literature, a great majority of the children under study were institutionalized before the time of being studied. The reasons for this institutionalization, no doubt, are varied, and pose major hurdles to adequate interpretation of the conditions of this population(s). Goffman's (1961) idea of the "looping effect" describes how psychiatrists interpret an individual's resistance to the environment of the institution as symptomatic of mental disorder. Obviously, this process negatively affects the degree of validity in institutionally-oriented diagnoses. Diagnosing the post-encephalitic child has not been shown to be exempt from this process. Researchers who were formulating the nomenclature on *encephalitis lethargica* never asked about the social variables which might have strongly affected childhood behavior. Causes for socially-inappropriate behavior were attributed to organic medical conditions. The most dominant stances

in today's discussion of ADHD hardly stray from this mentality: the roots of childhood defiance can best be understood through an analysis of the child's brain, rather than his/her social environment.

The discussion of *encephalitis lethargica* is significant, not because it draws suspicion to the causal connection between behavior and neurological impulse, but because it problematizes a myriad of symptoms, many of which seem unrelated. Many of these symptoms (like impulsivity, school difficulties, and hyperactivity) later become claimed by neurologists and placed under the rubric of ADHD. From the point in mental health history where encephalitis takes center stage as a cause of childhood immorality, up to the current era of ADHD, child psychiatry rests upon a belief that persistently defiant childhood behaviors represent physiological pathology. However, the specifics of this pathology, including the causes and cures for it, remain a bone of contention both inside and outside of this discipline. The discussion of this contention is highlighted in the next chapter which examines three different interpretations of ADHD symptoms: psychoanalytic, psychological, and neurological.

Chapter 3

Psychodynamic and Neurological Perspectives on ADHD: Exploring Strategies for Defining a Phenomenon

As this thesis began its historical inquiry into the advents of idiocy, imbecility, and encephalitis and these concepts' relationship to contemporary accounts of ADHD, this chapter will continue that chronology and examine three, more recent discourses which addressed ADHD. Through an analysis of the clinical literature which has addresses ADHD symptoms, this chapter elucidates a historical framework of the disorder, and explores more of the discourses which have sought to conceptualize it.

Historical accounts by Kessler (1980) and Barkley (1990, 1991, 1997), which are favorable to a neurological perspective on the disorder discuss the history of ADHD as one characterizing the progress of modern neurological practice, slowly honing its diagnostic and treatment effectiveness. These second types of historical accounts presented by those who are "in the ADHD field" represent a perspective which has overwhelmingly achieved the greatest amount of visibility in the public eye. Popular accounts of ADHD that summarize the disorder for lay persons, for example, are dominated by such perspectives. Within such accounts, ADHD is repeatedly articulated as the result of neurochemical processes in the brain.

ADHD has not always been the property of neurology, though it might be easy to think that, given a 700% increase in prescriptions for stimulant medication since 1990 (Diller, 1998), and the relative absence of psychotherapy for the ADHD-diagnosed (Walker, 1998). Other perspectives have provided conceptual frameworks with which to understand the collection of symptoms of what is today called ADHD. Since the time George F. Still (1902) "discovered" the disorder, these perspectives have posited numerous etiologies and treatments. Such perspectives, comprising no small part of the history of the discourse surrounding ADHD, have argued that symptoms of hyperactivity and impulsivity can be linked to a variety of sources, including: 1) the previously mentioned outbreaks of *Encephalitis Lethargica* (Paterson & Spence, 1921; Hohman, 1922; Ebaugh, 1923; Kennedy 1924; Stryker 1925; Strecker, 1929); 2) the phenomenon of

premature birth (Shirley 1939); 3) the ingestion of food additives (Feingold, 1975); and 4) exposure to media imagery (Rutstein, 1974; Dumont, 1976; Soper & Miller, 1983; Winn 1985).

In conjunction with the variety of past discussions about ADHD were numerous categories of pathology. The portrayal of ADHD-symptoms are contingent upon a historical period and modality which guide inquiry into the disorder. This chapter examines two influential and vastly different clinical perspectives in the history of ADHD: 1) the psychodynamic perspective; and 2) the neurological perspective. "Psychodynamic" refers to etiological positions on ADHD-like symptoms which implicate interactive difficulties between a child and his/her parents, school, church, etc. ADHD, from this stance, is a "behavioral reaction" on behalf of children towards the environment. This perspective has been subdivided into two facets: psychoanalytic and psychological. "Neurological" refers to etiological positions on ADHD which directly implicate an organic, neuro-impulse. Both of these positions have owned a considerable amount of public and academic legitimacy in understanding childhood behavioral problems. Both have also been the subject of skepticism.

It is not my intention to show one perspective as more objective or "correct" than another. It might be more useful to understand psychodynamic and neurological perspectives as differing "research narratives" (Young, 1995; also see Hacking, 1995), both strategizing to lay claim to the disease category of ADHD. If these two perspectives can be framed within a field of discursive strategy rather than as embodying greater or lesser degrees of truth, a more critical discussion of ADHD may ensue. The heated historical debate between these two perspectives highlights a process in which one discourse challenges the established notions of the other. This chapter furthers a discussion of the conceptual history which has shaped ADHD into an object of knowledge, from a disorder viewed as a result of a flawed psyche and/or discouraging social environment to one which is almost exclusively discussed and researched through the modalities of neurology. This conceptual history documents: 1) a discussion of psychodynamic perspectives towards ADHD symptoms; 2) neurology's perceived weaknesses in psychodynamic reasoning towards ADHD symptoms; 3) the relationship between the administration of medicines and

mechanisms of diagnosis in neurology; and 4) neurology's physiological explanation for ADHD. The chapter concludes with a discussion of current dissent against some of the dominant perspectives in neurology. Such dissent explicates ADHD as conceptually dynamic, and shows that neurology does not have a monolithic understanding of ADHD.

Psychodynamic Perspectives

Psychodynamic schools of thinking understand ADHD-like childhood behavior as reactions to environmental conditions, rather than being specifically linked to organic causes. This is not to say that all psychodynamic perspectives deny that immoral or disturbing child behavior was caused by organic brain trauma; many publishing in this area certainly present a case for organic brain damage. However, the psychodynamic etiological emphasis is on the degree to which children demonstrate a healthy psycho-social reciprocity with their environment, rather than on neurological dysfunction. Perspectives with such an etiological emphasis on these childhood symptoms, though avoiding focus on neurological diagnoses do not represent a unified discussion of ADHD. It is important, therefore, to distinguish psychological perspectives of ADHD-like symptoms from those perspectives more appropriately labeled psychoanalytic. Psychoanalytic etiology rests firmly upon the Freudian lexicon, whereas the psychological perspective is less inclined to adopt such nomenclature.

Psychoanalytic perspectives: Anna Freud and Melanie Klein

Perhaps two of the most significant figures in the psychoanalytic discussion of children are Anna Freud and Melanie Klein. Both Freud and Klein felt that the child mind was developed enough, even in infancy (both believed in the notion of "infant neuroses") to demonstrate marked mental impairment. The key to curing childhood neurosis, both authors argue, rests primarily in an understanding of the "latency period" of mental development. Beginning around the age of five up to puberty, the highly sexual latency period is a crucial component in childhood restlessness, mischief, and social detachment. The psyche's adjustment to the latency period manifests itself in

varying degrees of anxiety. Latency invariably involved psychic struggle which could appear as neurotic symptoms. Many of the childhood behaviors which today's clinicians attribute to symptoms of ADHD, psychoanalysts felt were due to an abnormal amount of latency-related anxiety. In Klein's (1932) words:

Children often show a kind of over-liveliness which often goes along with an overbearing and defiant manner and which people frequently mistake either for a sign of temperament or for disobedience, according to their point of view. Such behavior is, like aggression, an over-compensation for anxiety and this method of modifying anxiety greatly influences the child's character-formation and its later attitude to society. The fidgetiness which often accompanies this over-animation is, in my judgment, an important symptom. The motor discharges which the little child achieves through fidgeting often become condensed at the beginning of the latency period into definite stereotyped movements which are usually lost to view in the general picture of excessive mobility which the child presents (p. 144).

This passage offers a position which concurs with at least one aspect of contemporary ADHD discourse: over-activeness is a symptom of a more essential pathology. Psychoanalysis depict behavioral symptoms secondary to emotional states, which were psychic manifestations of a basic phase of human development. "Fidgetiness," in this instance, was a physical over-compensation for the emotional state of anxiety, and anxiety represented the psychosexual processes of latency. Depending on the other social actors involved with the latency period (primarily the child's parents), the severity of the symptoms would vary. A warning is implicit in this passage: the child's over-compensation will solidify itself into a form of "character" or an "attitude to society" in which the world will be treated as antagonistic and dangerous. The possibility of this crystallized condition is grounds to implore psychotherapy.

The discussion of "nipping the mental illness in the bud" is still a prevalent part of ADHD clinical narrative. Numerous studies have been published which show a relationship between

childhood ADHD and later anti-social mental disorders more associated with teenagers and adults. For example, it has been argued that there is a high coincidence (or "comorbidity" in psychiatric terms) of ADHD with Conduct Disorder and Oppositional Defiant Disorder (ODD) as ADHD children grow older (Baving et al., 1999). Though the rates vary, some studies have shown comorbidity rates to be as high as 93% in community-based samples (Jensen et al., 1997). The levels of comorbidity are argued to have both organic and social causes. Some researchers argue that the comorbidity of Conduct Disorder and ODD with ADHD are simply due to abnormalities in brain function (Matthys et al., 1999), but others lean more towards an interpretation favoring social maladjustment, or "psychosocial" difficulties due to early ADHD (Barkley et al., 1993). Regardless of the various arguments which depict the reasons for this comorbidity, current clinical discussions contend that ADHD symptoms must be addressed before the condition solidifies and becomes "too late" for the child.

Compulsion neuroses

The "compulsion neurosis" was a common psychoanalytic diagnosis for children. This condition refers to a mental maladjustment in which children and adults alike feel compelled to repeatedly perform or refrain from particular actions.¹⁸ Anna Freud (1926) describes a case of compulsion neurosis in a six year old girl:

I had to determine whether the difficult, silent and unpleasing nature of the child was due to a defective disposition and unsatisfactory intellectual development, or whether we had here a case of an especially inhibited and dreamy child. Closer observation revealed the presence of a compulsion neurosis, unusually severe...together with acute intelligence and keen logical powers (p. 6).

¹⁸ In the translator's note to Anna Freud's *the Psychoanalytic Treatment of Children* (1946), Nancy Proctor-Gregg defines compulsion neurosis as a condition when people "cannot (or must) step on the cracks in the pavement" (vi).

This is a case of what clinicians today would call an "inattentive" ADHD subtype¹⁹. The little girl was extremely inhibited in her reactions to others, totally withdrawn and "dreamy." She also performed poorly in school, prompting Freud to extract a demonstration of her intelligence via psychoanalytic observation. The question of intelligence is addressed immediately: psychoanalysis, it is implied, is not a cure for retardation. Here is a mentally disordered girl, driven by the compulsion to be withdrawn and silent, yet her mental faculties of logic and reason remain intact. She is not delusional, yet she is driven by something outside of her will; some force of introversion she cannot explain. The girl herself has an awareness of this outside force, telling Freud, "I have a devil in me. Can it be taken out?" (Freud, 1926, p.7).

Later psychoanalytic discourse concerning the mental adjustment of children show minor shifts in nomenclature, though retaining much of the same premises for interpreting neuroses. For example, in a paper presented at the International Institute of Child Psychiatry in Toronto, August 1954, Beata Rank describes a condition dubbed "atypical development" in preschool children. These are children of normal intelligence who exhibit inappropriate, anti-social behavior. For Rank: "'Atypical development" included impassivity or violent outbursts of anxiety and rage, identification with inanimate objects or animals, and excessively inhibited or excessively uninhibited expression of impulses" (Rank, 1954, p. 491-492). These symptoms represent the psychodynamics of a "fragmented ego"--a refinement of a prior psychoanalytic term, "defective ego", of which Rank is highly critical. Fragmentation denotes an unpredictable relationship between the ego and the world. The relief of antagonism between the individual psyche and the outside world through normal processes of cathexis is not consistently achieved with the fragmented ego. The world becomes a precarious place for this type of ego, which asserts itself with violent cathexis or utter complacency.

¹⁹It is probably more than a coincidence that Freud's patient was a little girl. Modern scientific narrative about ADHD, though still "in progress" regarding gender, contends that girls have different electroencephalographic activity than boys, prompting them to exhibit more inattentive types of behavior (see Baving et al., 1999).

The fragmented ego is argued to not be caused congenitally, but through the interactive dynamics of the family system and its effect upon the development of an infant (Rank, 1954, p.494). Rank argues that these symptoms come from an "infant's unsuccessful struggle to obtain vital satisfaction from his parents" (Rank, 1954, p.495). The results from this lack of satisfaction are an increasing psychic isolation of the child from his/her greater social world. Such isolation apparently impedes the development of a normal ego, forcing the child to "pursue only those self-circumscribed activities that provide him with narcissistic and autoerotic gratification without intrusion or interruption from the outside" (Rank, 1954, p. 495).

Rank and other psychoanalysts advocate psychotherapeutic techniques for these disturbed children. For them, the "atypical" child is not an isolated system unto him/herself, but part of a poorly functioning family system. It was commonly recommended, therefore, that the entire family undergo psychotherapy.

Psychological perspectives

Similar to psychoanalytic discussions of ADHD-like behavior, psychological discussions of symptoms such as inattention, impulsivity, and hyperactivity give little play to organic etiologies. However, there are organic overtones to the psychological argument. For psychologists, these symptoms are accepted as neuro-impulses, yet the discussion of the source of these symptoms barely implicate physiology. Similar to the perspectives of psychoanalysts, behaviors which exemplify an organically damaged, yet apparently normal child, are said to be secondary to a condition of anxiety, but are not attributed to the latency period, nor to compulsion neuroses. Anxiety is understood as a response of a child to his/her inability to adequately function within the conventions of modern living, namely, within institutions believed to be integral in childhood development: schools, family, church, and so on. Such anxiety is believed to be secondary to an organic cause, but the focus of diagnosis and treatment downplays the significance of organic brain trauma. The major way in which these secondary emotional responses are addressed is through one of various forms of psychotherapy.

Renowned for discussing the connection between childhood anxiety and organic brain trauma, Phyllis Greenacre's (1941) work exemplifies the psychological perspective towards ADHD children. Citing Greenacre, Laretta Bender, in "Problems of Children with Organic Brain Disease" (1949), states that behavioral problems of children are a mechanism used to mask a hard-wired, organic difficulty: "The question of anxiety in the brain-damaged child has been very much misunderstood except for the work of Greenacre. The anxiety is of a diffuse type, and the child, too, becomes inured to it and conceals it as he has learned to conceal many of his neurological signs" (Bender, 1949, p.412). For Bender and Greenacre alike, behavioral problems of the organically damaged child are the residuals of a physiological problem. Behavioral outbursts from this type of child are only an effort to mask the anxiety from a failure to fit into the social world as normal children do. This discussion preserves the notion that these children suffer from an organic condition, but deny that this condition is the sole cause of a child's behavioral problems.

The psychological account of ADHD-like symptoms argues that the behaviors which children exhibit are a mechanism of survival. Over a considerable time after an organic brain trauma (either through brain injury or illness) these behaviors become crystallized into habits of conduct. The belief is that these habits: 1) mask the nature of the organic pathology; 2) mask themselves from the child's own awareness. The second characteristic of these habits is the one with which psychological discourse most often engaged: the psychotherapeutic method of treatment is purported to bring an awareness of a child's behavior to both the child and his/her family. This awareness, it is argued, could provide behavioral alteration.

Today's advocates of psychotherapy stay true to this perspective. Lawrence Diller's, *Running On Ritalin* (1998) provides a contemporary example. Often critical of an exclusively bio-chemical perspective of ADHD, Diller presents the case for both the biological and social factors contributing to the disorder (for a similar, yet less-critical perspective of ADHD, see Thomas Armstrong, *The Myth of the ADD Child* [1995]). ADHD, although diagnosed carelessly and too often in Diller's opinion, is presented as an organic reality whose symptoms are merely

individual responses to the inadequacies these organic problems foster. In treating ADHD, Diller advocates a philosophy of pediatrics which favors a "family orientation" (Diller, 1995, p.5). Much like his psychological and psychoanalytic predecessors, Diller believes that the symptoms which surround ADHD are partially rooted in the social dynamics of the family, therefore, the entire family must undergo psychotherapy in order for the behavioral problems to be rectified.

Diller describes his patients (overwhelmingly, young boys) as suffering from both biological abnormality and consequent social maladjustment. His claim is that the more difficult cases of ADHD would be unresponsive to psychotherapy without some form of chemical therapy: "Many of these kids were quite out of control, and intervention with medication (usually Ritalin) was often needed to give other treatments a chance to work" (6). This statement contends that the biology of ADHD, if not quelled, is formidable enough to render psychotherapy fruitless. Medications, such as Ritalin, provide a necessary chemical treatment in which the child can become physically "settled down" enough to be able to undergo psychotherapy. During the therapy process the becalmed child can express his/her anxiety about school, family, and friends, hopefully ceasing problem behaviors in these contexts. Chemical therapy alone, Diller warns, will have no staying power if it is not supplemented with some psychotherapeutic approach. He remains highly critical of perspectives towards ADHD which have reduced its treatment to the mere "popping of a pill". Diller's position begs the clinical community to add a social sensitivity to their diagnosis and treatment of ADHD.

Another contemporary account which addresses both biological and environmental etiologies of ADHD is Gabor Mate's *Scattered Minds* (1999). In this text, which is quite critical of the strictly genetic etiologies of ADHD, Mate argues that ADHD may be a condition one is predisposed to, but also one that may be cultivated by social environment. Placing an etiological emphasis upon the process of child-rearing, the primary influential factors in one's social environment, according to Mate, are parents. If, for example, a child is raised in a home which is not sensitive to his precondition to ADHD, the symptoms will begin to occur and unalterably

change brain chemistry. Mate's is one of the most synthetic perspectives on ADHD thus far encountered in my research. He has effectively combined physiological and social etiologies.

Both psychological and psychoanalytic examinations of the symptoms which qualify as a case of ADHD adopt a common position on a method of treatment, but differ strongly in their etiological accounts. Psychology has appropriated some of the etiological position of neurology, namely that ADHD symptoms were a "true" physiological state. Psychoanalysis, on the other hand, rest upon conceptual frameworks which do not inform a discussion of physiological processes. The psychoanalytic stand-by's, concepts like "ego" and "cathexis" form a base for their argument which many later criticize as too abstract and impractical. Psychology was able to preserve its legitimacy in the discussion of ADHD because it invoked terminology congruent with the epistemological stance of Western science; it believed ADHD was empirically understandable and deferred further analysis to neurology. Psychology carves out a territory of its own in which the *reaction* to a physiological brain problem is treated, rather than the brain problem itself. Because psychology addresses the coping skills associated with ADHD, it avoids plunging into an argument over the finitudes of the etiology of the disorder. As will be shown, the etiological territory of ADHD is vehemently defended by neurologically-oriented perspectives. Psychoanalysis appears less fortunate than psychology. Because its concepts are perceived to have less clinical utility, psychoanalysis has had little influence in establishing itself as a pillar in the system of ADHD knowledge. Psychoanalysts, whether right or wrong, are left speaking to each other, rather than to the larger medical and academic communities.

It is important to examine neurology's argument against psychodynamic explanations for ADHD-like behavior. A crucial point of difference concerns the perceived essence of hyperactivity or impulsivity. Neurology reduces ADHD-like symptoms to neurochemical processes, therefore largely removing the burden of treating ADHD symptoms from the shoulders of the psychotherapeutic enterprise. In positing an etiology of ADHD, neurology subsequently claims ownership of the right to treat it. Amphetamine-based medications, it will be shown, are the single most crucial element in providing the separation between psychodynamic

perspectives and neurology. These medications validate neurology's complicated nomenclature, ratifying a biologically-oriented clinical practice, while providing a window into the true "soul" of the ADHD child--a neurologically-challenged soul where the blame for deviant behavior is attributable to a non-human agent. However, it is important to note that neurology's subscription to a physiological etiology of ADHD and pharmacological treatment is not without its own internal debates and larger validity issues. Two cases in point to be examined are: 1) the debate over the meaning of the "paradoxical effect" of medications, and 2) the debate between leading ADHD researchers over the actual biochemical mechanism associated with ADHD.

The dominance of neurology

Lawrence Diller, Gabor Mate and other authors who contribute to the modern psychologically-based discourse on ADHD profess two propositions that pull their audiences in contradictory directions: 1) ADHD is a biological reality; 2) ADHD is a misunderstood, overly-diagnosed, social construct. Diller (1998) states:

There is some evidence that children identified as ADD at age three or four continued to show problems later in childhood; this suggests that ADD is a "stable" characteristic. ...However, I'm not so sure that biologically driven behavior is the only problem in this scenario; sometimes being labeled as having a "disorder" can contribute to ongoing negative behaviors (p. 82).

From a sociological angle, Diller claims that there are outside forces which contribute to the problems associated with ADHD. There are labeling agents perhaps as powerful as the actual biological phenomenon of ADHD. The bona fide case of ADHD, then, has an organic and social etiology. Critics of this perspective claim it leaves too many unanswered questions about the nature of ADHD, and allows too many ADHD children to fall through the psychotherapeutic cracks. Such a position, they argue, prevents the formation of a universal discussion of ADHD and a universal treatment of the disorder.

Discussions of the etiology of ADHD in terms of family dynamics and the consequent promotion of psychotherapy as a crucial form of ADHD treatment have, and continue to be, under considerable attack. Perspectives which depict ADHD-symptoms as a pure neurochemical entity, have sought a unified theory on the nature of ADHD. Such a perspective would first provide a solid position on the etiology of ADHD--as solid as other well-understood diseases--and, second, champion an incontrovertible form of treatment.

Neurology's response to the psychodynamic perspective

The strictly physiological perspective on ADHD championed by neurologists frame children with ADHD-like symptoms into an uncharted area of pathology. According to this perspective, these children exhibit "soft" neurologic signs (Bray, 1969, p.14) that are not clearly identifiable within the available conceptual schemes in neurology. For example, disease categories such as the *aphasias*, which denote disturbance in language ability, the *apraxias*, which affect the ability to carry out motor activity and contain focused attention, and the *agnosias*, which involve strong disturbances in recognition, prove inadequate for accounting for this shape-shifting childhood malady (Ford, 1948). There are two major reasons for this inadequacy. First, the aforementioned disease categories and numerous others all directly implicate organic lesions, commonly attributable to a localized region of the brain. For ADHD-like symptoms, there are no discernible lesions to be held accountable. Second, such ailments are given empirical credibility through their representation in tests which hone in on the specific nature of the neurologic impairment. The Bender-Gestalt test, for example, proves adequate in discovering children with language impairment, as in the case of a form of *aphasia*, but fails to validate a hyperactivity diagnosis. We are left, then, with a mode of reverse engineering not uncommon to modern neurology and the psychiatrists who stay true to the aims of the neurological enterprise. The collection of symptoms to be diagnosed as ADHD are better understood if treated first and analyzed later.

In the forward to Paul Wender's *Minimal Brain Dysfunction in Children* (1971), (Minimal Brain Dysfunction was the nomenclature en vogue prior to that of ADHD) physician Leon

Eisenberg discusses the case history of a typical case of MBD, John, a seven year old who exhibited all the symptoms associated with the disorder. John's behavioral problems, which include severe hyperkinesis and impulsivity, are initially assessed by a psychotherapist and attributed to a family difficulty (Eisenberg in Wender, 1971, p. ix, x). Eisenberg claims that 6 months of psychotherapy in this case

brought no obvious relief, and once the school insisted on retention in grade, the pediatrician sought help from consultation at a prominent medical center, where, at long last, the existence of MBD was stated "authoritatively" on the basis of the total clinical picture. A trial of amphetamine therapy brought about striking behavioral changes, a decisive improvement in school performance, and a consequent uneasy peace among the "warring factions (p. x.)

For Eisenberg, this child's clinical profile reveals symptoms which are not only associated with, but caused by, brain chemistry. John, in Eisenberg's opinion, was someone with a clear-cut case of a physiological illness. The "warring factions" have no choice but to cease their conflict over the cause and cure of John's difficulties when amphetamine therapy markedly reduces his symptoms. Eisenberg presents a case study where the treatment of MBD with amphetamine is akin to providing antibiotics for a bacterial infection. An organic cause deserves a pharmacological cure. Eisenberg claims that the psychologists who initially assessed John

had indeed noted real phenomena in this family; their error lay in ascribing causal priority to these issues because of a psychogenic bias whose origin is to be found in the one-sided nature of the clinical training of the orthopsychiatric team. The task of the medical center had been made easier by the interval history, but it was the response to stimulants that "settled" the dispute (p. x).

John's response to medications is the great equalizer. The chemical interaction between medications and the brain which can be seen in visibly improved behavior make the case for a physiological understanding of MBD.

The term Minimal Brain Dysfunction was adopted as the official diagnosis of impulsive and disruptive childhood behavior by the United States Public Health Service in 1966, and was in considerable use during the writing of Paul Wender's book; however, there were a plethora of other clinical terms also used to describe similar symptoms. Arguing from a neuro-chemical stance, Wender expresses a strong desire to unify the nomenclature which describes the symptoms of impulsivity, hyperkinesis, and the like in children. Wender's is one of the first texts which asks the medical community to unify the nomenclature of "minimal brain damage," "minimal cerebral palsy," "minimal cerebral dysfunction," "maturational lag," and "post-encephalitic disorder" into the sole clinical entity of minimal brain dysfunction (Wender, 1971, p. 2).

The perspectives regarding the childhood difficulties of impulsivity and hyperkinesis that were purported by Wender, Eisenberg and others gained considerable universality in the psychiatric community (Conrad 1976). By the mid 1970's, minimal brain dysfunction became the dominant way both clinicians and researchers characterized such childhood problems. The terminology of MBD was deemed appropriate for a neurological perspective towards childhood behavior that was unconventional, and anti-institutional, and yet not so deviant that it warranted a more serious diagnostic category. The MBD acronym described a condition in children that was rooted in a physiological malfunction (e.g. "brain dysfunction"), and yet through the use of the word "minimal," this condition was described as mild enough to be effectively treated. In spite of the fact that their problematic behaviors were perceived to be a result of a neurological impairment, children diagnosed with MBD (and their parents) were promised that they could be reintegrated into conventional living through treatment with stimulant medication. MBD was to be taken seriously--it was a collection of symptoms worthy of a medical diagnosis--but it was also fixable. Keeping in line with the same reasoning that typified the discussion of moral

imbecility and the psychiatric sequelae of *encephalitis lethargica*, MBD described anti-institutional childhood behavior, but the diagnosis of MBD furthered these discussions by providing a specific method of treatment.

The advent of the term minimal brain dysfunction eventually fell out of favor with those in clinical circles (Kessler 1980). One main reason for this was the stigmatizing effects of the words "brain dysfunction," primarily that it denoted that children with impulsivity and attention problems were considered to have some kind of brain damage--a condition understood to be irreparable and hopeless. The APA addressed this matter with the publication of *DSM II* in 1972. Though not widely used in clinical circles, *DSM II* represented a strong effort to remove stigmatizing types of nomenclature in describing mental disorders. *DSM II* abandoned the language of "brain damage" and "dysfunction" and adopted the phrase, "hyperkinetic impulse of childhood." At the time, "hyperkinetic impulse of childhood" represented yet another interpretation of such childhood symptoms and was far from universally adopted by clinicians and researchers. By the time the APA published *DSM III* in 1980, however, the APA's nomenclature had become the dominant way to interpret these childhood behavioral problems. Immensely popular with clinicians (see Kirk and Kutchins 1992), this manual was the first of the *DSM's* to include a discussion of childhood problems of childhood inattention in addition to hyperactive symptoms (Breggin 1998). With *DSM III* came the acronym, ADD, or attention deficit disorder. Subsequent neurological theories that began to link physiological mechanisms of attention and overactivation prompted the APA to reformulate the typology for both childhood inattention and overactivation. The term Attention Deficit-Hyperactivity Disorder (ADHD) combined both ADD and hyperkinesis into one disease category and was included in the publication of *DSM III-R* in 1987. The term ADHD denoted the neurological dominance of the discussion of such childhood problems, particularly that the same neurological problem could manifest itself in different ways with different children. Hence, a case of ADHD might be of the inattentive variety, the hyperactive variety, or combine both of these problems.

One of the major obstacles to this unity, in Wender's opinion, is the misunderstanding of MBD within the psychodynamic community. Psychodynamic interpretations of MBD fail to address an "underlying disease process" (Wender, 1971, p.83). Though most did not deny some organic brain difficulty, Wender claims that the continuing psychodynamic studies of MBD, that examine constantly changing manifestations of the same neurological pathology, rather than the organic trauma itself, are clinically useless. Due to the large variability in the symptoms of this condition, Wender claims that psychologists and psychoanalysts provide a chaotic myriad of causes and treatments of these symptoms. They are lost in the symptoms, and psychotherapy provides mere "band-aids" for a more complex phenomenon. Over time, the inadequacy of psychodynamic treatments becomes easier to assert as people who exhibit MBD symptoms as children continued to struggle into adulthood (Wender, 1971, p.84). From Wender's view, people do not grow out of MBD. This was not because psychotherapy was not refined enough or insightful enough, but because the underlying disease remains untreated.

In criticizing Phyllis Greenacre's work, Wender argues that psychological perspectives of MBD that analyze non-physiological influences upon the child's behavior (i.e. the family), are predisposed to an examination of "secondary reactions" to the syndrome (Wender, 1971, p.82). Wender contrasts these secondary reactions with the less-understood primary reactions to the disorder. The primary reactions are directly linked to the physiology of MBD and include "decrease in the experience of pleasure or pain," "poorly modulated activation" (being overreactive to stress), "generally high level of activation" (hyperactivity), and "extroversion" (social aggression) (Wender, 1971, p.136-141). The secondary reactions which comprise the bulk of data for psychological studies include "narcissism," "depression," and "immaturity" (Wender, 1971, p.141-151).

Wender argues that psychologists often interpret such secondary reactions as coming from "events" in the child's life, rather than neurological difficulties. These "events," as psychologists understood them, are believed to be directly linked to the anxiety experienced by children as it arose from their inability to succeed in the world. Organically disordered children

react violently to a world he/she does not understand. A cycle of hostility is then perceived to take place involving the child and his/her social world, comprising "the events" psychologists choose to unravel. The perception is that an initial difficulty or anxiety would become greatly exacerbated by the reactions of others towards the child. The physiological difficulty becomes far less significant than the damaging patterns children and their families incorporate into daily life. An example of the relationship between organic brain trauma, anxiety, and consequent behavior can be found most commonly in schools. A student who has a physical incapacity to perform well in school might exhibit moderate to severe disciplinary problems due to continued frustration with that environment. Psychologists and psychoanalysts alike view the cause of these problems as social rather than neurological.

Wender and others who argue from a neurological stance contend that anxiety is very difficult to measure empirically. Moreover, to say that anxiety has become a disabling agent for an MBD child is equally questionable. Wender provides two grounds for this assertion: 1) in "pure cases" of MBD the conditions which psychologists call anxiety are difficult if not impossible to find; 2) the history of studying childhood anxiety has been tainted by samples of children who had a variety of different mental disorders--schizophrenia, for example--rather than cases whose symptoms specifically implicated MBD (Wender, 1971, p.146, 147).

Wender argues that MBD should be understood as a syndrome with a complex of symptoms rather than a disorder with a specific set of symptoms (Wender, 1971, p.135). The variations in symptoms could, in effect, be attributable to sub-types, and MBD may adequately become the rubric under which related pathologies would be categorized. A clinician might diagnose MBD of a hyperkinetic type, or another with a more cognitive manifestation, for example.

Regardless of subtype, and Wender hypothesizes that there are many, the proponents of neurology argue that the basics of MBD can be understood through a greater accumulation of knowledge about the chemical structure of the brain. The first and most important key into acquiring this knowledge is the chemical treatment of MBD symptoms. The physical reaction to

medicines (initially Bensedrine, and later amphetamine-derivatives, such as Ritalin) becomes an inductive tool to understand the physical condition of the child. Through the administration of medicines, where children's responses can be monitored, dosages altered and medicine type changed, a thorough neurological picture of the child's difficulty becomes visible.

Charles Bradley and Bensedrine

The first account of children's reactions to stimulant medication is provided in Charles Bradley's (1937) article "The Behavior of Children Receiving Bensedrine."²⁰ Bradley comments that studies on adult responses to stimulant medications had been widely recognized, but nothing up to the time of his study had been published concerning the effect of stimulants on children.²¹ His study sample consists of 30 hospitalized children, comprising a wide variety of mental disorder diagnoses:

The children's behavior disorders were severe enough to have warranted hospitalization, but varied considerably. They ranged from specific educational disabilities, with secondarily disturbed school behavior, to the retiring schizoid child on the one hand and the aggressive egocentric epileptic child on the other (p. 578).

In addition, Bradley comments that none of the children under study are mentally retarded, or markedly unintelligent: "The patients' intelligence was in general quite within the so-called "normal" range" (Bradley, 1937, p.578). Despite this, all of these children were sufficiently mentally impaired to prevent them from functioning within conventional institutions. The children under study were institutionalized and out of mainstream life; however, the hospital

²⁰To examine later researcher accounts of stimulant medications and children, please see the following: Connors and Eisenberg (1963); Douglas et al (1969); Eisenberg et al. (1963); Eisenberg (1972); and Sprague et al. (1970).

²¹Charles Bradley is considered to be the most significant contributor to the early study of children and stimulant medications, not just due to his 1937 account, but also due to his other publications that postulated stimulants drugs to be a viable treatment for childhood behavioral problems. For example, see Bradley and Bowen (1940), Bradley and Green (1940), and Bradley and Bowen (1941). It was also Bradley (1950) who first purported that Dexedrine may be a superior medication for treating problem children than Bensedrine. Currently, Bensedrine is rarely prescribed for ADHD children, whereas Dexedrine is widely-prescribed, especially in Canada.

within which they lived had periods of time throughout the day when conventional activities, such as schooling, took place.

After taking Benzedrine for only a few days, Bradley documents a dramatic alteration in the scholastic behavior of almost half of the study sample. Within one week of taking Benzedrine, 14 of the 30 children displayed "spectacular" improvement in school performance. With these 14 children, "There appeared a definite 'drive' to accomplish as much as possible during the school period, and often to spend extra time completing additional work. Speed of comprehension and accuracy of performance were increased in most cases" (Bradley, 1937, p.578). The administration of Benzedrine, at least in the short term, was shown to improve the relationship between children and school. Through chemical intervention, the children in this study perform to a more acceptable level, including an increase in the mechanical comprehension of school lessons and an increase in the speed of this comprehension, and show a marked increase in enthusiasm for academics.

Bradley also comments on the children's emotional reaction to Benzedrine. In all 30 cases the children's emotions appear to be "subdued," leading to overall improvements in social skills. These children, Bradley argues, demonstrated a greater interest in their surroundings and in other children. Bradley claims that Benzedrine got children "out of themselves" and more constructively involved with their physical and social environment. He describes some of the children's comments:

Although questioning the children in regard to their subjective feeling was studiously avoided in all instances, spontaneous remarks such as "I have joy in my stomach," "I feel fine and can't seem to do things fast enough today," "I feel peppy," "I start to make my bed and before I know it it is done"...All of these patients showed a widening of interest in things around them, and superficially at least, a diminished tendency to be preoccupied with themselves (p. 579).

Children's responses to the medication were not confined to performance in school. An improved performance and attitude was also visible in the ordinary events of daily life. Children on Benzedrine behaved in ways which mirrored some of the larger cultural expectations of what it means to be "well-adjusted." Self-centeredness--something Bradley sees as a common thread amongst all of these mentally disordered children, despite variation in diagnoses--is drastically reduced. Bradley's findings open a new path in child neurology in which the effects of stimulants upon child behavior attain an immediate interest with his cohorts. Shortly after the publication of Bradley's seminal account, researchers would explore the relationship between Benzedrine and children's scores on intelligence tests (Motlitch and Eccles, 1937), as well as the new Stanford achievement test (Motlitch and Poliakoff, 1937).

Paradoxically speaking

For Bradley, it is curious that Benzedrine, a drug known to foster increased activity in adults, provides a subdued reaction in half of the 30 children he experimented with: "It appears paradoxical that a drug known to be a stimulant should produce subdued behavior in half of the children" (Bradley, 1937, p.582). Overall, Bradley sees the subdued reaction by these children as very promising for future study. He comments that the EEG's of these "paradoxical cases" are generally abnormal, and that Benzedrine might affect these cases differently than those with normal EEG's. His tentative conclusion: a physical brain abnormality may very well be linked to the paradoxical effect of Benzedrine. Bradley's study is not only the first clinical account of children receiving amphetamines; it is the seminal discussion of the "paradoxical effect" of stimulants upon mentally disordered children--something which pro-Ritalin researchers attempt to prove (Conners, 1972; Gainetdinov et al., 1999) and anti-Ritalin researchers attempt to disprove (Breggin, 1998; Nicholls, 1999).

C. Keith Conners²² work strongly exemplifies the pro-stimulant, neurological discussion of the paradoxical effect of such drugs on hyperactive children. His 1972 *Pediatrics* article, "The Psychological Effects of Stimulant Drugs in Children with Minimal Brain Dysfunction," makes the first attempt in the neurological literature to demystify and redefine the paradoxical effect. As he states:

A number of myths have grown up regarding the behavioral effects and use of stimulant medications with children. The first is that there is a type of child uniquely responsive to stimulant compounds, namely, the hyperkinetic child. The second is that the hyperkinetic child is any child who is sufficiently overactive to be considered a menace by adults. The third is that the stimulant medications act primarily to reduce motor activity in a paradoxical "sedative" fashion... (p. 702).

The second myth Conners addresses refers to the criticism of the validity of the MBD diagnosis, namely, the position that children diagnosed with MBD are not truly ill, but instead, are an inconvenience for authority figures.²³ Relevant to the topic of stimulants' paradoxical effects are the first and third myths Conners mentions, both referring to perceived misunderstandings about the physiological effects of stimulants in the brain. Such myths are addressed through a summary of his study of 75 (5 female) MBD children who were prescribed stimulants for their cognitive and behavioral problems. Such a variability was found in the subjects' response to the medication that Conners clumps the behavioral responses of the children into seven different groupings. Within these categories are only a few examples of stimulants having the "sedative" effect. This tremendous variation in children's' responses to medication prompts Conners to conclude:

²² C. Keith Conners is the inventor of the famous Conners Scale, which is the primary diagnostic device for ADHD in clinical settings (see chapter 6).

²³ Other than regarding such a position as a "myth," Conners' study does not elaborate why such a criticism of MBD is unfounded.

Thus it is apparent that there is both physiological and psychological heterogeneity in this group of children. All children with this diagnosis do not respond in the same way to drug therapy, and the types of response appears to depend on the profile of abilities, and possibly an underlying physiological responsiveness in the cerebral cortex (p. 708).

In addressing the notion that the hyperkinetic child is uniquely responsive to stimulant medications (myth #1), and that these medications act as a sedative (myth #3), Conners' findings suggest that MBD may take on many different forms, and therefore, reveal varying reactions to stimulants. MBD may be characterized, for example, by hyperkinetic symptoms, or by cognitive problems, or varying combinations of the two. Keeping in line with psychiatric "reverse engineering" reasoning that views the responses to medication as indicative of the pathology being treated, Conners study draws the conclusion that MBD is a syndrome as varied as children's responses to its treatment. The hyperkinetic or "overactive" child, according to this reasoning, cannot uniquely respond to stimulants because hyperkinesis is not the only manifestation of MBD. There are, for example, many other components to the condition, such as cognitive, and attention-related problems. Therefore, the assertion that MBD children are "susceptible" to the effects of stimulants, and that this effect is generally sedative, are unfounded.

Conners' assertions, however, do not mean to be a declaration that stimulant medication acts in entirely unpredictable ways. Rather, his conclusion that the responses to the drugs are highly variable is a way of opening larger research questions concerning the effects of stimulant medication and why they apparently alleviate the behaviors associated with MBD. This question is implied in Conners' discussion of the relationship between "an underlying physiological responsiveness in the cerebral cortex" and the various and sundry effects of stimulants. Conners ponders the presence of a more sophisticated biochemical process in the MBD condition--one that may provide grounds for reinterpreting the condition's etiology. Such musings bore fruit when later researchers in the ADHD field asserted that the disorder was not caused by an overactivation of the brain, but instead an *underactivation* (Barkley 1997). Hence, the issue of the

paradox of ADHD was recast by researchers in the field. Stimulants medications, they contended, acted exactly as they were supposed to: they sped up brain activity in the frontal regions of the brain. The paradox that needed to be understood, such researchers argued, was that the distractibility and hyperactivity so characteristic of ADHD reflected brain activity that was not too fast, but too slow.

Conners study is an attempt to disprove the myths surrounding MBD children and stimulant drugs, but it reveals much about the process of how data are framed and how this framing can be used to further a line of research. For example, in accounting for the tremendous variability in his subjects' response to medication, Conners mentions children's "profile of abilities." To translate this: the response to medication may depend upon a child's cognitive strengths and which parts of the brain he/she uses best. What is peculiar (if not ideological) about this type of framing is how it ignores--and simultaneously discounts--the notion that there may be flaws in the diagnostic criteria for MBD. According to the principles of psychopharmacology, a disease is supposed to reveal more of itself through its response to medication. It follows, then, that a large variability in the response to the medication would imply that either the medication is erratic and/or the diagnosis has validity problems. Conners addresses neither of these concerns, nor do any of his pro-stimulant, research contemporaries.

A peculiar case in the psychiatric literature reveals another facet of the paradoxical discussion of stimulant medications, again, stemming from the pro-Ritalin camp. In an *American Journal of Psychiatry* article, "Report of an Unusually Large Dosage of Methylphenidate Hydrochloride," Benjamin Pollack (1964) documents the case of a woman suffering from both depression and insomnia. Part of her daily medication regimen, according to Pollack, included 40 mgs. of Ritalin, a relatively normal dosage of the drug by clinical standards. This patient--a woman Pollack contends was prone to excessive drinking, as well as abusing her medication--defied the medication recommendation. As Pollack states: "In spite of my imposing various types of restrictions, she voluntarily and openly kept increasing the amount of methylphenidate

hydrochloride until she was receiving 1200 mgs. a day" (p. 190). This unusually high dosage of Ritalin was taken by the patient for a period of six months.

Paradoxically, in spite of the fact that she was taking amounts of Ritalin that exceeded normal dosages many times over, this patient, according to Pollack, reported no difficulty sleeping and had an apparent *increase* in appetite. After this six-month period, the patient reportedly stopped taking the Ritalin "cold turkey" and suffered no symptoms of withdrawal. This patient's response to the drug was considered remarkable, prompting Pollack to conclude:

This case is of interest in that it demonstrates the relative safety and freedom from toxicity when methylphenidate hydrochloride was taken in huge doses of 1,000 mgs. or more daily. ...The freedom from toxicity, side-effects, and the lack of physical dependency is noted. There thus appears to be a very wide margin in the use of this drug (p. 190).

Such an account argues that Ritalin is relatively non-toxic and therefore, even in large doses, innocuous. The fact that the woman he was treating had such favorable responses to the drug (for example, increased appetite and reduction in insomnia) serves, according to those favorable to Ritalin treatment, as a testament to the wonder of such a drug. Ritalin proponents consistently claim that this drug provides all the benefits of amphetamines, such as making one feel more engaged, less depressed, and so on, while simultaneously avoiding the side-effects, (nervousness, anxiety, insomnia, etc.) typically associated with such drugs.

For many of those who are skeptical of the wide use of Ritalin, the position that Ritalin is safe is highly contestable. For example, in a brief article, "A Paradoxical Effect," Tracey Nicholls (1999) offers a biting commentary on the supposed and actual effects of stimulant medication. The "paradox" in the title of this article is that drugs, such as Ritalin, which are purported in clinical circles to engender a reintegration into family and school activities and to increase chances of success for ADHD children, may actually cause anti-social, self-destructive behavior. Nicholls uses two provocative examples of known people who were prescribed Ritalin to back

her claim, one being that of Nirvana front-man Kurt Cobain²⁴ who shot himself in 1994, the other, former Thurston High School student and mass murderer, Kip Kinkel. In an argument as impassioned as it is non-scientific, Nicholls contends that Ritalin and drugs of its kind may foster feelings of hopelessness and outright psychosis.

The discussion connecting stimulant medication to psychosis began in 1938, when two clinicians noticed psychotic symptoms in patients who were being treated with Bensedrine for narcolepsy (Young and Scoville, 1938).²⁵ The first of two cases these doctors describe is a 34-year-old white male whom, after being prescribed 20 to 30 mgs. of Bensedrine a day, "became tense and anxious, feared for the safety of his family and had ideas of influence. He sought police protection and believed his house was wired" (p. 639). The second case involves a 25-year-old white male the doctors describe as "exhilarated and self-conscious, thinking that people were noticing him and later that they were calling him a 'homo' " (p. 640). Both of these cases, according to the authors, particularly displayed paranoid types of psychoses, that is, they felt that forces outside of their immediate control were infiltrating their lives, plotting their demise, or attempting to stigmatize them. This paranoid component, according to the authors, may result from the increased sensitivity that ensues when Bensedrine is administered. They state: "The patient becomes more alert and observant; when extreme, this leads to ideas of reference and misinterpretation" (p. 644).²⁶

With regard to adult patients, a plethora of literature existed prior to when the first prescriptions for Ritalin were written in 1961. This discussion culminates in what is arguably the most comprehensive treatment of the topic in P.H. Connell's *Amphetamine Psychosis*(1958).

²⁴In *the Hyperactivity Hoax* (1998), Sydney Walker also mentions Kurt Cobain as an example of the psychological damage Ritalin may cause.

²⁵ For an examination of what is considered to be the most comprehensive discussion of psychotic episodes and amphetamines, please see Connell (1958).

²⁶It is also important to note that Young and Scoville attribute much of the cause of psychosis in these cases to narcoleptics' apparent propensity for psychotic reactions. As they state: "Thus in patients with a latent paranoid trend, as appears to be the case in some narcoleptics, a psychosis may be precipitated" (p. 644). This account, therefore, is not a recommendation to reevaluate the general use of Bensedrine, but is rather a recommendation to use care with this drug when treating narcolepsy.

However, the first account of children's psychotic reactions to stimulants, was not until Philip G. Ney's (1967) article, "Psychosis in a Child Associated with Amphetamine Administration." This account begins with B.D., an 8-year-old a boy who was receiving Dexedrine for "disruptive classroom behavior and poor performance at school. ...He was (also) fidgety, easily distractible, frustrated, disobedient, defiant and unable to follow directions" (p. 1026). In addition, Ney contends that B.D. was "angry toward authority figures, but also had a great deal of self-blame for his failures" (p. 1026).

Ney profiles B.D. as a patient in need of medical intervention and reports that the initial prescription for dexedrine (5 mg twice, daily) showed results deemed favorable by those who subscribe to the gravity of the hyperkinetic syndrome. Behavioral improvements were apparently made both at school and at home after undergoing Dexedrine treatment, but these improvements gave way to unforeseen complications. As Ney describes:

Suddenly one snowy day he appeared very perplexed and began taking about people throwing snowballs at him. Although he could not see these people, he could see the snowballs coming at him from behind and hitting him on the upper arm.

On more detailed examination, he complained of people spying on him and talking about him although he could not figure out where the sound was coming from. ...He could not be persuaded that they (the hallucinations) were not real (p. 1027).

As a result of this apparent state of psychosis, Ney withheld the medication to see if the hallucinations would disappear, which they did. However, after being removed from the medication, B.D.'s hyperkinetic symptoms returned, prompting Ney to place him back on Dexedrine albeit at an increased dosage (10 mg in the morning, 5 mg at noon). Ney describes the results: "With the increased dosage, he reported the telephone poles went 'blup blup' and on one occasion he jumped off the trampoline to look around the corner because he thought someone

was there" (p. 1027). Despite what appears to be a resurgence of B.D.'s psychosis, Ney dismisses this reaction, claiming it was less pronounced than those experiences B.D. previously described.

Ultimately, Ney concludes that B.D. may have had only a mild recurrence of psychosis and that these psychotic symptoms later disappeared. B.D., therefore, remained on the medication. Ney concludes his discussion:

It (this case of psychosis) poses many interesting theoretical questions and a practical dilemma. Since Bradley, in 1937, first reported the use of amphetamine in controlling hyperkinetic children,²⁷ it has been found that, although a paradoxical quieting may not always occur, when it does, it is quite dramatic. Controlled studies have shown the greater effectiveness of central nervous system stimulants over placebos, phenobarbitol and tranquilizers (p. 1027).

With such a comment, Ney relegates this case of child psychosis to the realm of "exception," rather than "rule." In that his response to Dexedrine was psychotic, rather than socially-approved, the case of B.D. demonstrates an instance in which the "paradoxical quieting" did not result from Dexedrine administration. However, this instance is framed as an isolated, almost freakish occurrence, and not grounds for a larger critique of these medications. Hence, Ney concludes by demonstrating his knowledge that medications like Dexedrine and Bensedrine have proven to be more effective than placebos and drugs like phenobarbitol.

The first report of child psychoses resulting from the administration of Ritalin was published in the *Journal of the American Medical Association* by Alexander Lucas and Morris Weiss in 1971. In this article, succinctly entitled, "Methylphenidate Hallucinosiis," the authors describe 3 cases: two girls, six-and-a-half, and fifteen years of age, and one boy, age 10. All three

²⁷This assertion is simply wrong. Bradley's (1937) account mentions institutionalized children with a variety of apparent mental illness problems, and never invokes the phrase "hyperkinetic syndrome"--a nomenclature which would not become popular in clinical circles for another 25 years.

children suffered from marked hallucinations. In the instance of the youngest girl, the authors report that

her behavior became grossly bizarre. She cowered in a corner and hid in a closet. She had become apathetic and mute, failing to respond to her parents' questions. They stated that she appeared "almost like a vegetable." Occasionally, she shouted and struck out indiscriminately. She began to babble incoherently, stared into space glassy-eyed, and grimaced and contorted her body (p. 1079).

The 10-year-old boy reported psychotic experiences that were more visual in nature. As the authors state: "When...questioned about his subjective experiences, he stated that he saw a rainbow and a whirlpool of colors. Lions, tigers, and elephants appeared to be marching around the whirlpool. He stated, 'I feel strong like I could tear everything apart' " (p. 1079, 1080). The oldest girl also demonstrated visual hallucinations: "Riding to church, she experienced visual hallucinations. Shadows in the woods seemed to materialize into people and bears. Objects such as logs were mistaken for animals" (p. 1080).

Similar to the position taken by Philip Ney, Lucas and Weiss do not report these cases in an effort to question the general safety of Ritalin. This report serves as only a tentative admonishment to clinicians. As the authors state: "Used judiciously, they (stimulants) are among the safest drugs for preadolescent children. The possibility of certain adverse reactions, however, attests to the fact that they are not innocuous" (p. 1080). Implied here as that psychotic side-effects are a possibility with Ritalin, however, such adverse reactions may be effectively mediated through a heightened sensitivity on behalf of clinicians.

Much of the clinical literature that discusses instances of child psychosis and its relationship to stimulant medication, address such issues in an understandably clinical fashion: psychoses are framed as relatively rare phenomena, are a curiosity, rather than alarming. However, not all clinicians who bring attention to stimulants and their connection to child psychoses take such a distanced position.

Peter Breggin's *Talking Back to Ritalin*(1998) is considered fundamental to today's criticism of the administration of stimulants to children. Breggin's work, perhaps more than any other, elaborates the "paradox" mentioned by Tracey Nicholls. In being one of the foremost critics of Ritalin use, Breggin represents considerable dissension within modern psychiatry and its discussion of stimulant medication. As a clinician, he provides an "insider's" perspective on the practice of prescribing Ritalin, and he devotes considerable space to the issue of psychosis. In describing such mental impairment, Breggin states:

Toxic psychoses caused by stimulant drugs are usually different in important ways from what the lay person thinks of as being "crazy." Signs of general impairment in brain function are typically present, including confusion, memory loss, and perhaps disorientation. In medical terms, it can be called a delirium or acute organic brain syndrome to designate that overall brain function has been impaired. Hallucinations, if they occur, are commonly visual and may involve seeing and feeling small creatures, like bugs. The experience is usually terrifying (p. 16).

Breggin continues to describe that such psychoses in children usually end when stimulant medication is ceased. However, he also mentions the residual effects of such psychotic episodes, describing their possible lasting impact upon a child:

Even if full recovery seems to occur, the individual may be left with a variety of fears and anxieties. I have evaluated patients who were considered fully recovered by previous physicians but who continue to display residual effects, including recurrent strange ideas or sensations, insecurity, and fearfulness (p. 16).

This passage denotes a perspective towards children that defies some of the highly mechanical perspectives taken by neurology, namely, that childhood misbehavior is a physical process with discernible mechanisms and similar remedies. In describing the possibility that the immediate

effects of psychoses may give way to longer-lasting residual ones, Breggin humanistically asserts that children and their mental aberrations cannot be turned on and off like a switch.

Neurological discourse today

Charles Bradley's, and other studies, effectively begin the neurological study of ADHD in which the reactions to medicines inform the researcher of the nature of the ailment. For a child to have a subdued and culturally-approved reaction to a drug means that the drug is "treating" some form of ailment. From this perspective, all that remains, then, is to find out the physical specificity of the mental illness so that medications can be refined. From the time of Bradley's article the inquiry into the nature of ADHD has become inextricably linked to the administration of medications. It is stated repeatedly in the ADHD literature that the paradoxical effects of Ritalin are proof that ADHD is a chemical condition.

The contemporary neurological ADHD narrative occupies a technical territory which removes its findings from mainstream debate. This perspective has apparent exclusive rights to the description of ADHD epidemiology.²⁸ Long gone are the days when neurologists and neuropsychologists traded punches with the nomenclature of psychoanalysts and psychologists. The process of compiling children's EEG readouts from a recent ADHD study exemplifies the specificity of neurological discourse:

²⁸The epidemiological breakdown of ADHD in the United States is constantly changing, partially due to the fact that ADHD is nebulous and comprises so many symptoms, but also because the presentation of the data of those who are afflicted tends to serve the ideological interests of the researcher. For example, the "anti-Ritalin" camp has estimated that between 10 and 12% of school-age children are diagnosed with ADHD and taking medications (Breggin 1998, Diller 1998), while proponents of ADHD and Ritalin treatment estimate that only between 3 and 5% of school-age children are diagnosed with the disorder (Shaffer et al. 1996). Controlling for gender, the epidemiological breakdown has an estimated male-female ratio of 5:1 (Arnold 1995, 1996), but the prevalence of the disorder in females remains unclear (Biederman et al. 1999). In addition, the difference in rates of ADHD is marked when clinic-referred data are compared with community samples, with male-female ratios of 10:1 and 3:1, respectively (Gaub and Carlson 1997). Controlled for race, recent studies argue that the cases of ADHD in African American children is proportional to the cases in the white population. Data which describe the incidence of ADHD by other racial categories, such as Latino, Asian, and Native American could not be located. In addition, class-specific data were also unavailable.

During EEG recording, children sat in a dimly illuminated, sound-attenuated, and partially electrically shielded chamber in a comfortable reclining chair. After the skin was gently abraded with OMNIPREP[R] gel, Ag/AgCl electrodes were applied with Grass EC2[R] as conducting agent. Impedances less than 5 [Omega] were accepted. Three minutes of resting EEG activity with eyes open were recorded over frontal (F3, Fz, F4), central (C3, Cz, C4), parietal (4/12 years: Pz; 8 years: P3, Pz, P4) and occipital leads (O1, O2) according to the 10-20 system with a Schwarzer amplifier. ...Vertical and horizontal electro-oculography was recorded with electrodes placed above and below the left eye and in the outer canthi. Bandwidth ranged from 0.5 to 70 Hz. Data were digitized at a rate of 256 Hz (Baving et al., 1999, p. 1367).

The above passage envisages hard science at work: lab coats, detached observation, notepads, datum upon datum. Yet anxiety in the reader is quelled to some extent: each subject sat in a "*comfortable* reclining chair," and was "*gently* abraded" with conductive gel. Along with the lengthy enumeration of technical language, describing both the locations on the brain to be studied, as well as the equipment used to study them, is an intentionally-exhibited kindness. The reader is lead to believe that this study was as humane as it was meticulous.

The current discourse of neurology directs a focus upon the components of the brain unlike any other enterprise. The etiology of ADHD, though continuing to be a topic of debate within the discourse of neurology, is almost entirely argued as a result of certain biological properties. Hence, the etiology of ADHD is discussed in terms of abnormal development of the *caudate nucleus* (Mataro 1997), *dorsolateral prefrontal circuits* (Fuster 1997), the *basal ganglia* (Castellanos 1996), and so on.

Russell Barkley (1991, 1997) has been at the forefront of the neurological perspective. His work has been pivotal in depicting the relationship between ADHD and nerve cell receptor site abnormalities, with a specific research focus on the connection between the neurotransmitter,

dopamine, and the ability to resist impulses. Dopamine, it is argued, is a chemical that regulates emotion and movement. A faulty receptor site for dopamine can fail to register incoming dopamine signals from another neuron. A dopamine transporter is said to reclaim the unused dopamine before the receptor can receive it. Hence, not enough dopamine travels appropriately through the nerve fibers. Without enough transference of this neurotransmitter, the ADHD-child is unable to inhibit emotional and physical responses to outside stimuli.

Taking a stance opposing Russell Barkley, Barbara Fisher (1996) has argued that impulsivity and the inability to pay attention should be understood as two completely different chemical processes, rather than describing them as variables in one chemical mechanism. She claims: "...serotonin has been consistently implicated in impulsivity..." (Fisher, 1996, p. 54), and that "Norepinephrine is implicated in the ability to pay attention to what is important and only what is important" (Fisher, 1996, p.55). Despite the internal differences within the neurological narrative there remains little room for discussion of environmental causes for ADHD. Neurological arguments imply that children and families can certainly be victimized by ADHD, but categories like compulsion neuroses, or the latency period, they argue, are antiquated mysticism which offer no truth for solving what is clearly a chemical problem.

Popular accounts of ADHD are also heavily influenced by neurological discourse²⁹. Citing the work of ADHD researcher, Russell Barkley, a recent *U.S. News and World Report* article summarized the condition of ADHD in terms congruent with the discourse of neurochemistry, yet simplified enough to be digestible by a lay audience (Brink 1998). The author provides a colorful graphic of the child brain in order to illustrate what the reader is meant to see as the physical reality of ADHD. Under the subtitle "What's the problem?", text accompanying the graphic describes the physical reasons for ADHD symptoms: "An ADHD sufferer's brain interferes with the effect of dopamine, a chemical that regulates emotion and

²⁹For recent popular accounts of ADHD see *Business Week* Nov. 22, 1999 p70; *the Clearing House* Sept-Oct 1999 p43; *Newsweek* Dec. 7, 1999 p60; *Runner's World* July 1999 p84. *Time* Nov. 30, 1998 p86-92; *U.S. News and World Report* Dec 27, 1999 p12.

movement" (80). A close-up image of a nerve cell is provided. A faulty receptor cite for dopamine, labeled with an "A" on the diagram, is said to "fail to register incoming dopamine signals from another neuron" (80). The dopamine transporter labeled "B" on the diagram is said to reclaim the unused dopamine before the receptor can receive it. Hence, not enough dopamine travels appropriately through the nerve fibers. Without enough transference of this neurotransmitter the child is unable to inhibit emotional and physical responses to outside stimuli. The diagram continues to describe the affected areas of the brain. These include: 1) the *right prefrontal lobe*--believed to regulate a person's ability to resist distraction and, hence, sustain attention, 2) the *caudate nucleus*--a crucial component in the cerebral cortex's coordination of neurological inputs, 3) the *globus pallidus*--also crucial in coordinating neurological information, and 4) the *vermis region*--a part of the brain which regulates physical movement.

This article, and countless others, summarize the condition of ADHD and present it in a manner somewhat understandable to lay persons. The perspective given by these popular articles represents the hegemony of neurological discourse in popular understandings of ADHD. With articles of this ilk we are presented with "hard facts", given the names of specific chemical culprits, and shown where these culprits do their dirty work--an understanding not clouded by subjective explanations.

It is important to inquire about the reasons for why the neurological perspective towards ADHD has gained practical dominance.

First, its scientific "evidence" continues to be technically supported through diagnostic devices that are directly linked to the diagnostic criteria for ADHD. This represents a significant point of departure for neurologists in comparison to their psychodynamic counterparts. As they are largely inductive in nature, psychodynamic methods of diagnosing and treating ADHD-like symptoms fail to consistently implicate a singular disease process. As asserted by Wender, it is widely believed in neurological circles that perspectives towards ADHD symptoms that do not

recognize neurology become hopelessly intertwined with a melange of symptoms, and therefore fail to address an essential organic condition.

Two of the most popular diagnostic technologies for ADHD include the Conners Test, and Positron Emission Tomography (PET). Formulated by C. Keith Conners in 1966, the Conners Test remains the most dominant method for diagnosing cases of ADHD in clinical settings (see chapter six for clinician accounts of this test). In its current forms, the Conners Test is adapted to *DSM IV* criteria for ADHD and comes in three major formats: a clinician questionnaire, a parent's questionnaire, and a teacher's questionnaire. Clearly, the current formats of the Conners Test reveal much about the institutional specificity of the ADHD diagnosis as such questionnaires are directed towards the institutions of the clinic, the school, and the domestic realm.

Positron Emission Tomography (PET) scans of the brain begin by having a patient swallow a small amount of radioactive glucose that makes its way into the circulatory system of the brain and becomes visible through electromagnetic scanning. By charting where the glucose can be seen, researchers claim that they find fundamental differences in the brains of patients with ADHD and patients without the disorder. The contention is that patients diagnosed with ADHD have less of the glucose visible in specific regions of the brain that enable impulse inhibition and the discrimination between important and unimportant stimuli. These differences in brain structure are argued to cause an underactivation in the brain's frontal lobe which in turn cause distractibility and erratic behavior (Mataro 1997, Mathys et al. 1999). Furthermore, researchers argue that medication therapy restores the frontal lobe to a normal level of activation which can apparently be seen in the increased amounts of radioactive glucose with subsequent PET scans (Barkley 1997).

It is notable that PET scans have been subject to considerable criticism, often claimed to examine patients who have already been prescribed stimulant medication (Breggin 1998) and also, that the interpretation of PET scans are highly unreliable (Walker 1998). Critics assert that test groups who comprise the bulk of subjects for PET scans have previously been diagnosed

with ADHD and have already begun taking stimulant medication. This argument states that the results of PET scans actually serve those who are opposed to the ADHD diagnosis as such scans reveal the brain-damaging effects of Ritalin, rather than an inherent brain structure abnormality. In addition, it is asserted that electro-chemical reactions in the brain are naturally volatile, subject to emotional states and levels of physical stress. Because of this, it is argued that the brain profiles of children who undergo PET scans may vary from day to day, even from moment to moment. Researchers such as Sydney Walker (1998), for example, argue that those who are sympathetic to the validity of the ADHD diagnosis find what they seek in a PET scan, even if it was not there in the first place.

Second, these findings do not describe social processes or psychological dynamics, but, rather, physical entities inside the human body. Such entities are increasingly argued to be calculable in the closely examined behavior of children, especially through new testing procedures. For example, a new test, known as the "OPTax" (short for "optical tracking and attention test") is the current pinnacle of neurology's quest to definitively detect the presence of ADHD (Wronski 2001). Invented by Harvard University psychiatrist, Martin Teicher, this new test has children track moving targets on a computer screen and monitors their success in responding to them. As Richard Wronski states in a *Chicago Tribune* article: "During the 15 minute OPTax test, the child sits before a computer screen and is challenged to respond to the appearance of moving stars. The speed and accuracy of the child's responses provide data on attentiveness and impulsiveness." While the child is responding to the stars moving on the computer screen, an infrared camera follows a marker that has been placed on the back of the child's head. With the OPTax exam every minute fidget a child may exhibit is monitored and tallied. The data collected from the OPTax test are compared with scores from thousands of other children. From these scores, a continuum of hyperactivity and/or inattention is constructed and becomes the standard by which children who take the OPTax are assessed.

In the face of such an onslaught of technical explorations of ADHD, psychodynamic perspectives struggle with how they will account for and treat the disorder. Through its

examinations and documentation measures, neurology offers a biological explanation which distinguishes between the "maladjusted" child and the ADHD child. Psychodynamic nomenclature cannot capture this distinction. The psychodynamic perspective wallows in the ambiguities which its discourse describes: an ADHD child may or may not have organic brain damage, may or may not need extensive therapy, may or may not need to be medicated. From the perspective of neurology these become non-issues once a positive diagnosis of ADHD is made. If a child responds positively to the administration of a medication, the diagnosis is validated.

It is well known that medicinal therapy, through drugs like Ritalin, Cylert, and more recently, Adderall, are the dominant mode of treating ADHD. Some researchers estimate that between ten and twelve percent of school-age boys are taking some form of amphetamine derivative for problems with what psychologists call "inattention" or "hyperactivity" (Breggin 1995, 1998). The presence of such large numbers of medicated school-children is defended by those speaking from the neurological perspective. Barkley (1995) for example, has argued that the strong increase in Ritalin prescriptions over the past ten years is nothing to be alarmed about. He claims the sharp increase in Ritalin prescriptions will level off and is a normal trend when a new disease is being diagnosed.

Propelled by the work of Russell Barkley (1997) and Barbara Fisher (1996), the neurological discussion of ADHD, while far from being a unified discourse, is clearly the most supported in contemporary times, at least in the current practices of treating ADHD. The dominance of this discourse as the accepted mode of explanation for ADHD-like symptoms can, in part, explain the massive increase in prescriptions for Ritalin in North America since 1990 (Diller 1998). The population who see themselves as victimized by the condition of ADHD have embraced medications to relieve their children's symptoms.

The essence of childhood behavioral problems that occurred amongst those who were not markedly catatonic or developmentally retarded was a very elusive target for the variety of nomenclatures which sought its location. It seemed that as the discourse which described ADHD-like symptoms changed, and propagated new discourses, the essence of ADHD also changed.

Depending upon the time period, ADHD-like symptoms were understood as: a) an unfortunate condition of the general populace (imbecility); b) the sequelae of a specific infestation of the body (encephalitis lethargica); c) the results of unhealthy dynamics within key agents of socialization, primarily the family; d) the results of frustration to some unnameable organic condition of the mind, preventing normal functioning within conventional institutions; e) the behavioral results of a specific neurological process, traceable to neurotransmitters and regions of the brain.

It is an understatement that the discussion of imbecility and the later discussion of encephalitis were inadequate in positing an etiology and treatment of ADHD-like symptoms. At best, they represent the musings of the medical enterprise, seeking out a more exclusive nomenclature. It was quite a different picture with the discourse which tended to describe childhood immorality and impulsivity as psychologically-based: the results of pathological *dynamics* within the human mind and interactive contexts. Backed by the considerable acceptance of Freudian psychoanalysis³⁰ in both theory and practice, such perspectives posed what were understood to be reasonable alternatives to the medical perspectives which preceded them.

However, the concept of "dynamics", and the description of the pathological development of certain entities--for example, the childhood ego and its compulsion neurosis--lacked explanatory power in the eyes of the professionals who would later critique these perspectives. In a field where empirical "results" were increasingly valued, neurochemistry filled the chasm between phenomenon and explanation. Enter Paul Wender's skepticism towards psychodynamics. Neurology exploited the ambiguities in the psychodynamic perspective through re-conceptualizing the problem of the ADHD child, and simultaneously offering a medicinal

³⁰In leveling their criticisms at psychoanalytic interpretations of ADHD-like symptoms and psychotherapeutic treatment, neurologists were aiming at neo-Freudian ideas, rather than the ideas of Freud per se. It is widely known, for example, that Freud, a student of neurology, strongly believed in the marriage between psychoanalysis and somatic medicine.

solution to this problem. Pharmacological treatment appeared to offer swift results, thereby legitimating neurology's etiological position.

In addressing the dominance of neurology in the ADHD discussion we may conclude that neurology's status was attained through its ability to find truth in the ADHD phenomenon. Such a view of neurology, however, would miss the political dynamics associated with the debate between neurological and psychodynamic perspectives towards ADHD. As these perspectives opposed each other in the past, they have followed the rules of engagement that are characteristic of a "science war." In her essay on the 19th century debate over the usefulness of Euclidean geometry and the subsequent rise of noneuclidean views of time and space, Joan Fujimura (1998) states:

The issue I address by discussing this early science war in the context of current debates is that of scientific authority. I argue that science wars then and now are not about science versus antiscience, not about objectivity versus subjectivity, but about authority in science: What kind of science should be practiced, and who gets to define it? (p. 348).

Within this essay, Fujimura lends considerable space to a rather famous incident in which a New York University theoretical physicist, Alan Sokal, published a mock article in a 1996 "science wars" issue of *Social Text*. Sokal's essay, "Transgressing the Boundaries: Towards a Transformative Hermeneutics of Quantum Gravity," which was published without revision, intentionally misstates scientific "truths" and expresses mock praise for some of the poststructural luminaries, such as Jacques Derrida and Bruno Latour. Sokal published a later article revealing his hoax, beginning a campaign in which he attempts to dismantle the "sloppy thinking" of today's postmodern intellectuals. Fujimura aligns some of Sokal's tactics to elements of the geometry debate in the 19th century, claiming that the way Sokal attacks contemporary intellectuals mirrors the way the warring factions encountered each other in the Euclidean versus noneuclidean debate.

One method used by Sokal and others who engage in science wars, Fujimura argues, is the tactic of constituting those they attack as "the Other" (p. 357). Through this process, Fujimura claims that the attacking party presents the opposition as naive, flawed in its reasoning, and claiming truth it has no legitimate right to own. This process of "othering" is prevalent in the discourse of ADHD, particularly in the way that researchers such as Paul Wender characterize psychodynamic proponents as ineffectual, using methods more akin to mysticism than science. Another method of attack used in science wars that is particularly germane to the study of ADHD discourse concerns the defense of "universal truth." Adopting such a stance creates the illusion of a moral obligation on behalf of the attacking perspective, in which their defense of truth is realized through becoming an arbiter of truth. As Fujimura states: "In the pose of defender of universal truth, he becomes the arbiter of truth" (p. 357). With regard to neurology's dominance of the ADHD discussion, we see neurology position itself as a defender of at least two truths, both with moral overtones. First, there is the defense of science. Neurology purports to subscribe to the conventions of scientific method, including the empirical gathering of evidence, hypothesis testing, replication etc. Second, there is the defense of the larger principles that supposedly drive child neurology in the first instance, namely that children's health is at stake. By claiming the inefficacy of psychodynamic approaches to ADHD, neurology casts itself as the "caring" alternative.

Antagonism and the absent center of ADHD

To say that neurology had exclusively defined the ADHD problem and engineered its answer would be analytically spurious. Allow me, therefore, to explore some theoretical bases for why neurology has reigned supreme in the ADHD debate. There were a number of contingencies that may have proven favorable to the neurological enterprise. First, the dominance of neurology occurred as a result of what psychodynamic perspectives lacked in their conceptual frameworks. Second, this may also be the case with those so critical of the administration of stimulants to children, where a case may be made for alarmism, rather than "research-driven" concerns.

Allan Young (1995) in his discussion of the neurological dominance of psychiatry in understandings of PTSD states:

Within any scientific field, the line between results worth preserving and results that ought to be discarded is fluid--usually contested--unless the theory or hypothesis has attracted no attention. Where the line is drawn by a particular network of knowledge producers depends on the play of contingencies: the urgings of interests, the ability of individuals and groups to control access to the means needed for producing knowledge (money, institutional support, patients, etc.), the skill and energy with which participants deploy their rhetorical resources, and so on (p 268).

Young presents a field of knowledge production which depends upon politics as much as it does upon methodology or the use-value of concepts. The political dynamics of knowledge producers is a direct reflection of the antagonistic nature of social life in which the Real and the metaphors which describe it can never reach a stable end. Hence, knowledge is constantly in production and is culturally and historically contingent.

The contemporary account of ADHD is clearly an example of psychiatry "re-biologizing itself" (Young, 1995, p. 270). There has been an increasing push in psychiatry to realign itself with the natural sciences, and return to the time before the psychoanalytic "mental hygiene" movement (Young, 1995, p. 270). The acronym, "ADHD," is a representation of the discipline of neurology, its wide recognition reflecting the discipline's substantial influence. From Michel Foucault's (1978, p. 101, 102) perspective, ADHD may be said to represent a moment of dominance within the field of "force relations" in which discourses strategize to lay claim to a particular object of knowledge. Objects of knowledge are realized simultaneously with the deployment of power. As Foucault (1978) proposes: "...the rationality of power is characterized by tactics which, becoming connected to one another, attracting and propagating one another, but finding their base of support and their condition elsewhere, end by forming comprehensive systems (Foucault, 1978, p.95). When we think we have reached a "comprehension" about

ADHD, we are subject to a relation of power. This moment of knowing designates one narrative's temporary dominance over another. For Foucault, the objects that are constructed by these discourses and their proponents are constantly in flux. Borrowing from Foucault, "ADHD Regimes," have been created, but are not entirely monolithic.

The process of ADHD diagnosis and remedy is riddled with antagonism both between the object of knowledge and system of inquiry (i.e. ADHD and neurology) and between differing investigative systems (i.e. social constructionism vs. psychoanalysis vs. psychology vs. neurology). One system may, upon formulating a well-received argument or demonstrating an effective treatment technique, claim to have tapped into or be in certain pursuit of an essence. But to draw the absolute linkage between symptom and essence is naive in the face of the reality of social life: antagonism is the basic condition between language and its explanatory power (Laclau and Mouffe, 1985). Any attempt to explain relieves the antagonism between object and experience, hence language can provide a cathartic moment where we feel an experience of knowing. But as outside pressure is applied to explanatory discourse its structure frays, revealing its own contradictions, ideologies, aporias. Hence, social constructionists find reason to question the assumptions of modern psychiatry, psychoanalysts find reason to question the decontextualized postulates of neurology, neurology finds reason to question the conceptual premises of psychoanalysis, and so on. We are witness to the weaknesses of any explanatory system by those that criticize them. Each tells us that they are the ones with the answer, the ones who are honing in on the truth, yet another explanatory system always waits in the wings. Riding the crest of high book sales or a medically validated form of treatment, the latest system has its moment in the spotlight. The latest system occupies a "nodal point" of meaning (Laclau and Mouffe 1985)--a place where antagonism is only temporarily relieved.

Supporting these tenets of social theory are signs that the clinical discussion of ADHD is by no means unified. Dissension has arisen from major organizations against the most dominant perspectives in ADHD research. Two examples come to mind:

In the Fall of 1998, a National Institutes of Health conference between experts in ADHD research and treatment came to some unsettling conclusions for the neurological establishment. Participants at the conference concluded that ADHD, though an established part of the APA's nosology since 1987, has little consistency in diagnosis. There remains no test for ADHD that confirms its existence as one of many other illnesses of the body. The results of PET scans, as reputable as they have been amongst North American researchers, are merely conjectural when postulating the chemical nature of ADHD. There are a number of psychological instruments that measure rates of attention, concentration ability, emotional responses to stressful situations, etc.,--many of which are given to children who have been suspected of having ADHD--and these also have demonstrated scant reliability. Behavioral measurement instruments, such as the Conners Scale, SNAP IV, and Disruptive Behavior Disorder Scale, and attention measuring tests, such as the Continuous Task Performance Test, the Wisconsin Card Sorting Test, Test of Variables of Attention, and the Weschler Intelligence Scale for Children, are not adequate measuring devices for ADHD. Such scales may be adequate in providing accounts of how an individual responds to medication--and these tests are being increasingly used in that capacity--but they fail as a diagnostic measuring device (Goldman et al. 1998) To date, there is no examination that can detect ADHD with unequivocal certainty.

Furthermore, a Working Party of the British Psychological Association remains highly critical of the APA's treatment of ADHD. Though more sympathetic to the criteria found in *DSM IV*, the Working Party argues that ADHD is a vacuous disease category and that the International Classification of Diseases (ICD) criteria for "hyperkinetic disorder" provides a much greater utility, as it is a set of criteria more stringent in its nosology, and more likely, therefore, to reduce the prevalence rate of ADHD. In light of such criticism of North American psychiatric practice and its conceptualization and treatment of ADHD, it would be premature to say that neurology has found the answer. Such clearly stated doubt and opposition to the prevalent discourse on ADHD exhibits this disorder as a continuing topic of contention.

Laclau and the irony of the 'undecidables'

In sum, the aforementioned examples represent strong internal conflict within the dominant perspectives in psychiatry and denote the possibility of continuous shifts in researcher accounts of ADHD. The debate over who has "found the answer" speaks to the issue of negotiating a field of discourse and practice which apparently owns little true foundation. Ernesto Laclau (1989) states: "...it is the 'undecidables' which form the ground on which any structure is based. I have elsewhere sustained that in this sense, the subject is merely the distance between the undecidable structure and the decision" (introduction to Slavoj Žižek's *the Sublime Object of Ideology*, p xv.). This statement, largely a reformulation of statements containing similar "deconstructionist" themes, can be directly applied to structures, such as the discourse of neurology. From this perspective, neurology is not founded upon some metaphysical principle of "truth", but rather upon a field of undecidability. The ambiguities within this field give way to the politics of knowledge production; the undecidability, if you will, is exploitable, providing the fertile soil for strongholds of knowledge that may become so legitimate, so backed by research dollars that they appear to be garnering truth. Disciplines that address mental illnesses, such as neurology, for example, purport an etiological stance, which, through gaining a legitimacy in the public eye promote a particular course of action. Nowhere is this more true than in the debate over the etiology and treatment of ADHD.

The concept of the "field of undecidability," however, is far from universally understood. For many who have a child diagnosed with ADHD and are offered a physiological explanation and pharmacological solution, the undecidability upon which neurology's claims are founded is of minimal concern. A key question here is: why is the undecidability, the ambiguity, the contradiction, not made more accessible to lay people? Given the fact that the medicinal treatment of ADHD is virtually universal, and assuming that Laclau is correct in his assertions, it might be concluded that the condition of undecidability is deliberately obscured, or made invisible. Lay people may be inclined to perceive ADHD as a medical fact, instead of something contestable, arguable.

One might point to two significant and interrelated processes that conceal undecidability: 1) the deployment of the voice that transmits both symptom and cure for ADHD; and 2) the specific nature of ADHD discourse.

First, the lexicon from which this voice borrows is a direct result of the allocation of resources that contribute to its own creation and legitimacy. Private and governmental economic support are the crucial components for purchasing and evaluating data collection technologies (PET, MRI, and EEG machinery), sponsoring multiple-subject, long-term studies, and testing the effectiveness of medications. This process of ADHD knowledge production results in increased visibility in both popular and academic accounts, sparking a continued believability in those who read them.

Second, the language of neurology, in that it is so specific, largely removes itself from public debate.³¹ In order to argue the case for an alternative etiology and treatment for ADHD, a common grammar must be achieved between the warring factions. Those representing the opposition must debunk the arguments of neurology and reveal the undecidability, but only *within* neurology's jargon. To invalidate a concept, the opposition must delve into the elements of that concept which show it to be faulty or outside the conventions of logic. Conversely, there is no motivation whatsoever on behalf of neurology to defend itself in the language of its opposition. Virtually no one has stepped forward to specifically invalidate the conceptual framework of neurology in the same manner that neurology dismantled psychoanalysis, that is, by looking at the logistics of their theoretical position and showing its implausibility.

Rather, modern neurological psychiatry is invalidated in other ways. The "politics" of modern psychiatric practice, for example, becomes scutinized. Kirk and Kutchins's *The Selling of DSM* (1992) is an excellent example of such a critique. Through examining such alleged absurdities as listing homosexuality as a mental illness, and more generally, the biases of *DSM's* diagnostic language, and through a critical examination of such methodological artifacts as

³¹This is a place where I clearly agree with the aforementioned position of social constructionists (i.e.-Peter Conrad), namely the assertion that the discussion of hyperkinesis largely excludes everyday people.

Robert Spitzer's *kappa* statistic, Kirk and Kutchins do much to show the flaws of psychiatry. However, regardless of Kirk and Kutchins' political portrayal of psychiatry, the authors do not offer alternative diagnoses, nor do they question the physiological assertions psychiatry posits. We are left skeptical of psychiatry and its practices, but without a course of action through which we may construct a new discussion, or at least be aware of alternative discussions.

Another way of offering a critique of modern psychiatry is through a process of historicizing the concepts that have formed psychiatry's position. The aforementioned work by Hacking (1995) and Young (1995) are examples of this and indeed, are the methodological frameworks for the first four chapters of this thesis. Both authors are extremely well-versed in the grammar of psychiatry's discussion of two specific mental disorders (Hacking--MPD; Young--PTSD), and offer no criticism of psychiatric practice. Their lack of criticism is no methodological oversight. Remaining true to their "genealogical" projects, neither author is in a position to offer remedial action. Engrossed in the language of the "research narrative," both authors present the discussion of mental disorder as a morally-neutral and interesting story.

This distanced perspective, so characteristic of contemporary philosophers of science like Hacking and Young, is exceedingly valuable in addressing the grammar of mental disorder diagnoses and treatment. Those who read such genealogical accounts can be confident that they will at least attain some modicum of understanding into the history of psychiatric nomenclature. Therefore, the course of action one takes when encountering one of these mental disorders would invariably be from an informed perspective. Regardless, it is a safe assumption that more people are reading the best-selling books of Russel Barkley, rather than those by Hacking and Young.

In the face of undecidability there are consistent actions, consistent decisions which are made by the social actors involved with the suspicion and diagnosis of ADHD. ADHD, regardless of public opinion, is treated almost universally as a chemical phenomenon. The overwhelming amount of popular and academic accounts of ADHD portrayed in such a way are a testament to this. It is estimated that almost four million school-age children are taking medications for hyperactivity and inattention problems. This number has skyrocketed from the

estimated 700,000 who were taking medications in 1990. Though psychiatry's framing of ADHD as a physiological phenomenon can be shown to fray upon the applied pressure from social theory, and though the "objectivity" of psychiatry can be severely interrogated and shown to be non-existent, people are moving in unison in the actions they take to treat ADHD.

The history of the nomenclature that has conceptualized ADHD, in that it is characterized by intense debate, exemplifies the antagonistic principle of social life. It might be interjected at this point, that ADHD has no center, no great mystery to discover and understand. Perhaps it is this condition of an "absent center" which propels the ever-changing face of ADHD. It would be a hasty generalization to say that the neurological perspective, in that it has reigned "victorious", has also found the truth of ADHD. In its practical application, that is, in its ability to advocate and defend drug therapy, neurochemistry's sway is undeniable. But, does the prevalence of the administration of medications necessarily mean that neurology is an irrefutable approach with respect to ADHD?

The next chapter will address the implications of such a question. Through examining literature that is directed at parents, chapter four will show that even in the face of neurology's dominance in defining ADHD, there are a plethora of perspectives that go into the management of the ADHD disorder.

Chapter 4

ADHD Discourse in the Domestic Realm: Parental Guidebooks and the Disciplining of Domesticity

Thus far, we have explored significant discourses that have comprised part of the discussion of ADHD, its treatment and etiology. Sources of these discussions of ADHD have mainly been taken from journal articles, and medical manuals--sources that address a rather specific and professionally-oriented audience. What is necessary at this juncture are supplemental analyses of discourses that are specifically directed at lay audiences.

This level of analysis provides a necessary component to the genealogical section of the thesis for two reasons. First, an analysis of texts that are directed at audiences outside of the medical enterprise, and yet are still influenced by such medical perspectives, shows the highly pervasive nature of such perspectives. This analytical emphasis demonstrates how notions that have attained widespread legitimacy in research and clinical circles have made their way into books widely read by lay people. Furthermore, it will be shown that such notions about ADHD, including its causes and treatment, do not stem entirely from the neurological stance examined in the previous chapter. As will be seen, much of the literature that is directed at a lay audience is an interesting hodge-podge of perspectives on ADHD, invoking both neurological and psychodynamic perspectives towards the disorder. This is an interesting characteristic of ADHD discussions that inform a lay audience, and may indeed be one of the reasons why ADHD remains so widely interpreted and disputed. Second, an analysis of texts directed at a lay audience represents how the historical discussions that address ADHD have staying power, moving through generations of researchers and affecting popular conceptions of the disorder.

Of primary concern here is the literature which has been so crucial in framing the ADHD experience and providing direction for parents. Through the examination of a cross-section of popular ADHD parenting guides and supplemental textual data sources, this chapter explores the manner in which texts embodying simplified etiological and treatment discourses surrounding ADHD and its diagnostic precursors (hyperactivity, hyperkinesis, minimal brain dysfunction, ADD etc.) provide frameworks for an administration of behavioral discipline in domestic life.

The literature being analyzed for this chapter should be understood as "ideological representations" (Smith 1990), the analysis of which resonates with much of the disciplinary critique in contemporary social theory, especially the positions of Michel Foucault (1977).

Examining the ADHD parental guidebook

Referring to sociological and anthropological discussions of mental health, it can be surmised that ADHD becomes an integral aspect of the social life of the diagnosed person. This is certainly the case for the ADHD-diagnosed, but also their caretakers. Due to their dependency upon the adult world for everything from basic sustenance to the needs of education and recreation, children are especially subject to the social ramifications of the ADHD diagnosis. Through the eyes of their educators, clinicians, and parents, the ADHD child's world requires regulation to promote the "management" of his/her disorder. Invariably, the active agents in this management are the authority figures surrounding the ADHD child. In applying the ADHD mental disorder label to the child, adults take on the responsibility for structuring the child's life to meet the perceived treatment requirements in conjunction with the diagnosis.

This chapter examines a cross-section of literature which is devoted to structuring the ADHD child's everyday world. Of primary concern here are texts which have appealed to the lay audience affected by the ADHD diagnosis. The most scrutinized text in this study is what I have summarized as the "ADHD parental guidebook." Such guidebooks are meant to be concise manuals for parents to use in the application of ADHD treatment techniques. The guidebook strives to cross the discursive chasm between clinical jargon and the household, using accessible, everyday language. It is an extension of clinical expertise which advocates a regimented structuring of domestic life in the special circumstance of the ADHD child.

This chapter hopes to continue a critical discussion of ADHD by shifting focus from clinical issues of diagnostic validity, and placing an emphasis upon how texts seek to affect domestic relations associated with the disorder. Put simply, this chapter examines how books that are meant to be user-friendly for parents, advocate a re-evaluation of household life and a

restructuring of child-rearing practices. Such texts that direct remedial action against ADHD in the home may be viewed as an extension of the aforementioned neurological ADHD discourses, as well as psychoanalytic and psychological perspectives on the disorder.

Texts may be understood as "ideological representations" (Smith 1990, pp. 83-100), and ADHD guidebooks in particular serve as manuals for the implementation of modern "disciplinary mechanisms" (see Foucault 1977). Dorothy Smith (1990) has portrayed texts as a viable data source for understanding relations of ruling, while Foucault has constructed a cultural critique about discipline in which to understand the analysis of these textual data. ADHD guidebooks are vying for ownership of particular "frames" for ADHD, to the exclusion or dismissal of alternative opinions on the disorder. From Smith's point of view, the text most read and most legitimated has won a kind of ideological battle. This ideology does not end at the point of the written word, but manifests itself in the social practices of an individual, their behavior, and their everyday language³². The examination of the literature in this chapter provides insight into the textual side of the relationship between discursive formation and lived experience. Smith (1990) offers a description of this relationship:

Such textual surfaces presuppose an organization of power as the concerting of people's activities and the uses of organization to enforce processes producing a version of the world that is peculiarly one-sided, that is known only from within the modes of ruling, and that defines the objects of its power (pp. 83, 84).

The ADHD parental guidebook summarizes the "experience" of ADHD, that is, it tells the audience what ADHD is like, and professes knowledge of the best way to treat the ADHD condition. ADHD is placed within a "mode of ruling," which determines the appropriate methods

³² Smith's (1990) position which implores the critical examination of texts, I believe, runs parallel to Foucault's earlier assertions about the "extradiscursive" dependency, in which social practices are depicted as greatly connected to discursive establishments, or "regimes of truth" (see Barrett 1991, p. 129) For Foucault, these "regimes" were excessively visible through their insitutional manifestations (mental institutions, prisons, schools, hospitals, and so on). It may be asserted that Smith's work represents a "textual application" of Foucault.

for its treatment. Implicit within this literature is the assumption that ADHD children are "abnormal", and that measures must be taken to aid them in living a "normal" life. Hence, the ADHD guidebook documents specific techniques of behavioral reform, driven by similar modalities Michel Foucault interrogates in *Discipline and Punish* (1977). After ADHD guidebooks clarify the "nature" or "essence" of the ADHD child, they outline the way the ADHD child should be trained. The mode of ruling that is maintained within the content of the ADHD text aims to play itself out on the "docile body" (Foucault 1977, pp. 135-169) of the ADHD child.

Texts devoted to the topic of ADHD speak to a variety of audiences. Amongst these are the audience of educators, to whom the text may outline techniques for classroom reform, and clinicians, to whom the text may invoke the nomenclature of neurology, addressing diagnostic and treatment issues. Specific to this chapter are texts which are directed at parents of ADHD children. I chose a cross-section of 6 ADHD parental guidebooks as a primary data source. For the sake of breadth in examining the accounts of ADHD, it was necessary that some texts were authored by clinicians and others by parents. These texts were: 1) Colleen Alexander Roberts' *ADHD and Teens* (1995), 2) Russell Barkley's *Taking Charge of ADHD* (1995); 3) Grad Flick's *Power Parenting for Children with ADD/ADHD* (1996), 4) Edward Jacobs' *Fathering the ADHD Child* (1998), 5) a selection from Diane Knight in W.N. Bender's *Understanding ADHD* (1997), and 6) Paul Weingartner's *ADHD Handbook for Families* (1999). Guidebooks were chosen based on their popularity within the ADHD-affected community. Though this cross-section is by no means exhaustive, it portrays visible themes within the ADHD parenting discourse. Most significant in this regard is the way that such guide books embody multiple perspectives on the causes and treatment for ADHD.

A later portion of the chapter introduces supplemental textual data sources, serving as alternative frames for explaining and treating ADHD. These are necessary as they provide a degree of contrast with the conventional ADHD parenting guidebook. Amongst these are books and journal articles linking hyperactivity to diet, television, and video games. Some of these include: Thomas Armstrong's *The Myth of the ADD Child* (1995), Richard DeGrandpre's *Ritalin*

Nation (1999), Ben Feingold's *Why Your Child is Hyperactive* (1974), Nat Rutstein's *Go Watch TV!* (1974), and Marie Winn's *The Plug-in Drug* (1985).

Guidebooks and supplemental textual data were examined for content which accommodated three analytical questions:

- 1) How did these texts establish themselves as "authoritative" or "definitive" in the eyes of their audience?
- 2) What language did these texts use to portray the subjective experience of ADHD?
- 3) What plans of action did these texts advocate to rectify the behavioral problems associated with ADHD?

The body of this chapter is organized around these questions and discusses the way ADHD guidebooks establish credibility with their audience, the manner in which their language frames the ADHD disorder, and the way such texts dictate a structuring of the domestic environment.

Articulating experience and credibility

To promote some assurance of their efficacy, ADHD guidebooks establish a credibility with their audience. Such texts are pervaded by statements which assure parents of ADHD children that they are reading the work of experts in the field, and, due to this expertise, their ideas have a practical application. One method of establishing credibility is through the articulation of the "personal experience story" (Denzin 1989, p. 38). For example, in *the ADHD Handbook for Families*, Weingartner (1999, p. vii) begins the text by telling his readers that he is diagnosed with ADHD: "Well, I wasn't lazy or retarded or acting out to get attention. I had--and still have--attention-deficit/hyperactivity disorder" and is now in the profession of helping people with the disorder. Next to the author's photograph, the back cover of Alexander-Roberts's *ADHD*

and Teens (1995) states: "Colleen Alexander-Roberts is the mother of two children with ADHD." In conveying their experiences with ADHD, both at the personal and parental level, the authors validate their perspective on the disorder. Such disclosure by authors places them "in the know" in relation to their readers, occupying the same "team" as their readership (Goffman 1959, pp. 77-105). Through the imbrication of the signifier of ADHD and the "personal experience story", readership and author may reach a common definition of situation regarding the nature of ADHD.

Statements are also made about authors with clinical, rather than personal ADHD experience. On the back cover of Barkley's *Taking Charge of ADHD* (1995) it states:

Russell A. Barkley, Ph.D., is Director of Psychology and Professor of Psychiatry and Neurology at the University of Massachusetts Medical Center. He is the author of the books *Attention-Deficit Hyperactivity Disorder* and *Defiant Children*, as well as an award-winning video series on ADHD. In demand internationally as a speaker, he is also editor of *The ADHD Report*, the leading newsletter in the field.

Authors also combine both the "Ph.D." credential with personal experience. Such accounts present an author who has both a personal investment in the treatment of the ADHD condition as well as clinical know-how. For example, on the back cover of Flick's *Power Parenting* (1996) it states: "Grad L. Flick, Ph.D., has extensive experience in both research and clinical practice with children who have attention deficit disorder... Dr. Flick and his wife are the parents of a child with a learning disability and attention deficit disorder."

Presentations of personal and clinical expertise are integral in cultivating a rapport between clinician and the audience he/she wishes to address. By gaining the status of "expert,"³³ an ADHD researcher can become influential in helping the parents of an ADHD child glean an awareness of their child's condition. This is a facet of the process of medicalization where

³³ For two classic sociological accounts of "expertness" and its effect on society, see Brewer (1971) and Meyer (1968).

systems of experts are given etiological and treatment authority in accounting for ADHD (Conrad 1975, p. 18). Upon owning legitimacy in the eyes of the public, the system of medical experts becomes a significant resource for the formal resolution of consistent "troubles" in social life (Emerson and Messinger 1977, p.123). The efforts to solve these troubles can take on an increasingly complex form (Emerson and Messinger 1977, p. 126). The ADHD guidebook is a resource for lay actors to solve a social difficulty which informal measures had repeatedly failed to rectify.

Cases in which parents are uncertain about whether or not their children have ADHD are accommodated by ADHD guidebooks. Parents may consult a guidebook because they might only have suspicions of ADHD in their children, rather than from a formal diagnosis. Many ADHD guidebook authors include a questionnaire or other form within the text which can be used to document a child's behavior³⁴. If particular criteria are met, parents may be better equipped to seek some form of medicinal or behavioral therapy, and consequently, use the guidebook more effectively. For example, Flick (1996, p. 204) has the "Home Situations Questionnaire," Weingartner (1999, p. 26), in his "collecting information" chapter has the "Parent's Questionnaire." These place the behavior which the parent sees as undesirable against a backdrop of various social situations, documenting the behavior's perceived frequency and severity. In addition, assessment instruments like questionnaires provide a specific application of ADHD expert knowledge.

Framing the ADHD Child

Establishing credibility fosters the process of framing the ADHD child, making him/her "known" to a parental audience. Guidebooks bridge the worlds of clinical research and child-rearing. They purport to make clinical theory real, using language which conveys a fruitful, parsimonious insight into ADHD. While remaining sensitive to the needs of a lay audience, these experts are

³⁴ As mentioned by one reviewer, a content analysis of questionnaires and other mechanisms for documenting childhood behavior would be an intriguing study.

expected to paint a picture of the nature of the ADHD child, and describe the conditions which separate this type of child from normal children. Part of this portrayal discusses ADHD children as excessively impulsive and in need of a repetitive enforcement of household norms. The production of knowledge surrounding the child's disorder is believed to outline principles for why the child's personality structure exists in its current form.

Take, for example, Weingartner's (1999, p. 1) autobiographical account of ADHD: "Having ADHD is like punching through a wet paper bag only that outside that bag is a larger wet paper bag that will also need to be punched through. Sometimes you honestly think you are making progress, but you are getting exhausted, while others seem to be walking effortlessly through the bags as if they were only shimmering veils of light". Such a non-clinical, personal account places the author in a position of experience and consequent "down to Earth" understanding of ADHD. He is appealing to those who may be confused by clinical discourse; those who do not understand *DSM IV* criteria, or the research behind these, but still have a suspicion that something is amiss with their child. In translating his experience with ADHD into common language, Weingartner frames his subjective experiences and those of the ADHD child simultaneously.

ADHD children and the disciplinary moment

In an introduction to what is one of many guidebooks invoking the behavior modification of ADHD children, Jacobs' *Fathering the ADHD Child* (1998, p. 3) describes some of the subjective conditions of ADHD:

Since children with ADHD are more driven by the moment, since they are unable to delay gratification the way other children do, and since they have a deficit in anticipating future rewards and consequences, there is limited value in using language to affect their behavior. It is not that a parent should not try to talk to the child... It is that the ADHD child's behavior is

much more controlled by real-world consequences and actions than by words.

Such framing attempts to characterize some of the essences of the ADHD child, and differentiate him/her from other children. Disciplinary conventions, like verbally reprimanding a child who behaves undesirably, need to be given less weight with ADHD children. Parents cannot "intellectualize" with ADHD children in an effort to get them to change patterns of behavior. The ADHD child responds much better to physical consequences than to linguistic exchanges. The ADHD child, this passage denotes, tends to "feel" the world rather than cognitively process it. Unable to rationalize or think through the results of his/her actions, he/she is disciplined through experience that only the moment can bring.

Parents are encouraged to be influential in the ramifications of these disciplinary moments. Barkley (1995, p. 130) urges parents to become involved in the momentary nature of the ADHD child: "...children with ADHD seem much more under the control of the moment than normal children. Either you become part of that moment or you will have little influence over your ADHD child." Through mutually existing within a subjectivity dictated by the moment, Barkley and Jacobs argue that parent and ADHD child will be less estranged from each other.

The ADHD child is commonly framed in this fashion; living from one moment to the next. Not a goal-oriented, forward thinking creature, this child is short-sighted to the point of disability. The ADHD child is cast in a light of bewilderment, staring at a world which moves in a baffling self-aware manner. The moments gobble up the ADHD child who loses grasp of the turning of events around him/her. Parents are urged not only to subscribe to this framing, but to tailor their behavior to align themselves with their child's subjective state.

Volatile children

ADHD child behavior is often described as erratic. Knight (1997) states:

...the child with ADHD appears to want to comply with their (his/her parents) requests but seems unable to do so. As a point of further

frustration, these children are also capable of appearing caring and considerate at other times. ...children with ADHD are able to display exemplary behavior (Knight in Bender 1997, p. 46).

This characterization reflects the powerful influence of neurochemical clinical discourse (see Baving et al. 1999, Fuster 1997, Mataro 1997). The ADHD child has the appearance of wanting to comply with the rules. But, as the neurochemical understanding of ADHD mandates, this child is understood to be suffering from a condition which makes any sincerity to comply on his/her behalf futile. He/she is portrayed as being driven by a "non-human agent" as Weinberg (1997) discusses. Sincere, yet unruly, the ADHD child constitutes part of a frustrating interpersonal dynamic with his/her parents. These parents see the potential "good boy" in their child (the child is "able to display exemplary behavior," in Knight's words), but the neurochemical dysfunction, Knight implies, prevents this person from becoming a consistent reality. Parents are left with a child driven by impulse. Knight describes a 4-year-old, Tim: "At four years of age he is still overactive and temperamental. ...He acts impulsively and appears to engage in a very high degree of risk-taking behavior. This has resulted in numerous bumps, bruises, and half a dozen trips to the hospital emergency room" (Knight in Bender 1997, p. 46).

Impulsivity is often connected to the ADHD child's inability to actively regulate his/her behavior. For example, Barkley (1995, p. viii) states: "Within the last few years scientific studies have shown, for example, that ADHD probably is not primarily a disorder of paying attention but one of *self-regulation*: how the self comes to manage itself within the larger realm of social behavior." ADHD, in this instance, is presented as a social illness, requiring that the basic skills of self-regulation be cultivated externally, through control exerted by others. From this perspective, impulsivity is not a basic condition of ADHD as much as it is symptomatic of the failure of internal regulation mechanisms. By invoking the idea of "regulation" Barkley illustrates conditions perceived basic to social life.

The Narrative of Domestic Mangement

ADHD guidebooks are often characterized by words in the title which imply that it is not a clinical research text, but a user-friendly tool. Words like "proven" and "practical" garnish many guidebook covers. Once an understanding of the ADHD child has been achieved, it becomes necessary to apply that knowledge. The framing of the ADHD child is a precursor to techniques of behavioral reform, or *dressage*, as Foucault (1977) would state. This implies a supplemental process of framing, not of the ADHD child, but the parents of this child. Guidebooks outline parameters for parents, dictating how they should constitute themselves in the process of raising an ADHD child.

Coextensive with the framing of the ADHD is the notion that the proper care of this type of child is a formidable task. Because their children exist under special circumstances, so must ADHD parents:

A parent needs abundant love and wisdom, a parent must be knowledgeable about education, a parent must acquire the skills and sophistication in managing behavior that psychologists have acquired after years of study, and a parent must develop the patience of a model clergy man or-woman. Although it can take a lifetime to acquire any of these skills, the demands of parenting an ADHD child necessitates that all of them be acquired in an instant (Jacobs 1998, p.1).

Parents are also encouraged to keep a firm mental picture of the nature of their child's condition. Barkley (1995, p. 134) encourages parents to "keep a disability perspective" on their child's behavior. Barkley contends that parents should maintain a psychological distance from the problems of their ADHD child and avoid personalizing them. Barkley continues: "This is hard, so you may have to remind yourself of your child's disability each day, perhaps even several times a day, and especially when you are trying to deal with disruptive behavior" (Barkley 1995, p. 134). Conversely, Knight (1997) encourages a different perspective. She warns parents not to develop a "co-dependent" relationship with the disabled child: "The family environment may

change from one of spontaneity and freedom to one of anxiety and control. Parents may become dependent on the disability, as well as on the child, for making life decisions" (Knight 1997, p. 49).

Regarding teenagers with ADHD, Alexander-Roberts (1995, p. 65) states: "Parents know their teenagers need more freedom to grow, but many parents of teens with ADHD fear this stage of development. For them it means letting go--letting go of a child who has required much guidance through the years and still requires assistance and management in several, if not many, areas. How do committed parents let go? They do it by taking one step at a time." The discourse of "steps" or "ways" or "principles" is commonly propelled in ADHD guidebooks. To achieve the skills Jacobs (1998, p. 1) highlights, parents must undergo a transformative process. Guidebooks proclaim to serve as maps to navigate this process. Some prevalent examples from the literature I have surveyed are Thomas Armstrong's (1999, pp. 61-257) "50 ways to improve your child's behavior without drugs," Grad Flick's (1996, pp. 105-123) "12 special problems" for the child with ADD/ADHD to overcome with parental help, and Russell Barkley's (1995, pp. 149-173) "8 steps to better behavior."

The dominant rubric under which these behavioral improvement programs fall is that of "behavior modification" or "behavior management." Such programs are only a slight permutation from many of the ideas of Burrhus F. Skinner (1938). The programs of behavior modification for ADHD children represent the investment of Skinnerian concepts like *reinforcement* into the domestic sphere. The processes of reinforcement are dictated by the well-known "positive" and "negative" types of sanctions (i.e.- rewards and punishments), but also the swiftness with which consequences appear after a behavior has taken place. Alexander-Roberts (1995, p. 68) states: "Teens with ADHD must learn that noncompliance will result in immediate, predictable, but fair consequences." Weingartner (1999, pp. 53-62) asserts similar Skinnerian nomenclature in discussing forms of "psychosocial intervention" for ADHD: "The research has been telling us for years that you will likely see more of any behavior you reward" (Weingartner 1999, p. 62). In addition, Barkley (1995, p. 131) argues that the key to solving much of the behavioral problems

associated with ADHD is providing "larger more powerful consequences" that are felt immediately.

Parents are repeatedly reminded in these texts to "stay on top of" the behavior of their children. Reminder systems, for example, are often recommended for parents to employ. Barkley (1995), for example, recommends that parents place smiley-face stickers around places in their home in which parents frequently find themselves. "Whenever you spot a sticker," Barkley states, "comment to your child on what you like that the child is doing at that very moment--even if it is just quietly watching television (Barkley 1995, p. 131). Consistency in verbal praise is supposed to award non-disruptive behavior and cultivate more of it. The recommendation of smiley-faces shows that behavior modification techniques are not only directed at children, but at parents, who also need to be trained to manage their child's disorder.

Technological devices are also implicated in the process of disciplining parents. For example, Barkley (1995, p. 131) recommends that parents use the MotivAider device to prompt them to reward children for good behavior or "check in" with their ADHD children at regular intervals. Initially intended for classroom use, the MotivAider (\$90.00 retail cost) is a pocket-sized, battery operated device which can be set to provide a gentle vibration at determined intervals for the ADHD child and/or parent. The *ADD Warehouse* on-line catalog states: "The MotivAider sees to it that a child receives enough of the right reminders to make a specific improvement in behavior." Devices like the MotivAider and retailers like the ADD Warehouse reflect the growth of an industry devoted to the daily management of ADHD.

Immediacy and consistency of consequence is the unifying thread within the behavior modification narrative, representing a general mechanism of discipline with earlier origins in modern society. In Foucault's discussion of the penal colony, Mettray, in 1840 (an institution he calls the beginning of the "carceral system" of discipline), he comments that the colony had employed "technicians of behavior: engineers of conduct" and that punishments were swift and given to the slightest infraction (Foucault 1977, p. 294). Foucault argues that the "engineering of conduct" represents a shift in disciplinary practice that transcended the walls of the institutions in

which its effects were so blatantly seen. The techniques and technologies implicit in behavior modification and MotivAider devices are a testament to this.

Negotiation and contract

Organizational metaphors are another part of the narrative which attempts to structure parents' disciplinary relationship with their ADHD children. Apart from the discourse of "boundaries" and "consequences" are terms which are used to guide the types of disciplinary and communicative action deemed so integral for ADHD children. Two terms in this part of the behavior modification narrative are: 1) the *negotiation*, which is designed to cultivate the ADHD-child's autonomy; and 2) the *contract*, which cultivates the child's appreciation for commitment.

ADHD guidebooks repeatedly argue that a more effective establishment of rule and consequence systems depends upon a dialogical relationship between parent and child. The concept of negotiation is foundational in this respect. Barkley (1995, p. 195) states: "Research has found that a more democratic approach, involving the adolescent in the decision making when possible, generally works better than a strict dictatorial approach. Negotiating solutions that everyone can live with seems to foster responsible adolescent conduct, perhaps because the teen sees the reasons for the decisions and takes part in them." Alexander-Roberts (1995, p. 67) states that parents should:

Provide him (the ADHD child) with a list of negotiable and nonnegotiable issues so he can study the list before you sit down to discuss it. ...As you go down the list, ask for his input. Listen carefully to all suggestions, and do not reject any as silly or ridiculous (even if it is). At this point you are brainstorming for solutions together.

She continues to say that a parent should "take notes" throughout the course of negotiation and have the child "repeat back to you the established rule and consequence" (Alexander-Roberts 1995, p. 67).

Alexander-Roberts also advocates a household forum in which "meetings" would be a dominant part. She provides a sample note a parent may write to a child to request a meeting:

Dear John, Our agreement was that you would set the table for dinner on Tuesdays. I was very upset to see that the table was not set because I was already running late for my class tonight. I think we better have a short meeting at 7:30 tomorrow evening. Please let me know if that time is all right with you. Mom (p. 71).

"John" is informed of his actions--his expected domestic chore was not completed--and also that these actions (or lack thereof) had an effect upon his mother. He is given a choice as to whether or not he can make the 7:30 appointment. Within the context of this scolding from parent to child is the preservation of the child's role as a "negotiating party" even when he has committed a domestic infraction.

Contracts are a product of the negotiation process. They are a textual rendition of understanding between parties in the domestic sphere, representing a standard which both parent and child can be held to. For example, Knight (1997, p. 62) states:

After discussing behaviors of concern with the child with ADHD, a target behavior (task) should be decided upon and properly defined so that it is understood by all. ...The conditions under which the behavior will be performed are then identified, followed by the reward, which will be earned when the behavior has been changed/completed.

Knight provides a sample behavioral contract, including the behavior to be performed, the duration of the contract, the rewards, and the consequences. The child's name is printed on the contract, along with a mock child signature. The voluntary nature of the signature and the dialogue preceding it denote that the child should be an active agent in the structure of behavior modification.

Numerous, non-ADHD parenting guides also subscribe to the negotiation formula. For example, in the New York Times bestseller *The Seven Habits of Highly Effective Families*

(1997), Stephen Covey outlines communication strategies in which the solution to family problems is performed dialogically. The fourth of the seven habits, something Covey calls "think win-win" (Covey 1997, p. 169) involves a negotiation process where children and parents cooperate to achieve a particular disciplinary aim. Numerous other non-ADHD parenting guidebooks profess negotiation as a way of managing domestic communication. Texts like Anthony Wolf's *Get Out of My Life* (1991, pp. 75-79), Nelson and Lott's *Positive Discipline for Teenagers* (1994, pp. 253-257), and Cohen-Sandler and Silver's *I'm Not Mad At You, I Just Hate You!* (1999, pp. 181-194), exemplify the prevalence of negotiation discourse in current parenting literature. The process of negotiation in contemporary domesticity is arguably a larger trend in the literature directed at parental practice which has been appropriated to some degree by those publishing in the ADHD ilk.

Token economies and points systems

Both token economies and points-based systems have a reputation as effective behavioral modification techniques, and are the most common for regulating ADHD children in the domestic environment. Guidebooks often argue that these systems are effectively established after a process of negotiation and/or the signing of a contract. In the token economy (Barkley 1995, pp. 161-164; Flick 1996, p. 86; Knight 1997, pp. 62-64) behaviors which are deemed desirable are rewarded with some token to represent that behavioral achievement. Poker chips are a common symbol of such correct behavior. When the child accumulates a certain number of these tokens, some type of reward will be given: "The reward may be a trip to a fast-food restaurant, or to the zoo, or what ever else may motivate the child" (Flick 1996, p. 86).

A particularly rigid behavior modification system is the "points system." It is a punishment and reward system which draws its effectiveness through the commodification of behavior. That is, desirable and undesirable behaviors are both attributed a value as determined by a currency system established within the domestic realm. The mutual understanding of this value fuels the logic of exchange, if you will, in the domestic "market," where currency is traded

for behavior. Unlike the token system which is geared at younger ADHD children, the points system is directed at the older ADHD child and involves a process of exchange in which child agency is increased. The accumulation of points can be exchanged for privileges. Values of certain privileges, or the costs of certain undesirable behaviors are established through the aforementioned processes of negotiation. Alexander-Roberts (1995, pp. 71, 72) provides a sample of how this exchange system is organized. In a sample contract involving the implementation of a points system, the ADHD child receives and or loses 2 points for meeting curfew, 4 points for doing weekly laundry, and 4 points for doing homework on time. These points can be exchanged for privileges; for example, the use of the family car costs 10 points; a telephone call, 2 points; and a 5 point fee is levied for 1 hour of television or video games. Many authors who advocate a points system for ADHD children recommend that a ledger be used in the household. The amount of points given and spent cannot be disputed if this economy is conscientiously documented.

Guidebook authors recognize that the documentation of the points economy is necessary, but has the tendency to become labor intensive and tedious. The ledger, they argue, is not designed to be a permanent fixture in the relations between parent and ADHD child. The intended effect of this aspect of behavioral modification--i.e., the promotion of positive and discouragement of negative behaviors--precedes a removal of the ledger, a removal of the points system altogether. A consistent cessation of the behaviors parents deem to be problematic is what many guidebooks call a *natural* integration of the behavior into the structure of the household. The rigid regulatory system parents put into effect (token and points systems) can gradually be removed. As Flick (1996, p. xxi) states: "Gradually the child may be weaned from the formal program...so that you simply use praise without "points" (but with an occasional additional reward) to maintain the new level of the desirable behavior". With this statement we are witness to the "normalizing" sentiments of behavior modification. A successful behavior modification program can be maintained by through verbal praise--a position in contrast to Jacob's (1998) earlier statements regarding the inefficacy of verbally communicating with ADHD children. Does

the consistent absence of inappropriate behavior alter the essence of the ADHD child's behavior and somehow make him/her responsive to verbal communication? And, if this is so, what are the fundamentals by which the guidebook distinguishes the ADHD child from other "non-disordered" problem children?

The point of success in a behavioral modification program denotes that an outside regulatory mechanism is no longer the source of behavioral change. Behavior modification could help to alleviate what Barkley (1995) claims to be a fundamental problem with self-regulation. If an outside mechanism can be removed and problem behaviors still remain relatively invisible, it could be argued that an internal regulatory mechanism has been cultivated.

The processes of behavior modification advocated in these guidebooks adds another dimension to established notions of disciplinary mechanisms, especially within Foucault's (1977) framework of Panopticism. For Foucault, Panopticism represented the conflation of the interests of the human sciences with the technologies that could effectively realize their aims: 1) the production of knowledge of the human subject; 2) the compilation of this knowledge into a localized discursive location (i.e.-within the lexicons of criminology, psychology, sociology, medicine, and so on); 3) the potential application of this knowledge into programs of behavioral reform. In its hardened, institutional form, Panopticism is the pinnacle of subjecting human beings to scientific scrutiny. In its everyday, perhaps more insidious form, Panopticism regulates the entirety of the disciplined modern populace. Panopticism represents a condition of surveillance in which a constant watch is upon any one at any time. The apparent omnipresence of this watchful eye invests itself into the subjectivity of the disciplined individual:

He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection (Foucault 1977, p. 203).

We act disciplined, according to Foucault, because we have been trained through a continuous response to the presence of being ever-sought, ever-seen. He contends that the "ism" of Bentham's Panopticon "must be understood as a generalizable model of functioning; a way of defining power relations in terms of the everyday life of men" (Foucault 1977, p. 205).

The disciplined subject, from Foucault's perspective is defined as a *product* of the mechanisms of Panopticism. That is, he/she becomes "self-regulating," in Barkley's terms, because of the continuous presence of the surveillance apparatus. The parents with MotivAider's strapped to their hips; the parents who meticulously document the behaviors of their children via the points system; the parents who are encouraged to keep a watchful eye and provide immediate consequences--all represent Panoptic interest and effect.

The role of the child's will in the process of negotiation, that is, the degree of the child's personal agency in the behavior modification process, is a subject of analysis which requires careful consideration. Foucault's assertion about Panopticism does not posit that the disciplined subject has a say in the conditions of surveillance. For Foucault, the conditions are simply there before their subjective manifestations. We, as the disciplined, operate under the mere *illusion* of self-regulation.

According to ADHD guidebooks, the microcosm of the household of the ADHD parent and child should construct conditions of discipline in which the rewards and punishments, as well as the methods of documenting behavior are understood by "disciplinarian" and "disciplined" prior to their implementation. From this, we may be inclined to add a new facet to the Foucauldian disciplinary narrative. The interests of the human sciences, most notable for our purposes, those of Skinnerian behavior modification, may realize their aim through the appropriation of human agency. A child signs his/her name to a contract which is contingent upon a process of negotiation, undoubtedly inundated with pleas for compromise, the deployment of numerous rhetorical devices, and so on. The moments prior to disciplinary control could be characterized by a dialogue, rather than an insidious monologue to which children succumb. The question remains as to whether or not the child's part in this dialogue represents a condition of

bona fide autonomy, or whether this child's participation is a means to compliance. In short, we may ask whether the bargaining table at which ADHD children find themselves is real or illusory.

Alternative Explanatory Frames for ADHD

There are perspectives in the parental self-help literature which explore external influences on ADHD behavior, promoting specific regulation of household activities. Activities under particular scrutiny in this regard are eating, television viewing, and the playing of video games. With regard to ADHD and diet--a discourse spearheaded by physician Ben Feingold in the early 1970's--it is clearly argued that ADHD symptoms are externally caused by the body's reaction to artificial food additives. Television and video gaming are also attributed a causal status in ADHD, but part of this discourse also argues that ADHD children are much more sensitive to these stimuli than other children, therefore requiring a special regulation of these behaviors.

Diet

Both academic and popular accounts of ADHD symptoms (especially the symptom of "hyperactivity") posit dietary etiologies. In the early 1970's, clinical nomenclature began linking hyperactivity to diet, pointing the diagnostic finger at food additives.³⁵ The most famous of these positions is what has come to be known as the "Feingold diet" (Feingold 1974). The discussion of ADHD and diet has been overshadowed by the increasing dominance of neurochemical discourse which has, through its voluminous research and rhetorical mastery, asserted that ADHD is a chemical phenomenon not attached to any other condition other than brain formation

³⁵ A considerable amount of research explores the linkage between ADHD symptoms and diet (Chernick 1979; Forness et al. 1997; Grossman 1982; Janssen et al. 1996; Lindsey and Frith 1982; Mattes 1983; Rowe 1988; Wender 1986; Wolraich 1998). Clinical research on hyperactive children has given the diet hypothesis mixed reviews. For example, a study by Wolraich (1998) concluded that dietary interventions into the daily lives of hyperactive children proved to be inconsequential, prompting either a refutation of the diet hypothesis or a case for considerable reconceptualization of the theory. On the other hand, a study by Rowe (1988) concluded that of 55 hyperactive children subjected to a six week trial of dietary intervention, 40 (72%) showed marked behavioral improvement.

and development. ADHD guidebooks overwhelmingly side with this narrative and deny dietary causes for hyperactivity. For example Flick (1996, p. 140) states: "In actual clinical research it has been found that less than five percent of hyperactive behavior can be attributed to this (the dietary) factor (also see Barkley 1995, p. 70).

For our purposes, it is not significant to explore the clinical possibilities of diet, and its influence, or lack thereof, upon ADHD. Despite its (im)plausibility, the discussion of diet and hyperactivity, as first purported in the early 1970's, introduces a regulatory mechanism into domesticity. This includes a rigorous documentation of child behavior and the presence or absence of food additives during the exhibition of undesirable behavior.

In *Why Your Child is Hyperactive* (1974), physician Ben Feingold systematically outlines why food additives are linked to hyperactivity. Approaching retirement before the barrage of medical discussions of hyperactivity during the late 1960's, Feingold has a change of heart: "Suddenly, retirement did not interest me. I launched into educating myself on the problems surrounding the hyperkinetic child" (Feingold 1974, p. 17). As a pediatrician turned allergist, Feingold is very interested in seeking allergenic reasons for what the media had presented as an increasing learning and behavioral childhood deficiency. Feingold asserts that the problems of inattention and hyperactivity are a new phenomenon--something he had not seen in 50 years of pediatric practice: "...I had no recollection of a high frequency of hyperactivity and behavioral problems through all these years" (Feingold 1974, p. 19).

For Feingold, the problems of hyperactivity are new to a culture which is increasingly using artificial means to enhance the taste and color of its food. In addition to providing a new etiology of hyperactivity, Feingold serves as a cultural critic. His work acknowledges that consumers derive sustenance from foods with polysyllabic artificial ingredients, and that maybe these had unrecognized adverse effects. For Feingold, that cultural moment of artificial nutrition is most visible within the household, where adults feed their children. Feingold's mission is to raise awareness of the types of foods people consumed, and implement practices to regulate their consumption. His assertions countered much of the neurochemical discussions of hyperactivity

during that time (see, for example, Wender 1971). During a time when neurochemical theories about hyperactivity are relatively unsophisticated, Feingold's work represents a growing skepticism about the organic causes of hyperactivity and its treatment with stimulant drugs. His book demeans the use of medications, citing case studies where he had children taken off medication. Referring to the case of "Johnny B," Feingold states: "With absolutely no drug support, the next three weeks were very erratic, both in the classroom and on the playground. Schoolwork, however, continued to improve rapidly. The home behavior remained good. There was no reason to panic and place him back on drugs" (Feingold 1974, p. 38). Feingold becomes famous because he offers a non-medicinal solution to a problem believed to be inextricably bonded to pharmacology since the first prescriptions for Ritalin were written. The responsibility for treating hyperactivity could be removed from drug-dispensing clinicians and placed into the hands of parents, who will have to keep a close eye on their children, watch what they eat and how they behave. The results of this scrutiny, Feingold contends, will be worth their effort.

Feingold suspects that numerous food additives cause hyperactivity. The additive most commonly connected to Feingold's assertions is Food, Drug, and Cosmetic (FD&C) Yellow #5. Still a common additive in everything from breakfast cereal to children's vitamins, FD&C Yellow #5, or tartrazine, behaves "within the human in the same manner as a "drug" used for medication--a fact some physicians overlooked" (Feingold 1974, p. 6). Feingold argues that the presence of this additive and/or others was a consistent variable in over 100 cases of hyperactivity he treated.

Similarly to those purporting behavior modification in ADHD guidebooks, Feingold recommends that a careful log of diet and behavior be maintained. The belief is that diet should not be universal for all children, but rather, needs to be tailored to meet their diverse needs. Feingold gives an example of this type of documentation in the case of "Johnny A":

The next day, a Saturday, Johnny A began rigid food and beverage management. His dedicated mother, a remarkable woman, began a diary that lasted, with few breaks, until April 16, 1973.

...On the 18th Johnny had spaghetti for dinner. The sauce was homemade. She wrote: "I goofed. Used Tomato sauce but there was no obvious behavior change.

...Tuesday, the 21st, she underlined chocolate bar. "At 11:30. Very noticeable behavior change by 2:30.

From that incident on, a pattern developed Any candy infraction (store-bought), ingested singly, appeared to cause a reaction in two to three hours.

Wednesday. A question mark. "Something off diet here. Slight behavior change."

I checked the items. Perhaps the breakfast bacon was artificially flavored with hickory.

...December 1: "1 teaspoon of antihistaminic cough syrup at bedtime produced a raving maniac the early part of December 2."

I knew the brand. It was both synthetically flavored and synthetically colored (p. 32, 33).

This passage represents the relationship between the interests of a medical practitioner and a "remarkable" mother. At least two social roles are present: 1) the role of mother as "dietary archivist"; 2) Feingold's role as postulating physician. The mother documents what her son eats and how he behaves; the italicized words, obviously the contemplative voice of Feingold, are in direct response to the mother. The analysis of the Feingold diet by Johnny A's mother is a less extreme version of what Foucault (1977, p. 196) would call the "permanent registration," in which authorities consult a document and evaluate the effectiveness of a technique being applied to the body.

Television and video games

The discourse of ADHD symptoms and television takes on at least 2 themes: 1) the theme which proclaims that ADHD children are in need of special television regulation; 2) the theme which depicts television as a causal factor in ADHD symptoms.

Flick (1996) contends that television needs to be regulated in any home. However, television is one of many "Special Problems for the Child with ADD/ADHD" (Flick 1996, pp. 105-123), requiring particular regulation in such cases. He states: "Compared with movies, TV is also regulated much less by the parents. In fact, many parents may be surprised to hear what type of TV shows their child may watch when not supervised. What can you do?" (Flick 1996, p. 115). The ADHD child, Flick asserts, is especially susceptible to violent and aggressive television images. Such television programming "makes it more difficult to deal with children's social behavior problems, and especially those of the child with ADD" (Flick 1996, p. 115). Barkley (1995) expresses a similar view: "While exposure to the violence that seems endemic in so many children's programs, including cartoons, usually doesn't increase the aggressiveness of normal children, it can do so for children already prone to aggressive and impulsive behavior, such as your ADHD child" (Barkley 1995, p. 184).

In addition, Barkley (1995), cites a recent study at the University of Kentucky, arguing that the relationship between ADHD children and television can provide insight into the nature of the disorder:

When there were no toys in the room, the ADHD children watched the television show as much as the non-ADHD children and were just as able to answer questions about what they watched... However, when toys were placed in the room, the non-ADHD children continued to watch the TV program. The ADHD children were more likely to play with the toys and less likely to watch the TV program (p. 31).

Barkley concludes that "ADHD children seem to be drawn to the most rewarding, fun, or reinforcing aspects of any situation" (Barkley 1996, p. 31). He argues that ADHD children are

less inclined to participate in the passive activity of television watching when provided with more interactive activities.

In *the Myth of the ADD Child* (1995)--a text written to debunk the neurochemical conceptions of ADHD--Thomas Armstrong asserts that television could be one of the reasons why childhood behavior has begun to deteriorate: "...in the case of certain Nintendo-crazed, television-addicted youngsters, broader cultural issues could become primary" (Armstrong 1995, p. 34). Armstrong's text, devoted to providing "50 ways to improve childhood behavior without drugs" lists television regulation as an important aspect of controlling child behavior. On his list of 50, television regulation is number 3 (Armstrong 1995, pp. 75-78). His recommendations are that: 1) parents drastically limit the amount of television a child watches; and 2) parents totally eliminate violent programming of any kind in their household.

Richard DeGrandpre's *Ritalin Nation* (1999) expresses similar sentiments about the effects of television. DeGrandpre's argument is entirely devoted to describing ADHD and the rampant use of Ritalin as strictly cultural phenomena, having no basis in clinical reality. His analysis implicates the social effects of television on youth:

That so many people drift into TV world without thinking, or find that they cannot separate from it once it's on, tells us how easy it is to forfeit self-control and succumb to the never-ending providers of effortless stimulation. In the case of children, this takes its greatest toll, for we know that they are much less likely to develop other ways of occupying themselves--other habits, other skills--as long as the television sits on its throne, staring down at them (pp. 25, 26).

DeGrandpre insists that ADHD symptoms are the result of an over-stimulated populace, who falter when presented with challenges of the everyday world. These "other habits, other skills," so crucial to normal functioning are non-existent in a culture DeGrandpre claims is plagued by television and a litany of other "sensory addictions" (DeGrandpre 1999, p. 31).

Armstrong and DeGrandpre's TV etiology, much like Ben Feingold's dietary etiology, stands strongly opposed to neurochemical positions of ADHD. Similar to Feingold, both Armstrong and DeGrandpre examine hyperactivity from a cultural, rather than organic perspective. Childhood behavior is a reflection of culture. A culture inundated with fast moving images and constant visual stimulation will be mirrored in the thoughts and behavior of its children. The psychologically harmful forms of culture are not going to disappear, Armstrong and DeGrandpre imply. Instead of subscribing to a neurochemical myth, and, in effect, "blame the victim" in the case of ADHD, both authors allude that the domestic sphere should exercise more control over the interaction between child and culture.

Arguments concerning television and video games are not novel to the discourse surrounding ADHD. Suspicions of television being a causal ADHD variable have owned a small, yet not insignificant part of the discourse. For example, Matthew Dumont (1976), in a letter to the *American Journal of Psychiatry* states:

I would like to suggest that the constant shifting of frames in television shows is related to the hyperkinetic syndrome. Television has emerged as the single major cognitive experience during the developmental years of huge numbers of children. Apart from the vapid and violent content of the programs, there are incessant changes of camera and focus, so that the viewer's reference point shifts every few seconds. This technique literally programs a short attention span and probably accounts for the almost hypnotic attraction television has for many of us (p. 457).

Dumont goes on to argue that it was problematic for children to be expected to behave in the classroom when their television-influenced frame of reference had no isomorphism with the dullness of the classroom structure. In addition, Dumont hypothesizes that "amphetamines control this behavior by providing a subjective experience comparable to the fleeting worlds of television and hyperkinesis" (Dumont 1976, p. 457). Dumont's letter also expresses a cultural etiology. The administration of medication might not be linked to the regulation of a

neurochemical imbalance as much as its effect might mimic a type of world which children have become accustomed to, if not "hypnotized" by. Medication calms children because it makes the world appear familiarly hyperreal.

Authors who associate television with hyperactivity and inattention argue that the fractured experience of television, in that it is a normal part of childhood, is something that children carry with them into a variety of institutional settings. A crucial institution in this regard is education. In *Go Watch TV!* (1974, p. 164) Nat Rutstein states: "Too many children sit in classrooms in body only, thinking technicolor thoughts of distant lands and beyond, where Star Trek circulates, of the moon, where astronauts pick for clues, and of being back home, embraced by television beams." A similar stance is taken by Marie Winn in *the Plug-in Drug* (1985) in which she argues that children's educational shows, like *Sesame Street* make children equate learning to a technicolor, scene-shifting experience. The classroom, in comparison, is a boring let down, responded to with restlessness and contempt. This sentiment is also expressed in a recent study of video games by Steve Dorman (1997). He contends that "a more subtle impact of video game technology on education is the expectation by children that all learning must take a gaming approach and be fun" (Dorman 1997, p. 136; for other examples of literature which explore the relationship between video games and childhood behavioral problems see Bruno 1995; Keepers 1990; Soper and Miller 1983).

The fairly extensive clinical and popular discussion of television and video games and child hyperactivity and/or inattention is as much a commentary on the nature of domesticity as it is one about contemporary media. The world view that is inculcated in the image-saturated living room, numerous authors assert, has a lack of fit with the outside world--the "real world" of school, work and responsibility. Whether a product of TV, or more easily influenced by it than normal children, ADHD children are framed in a continuously vulnerable way. His/her household requires a special kind of restructuring in which domesticity carefully filters the simulated experiences of the image-based, modern world. Despite obvious differences in their

perspective on the cause of ADHD, these discourses propagate similar mechanisms of discipline designed to be enacted on the body of the ADHD child.

Guidebooks and the Disciplined ADHD Body

Foucault contends that the creation of binaries are integral in the maintenance of discipline and the exploration of new disciplinary techniques (Foucault 1977, p. 199). These binaries denote a heavily dichotomous relationship between those who are labeled sick and healthy, sane and insane, mentally-ordered and mentally disordered, and so on. Inasmuch as ADHD is a mental disorder it falls outside the confines of what is constructed as normal mental functioning. The ADHD child is constructed as a "disordered" mind, placed against the backdrop of the "ordered" mind--the mind without need of drastic discipline or the inscription of behavior modification. Foucault argues that a relationship develops between the problematic side of the binary (the "sick," the "disordered") and at least two essential elements of discipline. The first are the *techniques* for rectifying the perceived problematic symptoms. For example, this study has highlighted the principles of behavior modification, the meticulous documentation of regulation of diet, and the regulation of media imagery. The second is the *geography* in which these techniques are deployed. By appealing to a parental audience, ADHD discourse present in the literature we have analyzed finds a specific site of application in domesticity. The application of disciplinary techniques and the consequent alteration of the dynamics of the domestic sphere, ultimately increase the legitimacy of binary discursive structures. For Foucault, disciplinary techniques and the construction of normalcy go hand-in-hand.

Despite both etiological and treatment differences, these discourses overlap within domesticity. It is within the domestic realm, in which such a tremendous potential for behavioral regulation exists, in which clinical skills find their application, that these discourses can be seen in their interplay. Within domesticity, behavior modification meets dietary regulation, points system meets MotivAider, television regulation meets "moment-by-moment" children. Common to the endless application of all of these narratives is a consistent mechanism of discipline.

Domesticity must enter into a kind of contract with the means to rectify the manifestations of ADHD. The elements of this contract begin at the level of discourse (i.e.--the clinical modalities that make a disorder like ADHD "possible"[Blum 1970]), which makes its way into popular renditions (i.e.--guidebooks and forms of lay commentary), ultimately finding its investment in the domestic sphere.

The geography of the home, combined with the practices of the newly-constructed ADHD parent, formulate the body of the ADHD child; the types of motions this body will exhibit, the types of entertainment it will enjoy, the foods it will eat, and so on. As Foucault (1980, p. 58) states: "One needs to study what kind of body the current society needs... ." A reflection upon the conditions of the body will, in Foucault's opinion, illuminate larger social conditions.³⁶ The mechanisms of how societal conditions play themselves out on the surface of the ADHD child's body directly implicates institutional practices which have made their way into the everyday life of the household. Disciplinary practices inscribed upon the body of ADHD children demonstrate a linkage between formal and informal worlds (Goffman 1961)³⁷, where narratives about the causes and conditions of unruly childhood behavior strategize to make their way into domestic practice.

³⁶Foucault's larger project concerning the politics of bodies, especially that concerning childhood sexuality and its impact on the social construction of the body has been summarized nicely by Nancy Fraser (1994, pp. 60): "...he calls his project the study of the history of the political technology of the body." From the articulation of this history, Fraser argues, Foucault illustrates the modalities of human scientific and medical practice in contemporary life.

³⁷ Goffman's *Asylums* (1961) documents the process by which informal suspicion of mental illness culminates into its institutional form, or "formal" suspicion. The process begins in the world of everyday life, and reaches its first conclusion inside the confines of the "total institution." The process of disciplining domesticity through popular ADHD discourse effectively reverses that process. Through the popular ADHD narrative, the confines of the domestic sphere could be arguably more akin to a "formally suspicious" environment. I believe, there is more to be said here. For example, would a Foucauldian interpretation serve as an effective theoretical apparatus to understand how suspicions move through their formal and informal phases?

Part II: The Everyday Framing of ADHD

Chapter 5

Methodology and Profile of Interview Respondents

Qualitative analyses are some of the most effective means of articulating the experience of mental disorder at both institutional and social psychological levels. Sue Estroff's discussion of ex-mental patients in *Making it Crazy* (1987) and David Karp's intimate portrayal of people with depression in *Speaking of Sadness* (1996) serve as two excellent examples of such research. With both of these texts and others of their ilk we are witness to a very enriching portrayal of mental illness's affect upon families, the negotiation of the meaning of mental illness in everyday settings, the relationship between social actors and mental illness treatments, and so on. Such issues, as thoughtfully presented by Estroff and Karp, are also very relevant to the study of ADHD.

In studying ADHD, it is important to engage in varied locations of data collection. This is due to the fact that ADHD is a mental disorder inextricably linked to a number of institutional settings, many of which have a distinct role in suspecting and ultimately treating the phenomenon. Failing the collection of data from a wide range of locations, we will have only another text on ADHD reporting on some specific context, whether that context be the home, the school, or any number of social settings. Emphasizing the variety of locations that contribute to ADHD suspicion and treatment ultimately provides a richer account of the disorder and the social roles which arise out of its diagnosis. For data collection in this thesis I chose three primary locations: the home, the school, and the clinic. Since the accessibility of resources was too limited for me to do elaborate ethnographies of each of these locations, it became necessary to interview social actors who were linked to these locations. Hence, from the home I interviewed parents, from the school, I interviewed teachers, and from the clinic, I interviewed the individuals who participate in the formal diagnostic and/or treatment process.

This section of the thesis is designed to provide a narrative account of ADHD. That is, there is a kind of "life story" attached to ADHD and its diagnosis. As Julie Cruikshank (1998) conveys about her experiences with persons in the Yukon territories, narrative is the basis for articulating the voices of people. Though my study of ADHD does not involve a years-long ethnography of the people implicated in the disorder, it is done in the spirit of Cruikshank's work. The voices of the people involved are essential to understanding the social vicissitudes of ADHD. Their stories are representative of a condition of life which is unique to the circumstances of ADHD.

This section is theoretically informed by the symbolic interactionist (SI) perspective. Though the tenets of SI are clear in the work of Mead, Cooley, and Thomas, they are perhaps most succinctly illustrated by Herbert Blumer (1969): "The position of symbolic interactionism...is that the meanings that things have for human beings are central in their own right" (p. 3). Rather than theorizing a deeper driving force such as collective conscience, or ideology, or primal drives, SI places everyday meaning at the center of social action. Humans are interpretive animals and this interpretation is what provides the grounds for the actions we take. In this scheme, action and interpretation are so intensely imbricated that one cannot occur without the other. In the case of ADHD, we encounter many assumptions about why parents medicate their children, or why teachers and doctors may be so sympathetic to a positive ADHD diagnosis. But, from the SI perspective, this is merely conjectural. Prior to theorizing about the essence of what motivates such social actors to take the steps they do, we must understand how they derive meaning from their ADHD-related experiences.

In the remaining sections of this chapter I will provide a detailed discussion of the methodology used in the interview-based, second half of the thesis. This will include a profiling of the respondents who participated in the interview process, the methods of recruitment I employed to attract respondents to the study, the specifics of the interviewing procedure, and the methods used to analyze the interview data.

Respondent Recruitment

The first thing I needed to develop in seeking out respondents for this section of the thesis was a strategy of recruitment. I needed to find methods of making my study known, but at the same time remaining sensitive to some of the private concerns surrounding ADHD. For example, running an ad in the *Vancouver Sun*, though certainly a method of making my study visible, would be too much of a "bull in a china shop" approach to recruiting respondents. More subtle approaches were necessary.

Upon the suggestion of my supervisor I began to seek out others in the ADHD research community. By reaching out to this community I could find out what approaches to ADHD were being taken while letting them know about my own research. I found this approach very helpful in creating leads to subtly and effectively recruit respondents. No one in the larger research community breached the anonymity of their patients or respondents, but they were still very helpful in offering suggestions about how I might find my own respondent group. Amongst the persons I contacted were faculty at the UBC Departments of Psychiatry and Psychology, clinicians and nurses at the BC Children's Hospital, and representatives from the Attention Deficit Disorder Association (ADDA). From these contacts I was directed to a lot of useful information, including some current literature which I had not yet explored.

A particular meeting which sparked considerable momentum for this thesis--in both a practical and inspirational sense--was with Dr. Gabor Mate, author of a best-selling book on ADHD, *Scattered Minds* (1999). Arranged by my supervisor, this 2 hour meeting was one of the most thought-provoking I have had about the nature of ADHD, the social actors surrounding this disorder and the plethora of ADHD treatments. The meeting with Dr. Mate validated some of my thoughts on ADHD, namely that it was a diagnosis with a considerable amount of variability in its etiology and also that it was a disorder intertwined with family dynamics. This particular perspective towards the family bolstered my efforts to interview parents and see how their responses reflected the relationship between ADHD and family struggle.

Dr. Mate also provided some practical advice on how to find respondents. One way, he contended, was through contacting the Vancouver chapter of Children and Adults with Attention Deficit Disorder (CHADD). An international organization since 1990, CHADD has been in the Vancouver, BC area for the past 5 years. After contacting the CHADD phone line--a residential phone, answered by a volunteer--I was advised of the location of their next meeting. I explained my research to the volunteer and was assured by her that I was welcome to attend. She stated that CHADD was an entirely public forum which excluded no one. I attended a CHADD meeting the next night, which quite fortuitously, was only a few blocks from my apartment.

The meeting itself was very informative. We watched a video cassette discussing teaching strategies for ADHD children and then engaged in personal testimony. During this time I announced my research and that my motive for being at the meeting was to find respondents who may be willing to participate. I was elated by the reception to my work and left the meeting with almost a dozen phone numbers of attending parents and also professionals who had helped them in their struggle with ADHD. My association with CHADD proved to be pivotal in recruiting respondents. CHADD is very devoted to community outreach; its members have consistent contact with other professionals who deal with ADHD. The parents who attend CHADD also provided me with a wealth of information. With rare exception, parents I interviewed frequently gave me the contact information of teachers who had dealt with their ADHD children, and the names and numbers of clinicians who provided ADHD diagnoses.

One parent informed me about a workshop that was scheduled to occur at a local school conducted by Steven Frasier, an expert on ADHD and the classroom. The workshop focused on ADHD, its impact on the educational community, and the strategies teachers could employ to identify ADHD children and aid in their diagnosis. The specific way ADHD was being addressed in this forum was especially germane to my analysis of teachers of ADHD children as I was concerned with the processes of suspicion and consequent diagnosis which may arise within classroom situations. The workshop proved invaluable in sensitizing me to some of the issues teachers face as a result of having ADHD children in their classrooms, including their role as

people who may need to "detect" the early signs of ADHD and start the process of getting a child a clinical referral.

My approach to ADHD sought to examine the adult figures typically surrounding a case of ADHD. The best starting place for such recruitment was with parents at CHADD meetings. Interviewing parents seemed to be a logical first step because they are the most common mediators between children and larger social structures. In beginning the formulation of my sample, parents were crucial gatekeepers, who invariably held information about clinicians and educators who were close to their children, and, more generally, had knowledge about ADHD. Beginning with parents also made the recruitment of clinicians and teachers associated with a case of ADHD much less time consuming. By using parents as a referral source I avoided the random sampling of clinician and teacher populations for those who had experience with ADHD. My approach is often referred to as "snowball" sampling, denoting a sample that gains strength and reaches a desired size based upon referrals made by previous respondents.

Beginning with parents, I asked them who their child's teacher and clinician were at the time of his/her diagnosis, or which clinician and teacher had a significant rapport with the child and knowledge of ADHD behavior. Such inquiries were done at the beginning of the parental interviews. I would preface these interviews by stating something akin to: "In doing my research, I am also asking for referrals to other clinicians and teachers who have been associated with your child, or clinicians and teachers who you may know to be knowledgeable about the ADHD condition. Which teachers have been most closely associated with your child and have knowledge of his/her ADHD? Which clinician has been the most influential in the diagnostic and treatment process for your child?"

Asking parents to provide contact information for teachers and clinicians proved very effective. In supplying information about teachers, parents usually provided a name and the school where they worked. Such potential respondents were contacted via the yellow pages. In communicating directly with teachers, I would state the nature of my research and that I was referred by one of their student's parents. Teachers were, by far, the most amenable and willing of

all the respondent groups. This was probably due to the fact that teacher respondents commonly viewed ADHD as an impediment to the learning process, and hence, was a topic of particular professional concern. This enthusiasm for my research was exemplified by two teachers who asked if they could be interviewed after hearing of my research, even though they were not recruited to participate. As they had considerable experience with ADHD, both teachers were included in the sample, hence the teacher respondent group is comprised by twenty-two respondents, rather than twenty. I was also provided with contact information for clinicians. Clinicians were also amenable to being interviewed, though, it seemed, to a lesser extent than teachers. Contacts with clinicians often began with a round or two of "phone tag," and, with persistence, culminated with a scheduled interview. Such interviews were done on lunch hours, between patients, or on specified days off. Anticipating some degree of difficulty in contacting clinicians, I asked parents if they would be willing to call these potential respondents and let them know of my research in advance. In a number of cases parents honored this request. This approach proved very favorable to my research, as many clinicians were already given my name and had spoken to parents about the interview procedure.

After being given an introductory letter summarizing my research (see Appendix I), and showing a willingness to participate, all adult respondents were required to sign a consent form as approved by the UBC Ethics Review Board of the University of British Columbia (see appendix II). The consent form guaranteed that the data obtained in the interview process would be held in strict confidence and that any publication or presentation of the material would protect respondent anonymity.

Respondent Profile

*Parents*³⁸

There were a few criteria parents of ADHD children had to meet for inclusion in this part of the thesis. First, it was desirable that their child be within a particular age range. My supervisor and I had demarcated this as between grade eight and grade two. The clinical literature (Barkley 1997) describes that children younger than this age group rarely encounter enough school difficulties to demonstrate symptoms of ADHD, and that children older than this who have not been suspected of having ADHD may never be suspected of having the disorder. This age range, roughly between seven and 13 years of age, reflects the parameters around younger children who exhibit frustrations with school and other environments and tend to "act out," and the older ages in which the visible symptoms of ADHD may not be detected because the impulse to physically act out is diminished. It was important that the children the parent respondents discussed were being specifically framed within the nomenclature of ADHD. This age range seemed to optimize that possibility, though there were some parents I interviewed whose children were younger (age six) than this range.

Second, their children had to have a formal diagnosis of ADHD or any of its subtypes (see the introduction for a description of these). To *suspect* ADHD was simply not enough for inclusion into this respondent group. There were, for example, two possible parent respondents at a CHADD meeting I attended, but after informal conversation in which I disclosed information about my study, they revealed they were only "wondering" or were "curious" about ADHD and their child. Such potential respondents were excluded. This was done in the politest manner possible as I informed them that I needed to speak with parents who had been through all of the stages of the diagnosis process with their children.

³⁸With the exception of clinician respondents, whose specific occupation seemed very influential in their perspectives towards ADHD children, the age, gender and race breakdowns of all three respondent groups are not presented as a variables to be correlated with experiences with ADHD, but rather, to simply describe the sample to the reader more thoroughly.

During my research I explored the possibility of talking with children about their own experiences with ADHD. There were some significant roadblocks to attaining this data. Parents tend to have strong boundaries when allowing an outsider to interact with their children and this was evident when I approached them about the possibility of speaking to their children. I was able to speak with three older children (age 10-13 years) and this was done after attaining a signed parental consent form. I have briefly mentioned interactions I had with these children, but this is done as an exploratory measure, rather than as one that is considered to significantly contribute to the main direction of this thesis. As this thesis is primarily concerned with examining how adults frame ADHD children, adult respondents are the primary empirical focus. My talks with children were interesting moments for me as a researcher. Though brief, the conversations with children demonstrate the potential for another type of qualitative study of ADHD children. I expand on this sentiment in the conclusion, chapter ten.

Many parent respondents I contacted participated in this study through word of mouth, rather than from formally meeting them at a CHADD meeting. Upon completing the interviews parents seemed very supportive of my study and often gave information about other parents they knew who also had ADHD children. In such cases, these respondents would pass my phone number on to their acquaintances, and often such acquaintances would call and schedule an interview. It is important to note that after the interview was completed, parents had many favorable comments to offer about the interview. Comments like "I guess that wasn't so bad, after all, was it?" and "You know that was kind of fun," were fairly common from all categories of respondents. Because of this favorable reception to my work, parents seemed more inclined to pass my name on to someone else.

There were 20 parent respondents in total. They ranged from 29 to 49 years of age, with a modal age of 42 and a median age of 40. Their children's age ranged from 6 to 14 years, with a modal age of 8 and a median age of 8. Eighteen of the parent respondents had boys with ADHD and two respondents had girls with the disorder. One parent stated she had two boys with the disorder, and one other respondent claimed to have two girls with ADHD. All other respondents

claimed to have only one child with the disorder. Seventeen parents, or 85% of the total stated that their children were taking some type of stimulant medication to manage their child's condition. There were thirteen female and seven male parent respondents. This respondent group occupied a wide range of socio-economic class positions, but was primarily Caucasian. A more careful analysis of ethnicity, immigration and language would be needed to consider the pluralities of Vancouver's communities. Given this sample size and methodology, these categories are a not a legitimate level of analysis and would indeed be inappropriate here.

Teachers

Teacher respondents qualified if their names were passed on to me by parents and if they were involved with the parents' child at the time of the child's diagnosis. It was not mandatory that these teachers had specific knowledge of ADHD, but I presumed that they would have minimal knowledge. As will be seen in the analysis of teacher respondent data in chapter seven, I was fairly accurate in that assumption. Amongst those with the most knowledge of ADHD were teachers involved with one of many Learning Assistance Centers (LAC's) which are located in the Vancouver School District elementary schools. The LAC program was developed to provide assistance to children with learning disabilities, and although ADHD is not recognized by the BC Ministry of Education as a bona fide learning disability, many ADHD children are being taught in these learning centers.

There were 22 teacher respondents in all, slightly overshooting the intended number of 20. Teacher respondents ranged in age from 30 to 64 years, with modal ages of 34, 44, and 52, and a median age of 43. The gender breakdown of the teacher respondents included 10 males and 12 females. The grade levels taught ranged from preschool to grade 8. Seven of the respondents taught mixed grade levels. One respondent taught a 2/3 split, another a 4/5/6 split, another a 5/6/7 split, and another a 5/6 grade split. Three respondents taught a 6/7 grade split. Five of the respondents specifically taught in an LAC at their schools, effectively teaching students in grades kindergarten through grade 7.

Clinicians

Clinicians who were qualified to participate in this study needed to meet two criteria: 1) their names needed to be referred to me by parents I had interviewed, and 2) their roles needed to be considered integral in providing treatment and/or diagnosis of a case of ADHD.

There were 20 clinician respondents in all. They ranged in age from 34 to 60 years, with a modal age of 47, and a median age of 47. Professionally, clinician respondents comprised seven clinical psychologists, five pediatricians, three general practitioners, one area school psychologist, one psychiatrist, one psychiatric nurse who manages the BC Children's Hospital ADHD Clinic, one family therapist, and one psychoeducational assessor. Fourteen of the respondents were male and six were female.

Interviewing

Qualitative researchers Andrea Fontana and James H. Frey (2000) state that "...interviewing is one of the most common and powerful ways in which we try to understand our fellow human beings" (p. 645). This, of course, applies to qualitative researchers, but more generally, to the larger populace. Social actors gain an understanding of their social worlds through a constant process of interviewing each other. The quality of the information we receive, and the meaning we derive from it, is often a result of our connection to the social context in which the questions are asked. The level of disclosure we request and the level of disclosure that we attain are both coextensive with the amount of social fit we have with those we interview. The insider tends to get more information than the outsider.

Howard S. Becker (1956) corroborates this assertion. In the methodology discussion of his now classic study of medical school students, he describes a very large chasm between the amount of information shared amongst medical students and the amount shared between medical students and the outside world. Perceived to be an "outsider" by those he was studying, Becker articulates that his presence was seen as potentially threatening:

In many situations interviewees perceive him (the interviewer) as a potentially dangerous person and, fearing lest he discover secrets better kept from the outside world, resort to the "official line" in order to keep his inquisitiveness at bay in a polite way (p. 199).

Becker argues that defensiveness on the part of any respondent is an obstacle to getting more of the authentic story of the group under study. By resorting to the "official line" Becker is referring to a group or individual treating the researcher as if he/she was just a random social actor, and hence, undeserving of any special information.

Becker's experiences with medical students treating him as an outsider mirror my experiences with interviewing the social actors surrounding ADHD. ADHD is a disorder which many parents do not see as well-understood in the greater popular community and they are hesitant to advertise their child's diagnosis. The reasons for this speak to well-researched discussions in the sociology of deviance, namely those discussions implicating process of stigma and the management of information between stigmatized and the "normal" population.

As an attendee at CHADD meetings I was a conspicuous outsider. I have no children, much less ones with ADHD, nor do I myself have the disorder. According to Becker, it is at this point that I could be perceived as something of a threat to potential respondents--something which may not be seen in the immediate response to my presence at CHADD meetings. In fact, people at CHADD were very cordial and welcoming. It was at the moment of presenting my research that the outsider status and its threatening nature became more visible. Being entirely honest with people was essential. I publicly identified myself and stated that I was engaged in writing a doctoral thesis on ADHD. The perception of me as a threat was further dispelled when I told parents some of my knowledge about ADHD and they could then see that I was "in the know" (Goffman 1959).

According to H.M. Trice (1970, p. 77-82), being the outsider can create a unique analytical perspective, and therefore can be an asset to the research process. Trice argues that the outsider role is one which needs to be preserved, almost protected, in order to keep the research

authentic. He contends that a compromise needs to be made between the stigma of the outsider and the valuable insights which accompany "outsiderness". There are three strategies he outlines that preserve the status of outsider, but also reduce some of this role's stigmatizing effects. These are:

1) *Insist that the respondent has the information.* This proved to be an excellent method for validating ADHD respondents. I insisted that what they had to say was important. I especially explained to parent respondents that having specific technical knowledge of ADHD was not vital and that their own experiences were important.

2) *Disseminate knowledge of the research area.* As stated, it was important that I clarify the nature of my study and demystify it as much as possible to potential respondents. Potential interviewees had many questions about my research and I fielded these with the utmost sincerity.

3) *Overtly state researcher "outsiderness."* In order to clarify my identity and why I was attending CHADD meetings, or an ADD workshop, I would openly state that I was a Ph.D. candidate and that I was not a parent with an ADHD child, nor an educator.

In addition to implementing these three techniques, I also made sure that potential respondents knew that the data I was collecting was to be done so in the strictest confidence. No personal names were written on the interview schedules (to see the interview schedules for parents, clinicians, and educators, please see appendices III, IV and V, respectively), and respondents were assured that I was the only one who would be analyzing their responses.

In order to ensure a meaningful and revealing interview, it is important that the respondent feel as comfortable as possible with the interviewer and his/her research. Therefore it was very important that I took measures to relieve the anxiety of respondents. With some respondents I sensed skepticism which, ultimately, could undo my research. Clearly, it was necessary to cultivate a sense of willingness in my respondents, in order to produce telling responses to my questions. Fred Blum (1952) articulates this necessity in his article, "Getting

Individuals to Give Information to the Outsider." In this essay, Blum conveys his experiences in producing a less defensive exchange between himself and those he was interviewing:

At the preliminary stages of the field work, interviews were administered in the usual fashion. But in the attempt to create a permissive atmosphere I found myself becoming involved with a conversation during which I told the interviewee several things out of my own life. This departure from the regular interview procedure led to a notable change in atmosphere and a greater facility in obtaining information (p. 37).

As a result of "opening up" to the respondents Blum was able to encourage a more productive interview procedure. By engaging in social reciprocity Blum reduced respondent skepticism. Indeed, this was also the case with my field work on ADHD social actors, especially the parents I interviewed. Parents were exceptionally curious about the research I was doing, where I had studied before UBC, where I was from in the States, why I was curious about ADHD, and so on. My willingness to respond to such queries was certainly not motivated by the solitary goal of obtaining a better data set, but what resulted, despite personal motives, was a much richer exchange between myself and my respondents. This is a moment where researcher occupies dual roles as sociologist and social actor. I believe balancing these two roles is a key to effective qualitative research.

Procedure

After acquiring contact information for potential respondents I began calling down this list. Upon beginning a phone conversation with the potential respondent I would reintroduce myself (something that did not really prove necessary as most people remembered me), and reiterate the nature of my thesis. I would then try to set up an appointment with the respondent at a time they found convenient.

I requested in-person interviews with respondents as such interviewing can be very effective. Many respondents were favorable to the idea of in-person interviews, but a

considerable number (twenty-five of the sixty-two respondents) asked whether or not the interview could be done over the phone. Rather than force my way into a respondent's home or make them feel awkward by disclosing information about ADHD in a neutral public place, I elected to move ahead with a phone interview in these cases.

Whether the interview was done over the phone or in-person, each varied between 20 minutes and one hour in length. After asking the questions set out in the interview schedule I would write down the participants' responses, some of which were fairly lengthy. In many cases I would repeat questions to respondents in an effort to make sure they understood the content of the question. Once these responses were documented, I would read them back to the respondent to ensure their accuracy. This dialogue extended the interview time, but it was a worthwhile procedure. In addition, I learned to not be hesitant in asking a respondent to slow down his/her response so that I could write accurately.

Staying on task

In *Unobtrusive Measures* (1966), a text subtitled as "non-reactive research in the social sciences" the authors argue that there is a large amount of validity and reliability-oriented problems which can occur between interviewer and respondent. In referring to "waivering calibrations" (p. 22) the authors argue that interviewers can change their interpretation of data over time and through different experiences. This means that interviewers, despite any social scientist guise, always have the potential to shift the way they analyze data, but perhaps more importantly, shift the manner in which they collect data throughout the course of research. The authors claim there is no way to entirely remove all possibility of "waivering calibrations," and this is especially true for qualitative research. However, within this interview procedure I have taken some pains to minimize some of these inconsistencies.

Staying on topic is a common difficulty with open-ended interviews and it is one the researcher must be very sensitive to in order to reduce disjuncture between data gathered from each respondent. To ensure an "on task" interview, each group of respondents was asked a

specific set of questions, which were asked consistently from one interview to the next. I found that it was important to preface the interviews by gently telling people to be specific in their responses and to ask me at any time during the interview if a question seemed unclear. This proved to be a useful suggestion as a person can interpret a question--however thoughtfully asked--very differently from someone else.

Another technique I employed to counteract wavering calibrations was reading back to the respondent each answer they provided to the interview question (see Webb et al, 1966). This made the interview a bit longer than if no clarification was requested of the respondents, but it certainly made myself and them more confident that I was writing down the response they meant to provide. In clarifying an answer I would ask them something like, "OK, for this question I have (written response), is this accurate?" If what I had written was an accurate portrayal (and it was in most cases), we could steadfastly move on to the next question. If not, an immediate revision would be made to the response. This type of dialogue between myself and the respondents not only kept the interview accurate and on schedule, it also cultivated, I believe, a sense of trust that I was a researcher who truly wanted to represent people's voices. In addition, when it came time to analyzing the data I had collected, I felt confident in the material.

Analysis

Amidst contemporary postmodern and multi-cultural movements in qualitative research the process of interpreting data is especially problematic (Denzin 2000). This is true for the actual process of analysis, but postmodern perspectives in qualitative methods also place into question the privilege of the researcher. The social role of "sociologist" as someone who can innocuously gather data and provide objective analyses of it has been under tremendous scrutiny over the last 20 years (Denzin 2000). Postmodern and multi-cultural critics have argued that representation is a key factor missing from sociological and anthropological inquiry. Data analysis, proponents of such perspectives argue, is constantly filtered through racial, gendered, and epistemological lenses. Further, they contend that the process of making a legitimacy claim

about the interpretation of data is more a result of micro-politics than of intrinsic interpretative validity. What is ultimately represented through data interpretation, it is argued, is the ongoing asymmetry of power between the boisterous and voiceless.

The discussion which places a cloud of skepticism around the conclusions of past and current research is, I believe, a healthy transformation in qualitative social science. It is a discussion which sensitizes researchers to the many issues which may surround a respondent group or strategic site of study--issues which may not be addressed through a research procedure, however thoughtful that procedure may have seemed. The interview section of this thesis finds itself within a discourse of skepticism.

Norman Denzin (2000) also asks whether or not--in the wake of postmodernism--we will find ourselves entirely fractured as researchers and without a common ground to offer analysis. He argues that we will be unable to find one hundred percent interpretive reliability in discussing the results of qualitative research. The degree of flexibility we offer in interpreting each other's work will continue to markedly increase in light of postmodernism's sensitizing characteristics. It is not that researchers are going to become warring factions, each fighting for his/her own research agenda, but rather that we will become more open to the multiple interpretations of the results of the studies we undertake.

In analyzing the interview data from parent, educator, and clinician respondent groups I was especially affected by some of the issues Denzin (2000) outlines. Of primary concern was my role as a researcher and the privilege I had adopted as a result of being an interviewer rather than an interviewee. I could tell intuitively from a preliminary examination of the data I had collected that there were more than a few common themes between and within respondent groups. In the face of this it seemed pertinent to make a compromise. While analyzing the data, I would be willing to relinquish grasp upon some universal theory of the social actors surrounding cases of ADHD, yet I needed to acknowledge that the data I had analyzed showed strong "moments" of theoretical relevance.

Coding

The first sociological study of hyperactivity (Conrad 1976) was based upon a grounded theory approach (see Glaser and Strauss 1967, Glaser 1978, Strauss and Corbin 1997). Keeping in line with grounded theory's commitment to the teasing out of basic social processes, Conrad's study is one which focused on the process of "medicalization" as it was made visible through data collected at a hyperactivity clinic. Though the method of data collection and analysis for this thesis was rather different from grounded theory, the methods by which grounded theorists organize data proved useful. Of particular relevance to my thesis were the methods outlined for the codification of qualitative data by Barney Glaser in *Theoretical Sensitivity* (1978). In this text, considered by many in the grounded theory camp of social research to be the methodological Bible of qualitative analysis, Glaser highlights numerous strategies with which to organize data and allow this organization to inform the generation of theory. There are a few tenets of Glaser's strategy which I have employed in analyzing the interview data. Allow me to illustrate some of these and also explain where my approach diverges from Glaser's.

The process by which I have analyzed the interview data was partially based on an inductive model of research. In its purest form--a form which I would argue is a natural impossibility--grounded theory begins with no theoretical assumptions about the site of study. Glaser states: "...a theory is induced or emerged after data collection starts" (p. 37). There is a constant dialogue between the researcher and the strategic site: as data is collected theory emerges and informs the process of further data gathering. In my study of social actors and ADHD, I refrained from formal analyses until I had collected an adequate amount of data. However, the research design for the interview section of this thesis was not entirely inductive, but employed elements of induction and deduction. The interview schedule had specific questions that were formulated around some initial research problems (the processes of ADHD suspicion, processes of stigma management, and so on), and these questions were also heavily influenced by my genealogical analysis of ADHD--both deductive methods--but the interview data themselves were not confined within these parameters. The interviews were open-ended,

leaving space for the personal expression of respondents. Because of this, the interviews presented a side to the qualitative study of ADHD that reflected a great deal of fit with the genealogical analysis, but also stood on their own as a uniquely human account of the disorder. Hence, the interview data provide a fitting compliment to the genealogical section of the thesis, without being redundant or unnecessary.

Throughout the process of interviewing I reflected upon a relevant body of literature with which to understand some of the processes that seemed apparent in the data. This differs from the very inductive position of Glaser who states: "Accordingly, the theory is rooted in data not an existing body of theory" (p. 38). The analysis that I undertook does not entirely emphasize data, but rather, relies upon a combination of the data itself and an existing body of theory. It was an impossibility for me not to think of Sykes and Matza's "techniques of neutralization" when parents downplayed their ADHD child's effect on other children, or Goffman's notion of "blemishes of individual character" when teachers described the incorrigible nature of ADHD students.

Glaser's discussion of "emergent categories" in data analysis is especially relevant to the analysis I have undertaken with the interview data. He states: "The goal of the analyst is to generate an emergent set of categories and their properties which fit, work and are relevant for integrating into a theory" (p. 56). Categories became increasingly clear through examining the interview data, the detailed analysis of which comprise the latter chapters of this thesis. These categories include, but are not limited to: 1) the difference between formal and informal worlds in diagnosing ADHD, 2) the adaptations social actors surrounding ADHD employed in both institutional and social settings, 3) the social psychological relationship between these social actors and their environment. It is important to see how specific incidents within the data can be understood through emerging categorical schemes.

Glaser (1978, p. 57) argues that there is a reflexive relationship between emerging categories and the interpretation of events in the data. When charting an incident within the data, for example, it becomes necessary to see how this incident ties into developing category notions.

One example of this reflexive process came out of discussions with parents and teachers regarding incidents of school bullying. This referred to physical and/or verbal aggression demonstrated by ADHD children, and towards ADHD children. In seeing repeated incidents of bullying expressed in the interview data, I began to ask analytical questions. For example, did bullying relate in any way to processes of informal suspicion? If so, what are some of the specific ways in which sociological knowledge of informal suspicion can help further understand this process? What was concluded was that the child's aggressive behavior, regardless of who it came from and to whom it was received, was a key to beginning a teacher down the path of informal suspicion. In the words of Emerson and Messenger (1977) bullying represented a "trouble" in the social fabric, perhaps rectified through remedial action, perhaps necessitating more formal measures. Bullying often served as a beacon for a "more serious" problem.

It was necessary that I painstakingly go back and forth between the data I was seeing and the categories which emerged and became a template for understanding that data. As the elements of these categories became more detailed I began to look at them more theoretically. Throughout this entire process, from initial observation of the field notes to theoretical discussion, I wrote down my findings. This is an example of Glaser's (1978, p.83) process of "memoing." As I documented the things I was seeing in the data, both my understanding and the notes I wrote became more sophisticated. I eventually raised my understanding of the interview data from a specific to a conceptual level. These memos eventually became outlines for the write-up of the interview data and I began to see how this data tied into the genealogical half of the thesis.

Through performing qualitative analyses of social actors associated with ADHD in conjunction with an elaborate genealogical account of the disorder, it becomes possible to evaluate these data within a historical context. The process of suspecting ADHD, the popular legitimacy of modern ADHD treatments, and the strategies for managing ADHD, may be analyzed as extensions of discursive formations which give contextual meaning to an interview-based, empirical account. The analysis of this interview data, therefore, operates under the

presupposition that modern social actors are in an interdependent relationship with the prevailing discourses constituting the disorder. The respondents' stories are a crucial element in examining how the discourses of ADHD become embedded in the thoughts and actions of lay actors.

There are many issues which have been constructed or made visible through the many discussions of ADHD symptoms throughout the 19th and 20th centuries. These discussions serve as a backdrop for the analysis of the experience of contemporary social actors associated with cases of ADHD. By placing interview data against the socio-historical context established in chapters two through four we can see how the academic and everyday discussions of ADHD have made their way into everyday life. There are many examples of this connection between everyday and academic worlds which will be expanded in the following chapters. Allow me to illustrate a few of them.

---The issue of medications as addressed by the interviews would enlighten the reader as he/she examines these in conjunction with the documentation of Charles Bradley's experiments with children and Benzedrine, and/or look at the current discourse of neurology to see the contemporary rationale for the large-scale use of stimulant medications, such as Ritalin.

---The notion that ADHD children can be impaired, but not developmentally disabled or retarded speaks to the medical discourses of imbecility discussed in the beginning of the thesis.

---The issue of whether or not ADHD children can control their behavior is illuminated through the discussion of ADHD symptoms by warring neurological and psychodynamic enterprises.

In examining the "contemporary" character of ADHD, this thesis will look to everyday social actors. In many cases, these are people without a sophisticated etiological position towards ADHD, who often had little or no knowledge of ADHD before a case of the disorder was brought

before them. These everyday social actors are not the ones selling a new book or a new treatment, but are instead the ones who simply want what is best for their children, students and patients.

After gathering this interview data I began to realize the significance of some of the statements of Thomas J. Cottle in *Private Lives and Public Accounts* (1977). In this text, perhaps one of the most clear and enlightening books on qualitative research, Cottle describes the connection between researcher and subject. He states: "The interviewer cannot help but become immersed in the lives of those people whom he or she is interviewing" (p. 8) Through speaking with parents, attending CHADD meetings and workshops, through invitation to their children's sporting events, and through the invitation from teachers to attend their classes, I realize some elements of the immersion Cottle speaks about. I also realize that when he says that the researcher "cannot help" becoming involved he means that the research begins to direct the researcher rather than vice versa. Developing this respondent group has been a wonderful and humbling experience.

Chapter 6 **Clinician Frames for ADHD Children**

In examining some components of the various and often opposing discussions of ADHD, Chapter three explored the methods and rhetorical devices that have elevated neurology to prominence in framing etiological and treatment perspectives towards ADHD over the past few decades. Underscoring the dissemination of this neurological voice, chapter four reveals how copious tracts of the neurological perspective have turned up in guidebooks, providing the groundwork for parents to modify the disciplinary environments of their children. Within these guidebooks, for example, were reminders to parents to keep a "disability perspective" towards their children, and to remember how particularly sensitive the ADHD child's mind is to certain stimuli, such as that found in television and video games. Clearly, it can be seen that much of the academic discussion regarding the etiology of ADHD has not stayed within the confines of academe.

Characterized by the scathing critique of psychodynamic perspectives by Paul Wender and Leon Eisenberg in the 1970's up to the meticulous physiological discussion of ADHD by Russell Barkley, Barbara Fisher, and many others in today's discussion, the academic take on ADHD has been defined through neurological nomenclature. Regardless of the considerable disagreement about the true nature of ADHD and its representation in manuals like *DSM IV*, entrance into the ADHD debate requires some degree of neurological expertise before one can participate with any efficacy. Granted, Peter Breggin's *Talking Back to Ritalin* (1998) exemplifies an argument that has gone toe-to-toe with the dominant perspectives in neurology, but such work is in a distinct minority. Nor would I include the work of Sydney Walker, Lawrence Diller, or Richard DeGrandpre in the same category as Breggin's. Despite demonstrating an obvious talent for writing that evokes feelings surrounding ADHD children, the aforementioned work does little, if anything, to further or rescind the etiological and treatment discussion of ADHD. Such work represents excellent cultural commentary, but lacks arguments which could be perceived as

scientifically substantial. The arguments of Walker, Diller, DeGrandpre and others, fall on deaf ears in academe and "preach to the choir" in the popular forum. So the story goes for the academic discussion of ADHD: neurology reigns supreme; outside of neurology, you are conceived as merely an ill-informed journalist.

We may conclude an academic history of ADHD with an elaborate discussion with the finitudes of the neurological understandings of ADHD--something that would be a valuable undertaking indeed. However, there certainly is more to ADHD than its academic discussion. There is, if you will, the everyday circumstances of ADHD. These circumstances may or may not reflect the ADHD discourse found in the academy. The everyday experience of ADHD is largely removed from academic jargon, largely removed from the conceptions of ADHD presented in scholarly articles and academically-oriented books. Beyond the latest grant proposal and breakthrough theory, ADHD is a lived reality that needs to be illuminated.

The following four chapters will move away from an analysis of the academic discussion of ADHD and present the everyday lived experience of ADHD--an experience demonstrating greater and lesser degrees of isomorphism with the discourses we have examined in chapters two through four. Through interviewing clinicians, teachers, and parents, this section of the thesis will convey a segment of the experiences people have when encountering ADHD in the clinic, classroom, and in the household. These experiences comprise the manner in which such respondents frame the ADHD phenomenon.

These interviews provide a necessary empirical compliment to the genealogical analysis in the previous chapters. Taken in their own right, these interviews represent qualitative data, replete with differing perspectives, and provide a window into the subjective experiences of my respondent group. In isolation, however, the analyses of such qualitative data cannot adequately take into account the role both academic and popular discourses play in formulating the experiences of those who are intimately linked to a case of ADHD and/or those who make a career in studying this disorder. It is very important to acknowledge that the experiences people have and the attitudes people formulate about ADHD, reflect conceptual antecedents. As it is so

often written about, discussed and debated, ADHD conjures various connotations--connotations that invariably shape the phenomenology of the disorder and hence, shape the types of action people take when encountering it in a variety of social contexts.

The present chapter is an analysis of interview data from the 20 clinician respondents profiled in chapter five.³⁹ My intention in interviewing these respondents was not to present an all-encompassing general theory about ADHD practitioners, but rather to provide a rich analysis of some of their experiences, including their reservations, skepticism, successes, and so on. Throughout the analysis of the clinician interviews I will elucidate how such data are a reflection of the discourses previously discussed in this thesis, and also, how these data deviate from such discourses. There are varying degrees of fit between the dominant academic perspectives towards ADHD and the interview data examined here. For example, in being asked about the actual physiological causes of ADHD, clinicians agree with much of the neurological discussion of the disorder. In many of these responses ADHD is argued to be a result of some kind of frontal lobe dysfunction and/or dopamine dysregulation--responses that fit nicely with today's dominant etiological ADHD perspectives. We find a lesser degree of fit between the academic discussion of ADHD and the experience of clinicians when addressing medications and the use-value of the diagnostic criteria of *DSM IV*. Many of the clinicians I interviewed expressed reservations about the administration of stimulant medication to ADHD children and many also felt that the *DSM IV* criteria for ADHD were either too broad or lacked more useful nomenclature.

As will be the case in chapters seven and eight, this chapter will be organized around central themes formulated by the interview questions. In addressing each of these themes I will present a table with a breakdown of the types of responses clinicians made to specific questions, including the number of clinicians responding in a particular way and the proportion of these

³⁹In presenting excerpts from these interviews in the following chapters, I have included the age, occupation and gender of the respondent. The presentation of such information is not meant to open an analysis of such variables, but rather, to provide a more human portrayal of the respondent. The differences in these variables and their reflection upon the types of responses given would certainly be an excellent topic for further analysis, but would detract from the purposes of this thesis, namely, the connection between the various discussions of ADHD and the way lay actors reflect those discussions.

types of responses to the entire sample. The use of tables here does not imply an elaborate quantitative breakdown of the interview data. The tables merely demonstrate a general profile of clinician responses. The column furthest on the left of each table provides a general description of the type of response given to the interview question at hand. With this column, I am parsimoniously summarizing a particular type of response and am not directly quoting any respondents. After presenting the table, I will offer an analysis through examining excerpts from the interviews. In offering this analysis it is important to mention that a focus will be given on answers that were the most dominant in the data, usually the top two or three categories of responses. The "major themes" in this regard will be emphasized, rather than addressing every single type of response.

Addressing the length of time clinicians had become familiar with ADHD

Before examining excerpts of the interviews, it is important to briefly describe the length of time over which clinicians in my sample had become familiar with the diagnosis of ADHD. In being asked: *How much time have you spent becoming familiar with the ADHD disorder?* clinicians expressed considerable variation in their responses. See Table 6-1 for a breakdown of these.

Table 6-1: Length of time clinicians reported familiarity with ADHD⁴⁰

<u>Years of familiarity</u>	<u>Number</u>	<u>Percentage (%)</u>
1-5	2	10
6-10	7	35
11-15	6	30
16-20	3	15
Unspecified	2	10
Total:	20	100

⁴⁰It may be important to mention that this table does not reflect the particular caseload of a respective clinician--a variable which may strongly influence the length of time over which familiarity with ADHD may be developed.

Suspecting parties and referral sources

With the intention of highlighting the connections between social agents during the process of diagnosing a case of ADHD, and also with the intention of uncovering the motivations for people to approach clinicians with such suspicion, clinicians were also asked: *From where or from whom do you usually hear the first suspicions of a child possibly having ADHD?* As clinicians articulated their response to this question, explaining in some detail how they were approached, and what they felt were some of the motivating factors of being approached, the response to this question revealed specific examples of how people will attempt to resolve consistent social troubles with a formal diagnostic apparatus. Throughout this process, referred to as the "micro-politics of trouble," by Emerson and Messenger (1977) the failure to resolve consistent troubles in everyday social life will prompt an appeal to agents with the authority to formally declare the essential nature of the problem. See table 6-2 for a breakdown of the types of persons who have appealed to clinicians.

Table 6-2: Most common referral sources as reported by clinicians.

Referral Source	Number	Percentage (%)
School Counselors	5	25
Teachers	5	25
Parents	4	20
Other Doctors	3	15
1/2 parents	2	10
1/2 teachers		
Mixed referral source	1	5
Total:	20	100

There were a variety of responses to this question. Of the greatest number are clinicians who stated that the majority of their cases of ADHD are prompted by representatives of the schools and to a lesser extent, parents. Also mentioned are referral sources from other doctors (N=3, or 15%), 1/2 teachers and 1/2 parents (N=2, or 10%) and mixed referral sources (N=1 or

5%). I will now examine the top 3 categories (comprising 14 respondents, or 70% of the total) at some length.

School counselors and teachers

As can be seen from table 6-2, the top two answers from clinicians (N=10 or 50% of the total) mentioned school intervention as the major action that moves a suspected case of ADHD into the realm of a formal clinical environment. The consistent mentioning of the school environment on behalf of clinicians reveals that there is an institutional component to the suspicion of ADHD that appears more dominant than in other social contexts. And, as will be shown in chapter eight, parent respondents consistently invoked the school as a source of struggle that motivated possible suspicions of ADHD and a subsequent visit to some type of clinical expert on the disorder.

Institutional locations of suspicion, such as the school, are consistent with the very early discussion of ADHD-symptoms implicit in the work on the psychological sequelae of *encephalitis lethargica* by Kennedy (1924), Ebaugh (1923), Stryker (1925) and others discussed in Chapter two. What was demonstrated in the historical depiction of ADHD symptoms were problems in institutional contexts, the school, chief amongst them. The institution of education was also mentioned by Charles Bradley in his experiments on children with Benzedrine in 1937. Bradley concluded that children who took Benzedrine began making dramatic improvements in both comprehension of and enthusiasm for schoolwork.

We understand the desires of an institution by its representatives. Therefore, if we are to understand the situation of a to-be-diagnosed case of ADHD, we need to see how these institutional representatives interact with formal mechanisms of diagnosis and treatment. In discussing the school's role in presenting a possible case of ADHD to a formal clinical realm, the interviews reveal that schools, or at least the element of schools which are the most antagonistic to suspected ADHD children, are integral in bringing such children to a formal mechanism of diagnosis and treatment. Common representatives in this regard are school counselors, whom

many clinicians claim are crucial in not only suspecting ADHD but in providing a preliminary diagnosis of the disorder. Therefore, clinician respondents often saw themselves as people who confirm an ADHD diagnosis, rather than originate one. One pediatrician, with 15 years of experience in treating ADHD stated: "A majority of the referrals come from the schools. The teacher will say they need to get a kid assessed. There are times when they say, 'we have an ADD here.'" Another clinician put the experience this way:

The child is most often referred to me by the school. I usually talk to a guidance counselor or a resource teacher or something like that. The school tends to diagnose these kids prior to them coming to me. They are sent to me for a reason and that's medication. The school doesn't usually directly confront the parents and tell them to go to the doctor and get some pills to fix their kid. They come to me first, but they want me to refer them to a doctor for the meds (Family therapist).

In stating that "the school tends to diagnose these kids prior to them coming to me," this clinician minimizes his diagnostic role. The children and families whom he sees are already given a diagnosis prior to entering the realm that is considered uniquely qualified to provide these diagnoses. This clinician also states that the issue of medication is the underlying motivation for the school counselors to approach him with suspicions of an ADHD child. Portraying himself as a linchpin between the schools and a physician who has the authorization to prescribe medications, this clinician can be seen as a means to an end sought by the school. The "ends" in this case are a change in the child's social and/or academic behavior, believed to be achievable primarily through stimulant medication.

The clinician's role is simplified in this sense. Through hearing of an apparently "confirmed" ADHD diagnosis from a school counselor, he feels pressure to confirm these suspicions and start the process of medicating that child. Moreover, he implies that his involvement with a case of ADHD makes the school's intervention less intrusive. As he states, instead of directly confronting the parents and recommending that a child be placed on

medication, the school recommends his services as a family therapist to confirm the abnormalcy of the child's behavior and prompt a physician referral. Implied in this discussion is that parents will be more inclined to accept their child's diagnosis if confirmed by a mental health expert rather than the school. This denotes an interesting aspect to the reception of school counselors by parents: they are supposed to find concern with abnormal behaviors, but are not considered a legitimate source for defining them.

Further confirming the school's role in sounding the alarm to a specific case of ADHD, clinicians also stated that their experience with a child suspected of having ADHD does not begin the moment the child steps into the clinician's office. As one clinician put it:

I get most of my referrals from schools, but parents are the ones who actually approach me. So, I will probably know about a kid before the parents will talk to me because the school psychologists or a resource teacher will have already called (Psychoeducational assessor).

In many cases of clinical referral for an ADHD assessment, the child's reputation precedes him/her. In fact, some clinicians, such as the psychoeducational assessor represented by this passage, begin designing profiles of children prior to a face-to-face consultation.

Parents

Clinicians also mentioned parents as a common source of ADHD suspicion (N=4, or 20% of the total). In discussing the rôle of parents in presenting a suspected case of ADHD, it was mentioned that parents had their own motivating factors for requesting a formal diagnosis. Clinicians often felt this motivation was prompted by the school. As one pediatrician stated: "They (parents) approach me after having some problems with the school. They say "the teacher has some real problems with my kid and wanted me to have him assessed." In this regard, parents are not presented as parties owning sole agency in bringing their children to be formally diagnosed. They arrive in the clinician's office with an incentive from the school. In this capacity,

much like the case of teachers and school counselors, parents are representatives of the desires of the institution of education.

In contrast, one clinician respondent mentioned that the parents he sees often approach him of their own volition. He felt he was approached by parents in this manner because of his emphasis on alternative methods for treating ADHD:

I think most often parents approach me as kind of an alternative. They may be very opposed to medication or have had some bad experiences with it. I don't approve of medication in most cases and I won't see a child who is on it because there's no way to tell who is in there (Pediatrician).

The above passage denotes that parents approach this particular clinician out of a need for the administration of different treatment techniques for their ADHD child. Clearly in the minority in my sample, the experience of this clinician elucidates that parents can own a degree of agency in interpreting the experience of their ADHD children.⁴¹ This may involve the acquisition of alternative diagnoses for their child's behavior and exploring treatment methods that other clinicians do not utilize.

With the discussion of parent agency in suspecting and treating their children, it is important to draw a relationship between the relatively small number of alternative practitioners who treat ADHD and the vast majority who subscribe to medication therapy as the primary means to alleviating ADHD symptoms. With the dominance of neurology in understanding and treating ADHD, it makes sense that it would be difficult for parents to find alternative treatments for their child's behavioral problems, and perhaps that only exceptionally vigilant parents will find these locations of alternative perspectives on the disorder.

⁴¹See Chapter 8 for an in-depth discussion of the experience of parent respondents.

Factors in providing diagnoses for ADHD

In attempting to document a segment of the process of formally diagnosing ADHD, the interview proceeded through asking clinicians: *How much time do you spend with a child before providing a positive or negative diagnosis of ADHD?* This question attempted to find out how much time it took to provide a diagnosis of ADHD and then make a comparison amongst the different members of the respondent group. Instead of these patterned kinds of answers, clinicians expressed a great deal of variability in not only the length of time used to provide an ADHD diagnosis, but also in the methods employed for diagnosing the disorder. The discussion of the length of time used to confirm or deny a case of ADHD prompted by this question was used by many clinicians as a springboard to discuss diagnostic tools, and also to discuss the complexity inherent in many ADHD cases. At least four clinicians (20% of the total) expressed major difficulties in diagnosing ADHD in any instance. These respondents--all of whom believed in the existence of ADHD--denied that they had a role in formally diagnosing ADHD, stating they were instead "collecting information" about behavior, family history, school performance, and so on. One respondent stated that such a diagnosis was a pointless endeavor since ADHD does not exist.

Diagnosis time depends on the complexity of the case

If there is one thing that can characterize ADHD, it is that this disorder has a multifaceted symptomatology. The historical discussion of ADHD in Chapter two is a case in point. When clinicians were asked, *How much time do you spend with a child before providing a positive or negative diagnosis of ADHD?* 45% of the respondents stated something to the effect that the time for a diagnosis depended on the complexity of the case of ADHD. One clinical psychologist explained it this way: "I am hesitant to provide diagnoses, so I may say "probable ADHD" until I get more information. Usually by the 2nd visit I am pretty clued in as to what the problem is." Rendering a diagnosis of ADHD is expressed as a complicated process that requires

a considerable amount of information, often testimonials from parents, teachers, and siblings, and records from the child's school.

Clinicians also stated that a certain degree of care needed to be taken to provide a diagnosis of ADHD so that psychological dysfunction can be separated from other kinds of problems. That is, many clinicians stated that it was important to understand the difference between malfunctions that were hard-wired into the child's brain, and those that were linked to social environmental. The distinction between these types of problems is stated by one clinician when he discusses the difference between primary and secondary diagnoses:

It depends on the circumstances of that child, but they all will get an in-depth clinical interview. I'll try to find out if ADHD is a primary or secondary diagnosis. If its secondary we probably don't have real ADHD--there's something else going on that needs to be addressed. So, we run a Conners and we try to get some comments from teachers to see what they have to say (Clinical psychologist).

This clinician argues the possibility that behaviors can prompt the suspicion of ADHD, but are not necessarily the "real" condition of this disorder. The use of the Conners Scale⁴² in this instance, denotes a device that can be used to affirm the non-existence of ADHD and direct the clinician in a productive therapeutic direction. In separating a real case of ADHD from psychological problems which only "mimic" the disorder, this clinician and others preserve both the notion that ADHD can be falsified and that it is a very real condition. The perceived separation between real and false ADHD and the methods used to determine this authenticity, demonstrates a neurological mode of inquiry into the disorder. Because it is perceived that

⁴²The Conners Rating Scale (CRS) was originated by C. Keith Conners (1969) and has become the most utilized method of trying to diagnose ADHD and other problem childhood behavior. This scale, originally intended to provide a basis for prescribing children stimulant medication, has gone through many revisions in its 30-plus year history. Currently, it follows *DSM IV* guidelines to try and tease out problem childhood behavior. In the long version of the forms (there are forms for teachers and parents, both of which are gender-specific), a white to red shading scheme reveals the possible presence of a *DSM IV* diagnosis. If the score falls within the red color, the clinician may be alerted to a possible disorder. There is also a Conners "Self Report" that children themselves fill out.

ADHD is a very real phenomenon, psychodynamic interpretations of the disorder--that is, those that discuss family or other environmental factors--are assumed to provide the basis for false positive or Type II errors in diagnosis. By relying on testing procedures, such as a Conners Scale, primacy is given to an organic, neurological perspective on ADHD.

The distinction between real ADHD and psychological troubles that only mimic the disorder is further articulated by a clinical psychologist, whose background is in child neuropsychology. In terms that reflect the continuing debate between psychodynamic and neurological discussions of ADHD, he states:

I typically do a full work up which includes diagnostic testing, but I also do a full neuropsych battery of tests including a Conners, and Achenbach, just to see how the kid operates. During this time I am looking to see if I can separate the neurological stuff from the psychological. (Clinical psychologist).

The discussion of ADHD that separates neurology from psychology and psychoanalysis is the same discussion that separates the child's environment from the organic conditions in his/her brain. In finding out "how the kid operates," this clinician lays claim to having a deeper understanding of the mechanics of a child's thought process. The perceived knowledge of this can be seen as crucial to removing indefinable psychological elements from the diagnostic process. Clinicians argue that both the organic condition of the brain and the broader social environment of the child can appear similar, yet declarations are ultimately made that separate one from the other. In providing the conclusive frame to the ADHD child these clinicians argue that it is essential that a specific neurological component be isolated in the diagnosis of the disorder, therefore rendering the child's behavior "out of his/her control."

Clinicians who report a regimented time for providing ADHD diagnoses

Another comparatively large segment of the clinician respondent group (6, or 30% of the total) described a fairly reliable routine in diagnosing ADHD. In many of these instances,

information was already provided to a clinician prior to seeing the suspected ADHD child, and aided in providing a diagnosis. Exemplifying this type of process in diagnosing ADHD, one pediatrician explained that diagnosing a case of ADHD may take: "One hour if it's straightforward... I'll look at a Conners if the child has already been given that test" (Pediatrician, male age 47). In the "straightforward" case of ADHD, the time to provide a diagnosis and prescribe a method of treatment is contained within the space of a doctor visit. The "straightforward" case of ADHD as depicted here, denotes the distinction between ADHD that is perceived to be blatant and clearly "hard-wired," and other psychological problems that may impede a clear and rapid diagnosis. Implied here once again is that a diagnostic emphasis should not become bogged down in psychological problems, and instead address the overdetermining cause of the ADHD symptoms.

It is important to note that clinicians who took a specific amount of time to diagnose a case of ADHD often had considerable information before seeing the suspected child. Prior to visiting a clinical psychologist, psychiatrist, or pediatrician, children, and parents, for example, had filled out questionnaires or had done Conners Scales in other locations, most often in school counselor offices, or at home. Much, if not all of the Conners Scale results were already provided to clinicians prior to a formal interview with a child. This demonstrates the role of non-clinical entities in applying the ADHD label. Clearly, one of the results of the Conners Scale was that it expanded the diagnostic abilities of non-clinical parties. Ideally, the scale provides a means to compiling data that could later be formally analyzed by a clinician. However, in its practical application, much of the analyses of the Conners Scale have already occurred prior to a clinical visit. In this sense, the Conners Scale is an integral tool of ADHD suspicion. This discussion will be expanded in Chapter seven when I examine the role of the school as a means to formal diagnoses of ADHD.

Clinicians who report that they are not diagnosing, just collecting information

Respondents also stated that their role was not always that of someone who provided ADHD diagnoses. These were clinicians who participated in every capacity in the treatment and management of ADHD, but did not consider themselves important in its diagnosis. Emphasizing the examination of behaviors only, they instead saw themselves as integral to the process of documenting family dynamics and the developmental history of the child. As one clinician stated:

I don't really see children for diagnostic processes. I mean my goal is not to do a diagnosis, that is usually done by a psychiatrist or pediatrician. I do an in-depth family and developmental history, trying to document problems the child may have had in the past. People usually come to me for a more thorough assessment of the child. We really look at the behavior and try to deal with only those behaviors (Clinical psychologist).

As this excerpt demonstrates, an emphasis on behavior can be understood to be more significant than an emphasis on the isolation of a neurological malfunction. Reflecting the rift between psychodynamic and neurological perspectives on the disorder, this clinician implies that the label of ADHD is not nearly as significant as the behaviors which a child exhibits. Hence, she discusses the necessity for "a more thorough assessment of the child" than a one hour clinical interview can produce. Clearly sympathetic to a psychodynamic, rather than neurological interpretation of ADHD symptoms, this excerpt demonstrates a holistic approach to a child's behavioral problems. In this sense, the acquisition of the clinical, neurological label of ADHD is regarded as irrelevant if that label fails to take into account the broader social psychological circumstances of the child.

Another practitioner, a physician emphasizing the synthesis of naturopathic and conventional medicines, provided a similar emphasis on behavior to the exclusion of a neurological label: "I don't really diagnose ADHD. I look specifically at what the child needs. You can label it whatever you want to, but the child needs something" (General Practitioner).

The clinical emphasis here is on the immediate needs of the child, rather than on the treatment demands mandated by a diagnostic label.

It is arguable that a psychodynamic stance may free a clinician to explore different treatment options for the child. There are at least two reasons for this: 1) the child's individual behaviors will be taken into account, including the unique circumstance of his/her family situation, thereby prompting specified forms of treatment; 2) the denial of the over-arching legitimacy of the neurological label of ADHD has potential to focus the treatment effort away from methods (i.e. the administration of stimulant medications such as Ritalin) most strongly associated with the label. There is also, I believe, an identity politics associated with clinicians separating themselves from the diagnostic process and consequently, the label of ADHD. To deny one's role as a "diagnostician" enables a different way of defining oneself in clinical practice. One becomes a professional especially suited to the needs of a child, rather than one fitting the child into a preordained box of symptoms.

Separating oneself from the status of "diagnostician" is also a rhetorical strategy. Distancing oneself from the conventional and neurologically-influenced methods of diagnosis, however, does not equally imply a separation from pathologizing childhood behavior. Through the process of a "thorough behavioral assessment", including profiling the child's behavior, school records and teacher accounts, clinicians who do not necessarily believe in ADHD are implicitly making a formal declaration that the child is abnormal. Clinicians who do not diagnose, yet aggressively pursue avenues of treatment for problem behaviors contribute very much to the labeling process, regardless of the nomenclature they use. This is one nexus point between psychodynamic and neurological perspectives towards ADHD: regardless of cause, hyperkinetic and/or inattentive problems reveal some type of abnormalcy.

Clinician Opinions on *DSM IV*

The American Psychiatric Association's *Diagnostic and Statistical Manual, 4th edition* is the primary text that describes ADHD, and stems from the neurological work done in the ADHD

field by researchers such as Barkley, Conners Eisenberg, and Wender. With regard to mental disorder, *DSM IV* represents the neurological establishment who view the ongoing research into mental disorder as a journey into physiology first and social circumstances, a distant second. Therefore, it can be surmised that the extent to which *DSM IV* was reportedly used by clinician respondents partially represents the degree to which neurological maxims were followed. All 20 of the clinician respondents had heard of *DSM IV*, most of whom had great familiarity. The question, *Do you use the diagnostic criteria provided by DSM IV? Why or why not?* was intended to solicit the degree of relevance the manual had for practitioners in diagnosing ADHD in children. As revealed in table 6-3, responses to this question had a considerable amount of variability, ranging from clinicians who used the *DSM IV* without question, to others who felt the *DSM IV* criteria were simply inadequate.

Table 6-3: Breakdown of Clinician Opinions on the Utility of *DSM IV*.

<u>Opinion on <i>DSM IV</i></u>	<u>Number</u>	<u>Percentage (%)</u>
Use <i>DSM IV</i> , but find it inadequate to entirely describe the ADHD condition	6	30
Unquestioning use of <i>DSM IV</i> .	5	25
Have doubts about the use of specific <i>DSM IV</i> nomenclature	4	20
Use <i>DSM IV</i> only out of diagnostic necessity	2	10
Do not use <i>DSM IV</i>	3	15
Total:	20	100

Clinicians who use DSM IV, but find it inadequate to entirely describe the ADHD condition

The slight majority of respondents (6, or 30% of the total) stated that they used *DSM IV*, but felt that it was inadequate in describing ADHD concisely and exclusively. Many of these clinicians were inclined to describe *DSM IV* as a general guide to ADHD behaviors, but that it

was not the final authority on the subject. When asked if she used the *DSM* in a suspected case of ADHD, one clinician responded:

Most definitely, when I do make a diagnosis, but I am more inclined to rely on something like a Conners Scale to see if the child has any problems with concentration or anything like that. The *DSM* is a guide, it doesn't account for all of the other variables that go into a diagnosis (Clinical psychologist).

DSM IV, it is repeatedly argued in such discussions, is not enough to account for the multiplicity of factors that go into a case of ADHD. More specifically, *DSM IV* may be so general that it fails to acknowledge that ADHD-like behaviors can arise from sources other than bona fide ADHD. Hence, clinicians may be inclined to rely on the specificity of a Conners Scale to sort out problems with attention or concentration, rather than *DSM IV*.

Another clinician also expressed concern with *DSM IV*, specifically the label of ADHD:

Oh yeah, without a doubt we use it, but we try to look for a lot more than just a diagnostic label. I mean we look at each case really individually because there may be a lot more going on than what the *DSM* can explain. With ADHD kids there usually is a lack of fine motor skills and the *DSM* doesn't talk at all about that stuff, so we look for things beyond the call of duty in that sense (Manager BC Children's Hospital ADHD Clinic).

Implied in this passage is that the *DSM IV* is inadequate in accounting for the unique individual profile of a child brought into a clinical setting.

Clinicians who have reservations about specific DSM IV nomenclature

Clinicians also expressed concerns about some of the specific language that *DSM IV* uses to describe ADHD. This is a more specific criticism of the manual, focusing on the words of *DSM IV* and how they do not always translate to a unified interpretation of behavior. This is especially relevant to whether or not that behavior is perceived as abnormal. As one 45-year-old

female psychologist explains, "I also think that ADHD is a loaded word. If a kid is unable to stay focused and on task, maybe there are some other reasons for this." ADHD, this clinician contends, may not always be the correct term to apply to problem behaviors, especially those that occur in a scholastic context. She continues: "A lot of times we might need to be focusing on the kid's learning process, rather than the problems he may have with attention or concentration," denoting that what *DSM IV* calls ADHD may just be a way of problematizing a different learning style. Addressing the large scope of ADHD symptoms, another clinician states, "I really think that ADHD is a garbage can diagnosis. I wouldn't be surprised if we see the diagnosis get changed within the next couple of years" (Family therapist).

Unquestioning use of DSM IV

In contrast to respondents who either had reservations about *DSM IV*'s ability to adequately describe ADHD, or questioned its specific language, some clinicians (5, or 25% of the total) expressed that *DSM IV* was an integral factor in providing a diagnosis of ADHD. Some had adopted the *DSM IV* criteria to questionnaires that were commonly filled out by their patients. As one pediatrician explained, "we give them a sheet with those (*DSM IV*'s) criteria to fill out in the waiting room. I let my secretary know what it may be and she gets it ready for them." Another physician explained that using the *DSM IV* was very important in keeping him focused in what he was treating. He stated: "The *DSM* gives me my box to work within. I use it to tell me the boundaries of the person's problem. If they fall too far outside that or don't fit into it at all, I may recommend a bigger psychiatric evaluation" (General Practitioner). In this case, the *DSM IV* is presented as a crucial tool of evaluation, providing the boundaries for further assessment.

Clinicians who do not use DSM IV

Some clinicians (3, or 15% of the total) also stated that they do not use the *DSM IV* in cases of suspected ADHD because the manual itself is not relevant to their clinical perspective on

the disorder. For one clinician, the *DSM IV* was not relevant because the emphasis in his treatment of children is on the collective types of behavior, rather than a specific diagnosis:

I don't (use *DSM IV*) because its not really relevant to me. When people are referred to me or hear about me through word of mouth, their kids are usually already diagnosed. Again, I just want to look at what the needs of that child are. And, it may very well be Ritalin, but I try to examine some other lines of treatment (General practitioner).

The above passage does not denote a complete rejection of the conventional methods for treating ADHD--Ritalin, for example, is not ruled out as an option--yet this clinician exercises a certain degree of unconventional freedom in interpreting the child's behavior. Similar to clinicians who did not cast themselves into the role as diagnostician, this clinician is presented with the choice to use Ritalin if necessary, or explore other options to meet "the needs of that child."

Another clinician, who was entirely skeptical of the ADHD diagnosis, found the *DSM IV* irrelevant, because it failed to describe a condition that was visible in contexts outside of school:

I look at the child's environment, the child's basic needs. If you think about what these needs are they revolve around home and school, because that is where they spend most of their time. These are the areas that need to be evaluated, not the child. ADHD is just plain BS. When a person has diabetes they have it everywhere they go. With ADHD, we are supposed to believe that these symptoms only exist when they are in school? Nonsense (Pediatrician).

Such skepticism stems from the very specific environments where we suspect that a child may have ADHD. As can be seen from *DSM IV* criteria described earlier, these symptoms often invoke scholastic difficulties, such as failing to stay in one's seat, and blurting out answers before one is called upon. If ADHD is a true disease, this clinician asks, why do we only suspect it in classrooms?

Discussion of treatment methods for ADHD

Though there are a few staple kinds of ADHD treatment, there was considerable variation in the types of treatment clinicians reportedly gave. Referring to table 6-4, the majority of clinicians reported using behavior modification therapy (8, or 40% of total), and behavior modification combined with medications (7 or 35% of total). Clinicians who solely used medications comprised 3 respondents, or 15% of the total. Two alternative perspectives towards treating ADHD were also represented, one by a clinician who subscribed to the use of herbs and nutrition, the other, a clinician who elucidated something he called the "bubble theory"⁴³.

It is important to offer a preliminary analysis of how such treatments are established by clinicians. Of primary importance is how the application of different treatments are contingent upon the professional divisions that characterize the clinician sample. These professional divisions are influential in the way clinicians' frame ADHD children and their choice of treatment methods.

One of the primary factors that affect how a clinician will treat ADHD concerns how a child's behavior is interpreted by the clinician. As a matter of course, this process of interpretation involves interaction between clinicians, parents and teachers. As information is shared amongst these social actors, certain treatment options become viewed as increasingly favorable. This type of interaction typifies the ADHD suspicion and diagnostic process in which consultation between these adult figures formulates a type of profile of the ADHD child. Consultations amongst adult authorities prior to the formal diagnosis and treatment of ADHD denotes that the framing of ADHD children is highly influential in how clinicians interpret their first-hand interactions with children, and how clinicians link what they observe in these initial interactions to signs of ADHD. A master frame of an ADHD child is constructed prior to the

⁴³In explaining his "bubble theory," one clinician--himself very skeptical about the existence of ADHD--explained that the way to treat a child with problem behaviors was through giving the child an awareness of the boundaries of "the bubble"--a euphemism for what are appropriate or inappropriate types of behavior. Within the bubble we had the realm of acceptable or "yes" behaviors and outside the bubble we had the realm of unacceptable or "no" behaviors. It was the responsibility of parents, this clinician argued, to help the child understand his/her bubble and to not "pop it."

initial visits to the clinic, and it is arguable that without this master framing there would be little consistency in the types of treatment ADHD children are given. As profiles of an ADHD child are developed, both through interactions with such children and through discussions amongst adults, they become the foundation for a choice in treatment measures.

The celerity with which the master frame of an ADHD child is put forth strongly reflects which ADHD narrative (neurological, psychodynamic, or both) a particular clinician follows. When the ADHD child is framed comparatively fast--denoted by brief consultations with parents and teachers, and by brief interactions with children in clinical settings, usually half an hour to an hour in length--the treatment is predominantly pharmacological. Furthermore, clinicians who performed relatively quick assessments of children were inclined to adopt a neurological perspective towards ADHD and also, towards the children they diagnosed with the disorder. Resonating well with the neurological perspectives articulated in chapter three, such clinicians viewed ADHD as a biochemical phenomenon, solved through medicinal means. In contrast, clinicians who took longer in applying a master frame to an ADHD child, or who never really subscribed to a consistent frame for such children, were more inclined to adopt a psychodynamic approach to the ADHD. The treatment methods such clinicians applied commonly involved behavioral modification, psychotherapy, or related therapeutic means. Clearly resonating with psychodynamic approaches to ADHD, such clinicians were inclined to look at the learned nature of behavior and how the cultivation of metacognition and general self-awareness were integral to its treatment. Such clinicians were also more inclined to implicate family dynamics as a causal factor in the ADHD phenomenon and also wanted to include family members in the therapy process. The range of treatment methods of ADHD appears to fall along professional lines. Those who seemed the most inclined to perform comparatively rapid ADHD assessments, and use pharmacological treatments, included pediatricians and general practitioners; whereas those who were more inclined to engage in longer assessments and use non-medicinal methods as primary solutions for ADHD included family therapists, clinical psychologists, and psychiatrists. Medical doctors seemed the least inclined to adopt a psychodynamic approach to ADHD, except

for those who were distinctly influenced by a psychodynamic perspective. Even those clinicians who subscribed to behavioral modification and family therapy did not always deny the usefulness of medications. Many claimed that both approaches were significant in treating ADHD, and that either method used in isolation would be less advantageous than if used in combination with each other.

Table 6-4: Breakdown of Clinicians' Treatment Methods for ADHD.

Treatment Method	Number	Percentage (%)
Behavior modification	8	40
Behavior modification combined with medication	7	35
Medication almost exclusively	3	15
Herbs and nutrition, or naturopathic medicine	1	5
"Bubble Theory" approach	1	5
Total:	20	100

Behavior modification

In being dominantly reported as the primary method of ADHD treatment, the subscription to behavior modification techniques revealed a hesitation on behalf of clinicians to embrace neurological maxims about ADHD. The belief in the effectiveness of behavioral modification demonstrated that many clinicians sought the remedy for ADHD-type behaviors outside of the physiological state of the misbehaving child. Family units, for example, were routinely described as integral to the process of ADHD treatment. It was expressed that behavioral modification needed to find its origins with the education of the parents, who needed to have a complete understanding of their child's condition in order for behavioral modification techniques to be effective. As one clinician stated: "We primarily try to educate parents and let them know a lot about their child's condition. ...We get parents into support groups, or we let them know where they are" (Manager at a Children's Hospital ADHD Program). This fits with the analysis of parental guidebook literature in Chapter 4, in which parents are considered to be the primary

reinforcing agents of their child's behavior. Without cultivating their own knowledge base about ADHD, it is perceived that the child's treatment will be useless. Another respondent put it this way: "Parents are usually very irritated and frustrated. Their kid is in all this trouble. I try to teach parents to remember that this is a neurological thing. Then we go over some techniques to help parents respond to their child, not react to what that child does" (Psychologist). It is important in this regard for parents to understand that their child's difficulties originate with a neurological difficulty and that having a clear understanding of this will aid in not reacting in a provocative way towards their child.

Clinicians also stated that parents need to develop regulatory mechanisms for how they will react to their children. In addition to learning a perspective that their child is disabled and/or neurologically-impaired, parents are also taught a certain degree of self-talk to keep them away from a provocative stance towards their children's behavior. As one respondent stated:

Working with parents on dealing with their child at home is probably the first thing we work on. ...I also try to teach parents coping statements like "I can remain calm." A lot of times parents blow up at their kids and with an ADDer that is not what you want to do. Things can really escalate (Clinical Psychologist).

Such a statement coincides with the Chapter 4 discussion of ADHD children as displaying a certain degree of volatility. Parents are taught to handle such children with care. The "ADDER" is clearly not a normal child in this sense. His/her volatility needs to be diluted through a carefully constructed interactive context whose boundaries are defined by the clinic and enforced in the domestic environment. One psychologist, for example, told me the story of an 8-year-old ADHD child who was consistently late for school--his lateness being just one of his many ADHD symptoms. During a therapy session this child's mother was instructed by the psychologist to specify a time that the child was expected to be at the car and ready for school, "not *running* to the car at this time, but *at* the car at this time," the psychologist explained. The instructions were that if the child was not at the car at the specified time, the mother would drive off and leave him.

The child's mother had an extremely difficult time with the enforcement of this rule, always fudging the time she allowed her son to get to the car. As the psychologist stated: "the lateness problem did not go away." Finally, the day came when the mother drove off and left her son at home. This alteration in the mother's behavior was considered a behavior modification breakthrough by the psychologist: "He was rarely, if ever, late again," he stated.

This story is of sociological interest because it conveys the resistance to the established role structure of a household. Parents, in their role as nurturers of children, are believed to be able to exercise degrees of flexibility, perhaps bending disciplinary rules for their children under certain circumstances. However, within the particular case of "the ADHD child," these forgiving compulsions need to be quashed. These moments of forgiveness, in which the time to get to the car, for example, is fudged by a few minutes, are given a new meaning: they are damaging to the future of their ADHD child. For parents this position is expectedly troubling, and we would have to wonder what degrees of rigidity would be effective.

Elected treatments by many clinicians placed behavior modification as the top priority in treating a case of ADHD. Argued by many respondents as a necessary step before the use of medication, behavior modification was repeatedly presented as a method for getting at the root of behavioral issues:

Behavioral modification is the main thing I use. I like to see if they can get the kids off the meds before we start all of it. Then we can really know what some of the issues are, you know, behaviorally. I also counsel parents a lot, because when the kids are acting up there is usually something going on in the family. Marital issues are another big concern when I make assessments. (Clinical psychologist).

The perception is that medication, in that it alters behavior, also obscures the environmental causes of these behaviors. Despite the prevalence of apparent neurological defect, many clinicians argued that ADHD has components which are rooted in other social environments. "Marital issues" are one excellent example of this. It is argued that a child struggling with

difficulties in the home and then being prescribed medication for these problems has not adequately "dealt" with these issues. The cathartic emotional moments of the child have been removed or strongly covered up by a medication. This treatment issue must be addressed before effective behavioral alteration can occur.

Combining behavior modification and medication

The perceived masking of behaviors by the use of medication also represents professional differences between psychologists (clinical and family therapists), who are more prone to use behavior modification, and those with medical doctorates (GP's, Psychiatrists, and Pediatricians), who are more inclined to prescribe medication for ADHD. Often, when treatments combine behavior modification and medication, referrals are made to parties who are understood to be best suited for supervising one of those aspects of ADHD treatment. Such referrals reflect professional relationships in which multiple possibilities for treating ADHD are explored. The combination of treatment methods--for example, behavior modification coupled with medication--demonstrates a compromise between neurological and psychodynamics stances towards ADHD. As one pediatrician explained:

I turn my focus to behavior and medication. As far as the behavior goes I will give referrals to family therapists or child psychiatrists who I feel are good at creating good behavior modification programs. But, medication and behavior mod have to work together. I really watch kids close on the medication end of things.

Clearly, there is a delineation of types of expertise in these instances. In the role of pediatrician, this respondent does not feel qualified to supervise an all-encompassing behavior modification program for an ADHD child. Hence, in cases in which the treatment combines both medication and behavioral therapy, it is common for ADHD child and their parents to consult at least two practitioners.

On the behavioral end of the combined approach to treating ADHD, many clinicians stated that it was important for ADHD children to learn coping skills and cues to help modify behavior. As will be demonstrated in chapter seven, some teachers felt that one of the characteristics that separate ADHD from others is that they fail to pick up on the social cues necessary for socially appropriate types of behavior. Hence, on the clinical end of things, these types of skills are integral. In describing his methods for treating ADHD, one clinician stated: "...usually coping skill development, and a lot of behavioral cueing" (clinical psychologist). Coping skills here refers to methods that enable the ADHD child to deal with the invariable frustrations that he/she will be expected to confront in dealing with the non-ADHD world.

In addition to addressing issues the ADHD child will face in everyday life, behavioral modification was also explained as a means to rectify the psychological problems specifically caused by medication. Behavior modification, in this sense, addresses both the condition of ADHD, and also one of the ADHD treatments. The previous respondent continued: "If medication is prescribed by their doctor we will spend some time evaluating how the child is doing. Sometimes there can be some psychological problems associated with the medication and that needs to be dealt with immediately before anything else can really be effective." The effect of medication, if not carefully evaluated, can be seen as a hindrance rather than a benefit to the behavior modification process. This reflects the sentiment of Lawrence Diller (1998), who argued that medication was a kind of necessary evil that could calm the child down enough to receive the fruits of psychotherapy.

Medication therapy

The minority of clinicians interviewed were inclined to favor medication as the sole method of treatment for ADHD. Such responses show a clear connection to neurological positions on the disorder. In one instance, this type of treatment was seen as necessary in "real" cases of ADHD:

If I am convinced a child has ADHD--real ADHD--I will recommend medical management of the disorder. With all the neuropsych stuff I've done I'm a little cautious about providing a positive diagnosis of ADHD. Most of the kids I see have a myriad of problems--I'm not really convinced that ADHD is a valid symptom category unto itself. It is not usually neurological, and so I try to stay away from meds unless I know it's neurological. (Clinical psychologist).

This response again speaks to the issue of what constitutes ADHD. From this clinician's perspective medication is only appropriate for a legitimate neurological condition--a condition he questions as a "valid symptom category." The appropriateness of medication in cases in which only behavior and not the neurological condition are addressed remains a bone of contention. Should practitioners only be required to administer medication if the ADHD condition can be proven to be neurological? If so, what does this mean for the cases of ADHD which are, as a previous respondent put it, "secondary" to some other kind of problem? Furthermore, if ADHD can be traceable to sources outside of the child's brain, and can therefore be deemed non-neurological, should clinicians not endeavor a larger examination of these sources?

Two clinicians who were highly favorable to medication therapy for ADHD stated that problem behaviors really needed to be addressed by medications and that behavior modification therapy was ineffective in the long run. Comparing the effectiveness of medication to other therapies one physician stated: "The recent MTA study clearly demonstrates that these work the best even when you have someone doing both behavior modification and all of the other kinds of therapies (General Practitioner). This respondent is referring to a 1996 collaborative multi-modal treatment assessment (MTA) study prompted in the United States by the National Institute of Mental Health. The 14-month long study, measured the responses of 579 ADHD children, ages 7-9, to various treatments methods, including behavior modification, combined treatment, and medication treatment (see Arnold et al 1997, Richters et al 1997, and Greenhill et al 1996 for discussions of this study.). What was concluded from the results of this study are that medication

does more to sway ADHD behaviors than any other approach to treating the disorder. The findings of this study have done much to bolster the efforts of those who purport that ADHD is a truly neurological condition.

The results of the MTA study represent a continuation of the way the diagnosis of ADHD has been validated in the research community. Through arguing that medication is the most effective treatment for ADHD, a neurological etiology of the disorder can be levied. In the tradition of pro-stimulant studies by Bradley (1937) and Conners and Eisenberg (1963) the MTA study further solidifies a modality which argues that the nature of the ADHD ailment can be understood through the child's response to medication--an act of reverse engineering that states the treatment defines the ailment it is treating. To be fair, it seems probable that Ritalin and other stimulants would do the most to alter behavior, but would this not also be the case with children who do not demonstrate ADHD symptoms?⁴⁴

Clinicians' Perceived Acceptance of their Treatment Methods

After disclosing information about the types of treatment they employ, clinicians were asked: *Do you see this line of treatment as accepted within your profession?* Clinicians' response to this question demonstrated the extent to which they saw their methods as fitting with one and/or another established school of thought towards ADHD treatment. As can be seen from Table 6-5, most respondents (12, or 60% of the total) felt their methods for treating ADHD were accepted within their profession. Common responses in this regard included, "Yes, its accepted," "Yes, definitely," and so on. Some practitioners who felt that what they did was accepted, also acknowledged that other clinicians treated ADHD in various ways. Hence one clinician stated: "Right now, there seems to be a lot of different approaches, but most of what I do is also done by

⁴⁴I am reminded of recreational Ritalin users who use this stimulant in the same capacity they would marijuana or methamphetamine. The recreational user of Ritalin certainly uses the drug for effect--an effect that would clearly be demonstrable through changes in behavior. The case of the recreational user of Ritalin is grounds for arguing that Ritalin is not only effective in children with ADHD. That being said, it could also be retorted that recreational users of Ritalin are really ADHD to some capacity and are using Ritalin and other drugs, as a way of "self-medicating."

other folks." Such responses, though brief, reveal that many of the respondents saw a degree of unity in their profession and also in the accepted ways that ADHD could be treated.

Table 6-5: Perceived Conventinality of Treatment Measures by Clinicians

<u>Perceived acceptance of treatment method</u>	<u>Number</u>	<u>Percentage (%)</u>
Yes, this method of treatment is accepted	12	60
The method is accepted, but tentatively and/or with certain conditions	5	25
No, this method of treatment is not accepted	3	15
Total:	20	100

Perception that treatment methods have a tentative or conditional acceptance

The perception of clinicians' methods of treatment as being accepted was not always in a solid "yes" category. Some clinicians (5, or 25% of the total) felt that their methods were accepted, but not unequivocally. One respondent, a liberal advocate of medication, stated:

Yeah, I think so. People would say I'm a little liberal, but with a cut in services, it becomes hard for parents to cope. The school copes by kicking the kids out, but parents don't really have any way to cope. It's really rewarding when parents come to me in tears saying they've just had their kid invited to a birthday party for the first time in three years (Pediatrician).

His advocacy of medication is justified by a reduction in publicly funded services for parents and by the favorable response parents give when their child acquires some degree of social acceptance. In describing the school's methods of coping with the behaviors by "kicking the kids out," this passage reveals a social role in which the physician is integral in getting the child back in school and functioning with a degree of social normalcy. Clinicians who placed themselves in this role distinguished between a child who was "in crisis" and a child whose situation was less

desperate. In the latter case, more information could be gathered and more time taken to seek the right treatment option. In the case of the former, a rapid pharmacological intervention was warranted. In immediately addressing the "crisis child," Ritalin, the above passage implies, reunites the child with the crucial institution of education and may also have the added benefit of putting the child back into the social graces of others. This passage demonstrates that practitioners can perceive themselves slightly askew from their counterparts even when using a treatment method--medication in this instance--that is statistically demonstrated to be the most common. They can become apologists for employing what has become a conventional method for treating ADHD. This speaks to the popular belief that we spend too much time "doping up our kids" rather than finding out the true nature of their problems. In defiance of this cultural sentiment, clinicians argue that an immediate crisis needs to be resolved, and what better and more humane treatment than medication?

Another clinician expressed that the methods she employs are accepted, but not to the extent that they should be:

Do you see this line of treatment as accepted within your profession?

I think not as much as it should be. I'm able to take a lot more time when people can afford it. This is a private clinic and it can be very expensive.

When people can't afford private assessments and care they seem to go right for the pills and that's it, end of story (Psychiatrist).

Coming from a psychiatrist in private practice, this response shows a possible rift between the types of ADHD treatments funded by private and public sources. In a private setting, this passage implies, children receive a greater quality of care. For example, the psychodynamic causes of the child's condition, in addition to possible neurological impairment, can be assessed more adequately. The time spent with the child is a commodity that certain parents can afford, others cannot. Such a response reflects an aversion to what some feel to be the consistent channeling of children towards medication therapy--a method that is argued to be far less expensive and hence, more widely used (Walker 1998).

Clinicians who state that their methods of treatment are not accepted

Three clinicians (15% of total) stated that they felt that their methods were not accepted in the greater practitioner community. One physician, specializing in naturopathic medicine had this to say: *Do you see this line of treatment as accepted within your profession?* "No, not at all. Definitely not accepted. I don't want to proselytize my approach, though. I try to keep a real low profile. All of my patients come from word of mouth. ...The demand for this kind of approach to behavior problems keeps increasing (General Practitioner). Another physician, who emphasizes an entirely non-medication approach to ADHD stated: "Unfortunately, no. The common response is a bottle of pills, and that is unfortunate for everyone involved, especially the child" (Pediatrician).

Reservations about medication

Despite the fact that medication is the most common treatment for ADHD in North America, there was a considerable amount of reservation about the use of medication by clinician respondents. These reservations demonstrate skepticism about the neurological perspective towards ADHD, specifically, that the physiological nature of ADHD mandates pharmacological intervention. Out of the 20 respondents who were asked, *Could you describe any reservations you have about the use of Methylphenidate by ADHD children?* eighteen or 90% of the total expressed concern about prescribing Ritalin and other stimulants to children. Most of these responses conveyed that Ritalin was overprescribed and that the ADHD diagnosis was given too freely. Other concerns included, chemical dependency later in life, removal of an internal locus of control, side effects, and not knowing the child well enough before prescribing the medication. A distinct minority of the respondents (2, or 15% of the total) expressed no reservations about prescribing stimulant medication. See table 6-6 for a summary of these responses.

Table 6-6: Breakdown of Clinicians' Reservations about Prescribing Medication for ADHD.

Type of reservation	Number	Percentage (%)
Stimulant medications are overprescribed	11	55
Physical side effects of the medication	2	10
Medication removes internal locus of control	2	10
Chemical dependency in later life	2	10
No reservations	2	10
Must know child before considering medication	1	5
Total:	20	100

Stimulant medications are overprescribed/the ADHD diagnosis is inadequate

The majority of reservations clinicians expressed about the use of stimulant medication concerned two factors that are inextricably linked.

First, the diagnosis of ADHD was perceived by many clinicians to have some gaps in its validity. Part of this validity problem concerns the *DSM IV* criteria mentioned previously: the language of *DSM IV* is too ambiguous, the diagnosis fails to address more specific problems with an individual child, ADHD is really a residual or "garbage can" diagnosis, and so on. Such validity issues are something that have plagued the diagnosis of ADHD for over a century, and largely contribute to the contested nature of the disorder. To date, there is no physiological test that proves the existence of ADHD. PET scans, though considered a breakthrough in analyzing how portions of the brain function, have not conclusively located the physiological mechanism of ADHD. Because the diagnosis cannot be conclusively validated, many clinicians argue that ADHD is diagnosed too frequently and with inadequate information. As one clinician stated: "...the diagnosis is given way to freely. That means more kids on meds who are not supposed to be on them or are too young for them. So, I think that if you're going to give meds, you should make sure you at least have the right diagnosis (Clinical psychologist). And another respondent:

I think ADHD is not a great diagnosis. It's an easy out for schools. They're under a lot of pressure and they respond by trying to whip kids into shape. What about class size? What about more effective teaching strategies? I also think ADHD is a parenting issue a lot of times. Ritalin is the pacifier for kids, like TV and Nintendo (Family therapist).

These excerpts bring us to the second concern many clinicians have with prescribing medication to ADHD-suspected children. If the diagnosis itself is questionable and given too freely, then so are its conventional treatments. Since the time Ritalin became widely administered, the confirmation of a diagnosis of ADHD has been linked to the effects rendered by the medication. Given that the validity of ADHD is largely questioned by clinicians in this sample, it follows that they would also have concern with medication. If the diagnosis is given too liberally, then this places into question the appropriateness of stimulant medication. Simply stated, many of the clinicians I interviewed claimed some children may be on the medication who do not need it.

Some clinicians viewed prescriptions for Ritalin, Dexedrine and other drugs as a means to skirt fundamental issues underlying childhood behavioral problems: "It (medication) can be seen as a quick fix. Some people will go to a GP or a pediatrician and get a quick and dirty diagnosis and a packet of pills, which is malpractice in my opinion. A pediatrician can easily just become a medication consultant, rather than someone who is really treating a real problem" (Psychiatrist). Some ADHD practitioners may feel others are too focused on the immediate behavior of the child they are treating. Rather than examining the greater social environment of that child, such clinicians may relegate themselves to the role of "medication consultants." Relieving the situation of the "crisis child," some clinicians argued, is really to relinquish the responsibility to probe deeper into the child's circumstances. Relating such responses to the genealogical section of the thesis, some clinicians argued that a strictly neurological perspective on a child discounts the influential variables addressed by psychodynamic perspectives.

The appropriateness of the medication was also addressed by one respondent, who felt that the supposed effects of the medication were akin to mythology:

Well, the drug is simply inappropriate. It is a lie to think that any drug will make you smarter or better able to perform in school. If there was a drug to make you smarter I'd be taking it. But there isn't. Ritalin is a way of addressing the society's needs, but not the child's. With this little child's brain he needs blue and we give him red. Our society is not geared to children; it hates children, it sees them as a necessary nuisance. (points to sign on the wall that reads: "CHILDREN ARE NOT ADULTS.") That is why I have this up on the wall, to remind people that children are different (Pediatrician).

From this physician's perspective, Ritalin is a way to pacify the annoying behavior of children, rather than address the larger societal issues that make us so intolerant of them. His sign on the wall: CHILDREN ARE NOT ADULTS was placed there as a reminder that children behave differently than adults because they are not adults. Ritalin, from this perspective, is a way to make children more somber, more adult-like. This respondent, a native of France, conveyed that the intolerance of childhood behavior was uniquely North American. It was not until he moved over from France that he saw apartment complexes where children were not allowed, or public displays of dislike for children's behavior. His account, while anecdotal, is not without merit. For example, 96% of the world's Ritalin is consumed in the United States and Canada and, as mentioned in Chapter three, the European mental health community is more inclined to adopt the World Health Organization's standards for hyperactivity than those outlined by the American Psychiatric Association.

Concerns about side effects

Clinicians also expressed concern over the negative physiological effects of stimulant medication. Such responses described situations similar to the examples of Benzedrine,

Dexedrine, and Ritalin induced psychoses mentioned in chapter three. One clinician mentioned her concerns and provided an example:

I get really worried about side-effects. It hasn't come up in a while, but some kids do not belong on meds. Some kids I've seen have developed other conditions. One kid became unusually paranoid. He had some major unrealistic fears about other kids, about his siblings. We had to petition his parents and the doctor to get him off the drugs. The funny thing is his teachers felt like everything was fine. I tell you, he was not fine (Clinical Psychologist).

Another respondent provided this account: "A lot of the kids I've seen on meds are a lot more somber, not as happy. When the meds wear off, the kids can become over-emotional, freak out, or get insomnia. You have to wonder how good the drug is working if that's what happens to the kids" (Clinical Psychologist).

Concerns that the medication removes internal locus of control

Amongst the reasons clinicians had reason to question the use of Ritalin, was its impact on the social psychological relations of the child who was taking the medication. Some clinicians explained that ADHD children's "nicely behaved" identity, as understood by both themselves and by the adult authorities in their lives, was dependent on the continued use of medication. The "locus of control" of the child, as one respondent put it, is placed upon an outside, chemical medium, rather than on the development of the child's own social and academic skills: "And then there's the issue of parental responsibility. Mothers will often say: 'He's acting like that because he didn't take his medication today.' There's no internal locus of control. It's all about the meds" (Clinical Psychologist).

One respondent also conveyed that he wished there would be a re-evaluation of the child's response to stimulants in order to examine to what extent the improved behavior remains after ceasing medication:

One thing that is concerning me more and more is the dependency upon the medication for continued good behavior. I sometimes see children whom I feel should stop taking the medication or should attempt it anyway, and they sort of refuse that. Its like the child cannot be a good boy unless the medication is around. ...There needs to be more independence from the effects the drug has upon behavior, allow people to kind of stand on their own and see how they do without it (Pediatrician).

Parents and other authority figures, this response illustrates, are resistant to the idea of ceasing medication because it is believed to be the primary linchpin between the child and appropriate conduct. It would be a misinterpretation, I believe, to state that parents want to keep their children on medication for disciplinary/behavioral reasons. More often than not, it is the child's welfare that is the primary concern for such authority figures. For example, a theme that will be examined in the following chapters concerns the proposed relationship between child self-esteem and the taking of behavior-controlling medication. In many instances, the use of medication--something some parents referred to as a "God send"--is the key for a child to attain social and academic success, and such successes it is argued, cultivate a favorable self-concept.

A relationship between medication, behavior and identity is strongly implied with the issue of internal versus external loci of control. It is argued that an alteration in behavior through a stimulant medication will often improve the reaction of others towards children. This, consequently, will relieve the anxiety of the child and the adults surrounding him/her that has been brought about by repeated failures in social contexts. The people surrounding the ADHD child become accustomed to the social successes brought about by the medication and are disinclined to give up this source of success.

This issue mirrors those that were mentioned in Peter Kramer's *Listening to Prozac* (1993). In the first chapter, "Makeover," Kramer describes the case of a female patient suffering from depression who becomes transformed through a new drug called Prozac. Through its use, she experiences rapid and remarkable social and work-related improvements. She becomes

admittedly dependent upon the drug for her new identity, dubbing herself "Ms. Prozac" (p. 12). When the marked improvement in her life becomes grounds for her to be taken off the drug, the patient states that she did not "feel like herself." As Kramer describes: "This is not a question of addiction or hedonism, at least not in the ordinary sense of those words, but of having located a self that feels true, normal, and whole, and of understanding medication to be an occasionally necessary adjunct to the maintenance of that self" (p. 20). Kramer eventually places her back on Prozac, rhetorically asking the reader: "Who was I to withhold from her the bounties of science?" (p. 10).

Kramer expresses concerns about if clinical depression truly returns when many of his patients are taken off Prozac, and ponders whether or not dependencies on this drug are more for personality enhancements than for medical issues. He ultimately concedes to the benefits of Prozac, giving in to the new era of what he calls "cosmetic psychopharmacology" (p. 15). Within this new realm of psychiatric practice clinicians are presented with the dilemma of prescribing medications not just for specified mental affectations, but for flaws in character, or simply to improve one's performance in certain social contexts. ADHD is very similar in this regard. Clinicians who have concerns about patients' dependency upon Ritalin for continued good behavior, yet continue to prescribe the drug, are caught up in the same dilemma as Kramer. The rectification of behavior, the relief of immediate crises, take precedence over addressing the way the ADHD child's self concept is imbricated with stimulant medication.

Concerns over chemical dependency in later life

Amongst other concerns clinicians expressed about stimulant use was the possibility that a prescription for Ritalin will lead to drug abuse later in the child's life. As one clinician stated: "I am really afraid of issues of chemical dependency. I don't think that Ritalin is that much different from something like meth, and if you're taking that drug everyday, it seems like it will lead to some severe problems" (Psychoeducational Assessor). Another respondent contended that the use of Ritalin could be dangerous in a family that may already have a tendency towards drug abuse:

"It seems like a lot of the kids I see already have a familial propensity for drug abuse and Ritalin may make that worse" (Child Psychologist).

The concern over Ritalin being a precursor to illicit substance abuse later in life is very similar to the issues of Ritalin and the locus of control in the ADHD child. We may ask whether or not the dependency on Ritalin for improved behavior motivates the child taking the drug to be more inclined to view other drugs positively, but how warranted this inquiry would be remains to be seen. A 1999 University of California at Berkeley study argued that childhood use of Ritalin increases the possibility of using other substances, such as cigarettes, alcohol and cocaine. However, this study was later refuted by a Massachusetts General Hospital study that concluded providing Ritalin to ADHD kids actually prevented later drug abuse (Chase 1999). Despite the lack of consensus on whether Ritalin is a factor in later drug abuse, or is itself an abuse hazard, some authors have taken the opportunity to frame Ritalin unfavorably.

In a recent *Christian Science Monitor* article, Alexandra Marks (1999) argues that Ritalin abuse is an increasing concern in North America: "In public schools and private universities across North America, Ritalin is increasingly the drug of choice for thousands of young people, from 10-year-old grade-schoolers dabbling with a first illicit high to graduate students in need of an all night push to finish a term paper" (p. 1). In addition, an article in *the Chronicle of Higher Education* states that Ritalin, in conjunction with other drugs, such as heroin and alcohol has become a legitimate health hazard for college students (Nicklin 2000). The underlying argument with such articles is that Ritalin is a "gateway drug" whose use in grammar and high school eventually opens the door to full-fledged drug abuse.

Clinicians with no reservations about prescribing stimulant medication

Two clinicians expressed that they had no major misgivings about administering Ritalin. If the medication was acting favorably and reducing or eliminating problem behaviors and the child seemed to be suffering no visible side effects, there was no reason to think that the drug might be damaging. Such responses also represented the neurological perspective in an

unadulterated form. As one pediatrician stated when asked if he had reservations about prescribing the medication:

Not really, if it's prescribed appropriately and well-monitored. The safety profile of the drug looks pretty good. I do think it's important to do a lot of follow ups when the child is taking medication. I try to see them once a week for 3 to 4 weeks to see exactly how the medication is working and so we can get the dosage correct. After that we do a check up once a year or as needed.

And a General Practitioner:

None really. As long as the child is adjusting well to the medication and the behavior is improving, I see no reason for alarm. Ritalin is one of the most studied drugs known to mankind. Some people think that Ritalin is poison or a quick fix. I've never seen any long term problems with using the drug.

Such respondents viewed the drug as safe as long as they were in close proximity to the ADHD child at the onset of taking the medication. Exemplifying the role of "medication consultant" so harshly criticized by a previous respondent, these responses demonstrate that such a role can be perceived as appropriate for treating ADHD. This line of reasoning fits very well with the positions of Eisenberg and Wender as discussed in chapter 3: ADHD is an organic, neurological condition, treatable through medications that set in order the neurological impairment. The role of the clinician in this capacity is very specific: monitor the progress of the medication and see if it continues to rectify the ADHD symptoms. If symptoms are no longer visible or obstructing the child's quality of life, then the drug treatment is effective.

Addressing the issues of the duration of medication treatment

Furthering the inquiry into medication, it was important to address the length of time practitioners felt was necessary for ADHD children to take the medication. In asking, *Based on*

your experience, how long should a person with ADHD take medication? , question #8 was a way of finding out how permanent some clinicians felt ADHD was and whether or not they felt that medication could eventually be ceased. As can be seen in table 6-7, the majority of respondents (13, or 65% of the total) effectively stated that the length of time a child should take the medication was totally dependent upon the severity and complexity of the particular ADHD condition. Four, or 20% of the respondents felt that due to ADHD being a neurological defect, medication would be warranted for the entire life of the child. Other responses concerning the duration of medication treatment included "until the child learns the appropriate skills" (1 respondent), "as long as necessary" (1 respondent), and one respondent claimed not to know.

Table 6-7: Length of Time Clinicians Feel a Child Should Take Medication for ADHD.

<u>Length of time on medication</u>	<u>Number</u>	<u>Percentage (%)</u>
Depends on the severity of the ADHD condition	13	65
Forever: it is impossible to function without the medication	4	20
Until they learn the skills to help them function normally without medication	1	5
As long as necessary	1	5
Do not know	1	5
Total:	20	100

Medication duration depends on severity and complexity of ADHD condition.

Closely related to issues concerning diagnosis time and method, this type of response once again speaks to the tremendous variability in cases of ADHD. These factors include not only the specific condition in the ADHD child's mind, but also the influential people around that child. As one respondent put it: "That just depends a lot on the situation of the child, how their family is coping, how therapy is working, all kinds of different factors" (Pediatrician). The

severity of the ADHD condition is not viewed as an entirely physiological problem, hence the length of time that medication may be necessary is largely dependent upon the management strategies of the entire social network of the child. This also includes the way influential people in the ADHD child's life manage his/her environment to minimize opportunities for behavior that is deemed socially-inappropriate. As another clinician said: "It depends on the severity and the behavioral opportunities the kids have to act out" (Clinical Psychologist). And another clinician: "It depends on the child and on the environment" (Child Psychologist).

In discussing terms of "severity" or "complexity" with a case of ADHD, clinicians are not only referring to the problems that are exclusive to these children. They are equally addressing the people who surround ADHD children and the roles they play in aiding in the management of the disorder. ADHD, in this sense, is framed as a social-psychological phenomenon, that may be partially neurological in nature. However, the efficacy of treatments for this condition does not always stem from neurological, brain chemistry types of sources. Medication certainly affects brain chemistry and alters the behaviors of ADHD children, but the more subtle aspects of the treatment--perhaps the most significant ones in the long run--depend upon sources of social support.

This perspective on the severity of ADHD treatment flies in the face of strictly neurological perspectives on the disorder that currently dominate the ADHD etiological discussion. The emphasis within this sample upon a social and physiological combined etiology of ADHD demonstrates the rift between practitioner and researcher. In the isolated situations of research it may be easier to focus on specific neuropathways and regions of the brain, but in the clinical world this perspective is not as easily attained.

Clinicians who state that it is impossible for ADHD children to function without medication

A significant number of respondents felt that ADHD was a disorder that necessitated a lifelong commitment to medication. Such responses reflect the dominant neurological discussion of the disorder, and demonstrate a recurrent theme in this analysis that distinguishes between

"real" and "non-real" types of ADHD. One respondent stated: "I think the rest of someone's lifetime will be associated with a medication of some kind if they have a real case of ADHD. The meds don't correct the problems, they simply alter behaviors so that people can function normally" (General Practitioner). And another respondent:

Again, if its a truly neurological case, then I can't see that person ever functioning normally without some kind of medical intervention. If someone has taken Ritalin for a long time and they still are having problems with memory and focusing on tasks, they may need to take it for a lifetime (Clinical Psychologist).

Such statements contend that a "real" case of ADHD is somatic in nature. It is a bodily disease that requires lifelong medical management. Much like the case of diabetes, in which person's have a malfunctioning pancreas, ADHD is a structural problem. Because of this underlying physiological defect, the real case of ADHD cannot simply be addressed at the level of behavior. From this perspective, to address only problem behavior falls back into the trap both psychologists and psychoanalysts were snagged in prior to neurological theories about ADHD. The people surrounding a case of ADHD should be obligated to assist the ADHD child, help increase self-awareness, social sensitivities, etc., but this should not be regarded as a significant treatment option. The obligation to provide emotional support for ADHD children is rooted in human decency--the way any sensitive person should care for a sick loved one--rather than a treatment necessity.

Clinician perspectives on the temporary cessation of medication

As with other mood altering medications, such as Selective Serotonin Re-uptake Inhibitors (SSRI's), anti-psychotics, anti-depressants, and so on, stimulant medications have a tremendous variability in how they are prescribed. This includes constraints about what times these drugs are taken, in what dosages, who dispenses the medication, and so forth. Because of ADHD's institutional specificity it was important to inquire how the use of medication coincided

with the demands of school, home life, etc. Of particular interest here were the conditions under which clinicians felt that ADHD children could temporarily cease taking medication, what one respondent referred to as a "medication holiday." Hence, question #9 asked: *Are there periods of time in which medication should be ceased?* As shown in table 6-8, a marked majority of respondents (15 or 75% of the total) effectively stated that a break from the medication is always recommended. Four respondents (20% of the total) stated that medication should be ceased whenever there is a build up of tolerance to the drugs, and one respondent stated that the issue was moot because medication was inappropriate in the first place.

Table 6-8: Perspectives on the Temporary Cessation of Medication

<u>Opinions on temporary cessation from medication</u>	<u>Number</u>	<u>Percentage (%)</u>
A temporary cessation of the medication is always recommended	15	75
Cessation should occur whenever there is considerable tolerance built up to the medication	4	20
3) This is a non-issue because medication is inappropriate in the first place	1	5
Total:	20	100

Temporary cessation from medication is always recommended

Because ADHD behaviors are so location specific--most commonly found in the school context--medication was often prescribed as a response to the demands of those environments. Therefore, the majority of clinicians stated that when the demands of school were not present, the medication became less necessary. This included weekends, Christmas vacations, summer time, and so on. As one clinician stated:

We do recommend that parents take their kids off the meds when the environment isn't as demanding. Holidays are always a good time to get off the meds and allow the body to readjust. Sometimes that doesn't work very well--parents say 'get him back on!'-- but sometimes it's really necessary. (Clinical Psychologist).

And another clinician:

During summer time they should take breaks and wash 'em out a little bit. I'm often curious to know what kind of learning explorations they do during those breaks. I think that seeing how kids behave without structure can help us see what kind of learners they are (Clinical Psychologist).

Because it requires behavior ADHD kids are supposedly unable to demonstrate, the "demanding" environment of school is contrasted with the less demanding, less structured circumstances of summer break. The term "summer" describes a block of time during a calendar year, certainly, but it is also a euphemism for being "outside of school." During this period of time, clinicians expressed that a child may be allowed to engage in explorations that are not mediated by medication. The ADHD child, from this perspective, can be better understood through his/her experiences in an unregulated, unmedicated environment. Without the specific behavioral demands being placed upon the ADHD child, an emphasis can be placed on the child's true nature.

By stating that observing children without structure can reveal their inherent learning strategies, this excerpt partially disputes that treating ADHD may render "normal" the condition in the child's brain. Normalcy is relative in this instance, the child being framed as merely a different type of learner, rather than truly pathological. This removes attention from the child's pathology and onto the school, which may be viewed in this instance as too demanding, too structured, etc. While being placed within the learning environment of school, the ADHD's child's nature impedes success, but when removed from those rigid confines this impediment seemingly disappears.

There is also a physiological concern that was common with respondents who made taking breaks from medication part of their treatment protocol. Many implied that the medication, even though it may be fixing problem behaviors and is beneficial in one sense, is also a foreign element in the body. As one respondent stated: "We can't constantly remain on a drug. Our bodies will start to break down" (Clinical Psychologist). Another clinician, whose son was diagnosed with ADHD, was more blunt about her opinion on the cessation of medication:

I am supposed to say that that is a medical issue, but kids are on it too bloody long. I used to have my kid's teacher make him run laps when he acted out. He was never medicated and he really got into shape from all of the running. We still joke about that (Clinical Psychologist).

With rare exception, the clinicians I spoke with acknowledged that Ritalin altered bodily chemistry in an unnatural way, however positive the child's behavior. Another respondent discussed the side effects of Ritalin, primarily its ability to reduce caloric intake:

I will recommend a break from the meds if there is a consistent lack of caloric intake. That is one of the common side effects, lack of appetite. With the younger ones we have to really watch that. We give them a break so they can eat normally and get their calorie count on par with others their age (Pediatrician).

The theme of the "medication holiday" reflects some of the perceived purposes of medication. We may ask: Is medication more than a means to better school behavior? That is, is medication also a learning device which enables ADHD children to develop social as well as academic skills? From the vast majority of respondents, the answer is no. Ritalin is seen as necessary to settle down disruptive behavior and to facilitate the mechanics of learning, but is not argued to be entirely necessary in other environments.

Cessation whenever there is tolerance to the medication

Another reason for clinicians to recommend a break from the medication concerned the issue of drug tolerance. Briefly, tolerance describes a condition in which the effectiveness of a drug is maintained only through increasingly larger doses. The person's body becomes "adjusted" to the medication and hence, the drug's efficacy decreases. This is one of the reasons severe alcoholics can have many times the legal limit of alcohol in their blood streams, but appear relatively unintoxicated. Though the drug's effectiveness declines, the potential toxicity for the drug does not. For clinicians specializing in ADHD, care is often taken to rectify this problem. As one clinician stated: "When tolerance is built up the drugs are far less effective and that often means an increase in the dosage. It is better to allow the child to take a break from the medication and let his body readjust rather than to change the dosage."

Respondents also contended that taking a break from one medication might mean switching over to another to see if the tolerance is alleviated. As one clinician stated: "Sometimes instead of taking a break altogether you may want to switch medications. They say with kids you get about 15% tolerance per year. That means constantly upping the dosage. But I'm always amazed at the little guys who don't get any tolerance and just keep plugging away year after year at the same dosage (General Practitioner).

In addition, the process of actually removing a child off of the medication depends very much on type of dosage the child is currently taking. As one clinician stated: "It also depends on the metabolism of the child. Some of the kids we see are only taking 5 mgs of Ritalin per day, but we have some others who are taking 60 mg per day. You don't just take a kid who is on 60 mg a day off the meds and see what happens. In that case, we may just lower the dosage to lessen the tolerance" (Manager at a Children's Hospital ADHD).

The question of ADHD eradication

Question #10 asked: *Do you find that there is any long-term treatment for ADHD which can eradicate or reverse the disorder?* As shown in table 6-9, the largest percentage of clinicians

(8, or 40% of the total), felt that ADHD was a disorder, that, under the right circumstances, could be eradicated if effectively managed. An almost equal number of respondents (7, or 35% of the total) felt that a true case of ADHD was a neurological defect that could never be eradicated. ADHD, such responses argued, was not something one could ever grow of, or forget about. Four respondents (20% of total) expressed that they did not know of any kind of treatment that could eradicate the disorder, exemplified by responses, such as: "I don't know, I have no idea. Too many kids in classrooms? I really don't know" (Psychologist). Finally, one respondent did not believe you could eradicate a disorder that did not exist in the first place.

The variation in these responses reveal the different ways in which ADHD children are framed within the clinical community. For clinicians who felt that ADHD was a manageable disorder that could be eradicated through diligence and commitment, the child with ADHD was perceived to be only a part in a larger social tapestry. His/her long-term mental health was contingent upon a collective effort by significant caregivers, primarily parents. For the clinicians who felt ADHD was not entirely curable, children with ADHD were framed in a more rigid, neurological fashion. Such respondents' statements portray ADHD as a biological flaw--a defect that no amount of behavioral therapy would ever correct.

Table 6-9: Clinicians' Perspectives Towards the Possibility of Treatment that would Eradicate ADHD.

<u>Opinion on the possibility of ADHD eradication</u>	<u>Number</u>	<u>Percentage (%)</u>
Yes, if the ADHD is managed appropriately	8	40
There is no treatment that can eradicate ADHD if it is a neurological problem	7	35
Do not know if there is such a treatment	4	20
Does not believe in the ADHD diagnosis	1	5
Total:	20	100

ADHD can be eradicated if managed effectively

Some of the responses in the interviews stating that ADHD can be effectively eradicated address the issue of the neurological versus the non-neurological forms of ADHD. Two respondents were very specific in pointing out that ADHD was manageable, but only in its non-neurological form. As one clinician stated when asked if he thought the condition was something that could be eradicated: "Yes, if the ADHD is non-neurological and if it is managed appropriately." And another: "If it's not neurological, yes it can be cured." The "if" in both of these responses is significant for describing the nature of ADHD. For example, stating "*If* the ADHD is non-neurological," denotes that ADHD has the other possibility of existing in a hardened, physiological form that will require a more intensive type of medical management. The possibility that ADHD may be curable is presented conditionally, presupposing that there are two forms of ADHD that exist. When placed against the backdrop of the neurological, academic discussion of ADHD, the idea that ADHD could be non-neurological and curable appears out-of-date, not in step with the current research on the disorder.

However the discussion of the existence of non-neurological and neurological ADHD does not originate from the research realm, but the clinical realm, the realm of treatment. In the clinical realm, non-neurological ADHD it is argued, can be conquered if the appropriate strategies for management are employed. Hence one clinician stated:

I think its a management issue. If you have learned some skills that you can apply to your life and these become habits, then I think you can do pretty well. That's another reason why I question immediately putting the kid on Ritalin. Why learn to change when the drug does it for you? The kid learns to become dependent on the drug to manage his personality.

(Psychoeducational Assessor).

The implication is that the ADHD child is fully capable of leading a normal life if correct methods of habitualizing the child are employed. Medication, in this instance, may be a hindrance to an effective management strategy. This respondent effectively asks: Why jump to

the conclusion that a child may need medication right away? Why not attempt rehabilitation for the child in the first instance? If it is not known whether or not the ADHD is of the truly neurological variety, why not see what non-neurological components can be addressed prior to applying medication treatment?

Habitualizing ADHD children also includes learning self-awareness, referred to by many clinicians in my sample as "meta-cognition." By engaging in acts of "thinking about ones thinking" it is believed that ADHD children will ultimately adopt management strategies and gain greater amounts of task-oriented skill. As one respondent stated:

They have to be in environments that are encouraging, not in an adversarial environment. If they're always in enemy territory, how can they grow to be able to respond to the situation? There's a lot of behavioral paradigms. Metacognition helps them think about their thinking (Clinical Psychologist).

Another clinician gave an example of how an ADHD child utilized techniques for remaining on task:

The biggest issue (in applying treatment) is to understand themselves. When people with ADHD get older they learn their little tricks. You have successful ADHD and non-successful ADHD. I often get the non-successful kids. Some of them just don't do well no matter how much you try. That has a lot to do with the type of family they grow up in. But you do have your successes. One girl used to put calendars in her bedroom and bathroom so that she would never forget what she had to be doing (Pediatrician).

The "successful" type of ADHD child has a strong supporting cast of people who can help propagate patterns of rehabilitating the child. These cases are contrasted with the "non-successful" cases of ADHD, which, according to the respondent, often lack success because of

family circumstances. Hence, in the case of non-neurological, and potentially curable ADHD, having success is heavily dependent upon the social circumstance of the child.

Within the scenario of "successful" ADHD children it is important to again address the issue of locus of control. In cases of ADHD perceived to be non-neurological, it is clear that social circumstances greatly affect the way in which the afflicted child negotiates his/her surroundings. ADHD is a habit, more than a true affectation. Regardless, breaking the ADHD cycle is not entirely dependent upon the child, but rather, upon those who provide social and emotional support for that child. The ADHD child as social actor, in this regard, is heavily dependent upon the support of the outside world for the maintenance of some semblance of normalcy in walking through everyday life. The locus of control is not perceived to be within the child, but rather within those social forces that cultivate normal behavior.

There is a strong contradiction within the scenario of non-neurological ADHD. We are left with a stance that states ADHD is "the child's problem, but everyone's responsibility." This narrative clearly points to non-neurological ADHD having its roots in family, rather than physiology. And yet, with the ADHD diagnosis, as will be demonstrated in chapter eight, parents continually exonerate themselves from being a source of the disorder. With this being the case for non-neurological ADHD, what is the utility of the ADHD diagnosis? If the locus of control is not held with a medication, or with the child's own ability to provide self-regulation, why elaborate the label of ADHD in the first place? It would be more fitting to label the child's problems as simply a part of a larger family dynamic, rather than placing the pathology solely onto the child.

ADHD cannot be eradicated if it is truly neurological

Following the dominant neurological discussion of the causes of ADHD, many clinicians argued that it was impossible to eradicate a neurological problem of ADHD's magnitude. With responses that resonate with the positions of Paul Wender and Russell Barkley, some clinicians saw ADHD as a lifelong condition. For example, when asked if ADHD could be eradicated, one

clinician responded: "No. A neurobiological thing like LD or Asperger's or ADHD you can't cure it, but you can add enough to that part of the brain, allow the executive functions to really function. Some never get full control" (Psychiatrist), and another: "For real ADHD? No. No, there is nothing that can eradicate it" (Psychologist).

Such responses imply that ADHD is akin to other biological defects. The social and academic defects of the ADHD child are attributed inside his/her brain. It is a condition that is treatable through offering a kind of exercise to certain regions of the brain, but curing this condition is an impossibility. Such a perspective invariably favors a medication perspective on ADHD, placing behavioral regulation upon a neurochemical medium.

Clinician opinions on the role of educators in ADHD

Given the specific institutional confines within which ADHD is suspected, primarily denoted by the context of school, it was important to ask clinicians how they perceived the ideal role of educators in relation to a child with ADHD. When question #11 asked: *What do you feel are the appropriate roles of educators in relation to ADHD children?* clinician responses were categorized in 4 groupings. As can be seen from table 6-10, half of the respondents (10 out of 20) stated something to the effect that teachers should be more aware of ADHD and recognize that these types of children are fundamentally different from others. Five respondents, or 25% of the total, stated that they felt teachers should put out effort to modify curricula in order to accommodate ADHD children more effectively. In contradiction to those who felt teachers needed to gain a greater awareness of ADHD, four or 20% of the total argued that teachers needed to become less involved with the process of diagnosing ADHD and instead focus upon teaching. Finally, one respondent argued that teachers need to teach greater degrees of self-advocacy.

Table 6-10: Clinician Opinions on the Role of Educators in Relation to ADHD Children.

<u>Opinion about role of educators</u>	<u>Number</u>	<u>Percentage (%)</u>
Teachers need to recognize that ADHD is real and learn more about the disorder	10	50
Teachers need to modify curriculum to suit ADHD children	5	25
Teachers are not qualified to provide diagnoses of ADHD and should stay within their field	4	20
Teachers need to teach students self-advocacy skills	1	5
Total:	20	100

Teachers need to recognize that ADHD is real and learn more about the disorder

A major theme mentioned in the interviews concerns the need to educate teachers on the ADHD diagnosis, and help them recognize that the disorder is a real phenomenon. This perceived need to make teachers understand more about ADHD is directed at both the classroom and administrative levels. As one clinician stated:

Well, some teachers think that it's not real. We need to keep trying to educate teachers that ADHD is very real. It's not recognized as an LD.

You've got these kids in classes who are "winging it" and because ADHD is not recognized by the ministry, they have no real way out (Psychiatrist).

To date, ADHD is largely unrecognized within classroom settings, nor is it recognized by the BC Ministry of Education as a bona fide learning disability. Because of this, many clinicians feel that children with ADHD are not receiving the type of attention they need in school settings. Ministry designations that define a child as having specific learning difficulties provide extra resources for that child, including extra time in a Skills Center or Learning Assistance Center (LAC). With the case of ADHD, perhaps in part due to the variability in the types and interpretation of behavior,

the Ministry withholds those extra resources. Hence, the kids who are "winging it" are the ones who do not have avenues within the school to rectify their learning difficulties. They may be taking medication, or seeing a clinical psychologist, but, it is argued, they are not provided with indispensable learning opportunities.

Clinicians also expressed the need for teachers to increase their role as people who can aid in the suspicion of ADHD:

It's important for teachers to ID the kids who may be at risk. They have to learn more about the disorder for that to occur. If you don't know what to look for, then you won't find it. Teachers spend all this time punishing kids who are acting out, but they never stop to think 'Hey, I wonder if this kid might have something really wrong here.' (Pediatrician).

There is a relationship between education about the ADHD diagnosis and an increase in the ability to profile the disorder, it is argued. That is, the connection between knowledge and recognition is one that exemplifies the process of framing deviant classroom behavior. If teachers learn more about the social actor known as the ADHD child and know what makes these kinds of children tick, they can be better recognized and teased out of the normal population. Through sensitizing teachers to the condition of ADHD, a more specific deviance label can be applied, rather than those that describe a "slow" learner or "lazy" student.

In conjunction with statements that teachers need to have an increased awareness of the symptoms of ADHD, clinicians also argued that teachers need to tailor their reactions to these children. As one clinician stated: "Teachers, for whatever reason, might not have the resources or the skills. They get into this pejorative stance, which really only rationalizes their frustration" (Clinical Psychologist). To level a judgment against the ADHD child is argued to be a useless endeavor. Because ADHD children are perceived to be fundamentally different, the normal standards for judging children's behavior do not apply. Rooted in the "disability perspective" examined in chapter four, teachers' reactions to ADHD children are perceived to require modification. This includes avoiding punitive stances, that in the instance of a "normal," unruly

and academically/socially challenged child might be appropriate. To punish ADHD children for their behavior, either through detention, or the removal of privileges, etc., is perceived as an act of ignorance.

Teachers need to modify curricula to suit ADHD children

Concomitant with the discussion of the necessity for teachers to view ADHD children from a disability perspective, some respondents argued that changes needed to be made at the curriculum level to suit these types of children. As one clinician stated: "Teachers need to modify their curriculum, modify their teaching styles and educate themselves about these kinds of conditions with their students" (Clinical Psychologist). Education not only leads to an increased awareness of the condition of ADHD and increased insight into why such children act up, it is also a means to adapting classroom strategies suited to ADHD.

In some instances, the adoption of alternative teaching perspectives can be seen as a much-needed substitute for conventional ADHD treatments:

They (teachers) have to recognize it (ADHD) and that depends on their own bent on the disorder. ...The school also needs to be more responsive. They need to make a school a successful place for these kinds of kids, whether that means changing the learning strategy, maybe doing more oral than written stuff. A great teacher may be able to see ADHD as a strength and go with that rather than forcing the kid to take medication (Pediatrician).

ADHD may be seen as a kind of strength, rather than a disability. In the event that a teacher may recognize ADHD as a different learning style, the medication option may be staved off or entirely substituted. In this regard, much of the responsibility for addressing ADHD is placed upon teachers and the front-line of the classroom environment in which ADHD is most often suspected. Presented as a relative concept and influenced by a teacher's "bent on the disorder," ADHD is not a condition addressed by classroom, school district, or ministry protocol. The

individuality of teachers, this passage denotes, can make a difference in how ADHD is interpreted and how it is addressed in the learning environment.

Also favorable to the modification of curricula, another respondent argued that such changes were not necessitated by the need to accommodate disabled children, but rather because schools unwittingly neglect students. This respondent argued that schools had fundamental institutional flaws, of which ADHD is a symptom:

Educators are well-meaning, well-intentioned, but they are bombarded by this crap (holds up list of DSM criteria). Their programs are so restricted. (draws bell curve on piece of paper) This is how kids are expected to behave in school (points within the 1st standard deviation), and for the ones out here and here (points to the far points of the curve, around the 2nd SD) they don't know what to do with them. Now, in Kindergarten the curve is really skinny (draws skinny bell curve), but what about 5th grade or high school? The curve gets very wide. You get to the point to where your program can only handle 2/3 of its students, the ones who work the best within the system, but if you have a restaurant and your chairs will not fit 30% of the population you've got a problem with your business. So, teachers mean well, but they don't see how the system is really the problem (Pediatrician).

From this perspective the ADHD diagnosis is a means by which schools shirk the responsibility of accommodating the vast differences in learning styles that become clear as children grow older, hence, the discussion of a wider bell curve as children get into the higher grades.⁴⁵ Instead of addressing the differences through advancing the curricula, it is argued, schools will aid in the effort to stigmatize children who underperform. The finitudes of this stance presents an empirical issue not addressed in any length by this thesis, however, the theme that places more

⁴⁵The statistic of 30% given by this respondent, however, is drastically inflated in terms of the percentage of the school-age population with ADHD.

responsibility upon the shoulders of the schools is also modestly prevalent in the interviews with teachers and parents.

Teachers are not qualified to provide diagnoses of ADHD and should stay within their field

In contrast to the positions of respondents that stated teachers needed to become more savvy at recognizing ADHD, other respondents argued that teachers have become too involved in the suspicion and diagnosis process:

First of all, teachers are not therapists. Their job is to teach, not to start labeling kids as having some kind of mental disorder when it may be their fault in the first place. Sure, they need to be aware, but they have to look at their part in things (Family Therapist).

The boundaries between teacher's role as pedagogue and informal clinician are blurred according to some clinicians. It is implied that the difference between informally suspecting a child and formally declaring what his/her condition is, represents the distinction between educational and clinical contexts. In a professional sense, to not honor this distinction, or to turn the classroom into a type of informal clinic is counterproductive. This excerpt also denotes that the process of teachers suspecting children of having a mental disorder may be an indirect way of avoiding their own professional responsibilities. By arguing that teachers avert their gaze from "their part in things" and label children as having ADHD, this clinician argues that teachers are assisting in a "looping process" (Goffman 1961), in which problem behaviors are connected to a mental disorder, rather than the environment that causes or exacerbates those problem behaviors. Through beginning the process of labeling a child, it is argued, the institution of education never reflects upon its own role in the child's difficulties. Another respondent provided a similar response:

I think educators spend a lot of their time trying to confirm that a kid may have ADHD, when they aren't necessarily qualified to offer that kind of

information. Teachers aren't doctors and I don't think they should be recommending that parents put their children on medication (Pediatrician).

Such excerpts denote that there can be a considerable amount of antagonism between professional realms that address ADHD children. This, I believe, partially defuses the popular and academic notions discussed earlier in this thesis that depict a kind of conspiratorial connection between professional realms. These discussions, comprising the backlash against the legitimacy of ADHD, refer to or imply a collusion between forces, whose primary objective is to eradicate any and all problem childhood behavior. Though it is obvious from these interviews that clinicians rely upon the testimony of teachers, they also want to maintain a degree of independence in determining whether or not a child with social/academic problems does in fact have ADHD.

Clinician opinion on the role of parents in relation to their ADHD children

Parents, as a matter of course, are the most significant people in any child's life, the ADHD child being no exception. Solicited by the question: *What do you feel are the appropriate roles of parents in relation to ADHD children?* clinician responses illustrated what they felt were the appropriate stances parents should adopt with their ADHD children, including how parents should understand such children, and how they should regard their children's problem behaviors. As seen in table 6-11, the highest percentage of clinicians (eight, or 40% of the total) felt that parents should adopt some degree of a disability perspective towards their children. This perspective, it will be shown, was argued as crucial for parents to understand the nature of their ADHD children and to avoid an antagonistic relationship with them. A slightly smaller number of clinicians (7, or 35% of the total) argued that the appropriate role for parents was to involve themselves, as much as possible in the treatment process of their children. Three respondents, or 15% of the total, responded that parents needed to not be defeated by the diagnosis of ADHD and find some degree of self-empowerment. In addition, one respondent briefly mentioned that

parents should find a support network of some kind and another mentioned that parents need to do more to cultivate their children's self-esteem.

Table 6-11: Clinician opinions on the role of parents in relation to ADHD children.

<u>Opinion on the role of parents</u>	<u>Number</u>	<u>Percentage (%)</u>
Parents must keep a disability perspective when dealing with their child's behavior	8	40
Parents must involve themselves in the treatment process	7	35
Parents must learn to empower themselves	3	15
Parents should help build the self-esteem of their children	1	5
Parents need to find others for support	1	5
Total:	20	100

Parents must keep a disability perspective when dealing with their child's behavior

Many clinicians stated that parents needed to constantly remind themselves of the neurologically-challenged nature of their ADHD child. A theme analyzed in chapter four, the disability perspective is one that shifts parent psychology away from conventional interpretations of childhood misbehavior. As one clinical psychologist stated:

They need to keep a disability perspective when dealing with their child's behavior. These kids don't act out because they want to. Also, they need to bring a sense of success to the ADHD kid rather than the discipline

approach. If mom is always nagging and telling him what is wrong, what he isn't doing right, the kid is gonna think he is really that way.

The "discipline approach" that motivates children to augment behavior through one type of punishment or another, is not fitting when dealing with the ADHD child. A pediatrician described it similarly:

I think parents should maintain a disability perspective towards their children and remember that they have a mental disorder and that is often at the root of their behavior. Because ADHD is tough to see or recognize, parents can also take a punitive stance and see their children as if they were normal, but they're not.

As demonstrated throughout this thesis, it is argued that ADHD children are continuously in conflict with their everyday environments, learning to view the world as a spawning ground for failure. Certainly a significant part of this threatening world is within the household, where parents who are unaware of their child's condition may be inclined to adopt a conventional disciplinary stance. By "reframing" ADHD children, the disability perspective engenders in parents an understanding that the source of such conflict is not will, but neurology.

With this perspective in place, it is argued, parents can become informed participants in the management of their ADHD children. They are expected to become pursuers of ADHD knowledge, and indeed, willingly adopt that role. The end product of this increased level of understanding, many clinicians argue, is greater parent participation in the ADHD treatment process. This certainly does not imply a dismissal of the "disciplinary stance" so criticized by the previous respondents. Rather, the increased knowledge of ADHD, and consequent disability perspective from which it arises, requires an intensification of discipline. Discipline needs to become more focused, more directed at specific types of ADHD-related behavior. As knowledge increases about ADHD, the prescribed disciplinary strategies for rectifying the disorder must be changed. Foucault (1965, 1977) illustrated this process quite effectively when he discussed the relationship between the compilation of knowledge of deviant individuals and how that

knowledge interrelated with the methods by which they were disciplined and/or treated. Foucault argued that scientifically objectifying criminals, madmen, homosexuals, and so on, paved the way for the implementation of modern techniques of their reform. The disability perspective that so many clinicians advocate in my sample is another instance of this process. The disability perspective cultivates an openness to techniques of behavioral reform that are different from "non-ADHD" methods of childhood discipline.

Parents must involve themselves in the treatment process

One result of the disability perspective is a restructuring of home life. As discussed in chapter four, clinicians repeatedly argue that the household should become intensively structured in order for ADHD children to be rehabilitated. As one clinician stated:

Parents need to give the child structure, a structured work system. The home has to be system driven rather than people driven. Kids can whittle away someone's patience, but if there's a system in place everyone in the family can defer to it (Clinical Psychologist).

In being "system driven," it is argued that a structure of rules and consequences, if sternly in place, will supersede the expression of individual will. In the same sense that a child's behavior can be reframed as resulting from disability, it seems probable that parents' traditional methods of discipline may also be labeled as "disabling." Through household restructuring, parents can relieve themselves of their own ego-involvement with their ADHD child's misbehavior and regulate any misconduct through a well-understood system. At the base of this discussion of a "system driven" household is one or more techniques of behavioral modification. Certainly addressed in this behavior modification are the reactions parents take towards their children that apparently serve to exacerbate their child's behavior. The new structure that is in place defuses parents' previous disabling disciplinary practices.

Clinicians also stated that parents should involve themselves more with their ADHD child's education process:

Parents need to keep in close contact with their kids performance in school. Some parents just seem to drop their kids off and let the teachers take over for 8 hours. That's a surefire way to problems. If that kid starts struggling and the teacher's too overwhelmed to intervene you could see your kid drop a grade behind in no time. Then they wonder what went wrong with their kid. They're part of the blame there (General Practitioner).

Parents are encouraged to breach the boundary that separates home from school. In what could be understood as yet another shift from conventional to "disability" perspectives towards their children, parents are partially implicated if their child does not achieve success. Assumed in this response is that teachers may not always be able to effectively intervene if a child is struggling academically and/or socially. Because their child is considered disabled, and because teachers may not be entirely qualified to deal with such disabilities, the responsibility rests upon the parent's shoulders.

Perspectives that advocate more parent involvement in the child's rehabilitation process reveal that clinicians may feel there needs to be a degree of overlap between household and clinic and between household and school. Parents are encouraged to adopt a role as educator, closely monitoring their child's progress in school, and be prepared to intervene. In addition, parents are expected to bring the structure of behavioral modification into the household, applying what they learn about ADHD to the domestic management of their children. By mediating the way their child is diagnosed and treated for ADHD, parents are expected to represent the disability perspective in a variety of social contexts. ADHD children may or may not speak for themselves, but, in any case, their parents are held accountable for what they do. This accountability, clinicians argue, is impossible without a considerable amount of knowledge and proactive participation.

Parents must learn to empower themselves

The third prominent theme in addressing parental roles with ADHD children discussed the need for parents to find a degree of self-empowerment in addressing ADHD. One response exemplified this perspective:

Parents so often think that their kid is having problems because of them. If you've got parents who are feeling bad about themselves and kids who are failing out of school you have a real crisis and it becomes very tough to get out of it. So, yeah, I think parents need to give themselves a break and be patient with their child's progress (Psychoeducational Assessor).

Similar to clinicians who felt parents should adopt a disability perspective towards their children and consequently remove their own egos in intervening in the behavior, this excerpt articulates that self-blame only feeds the ADHD crisis. The entire family unit, in this instance, is denoted to be highly interactive, with the child's struggle and parental self-blame feeding off of each other. In giving themselves "a break," this clinician is arguing for parents to remember that ADHD is a mental disorder and allow this knowledge to motivate the correct response. Through becoming somewhat detached and removing themselves from the emotional experience of self-blame, parents may be able to more effectively participate in the labeling of their child's behavior. The label of ADHD is not something that can only be applied from the outside, that is, upon a visit to the clinician's office. Parents must aid in their children's internalization of the ADHD label, and a crucial component to this is reminding themselves that they did not cause the ADHD condition. The belief is that by viewing their own role in their ADHD child's life differently, this will have an effect upon the child's treatment process.

Clinician descriptions of the physiological process of ADHD

In an effort to see whether or not clinician perspectives on ADHD matched up with dominant neurological perspectives, the final question of the interview asked clinicians: *Can you briefly describe the neurochemical structure of the disorder?* Referring to table 6-12, eight

respondents, or 40% of the total felt they could not adequately respond to this question. An equal number of respondents offered a description of ADHD that in many ways paralleled the dominant neurological perspectives on the disorder. Other respondents offered a plethora of theories about the disorder, including one clinician who generally argued ADHD resulted from "erratic arousal patterns in the brain," another who stated that ADHD resulted from a lack of a "focus chemical" in the brain, and yet another clinician who favored a psychological theory stating ADHD is the result of a collection of small or "little T" traumas throughout a child's life. Finally, one clinician claimed there was no physiological process because ADHD was not a real entity in any sense of the word.

Table 6-12: Clinician Descriptions of the Physiological Nature of ADHD.

Explanation for ADHD	Number	Percentage (%)
Cannot adequately describe the physiology of ADHD	8	40
Dopamine disregulation/brain underactivation	8	40
Erratic arousal patterns in the brain	1	5
Lack of a "focus chemical" in the brain	1	5
ADHD results from a collection of "little T" traumas	1	5
ADHD does not exist	1	5
Total:	20	100

Clinicians who felt they could not adequately describe the physiology of ADHD

Focusing on one of the two most frequent responses to this question, a large number of clinicians claimed to not be able to adequately describe the physiological process of ADHD. As one respondent replied: "I haven't really gone into it," and another: "I am not too sure what

current causes are being considered." Such responses generally came from respondents whose perspectives on ADHD favored a psychodynamic rather than neurological approach to the disorder. Underlying this is the belief that if ADHD behaviors cease, or are adequately contained, a greater understanding of the physiology of ADHD--if there even is such a physiology--is unnecessary.

In addition, clinicians also expressed that they felt ADHD was not concretely understood at this point by medical science. As one clinician stated: "I don't really think anyone knows what ADHD is at this point. The research doesn't seem very conclusive, but its getting better" (Clinical Psychologist). ADHD is perceived by some to be a disease "in process," with no solid cause determined at this point.

The irony is that for this significant number of respondents ADHD is an affectation they treat as if it were physiologically visible. This focus on behavior, rather than on physiology, exemplifies the treatment of other mental illnesses. As Thomas Szasz (1974) argues, mental illnesses are often "declared" to be what they are, rather than being confirmed through physical evidence. Immediately following this declaration is, of course, some regimen of treatment, and as described previously, this treatment is overwhelmingly perceived to be accepted in the mental health community. It appears common sensical that a child in a scholastic context intrinsically has a desire for success above all others. Therefore any bad behavior on that child's part must be outside of his/her will. Bad behavior, in this instance, must indicate something that is fundamentally wrong with the child. The cause of the behavior is less significant than the fact that the child is suffering from the repercussions of the behavior he/she could not help in the first place.

Clinicians describing dopamine disregulation/brain underactivation as a cause of ADHD

Though there is no exam that specifically describes ADHD, some of the common narrative about the cause of this disorder invokes neurological dysfunction, often attributable to

brain underactivation and a problem with the regulation of dopamine (Barkley 1997, Fuster 1997). As one clinician described:

There's an underactivation in the prefrontal cortex, primarily with the dopaminergic pathways that are not being activated correctly. There is less ability to regulate oneself from this. Executive functions are asleep at the switch. Stimulant medication may stimulate activity in that center (Psychiatrist).

Another respondent linked dopamine dysregulation to specific regions of the brain:

...The frontal region controls impulses, gives us social inhibition. We can see that kids with ADHD don't have this area of the brain activated as well. ...Ritalin is a dopamine stimulant that activates this part of the brain. It's like taking insulin if you're diabetic. The body isn't circulating a chemical properly, so drugs like Ritalin make an abnormal situation normal (Pediatrician).

These two excerpts contain 3 propositions that strongly represent the bulk of responses that addressed the issue of dopamine dysregulation and brain underactivation.

First, there is the description of the ADHD child's brain as underactivated. This condition, described very well in lay person's terms by Gabor Mate (2000, p. 40, 41), is the root of the "ADHD paradox." Common sense might conclude that ADHD children exhibiting hyperactivity and an inability to focus on important tasks suffer from an *over*-activation of the brain. With the case of ADHD, the reverse is supposedly true: Certain mechanisms within the brain that facilitate focus and social restraint are argued to not be adequately activated.

Second, ADHD symptoms are seemingly linked to underactivation in a particular region of the brain: the frontal lobe, more specifically, the prefrontal cortex. With the ADHD brain, dopaminergic pathways are not operating to full capacity, hence, the neurotransmitter dopamine is argued to be greatly reduced. Dopamine, as mentioned in chapter 3 is the neurotransmitter most commonly linked to the ability for social restraint. Less dopamine circulating throughout

the frontal lobe equates to less inhibition. Inhibition, in this sense, keeps a child on task by effectively staving off interest in outside distractions. A child with normal brain activation and normal levels of inhibition can demonstrate restraint in negotiating between the tasks at hand and outside distractions. These include distractions such as peripheral sounds, friends making funny faces, or the internal desire to get out of one's seat and run about the classroom. In addition, the prefrontal cortex is also strongly associated with metacognition and self-awareness. In a normal brain, the "executive functions" as one respondent stated, are intact, enabling a normal amount of awareness about one's own thinking and how one's behavior affects other people. ADHD children are supposedly very limited in this neurological capacity. Because the pre-frontal cortex lacks adequate stimulation, such children are not able to take a reflective stance towards their patterns of thinking, or their behavior. They act out because "they have to."

The third proposition concerns the effect of stimulant medication upon the ADHD brain. Through PET scans, it has been demonstrated that stimulants, such as Ritalin increase the circulation of dopamine in the frontal region of the brain and consequently enhance an ADHD child's ability for restraint and task-oriented behavior. Supposedly, such medication takes an abnormal situation and makes it normal by increasing the dopamine to levels comparable with people in the normal population. As mentioned, the response to Ritalin has been integral in enlightening researchers into the nature of ADHD and at the same time demonstrating that this disorder can effectively be treated.

Concluding remarks

This chapter has examined an empirical account of the discourses addressed in the genealogical section of this thesis in chapters two through four. Of primary significance are the neurological and psychodynamic perspectives towards ADHD and how these strategize to lay claim to the disorder. In addition to being a qualitative inquiry into the way ADHD practitioners are shaped by and shape the experience of treating and diagnosing ADHD, these interviews reveal the extent

to which ADHD discourses find their way into clinical practice. Clinical practice, therefore, is a means to perpetuating a particular discourse, or a combination of them. Through the accounts given by clinicians, we see the relationship between academic, research-oriented discussions of ADHD and professional ones. As indicated by the above interview excerpts and analyses, clinicians are social actors who negotiate their own relationship with ADHD. They have agency in deciding which perspectives they feel to be the most useful in formally diagnosing and treating ADHD children. This agency can be seen in the variability of perspectives clinicians exhibit. In some instances, the antagonism between neurological and psychodynamic discussions of ADHD described in Chapter 3 is maintained in clinician accounts, but at other times, there is a compromise between these perspectives.

The rift between psychodynamic and neurological perspectives towards the disorder are most clearly articulated with the distinction some clinicians made between "real" and "false" ADHD. Recalling the testimony of one clinician, it is believed that there is a tendency to not distinguish between primary and secondary diagnoses--a practice regarded as a diagnostic mistake, which sets up the potential for "false positive" or Type II errors. Through invoking the difference between "real" and "false" ADHD, clinicians are providing a replay of the harsh criticisms Paul Wender leveled at proponents of the psychodynamic perspective. Therefore, to provide a false positive diagnosis of ADHD is to repeat the supposed mistakes psychodynamic researchers made prior to the dominance of neurology. This position implies that a competent clinician can adequately tease out ADHD, separating the bona fide neurological condition from a psychological response to environmental problems.

The reverse of this perspective was also given by clinicians who argued that ADHD is not sophisticated enough of a diagnostic category to warrant consistent diagnoses. Given this, some

clinicians argued that their emphasis in examining children with behavioral problems was not to find ADHD per se, but to provide a greater assessment of that child's social environment. From a "treat the whole child" perspective, clinicians implicitly argue for the necessity of a psychodynamic approach in treating children with behavioral problems, whether they are labeled as "ADHD" or not. The neurological stance towards ADHD, this perspective implies, has an undue coldness in examining children. There are few "straightforward" cases of ADHD as other clinicians have asserted, and the treatment of such children with medication is a way of skirting adult responsibility.

Clinician responses also reveal compromises between neurological and psychodynamic perspectives towards ADHD. This can be seen with clinicians who combine behavioral modification with pharmacological treatment. Such an approach demonstrates the belief that ADHD behaviors can be unlearned--a process that may be enhanced through the administration of medication. More generally, the compromise between these two approaches can also be seen by the fact that childhood behaviors impeding success in social environments deemed crucial for life success are considered almost universally abnormal. Regardless of the specific etiological stance a particular perspective on ADHD employs, the notion that unconventional childhood behavior is seen as "symptomatic" is very telling about how mental health practitioners collectively perceive the boundaries of child normalcy.

The next chapter will extend this empirical analysis. In addressing the perspectives of teachers associated with children with ADHD, I will further examine the boundaries of normal behavior teachers construct for ADHD children, how they suspect such children in their schools, and how they implement strategies to rectify their learning problems.

Chapter 7 Educator Frames for ADHD Children

This chapter provides an examination of interviews with 22 school teachers in the city of Vancouver, BC and its greater metropolitan area. Teachers from a variety of different grade levels were asked questions that addressed the recognition of ADHD children, knowledge of the ADHD diagnosis, teaching strategies employed for such children, and the perceived gender profile of ADHD children. Interviewing teachers for this thesis was necessitated by the fact that the institution of education is more associated with ADHD than any other. Ritalin advertisements during the 1970's in psychiatric journals like *the American Journal of Psychiatry* for example, feature attentive students raising their hands in class. In addition, *DSM IV* criteria for ADHD specifically describe child struggle within a classroom environment. Such a connection between ADHD and this particular institutional framework also represent the influence of historical ADHD discourse. Of particular interest here is the early discussion of ADHD symptoms and how these were deemed pathological because they apparently prevented children from learning school lessons. This type of conceptualization of ADHD symptoms can be found in both the discussion of the 1920's psychiatric sequelae of *encephalitis lethargica* and the later psychological perspectives towards the disorder that explained overt behavioral problems as resulting from frustrations with institutional environment, the school primary amongst these.

The association between ADHD diagnosis and the classroom is made from both those on the pro and con side of the ADHD debate. Those skeptical of the validity of ADHD label the school as an institution where an antagonism between staff and student is equalized through mental disorder labels. (For a scathing critique of the school system's role in identifying hyperactivity see Shrag and Divoky [1975]). On the other hand, those who subscribe to the validity of ADHD will identify the school as a crucial context for discovering this potentially devastating disorder and aid in its diagnosis. What one camp calls politically-charged "medicalization," the other calls an educational necessity.

In *Children on Medication* (1986) Kenneth Gadow summarizes the role of the school system in the life of an ADHD-diagnosed child:

The school is often in the middle of this controversy because it is: a) frequently the source of medical referral, b) intimately involved in fostering academic achievement, and c) one of the most challenging settings for the hyperactive child (31-32).

Gadow implicates the school as a major catalyst to a ADHD diagnosis. School is the place, due to the demands it places upon the child, where the signs of ADHD are most visible.

Education literature demonstrates a growing interest in those who have or are suspected of having ADHD. A brief examination of a cross-section of this literature reveals the extent to which the discussion of ADHD has become common place in teaching circles (see, Bloomingdale 1985; McCall 1989; Buchoff 1990; Black 1992). Take, for example, an article in *Instructor* magazine, "How To Manage Your Students with ADD/ADHD" adapted from Linda J. Pfiffner's *All About ADHD* (1996):

Odds are you have one or two students in your classroom who have ADD or ADHD--attention deficit (hyperactivity) disorder. As you know well, these students are not easy to teach. Their high rate of movement and talkativeness may be difficult to handle.

...ADD students are challenging even for the most seasoned teachers. Getting them to focus, pay attention, and follow directions can be like trying to herd cats (p. 63).

The article then describes a variety of methods that can be employed to effectively teach the ADHD child. These include classroom design and student-teacher interaction models that minimize distractions for the child. Another article, written by a school principal describes how her school will begin to use an "acting out" room for ADHD children in addition to employing more human resources in this disorder's management (Dyer-Wiley 1999).

Through its literature, the educational community expresses a desire to gain knowledge about ADHD. The discussion of the habits of those who have ADHD, and the articulation of difficulties in dealing with such children, have prompted educators to advocate pedagogical methods for teaching children with this disorder, as well as methods for enhancing ADHD recognition.

Educator knowledge of ADHD has increased teachers' diagnostic capacity in relation to the disorder. Numerous articles argue strongly for the teacher to become a more effective diagnostician. Recent articles in journals such as the *School Psychology Review* and *Teacher Education and Special Education* have repeatedly stressed the importance of teachers playing both an intervention role with regard to the ADHD child as well as an intermediary role between the child's domestic and clinical environments (Schultz et al 1997; Power and DuPaul 1996; Sheridan et al. 1996; Greene 1995). To be at the forefront of knowledge of education practices, such articles claim that a knowledge of the pervasive disorder of ADHD is urgently needed. An article by McFarland, Kolstad, and Briggs (1995) exemplifies this urgency. In a section subtitled, "The Teacher's Role in Diagnosing and Teaching ADHD Children," the authors provide a case for the inevitability of an educator encountering an ADHD child and an admonishment for teachers to learn to recognize such a child:

Educators play an important role in diagnosing and treating ADHD children. ...Teachers must have an awareness of ADHD symptoms and the methods of treating this abnormality.

Although virtually all elementary classroom teachers would prefer to go through their careers without encountering an ADHD student, this very likely will not be the case.

...What should teachers do to prepare for this inevitable encounter with an ADHD student? The first thing teachers must do is to develop an understanding of ADHD behavior so they can help in the diagnosis of the

condition. The teacher's training programs should include sufficient information to help identify possible cases of ADHD (p. 601).

State education policies in the US have also begun to establish a relationship between the practice of education and the diagnosis of ADHD. As of 1998, 21 States had an active policy for the special education of students who have been diagnosed with ADHD. These policies are in the form of state mandates which are handed down to school boards in an effort to enhance local school districts' ability to educate these particular children. Thirteen states have a specific written policy which directs school districts in the process of assessing ADHD in the classroom and in the offices of school psychologists. All 13 of these states use *DSM IV* criteria in the process of assessment.

In Canada, the bureaucratic recognition of ADHD is very different than in the United States. No provincial ministries recognize ADHD as a bona fide learning disability, the British Columbia Ministry of Education being a case in point. In order for a child to receive a ministry designation for ADHD, the diagnosis is often "hidden" within other diagnoses. Hence, students who do not exhibit explicit signs of a Learning Disability may get labeled as learning disabled by the BC Ministry of Education in order for more resources to be allocated to that individual student. Currently, there is no ministry protocol to use *DSM IV* criteria to determine whether or not a student may have ADHD.

DSM IV, the manual which has definitively provided the nomenclature of ADHD, has diagnostic criteria which implicate behavioral problems in the classroom: *DSM IV*'s "hyperactivity-impulsivity" component of ADHD focuses upon the inability to participate in classroom activities according to the conventions of that environment:

Hyperactivity

(b) often leaves seat in classroom or in other situations in which remaining seated is expected

...(f) often talks excessively

...Impulsivity

- (g) often blurts out answers before questions have been completed
- (h) often has difficulty awaiting turn
- (i) often interrupts or intrudes on others (e.g., butts into conversations or games) (p. 84; emphasis in original)

Psychiatric research has responded to the teaching world's understanding of ADHD. A study by Wolraich et al (1996), for example, utilized data provided by school teachers to evaluate the validity of *DSM IV's* criteria for ADHD. This study affirms that the understanding of ADHD within the educational environment represents a parallel understanding to that of the American Psychiatric Association. Such a study clearly demonstrates a point of interaction between formal medical nomenclature and the production of ADHD knowledge in the classroom setting. There is a reflexive relationship between educational and psychiatric discourses, in which one uses the other to validate an established understanding of ADHD, or to expand that understanding.

Framing ADHD children

The interviews initially explored some of the ways in which teachers were able to distinguish between ADHD and non-ADHD children. Crucial to this exploration were the characteristics teachers attributed to ADHD children, making them identifiable. Teacher conceptions of ADHD children facilitated a notion of difference between children labeled as having academic and/or social success in the classroom and those who struggled in these areas. Hence, when asked: *In what way(s) do ADHD children differ from other children?* teachers often responded in ways that described kids with maladroit classroom behavior, including social and academic difficulties. As seen in table 7-1, there were three categories of teacher responses. The most common response (15 respondents, or 68% of total) implicated ADHD children's inability to maintain focus and to stay on task. The next common response (4 respondents, or 18% of the total) effectively described ADHD children as having an excess of mental activity, and three

respondents (14% of total) described ADHD children as different because of specific social deficiencies.

Table 7-1: Teacher Descriptions of how ADHD Children Differ from Normal Children

<u>Description of difference</u>	<u>Number</u>	<u>Percentage (%)</u>
ADHD children differ in their on-task behavior and general ability to focus	15	68
ADHD children have an excess of mental activity	4	18
ADHD children demonstrate specific social problems	3	14
Total:	22	100

ADHD children differ in their on-task behavior and general ability to focus

Coinciding with some of the descriptions of ADHD in *DSM IV*, teacher respondents overwhelmingly described ADHD children as having an inability to maintain a consistent focus on a particular activity. This lack of focus primarily affected academic performance. As one teacher stated: "It's hard for them to maintain focus, to maintain any kind of focus. They have bad follow through, bad organization skills. It's really hard for them to follow any kind of lengthy direction" (G7¹). ADHD children, it is believed, have a neurological block between themselves and the completion of significant school-related tasks. Their impulsivity may lead them to approach something interesting or important, but they lack the ability to follow through on what they have begun. When asked how ADHD children differed, another teacher also implied academic difficulties: "Well, in their hyperactivity, their inability to concentrate. Some may have really erratic impulses, you know, do things which are way out of line. ...But, the concentration and focus, that's a big one" (G6).

¹Descriptions of teachers will only include their grade level. Variables of gender and age are omitted for the sake of respondent anonymity. Throughout this chapter the description of teachers will be abbreviated. For example, a grade four teacher will simply be summarized as "G4," and special education teachers will be summarized as "LAC" for Learning Assistance Center teacher.

Teachers also described the inability to concentrate on conventional kinds of classroom projects as an example of a different learning propensity. As one teacher stated: "They have difficulty attending to one task and a real difficulty with seat work. They're much better at hands on work. They tend to move around the classroom and are highly distractible" (G7). Such a perspective denotes ADHD children as having the possibility for more academic success if provided with the means to achieve it. This excerpt also describes ADHD children as more of what many teachers call a "kinesthetic learner," or learning through the physical manipulation of objects. Underlying this notion is that ADHD children have a difficulty conceptualizing without the use of the hands. Their learning is articulated as a more physical process, and indeed, ADHD children are repeatedly described in the interviews as more physically-oriented than their non-ADHD peers.

An emphasis on the physicality of the ADHD learner is also implicit in responses that depict ADHD children as processing information differently. As one teacher stated:

In what way(s) do ADHD children differ from other children?

In the ways they process information and react to stimuli. They process more kinds of information at once, and can't really sort out the different messages that are being transmitted to them. I think their reactions to things also vary. They may be overwhelmed by something another kids just shrugs off. Its like they're sensitive to things in odd ways (G7).

ADHD children are seen as having an inability to sort out the stream of different stimuli that come at them in a classroom environment. This description of the ADHD child's physicality maintains that such children are wired differently. Their behavioral difficulties may be a result of frustration, rather than a neurological impulse. In a position very similar to the psychological stances taken towards ADHD symptoms examined in chapter three, this respondent and others explain that ADHD children's behavior may be the result of not being able to make sense of the information bombardment in a classroom. They reach a point of being "overwhelmed" and have to act in a way that alleviates this psychological reaction.

ADHD children have an excess of mental activity

Teachers also described ADHD children as different, but in a less-stigmatizing way. Some responded that ADHD children have potential to be high achievers if they could just be aided in focusing on important tasks. As one teacher stated:

Well, I think these kids are very bright and intelligent, but don't get things done the way they are supposed to. ...They have this tremendous imagination, but they can't seem to pull it all together. That's why medication can really help--it helps them put the pieces together. (G 4,5,6).

ADHD children's higher level of activity, in this regard, can be attributable to having high intelligence and imagination. Medication is articulated as an aid to getting the energetic, and fractured ADHD imagination back in order.

Another respondent also described ADHD children as having a more active intellect than other children:

I think they have a more active mind. They're very easily stimulated by things outside of what is supposed to be the focal point. They need a tremendously intense experience to focus adequately. Like when you put them in front of a computer, you can keep their attention (G4).

The ADHD child's intellect is explained as a more demanding one, requiring a concentrated dose of stimulation in order to become focused. This same teacher, whose interview is excerpted here, depicted this perspective on ADHD through a story of one 4th grade ADHD boy who had intense classroom struggle and found himself in the principal's office on numerous occasions. Upon one visit to the principal, the boy, while in the waiting area of the main office noticed that the secretary was having some problems with her computer. Her colleagues were standing over her shoulder trying to help troubleshoot the problem, to no avail. After watching this for a while, the boy told them that he knew the solution to the computer problem. Giving up on their own resources the secretary and surrounding troubleshooters allowed the boy to have a go at it. Within a few minutes the ADHD boy fixed the computer problem and effectively explained how to

avoid it in the future. Since that time, the staff at his school have asked him, on more than a few occasions, to assist in the repair of computer difficulties. As the teacher explained, "this was a kid flunking out of school, but who had spent hours in front of a computer." In a reversal of the clinical stereotype of ADHD children as neurologically-underactivated and disabled, such a story casts these children in a much more favorable, and socially-acceptable light. ADHD may even be seen as a gift through such narrative.

ADHD Children have specific social problems

Educator Dale R. Jordan's (1988) work casts ADHD-children in a light that emphasizes a lack of self-awareness and the propensity for disturbing, anti-social behavior. He makes claims about the nature of the ADHD-child's brain, and its ability to comprehend information:

The ADD syndrome child seldom comprehends more than 30% of what occurs around him or her. ...New vocabulary is not added to the language stock on schedule. New data is not fully recorded by the mind. There is no steady, ongoing growth of skills in academic work or social development (p. 29).

The ADHD-child is one who does relate to the world around him/her because he/she cannot neurologically process this world.

The skills which other children develop, including social skills, are missed by this type of child. ADHD children, in Jordan's opinion, are socially maladjusted. They have the ability to formulate some types of relationships and feel emotions, but ultimately cannot express these appropriately. Jordan states: "Most ADD syndrome youngsters are likable in one-to-one relationships. ...These children are often deeply sensitive, feeling the same emotions felt by other sensitive youngsters. They care deeply for pets" (p. 29). The pet-loving ADHD child is one who is depicted as having the emotional qualities of "normal" social actors, yet not having the neurological prowess to express these and involve themselves in a reciprocating relationship with their social environment. They are inclined to become socially isolated.

Such isolation can lead to a litany of disciplinary problems, which, as psychologists stated decades earlier, are due to the frustration incurred from consistent failure, especially within school: "These children bring a cluster of problems into the classroom..." (p. 29). A consistent frustration with the outside world fuels a growing self-centeredness in the ADHD child. They fail to recognize the effects their actions have upon others:

Inattention makes it impossible for the ADD syndrome child to recognize the need to put self aside in the interest of others. ...Hyperactive ADD syndrome children act out their inner stories, rocking their chairs, turning furniture upside down for fortresses (p. 30).

Moving away from a portrayal of ADHD children that describes their cognitive processing of concepts and academics, respondents also stated that ADHD children were different because they exhibited markedly disturbing behavior. As one teacher stated: "With the kids who are unmedicated, their behavior is a lot worse. I've had kids doing all kinds of things in here, you know, hiding under the table, barking like a dog" (LAC). Underlying such responses are beliefs that ADHD children do not have an awareness of themselves like other children. Therefore, when acting out, ADHD children do not realize the ramifications of their actions, including how those actions may affect the learning environment.

Another respondent described ADHD children as having social difficulties on an interpersonal level. In contrast to the positions of Dale Jordan, that depict ADHD children as having success in more intimate, one-on-one settings, this respondent stated: "They also have a really hard time creating deeper relationships with other kids. As they get older, that becomes really apparent. When they're younger its not as obvious. Its like the class clown starts becoming more of a serious social problem" (G 6/7). ADHD children, this excerpt denotes, have an inability to formulate deeper relationships as they get older. The "class clown," regarded as funny by children and a tolerable nuisance by teachers, becomes viewed as truly maladjusted as he/she gets older. Linked to this maladjustment is an inherent inability to attain self-awareness.

Teacher discussion of ADHD children's disciplinary problems

The framing of ADHD children that portrays them as volatile was further reflected in responses to the question: *What are some of the disciplinary problems ADHD children have in your classroom?* Referring to table 7-2, eleven respondents, or 50% of the total, stated that ADHD children engaged in disturbing behavior, primarily the types of behavior that disrupt the learning process. A markedly smaller number of respondents (10 or 45% of total) stated that ADHD children are most inclined to engage in behaviors that are anti-social in nature, including fighting with other students. Finally, one respondent (5% of total) stated that she was uncertain about the kinds of disciplinary problems exhibited by ADHD children.

Table 7-2: Teacher Perceptions of Disciplinary Problems with ADHD children

<u>Type of disciplinary problem described by teacher</u>	<u>Number</u>	<u>Percentage (%)</u>
Disturbing others, especially in the process of learning	11	50
Anti-social behavior, especially fighting	10	45
Unsure	1	5
Total:	22	100

Teachers who stated that ADHD children disturb others, especially in the process of learning

In conjunction with the discourse of ADHD examined in chapters two through four, as well as the previous testimonials of teacher respondents, ADHD children, it is argued, are believed to have major difficulty in keeping themselves engaged in task-oriented behavior. Often believed to be a result of a cognitive deficiency, ADHD children's inability to remain on task was seen by many teachers as a causal factor in such children disturbing others. As one teacher stated: "They don't understand the idea of a boundary or a limit. The routine handing in of assignments, now that's totally foreign to them. They're very scatterbrained, have no idea of completion in their work" (G 2/3). Such children are framed in a way that portrays them as lacking an awareness of

the social definitions of situations--situations that prescribe boundaries for conduct. Hence, many teachers stated that ADHD children, as they fail to see the relevance of completing assignments, also fail to see the relevance of rule systems that prevent them from untimely social interactions with other kids.

Another common theme from teachers who described ADHD children as disturbing to others described the apparently incorrigible nature of such children. Disciplinary mechanisms as simple as telling a student to stay seated were articulated as fruitless in dealing with ADHD children. As one respondent put it: "The ones I've had you tell them to sit down and they're right back up again. Two minutes later or 3 minutes later they're back at it again, over and over" (G7). Such responses clearly reflect the neurological narrative about ADHD that frames children with the disorder as suffering from forces of compulsion outside of their individual will. This kind of framing of ADHD children's disciplinary problems pleads a case for outside intervention into the lives of such children. ADHD, it is argued, is a foe that prompts disciplinary problems and places ADHD children in punishing situations that damage self-concept. These kinds of situations are not attributed to the ADHD child's character, but to neurological impulses.

Teachers who stated that ADHD children engaged in anti-social behavior, especially fighting

ADHD children were also framed as having problems with confrontational, anti-social behavior. As one teacher stated: "Just that they are so impetuous, not finishing their work, getting into fights on the playground. I'd say half the time when a fight occurs its usually involving one of the ADHD kids" (G6). Other respondents emphasized that even though ADHD kids were often involved in physical disputes at school, they were not always the aggressor in such altercations:

I think they do get into fights more than the non-ADHD kids, but I don't think they're always the ones starting it. Some of these kids have a target painted right on their forehead and the other kids just go for it. They really take aim on them (LAC).

ADHD children's tendency to fight was not always a result of their neurological dysfunction, but the way other kids responded to their disability. When this respondent states that "some of these kids have a target painted on their forehead" he is expressing that such children own a particular social vulnerability. As will be examined in the next chapter that analyzes the interview data from parents of ADHD children, it was commonly articulated that ADHD children were often the recipients of bullying from other children. Academic shortcomings, failure to formulate strong social bonds, and other social and psychological manifestations of ADHD, are argued to be weakness areas that other children exploit in order to antagonize ADHD children.

In interpreting the nature of such disciplinary problems, one may examine the psychological discussions of ADHD that were examined in chapter three. Within this perspective, ADHD children cannot only be framed as acting out in ways that annoy the teacher, or innocuously disturb other kids. When endured at extreme levels, the frustration that many ADHD children are argued to feel may prompt more intense kinds of reactions towards other children. These reactions, as they stem from psychological frustrations, may account for physical altercations in which ADHD children are the aggressors, but also those instances when they are the recipients of aggressive behavior. In instances in which they are the aggressor, ADHD children are portrayed as social actors who have "had enough" and can no longer tolerate the apparent cruelty of the non-ADHD world. In the case of ADHD children who are subjected to violence--perhaps even victimized by it--the explanation is different, yet adheres to the psychological explanations for ADHD-like behavior. ADHD children, in this capacity, are described as not only frustrated by the mental demands of the learning environment, but also by its social demands. In social situations there is a notion that individuals should maintain a certain thickness of skin, a certain tolerance to the prodding of others. For ADHD children, who are clearly framed as lacking some of these tolerance thresholds, it may be argued that withstanding the teasing assault of other kids may be an impossibility.

Connecting behavioral and academic troubles

Furthering the inquiry into the disciplinary problems most prevalent with ADHD children, teachers were also asked: *Are these problems usually behavioral, or are they academic?* Though the question was styled in an "either/or" type of format, table 7-3 reveals that 95% of teachers stated that ADHD children's disciplinary troubles were both academic and behavioral in nature. When answering this question in such a way, teachers often depicted something about the nature of ADHD children; hence, in mentioning that ADHD children had both academic and behavioral problems, teachers demonstrated additional ways in which ADHD children were framed.

Table 7-3: Teacher Description of Children's Problems as Academic, Behavioral, or a Combination of the Two.

<u>Teacher description of child's problems</u>	<u>Number</u>	<u>Percentage (%)</u>
ADHD children's problems are a combination of academic and behavioral difficulties	21	95
Response did not reveal a definitive answer to the question	1	5
Total:	22	100

Teachers who explain ADHD children's problems as a combination of academic and behavioral difficulties

Perhaps most significant in this framing was the way the ADHD child as social actor was seen as a creature lacking varying types of classroom skill. There was a range of ineptitude ADHD children were perceived to have--ineptitudes that fed into each other. One teacher, who kept a meticulous log of students with behavioral difficulties in his class, stated:

I try to keep a log of all the incidents, you know written records of what has happened. With any behavior problem you will usually get some kind of an academic ramification to it. I see that with the kids who I spend the

most time logging and charting are usually the ones who are doing the poorest in school (G 6/7).

Through documenting incidents of problem behaviors and who perpetrated them, the above respondent formulated conclusions about the relationship between disruptive classroom behavior and academic failure.

The perceived connection between behavioral problems and academic failure is strongly linked to propositions about the neurological nature of ADHD and the effective methods of treating the disorder. For example, chapter three examined how both psychological and neurologically-oriented clinicians often saw medication as a necessity because it calmed the body and hence, made ADHD children more susceptible to psychotherapeutic treatments. These perspectives are most typified in the psychological camp by Lawrence Diller, and in the neurological camp, through Paul Wender. Through the administration of medication the body becomes calmed, and that is believed to have an impact on the way the mind internalizes behavior modification strategies, family therapies, different teaching strategies, and so on. Implicit within the psychological ideas about ADHD treatment is that the condition of the body has a direct affect upon the development of the mind. Given the popularity of such propositions, it is not surprising that many teachers contended that an out-of-control body would affect the mind by impeding the learning process. As one teacher stated: "The behavior gets in the way of the academics. If you can't control your arms and legs, you can't hardly learn the lessons for the day or know what the homework assignment is" (G 2/3). Another teacher stated: "With the ADHD kids if they can't focus, and feel compelled to get in the way of one another, it means their grades start going down, or they get so far behind that they can never make it back up" (LAC). The compulsion to act out, it is argued, eventually enslaves ADHD children. Because their bodies are considered uncontrollable it is argued that such children will suffer greatly in their future academic endeavors.

Neurology or will: teacher perceptions of what motivates ADHD

Teachers were also asked about what they felt were the underlying factors for an ADHD child's behavior. The question, *Do you believe these children are acting according to an unstoppable impulse, or can they control their behavior?* pitted a neurological perspective--characterized by the phrase "unstoppable impulse"--against alternative perspectives on the degree of control ADHD children had over their own behavior. Most respondents (14, or 64% of total) argued that they felt ADHD children could exhibit some degree of self-control, thereby largely dismissing the neurological notions that ADHD children act entirely out of physiological impulse. Within these responses it was often implied that self control was a skill that ADHD children simply had not been taught, and were not exempt from learning. Six respondents (27% of total) sided with the neurological perspective on ADHD, stating that they felt it was impossible for ADHD children to exert control over themselves. Finally, two respondents (9% of total) argued that ADHD was something that ADHD kids eventually grow out of; hence, degrees of self-control increase as these children grow older.

Table 7-4: Teacher Opinions on Whether or not ADHD Children can Control their own Behavior

<u>Opinion on child's control over behavior</u>	<u>Number</u>	<u>Percentage (%)</u>
ADHD children can control themselves to some degree	14	64
It is impossible for ADHD children to control themselves	6	27
ADHD children eventually outgrow the behavior	2	9
Total:	22	100

ADHD children can control themselves to some degree

The dominant neurological perspective towards ADHD rests on a few core propositions. Two of these that are key include the proposition that ADHD children suffer from a bona fide

organic deformity or lesion in the brain, and secondly, that this deformity or lesion prompts children to act in anti-social ways.

Contrary to this perspective, a significant majority of the teacher respondents argued that ADHD was in fact something that children afflicted with the disorder could control. Such control, it was often implied, involved interventive tactics external to the child. As one teacher stated: "I think they definitely could. They would have to have someone show them how to understand their behavior, then they could control it, I think. No matter what, I think they should be responsible for their behavior whether we think they can control it or not" (G4). Such a response was exemplary of those who felt that ADHD children could exert self-control if given the proper tools to develop this integral skill. ADHD behavior, in this regard, is framed as much more of a social phenomenon than a neurological one. A degree of responsibility is placed upon those who provide the ADHD child with the tools to exert self-control and also upon ADHD children, who are perceived to need to utilize those tools once they have been adequately given. As outside intervention increases, so does the accountability of ADHD children to their own actions.

Continuing with this social perspective towards ADHD behavior, respondents also argued that ADHD children acted out in response to the social environment around them. One teacher put it this way:

A lot of it depends on the people around the child and what the expectations of that child's behavior are. You will find that even the worst kids will do a lot better when the expectations are set higher for them. For one ADHD kid I have right now, we have this nod to the door, a private signal that is our way of letting him get outside for a couple seconds and get out some of that energy (LAC).

This excerpt denotes that the energetic and often disturbing ADHD behavior is largely in response to the standards that are established around ADHD children. Following the common sense notion that one's achievements will reflect one's expectations, this response implies that if

you expect disruptive behavior, you will certainly get it. Teachers, in this capacity, are crucial agents in the self-fulfilling prophecy of ADHD children. Largely formulating the "expectation structure" for ADD children, teachers are shown as tremendously influential in the creation of classroom disruption.

Such a line of discussion that frames ADHD behavior within the context of what is expected of ADHD children resonates with previous discussions in chapter four and in chapter six about the necessity for structure in ADHD children's lives. It is argued that ADHD children have an inherent desire to test boundaries, often exploiting rules that are unclear or poorly enforced. Part of effective ADHD treatment, therefore, mandates a constant reminder to children about what the rules are and what behavior is expected of them. These expectations should be somewhat designed on the presence of the ADHD disorder. The example of the child nodding to the door is very telling for it reveals that the things expected of ADHD children should differ from other children. Nodding to the door is a way of allowing the ADHD child to establish personal agency in regulating his own conduct. In allowing this exchange of glances to occur, this respondent is acknowledging that the child has an ability for self-control.

It is impossible for ADHD children to control themselves

Teachers also responded in ways that resonate very strongly with some of the neurological perspectives towards ADHD, namely, that the disorder, if left untreated, is impossible to control. As one respondent stated: "I really don't know if they can adequately control themselves once they get the urge to do something. So, when they get in trouble we act like they are supposed to understand how to control themselves?" (LAC). Implicit within this type of response is that ADHD children--or any children, for that matter--do not have a desire to get into trouble. Therefore, if a child is chronically having disciplinary problems in school, this behavior must be outside his own will. From this perspective, the appropriate role of teachers is one in which understands that the actions of ADHD children stem from something beyond their control. Hence, when he respondent states: "we act like they are supposed to understand how to

control themselves," he is elucidating the futility of conventional interpretations of ADHD behavior. The disability perspective would be much more favorable in such instances.

A perspective towards ADHD behavior that pins the responsibility for such behavior on the ADHD condition also favors non-human forms of intervention. As one teacher stated:

For a teacher to say "pay attention" is not always effective. Its a stimuli issue, more than a disciplinary one. I'm not a huge fan of medication, but it works, in a miraculous way, sometimes. Yeah, they definitely need help.

They want to pay attention, but the impulse is beyond them (LAC).

Again, conventional perspectives towards classroom misbehavior are ineffective with ADHD children. As this respondent proclaims, ADHD is not an issue about discipline, but is an issue about the way ADHD children process the world. The impulse these children receive to behave in a particular way is beyond the scope of their own self-control. Because of this neurological condition, medication may be seen as a necessary intervention strategy.

ADHD children eventually outgrow the behavior

Taking a developmental stance towards ADHD, some respondents argued that they felt that the disorder becomes less severe as a child matures:

Some kids just outgrow ADHD. As they mature, things become more calm, mellowed out. That's why meds are something I'm not too sure about. If the kid is going through a phase of his emotional development, is it a good idea to medicate when the phase becomes difficult for people?

(G6, 5/6 and 6/7).

The "class clown," this excerpt implies, develops emotionally and eventually grows into a more calm individual. An ADHD case, in this instance, is not a true neurological condition, but a state of maturity. Given that premise, medication would be an inappropriate intervention strategy. What ADHD children really need, this passage implies, is patience and an understanding that some children take longer to develop skills of self-regulation.

Not explicitly mentioned in the interviews, but worth exploring, is the extent to which such responses implicate the informal social regulation of the classroom as a source of quashing ADHD behavior. Certainly, alongside with the development of emotional maturity and behavioral regulation comes an increase in one's social sensitivity. The social psychological development of self awareness, in the Meadian sense, would be inextricably linked to anticipating the judgment others may have of ADHD children's actions, and also the judgments they may level against such children's character. Hence, the notion that ADHD children may "outgrow" the disorder denotes both a physical development and a concomitant social development.

Teachers and other social actors surrounding a suspected case of ADHD.

The process of suspecting a child with ADHD involves a variety of social actors, many of whom come together to discuss a child possibly having ADHD within the confines of the school, and at times arranged by the school. The discussions that take place are some of the most critical in propelling a case of suspected ADHD into the realm of formal evaluation. That is, the psychiatric nomenclature of ADHD is utilized and, in many ways, tested against the knowledge of the child's behavior, ultimately resulting in moving the child to the next phase of evaluation. Particular to the interviews of teachers was an inquiry into the parties they first approach when they suspect a child may in fact have the ADHD condition. When asked: *Whom do you usually first talk to when you think that a child might have ADHD?* teachers reported the contacts they considered to be the most pertinent when a child was thought to have ADHD. The majority of respondents (13 or 59% of total) stated that they would bring the information they had about an ADHD child to a meeting of a school-based team (SBT)--an established part of the public school curriculum that offers an avenue for teachers to discuss issues with particular students' learning or disciplinary problems. Five respondents (23% of total) stated that they would make direct contact with parents, and present what they felt were some of the warning signs that the child may have the disorder. Two respondents (9% of total) stated that they would talk to other

teachers (itself a redundancy as teachers comprise much of the membership of the SBT), and the same number of respondents stated that they do not observe any kind of protocol in contacting people about ADHD.

Table 7-5: Teacher descriptions of the parties they initially contact when they suspect a child may have ADHD

<u>Initial contact</u>	<u>Number</u>	<u>Percentage (%)</u>
Members of a school-based team	13	59
Parents	5	23
Other teachers	2	9
No protocol	2	9
Total:	22	100

School-based team

The SBT typically has a variety of participants, including a child's past and present teachers, a principal, school counselor, and at times, a medical doctor. Exemplified by the work of Georgia Burnley (1993), the approach to this method of identifying ADHD is based around a 6 phase procedure: 1) preliminary assessment; 2) initial child-study team meeting; 3) formal assessment; 4) follow-up meeting of team; 5) collaborative meeting for strategy development; and 6) follow-up meetings and progress review (Burnley 1993: 228-230). Observations of the child presented at these meetings begin the larger machinery of the ADHD-assessment process. Therefore, doctors, or other mental health professionals should be privy to the information gathered by the school to make the assessment process more effective.

Demonstrated as the standard method of intervention in the interview data, the SBT is a documentation of the phases of the transition from informal to formal suspicion, culminating in pedagogical changes designed to suit the needs of the ADHD student. The "preliminary assessment" denotes a team building phase in which clinically-unsubstantiated suspicions are discussed with other school personnel. Within these discussions stories are shared and patterns are established. Formal assessment begins when a team begins a process of disclosure between

members that particularly invokes ADHD. At this phase, children may be asked to complete one or many attention or behavior disorder tests, the results of which may solidify a formal assessment and move the child down the path to medical intervention.

In enhancing the team approach to observing ADHD, Carol Dowdy (1998) argues that the teacher's role should be expanded in a clinical capacity. The author argues that teachers should not be mere automatons, informing a team about the events of their classroom, the antics of certain children, etc. Teachers, Dowdy argues, must have a degree of knowledge of ADHD: "Every teacher should have access to a copy of the...(DSM IV) criteria and should be trained in identifying the characteristics that may be manifested in the classroom" (33). Knowledge of ADHD symptoms should be accompanied by a procedure for documenting these behaviors:

When teachers observe that several of the *DSM IV* behaviors are characteristic of one student...they should begin to keep a two week behavioral observation log. The log should document the child's attention-deficit-like behaviors and the times during which the behaviors appear to be more intense, occur more frequently, or are of longer duration. The specific classroom activities should also be noted, including the academic task and the type of activity (p. 33).

Documentation bolsters the in-school ADHD-assessment: "...If the teacher's observations continue to reflect significant attention-deficit-like behaviors the school district's referral process should be initiated. The observation log should be attached to the referral" (p. 33).

A documentation of behavior is an important component, many teachers argued, in confirming a suspected case of ADHD. The preliminary discussions at an SBT meeting, where parents are absent, serve as a primer for the more pivotal meeting to which parents are invited. Such preliminary meetings serve the purpose of compiling information and developing a case to present to parents. As one respondent stated: "We present the findings of our meeting with the parents and explain our concerns and we recommend that the parent pursue it through medical channels if it's severe enough" (LAC).

Such meetings with parents, many teachers argued, had potential to be counterproductive if inadequate or unconvincing evidence was presented. Many teachers argued that parents were inclined to be very defensive about the mental states of their children, and might quickly dismiss unwarranted opinions of the school. The SBT meetings, it was repeatedly argued, were places where a preliminary assessment of a child must be refined enough to prompt a convincing argument to the parents. As one respondent stated:

I bring it (the possibility of a child having ADHD) up at an SBT meeting. From there we go in a lot of directions, but we usually bring the parents in to talk over some of the things we have been seeing and documenting. It's become really important that parents come in and know that we have been closely watching their child, otherwise they're likely to blow us off and not get any kind of medical intervention (G6, 5/6 and 6/7).

As stated, the end goal with much of the SBT meetings surrounding ADHD is for the parents to begin some process of medical intervention. Without a solid case, members of the SBT may be seen by parents as incompetent or unqualified to make medical recommendations. They need to present their case in as formal a way as possible to parents without giving off the perception that they are practicing medicine.

With the case of the SBT and its use and presentation of psychiatric nomenclature, we may see a different side to the informal/formal suspicion dichotomy established by Erving Goffman in his classic study of how potential mental patients become institutionalized (1961). Because the SBT uses the language and diagnostic criteria of *DSM IV*, and because they recommend assessments specifically for ADHD we may be inclined to conclude that the SBT has many attributes characteristic of formal realms of mental health diagnoses. However, despite their continued use of clinical language and diagnostic tools (recall the previous chapter in which doctors often had students fill out Conners questionnaires in school) the school does not have the legitimate power to make a formal declaration of the mental state of the problem child. The school is between the lay world and the world that has the authority to diagnose children.

Because of this status, it might be more appropriate to examine the school, more particularly the SBT, as a realm of semi-formal rather than informal suspicion.

Speaking directly with parents

A smaller number of respondents stated that the first parties they approach, when suspecting a child may have ADHD, are the child's parents. For some teachers, talking to the parents directly was a way to avoid delay in dealing with an issue that may be very pertinent to a child's education. As one respondent stated: "I may look at the permanent record card for the child and see what other problems he or she may have had. I try to discuss things with parents when conferences come up, or I'll call them at home if it is something of a crisis which has occurred (G 6/7). From this perspective, children are often viewed as "in crisis" and needing a swift intervention--something that may not be provided by the SBT. Swift and direct contact with parents was also viewed as a means to developing rapport with them. The implication is that in some instances, parents may be very skeptical of the findings of the SBT and would be more receptive to the opinions of the person who spends the most time with their children.

Discussion of teaching techniques for ADHD children

As ADHD children were perceived to be mentally different, it followed that the majority of teachers adopted certain strategies to accommodate such children in the learning environment. The nature of different teaching strategies often provided insight into how teachers saw the inner-nature of ADHD children. Often, when answering the question: *What teaching techniques have you tried to use to educate children with ADHD?* many teachers revealed more about how they framed ADHD children in their own minds, more specifically, how they perceived such children's learning abilities. Responses to this question most commonly addressed the modification of assignments to suit the ADHD condition, comprising 12 respondents, or 54% of the total. Another considerable number of respondents (7 or 32% of total) stated that they did not really employ a method of teaching ADHD children, per se, but that what was necessary for

children of all learning levels was a generally effective method for teaching. Finally, 3 respondents (14% of total) stated that the best way to cultivate an ADHD child's learning was to develop his/her self-esteem and self awareness.

Table 7-6: Teacher description of teaching techniques employed for ADHD children

<u>Teaching technique</u>	<u>Number</u>	<u>Percentage (%)</u>
Modify assignment structure to suit ADHD children's needs	12	54
Employ a general effective method of teaching	7	32
3) Build self-esteem and self-awareness	3	14
Total:	22	100

Teachers who modify assignment structure to suit ADHD children's needs

The majority of respondents stated that they augmented their teaching approaches to accommodate children with ADHD. In many cases this involved shortening the length of assignments so that such children could complete some of the tasks at hand. As one teacher stated: "I guess I try to make sure the activities are a little bit shorter than normal. If I notice a child beginning to get restless, I try and break things up a little bit, if I can. In smaller chunks these children can do pretty good" (G 5/6). Such augmentation of assignments is said to cultivate a sense of accomplishment for ADHD children and make them feel more a part of the classroom environment. Another respondent stated it this way: "I use shortened assignments to enable them to get a sense of success. I also like to give choices in what the kids are able to do. They don't have to do the things in order if they don't want to" (G 2, 3).

Referring to the discussion of psychological perspectives towards ADHD in chapter 3, ADHD symptoms can be perceived as a reaction to a world that seems to misunderstand or is unsympathetic to the special condition of ADHD children. What appears to be impulse-driven behavior, from this perspective, is really an expression of frustration children have in dealing

with the conventions of everyday life. The modification of assignments on behalf of teachers is meant to relieve the frustration believed to cripple children with ADHD. By modifying assignments, and breaking them into smaller, more digestible pieces, teachers try to relieve the negative associations ADHD children may make with the classroom. In making class work easier, teachers argue that ADHD children can have more cohesion with the rest of the learning community.

In further accommodating ADHD children and removing the negative associations from the classroom, teachers also stated that it was important to acknowledge that ADHD children have an inclination for unconventional classroom behavior and that this was not to be entirely discouraged. As one teacher stated: "It's also really important to let these kids work with other kids, you know, work a little, talk a little. I try not to be draconian when it comes to the kids because I think they really need to talk sometimes. Giving them motion and movement is also really important" (G 2/3). Another respondent allowed the use of CD players, as they were perceived to help ADHD children focus: "I'm also not opposed to allowing the kids to wear headphones (CD players) while they're working. The ADHD kids just settle right down once they get the headphones on" (LAC).

Such responses clearly demonstrate that teachers, to some extent, frame ADHD children in a different light than their non-ADHD counterparts. This framing promotes a certain pliability in dealing with such children. Instead of the school being perceived as an unyielding, rigid institution, responses that describe alterations in the curriculum or allowances in behavior demonstrate that the school attempts to address ADHD through its own internal adjustments. However, in response to these adjustments it may be pertinent to ask whether or not the creation of a sense of success is being done at the cost of the quality of the curriculum. Does the reduction in expected workload of ADHD children keep them involved with the pedagogical process, or does it further separate these children from others?

Teachers who employ a general effective method of teaching

A considerable number of respondents stated that they did not employ any specific method for teaching children with ADHD. In many cases, special teaching techniques were believed to be best implemented at a Skills Center or Learning Assistance Center. As one respondent stated: "For me, its really about being an effective teacher. I haven't seen any kind of protocol for ADHD kids in our school or from the district. What the kids need is some intensive attention from a teacher, like someone at the LAC" (G7). This excerpt is an excellent example of respondents who do not advocate any particular teaching strategy other than being competent at the teaching profession.

Such sentiment was also expressed at a professional development workshop on ADHD I attended at a local Vancouver school. During the workshop many techniques for teaching ADHD children were mentioned, including: 1) Being specific in the directions you give; 2) Giving notification well in advance of any upcoming work that may require extended effort; and 3) Spending more one-on-one time with ADHD students, if possible. In talking with teachers after the workshop, it appeared that many people felt these kinds of recommendations were strategies applicable to all students, not just those with ADHD. These informal teacher comments implied that an ADHD protocol could not be developed because the methods prescribed to teach ADHD children were already used by any competent teacher in the first place.

In being asked to specifically accommodate ADHD children, many teachers stated that they were being asked to become more effective teachers--a task considered by one teacher to be more daunting than it used to be:

I think just solid teaching is what needs to be done for these kids, but that's tougher these days with the increase in class sizes that have been occurring. I don't really know of any techniques that we use to just teach ADHD kids, other than being present and taking part in giving them attention and care (G 6/7).

Addressed in this excerpt is the issue of structural constraints encroaching upon the profession of teaching. Solid teaching for ADHD and non-ADHD children is argued to be more difficult given the increasing demands placed upon teachers, namely, increases in class size. Interestingly, even though a few respondents mentioned class size as an impediment to providing effective teaching strategies, no respondents alluded to the idea that increases in class size affect the extent to which children in the classroom may be suspected of having ADHD. In other words, no teacher I interviewed drew a linkage between increased class size and increases in diagnoses for ADHD.

The fact that there is no ADHD teaching protocol in British Columbia nor a ministry designation for ADHD children speaks again to the perceptions of what constitutes ADHD, and whether or not ADHD is a valid diagnostic category. Unlike other learning impediments, such as dyslexia, dysgraphia, or learning disability, in which there are specific teaching protocols, ADHD remains unrecognized. This lack of recognition stems from at least two factors. First, ADHD symptomatology represents such a plethora of behaviors it would certainly be difficult to establish one teaching protocol. Teachers are told that they have students with problems focusing and completing their work--problems that are perceived by many teachers to be conventional and "part of the job." Second, when examined closely, ADHD symptoms, such as impulsivity and lack of focus, are behaviors expected of children. Most children surely experience restlessness or academic struggle from time to time, but determining when these instances represent ADHD or not remains highly subjective.

Teachers who advocate building self-esteem and self-awareness

A small number of teacher respondents stated that their primary purpose in addressing children with ADHD was to help children become more aware of themselves: "It's important to teach kids to be self-aware. Most of the time they have no idea that they're off-task, or that they're disturbing other kids" (G 5/6). ADHD children, it is argued, have an inability to realize that they are not performing according to the requirements of a particular assignment. A teacher's role, this excerpt denotes, is to help such students see the difference between themselves and the rest of the

learning community. In order to get ADHD students back on task, it is argued that teachers need to endow students with the awareness skills to step outside of themselves and recognize the differences between their behavior and the behavior of others.

Another respondent argued that the classroom needs to become an environment that elevates a child's self-concept. As one respondent stated: "Well, a big thing I work on with them is self-esteem. With ADHD kids the self-esteem can be really low, people are always telling them they're wrong" (LAC). For ADHD children, it is believed that the classroom symbolizes failure and struggle. Consistent failings in this environment, it is argued, have a marked impact upon ADHD children's belief in themselves. Therefore, many ADHD children's learning difficulties do not necessarily come from the neurology of the disorder, as much as they come from feelings of inadequacy.

Classroom restructuring

Teachers were also asked whether or not they made changes to the geography of their classrooms in order to better suit children with ADHD. The incentive for inquiring about classroom structure was to examine the extent that pedagogical accommodation of ADHD was enhanced by changes in the way a classroom was designed. In response to question #6: *Have you restructured your classroom to accommodate these children? If so, in what ways?* half of the teachers (11 or 50% of the total) responded that there was no specific structural changes they made to the classroom with regard to children with ADHD. Seven respondents (32% of total) stated that they restructured their classrooms only to the extent that they changed the proximity of ADHD to themselves and to other students. Finally, four respondents (18% of total) stated that they taught in classroom environments that were already designed to accommodate children with ADHD and other learning difficulties. Such respondents in this final category taught in Learning Assistance Centers, all with very similar design.

Table 7-7: Teacher response to question concerning restructuring the classroom for ADHD children

<u>Classroom change</u>	<u>Number</u>	<u>Percentage (%)</u>
No structural changes to classroom for ADHD children	11	50
Change proximity of the ADHD children to the teach and other students	7	32
Particular teaching environment accommodates children with ADHD and other disabilities	4	18
Total:	22	100

Teachers who state that they do not implement structural changes to the classroom for ADHD children

Respondents who stated that they did not make any major structural changes in their classroom for ADHD children also discussed the issue of the absence of any school protocol for such changes. As one teacher stated: "But the school isn't very flexible in terms of what can be done. So, no I guess I don't do that much in that regard" (G 4,5 and 6). Concomitant with the fact that there is no ministry designation for ADHD, nor any bona fide teaching strategies for ADHD children, there are no mandates for the way classrooms should be restructured to deal with the ADHD condition. Essentially, this lack of a mandate translates to little action in the classroom environment.

The bureaucratic reception of ADHD that essentially dismisses the disorder is, according to some teachers, part of a larger issue of rigidity in the BC Ministry of Education. For many teachers the simple matter is that different learning styles are not addressed in ministry protocol, and if such protocols did exist, they would be impossible to implement because of increasing class size. As one respondents stated: "Its really hard to try to implement anything that's just for one type of learner. And if we were asked to do that we would probably have to double our staff." (G 6/7). Hence, the issue with not accommodating ADHD students has at least two facets: one being the recurring problem of the perceived invalidity of the ADHD diagnoses on behalf of the

Ministry, the other concerning the fact that there are not the staff resources available to employ effective techniques even if a diagnosis of ADHD was a legitimate ministry designation.

With the lack of restructuring in the classroom we see the ramifications of the Ministry's reception of ADHD--a reception that certainly has not occurred in a vacuum and is not particular to British Columbia. The reasons for the provincial education ministry's response to ADHD reflect the disorder's genealogy. As demonstrated in chapters two and three, ADHD has never had a history of being an elegant category of illness. Because of the gelatinous nature of ADHD's symptoms, the cause of the disorder has had various interpreters, most of whom vehemently deny the legitimacy of other interpretations. Despite the prevailing dominance of neurology in framing ADHD, the disorder remains shrouded in popular and academic debate. The diagnosis, many critics contend, remains highly subjective, its ultimate impact on our culture ambiguous. At the level of education policy, where the most cutting edge research remains largely unintelligible and irrelevant, the ambiguity of ADHD is strongly preserved. Unlike the unequivocally physical conditions that are recognized by the BC Ministry of Education, such as visual impairment (Ministry code: 118A4), deafness (118A5), or autism (118A6), ADHD has not found its place. Until the time comes when ADHD becomes recognized as a bona fide learning impediment--a time, many may argue, that will never arrive until the disorder's legitimacy can be firmly established--it seems unlikely that teachers will implement significant changes in classroom design.

Change proximity of the ADHD children to the teacher and other students

Lacking ministry protocols and funding, teachers still contended that they were able to demonstrate some agency in how ADHD was addressed through the structure of the classroom. Instead of adjusting the room, making it more suitable to students with ADHD, many teachers claimed to adjust the students. Often this involved allowing students to work in groups. As one teacher stated: "We try to do things in small groups and that works really well for the LD and

ADHD kids" (G4). The justification for allowing students to work in groups is that it creates a less rigorous, more socially-loose environment for the kids who struggle with too much structure.

In addition, many teachers argued that allowing students to work in groups provided a kind of one-on-one peer support that acted as an adequate substitute for direct teacher interaction. This helped cultivate the sense of success teachers deemed to be so important in teaching students with ADHD: "I've restructured the classroom so that they can work with a really strong group of their peers. Team projects are a way to help the ADHD kids feel some sense of success, although, sometimes kids complain that the other kids aren't pulling their weight" (G6). This excerpt implies that combined with a sense of success comes the possibility of negative social ramifications, such as students resenting the lack of effort of their peers, and so on. However, this teacher and others argued that the sense of success from completing a project is important to cultivate, despite these social rumblings. By making allowances in how the classroom is utilized and therefore allowing more peer interactions, teachers are demonstrating their role as mediators in ADHD children's school interactions.

In further addressing ADHD student proximity to the learning process, teachers also stated that they made a specific effort to position themselves in the classroom in such a way that would accommodate students with ADHD. As one teacher stated: "I guess I try to orient myself towards those kinds of students more" (G7). Another teacher stated that lessons could be more effectively transmitted to students if they kept such students close to them: "I try to make sure that if I have a kid with ADHD that I stay close to him, and make sure he's getting what I'm saying" (G7). Such responses rests on the idea that ADHD students are highly distractible and need constant reinforcement in order to retain the contents of a lesson.

Particular teaching environment already accommodates children with ADHD and other disabilities

Other respondents also mentioned that their own place of work was inherently suited to the needs of ADHD students as well as other students with specific learning difficulties. All of

these teachers I interviewed were the resident Learning Assistance Center instructors of local elementary schools. One teacher brought me into his center after our interview to show me around. A semi-circle of tiny chairs were oriented towards the chalkboard, the chair closest to the board facing outward was for the teacher. He sat in the tiny chair and demonstrated to me how he does a lesson. Remarkable about the orientation of the chairs and the design of the room was the degree of intimacy such conditions must cultivate between everyone in that learning environment. Lessons were neatly stacked along some bookcases on either side of the room. One could not help but feel the lack of conventional classroom items. Mobiles hanging from the ceiling, colorful paintings on the walls, cartoons that advocate learning, all of these were omitted from the contents of this LAC. During the course of collecting the interview data, I asked respondents to grant permission for me to see the LAC in which they worked. Invariably, the designs in each of the four centers I visited had marked similarities. Allow me to illustrate some of these features of the LAC and describe how they relate to the perceived needs of ADHD children.

First, all of the LAC's I saw were considerably small compared to a conventional classroom. It would be difficult to accommodate more than a dozen students in one LAC at one time. Because of this reduced size there was potential for a tremendous amount of direct teacher to student interaction--something that specifically addresses the needs of ADHD children. In accordance with some of the neurological postulates about ADHD children, namely, that ADHD require a stable reminder system, the LAC fosters a constant reinforcement of school lessons. Such reinforcement comes not through an occasional reminder to get "back on-task," but rather, through a constant teacher presence.

Second, the LAC's had a standard, "no frills" decor that frankly, appeared rather drab. As it was explained to me, the absence of superfluous items was justified in two ways: 1) as part of a teaching technique that sought a minimum of outside distractions; and 2) as a way of avoiding the display of children's completed projects that would cultivate a sense of competition and bad feeling amongst them. With the absence of such items the decor of the LAC represents a

compromise between psychological and neurological perspectives on ADHD. From the neurological perspective, minimizing distractions is an obvious way to control the stimuli that ADHD children receive in the learning environment, therefore aiding them in focusing on their work. In accommodating the psychological mandates about ADHD, the reduction in competitiveness that stems from not displaying children's work makes the environment less belittling for kids who strongly associate school work with failure.

Teacher discussion of *DSM IV*

As the role of the schools are integral in beginning the process of ADHD suspicion, it was important to examine the extent to which *DSM IV* criteria were familiar to teachers, who were asked the two-part question: *Are you aware of the diagnostic criteria for ADHD found in DSM IV? If so, are these criteria relevant or useful to you?* As seen in table 7-8, the bulk of teachers (10 or 45%) stated that they had no familiarity with *DSM IV*, and therefore, did not find these criteria of any use or relevance. Teachers who effectively stated that they were aware of *DSM IV* and also used these in identifying children with ADHD, comprised eight respondents, or 36% of the total. Four respondents (19% of total) stated that they had heard of *DSM IV*, but did not utilize it in suspecting children with ADHD.

Table 7-8: Teacher description of knowledge and/or relevance of *DSM IV*

<u>Description of knowledge or utility of <i>DSM IV</i></u>	<u>Number</u>	<u>Percentage (%)</u>
Never heard of <i>DSM IV</i>	10	45
Have heard of <i>DSM IV</i> and utilize these criteria in suspecting children of having ADHD	8	36
Have heard of <i>DSM IV</i> but do not use it.	4	19
Total:	22	100

Teachers who never heard of DSM IV

For teachers in this category, responses to the aforementioned questions were brief. The fact is that one has either heard of *DSM IV* has as not. Hence, teachers gave terse answers, such as, "No, that's all foreign to me" (G7), "Nope," (G4), "Not really," (G 5/6), and so on.

The fact that this response was the most common, comprising almost half of the teacher respondents, sheds some light on the irony of the diagnostic role of the school. Within this sample we witness a large percentage of respondents who have no familiarity with *DSM IV* but still, because of reasons discussed in previous sections of this chapter, largely participate in the process of suspecting and ultimately diagnosing ADHD. If the process of ADHD suspicion is alive and well within the classroom, yet is not informed by the nomenclature that has given ADHD its name, from where do these suspicions arise? A tentative answer to this question might include addressing the different levels with which ADHD is suspected--and consequently, specifically invoked--with the school context. We may state that many teachers raise a flag of suspicion that promotes the more sophisticated labeling mechanisms with the school. Suspicion, therefore, need not begin with a particular nomenclature, or even hints of it. Rather, suspicion begins in an unsophisticated way, in response to an unidentifiable trouble, that may later become medically defined.

Teachers who have heard of DSM IV and utilize these criteria in suspecting children of having ADHD

Through the process of labeling childhood behavior as "possible ADHD" many teachers expressed that *DSM IV* criteria were something that they understood and also influenced the way a particular child's behavior was framed. Such responses reflected the influence psychiatric nomenclature has in defining childhood behavior in the classroom. One teacher, in a way minimizing her role as someone in the diagnostic process of ADHD, stated: "Yeah, I'm aware of it, but that's more of a medical issue. I look for kids who are having problems, and even though I may suspect that a kid has ADHD, I'm not going to state it like I have made a diagnosis" (G6/7).

The event of suspecting ADHD in this instance is influenced by the nomenclature of *DSM IV*, however, this respondent expresses that the use of the word "ADHD" is something left up to others with the legitimate authority to make such declarations about a child. ADHD as a medical category influences the process of how a child is being perceived in the classroom, but restraint is exercised when presenting these suspicions in any sort of definitive way. Refraining from stating "ADHD" in any kind of conclusive way further emphasizes the non-medical role teachers perceive themselves to be in, but also the role they feel that is expected of them by others.

Other teachers expressed that having knowledge of *DSM IV* criteria is an important element in informing parents about their child's condition. As one respondent stated: "Yeah, I have read those criteria. We had it handed out at a "pro d" day 2 years ago. We refer to it once in a while especially when parents are in denial or are really defensive about their kids problems" (G7). Similar to the perceived necessity of the SBT developing a sound case for ADHD before informing parents of the teams' conclusion, specific teacher knowledge of *DSM IV* can be seen as important in relieving parent defensiveness. As this respondent stated, parental "denial" can be alleviated when a child's behaviors are presented against the backdrop of *DSM IV* criteria. Teacher awareness of *DSM IV* can be an important component of the efficacy of the SBT's recommendations. It is argued that in order for parents to be more accepting of a teacher or team recommendation the invocation of some type of medical label for their child may be crucial.

Respondents also stated that knowledge of *DSM IV* criteria for ADHD can assist in the way the SBT deals with a suspected case of the disorder. As one teacher stated: "Yes, I am (familiar with *DSM IV* criteria for ADHD). I don't provide diagnoses, but if I think a child may be wrongly diagnosed I will bring that up to the team. Because I understand the *DSM* criteria OK, I can sometimes identify the problems" (LAC). Such responses reveal the perception that teachers who are informed about *DSM IV* and utilize this diagnostic clarification effectively can influence the channels explored by the SBT and the type of recommendations the team makes to parents. Here a reflexive relationship between the school teacher and the SBT can be seen. In contrast to instances in which teachers refrain from using the ADHD label, teachers can play a

role akin to a diagnostician. Again, an irony is presented when this respondent states that he does not "provide diagnoses," yet uses his knowledge of *DSM IV* to influence the actions of the SBT.

Teachers who have heard of DSM IV, but do not use it

Some respondents also conveyed a degree of knowledge about *DSM IV*, but did not find it relevant to how they deal with children with specific learning or behavioral problems. Such responses commonly referred to not having specific training in ADHD: As one teacher stated: "No. I've heard of it, but I didn't recognize the acronym. The special ed training I had never covered ADHD" (G7). Another respondent deferred the specific use of *DSM IV* to parties believed to be more able to apply those criteria: "I am aware of it, and I have looked at the criteria, but I don't use it. The school counselor might know more about that" (LAC). Such responses clearly demonstrate a belief in the demarcation of differing types of expertise in dealing with problem children. Having an awareness of *DSM IV* may affect whether or not a child's problems are framed as part of a larger medical problem in the classroom, but the actual application of the manual is believed to belong to another occupational identity.

Teacher perceptions of school consensus regarding ADHD

The mechanisms for dealing with possible cases of ADHD comprise many elements. As mentioned, teachers may approach members of the SBT with suspicions of a child having ADHD, or may individually approach school counselors or parents. Continuing with the collection of data that illuminated the process of raising suspicions of ADHD, the interviews inquired about whether or not teachers felt there was uniformity within their school in identifying ADHD children and applying interventive strategies towards them. Following much of the previous discussion that discussed school policy and the lack of uniformity in interpreting the nature of ADHD, the overwhelming majority of respondents (17 or 77% of total) argued that there was no consensus on how to deal with ADHD in their schools. A distinct minority of

respondents (5, or 23% of total) stated that their school had some kind of consensus regarding ADHD students. Please see table 7-9 for a summary of these responses.

Table 7-9: Teacher opinions on the level of consensus in their school about how to deal with ADHD children

<u>Opinion on school consensus</u>	<u>Number</u>	<u>Percentage (%)</u>
Teachers who feel there is no consensus in their school about how to deal with ADHD children	17	77
Teachers who feel there is some degree of consensus about how to deal with ADHD children	5	2
Total:	22	100%

Teachers who feel there is no consensus in their school about how to deal with ADHD children

Most teachers felt that there was a lack of consensus in their school when it comes to addressing ADHD children. For many of these respondents the lack of consensus within the school was equatable to a kind of child neglect. The school, it was argued, failed to accommodate children with ADHD through its curriculum design. As one respondent stated: "Its a question of do you force the student or do you adapt the curriculum, and I don't think we have sorted that out yet" (G7). In some instances, perhaps in the case of a ministry designation for another learning difficulty, curriculum may suit a student's needs. Funds may be allocated and a student may be able to spend valuable time in a Learning Assistance Center. In other instances, far more common with a case of ADHD, curriculum will remain unyielding, and perhaps lean towards pressuring parents for medical intervention.

Failure to provide the needed structure for ADHD children put such children at an increased risk for academic hardship, many teachers argued. For example, when asked whether or not he felt his school had a consensus on how to deal with ADHD children, one teacher stated: "No, not at all and its a big problem. You get a kid who might have a bad mental problem and no

one knows what to do when he gets into a later grade and starts having problems" (LAC). This excerpt implies that the school must begin the process of identification and accommodation earlier when it comes to ADHD children and certainly speaks to the argument that teachers need to have a greater awareness of what constitutes ADHD. Also implied here is that when older students begin to demonstrate severe learning problems there is no comprehensive intervention program within the curriculum. Hence, the lack of consensus that impedes an earlier intervention upon a child becomes increasingly problematic as the child gets older and encounters a more challenging work load. Because there is no protocol for dealing with all of the manifestations of ADHD (i.e.-social, academic, disciplinary, and so on), it is argued that students will fall through the cracks.

The lack of consensus was also attributed to a void in teacher understanding of ADHD symptoms. As one teacher remarks, the difference between times when a child is making normal adjustments versus the times when he/she is demonstrating ADHD symptoms remains unclear: "Good question. Probably not in terms of school wide consensus. What if a kid is just having a bad day or a bad month? Do we just put him in remedial classes and recommend that he be medicated?" (LAC). The issue here concerns the interpretation of childhood misbehavior. At what point, this teacher's questions imply, do schools determine that a child's misbehavior is in fact pathological? Further, when the determination is made that the behavior might be ADHD and warrants medical treatment, what is the basis of such a determination?

Teachers also contend that some of their colleagues spend too much time focusing on issues of hyperactivity, rather than the cognitive manifestations of ADHD. As one teacher stated: "We focus way too much on the hyperactivity criteria rather than the ADD criteria. With those kids the mind is all over the place, rather than the body. Teachers tend to focus on the physically active kids and that's a mistake" (LAC). The mind of the inattentive case of ADHD is ignored because of the very visible and disturbing behaviors exhibited by students who are more easily labeled "hyperactive." This emphasis on behavior rather than academic failure as signs of possible ADHD is no doubt a factor in teacher support of medical intervention through the

administration of stimulant medications. Hyperactivity, it is argued, can be greatly reduced once a trial of Ritalin begins, and this verifies that the teacher's suspicion was correct in the first instance.

The perceived causes of disruptive classroom behavior by teachers was also placed into question. For many teachers who subscribed to misbehavior as symptomatic of ADHD, their schools were a place laden with those who refused to see such behavior in the same way. As one respondent expressed: "Today we still have a lot of disbelievers, you know, "spare the rod" kind of thinking" (G 6/7). Such "disbelievers" were argued to be an impediment to constructing a school-wide consensus in ADHD. Their colleagues contended that these teachers viewed behavioral problems in a manner that defied a lot of the neurological positions about misbehavior and ADHD. Instead of interpreting overt hyperactive behavior as originating from a neurological dysfunction, respondents argued that some of their colleagues viewed these problems as character misgivings, rectified through traditional disciplinary avenues.

Teachers also echoed issues examined in previous sections of this chapter, namely that there is no ministry designation for ADHD children. As one respondent stated: "We do have the LAC, etc., but the ministry does not recognize ADHD. Sometimes these kids are held accountable when they do not need to be. Sometimes they just can't help it. We simply need more support from the administration" (G8). Through its reluctance to provide resources for ADHD children the ministry is effectively taking a traditional stance towards ADHD behavior. As this teacher implies, the ministry facilitates children being held accountable for their actions, even when many teachers feel such untreated behavioral problems cannot be helped through conventional mechanisms.

The lack of school consensus in dealing with ADHD once again reflects the nature of past and current ADHD discussions. Aside from the criteria provided by *DSM IV*, there is no unifying mode for a diagnosis of ADHD. The attitudes of teachers towards ADHD are indeed a reflection of this state of ADHD discourse. For some teachers, the "class clown" has not changed and requires no deeper examination: certain kids act up and these kids need to be held accountable

for their behavior. For others, the discourse of ADHD has shed new light on what prompts a kid to act out: neurological malfunction. It is the nature of the discussion of ADHD that prevents teachers from coming together under a common interpretation of what constitutes child misbehavior and academic failure.

The issue of school consensus is also further complicated by the wide range of behaviors that comprise ADHD. In interpreting kids' severe academic problems, teachers are more inclined to link these problems to learning disabilities, or dyslexia than to ADHD. As the description of the difference between ADHD and non-ADHD students demonstrates, the ADHD label is almost exclusively pinned on the kids who misbehave, as opposed to those who have academic problems. In this sense, the diagnosis of ADHD--one that most often pathologizes disciplinary problems and academic problems--is a poison pill for some teachers to swallow. To subscribe to the ADHD diagnosis is a means to fostering curriculum complicity, rather than maintaining disciplinary and academic standards.

Teachers who feel there is some degree of consensus about how to deal with ADHD children

A minority of teachers stated that they felt there was a significant amount of consensus in their schools regarding ADHD. For some teachers, the awareness of ADHD was still in progress and slowly forming the backbone of school consensus: "Oh yes, much more now than when I first got here 10 years ago. People are beginning to recognize the problem a lot more than they used to" (G 6/7). Such responses point to the fact that the nomenclature of ADHD is fairly recent when compared to the larger history of the disorder. ADHD, this response implies, is something people are growing more aware of as information about the disorder gets out to the public. Hence, when using the word "people" this response denotes that ADHD is something generally more understood and this wider awareness is making itself visible within the schools.

Respondents also stated that school consensus about addressing ADHD was linked to collective efforts, primarily seen through the interventive strategies of school-based teams.

"Yeah, I'd say there is. We all tend to go right at the individual child rather than the entire group of children. School-based team meetings help us get on the same page" (G7). SBT meetings, it is argued, establish a protocol for dealing with ADHD that emphasizes the finitudes of an individual case. Recalling the discussion of SBT's from the previous section; membership on these teams is varied and no doubt constitutes multiple perspectives on the type of interventive strategies that can be implemented in a case of ADHD. When applied to individual cases, the various perspectives on the team reach a compromise and advocate a collectively-supported intervention.

Teacher discussion of the process of labeling kids "ADHD"

As with other medical conditions, ADHD comprises a specific diagnosis with social consequences. ADHD has a meaning in social life that affects the identity of the labeled person and his/her consequent social reception by others, therefore, it is almost incontrovertible that the label "ADHD" affects the everyday life of the diagnosed person. What is left to debate, however, is the way people judge the effects of a particular label. When asked: *Do you have any concerns about the process of labeling that can result from a child being labeled as having ADHD?* the majority of teachers (16, or 73% of total) stated that they had some concerns about the effects of the label of ADHD, including concerns about the label's permanency, accuracy, and ways in which the ADHD label is internalized by children. A markedly small minority of respondents (6 or 27% of total) responded that they had no major concerns about labeling a child "ADHD." Such respondents stated that the ADHD label representing nothing overtly serious and, if used correctly, could be an important pathway to adopting appropriate teaching strategies.

Table 7-10: Teacher responses on whether or not they are concerned about labeling children "ADHD"

<u>Response</u>	<u>Number</u>	<u>Percentage (%)</u>
Teachers who stated that they had concerns about labeling children as ADHD	16	73

(Table 7-10, continued)

Teachers who stated that they had no major concerns about the ADHD label	6	27
Total:	22	100

Teacher concerns about labeling children as ADHD

As table 7-10 summarizes, responses that invoked concern over the process of labeling a child "ADHD" commonly resonated with much of the positions established in the classic sociology of deviance. Within these responses were concerns over the fact that labels, especially those that concern a mental health diagnosis, have a permanent quality:

Once labeled it travels with them everywhere. That's a big concern that I have. Once they get a ministry designation as LD--which is really ADHD for a lot of these kids--they will always see themselves that way. Maybe in the short run its OK, but down the road that has got to affect self-esteem (G6).

In stating that the ADHD label "travels with them everywhere" this teacher is highlighting significant contributions from labeling theory in sociology (see Rosenhan 1973). The contents of the label become more widely known to larger social networks and prompt interactions that are filtered through the meaning of the label. This culminates in changes in the identity of the child--changes that many sociologists argue cannot be reversed. Hence, this respondent claimed that ADHD kids "will always see themselves that way." Not explicitly mentioned by teachers, but strongly implied by these types of concerns over labeling a child "ADHD" are the way shifts in personal identity foster a process of social exclusion. In Edwin Lemert's famous essay, "Paranoia and the dynamics of exclusion" (1962), the author characterizes an interaction called "the generic

process of exclusion," persons who had acquired some type of deviant identity were slowly pushed away from mainstream life. Two crucial elements of this process of exclusion include: 1) an increasing tendency for the interactions between the labeled individual and the social group to become more spurious in nature; and 2) a lack of fit between the affect of the "exclusionary group" and the attitudes this group carries about the labeled person.

Interactions between the labeled person and the exclusionary group become more spurious as the status of the deviant individual is perceived to be a dominant part of his/her character. In the case of mental disorder labels, interactions become more shallow because the larger social group collectively feels that the deviant person is socially incompetent. Justified by the notion that the deviant label must have originated from somewhere and therefore is valid, this assumption of incompetence ultimately affects the way in which the labeled person imagines how he is being perceived.

According to Lemert, the labeled individual rightfully assumes that there is a different perception of him/herself than the image conveyed through symbolic exchanges between him/herself and the larger social group. The group's affect has become more "small talk," and patronizing, and this prompts the labeled person to attempt to rectify the discrepancy. He/she becomes confrontational, demanding that the group give up the information and reveal what they are really thinking and why. Unaware that their own attitude shifts have caused this confrontational behavior, the group interprets such confrontations as further signs of mental disorder. Thus, a vicious cycle of interaction ensues in which the deviant individual becomes increasingly paranoid and further detached from those who used to provide a stable component to the social-psychological process of "normal" identity.

Lemert's discussion of the dynamics between excluded individual and exclusionary group are rooted in his theoretical positions about the progressive stages of deviance, especially his notion of "secondary deviation." At this phase of social deviance, the individual, having been rejected by mainstream society, fully adopts a deviant identity and seeks others with similar social status. Persons with a mainstream identity become foreign to the deviant, and reintegration

into normal society a shrinking possibility. This move into a solidified deviant identity is attributed to social dynamics rather than to individual behavior. The deviant is effectively forced into a deviant lifestyle because the greater community refuses to allow that person to reintegrate.

Teacher concerns over the ADHD label demonstrate a social sensitivity to the effects of labels and prompts an inquiry into the extent to which the ADHD label may create circumstances similar to those Lemert describes. Within the confines of school there are myriad social situations, the dynamics of which certainly will be influenced by the meaning of the ADHD label. Situations such as a child being absent from regular class to attend a session at an LAC is one of many examples. It is logical that other kids will wonder why one student is being treated differently, why assignments seem to be modified for particular students, and so on. The children who ask about the ones who are being specially treated may formulate a type of exclusionary group who gossips about him/her and formulates judgments about that child's character. Such judgments could drastically alter the course of the ADHD child's social life.

The child's "ADHD" social identity can also be incorrect, according to some teachers. Rooted in the recurring issue of ADHD diagnostic validity and reliability, many teachers argued that the ADHD label, if given wrongly, can obscure some of the child's more significant circumstances. As one teacher stated:

Do you have any concerns about the process of labeling that can result from a child being labeled as having ADHD?

Yeah, and I'll use an example. 3 yrs ago we had one kid who was severely LD and he also was taking meds for his hyperactivity. We met with his mom and found out that his step father was supposedly beating him. So they're medicating this kid, and there is this major problem at home with probable child abuse. They're totally ignoring this kid and they could have given him a label that would have helped his situation rather than avoiding it (G7).

Pertinent to this quote are issues of accuracy in the identification and treatment of childhood problems. In the instance of a child who was likely being abused at home and acting out his home life frustrations at school, medication was argued to be an incorrect, if not inhumane choice. By quashing behavioral problems more attributable to external family dynamics than internal neurology, medication only places a veneer on the child's actual problems. Another teacher expressed a very similar concern about the application of the ADHD label in lieu of an examination of family struggles:

If the label is incorrect--and I think it can be--there could be some real problems. I would hate to think about a kid taking medication when there was really nothing wrong with him but that there was a problem with the family we all overlooked. You just have to be very thorough in dealing with trying to categorize the kid's behavior (G6).

The thoroughness recommended by this teacher seems problematic in addressing some of the immediate behavioral problems perceived to represent ADHD. Because the child who acts up is believed to be surrounded by crisis, action to alleviate the behavior is often taken immediately. In advocating a more exhaustive approach to exploring why a child may act out or suffer academically, such teachers present the case for an examination of the greater social world of the child before entertaining the idea that the child's problems are medical in nature.

For other teachers, diagnosing a child as having ADHD was a concern because the label had an element of volatility. The ADHD label, it was argued, needed to be controlled in some way. Primarily this control needed to be exerted by mediating the amount of knowledge people had about a child's condition: "It (the label) should be kind of kept quiet. Other kids can be pretty harsh when they know some other kid has a problem or has to take meds or something like that. I think teachers need to try and control that a little bit" (LAC). Within the hands of other children, for example, the knowledge about one of their peers having ADHD is perceived to be potentially damaging to the self-image of the labeled child. As stated, the responsibility for regulating this information rests upon the shoulders of adults, most especially, teachers.

It was also argued that knowledge about the ADHD label needed to not only be kept from the cruel grasp of other children, but also needed to be kept from ADHD children themselves:

With labeling you don't want the kid to know what label has been applied. You definitely want the parents and teachers to know so that they can be aware of what to do for the child, but the kid should be told that he is normal and OK (LAC).

The maintenance of the "OK" identity is argued to be integral to the psychological health of ADHD children. Children should not be told that they have a mental disorder because this will create an abnormal self-image, and foster a separation from mainstream life. Hence, being "OK" denotes an identity that fits with the mainstream and avoids drawing any overt attention and/or concern. This passage also places a huge emphasis on adult responsibility in mediating the knowledge of ADHD. The adults who surround the ADHD child must be privy to the knowledge that the child has ADHD so that appropriate remedial measures can be taken. Part of these measures includes preventing ADHD children from knowing the sorts of judgments the adult world has made regarding their mental health.

Teachers who stated that they had no major concerns about the ADHD label

As mediators between the ADHD label and the children to whom the label will be applied, teachers clearly express concern over the social ramifications of labeling and see themselves as integral social actors in softening the stigma for ADHD children. Contrary to such perspectives, other teachers in the respondent group expressed that they did not have any major concerns about the process of labeling children "ADHD." Such teachers contended that ADHD, if applied correctly, can be the beginnings of effective school-based treatment for the disorder. As one teacher stated: "No major concerns. The label can be beneficial if it's the right one. We can get those kids the help they really need, whether that's LAC work or a refined IEP (individual education program) (G 6/7). In the event of a correct diagnosis of ADHD it was argued that such

children would become more understood and therefore accommodated by pedagogical restructuring. Another teacher provided a similar statement, but expressed the necessity of medication "It can be really helpful if you have the correct label and get the kid on the right kind of medication. The label helps us develop strategies to aid the kid in his learning" (G5/6). Such statements reveal a subscription to a combination of both medication use and teaching techniques to deal with ADHD. The label of ADHD, if made correctly can prompt pharmacological attention and an alteration in classroom teaching strategies. Such combined approaches are perceived to be crucial in holistically dealing with ADHD.

In specific contrast to teachers who argued that knowledge of the label of ADHD must be kept from the child, some teachers expressed that the ADHD label is necessary for adults to correctly understand ADHD children, and also for ADHD children to have greater self-understanding. As one teacher stated:

The label can also promote self-awareness. If people see the kid and know what he has, then they can treat him accordingly. The media discussion of medication I think has a lot to do with the fear of labels, but this kind of judgment can be detrimental (G 4, 5 and 6).

As discussed in chapter 4, there is a perception that ADHD children do not have a strong ability to reflect upon themselves and the ramifications of their behavior. The ADHD label, it is argued, can be integral to the child's development of this awareness. Adults, it is argued from this passage, do not stigmatize ADHD children, but rather, treat the child appropriately. From the perspective of ADHD children and the adults that treat them, the ADHD label need not be a source of stigma. The diagnosis of ADHD is seen as correcting the relationship between ADHD children and the adult world that adopts responsibility for their treatment. In addition, this response also offers a commentary on the public perception of ADHD and medication. The public, it is implied, have fears about medication and ADHD, fears that can impede the process of identifying children with the disorder. The "detrimental" condition expressed by this passage

denotes that impediments to identifying children with ADHD will disrupt intervention into the child's life until it may be too late for such strategies to be effective.

Teacher concerns about the effects of failing to treat ADHD

Intervention strategies, it was repeatedly argued, needed to be done fairly early in a child's school career to adequately deal with the ADHD condition. The perceived negative effects of untreated ADHD increased in relation to the age of the child who was diagnosed. Teachers argued that a student first diagnosed with ADHD in high school, for example, had less chance of living a normal life than say, a child diagnosed in grade 2. However, despite the age of the student, intervention was always seen as a better option than no intervention. The undiscovered, or forgotten student with ADHD was perceived as highly vulnerable and "at-risk." Referring to table 7-11, when teachers were asked: *What worries do you have if a child with ADHD goes untreated?*, 18 respondents (81% of total) stated that they felt untreated ADHD may lead to academic failure. In expressing this concern, teachers conveyed the importance of the institution of education in providing opportunities later in life. A much smaller number of respondents (3, or 14% of total) stated that untreated ADHD may increase the chances that an untreated child may become violent and harm others. Finally, one respondent (5 % of total) made a brief comment that the failure to treat ADHD could negatively affect the self-esteem of the child.

Table 7-11: Teacher concerns about untreated ADHD

Type of concern	Number	Percentage (%)
Untreated ADHD may lead to academic failure	18	81
Untreated ADHD children may have the potential to harm others	3	14
If left untreated, ADHD may lower self-esteem	1	5
Total:	22	100

Teachers who stated that untreated ADHD may lead to academic failure

It was repeatedly expressed that a failure to treat ADHD would lead to inadequacies in an ADHD child's education. Often referred to as "holes" or "gaps," these shortcomings were argued to compile and eventually compromise the ADHD child's future. One teacher succinctly described this process:

They're sharp, but they may have some holes in their learning. They are getting a fragmented education, missing certain skills. ...They may drop out of school and not continue any kind of education. Then there's all kinds of stuff waiting for them. One boy I had and his parents were really afraid of medication, that it would be addictive and get him into other drugs. I told him "this will not get you into drugs. This will keep you away from drugs" (G4, 5 and 6).

Shortcomings in academic skills, it is argued, will eventually impede advancement into more complicated school lessons. In that it is unable to process certain kinds of information adequately, the neurologically-impaired ADHD child's mind will always stand in the way of academic success if left untreated. "Holes" in the child's learning will persist and fester until they make continuation in school an impossibility. By expressing to parents that the use of Ritalin will prevent children from taking drugs, this teacher presupposes that such medications are integral to academic success. The appropriate use of medication will enable a child to stay in school and hence, avoid some of the self-destructive behaviors that are perceived to arise when educational opportunities are squandered.

It was also argued that ADHD children who did not achieve academic success would be susceptible to engaging in deviant lifestyles. As one teacher stated:

Without treatment I think a case of ADHD can be really tragic. The last thing someone with untreated ADHD wants to do is go to school. Without school you just don't have a lot of options like you use to have. You can't even learn a trade without a high school diploma. It can really be tragic,

getting on UI, taking drugs. Without school there isn't a lot else to put your energy into (LAC).

And another teacher:

If that kid's need goes unmet in school then you can have all sorts of problems later in life. Where else are they gonna go? Where are they gonna get job skills? If we lose them here its gonna be a long hard road. Once they get isolated from other kids who are going somewhere, they become susceptible to all sorts of things like gangs, drugs, all of it (G4).

Strongly denoted here is the relationship between school success and the attainment of job skills and a consequently comfortable lifestyle. As addressed in chapter two, the history of ADHD is largely associated with institutional failings, primarily within the school context. It may therefore be argued that the perceived necessity of treating ADHD is coextensive with positions that argue for the significance of education. ADHD, in this regard, is not only perceived to be a neurological condition, but also one that is synonymous with school failure.

Other teachers implicated predatory kinds of people in the downfall of untreated ADHD children, and implied that success in school was a crucial factor in protecting children from such menaces. One teacher referred to these types of persons as "recruiters":

I'm afraid they can become very anti-social and drop out of school. This really puts them at risk for the social ills that are out there. These kids will rely on being cool, rather than fitting into the system and having success in it. ...Recruiters prey upon that, take advantage of these kids who have given up on themselves (LAC).

ADHD children, it is argued, will give up on the academic components of school and instead focus on the informal aspects of that environment: being cool, acting tough, and so on. Argued to be increasingly socially-isolated, ADHD children who lose their academic footing are more easily prey to representatives of deviant lifestyles. The teacher from whom this passage comes also told the story of a grade 6 girl who was diagnosed with ADHD, and was never treated

adequately. At 15 or 16 years of age she dabbled in drugs and eventually dropped out of high school. On his way home from work, this teacher stated that he saw her in the skid row area of Vancouver engaging in prostitution. He had not seen her since and had no idea what ultimately happened to her.

In accordance with the themes of volatility that characterize the discourse of ADHD, a small minority of teacher respondents expressed that failing to treat ADHD was a risky endeavor. Such responses framed ADHD children as having the propensity for violent behavior. In one instance, this framing equated ADHD children's volatility with that of other neurologically-disabled kids. As one teacher stated: "Much like the FAS kids, the ADHD kids just kind of placidly go with the flow and then they finally explode. There's a real potential for violence in some of them" (G6).

This potential for violence was also linked to ADHD children as having a different thought process and a different perception of what constituted a threat:

I think you have to understand that ADHD kids aren't thinking the same as other kids. They may see something as threatening that you or I don't. If you act wrongly towards them, they may lash out at you. They might do some real damage too. So, if we can intervene and get them thinking on the right track they become normal, like other kids (G 2/3).

Treatment of the ADHD condition is argued in this passage to be an important part of putting such children's thinking back in line with conventional standards. If effectively addressed, the thought process of the ADHD condition can be augmented to such an extent that volatility is reduced.

Discussing ADHD and gender

For the final question in the interview, teachers were asked about the gender of their ADHD students and how they might account for the gender differences in ADHD. Given the fact

that roughly one in ten ADHD children are female (see chapter three), it was no surprise that teachers responding to this question unanimously stated that boys comprise most of the cases of ADHD in their classrooms. Perhaps more interesting was not the fact that teacher responses reflected the known gender breakdown of ADHD children, but rather, the interpretations teachers offered as to why there would be a discrepancy between genders in the prevalence of ADHD. In offering these interpretations, summarized in table 7-12, teachers expressed a considerable sociological sensitivity, often discussing the socialization process and how that related to the visibility of the disorder.

Table 7-12: Teacher description of the gender of ADHD children in their class

Response	Number	Percentage (%)
Teachers who stated that the children with ADHD in their classrooms were predominantly boys	22	100
Total:	22	100

Teachers who stated that the children with ADHD in their classrooms were predominantly boys

In offering a kind of sociological commentary on ADHD and gender, teachers often described how the two genders had different types of emotional and expressive needs, and that these were often the product of social forces. For example, when asked about the gender of her ADHD students and why there would be this difference, one teacher stated :

Definitely more males. Probably double the amount of girls, but I think we miss a lot of the girls. They are more emotionally needy, trained different. With boys its very visible, they act out externally. But the inattention with both is the same kind (LAC).

This passage epitomizes many of the responses that offered reasons for the discrepancy between the genders for ADHD. There are two intertwined positions implicit here. First, girls have a

different set of interactive needs than boys. They are framed as being more inclined to seek out emotional support, and therefore have a smaller propensity to engage in overtly anti-social behavior. Second, girls are not framed as being entirely exempt from the disorder, however, if they have ADHD they are far less visible. Girls may in fact have the symptoms of ADHD (academic failure, socially inappropriate behavior, restlessness, and so on) but because their behaviors are less overt than the types of behavior exhibited by boys, they are not detected as readily.

The issue that lay at the core of why there is such a huge gender discrepancy in instances of ADHD has more to do with behavioral visibility than with the actual existence of the condition. Much like the case of compulsion neurosis documented by Anna Freud, teachers contended that girls are said to manifest the disorder in an introverted fashion, acting spacey and dreamy. As one teacher commented: "With the girls they may just space out when it comes to getting their work done, but we don't usually say that that's a case of ADD or ADHD. Maybe people just expect that more of girls" (G 5/6). From a psychoanalytic perspective, girls are disinclined to lash out at the outside world in moments of rapid cathexis. Teachers often attributed this difference to the process of socialization:

I think its a socialization thing. Girls are taught at a young age to not act out, to internalize their feelings. Boys are always taught to act out. I think that's why girls tend to have self-destructive problems when they get frustrated or upset. They haven't been taught to express themselves and get those feelings out. Boys tend to destroy the things that are outside of themselves, you know, externally (G7).

The above excerpt denotes that the identification of ADHD may be a moment in which we see gender socialization. We may ask whether or not the suspicion of ADHD is directly linked to behaviors that are directly related to those expected of boys. Because they are socialized to externalize their emotions, boys may find themselves in more conflict with the external world. Rather than turn their frustrations inward, boys are perceived to alter the external world to their

own specifications. That is, boys are socialized to avoid internal adjustments to difficulties with the world and are taught that the source of relief lay within making external changes.

Teachers also commented that the higher visibility of male ADHD cases may also be due to the restrictive behavioral expectations schools place upon their student bodies. The institution of education, it was argued, remains intolerant of behaviors that we commonly associated with boyhood. As one teacher stated:

Public schools are not geared towards adolescent boys. We do not tolerate the things we most associate with them, like rough housing, doing pranks, picking fights and all of that. Some of these things are clearly destructive, but some other things may not be so clear cut, like why is it always discouraged to talk out of turn? Maybe that's necessary for some boy's mental health (G7).

Such an institutional critique offers some compelling positions. First, schools encourage behaviors stereotypically associated with female socialization: passiveness, quietness, obedience, and so on. Because of these expectations, the larger spectrum of adolescent behavior is not tolerated, and some parts of it highly discouraged. It is also alluded that the restrictive quality of the school might not adequately address the mental health needs of boys. As the previous respondent mentions, perhaps talking out of turn is not a sign of mental disorder, but is instead a mechanism for boys to ensure their own mental health.

Concluding remarks

The above analysis of teacher interview data shows another respondent group who employ some of the perspectives outlined in the genealogical section of this thesis. Similar to the accounts provided by clinicians, teachers seem to be highly influenced by neurological perspectives towards ADHD. Though there is no uniform neurological perspective amongst these respondents, the strong influence of neurology can be seen in the ways in which teachers suspect ADHD

children in their classrooms, the types of ADHD intervention strategies they implement, and in the general way ADHD children are conceptualized.

The dominant characterization of ADHD children as having "on-task" behavior problems from teachers shows a close fit between their own classroom experiences and the neurologically-oriented description of ADHD found in *DSM IV*. One teacher's description of ADHD children as suffering from "erratic impulses" exemplifies such a perspective. Despite a consistent invocation of neurological perspectives towards ADHD, very few teachers had heard of or had any use for *DSM IV*. This reveals at least two coexisting possibilities about the ways neurological perspectives towards ADHD influence the way people deal with and conceptualize the disorder. First, there is the possibility that teachers' perceptions of ADHD children match the *DSM IV* criteria because there is a strong fit between these diagnostic criteria and the way ADHD symptoms are manifested in the classroom. This says a considerable amount for the match between the *DSM IV* criteria and the actual experience of teachers. It would be redundant for teachers to become familiar with *DSM IV* as their own experiences are the actual basis for *DSM IV* criteria. Second, there is also the possibility that teachers who deal with ADHD students (I would assume these to be most, if not all teachers) spend enough time interacting with people (e.g. doctors and guidance counselors) who are influenced by neurological perspectives on the disorder that these perspectives shape teachers' experiences.

By being semi-formal in the way they suspect ADHD children, teachers are in a hybridized role of lay persons and clinicians. Playing one part of this role, teachers witness rule breaking by certain students. It can be assumed that a good portion of such rule breaking is transitory and quickly normalized. In the instances in which this rule breaking is not remedied, teachers appeal to more informed parties, that is, those with expertise in diagnosing problems not remedied through normalizing measures. Enter the role of the SBT, a collection of people whose function is to provide a crystallized definition of the child's problems, and in doing so, provide a path for the rectification of such problems. Often the SBT will solicit the opinions of medical experts, such as psychiatrists or pediatricians. At the point of implementing strategies advised by

the SBT, teachers become a part of the diagnostic and treatment process. Teachers are requested to begin a more rigorous documentation of the child, listing his/her infractions, having the child fill out questionnaires, and so on.

It is a matter of course that the more teachers witness disruptive behavior and the more they participate in SBT assessments of unruly children, the more they will become familiar with the signs attributed to ADHD. Hence, teachers with considerable experience in dealing with disruptive children may be able to inform parents about how a particular child fits a profile of what they have seen before. This increasing familiarity is not necessitated by an expert understanding of *DSM IV*, nor any formal clinical experience. Teachers' increasing familiarity with ADHD results from knowledge being passed down from experts, primarily, those who reside on the SBT. Such a transfer of knowledge perpetuates neurological perspectives on ADHD, greatly influencing the way teachers view these students and the way teachers raise suspicions of such students to parents. In this sense, teachers represent a middle area between the breaking of academic and social scholastic norms and formal medical intervention.

In terms of drawing parents' attention to problems with their children, teachers are in a precarious place. By presenting their case to parents too definitively ("I think your child has ADHD") teachers risk appearing hasty in their generalizations. In addition, teachers also risk the appearance that they are overstepping their professional bounds. The "defensiveness" from parents many teacher respondents describe can be understood as a response to conclusions about their children that are seen as professionally inappropriate. Recalling some of the testimony in Chapter 6, clinicians also feel that teachers need to focus on teaching instead of providing diagnoses. In order to express suspicion of ADHD, and not appear too convicting in the eyes of parents, nor too encroaching upon clinicians' professional territory, teachers must appeal to the established ADHD knowledge, but not do so in an explicitly clinical manner.

This balancing act is partially achieved with the aid of the SBT and the case they build before presenting their suspicions of ADHD to parents. After the considerable documentation of infractions and after consultation with a mental health practitioner who can corroborate these

suspicious, the SBT, the teacher and the parents have a meeting in which these concerns are expressed. More often than not, these concerns are expressed through the language of neurology: parents are told that ADHD is an organic condition, that it is not their fault, that it is treatable through medication, and so on.

Despite this process of suspicion and intervention that is widely revealed in the data, there are also moments in which teachers seem to be skeptical of strictly neurological approaches to ADHD. A teacher's discussion of inappropriately labeling one particular child as having ADHD is an exemplary instance of this skepticism. In this case, the ADHD label was applied to a child who was consequently placed on medication. Later it became known that this child's misbehavior was attributed to physical abuse by his father, not because of neurological impairment. Through describing such an incident, this teacher expressed concerns over the hasty medical labeling of misbehaving children. Such a concern implies that it is possible that the label of ADHD can be used to skirt issues of parental responsibility and may thwart appropriate interventions in the classroom.

The next chapter will explore the experience of parents, primarily how they negotiate between their children and the parties examined in chapters six and seven. It will be shown that through negotiating with suspecting parties, and through the ways parents frame their ADHD children, parents are subjected to the power of the different discourses on ADHD, and express varying degrees of their influence.

Chapter 8

Parental Frames for ADHD Children

This part of the empirical section of this thesis analyzes interview data from parents of ADHD children. Because parents are understood to be so crucial to the social, physical, and mental welfare of children it is imperative that they be offered considerable space within this thesis to express themselves about ADHD. Being the primary social agents who negotiate between the established and/or contested knowledge about ADHD and their children, parents' testimonials are crucial to elucidating a mutually-informative dialogue between these lay actors and the discourses analyzed in chapters two through four. Within the interviews analyzed here, parents presented what is clearly and expectedly the most emotional and human of all the testimonials thus far examined. Parents' voices reflected a deep connection to their children, and consequently, to the ADHD condition. Although the clinician and teacher interviews certainly revealed professional passion and genuine concern for ADHD children, parents demonstrated the indelible link between themselves and their children. Parents rely on the world of ADHD experts for the management of their child's disorder, but after school or after the therapy session, there are no more mediating agents between parents and their kids.

ADHD parents are non-professional experts on the disorder. Their incentive to learn about ADHD does not come from the requirements of their chosen fields, but from their emotional connection to their children. The expertise parents develop about ADHD bolsters the effort to treat their child, their *individual* child. As will be demonstrated, parents often have great amounts of ADHD knowledge and certainly are capable of making generalizations about the disorder, but the core of their expertise is based upon the intimate and unique knowledge of their own children. Most parents I interviewed would contend that the diagnosis of ADHD does not provide an all-inclusive summary of their child. As parents are less-inclined to typologize their children they would also argue that everything their children do should not be considered indicative of ADHD. The ADHD label certainly carries with it some generally-understood connotations, but through parents' eyes, the disorder is only one facet of their children.

Because of this perspective, parents offer the largest array of interpretations of ADHD, how it manifests itself in different situations, and how the regulation of these situations can facilitate the treatment of the disorder. The domestic sphere becomes a kind of testing ground in which the treatment methods given to parents by the professional world are either adopted or abandoned. Many of the "tried and true" methods for treating ADHD are placed against the backdrop of the perceived uniqueness of their children. A treatment method that may be argued to work for a vast majority of kids with ADHD may not be effective when applied to a child with unique circumstances. One child, for example, may be highly sensitive to the side-effects of medication, another may be perceived by parents to be inherently resistant to behavioral modification, and yet another child may be perceived as having an unusual creative potential that is inadequately captured by the ADHD label.

Because of the perceived uniqueness of their children and because they are so emotionally invested in the ADHD diagnosis, parents provided a rich and subjective account of the disorder. As a result, the interviews with parents were a little longer than with the other respondent groups and recorded a much higher degree of variability in their responses. Similar to the previous chapters that discuss clinicians and teachers, this chapter is organized around central themes parents revealed in their response to the interview questions, summarized by tables that offer a rudimentary breakdown of their responses, and analyzed, where appropriate, within the context of the discourse of ADHD examined in chapters two through four. Because of the subjective nature of the responses parents provided, certain sections of this chapter will not provide a summary table. In addition, I have not here provided a table for the responses to question which asked parents their child's gender, age, and grade level. The results of this question are summarized in the profile of the parent respondent group in chapter five.

The parent interviews revealed themes that included: 1) the way parents frame or conceptualize their ADHD children, 2) the incidents and locations that led to parents to suspect that their child might have ADHD, 3) the sources of information from which parents gained knowledge about ADHD, 4) parents' perspectives on alternative diagnoses of their children, and

5) parents' own hypotheses about the underlying causes of the disorder. Also mentioned in this chapter are interactions I had with ADHD children whom I was granted written permission to speak with by parents. Though the conversations with children were few and brief, they will be brought into the discussion in order to enrich the analysis of the interview data.²

Parent impressions of their ADHD children's social and academic competence

Childhood mental disorder is primarily diagnosed through the comparison of a particular child's behavior to the perceived majority of children within the same age group. In many cases, when one child demonstrates less mature behavior than his/her peers and when these behaviors pose difficulties in informal and formal social contexts, a mental disorder diagnosis may be given. As his/her behavior is placed under rubrics of "maturational lag" and "slowed development," a discrepancy between a child and his/her peers may be construed pathologically rather than idiosyncratically.

Following this modality in modern child psychiatry, it was important to inquire how parents framed their ADHD children's disorder, and how comparisons were made between their children and others of the same age group. Hence, parents were asked: *How does your child measure up to other kids in his/her age group academically? Socially?* As can be seen from tables 8-1 and 8-2, parents mainly described their ADHD children as having significant difficulties in both academic and social settings. As table 8-1 summarizes parents' description of their child's academic performance, fifteen respondents (or 75% of total) effectively stated that their ADHD children measured up very poorly in comparison to their peers. Three respondents, or 15% of total, refrained from stating that their children were poor overall academic achievers, and instead stated that their children had serious gaps in their learning. Finally, 2 respondents (10% of total) stated that their ADHD children were markedly superior academically. In

²As mentioned, it was initially intended to do in-depth interviews with children and include them as a fourth respondent group in the empirical section of this thesis. Because parents were highly protective of their children, especially in the face of an unknown graduate student researcher, consent to speak with children was granted in only three cases.

addressing the issue of their children's social skills, ten respondents (50% of total) stated that their children demonstrated considerable immaturity in comparison to their peers, that they often had younger friends, or simply lacked social skills that were expected at their age level. Five respondents (25% of total) stated that their children demonstrated specifically aggressive behavior within social contexts, and an equal number stated that their children interacted with others normally.

Table 8-1: Parent description of their ADHD child's academic performance in comparison to their child's peers

<u>Description of child's academic performance</u>	<u>Number</u>	<u>Percentage (%)</u>
Parents who described their child's academic performance as poor in comparison to kids from the same age group	15	75
Parents who stated that their children had considerable gaps in their learning	3	15
Parents who described their child as academically superior to others from the same age group.	2	10
Total:	20	100

Parents who described their child's academic performance as poor in comparison to kids from the same age group

Comprising the bulk of respondents, parents who described their ADHD children as lagging academically had marked similarities in the type of statements they provided. Often such statements invoked a kind of helplessness in the face of the ADHD disorder. As one parent stated:

Academically he is in the bottom 10% of his class. We have tried everything. Even with the medication it still is not improving. He has been

getting LAC time and that seems to have some promise, but right now we just have no clue what to do.³

Despite school interventions, primarily in the form of special education, including time spent in an LAC, parents often expressed a degree of desperation about the academic prognosis of their ADHD children. The negativity of such prognoses can be attributed to a neurological perspective on the academic failings of their children: "In school he struggles a lot. His comprehension skills are also very poor compared to the other kids. That definitely led us to think it was a neurological problem." Throughout the course of the interviews, discrepancies in performance between parents' ADHD children and their non-ADHD peers were repeatedly explained as a result of fundamental differences in neurology. Such themes in the data reflect the dominance of neurological discussions of ADHD examined in chapter three.

Parents also described that the ADHD condition became prevalent when educational environments changed. This was exemplified by a respondent who described her child's experience in switching from a home-schooled environment to a public school:

Well, my oldest was home schooled up until his diagnosis. When he got into public school he was way ahead of the other kids. I worked with them both from 11-2 everyday. I was in total denial, because you couldn't really tell he had ADHD when he was being schooled at home. When he got into public school he started at the top of the class and ended up at the very bottom. His teacher began calling everyday because he started having serious disciplinary problems.

This excerpt denotes that the visibility of ADHD symptoms were contingent upon environmental conditions. The educational environment of the home, this passage denotes, provided a kind of psychological buffer for her child's condition. The public school environment, on the other hand, exacerbated the psychological frustrations associated with having ADHD, and was the location

³All information about parents has been omitted for the sake of preserving respondent anonymity.

where ADHD was recognized. Consequently, this respondent admits that denying the ADHD condition became more difficult to maintain as her child clearly started failing.

This removal of denial, is, I believe, part of a larger institutional commentary that stems from teachers' discussions of parental denial in the previous chapter. By stating that she was "in denial" about her child's ADHD while he was being home-schooled, this respondent presupposes an inherent quality to ADHD: the ADHD condition was always there, but her psychological defenses prevented her from seeing it. What requires further interrogation are the social dynamics of how her denial was both realized and then broken. The role of the SBT is crucial in this regard. As examined previously, members of the SBT do their best to build a case for ADHD prior to presenting such evidence to parents. The process of building a case for ADHD is a way of removing parental defensiveness about the neurological status of their children. As evidence is presented and soundly supported, it is argued that parents will have less room to offer rationalizations for their children's academic or social failings. In short, they will be less-equipped to deny the allegations brought to them by the SBT. Hence, when examining interview data that invoke notions of denial, we must ask about the SBT's role in parents' description of this denial and also in parents' use of nomenclature that originates from SBT meetings.

Nomenclature that comes from SBT meetings or from the greater psychological community was frequently invoked by parent respondents. Other conditions from which parents' ADHD children suffered were often mentioned and reflected the relationship between parents and other agents of mental disorder suspicion and diagnosis. As one parent stated:

Well, he struggles a lot right now. He also has pretty severe dysgraphia. His short term memory is also very poor. We are going to have him tested for other LD's. Right now he is working with the resource teacher and I think he is making some improvement, but he just thinks that we all have him labeled as dumb or something like that.

Parents frequently described themselves in an ongoing relationship with one or more sources of mental health assessment. The invocation of the term "dysgraphia"--a fine motor skills disorder

that distorts the way children draw shapes and write letters--demonstrates these relations. In addition, this excerpt also describes a parent's role in mediating between these forces of diagnosis and their own child's identity. As described, a consultation with the resource teacher can be internalized by their children as a sign that others think of the children as "dumb" or incompetent.

Parents who stated that their children had considerable gaps in their learning

Parents who did not describe their ADHD children as having markedly poor school performance in comparison to other children, but did address some kind of academic shortcoming with their children discussed that their children had gaps in their learning. One parent described her son's academic skills this way: "One of the things his teacher has mentioned is that she thinks there may have been some basic skills he missed in the previous grades. She says he is reading on a grade 3 level. So, now, we are looking at getting him some kind of learning assistance." These children were not described as overall failures, but were instead framed as children who lacked certain academic skills--a situation that could be remedied given appropriate intervention.

Other parents described specific shortcomings with their children, juxtaposing them with statements about skills their children wielded effectively:

He has a pretty big deficit in his math skills and I would also say in his language skills. He wasn't reading until the end of grade 2. But once he started picking it up, by now he is in the 80th percentile. Once he gets something, he can run with it. But his oral skills are the most strong. His oral vocabulary is very impressive. People comment and say, 'I didn't know he knew words like that.'

Contrary to respondents who described the consistent academic failings of their ADHD children, parents who highlighted specific shortcomings in their children's academic skills also brought to light positive aspects of their children. An example from this excerpt is the respondent's discussion of his son's verbal skill and the mentioning of people's reception of such skills. This

parent perceives others' reaction to his son's vocabulary as very favorable, and out of the ordinary.

This kind of focus upon other intellectual skills and the framing of these as unique in the eyes of others demarcates a point of diversion from the neurological discussions of ADHD. The more serious forms of the ADHD neurological impairment is reputed to devastate intellectual life of such diagnosed children and leaves no room for the discussion of other intellectual abilities. *DSM IV*, for example, contains no clause that states some ADHD kids may be prone to demonstrate an excellent vocabulary, or may have better math skills than verbal skills, or may be highly susceptible to dysgraphia. In drawing attention to positive qualities of their children, parents reveal a perception that their child, however diagnosed and framed by clinicians and teachers, has a uniqueness that defies the generalizing tendencies of the ADHD label.

Parents who described their child as academically superior to others from the same age group

In opposition to the conventional wisdom about ADHD, namely that it is a disorder characterized by academic struggle and the psychological association of school with failure, a significant number of parents stated that their ADHD children were gifted and academically superior. As one parent stated: "He's at the top of his class right now. He's ADHD gifted, which means that he has some pretty serious hyperactivity, but he is highly intelligent." The determining factors for ADHD in such cases strongly implicated behavioral problems, rather than strictly academic ones. This defies teachers' previous assertions that ADHD children's classroom problems were a combination of academics and behavior, more specifically, that academic problems and behavioral problems fed into each other. From this perspective parents framed their ADHD children as having a tremendous amount of energy, certainly capable of having difficulties, but also manifesting intellectual prowess.

Other respondents coupled the description of their child's intellectual gifts with discussions of the ways the school sought to accommodate the special needs of these children. In

some cases, teacher hypotheses concerning the inter-relatedness of behavioral and academic problems was affirmed. As one parent commented:

In fact, he is brighter than most of the other kids and performs very well, when given the right kind of direction. He has a real high IQ but was not able to regulate his behavior when he got into grade 2. They put him in the APEX program for gifted children. His behavior prevented him from being in the APEX program. They tried for a couple of weeks to make it work, but it just wasn't. With ADHD kids they're already bored easily, but being gifted on top of that kind of made him double-bored.

Such discussions demonstrate some of the perceived difficulties of children who are diagnosed with ADHD, but need extra intellectual stimulation. In describing her son as "double-bored," this respondent underlines the antagonistic relationship between ADHD children and school--a situation apparently made worse by the fact that her son was gifted. ADHD, in this regard, is framed as a detriment to the implementation of advanced kinds of scholastic programs, such as APEX. It is a disorder that thwarts the potential accomplishments of intelligent children.

In examining parent interviews that compare the academic performance of their ADHD children with their non-ADHD peers it is curious that ADHD kids were never once described as "normal" in relation to their peers. As seen in table 8-2, ADHD children were either described as having some significant shortcoming, or they were described as being academically superior. Such a condition in the data implicates at least two social situations within which ADHD children find themselves. First, as ADHD children are rarely in the "normal" category in academics, this points to the possibility that ADHD is understood primarily through the requirements of the academic environment. This gives a degree of credence to environmentally-based arguments about ADHD in which the disorder is argued to exist only under certain conditions. A previous parent's discussion about her son's adjustment to public school after excelling in a home-schooled environment is a case in point. Second, the perceived lack of academic normalcy in ADHD children may also be tainted by parents' desire for their children to

attain academic success. For example, an ADHD child may be performing adequately according to the normal distribution in a particular classroom, but the desire to see that child perform better or to "be the best" may negatively skew the perception of that child.

Table 8-2: Parent description of their ADHD child's social skills in comparison to their child's peers

<u>Description of child's social skills</u>	<u>Number</u>	<u>Percentage (%)</u>
Parents who described considerable immaturity in social interactions	10	50
Parents who describe that their ADHD child demonstrated aggressive behavior in social situations	5	25
Parents who stated that their child's social development was normal in comparison to other kids	5	25
Total:	20	100

Parents who described considerable immaturity in their child's social interactions

After being asked to make comparisons between the social skills of their ADHD children and such children's peer group, parents described marked shortcomings in their ADHD children's social skill development. What was visible in these comparisons was that the ADHD children were framed as "less mature" or not as sophisticated in social situations than one would expect from normal children of the same age. As one parent of a 3rd grade ADHD boy stated: "Socially he is very far behind the other kids. His teacher was saying that his behavior reminds her of a 1st grader."

Responses that framed social maturity in relation to others from the same age group were also demonstrated through descriptions of the relative age of their ADHD children's friendship networks. As one parent stated: "He has much lower social skills. All of his friends are much

younger. I think it's because he's intimidated by older kids, or kids his age. He is very immature for his age." Other parents who mentioned discrepancies between their ADHD children's age and the age of their friends also added that their ADHD children struggled in the maintenance of friendships. As a parent of a 12-year-old ADHD boy stated: "As with other kids with ADHD, he is very socially immature. He has probably a 10 or 11 year old maturity. I think he has some problem making friends his own age and keeping those friendships." And another parent: "Socially you can tell he is not up with the other children. He isn't able to maintain friendships yet."

Parents who describe that their ADHD child demonstrated aggressive behavior in social situations

Parents also stated that their ADHD children were prone to aggressive behavior around other kids. As one parent stated, instances of aggressive behavior precipitated her son's ADHD diagnosis: "He has some difficulty with aggression and frustration, you know, lashing out at other kids sometimes. That's when he was diagnosed." Other parents gave specific accounts of anti-social, violent behavior: "He is highly agitated very aggressive towards others kids. He has bitten one kid on the nose already this year. That was the big call that he needed to get some kind of evaluation."

In some instances parents described that their children's aggressive behavior also prompted mental health professionals to surmise the existence of other conditions. Describing her six-year-old son, the parent of two ADHD boys stated: "He is a mixed bag according to the psychiatrist. He thinks there is a good chance that he also has Conduct Disorder. He is also really smart and manipulative, which is a symptom of ADHD." Such accounts of ADHD and aggressive behavior frame ADHD as "comorbid" with more blatantly anti-social mental disorders. Conduct disorder--a diagnosis rarely provided to 6-year-olds--describes a tendency of children (usually boys) to feel compelled to act in aggressive and often violent ways. (For a brief discussion of ADHD and its comorbidity with conduct disorder and oppositional defiant

disorder, see chapter three.) In addition to discussing the possibility that her son may be exhibiting signs of conduct disorder, this respondent also provides an interesting frame for her son's ADHD, namely, that his manipulative tendency is also a symptom of the disorder. This position represents a significant departure from the neurological narrative about ADHD that mentions nothing about ADHD and the ability to manipulate others.

Parents who stated that their ADHD child's social development was normal in comparison to other kids

A significant number of parents described their ADHD children's social development as normal or without any kind of significant difficulty. In the absence of any serious social problems (i.e.-fights, screaming matches, etc.) many parents simply concluded that their children had no real social difficulties. As one respondent stated: "That's where he seems to be doing OK. The other kids really like him. He gets along pretty good, I'd say. He doesn't get into any major trouble with the others kids." Given the absence of social conflict, it is assumed that the ADHD children have the ability to develop social rapport with others.

Favorable social skills were also described by mentioning levels of popularity that ADHD children had with other kids. As one parent stated: "He seems to do quite well. I guess he's considered to be one of the cooler kids in class. He's invited to parties a lot. We like to think its good modeling." Another parent described the potential for her son to be well-liked by even his teachers: "He doesn't seem to have any problems. He is well-liked by the kids, and when he's behaving he's even liked by the teachers at his school."

Parent discussion of whether or not their ADHD children expressed resentment at going school

Since school is such a crucial social context for the suspicion and diagnosis of ADHD children, and is also considered an environment particularly frustrating to such children, parents were asked: *Has your child expressed any kind of resentment at his/her school?* In responding to this question, parents provided telling accounts of how their ADHD children expressed

resentment at their school, and also provided some reasons that they felt underlined their child's feelings. As will be shown, a lot of the reasons parents gave for their child's resentment at school fit well into the clinical and educator narratives that frame the nature of the ADHD child. Such narratives portray ADHD children as intolerant of structure, having difficulty completing tasks, missing common social cues, and so on. As seen in Table 8-3, the overwhelming majority of parents (16, or 80% of total) stated that their children expressed resentment at school, whereas only 4 parents interviewed (20% of total) stated that their children appeared to harbor no resentment at school.

Table 8-3: Parent discussion of child resentment towards school

<u>Response</u>	<u>Number</u>	<u>Percentage (%)</u>
Parents who stated that their child expressed resentment towards school	16	80
Parents who stated that their child did not express resentment towards school	4	20
Total:	20	100

Parents who stated that their child expressed resentment towards school

Parents who described that their children expressed resentment at school most commonly stated that their children simply did not like to attend. As one parent stated: "He hates going to school. I have to unhinge him from my leg to get him out of the car sometimes. I don't know if that's ever going to stop." Such resistance commonly stemmed from struggles with academic requirements, social interactions, school disciplinary standards and so on. Another common theme in these responses highlighted some typical problems ADHD children are believed to have with school. These include psychological frustrations with school and the apparent inability of ADHD children to perform according to academic standards. As one parent stated: "Oh yeah, he has decided that school is not the place for him. He associates school with failure. It's very frustrating for him." Certainly in accordance with the psychological discussion of ADHD examined in chapter three, ADHD is not necessarily seen through neurological impulses, but

through the psychological struggle children have with environments that demand prolonged task-oriented activity.

Parents also conveyed that their ADHD children's resentment at school stemmed from a variety of sources. One of the most prevalent reasons for their child's resentment at school was the way schools functioned as a labeling agent, summarizing children in ways many parents argued to be inaccurate. As one parent stated:

Yes, he really hates school right now. My husband and I are thinking about trying to get him into some other kind of program. The LAC work has not really worked because he thinks that we all think he is a dummy. And, the administrators are starting to label him a bully, which is totally untrue.

Conveyed in this passage is a resentment that stems from the social meanings attached to intervention strategies for a child's ADHD. The LAC strategy, for example, was argued to be ineffective because the LAC connotes a slower intellectual capacity and consequent difference between ADHD children and their peers. Another significant aspect of this passage concerns the non-medical labels of this mother's son. By being labeled a "bully" rather than mentally disordered, her son, it is argued, was miscast and wrongly placed within conventional interpretations of childhood misbehavior.

Similar examples of resentments based in the social dynamics of schools and how these fostered misdirected or embarrassing labels, concerned the way other children treated respondent's ADHD children. One parent described a "buddy system" that was established (and quickly discontinued) for the regulation of children's medication, and how this tainted the identity of her 8-year-old son:

For a while they tried a buddy system to help kids take their meds. The idea was that one kid would kind of watch out for the other and make sure that he took them. This was horrible for him because he felt embarrassed by the other children. All of the children knew he was taking meds. It got to where he wouldn't leave the car to go to school.

Expressed here is the potential cruelty ADHD children experience when their condition becomes public knowledge. The child's resentment conveyed by this respondent resonates with teachers' statements examined previously that stated the label of ADHD must be controlled and the normal identity of the ADHD child preserved.

These types of resentments are atypical of the kind that would be expected from ADHD children. Based upon the common wisdom about ADHD, we might conclude that most resentments ADHD children would harbor towards school would be founded in the difficult intellectual and social demands of school, including the mental and physical discipline school requires for students to learn lessons and remain relatively calm throughout the learning process. However, in these cases, it is the reaction to the ADHD condition and the pedagogical and treatment protocols practiced by the school that spark ADHD children's resistance. Resentment is harbored not as a direct result of the neurological condition of ADHD, but as a result of schools drawing attention to the disorder and compromising the normal identity of ADHD children.

Parents who stated that their child did not express any resentment towards school

In contrast to child resentments that were sparked by a school's intervention strategies, some parents expressed that their ADHD children truly liked their school. As one parent stated, his child's enjoyment of school was associated with the school taking appropriate pedagogical measures: "No, right now he loves his school. He has a great teacher and they are working really well with him." Such statements reveal that educational intervention strategies, such as time in a LAC can be effective methods for making school a place ADHD children may increasingly associate with success.

Another parent stated that her child did not express any particular resentment at school in spite of academic struggles: "He loves his school, even though he has some struggles in it. I think its because he is so well-liked. Even teachers say how much they like his personality even though he acts up so much." Such statements speak to the different definitions of the school context. Though this respondent clearly conveys her child has academic difficulty, school is not without

its redeeming qualities. Because it offers a social outlet for her son, school can be a place of enjoyment. In other words, the failure associated with school may exist in relation to academic demands, but this may be perceived by some ADHD children to be less significant or negligible when compared to the feelings of success that develop from having friendships and positive social interaction.

Precipitating incidents leading to the suspicion of ADHD and their location

As this thesis examined the process of teachers suspecting ADHD--something that demonstrated how ADHD children were typologized by authority figures--parent respondents were asked about incidents that sparked suspicions of ADHD. This inquiry was comprised by two questions: *What were some specific incidents which led you to think that your son/daughter might have ADHD?* and *Where did these incidents take place?* Responses to both questions are summarized in tables 8-4 and 8-5. With regard to the specific incidents parents documented, half of the respondent group stated that their children showed significant academic failings that served as beacons for the ADHD disorder. Another large portion of the parent respondents (8, or 40% of total) stated their child had demonstrated specific anti-social behavior, including fighting with other kids and acts of self-mutilation. Finally, 2 respondents (10% of total) stated that their children exhibited non-violent, disruptive behavior at school. With regard to the locations of these incidents, summarized by table 8-5, 17 out of the 20 parents (or 85% of total) interviewed stated that the incidents occurred at school, 2 respondents (10% of total) stated that the incidents occurred at home, and 1 respondent (5% of total) stated that the incidents occurred in both school and home.

Table 8-4: Parent discussion of specific incidents that led to suspicions that their child may have ADHD

<u>Incidents</u>	<u>Number</u>	<u>Percentage (%)</u>
Parents who stated that their child showed signs of academic failure	10	50

(Table 8-4, continued)

Parents who stated that their child demonstrated specific anti-social behavior	8	40
Parents who stated that their child was generally disruptive during class time	2	10
Total:	20	100

Parents who stated that their child showed signs of academic failure

Respondents who stated that their children were showing signs of academic failure most commonly described difficulties in attention that are characteristic of the inattentive subtype of ADHD. Most commonly mentioned by parents was that their children exhibited a "daydreamyness" and hence, could not adequately participate in school lessons. As one parent stated:

Well, in Grade 2, we started noticing things with G. She was so daydreamy during class that her teacher approached us and told about some of her concerns. She had begun writing down some incidents and showed us what she was seeing. We had to start looking at her problem in a real way.

Another parent discusses the same "daydreamyness" with his 5-year-old son, and mentions his son's self-diagnosis:

In preschool at age 2 and a half he was into his own thing, not really paying attention outside of what was right in front of him. We thought, 'OK, he's 2.' When he was about 4 and a half teachers started paying notice to some of his problems. I asked him what was going on, why he wasn't able to focus. He said: 'Dad, every time I start listening my pants make a noise or I see something and when I get back to what the teacher is saying I don't where we are.' Pretty good self-diagnosis for a 5 year old, eh?.

As can be seen from these excerpts, the condition of inattention was something that apparently emerged after the child became a little older and consequently had more demands placed upon him/her. Significant social actors, such as teachers, often normalized the tendency for young children (around kindergarten age, or younger) to daydream, but became more concerned about it as the child grew older and the behavior persisted. In such cases, the scholastic incompetence of the child was no longer considered a stage of development, but a solidified problem that was not going to disappear. One parent put it this way:

Well, when he was in grade one we started noticing that he was having some problems focusing on the lessons. The teacher didn't think anything of it, but we were beginning to wonder if he was ever going to pass through this phase, which was what she called it. He also had big problems forming numbers and letters, even after most of the other kids started to get it down pretty well.

Such an emergence of the symptoms of inattention is a testament to the fact that many mental disorders are suspected after an individual's performance in an institutional setting is evaluated and deemed inadequate in relation to the performance of others. In this example, it was impossible to assess the scholastic incompetence as "a phase" because it was perceived as abnormal in comparison to the performance of other students.

The term "phase," as it has a notion of normalcy attached to it, represents a moment of some kind of trouble for a child that is expected to be rectified through a natural course of events. When construed as a phase, daydreaming remains relatively unremarkable by teachers and other adults in a child's life. Daydreaming is a non-medical "trouble," according to Emerson and Messinger (1977). As the trouble of daydreaming becomes noticeable in relation to the more academically competent behavior of other children, it becomes an issue that sparks the mechanisms of formal assessment. Labels that were applied to the daydreaming behavior, such as "phase," no longer have utility as the behavior is seen as indicative of something more systemic

with the child. Though there are some who view ADHD as something a child may "grow out of," the overwhelming perspectives on the disorder do not portray ADHD as a phase.

The formal mechanisms of formal assessment that stemmed from consistent academic incompetence can take on many forms, assessments for ADHD and learning disabilities comprising only a few paths of evaluation. This is especially true in the case of older ADHD children. As one parent of a 14 year-old ADHD boy stated:

When he started failing out of school, we could really start to see that something might be really wrong. We knew it wasn't drugs or anything like that, but there was definitely something. His assignments weren't done on time and like every other day I was getting calls. The school psychologist...suggested that we run a blind drug test, which came back totally negative.

The trouble, in this regard, was addressed according to cultural notions of the kinds of problems adolescents may have. Demonstrated in this passage, a possible case of drug abuse seems a conventional way of interpreting academic failure in children who are considered older and susceptible to a larger array of social ills.

Parents who stated that their child demonstrated specific anti-social behavior

According to parents, events that precipitated a child being suspected of having ADHD also included the exhibition of behaviors that were considered directly anti-social, often violent. As one parent stated: "At age 4 he began getting violent. He'd take things out of the bedroom and throw them into the hallway. One time he took an air register out of the floor and threw it into a wall. We took him to a psychologist after that." Such events were presented in the data as random and unprovoked.

In addition to a general description of violent behavior, parents also conveyed that their ADHD children's violence was not easily quashed by authority figures. As one parent described:

Last year he was repeatedly aggressive and violent with the other children in kindergarten. He was also aggressive towards one of his teachers. She tried to pull him off a little girl and he acted like he was going to bite her. She says he was making some animal noises, but really scary and agitated, like he was totally out of control. None of this was happening during his preschool.

The apparent defiance of authority figures was considered grounds for framing such violent behavior as abnormal and worthy of further examination. Children who did not refrain the violent behavior were often labeled as unable to control themselves. As one parent stated: "He got into a scrap on the school yard. He had this boy on the ground and he was putting the boots to him. A teacher intervened and he attacked her. You know how kids usually are when an adult intervenes, they stop what they're doing. But he had no way of controlling himself." In the event that an adult intervenes it is commonly argued that children defer to that authority figure and cease those problem behaviors. However, when violent actions are not quelled by adult intervention, they are grounds for a deeper concern.

The description of violent behavior resonates with the clinical description of ADHD children who are believed to have a strong hyperactivity component to their condition, though most psychiatric narratives would probably interpret such behavior as more akin to conduct disorder or oppositional defiant disorder. Borrowing from Emerson and Messinger (1977), the pathological interpretation of violent behavior seems more likely than in instances of behavior that demonstrates academic struggle. Hence, the inattentive types of ADHD are less noticed, and may contribute to the discrepancy in the gender breakdown of the disorder. Perhaps because violent behavior is seen as a threat to others and is blatantly disruptive, it is rarely conceived of as a phase. Any degree of violence, if apparently unprovoked, is considered to be grounds for concern.

This concern is intensified when the remedial measures to thwart the violent behavior (i.e.-through the intervention of adults) proves inadequate. The remarks of parents that address

the inefficacy of adults in stopping children from being violent, and also their depictions of adults being attacked by such children when intervening, describe the failure of remedial action and presupposes a more pathological condition with the child. In the moment, the "trouble" is the immediate incidence of violence. It is a moment conventionally understood to be curtailed by the intervention of adults and the symbolic authority they hold. The assumption of mental defect occurs when the symbolic authority of adults has no behavioral effect. When adult authority is not recognized it is hypothesized that the violent child must have a fundamental error in the way he/she internalizes symbols. Understood sociologically, the interpretation of childhood defiance as symptomatic of mental disorder may also be a result of unrecognized adult power. This epitomizes the "micro-politics" that Emerson and Messinger (1977) describe. In the aforementioned cases of child violence, the connections between such behavior and mental disorder stem from situations in which children did not recognize adult authoritative power. The power struggle between adults and children, from this perspective is one that is rectified through formal evaluation measures.

Incidents that precipitated suspicions of ADHD also included acts of self-directed violence. As one parent stated: "I remember his grade one teacher mentioning that she caught him pressing a piece of glass into his own hand. Not enough to break the skin, but it just didn't seem normal." Another parent described her 6-year-old daughter's attempt at hanging herself:

Three years ago when my husband and I split up, it was really hard for my youngest. I guess to make up for the loss of their dad I decided it would be a good idea to buy the girls new kittens. My youngest went to tie a bow on the new kitten, and tied it way too tight. Well, I found the kitten which was totally unconscious and my daughter walked in and saw me trying to revive it. She thought she had killed it. She ran into her room and tied a skipping rope around her neck and tried to hang herself. After that I said, 'Well, you had better have both of these kids checked out.' I made an

appointment with a psychiatrist and she said that both kids had ADD and that my youngest had ADHD.

It is curious that such self-destructive behavior may lead to an ADHD diagnosis instead of other mental disorders. Nowhere in *DSM IV* criteria does it discuss a tendency for ADHD children to inflict harm upon themselves. A relevant question at this point is: How do acts of violence against oneself and others constitute symptoms of ADHD? One answer to this question may be found in the psychological discussion of ADHD symptoms that described problem behaviors as a response to the consistent frustration that ADHD children encounter in everyday life. From this perspective, there are a seemingly endless list of behaviors that can be exhibited. The behavior itself is symptomatic of the reasons for why those behaviors occur. Violent behavior may be rationalized as a coping mechanism on behalf of ADHD children to retaliate against a world they perceive as unyielding and hostile. Such behavior presumably points to a more fundamental condition.

Parents who stated that their child was generally disruptive during class time

Parent's discussion of the disruption of school activities primarily described moments in which children stood defiant in the face of adult authority. As one parent stated: "He shouted back at his teacher when she told him to come join the group and refused to participate until she took him aside and talked with him. He disrupted the whole class until he felt OK and was able to sit down." In an incident involving her son, another parent described the futility of teacher intervention:

Well, in Grade 3 we had an incident which was pretty telling. It was after recess and he wouldn't come back to class. People from the school were almost chasing after him trying to get him to come back in. It started raining and he still wouldn't come back in. It was almost like a psychotic episode. They had to call me down and so I came down there and took him

home because he still refused to come back to the class. We knew that something was pushing him to behave in such a way.

Similar to previous excerpts from the interviews, this one denotes that the child's resistance to the wishes of authority was construed as "outside his own will." This excerpt was "telling" from this mother's perspective because it showed how her child, who should have been submissive to adult control, apparently was unable to exercise self-restraint. As G.F. Still would have said, this inability to submit to the wishes of adults may represent a "morbid condition," that is, the inability for self-control is understood to be embedded in the actual physiology of the child. Such conclusions presuppose that children, by nature, do not want to have the negative experience of being reprimanded or punished by adults. If they have a normal psychological development, it is assumed, they should understand the ramifications of their actions, and be able to reflect upon their own behavior. In the event that an adult may not be able to control a child, assumptions may be made about the child's mental health.

Table 8-5: Location of incidents that precipitated parental suspicion of ADHD

<u>Location of incident</u>	<u>Number</u>	<u>Percentage (%)</u>
Incidents in the context of school	17	85
Incidents occurred in the home	2	10
Incidents occurred in school and at home	1	5
Total:	20	100

The dominance of the school as the primary context in which incidents precipitating the suspicion of ADHD occur

The dominance of school as the primary location where "ADHD suspicious" incidents occurred further demonstrates the significance of school as the major location for the detection of ADHD. Thus far, the connection between the school environment and ADHD has been demonstrated in three locations: 1) within the accounts clinicians provided describing teachers as

the primary parties who bring suspected cases of ADHD to their attention; 2) through the discussion of the anti-school behavior in post-encephalitic children in chapter 2; and 3) through the documentation of Charles Bradley's Benzedrine experiments on children and how that aided in the mechanical comprehension of lessons and children's enthusiasm for school work.

The account from parents summarized in table 8-5 further solidifies the argument that the suspicion of ADHD is directly related to antagonism between students and the institution of education. Because of this, we must interrogate the peculiar qualities of ADHD and its institutional specificity. On one side of this interrogation, we may state that the ADHD diagnosis has major validity problems. Recalling one clinician's comments calling ADHD a "garbage can diagnosis," we can surmise that ADHD is largely a catch-all typology for behaviors that schools deem disruptive and undesirable. Certainly such a position would be sympathetic to social constructionist arguments about ADHD. However, we may also conclude that ADHD, like other childhood disorders, is much more likely to be detected within a school environment, in the same way that autism or learning disabilities surely are. Such a position would proclaim that ADHD children do not find themselves in situations outside of school that are rigorous enough to bring out the symptoms of the disorder. Once the classroom places intense demands upon the ADHD child, his/her neurological shortcomings become visible.

Addressing the absence of incidents outside of school

The psychological perspective appears to serve as the rationale for parents in explaining that their child's ADHD behaviors seem to only occur during school time. At least 8 of the parent respondents (40% of total) mentioned that the ADHD-like behaviors only occurred in the school context and justified this by claiming the school was a unique and more challenging intellectual and social context than say, playing with the neighborhood kids, or lounging in front of the TV. I will state that with all three of the children I was granted permission to speak with, all seemed very calm, and comfortable in the surroundings of their home. One 10-year-old ADHD boy I spoke with lounged on the couch while watching TV, and seemed totally relaxed. It was difficult

for me to think that this was a kid getting into constant trouble at school. When asked whether or not he liked school, he lazily stated: "It's OK," then later included that he felt school was "kind of boring sometimes."

Many parents described their children as quite normal outside of school. The apparent presence of ADHD was often attributed to the increased intellectual demands of that environment. As one parent stated:

When she's home she seems like she's doing quite well. She has her friends over and they play. Just normal kid stuff. I guess we really wouldn't even think she had ADD except for the problems at school. But if you think about it, it makes sense. The school is a place where greater demands are placed on the kids intellectually.

Another parent placed an emphasis on the social pressures that are an inherent aspect of the school environment: "At home he's very easy to be with. Loves to talk--he's a great talker--loves to visit. He's quite pleasant when he doesn't have all of the social pressure around him" (Student, female age 33). Finally, another parent made statements that resonate well with the issue of ADHD behavior and the resistance to authority: "I'd say the bulk of his problems have been in the school and are really between himself and the teachers. It's like these kinds of kids have a real problem with authority."

Discussing the first formal suggestions of ADHD

Emerson and Messenger's (1977) discussion of the "micro-politics of trouble" asserts that the initial failure of remedial measures for deviant behaviors may prompt more formal remedial actions. This action may take at least two forms that are sometimes in conjunction with each other. First, there is the appeal to experts. In the case of ADHD, schools may call on the services of outside parties to evaluate problem children. The implementation of questionnaires and other mental health assessment instruments in schools is a case in point, as is the occasional presence of a physician at an SBT meeting. Second, formal remedial action may involve a consultation of

literature and other sources of knowledge that may shed more light on the nature of the deviant behavior. This acquisition of expertise is strongly exhibited by teachers who attend professional development days on ADHD, read literature on the topic, and try to implement ADHD teaching strategies.

As mediators between their children and parties who impart formal opinions of them, parents are the ones approached with the formal suspicions of their children having ADHD. Most often, those who approached parents were representatives of their child's school, most often a school teacher. Hence, in examining responses to the question: *Who first suggested that your child may have had ADHD?* it was clear that parents were made aware of formal suspicion of their children having ADHD from educators and that these initial discussions prompted parents to seek clinical opinions of their children. As can be seen in table 8-6, fourteen parents interviewed (or 70% of total) stated that the first suggestion of ADHD came from a teacher or some other school representative. A markedly smaller number of parents (4, or 20% of total) stated that they were the ones to first suspect ADHD, and 2 respondents (10% of total) claimed to hear the first suspicions of ADHD from clinicians. In addition to the types of people parents reported speaking to concerning their children's behavior, 18 respondents (90% of total) stated that the person who first suggested that a child might have ADHD also professed to have knowledge of the disorder.⁴

⁴ Parent responses stating that the person who approached them with suspicions of their child having possible ADHD had knowledge of the disorder were solicited by the question: *Did he/she profess a knowledge of the ADHD condition?* The two respondents that did not answer this question affirmatively, were themselves the initial suspects of ADHD, but did not claim to have any legitimate knowledge of the disorder. The other two respondents that suspected ADHD in their own children both claimed to have had knowledge of ADHD prior to suspecting their child of having the disorder.

Table 8-6: Parent description of parties who made the first suggestion that their child may have ADHD.

<u>Party who first suggested ADHD as reported by parents</u>	<u>Number</u>	<u>Percentage (%)</u>
Instances where the suggestion of ADHD was made by a teacher, or some other school representative	14	70
Instances where the suggestion of ADHD was made by parent him/herself	4	20
Instances where the suggestion of ADHD was made by a clinician	2	10
Total:	20	100

Instances where the suggestion of ADHD was made by a teacher, or some other school representative

Parents often reported that when approached by parties from their child's school, those parties often expressed prior experience with the disorder. As one parent responded: "They said there was another boy who had been diagnosed with ADHD and they saw a huge difference when he started taking Ritalin. They also brought in a school counselor and we got a referral to our family physician." Such statements may demonstrate the end product of the SBT meeting, and the compilation of information about a child before parents are contacted. Receiving a clinical referral, as is commonly prompted by the SBT, is a mark of the legitimacy of that group's recommendations. If their case is presented effectively, parents may act in ways that fit with school interests: recommendations for clinical referrals are accepted, children become clinically evaluated, and medication is administered.

As the interviews from clinicians demonstrated, school representatives were viewed as the most common group to approach doctors about a case of possible ADHD and often the necessity of prescribing Ritalin. According to clinicians, this is also true of parents who approach

clinicians after being prompted to do so by the school. Hence, parents often expressed that their opinions of their child's condition resonated with those of the school: "His grade one teacher suggested it (the possibility of ADHD). I was very inclined to agree with her, given his recent behavior." In approaching clinicians, parents are representatives of school interest, and school interest is rooted in a strong desire to rectify problem behavior.

The perceived ADHD know-how of teachers is integral in moving a child down the path to getting the ADHD diagnosis. Often mentioned in the interaction between parents and teachers is some demonstration of academic knowledge of the disorder, but more often in the capacity of everyday experience. By presenting themselves as people with experience in teaching ADHD students, teachers provide legitimacy to their authority in the detection of the disorder. By having such legitimacy, teachers are in a hybridized social role, combining both clinical and pedagogical statuses. As mentioned, their "semi-formal" suspicion of ADHD children is highly effective in soliciting formal diagnoses. This is especially true for teachers experienced in special needs children, particularly LAC teachers: "I guess the first mention of ADHD was from his teacher. She had had some experience working as an LAC teacher and said that he probably had some kind of problem that couldn't just be ignored."

Instances where the suggestion of ADHD was made by the parent

ADHD is a widely recognized acronym. From news commentaries to dialogues about the disorder on a televised episode of the HBO series, *the Sopranos*, ADHD is widely discussed in the public spotlight. Because of this high visibility it makes sense that people will be inclined to see the disorder in others, however removed their opinions are from clinical expertise. Though I would not go so far as to say we have an "ADHD hysteria," I would state that an increase in the invocation of the disorder may reflect shifts in people's self-perception. This would be especially relevant those who demonstrate shortcomings that presumably typify ADHD. This might be especially true for parents, who feel compelled to understand and correct their children's problems.

One respondent, a nursing student, claimed to be the one who suggested ADHD to the teacher, rather than the other way around:

I suggested it to his kindergarten teacher. Then I made an appointment for him at children's (Referring to BC Children's Hospital). ...I discovered I had it about 6 years ago. My reactions to my son were really getting in the way of our relationship. I got a diagnosis and meds to actually help me cope with him.

In a reversal of the stereotypically-understood knowledge exchange between a parent and school, this excerpt reveals a parent bringing knowledge of the disorder to the institution of education. Such an exchange further demonstrates the dissemination of ADHD knowledge that has permeated popular life. In some cases parents may suspect ADHD in their child because enough symptoms of the disorder have become popularized. That is, the popular connotation of ADHD has a degree of isomorphism to the clinical narratives that frame the disorder.

ADHD may be an example of a mental disorder that has had such a wide visibility and discussion that lay people may regularly claim to have some understanding of what the disorder is. In this sense, parents may also be understood as "semi-formal" in their suspicions of their own ADHD children. The case of ADHD is very different than, say, a mental condition like schizophrenia. Though the term "schizo" is a regular part of lay people's slang, the actual symptoms of the disease are understood within relatively small, clinical circles. Clinical knowledge about ADHD has completely spilled out into public life, and when parents suspect the disorder in their children, they are representatives of such knowledge.

Instances where the suggestion of ADHD was made by a clinician

It is a matter of course that the formal diagnosis of ADHD is made in the clinical realm, but the initial suggestion of the disorder is not. One reason for this lies within the nature of the process of ADHD suspicion. As can be seen by the dominance of teachers that initially suggest ADHD to parents, the institution of education is an integral part of the suspicion process. In

addition, the frequency of school incidents that led to suspicions of ADHD elucidates that the institution may be the most significant factor in ADHD suspicion as well. In regard to the relationship between parents and the school, clinical visits are largely an end-product of suspicion. The clinical realm is the place where suspicions are expected to be crystallized and upheld, or dissolved and torn down.

As the end-product of the process of suspicion the clinical visit makes real what previous parties surmised to be real. But, is the relationship between suspecting party and clinician one where suspicions are confirmed, as expected, or do clinicians confirm a diagnosis? As expressed earlier, some clinicians felt that teachers should do less diagnosing of ADHD and focus more upon matters related to their profession. This resentment reveals the encroachment of teachers upon clinical practice. As such a small minority in instances of suggesting ADHD to parents, clinicians are clearly removed from this aspect of suspicion. ADHD is discussed between teachers and parents, but is confirmed by the clinic.

Sources of knowledge about ADHD symptoms

Two consecutive questions were asked to solicit the sources from which parents began to learn the specifics about ADHD: *Where and from whom did you learn the specifics of ADHD symptoms?* and *Was there more than one informational or defining source?* In answering these questions, parents revealed more of the relationship between themselves and the parties who initially suggested the ADHD diagnosis, and the sources from which they began to derive knowledge about ADHD. What is demonstrated in these relationships is that parents were often prompted down the path of ADHD knowledge by the persons who first brought the notion of ADHD to their attention. These initial interactions with parties who suggested ADHD then precipitated the pursuit of more knowledge on behalf of parents. The bulk of this pursuit was comprised by actively collecting literature on the disorder.

The connection between suggesting party and ADHD knowledge acquisition

Parents described their initial interactions with suspecting parties to also be the interactions that began the journey of knowledge acquisition about ADHD. These exchanges of knowledge stem from the evidence presented at an interaction in which ADHD was initially suggested. Parents often left those interactions with something to examine that had summary information about ADHD. As one parent stated: "We first started learning from the stuff that his teacher gave us. It was a pamphlet and I think she might have given us a Time magazine article, or something like that." In this instance, the same party who first suggested ADHD began the processes of these parents' own education about the disorder.

Parents also described that the formal process of knowledge acquisition about ADHD began in a clinical setting. Such accounts separate the moments in which a child is suggested to have ADHD from the moments of medical intervention. It is the point of medical intervention that many parents felt to be the beginning of acquiring information about the disorder. One parent describes her experience with a behavioral modification program at a children's hospital:

He was finally diagnosed at BC Children's hospital. We started their "At Home" program and went through some pretty intensive behavior modification stuff. We were told to 'understand the diagnosis' and defy the prognosis.' I remember them also telling us that eighty percent of these kids will have drug and alcohol problems if the ADHD goes untreated.

And another parent: "Our doctor gave us a pretty good description of what ADHD is and this fit very well with both of them. He told us, 'If it isn't ADHD the Ritalin will make him more hyper!'"

What is of interest in both these excerpts is the way information is given through the conversation with the clinic. In one instance, a parent is given an aphorism to follow ("understand the diagnosis and defy the prognosis") and a fact ("eighty percent of these kids will have drug and alcohol problems if the ADHD goes untreated"), in the other case a parent is told that if ADHD was not the condition, the medication would not subdue the child. The transmission of these bits of information are moments in which parents are subject to the

authoritative voice of the clinic, and given digestible facts about the condition. In one instance, parents are given a fact about the self-destructive prognosis of ADHD, in the other, the paradoxical nature of stimulant medication (see chapter three).

Parental pursuit of literature

In beginning the process of knowledge acquisition about ADHD, parents often described their voracious appetite for information. As one parent stated: "I started reading everything I could get my hands on." This sense of urgency was prompted by two factors. First, referring to the publicly-understood grim prognosis of ADHD, people exposed to this disorder through its diagnosis in a loved one will be inclined to accumulate information in an effort to aid in its treatment. Second, parents who subscribe to the ADHD diagnosis in their children will want to bridge the gap of understanding between themselves and the children's behavior. Knowledge and the hunger for it, in this sense, is a tool of empathy. As one parent said: "I did whatever I could do to learn more about his condition and why he did the things he did."

Through the process of acquiring information about ADHD, parents stated that they accumulated a great deal of ADHD resources, mostly in the form of printed matter. As one parent commented: "Well, I have a library of information in my house, no joke, I must have 30 books on ADHD." Often found in the homes of the people I interviewed were many of the guide books discussed in chapter four. Parents also seemed very interested in giving me more information about the disorder. One respondent insisted that I sit at her table and search through her considerable stack of literature on the topic. Indeed, many parents described that they had reaped the fruits of their labor in the form of having increased expertise about ADHD. As one parent stated: "Now I feel like I'm almost an expert on the topic." And in many regards, such parents certainly were experts, perhaps on par with the clinicians I interviewed.

The acquisition of knowledge about a mental disorder, such as ADHD, is an example of some of the ideas offered in Erving Goffman's classic, *Stigma* (1963). Amongst numerous discussions of how stigmatized individuals manage the social impact of their condition, Goffman

mentions that certain people suffering from a stigma might become expert on that topic, and, as a result, undergo a change of identity. For example, drug addicts may become experts on the myths and facts about addiction, and in disseminating this information to the public, have a transformation in their deviant identity. In adopting a role as an expert, the stigmatized envision a responsibility for awareness in the greater community. From Goffman's perspective, such expertise lessens a stigma's social effects and helps to reconstruct the stigmatized identity to one that is more socially acceptable. The source of the stigma becomes something of a political cause, to be fought for on interpersonal and legislative fronts. In being armed with knowledge about ADHD, parents not only contribute to the treatment of their ADHD children, but also may influence educational policies surrounding the disorder.

In expressing this expertise, parents conveyed certain allegiances to particular books on the ADHD topic. One parent gave an example: "I first learned about it from some print-offs on the internet and then I began the book buying. *Driven to Distraction* was the one that I really got into." Written by Edward M. Hallowell and John J. Ratey, *Driven to Distraction*(1994) was mentioned by four of the parent respondents as a significant introduction into the topic of ADHD. Because it is mentioned so frequently, I wanted to take a little space and discuss this text and why it may be so influential with parent respondents.

Driven to Distraction is unique, first because it is the first clinically-oriented book in which the authors (both physicians) claim to have the ADHD condition, and second, because of its light-hearted discussion of ADHD. Because of the authors' autobiographical account of ADHD, this text (like others addressed in chapter four) enjoys a tremendous credibility with its audience. In expressing some of their personal experiences of ADHD, the authors present the condition in a way that avoids some of the inherent stigma that can be part of any clinical discussion of a mental disorder. The authors frame ADHD as a normal condition, a personality trait that has lost its place in our modern, limiting culture.

Because of its "normalizing" approach to ADHD, the text strikes a curious balance between raising awareness of a mental condition and rejoicing in the fact that people are unique

in their character traits. In many ways, I believe, this text embodies many of the perspectives parents have of their ADHD children. As mentioned in the beginning of this chapter, parents see their children as unique and are not inclined to adopt overly encompassing negative labels of them. Because *Driven* acknowledges the problems associated with ADHD, but also the more beautiful side to the disorder, it represents a balance that parents find desirable.

The allegiances to texts, such as *Driven* also demonstrate the very different interest parents have in learning more about ADHD. Unlike teachers and clinicians, who may have professional motives for looking at ADHD on an objective, "case-by-case" basis, parents may need to preserve a degree of mysticism about their children and avoid some of the all-encompassing arguments about the nature of an ADHD individual. *Driven* is an excellent appeasement to the desires of parents because it provides an account of ADHD--and certainly forms some generalizations about the disorder--while at the same time avoiding an overriding character summary of each and every ADHD child. For example, the book offers little discussion of brain chemistry and an equally small amount of discussion on the treatment of ADHD through stimulant medications. Such discussions of ADHD that are largely avoided by *Driven*, frame the disorder, and consequently the nature of children with the disorder, through a lens of technical sterility that parents may interpret as disenchanting. Such clinical accounts, parents may argue, can summarize a disorder, but they cannot summarize a child.

Finding out

The most subjective responses from parents concerned the description of their feelings when first hearing the news of their child's diagnosis. As can be expected, responses to this line of inquiry were highly varied, but did constitute some visible themes in the data. Parents who were inclined to see that there was something wrong, but had not been offered a clinical opinion as to why their children behaved in such a manner, most often expressed a feeling of relief when their children were finally diagnosed. Other parents who lacked strong suspicions of their children, conveyed feelings of shock and devastation.

Parents also expressed mixed feelings about the ADHD diagnosis, stating that they were relieved the diagnosis was made, but feared for their children at the same time. More specifically, some parents claimed that their children's ADHD was discovered too late to maximize the effectiveness of treatment measures. In other cases, the sense of being afraid for their children's welfare was offset by the perception that the ADHD was discovered early enough and could be effectively remedied.

Feelings of relief

In conveying feelings of relief at finding out the diagnosis of their children, parents articulated the point at which their children's problems were to be understood by a particular, medical nomenclature. Within the micro-politics of trouble, medically-defining a problem can provide a sensation of relief: the parties who had been so frustrated by their failing remedial measures feel a sense of success in bringing the trouble to the attention of experts. The response of one parent exemplifies this:

I was absolutely relieved to finally have someone define what his problem really was. I had known a little about ADHD prior to his diagnosis, so for me it wasn't hopeless and I felt that if we started dealing with it in time, we could make a difference.

At the point of medical definition, the troubles that had previously been indefinable and increasingly frustrating to grapple with, become clear and understandable. As in most cases with medical intervention, a type of treatment for the problem accompanies the declaration of the condition.

Feelings of relief reflected parents' fatigue with the consistent trouble of their children. Parents articulated that they had suspicions of their children, that something was amiss with them, but these suspicions were left unsubstantiated. At the moment ADHD was diagnosed, many parents felt validated in the eyes of experts and could adopt a new stance towards their children's problems. As one parent stated, finding out her son had ADHD was a moment in

which she felt people were "finally listening": "I was relieved that someone was finally listening to me. I was trying to convince people for so long. It made sense that finally something was going to be done about this." Expressing relief, in this sense, represents no longer being isolated in the interpretation that their child's trouble was in fact a larger medical problem. Relief stems from being legitimated within the medical community, which is concomitant with the knowledge that that community can take measures for solving the problem. The sensation of relief, as described by parents, has at least two variables. First, there is relief that stems from no longer being isolated as a "suspector." Parents no longer need doubt their own perceptions of their child's problems. Second, the burdens of responsibility for treating the child's ADHD are partially removed as they are adopted by medical experts. Relief comes from knowing one is going to get medical assistance.

Feelings of shock/devastation

Contrasting with moments in which parents described relief and validation from the ADHD diagnosis, other parents described that moment as uncomfortable and surprising. In opposition to parents who described that the diagnosis was a step in a positive, treatment-oriented direction, some parents immediately blamed themselves for their child's ADHD. One parent's description of finding out her son probably had ADHD stands as a strong example:

I was truly devastated when our doctor said that he probably had ADHD. He referred us to someone who knew more about ADHD, but we all knew what was up. I did not know what to do. I blamed myself very harshly for his problems. Where I come from, a parent is responsible for all her child's problems. I was lost.

Such sentiment strongly resonates with much of the psychological narrative thus far discussed in this thesis. Recalling one such narrative, family dynamics are perceived to be integral in shaping a child's behavior. If a child has consistent problems, especially in crucial institutions such as school, these are blamed upon a larger family dynamic. This perspective is also exemplified in

chapter six by a clinician respondent who claimed that ADHD was a collection of "little T" traumas throughout a child's life. The basis for many such traumas, it is argued, invariably rests within parents' relationship to their children.

Often the relationship between parent and child is seen as relatively normal prior to the diagnosis. This includes how parents and their children interact with each other, but also in how children interact with the rest of their social environment. There is a notion that children who are raised in "normal" households will extend this normalcy to their greater relationships. Hence, some parents felt that their child's behavior, however troubling, was simply a representation of age, or a common phase of youth. School problems, for example were perceived by some respondents to be normal for most children and therefore not representative of ADHD: "I was shocked that her problems in school were being considered a mental problem. I always thought that most kids have some problems in school, but I never suspected it was something like this."

Normalizing perspectives on one's child exacerbates a sense of shock: behaviors that were perceived normal are now being framed by ADHD experts as pathological. Through their legitimacy as the definers of the ADHD phenomenon, the collection of experts surrounding a case of ADHD mandate that parents adopt a pathological stance towards their children. This adjustment in perspective reflects considerable expert influence, the description of "shock" denoting the beginnings of the turning point in the way a child is perceived. One respondent described his experiences:

Well, we were pretty blown away when the teacher first approached us with this. We didn't know how to react to it. I don't feel like we were in denial or anything like that. We just thought he was an active kid, doing what kids do. It came as a pretty big shock. Now, of course its different. We understand a lot more about it and we don't see it as all that bad. Its a very manageable condition as long as you take part in its treatment.

A retrospective stance is visible in this passage--one that depicts a shift in perspective, a "breaking out of denial." This new position on ADHD reveals the turning point in parents'

perspectives towards their children. Shock gives way to a different understanding. The statement, "Now of course its different," denotes a subscription to the perspectives of experts that was previously a point of resistance.

The turning point in perspective was also demonstrated by another skeptical parent who eventually was swayed by the opinions of experts. Her initial shock and then shift in perspective was in response to the apparently rigorous processes of examination:

Well, I was totally devastated when I found out that he had this. We never would have guessed in a million years that he had some kind of serious problem in his brain. You know, you don't want to believe those things about your children, but when all of the assessments were done, you had to agree with what they were saying.

Such a shift in perspective that was sparked by the conclusions of the assessment process sheds light on the ways in which ADHD experts assert their case for ADHD through a scientific modality. This certainly is an instance that gives credibility to the positions of Peter Conrad (1975, 1976), namely, that the definitions of child hyperactivity are the property of specific circles of professionals. Going against their opinions, Conrad implies, is extremely daunting. In employing state-of-the-art diagnostic instruments, the case ADHD experts build for a positive diagnosis becomes almost monolithic in the eyes of some parents.

Mixed emotions: being "scared for him"

In conjunction with the highly subjective nature of the experience of finding out their children had ADHD, many parents described their emotions as mixed. Finding out one's child may have a mental disorder is rarely, if ever, emotionally black or white. Often these emotional experiences were described as a combination of relief and a sense of being afraid for their child. As one parent described it:

I was both relieved and devastated at the same time. I intuitively knew that something was not right with him, but I couldn't put my finger on it. I

always thought 'well if he wasn't so aggressive, he'd be just perfect.' But he couldn't seem to control himself at all. I was glad that we had defined his problem and could do something to try and help him out, but I was scared for him, that he was going to have to struggle to get through this.

Being afraid for one's child was concomitant with having a confirmation that the problem behaviors were something more significant than normal disruptions. Another parent described this concern: "I guess there was also an amount of grief on my part because I knew that my child was going to have to struggle through this for the rest of his life." Grief, in most practical senses, denotes an emotion that occurs after the loss of something valuable to a person, such as the death of a loved one, the loss of a relationship, etc. In the case of a positive diagnosis of ADHD, such grief is in response to the loss of a child's normal status--something parents appeared to vicariously experience.

Parents' emotional responses to their children's loss of status, such as grief, is indicative of Goffman's (1963) notion of "courtesy stigma" (p. 29). Such a stigma is adopted by someone close to the stigmatized, often in cases of family association. As Goffman argued, the social ramifications of a stigma can be a part of the experiences of everyday life for those who are associated with the stigmatized. Such a condition provides grounds for asserting why the stigmatized can become abandoned by, or have strained relations with those closest to them. In "feeling" a child's loss, parents expressed a degree of social sensitivity about the ramifications of ADHD. In addition to fearing the perceived physiological problems associated with ADHD, parents were also subjected to the ways in which the ADHD status would affect their children's social life.

Nipping the illness in the bud

As this thesis has uncovered in its exploration of neurological and psychodynamic discourses, it is perceived to be beneficial that ADHD be discovered and treated early. This imperative nature of early ADHD diagnosis and treatment stems from neurological,

psychological, and psychoanalytic positions towards the disorder. From the neurological end, it is argued that ADHD be treated with immediacy to get the brain functioning at normal standards. Recalling one clinician's position towards stimulant medication, drugs like Ritalin take an abnormal situation with the brain and make it normal. Early intervention keeps the brain on track so that normal cognitive development can occur. From the psychological position, a delay in treating ADHD will foster a growing sense of frustration in ADHD children and eventually alienate them from institutions and social networks believed to be integral to mental health. Finally, the psychoanalytic perspective, characterized by our previous examination of some of Melanie Klein's work, posits that a failure to intervene in the life of disruptive children will eventually allow such neuroses to crystallize into incorrigible character flaws. In conjunction with these perspectives' unified stance towards early ADHD intervention, some parents described relief at knowing that the ADHD was discovered early, while others conveyed a degree of hopelessness because the discovery was made too late.

As some parents described, the negative perception of their child's diagnosis was exacerbated by perceiving the diagnosis and treatment as "too little too late." In such cases, parents were concerned that because the ADHD was not discovered soon enough, remedial measures would not be effective. One parent described it this way: "This was something that was very treatable, but I knew that these kids can really suffer later. Plus we got the diagnosis relatively late and I wondered how much we could really do for him."

Other parents described mixed emotional experiences that combined vicariously experiencing their children's new status with a notion that the ultimate result of this status would be very positive. If the ADHD was discovered at an early age it was said that this would result in effective remedial measures. As one parent described:

I was devastated. I was in total denial and didn't want to believe it. I later was glad to know but at that moment of the diagnosis I just couldn't believe it. The prognosis was so glum and gloomy, but after we began early treatment I was very glad.

And another parent: "We were mortified at first, but then we realized that it was a good thing that we had caught this in time to make some real differences."

Parents' discussion of alternative diagnoses and treatment

As it seemed important to examine the extent to which parents subscribed to the interpretation of their children's ADHD diagnoses, parents were asked: *Did you seek alternative diagnoses for your child's behavior, and if so, from whom, and with what results?* As table 8-7 demonstrates, responses to this question were split, with 10 respondents stating that they did not seek any further diagnosis and 10 respondents claiming that they explored other diagnoses of their children. As will be shown, parents who perceived no need to seek alternative diagnoses of their children often conveyed that the treatment methods employed for their children (primarily stimulant medications) were effective and therefore revealed the presence of ADHD. Parents who sought alternative diagnoses were divided between parents who wanted to pursue the ADHD symptoms as a family problem and parents who explored the linkages between ADHD symptoms and diet.

Table 8-7: Parent responses when asked whether or not they sought alternative diagnoses for their children's condition

<u>Response describing whether or not alternative diagnoses were sought</u>	<u>Number</u>	<u>Percentage (%)</u>
Parents who conveyed that they did not seek any alternative diagnoses for their children's ADHD condition	10	50
Parents who conveyed that they did seek alternative diagnoses to their children's ADHD condition	10	50
Total:	20	100

Parents who conveyed that they did not seek any alternative diagnoses to their children's ADHD condition

Overwhelmingly the respondents who stated that they had not sought any alternative diagnoses for their children implied that they were relatively certain of the ADHD diagnosis. As one parent stated when asked if she had sought alternative diagnoses: "No, we were fairly convinced." In addition to providing statements that conveyed a certainty that the diagnosis was the correct one, parents also expressed that the effectiveness of stimulant therapies for ADHD further bolstered their belief in the validity of their children's diagnoses. Stimulants were often explained as the saving grace of their ADHD children. Hence, one parent stated: "He's taking Ritalin right now and that has been a miracle." Another parent described how her son's response to dexedrine was sufficient evidence for the presence of ADHD:

Not really, we felt like we had enough information. When he took dexedrine it was clear that he was being treated for something. He said, 'Mom, it makes things less fuzzy.' The only thing is he didn't want to take it during hockey game days. So, we said "OK, you don't have to take it then." But his behavior was definitely different on the days when he wouldn't take the medication (Housewife, age 42).

In stating that her child was being "treated for something," this respondent reflects the diagnostic modalities of modern psychiatry. With regard to ADHD, this can first be seen in the work of Charles Bradley (1937), in which the treatment effectiveness for ADHD-like symptoms prompted hypotheses into brain chemistry. Today, it is regularly stated in research and clinical circles that children who do not respond to stimulant medication must not have the ADHD disorder. Given the sentiment of parents who are true believers in the validity of the ADHD diagnosis, this modality has been maintained in lay circles as well.

In addition to how such responses reflect psycho-pharmacological modalities in psychiatry, it is arguable that at the moment of the expert suggestion of ADHD, alternative perspectives on the nature of childhood misbehavior become less possible. Because it comprises

so many different symptoms, ADHD can be applied in a variety of different ways. Recalling the *DSM IV* criteria for ADHD, symptoms that warrant suspicion of the disorder comprise both introverted and extroverted behaviors. Furthermore, these criteria become even more inclusive when examined outside of the confines of *DSM IV*: within classrooms and inside homes. As seen thus far, parents have attributed self-mutilation, manipulation, and outbursts of violent behavior to ADHD. Therefore, being convinced that the initial ADHD diagnosis was the right one does not necessitate that parents understand the disorder uniformly, or that every clinician addressed the disorder similarly. Moreover, the types of behaviors that may be quelled by stimulant medication may also be various.

Parents who conveyed that they did seek alternative diagnoses to their children's ADHD condition

Half of the respondents who claimed to have sought alternative diagnoses for ADHD stated that they sought the origins of the problem behavior within the dynamics of their own family. Such an approach to understanding childhood misbehavior again resonates with psychological interpretations of ADHD symptoms. In some instances this meant seeking solutions to their children's problems through a family-oriented, psychotherapeutic approach:

We went to a counselor who brought all of us into his office, to see if there were any kind of family problems that could be causing C. to act up like this. We went to a few sessions and it didn't seem to be turning out any results. We would talk about school about some behavior strategies at home, but it just wasn't very effective. After all of that we were more inclined to look at something physically wrong with him. The signs were pointing that way.

As stated from the excerpt, the apparent failings of the psychotherapeutic enterprise prompted a subscription to the physiologically-based ADHD diagnosis. Prior to the full adoption of a medical interpretation of child misbehavior, such respondents explored non-medical alternatives.

These non-medical approaches also involved internal family interventions. In some cases, this meant having an intimate discussion with the child to see if that would provide any insight into why he/she misbehaved:

Well, we first started trying to talk to him about what some of those problems were in school. We didn't really want to listen to what other people were saying, you know, that he might have had a mental disorder, but it started becoming more and more obvious that that is what the problem was.

Again, it is revealed in this excerpt that the failure of the non-medical approach prompted a subscription to ADHD as a physiological mechanism. Drawing specifically from this excerpt, the things that "other people were saying" imply a discussion of this respondent's child having a bona fide mental condition--something that was not going to be remedied through family discussions or traditional disciplinary mechanisms.

An equal number of respondents who claimed to have sought alternative diagnoses of their children stated that they explored the linkage between their child's diet and consequent misbehavior. Such responses clearly demonstrated the influence of Ben Feingold's *Why Your Child is Hyperactive* (1974) mentioned in chapter four. Given his allergist perspectives, Feingold was a champion for non-medicinal treatments for ADHD, or what was then called minimal brain dysfunction. This was in response to the widespread use of medications for youth behavioral problems--problems that Feingold attributed to bad eating habits rather than neurological malfunctions. For some parents, such an approach to ADHD was attempted, but considered unsuccessful: "When he was younger we looked into diet to see if it was affecting him, but that was a very tall order. After a couple of weeks, it just fell apart, long before we could see any positive results" (Insurance underwriter, female age 42). The difficulty of such dietary interventions into ADHD was exemplified by an interaction I had with a 12-year-old ADHD child and his mother. As his mother and I talked I could not help but notice all of the processed "junk" foods that lay around the kitchen and the can of Coca Cola this child drank as he paced

around the kitchen while his mother and I were doing the interview. I remarked in my notes: *Isn't Coke loaded with caffeine, and wouldn't this affect hyperactivity?* Clearly, in a society where processed foods are the cultural norm, seeking alternative food sources can be highly problematic.

Another parent, whose methods bore a strong resemblance to the Feingold Diet, including the elimination of artificial food additives stated:

We've tried a lot of diet stuff. My wife and I have read a lot of stuff about diet and it affecting behavior. A homeopathic doctor had us cut out red dyes and MSG. He also gave us some herbs to help with his sleeping. His insomnia got pretty bad when he was on the medication.

Implied in this passage are some of the common side-effects of stimulant medications, specifically insomnia. In consulting homeopathic doctors or in seeking treatment remedies that fall outside the pharmaceutical mainstream, parents are exhibiting a genuine concern for the long-term health of their children.

Indeed, the search for alternative diagnoses for ADHD children from such a large number of parent respondents does much to dismantle the popular stereotypes of parents who drug their children as easily as they might give them vitamins. The fact that so many parents sought other ways of interpreting and treating their children's behavior demonstrates the high degree of care parents utilize when dealing with their children's health. Their exploration of alternatives--many of which were described as failures--shows the diligence of parents who want to do right by their children. Finally, the search for alternative diagnoses represents a degree of subversion in the face of the dominant clinical narratives about ADHD.

Breakdown of treatment methods⁵

As examined in chapter four, behavioral modification comprises methods that attempt to habituate a child in socially appropriate ways. Based upon many of the behaviorist principles asserted almost 70 years ago, such approaches to childhood behavior are viewed as integral to the comprehensive treatment of ADHD. This perspective flies in the face of the recent MTA study that proclaimed the relative uselessness of behavior modification interventions. The MTA study argued that medications provided the greatest reduction in behavioral problems, with or without behavioral modification strategies. That is, medication combined with the practice of behavioral modification is no more effective than medication taken in isolation.

Though it is clear that the clinicians interviewed for this thesis most often use behavior modification, or medication in conjunction with behavior modification as the primary mode of treating ADHD, the majority of parent respondents (12, or 60% of total) claim to not employ behavior modification in their households. Such an abandonment of behavior modification strategies partially reflects some of the findings from the MTA study. Out of these 12 respondents, 11 (91% of respondents who claimed to not use any behavior modification, 55% of total) were giving their children medication for ADHD. Such figures certainly imply a heavy reliance upon medications to address ADHD behaviors. Out of the remaining 8 respondents (40% of total) who claimed to use some type of behavior modification, 6 (75%) of those parents also gave their children medication. In sum, eleven (55% of total) of the parent respondents used medication solely, 6 respondents (30% of total) used medication in conjunction with behavior modification, 2 respondents (10% of total) used behavior modification solely, and 1 respondent (5% of total) used neither treatment method.

⁵The data excerpted for this section does not cover all of the different treatment combinations outlined in table 8-8. Though it would be an intriguing study, the perspectives parents have on the various combinations of treatment for their ADHD children is not addressed in this thesis. In examining parents' use of behavior modification this section seeks to show the connections between the discourses examined in chapter 4 and parents' everyday application of such treatments. The breakdown of treatment methods described in table 8-8 are deduced from the information gathered throughout the interviews, and are not reflected in any lengthy responses.

Table 8-8: Parents' responses to whether or not they used behavior modification techniques to treat their children's ADHD

<u>Response</u>	<u>Number</u>	<u>Percentage (%)</u>
Parents who stated that they did not employ any type of behavioral modification to treat their children's ADHD	12	60
Parents who stated that they did employ behavioral modification to treat their children's ADHD	8	40
Total:	20	100

Parents who do not use any behavior modification techniques

Parents who did not use behavioral modification techniques often claimed that they had made other, less-specific changes in their parenting strategies. This mainly implied being more present for their children, and doing their part to cultivate their children's self-esteem. As one parent stated when asked if she utilized behavior modification techniques, "Nothing in particular, but I try to be more encouraging to him and the things he accomplishes." Another parent expressed the implementation of similar styles of parenting: "Not really, other than trying just to be more present, I guess. You know, listening to him more and trying to see what his immediate needs are."

Such responses demonstrate that behavior modification can take on forms that are not specifically outlined with practitioners of these types of behavioral reform. When respondents claim, for example, that they do "nothing in particular" in relation to behavior modification, this denotes that the alteration of behavior need not be done through a rigorous behavioral program. Coming from more of a "common sense" approach, such responses allude to the fact that many parents may see the finitudes of their child's behavior as stemming partly from their unique personality and partly from environmental circumstances. Life within the household may be construed as unique, as are the children who live there. Because of this, parents may be inclined to solve behavioral problems through intimate interactions with their children--being more

present, being generally encouraging, listening, and so on--rather than through regimented programs that are designed to universally fit unruly children.

Parents who use behavior modification

Resonating with much of the recommendations made by ADHD guidebooks in chapter four, many parents stated that they used behavior modification techniques. The primary method used by parents was a points and reward-based system. No parents who used behavior modification employed a token economy, which is a method believed to be effective with very young children. As one parent stated: "We have set up a points system for the morning time for his hygiene. Once he accumulates enough points, we take him out to a restaurant that he really enjoys."

Responses implied that the implementation of behavior modification had mixed results. For some parents the points system was successful but still had an uncertain future in the face of their rather unpredictable children. As one parent stated: "We're doing a lot of the behavior modification techniques we learned about at Children's. We have a point system and so far so good on that one, but with him you can never tell." Another parent, a father who only used behavior modification at the time of the interview, conveyed less success with the method: "We've tried a rewards system for his homework, but it isn't working too well at this point. The only thing to get this kid motivated about is something athletic, like football or basketball."

Parents' theories about the nature of ADHD

At the conclusion of the interview, parents were asked: *In your opinion, from where does the ADHD disorder originate?* Responses to such a question revealed a lot about how parents frame the nature of the ADHD disorder, and consequently, how they framed their ADHD children. As seen in table 8-9, the majority of parents (13 or 65% of total) postulated that ADHD was an unspecified genetic condition. This genetic stance towards ADHD was characterized by statements that framed ADHD as stemming from a specific personality gene in the greater gene

pool, and also, by statements that made direct linkages between respondents' families and the ADHD condition. A significant number of respondents (6, or 30% of total) stated that they felt ADHD was a neurological malfunction of some kind. Such responses showed a connection to the previously examined neurological perspectives towards ADHD. Finally, one parent (5% of total) argued that ADHD may have originated--at least in the case of her son--through traumatic events.

Table 8-9: Breakdown of parent's opinions on the origins of ADHD

<u>Parents' account of the origin of ADHD</u>	<u>Number</u>	<u>Percentage (%)</u>
Parents who claimed that ADHD was an unspecified genetic condition	13	65
Parents who claimed that ADHD was a result of physiological processes	6	30
Parents who claimed that ADHD was a result of trauma	1	5
Total:	20	100

Parents who claimed that ADHD was an unspecified genetic condition

Through articulating that ADHD was genetic the majority of parents separated themselves from arguments that would implicate family dynamics in causing ADHD. Regardless of intention, an appeal to genetics exonerates parenting styles and/or specific events from accepting the blame for creating ADHD symptoms. A genetically-based argument casts ADHD as an inevitable entity; one that may show up in the DNA strand at any time. Appeals to such arguments placed the genetic hypothesis against the backdrop of the greater society, or against the backdrop of one's own family. In some instances parents looked to the behavior of members of their own families, including themselves, to demonstrate the genetic nature of ADHD. In other instances, parents seemed to adopt a more "human species" approach to ADHD, stating that ADHD was a character trait that appears in the greater gene pool.

Taking an anthropological, gene pool approach to ADHD, some parents claimed that people who are today labeled with ADHD were actually some of the most useful members of an earlier kind of society. ADHD, in this sense, is an atavism. The nomenclature of ADHD was applied because the relationship between this personality type and modern society had become antagonistic. An ordered society characterizes the non-conformists as "disordered." As one respondent (herself diagnosed with ADHD) stated, people with ADHD are the ones who have a difficult time being molded to the constraints modern society mandates:

It's all part of the DNA. From the beginning of time we were the survivors. We are more nature people, not technical people. The society we have has placed us into some pretty rigid spots. We aren't really able to be who we are. So, they call it ADHD, but it is really a sign of a survivor.

From this perspective, labeling a trouble (Emerson and Messenger 1977) ADHD is historically contingent. The assumption is that during an earlier time, people who would today be labeled ADHD were highly valued members of society. People with ADHD, such respondents argued, were more sensually connected to their surroundings, constantly in-tune with the stimuli around them. In a society where an emphasis is placed on repetitive and focused kinds of activity, such personality types are deemed unproductive and a nuisance.

The other genetic stance towards ADHD adopted a familial position towards the disorder. Parents responding in this manner often stated that they could see ADHD in their families, or in themselves. A brief response by one parent exemplifies this: "I think it is familial, genetic. When I look at my own family tree, my mother has it and I think I may have traces of it." As another respondent stated, sometimes the familial connection to ADHD was made by opposing the characteristics of the two sides of the family:

I do think it's genetic. I have wondered about myself, you know whether or not I might have ADHD. I know that it doesn't come from his mom's side. They're all incredibly organized, high achieving people. Who knows? I may have a touch of it. I was never a very good student either.

By deferring to the contents of the DNA strand, parents who adopted this aspect of the genetic argument, removed themselves as a possible causal factor in the development of ADHD. This refutes much of the psychodynamic narrative that frames ADHD symptoms as a result of family dynamics.

Parents who claimed that ADHD was a result of physiological processes

Prevalent amongst the biological arguments for ADHD was the notion that a child's disruptive and punishable behavior could not have originated from an act of self will. The discussion of ADHD as a "non-human agent" in prompting behavior resonates well with such responses (see chapter three, especially the section: the dominance of neurology). ADHD children, it is argued, are said to be driven by something beyond their own notions of right and wrong. This stance follows the framing of ADHD demonstrated in chapter seven which states that children, by nature, do not desire punishment. Hence, consistently being in trouble is considered symptomatic of a larger condition. One parent gave a clear example of such a perspective:

Oh I think its definitely biological. There is no way (mentions son's name) would act like that intentionally. He is driven by something outside of his control. That's why he gets so frustrated with other people and has to lash out. Now, I don't know what causes this, but I can tell you that it's real.

When acting out, the child may be punished for behavior he/she cannot control in the first place. An unsavory cycle of behavior and punishment is believed to encapsulate ADHD children in which self concepts are damaged and negative attitudes towards crucial institutions crystallize.

As some respondents discussed the presence of an undefined, yet real entity called ADHD, others invoking biology as a causal factor in ADHD discussed brain function. Such responses lacked the jargon-laden language of the accounts clinicians provided. For example, no parents mentioned the frontal lobe, or basal ganglia as a location of their children's ADHD.

Regardless, these responses did reflect some clinical etiological narrative about the disorder, and also reflected the lack of unity in ADHD etiology. In some cases, responses had contradictory statements. The following excerpt serves as an example:

Well, I definitely think it's a physical thing. The wiring is not firing all the way when they get into certain environments. Out on the playground or in the gym they do fine, but put them in a class or in front of a new teacher and they just go haywire. I think that kids are born with this, and some learn to cope, but there are some like my kid, who just have too much brain activity, just too excitable in certain situations.

In invoking the term "wiring" this respondent draws attention to the physical make-up of the child's brain, and how it processes stimuli in different situations. A contradiction is clear in this passage as this parent likens ADHD to a condition in which "the wiring is not firing all the way," but then later states that ADHD may also be a result of "too much brain activity." The volatility of the ADHD child is invoked, in which he/she may fail academically, and/or have behavioral outbursts. The former case may denote having too little brain activity, whereas the latter may be linked to too much.

Such responses may demonstrate some of the contradictory ways ADHD is understood in both popular and clinical realms. As can be seen from the clinician interviews, clinicians also had very divergent views about what caused ADHD. In some instances clinicians believed it was a result of brain inactivity, whereas in other instances, ADHD resulted from brain overactivation. If the clinician sample shows a lack of unity in positing an etiology of ADHD, it follows that these contradictory stances will also invest themselves in the attitudes of parents.

Other parents took a tentative stance towards providing their opinion on the origination of the disorder, but countered such timidity by discussing some specific facts they had learned about ADHD. For example, one parent responded this way:

I am convinced that ADHD is a result of brain chemistry. There's just an imbalance in the brain somewhere. I heard that the neurons get interrupted,

like they're unable to fire and completely finish a task. The brain isn't aroused as it should be--it's kind of sleeping.

During this particular interview, this parent directed me to the work of Gabor Mate--a text I had already read by the time of the interview--as the location of his knowledge about the physical properties of ADHD. The unsure language at the beginning of this response--for example, stating that ADHD is caused by "just an imbalance somewhere"--gives way to the invocation of some specific theories about the disorder. In this instance, the respondent directed me to Mate's position about brain underactivation and his "traffic" metaphor. In short, this metaphor likens the brain of an ADHD child to a traffic intersection in which the mechanisms for directing traffic are asleep at the switch. The inactivity of brain regulation mechanisms causes chaos in the way the brain processes information. The different cars (metaphors for neurons in the brain) do not know when to stop or go. Children with ADHD are therefore said to be drawn in every direction, unable to filter out the important stimuli from the unimportant. They become hyperactive. From Mate's perspective, this condition contributes to the paradoxical appearance of ADHD: less brain activity leads to seemingly hyperactive behaviors.

Though Gabor Mate's *Scattered Minds* (2000) does not posit new research findings about the origins of ADHD, this text (a bestseller) is relevant for understanding something about how ADHD children are perceived (Fuster 1997). The text is geared for a popular audience and its etiological positions on ADHD strongly mirror dominant neurological perspectives on the disorder. That being said, it is important to examine how the invocation of Mate by this respondent represents the filtration of research-based knowledge through popular texts and into the knowledge base of parents who are affected by ADHD.

Parents who claimed that ADHD was a result of trauma

There was one parent who posited a non-biological argument about what may have caused ADHD in her son. As the previous types of theories about the origins of ADHD

exonerated parents from being causal factors--that is, outside of their DNA strands--this respondent directly implicated herself and an abusive marriage:

I think that trauma as a child may have something to do with it. I don't think I'm a bad parent, but when his dad and I were together, it was very abusive. I wanted to get out of this relationship, but I didn't want to take T. away from his dad. I think I might have stayed in it too long. There were altercations between he and I and I know T. witnessed that at least once.

That has got to have an effect on a child and how they're going to behave.

This type of response that attempts to make sense of childhood misbehavior takes on a more traditional flavor and resonates very clearly with psychological perspectives towards the disorder. ADHD, this response denotes, is not neurological, but environmental. A child's misbehavior is framed as a direct result of domestic circumstances. This response also demarcates the perceived fragility of children: they are not oblivious to the events around them. Such a perspective reflects some of the positions of the clinician respondent from chapter six who discussed the fragility of a child's attention- system. In events of trauma, this psychologist argued that the mechanisms that foster attention will be the first to give way. Hence, you cannot only entertain a brain chemistry hypothesis to see why a child may be acting out, or be unable to concentrate, but instead must look at his/her greater life circumstances.

Concluding remarks

In the empirical analyses thus far, the parent interviews reveal the greatest degree of variation in how ADHD discourses shape their interactions with suspecting parties and how such discourses are revealed through the way that parents conceive of their children. Within these accounts we find a mixture of neurological and psychodynamic perspectives towards ADHD, in addition to perspectives on the parents' regulation of their child's domestic environment, diet and hygiene. This variation, I believe, is crucial in offering a different perspective towards ADHD and

medications from those offered by sociologists (e.g. Peter Conrad), cultural critics (e.g. Richard DeGrandpre) and skeptical psychiatrists (e.g. Peter Breggin).

Such critics partially contend that ADHD is a phenomenon that is spoon-fed to the masses. Because the medical establishment has gained such dominance, such critics argue, people are left without the intellectual resources to critically examine the information they are being given. We presumably live in an era characterized by pill-popping sensibilities and overworked parents who want quick solutions to their children's problems. Based upon the data examined in this chapter, it seems that such propositions are conjectural, at best. The accounts provided by parents reveal a considerable degree of struggle with the ADHD diagnosis. Though it is clear that many parents, after feeling like they had attained enough information about ADHD, leaned towards a neurological understanding of the disorder, their accounts repeatedly implied that the diagnosis could not adequately encapsulate the essence of their children. For example, parents who interpreted their ADHD children as having special qualities--ones superior to non-ADHD kids--shows how the notions of difference implicit within the ADHD label can be viewed as an asset. As one parent described, her children were "less boring" than other children. Another parent described her child as "ADHD gifted."

Demonstrated in such accounts are people's resistance to diagnostic schemes and the experts who purport them. The process of accepting a diagnosis and subscribing to a particular narrative about ADHD is not always a rapid one. What slows this process and what enables parents to use the ADHD label for their children, yet not reduce them entirely to neurological problems, is a type of micro-level politics. The struggle over defining their children's illnesses and treatments represents a resistance to the dominant neurological perspectives towards ADHD. In clinical circles, clear definitions are necessary for what are perceived to be appropriate ADHD diagnoses. However, such procedures do not entirely formulate the way parents frame their own children.

The next chapter will integrate the preceding analyses of interviews with clinicians, teachers and parents. As we have been focusing on the role of discourse in shaping the

experiences of these social actors associated with ADHD, it is also important to examine how these respondent groups' interactions with each other illuminate the presence of differing ADHD discourses, primarily, neurological and psychodynamic discourses. As in the previous three chapters, there are moments when one perspective towards ADHD seems dominant in the types of attitudes someone takes towards ADHD, or in the manner in which remedial action is taken towards the disorder. What is of primary concern in this regard is not necessarily the dominance of a particular perspective, but the dynamics which lead up to this dominance.

Chapter 9:**Analyzing the Interaction between Respondents: Suspicion, Social Role Acknowledgement and ADHD Discourse**

Thus far, we have analyzed three sets of respondents: clinicians, teachers and parents. The analysis of interview data from such sources has illustrated the parameters around each of these groups in terms of how each utilize ADHD discourse and how these discourses are put into practice. Up to this point, such groups have been examined in relative isolation from each other. Within each of these groups, there is a clear relation between subscription to ADHD discourses and how these make their way into the actions such respondents take in relation to the disorder. The phenomenology of ADHD from each of these groups can be traced to the discourses we have examined in the first half of this thesis and hence, shows the degree to which such discourses have attained legitimacy.

The present chapter will examine the interrelationship between these respondent groups. Recalling the way respondents were recruited for this study, that is, by contacting parents at CHADD meetings and other contexts, and then approaching their children's teachers and clinicians as divulged by these parents, this chapter will focus on specific cases in which the interview data illustrate clear interactions between parent, teacher and clinician. These interactions reveal a number of conceptual issues that require analysis. Three of these that are pertinent include: 1) the way the process of ADHD suspicion reveals itself through these respondents' interactions with each other; 2) the way in which certain "frames" for a particular case of ADHD are constructed and may change over time; and 3) the way in which such respondents differentiate themselves from each other and formulate a unique identity within the ADHD suspicion and treatment process. An analysis of these and other issues will be grounded in the genealogical section of this thesis presented in chapters two through four. Underlying the suppositions presented by such an analysis is the notion that the subscription to particular discourses about ADHD are primary in motivating these respondents to take the actions that they do.

Within the analysis of these cases, some of the forces which characterize the respondents I have interviewed will be further discussed. This characterization is important, as an understanding of the different respondent groups will provide an understanding about how such groups interact with each other. Therefore, in examining the way different respondent group identities are formulated, I will address how both professional and familial relationships to the ADHD child foster interactions between clinicians, teachers and parents.

Discourse and group identity

Despite the variation in their perspectives towards ADHD, the data reveal that respondents within each group are introduced to a case of the disorder very consistently. The consistency in the initial "ADHD encounter" reveals the linkages amongst group members and how they demonstrate a commonality. For example, clinicians mostly encounter a case of ADHD within the clinical setting--a location that speaks volumes about how ADHD is framed: ADHD is an aberration, framed either as a bona fide illness, psychodynamic entity or combination of the two, and requires medical intervention. Through consistently encountering ADHD within the classroom, teachers also have a unified frame for the disorder: ADHD is an impediment to learning and must be removed in order for the teaching process to be effective. Parents' introduction to ADHD, on the other hand, is not specific to a place, but specific to whom parents first discuss the suspicions of their child having the disorder. Overwhelmingly, these initial suspecting parties are educators, sometimes approaching parents in an individual capacity, sometimes as members of a school based team. Hence, parents begin to know ADHD, not by the behavior of their children alone, but in how school representatives evaluate the success of their children within that institution. What unifies parents as a respondent group, therefore, is that they experience ADHD through their interactions with professionals (primarily educators) who explain to them the abnormalcy of their children's behavior and how such behavior constitutes a significant barrier to present and future success. From these initial, and alarming interactions,

parents begin the process of acquiring knowledge about ADHD and develop relations with professionals whose job it is to treat the disorder.

Analyzing each group separately heightens an understanding of how each of these groups has a unique experience in negotiating the meanings inherent in ADHD discourse, making the decision to accept or reject these discourses, and finally, to put beliefs about ADHD into social practice. Through the way beliefs about ADHD make their way into these practices and into the accounts of respondents, we may see the historical staying power of a discourse. For example, all three respondent groups are replete with perspectives that resonate well with the neurological positions examined in chapter three. Such a strong demonstration of neurological perspectives towards the disorder certainly conveys the resilience of such a perspective. This resilience may be, in many ways, attributable to the successes such a perspective has had through its proponents' rhetorical mastery, research resources, perceived treatment effectiveness, and so on.

However, also revealed in the interview data from all three respondents groups were accounts that demonstrate an affiliation with perspectives other than neurological ones. This condition in the data reveals how discourses and their historical interactions/confrontations with each other are continuous. Recalling Laclau and Mouffe's (1985) concept of "nodal points" of meaning, the mixture of different perspectives demonstrates that the dominance of one perspective towards ADHD is always momentary. A nodal point is something one may fix upon for the span of a research career, or for a fleeting moment before shifting to a new perspective. Interview data from these respondent groups reflect the momentary nature of meaning, and demonstrate how contradictory and antagonistic perspectives towards ADHD can coexist. This is exemplified, for example by clinicians who clearly expressed the belief that ADHD was a neurological phenomenon that was treatable through Ritalin, yet also subscribed to family therapy as part of ADHD treatment.

As established in our previous discussion, this perspective, in which contradictory discourses are revealed in practice, seems an impossibility. From Kennedy's (1924) discussion of the psychiatric sequelae of *encephalitis lethargica*, to Wender's (1971) and Eisenberg's (1963)

discussion of the neurology of ADHD, up to Barkley's (1997) research on brain structure and ADHD, the neurological perspective denies the influence of environmental factors. In fact, part of the success of the neurological discussion has stemmed from the dismantling of perspectives that invoked environmental factors in the etiology of ADHD. With regard to ADHD, neurology made a name for itself by lamenting the lack of sound science that went into psychodynamic perspectives towards the disorder, focusing on the inefficacy of psychotherapy and the antiquated nature of psychoanalysis. The specificity of the neurological message can be contrasted with people currently writing about ADHD from a psychodynamic perspective, Lawrence Diller (1998) standing as a case in point. Perspectives like Diller's fail to make a definitive statement about ADHD, what causes it and what treats it. It is arguable, therefore, that neurology's dominance is largely a result of exploiting this indecisiveness.

The respondent data reveal, however, that the dominance of neurology is more monolithic in theory than in actual practice. Through its seemingly meticulous analysis of data, its physiological nomenclature, and through its appeal to arguments that invoke the general principles of Western science, neurology has dominated the pages that comprise journal articles and technical manuals. But within the realm of social practice, neurology is often fractured, and hybridized with other perspectives. This calls forth the use of Foucault's theoretical position about the "extradiscursive" dependency. The extradiscursive, according to Foucault, reveals how people utilize discourse and how their world view becomes formulated by them. A reciprocal relation is implied with the extradiscursive, in which discourses affect the way people act and evaluate those actions, but also in how those discourses are maintained and given credibility.

The extradiscursive is the dependency that places an analytical emphasis upon human agency. There are certainly extradiscursive relations in which the actions of lay people are more predictable, and are influenced by what Foucault would call a "knowledge regime." The types of actions that occur in mental institutions would be an example of such a uni-directional and

unyielding relation between discourse and practice.⁶ But the actions taken in everyday life, I believe, have a high degree of variability. The accounts given by respondents in this study, though clearly influenced by neurological discourses, demonstrate that ADHD is continuously under negotiation.

Exploring cases of respondent interaction

With the description of the role structure characterizing clinicians, teachers and parents, it is important to examine specific cases of interaction amongst them. Such cases, rooted in the interview data, typify the aspects of ADHD suspicion, the way the disorder is framed and the manner in which respondents' social roles are regarded. There are four such cases that I wish to explore that exemplify a strong interrelationship between respondents and adequately represent the moments of ADHD suspicion to the moments of diagnosis and treatment. These cases were chosen for analysis based upon the continuity between respondents.⁷ The contents of each case are outlined briefly.

Case number one, concerning a 10-year-old grade five boy, represents the most common manner in which ADHD is initially suspected, diagnosed and pharmacologically treated. Characterized by relatively smooth transitions in the ADHD suspicion and diagnosis process, this case typifies how respondents can express a kind of togetherness and singleness of purpose. In addition, respondents in such cases adhere to neurological perspectives towards ADHD and generally believe in the effectiveness of medication therapy for the disorder.

⁶Even though mental institutions are considered to be highly "controlling" kinds of environments, they still have moments in which the actions that occur within them are out of line with, or subversive towards the discourses that direct their function. See Goffman (1961) for a discussion of the informal social dynamics that can occur within the confines of such institutions.

⁷Even though respondents were recruited according to the social connections to each other (see chapter 5), many teacher and clinician respondents were not able to discuss specific cases of ADHD children at any considerable length. This is the case for two reasons: 1) teachers and clinicians have numerous interactions with ADHD children over the course of their careers, and this may have impaired their ability to accurately recall specific children and specific parents; 2) especially with regard to clinicians, there was a common reluctance to discuss their patients with me, even after I had mentioned that I was referred to them from parents. Despite these two impediments to a "case-by-case" discussion of ADHD, these respondents provided valuable interview data for the empirical section of this thesis.

Case number two, addressing a 12-year-old, grade seven boy, typifies how the initial mechanisms of suspicion, especially one-on-one interactions with teachers, can be met with resistance from parents. As respondents in this case demonstrate, such resistance often begins the process of more formalized types of school intervention, primarily the scheduling of meetings between parents and a school based team. These formalized interventions are highly effective in bringing ADHD-suspected children in for medical assessments and perpetuating neurological narratives about ADHD etiology.

Case number three, concerning an 8-year-old, grade 3 boy, demonstrates that resistance from parents may come at the point of pharmacological intervention. In this case, there was a relatively smooth transition to a formal ADHD diagnosis, but the side-effects of Dexedrine and then Ritalin proved to be too significant for this boy's mother to continue with these treatment measures. As this case exemplifies, the switch to more psychodynamically-based treatments, such as behavioral modification, may also contribute to a change in the etiological perspective (from neurological to psychodynamic) towards ADHD.

The fourth and final case to be discussed exemplifies a stable psychodynamic perspective towards ADHD. In the case of a 10-year-old, grade-five girl, school authorities clearly suspected ADHD, but the route of diagnosis and treatment taken by the girl's mother was oriented towards environmental factors. The ADHD symptoms, her mother contended, were due to family dynamics and the school environment more than to a neurological problem. In this case, clinical consultation was sought from a professional who was sympathetic to other perspectives towards ADHD, and treatment measures involved intensive family therapy, rather than medication.

Smooth transitions from suspicion to treatment: case #1

There are accounts in my field notes that depict a relatively uneventful series of social transactions, beginning with the initial suspicions of ADHD, usually coming from someone associated with the child's school, and culminating with pharmacological treatment. In these instances, ADHD suspicions from school representatives were readily validated by parents as

were the clinical opinions later given about the disorder's etiology and treatment. These events were characterized by parent accounts that described feelings of "relief" in association with the intervention of educational and clinical authorities. Such intervention, some parents contended, began a much needed process in which their children's problems could be specifically identified and therefore, get them on the path to normal social adjustment. Such cases were typified by parents who subscribed to neurological perspectives towards ADHD and have children who take stimulant medication.

In describing these transactions as "smooth," I mean that the different social contexts within which ADHD was discussed as a topic of suspicion and ultimately diagnosed and treated, were characterized by a limited amount of social conflict. The presentation of "evidence" of ADHD-suspicious behavior combined with the presentation of "facts" about the disorder were accepted as truth. Such an acceptance of this information implies that parents within these cases were prone to view teachers and clinicians as helpful, rather than uninformed or malicious. This relatively small amount of discord between parents and the suspecting and diagnosing parties demonstrated a mutual acknowledgment of social roles. Neither teacher nor clinician respondents in these cases acknowledged any dispute over whether or not they had appropriately evaluated a child, or that their concerns about a child having ADHD were inappropriate to their professional environments. The interviews showed that as clinicians and teachers interacted with these parents, their roles as "experts" in relation to ADHD were given legitimacy. Similarly, parents in these instances expressed that they were given adequate agency in implementing their child's treatment measures, hence, the household and social roles within it were perceived as respected.

The case of "D," a ten-year old, grade-five boy, exemplifies how the process from suspicion to medical treatment can be uneventful, and regarded by adults as undeniably appropriate. According to his mother, a 38-year-old nursing student, D's form of ADHD was strongly inattentive, though there were moments when he had demonstrated hyperactivity; he had, for example, pulled a girl's hair and had had some physical altercations with a few of his classmates. Such altercations, however, were not attributed to ADHD proper, but to what his

teacher and mother linked to his continuing struggle with school. According to his mother, D had been showing a diminished capacity for school work since his entrance into grade one--something rather typical, as the suspicions of ADHD usually begin at this point in a child's school career.⁸

Towards the end of his grade four year, D's teacher had a conference with his mother, disclosing that he felt D was not keeping up with the other students and was falling into more types of anti-social behavior. As he stated:

With these kids you want to try and cut them a little bit of a break. With D, we had a really sweet kid, really nice most of the time. But it was like he hit this wall and just couldn't get over it. With a lot of these kids I think they take out their frustrations on the others because they aren't doing what they see all the other kids having such an easy time with. ...I guess there comes a point when you know that this isn't a phase and you need to get involved in a more serious kind of way (G4).

At this conference, D's teacher wanted to recommend him spending at least three hours per week in the learning assistance center. The rest of his grade four year was spent in this manner: three days per week he would leave class and be given some concentrated attention in the LAC. Upon being exposed to the LAC, it was found that D had virtually no mathematics skills, and, like many LAC students in this age group, was probably a year behind in reading. The new attention given to D in the LAC seemed to help his situation somewhat, but he continued to falter academically. As his mother stated: "The LAC was a start for us to try and figure out what was going on, but we knew it wasn't going to fix all the problems."

The words "us" and "we" in this passage represent the continuity of the phases in the suspicion and diagnosis process in this case. By using such words, D's mother implies that there

⁸The rationale for this is that the mental demands that are placed upon children when entering grade one are markedly more intense than those that are placed upon children in kindergarten. As many teachers and clinicians in this study contended, kindergarten functions as a place to socialize children into the institutional structure of school, rather than teaching academic lessons.

is a type of unity amongst the people associated with her son. Indeed, D's mother regularly mentioned a kind of "togetherness of purpose" which clearly denotes a respect for the role structure surrounding her son's situation. Referring to the meeting in which D's possible ADHD was the primary topic, she stated: "We just had to put our heads together to try and figure out what was really going on. At that point we'd pretty much tried what was available through the school, so we took it to the next step." Such statements demonstrate a belief in the sincerity of suspecting parties. As her son's well-being was her primary interest, the use of the term "we" in relation to school representatives that suspected D of having ADHD, shows how this mother also felt that her son's well-being was a similar priority for such suspecting parties. This unifying kind of language also denotes that D's mother felt connected to the suspicion process. As it appears that D's case happened incrementally--first with LAC intervention, then with the specific mentioning of ADHD--it may be concluded that the development of suspicions unfolded as a discussion between D's mother and her son's school. Suspicion, in this instance, unfolded as a dialogue.

The meeting between D's mother and the LAC teacher resulted in some conventional testing procedures: A child's rating scale for D, a parent's questionnaire for D's mother, and a teacher's questionnaire.⁹ The results of these were brought to a psycho-educational assessor along with D's school records. According to D's mother: "We had heard that going and getting a 'psyched' evaluation was going to put us on the right track as far as D was concerned. ...We wanted to get a referral that was from an informed source." As briefly discussed in chapter six, a psycho-educational assessment of a child is a much longer process (according to the psycho-educational assessor I interviewed who was associated with this case, a typical assessment can take between 6 and 8 hours) than a clinical interview either with a medical doctor or a clinical psychologist. Though more costly, this was clearly perceived as a more informed route for D. In discussing D's

⁹Respondents could not recall the questionnaire that D was required to fill out, but both her mother and the teacher filled out typical Conners rating scales.

case and also speaking more generally about his role in assessing children, the psych-ed assessor stated:

Well, you really want to try and make sure that a student with a learning disability is not going to be labeled as having ADHD, because they are totally different and they show up totally different in the profiles we do. There are some students who have very specific learning problems and it is hard to tease those out when you don't take the time to really analyze what the problems are. Schools just don't have the time, so that's why they come to us.

Referring specifically to D:

I knew that he had a lot of deficiencies in school, that's for sure. The major thing we look for with ADHD is the variation in the problems. He just had a ton of them, which shows that there was more going on than one kind of learning problem. ...I felt comfortable providing the referral for the pediatrician who normally sees these kind of (probable ADHD) cases (Psycho-educational assessor).

The referral in this case was to a pediatrician, who formalized the diagnosis of ADHD and prescribed a trial of Ritalin (5 mg twice per day). According to this pediatrician, diagnoses are made easier because of psycho-educational evaluations: "There's no doubt that a psych-ed evaluation makes this whole process easier. I wish everyone would go and get one prior to seeing me, but that's not realistic. Parents would be pretty smart to take the time to do it, even though they already kind of know what's going on" (Pediatrician).

D's case describes a series of events in which physiological explanations for ADHD are validated and the conventional treatments for this condition are considered effective. After taking Ritalin, D showed some improvement in school and his behavioral problems entirely vanished. As his mother stated: "I was amazed at the Ritalin, and he was taking so little, basically the minimum that gets prescribed." In conjunction with the pharmacological treatment of her son,

D's mother conveyed an entirely neurological perspective towards the disorder, claiming that the elimination of D's disruptive behavior came from the balance that Ritalin had restored to her son's brain chemistry. Despite the relative ease with which ADHD was suspected, assessed, and diagnosed, it should be mentioned that caution was exercised with the involved parties. D's teacher, for example, wanted to start D in an LAC program before entertaining other notions about why he was struggling so badly, and in approaching the psych-ed assessor, D's mother clearly demonstrated a perceived need for a thorough examination.

The smooth case of ADHD is not necessarily one in which the series of events that lead to a diagnosis of ADHD and medication occur without care and thought. That is, these cases do not automatically support a cultural stereotype, demonstrating the use of "quick fixes" for the adults involved with unruly children. D's case does a lot to dismantle some of the notions about ADHD being used as a cop-out for teachers and parents, and a catch-all childhood diagnosis for clinicians. Furthermore, this case shows that there is an interpersonal component to the extradiscursive, that is, there are a series of social exchanges that influence the perpetuation of a discourse, be that neurological or psychodynamic. Aside from the raw strength of neurological discourse, as it is represented by large research dollars and high-caliber institutions, a neurological perspective towards ADHD can gain legitimacy through a series of social relations that are far removed from the research forum within which these discussions commonly occur. The collective perception of "togetherness," for example, demonstrates that a discourse can be heavily mediated through collective action.

Experiencing formal intervention, semi-formal suspicion: case #2

The case of "M," a twelve-year old, grade 7 boy diagnosed with ADHD, demonstrates the process of ADHD suspicion in the school, specifically how such suspicion leads to intervention measures and eventually, diagnosis and treatment. This case exemplifies the way that initial intervention measures are resisted by parents, and how this resistance gives way to larger, more formalized processes of intervention. Intervention mechanisms, such as School Based Team

meetings with parents, are generally regarded by teachers to be highly effective in convincing parents to seek medical assessments of their children. Due to factors explained shortly, the meeting between SBT and parent typifies not only a key aspect of the ADHD suspicion process in schools, but the mechanisms for how such suspicions are presented.

There was some disagreement about the reasons for M's behavior. From his teacher's standpoint, M's behavior was very indicative of ADHD. He had demonstrated marked anti-social behavior, she contended, including violence upon others, and was at the bottom rungs academically. There were moments in which other students had conveyed that they did not want to be around M for fear that he would hit them or distract them from getting their work done. These teacher descriptions were partially corroborated by M's mother and father who both agreed that he had pronounced academic problems, but was less inclined to believe his violent exchanges with other students were of his own making. M's parents gave credence to the teacher's claims that he was a poor student, but felt that his problems with fighting were not necessarily connected to these academic problems. This dispute provides the context for the initial exchanges between M's teacher and his parents. M's teacher seemed very inclined to connect academic and behavioral problems in this case, something which clearly resonates with the teacher descriptions in chapter seven that depicted ADHD students' problems as combining academic and behavioral traits, but his mother was more inclined to interpret these problems as specific to certain children and the history M had had with them.

Here we have a dispute between parents who argue for the uniqueness of their child's circumstances, and a teacher who, having "seen this before," argues that M's circumstances are not that unique, but instead, characterize ADHD. As M's teacher stated:

I had seen this many times before, and I really wanted to do something about it before it was too late. When you don't intervene or say anything, that student moves on and then it becomes too late to help in any way. ...I spoke to his parents personally on this one, which isn't what we normally

do, but I felt that in this case I had to.¹⁰ They were very resistant to what I had to say, even after I showed them his performance report (G7).

This teacher continued to describe how the parents' resistance to the conclusions presented at this one-on-one consultation prompted him to bring this case to a school based team meeting. Through testimony that exemplifies the "case-building" measures explained in chapter seven, this teacher stated: "I brought up this boy at the SBT meeting and we started doing what we always do: trying to get enough information together so that the way we presented it to his parents was convincing and solid."

After the SBT had adequately compiled information, including statements from other teachers, and a school psychologist's preliminary assessment, another meeting with M's parents was arranged, this time with all of the members of the SBT, including M's teacher, an administrator, and a school counselor. As the teacher described, this intervention proved successful and the boy's parents sought a medical assessment for their son: "They did seek a doctor's opinion, so we could finally begin doing something about this." The boy's father described the SBT intervention:

I guess you might say that it kind of broke us out of the denial about M's problem, that it was something real and not just a thing with his teacher, or with some bullying problems. We had been down to the school more times than I care to recall, but we just did not want to address it. I look back, and of course, I'm glad, but it took us a while to see things a little more clearly. It was not normal for him to get into the trouble that he was getting into, and his school performance was really faltering. So, I was like, OK, what do you think is going on here?

¹⁰It is important to note that when stating that speaking personally with parents is not normal in this case, this teacher is not implying that she does not have personal contact with parents. Instead, this refers to the specific context of suspicion of ADHD. From this teacher's perspective, when a specific problem, such as ADHD, is suspected, this is usually handled through more formalized channels in the school.

This "denial breaking" experience eventually led to a medical assessment from their family doctor. A diagnosis of ADHD was provided by the doctor in this case, and M was prescribed a trial of Ritalin.

The clinician, a general practitioner, expressed that medical intervention in M's case was late, but still important. As he stated: "We should have kids in here when they're seven or eight, not when they're almost a teenager. But I guess sometimes it's hard to tell, or parents don't want to do anything about it." This statement denotes that suspecting parties did not adequately respond to the needs of M, who, according to the general practitioner, "must have been struggling for quite a while." This perceived slowness to act on M's behalf partially implies a judgment from suspecting and diagnosing parties towards the boy's parents, specifically, that they might have better served the interests of their son if they had taken the actions initially suggested by his teacher, and quite possibly, any other people who expressed concern for M. Interviews with the respondents in this case do not reveal that M's parents showed any further resistance to the possibility that their son's problems originated from ADHD. As a result of these measures, M demonstrated "modest improvement" in school performance, according to his parents. Both of his parents adhere to the neurological perspective towards ADHD, claiming that the basis for the disorder is hard-wired, and, now that they recognize the disorder in other family members, they believe that the cause of ADHD is genetic.

It is important to examine why the SBT intervention proved to be more effective than the previous one-on-one consultation. There are two factors which appear to cultivate success for the SBT in this and other cases. The first concerns the formalities associated with the SBT. Parents who are asked to speak with the SBT "stand before them" in much the same way as a person does before a courtroom. The case for ADHD is presented methodically, listing the dates and severity of infractions, both academic and behavioral. Such a formal environment may impede the more spontaneous types of emotional exchanges that occur in a one-on-one setting and may therefore thwart parents' efforts at disputing claims about their children.

The second factor in the SBT's success in convincing parents to seek medical assessments for their children concerns the expertise asymmetry between SBT members and parents. In presenting their case, the SBT discuss how they have "seen this type of thing many times" and that a particular case is not unique, but is typical of what they suspect to be ADHD. The presentation by such experts invariably invokes the idea that ADHD is biochemical, a position that exonerates parents somewhat from responsibility in their child's problems. As one teacher stated: "It's important to let parents know that this is not their fault. As soon as they realize this, we can begin doing something constructive."

It is common in SBT interventions to speak with parents to some extent about the nature of ADHD, mostly framing the disorder in neurological terms. In the case of M, his parents subscription to the neurological narrative about ADHD strongly reflects these types of opinions. In this sense, the SBT intervention is a place where neurological discourses on ADHD may be perpetuated. Such framing of the disorder seems integral in motivating parents to seek medical assessments. That is, by framing ADHD as neurological and then making a case for a particular child having the disorder, the SBT creates a smooth path for parents to seek the medical assessments the SBT views to lead to a resolution to the child's behavioral problems. These assessments are perceived to be a means to medication--the most common, and, according to many respondents from all groups, the most effective way to solve behavioral problems.

The SBT meeting is effective in prompting parents to take actions that are deemed appropriate for their children's behavioral and/or academic problems, especially bringing their children in for medical assessments. The effectiveness of the SBT intervention highlights the concept of "semi-formal suspicion." Because their ADHD knowledge base is largely informed by neurology, the SBT intervention demonstrates the way keepers of knowledge influence those who lack the same degree of sophistication. Much like the social role of teachers in suspecting ADHD, the SBT intervention process is a hybrid of clinical practice and pedagogy. The SBT meeting is a place where neurological nomenclature about ADHD is used, but no formal diagnosis given. This meeting is frequently the location where parents first develop knowledge

about ADHD, and perhaps begin formulating their own suspicions of their children. As this knowledge is furthered by clinicians through "formal suspicion," the disorder becomes framed according to the established neurological standard. There is, therefore, a connection between semi-formal and formal suspicion in the realm of the school, where the former provides a primer for the latter.

As it typifies the way suspicions and the dissemination of ADHD knowledge may occur in a school context, this case opens up a larger analysis of the connections between educational and clinical practices. Clinician and teacher relationships to ADHD are almost entirely professional. ADHD is an issue that brings clinicians and teachers together, in fact, it may be stated that in order for clinicians and teachers to adequately perform their role in relation to ADHD, they must interact and mutually-inform each other. As seen repeatedly in the interview data, adequate assessments of ADHD often involve the evaluation of information gathered within schools that are brought to clinics. In addition, the treatment procedures that are begun in clinical circles are commonly implemented in schools. Such exchanges demonstrate the dialogical relationship between clinician and teacher, clinic and school. Within the exchanges between clinicians and teachers, we see different types of authority and responsibility in relation to suspecting, diagnosing and treating a case of ADHD. In formally diagnosing and treating ADHD, clinicians are ultimately held accountable for the diagnoses they produce, and for the treatments they administer. If clinicians are crucial to the process of diagnosing and treating ADHD, teachers are considered crucial to the process of suspecting the disorder. Allow me to explore the differences between the role of clinician and teacher and how these different roles represent different types of authority and responsibility in relation to ADHD.

Clinicians are defined as ultimate authorities on ADHD in three important ways, and these authoritative roles largely determine teachers' roles towards the disorder. First, clinicians are the designated dispensers of information about the nature of the ADHD condition. In an advisory capacity, clinicians promote a particular perspective towards the disorder--perspectives that clearly will differ according to what the clinician reads, or his/her clinical experiences.

Second, clinicians are the ultimate authority in the diagnostic process. Despite some clinicians described in chapter six who claim to not be providing diagnoses, the medical label of ADHD is crystallized in the clinic; the clinic is the location where informal suspicion becomes formalized and concrete. Finally, clinicians are ultimate authorities in the treatment process of ADHD. Though clinician decisions about treatment are influenced by a variety of factors, including the observations of parents and teachers, the implementation, augmentation or cessation of treatment measures commonly go through clinical channels.

These three primary roles for clinicians help construct the types of social roles for teachers in relation to ADHD. For teachers, understanding the nature of ADHD is significant in the fact that such an understanding can aid the teaching process. Teachers' professional commitments can be met by understanding why an ADHD child acts the way that he/she does. Therefore, interest in ADHD for teachers is largely specific to their pedagogical obligations. This is the same case for teacher interest in the diagnostic process: they are not permitted to provide a final, formalized diagnosis, regardless of what they know about ADHD or how many times they have dealt with ADHD children. As seen in previous accounts, some clinicians argued that teachers spent too much time playing the role of diagnostician instead of focusing on their teaching duties. Finally, with regard to treatment, teachers demonstrate little interest in addressing the specifics of a treatment regimen for an ADHD child. Along with parents, teachers are relegated to an "observing" capacity when it comes to treatments for ADHD children, especially medications. Teachers may offer comment on how they perceive a child to be "progressing," but the data do not reveal that teachers, for example, offer advice on dosages of Ritalin, or the advantages of time-release medications versus fast acting ones.

Having discussed the roles of clinicians and how these formulate the roles teachers adopt, it is important to add that teachers are not mere receptacles of clinical knowledge, nor are they automatons for clinical practice. Because of the time they spend with ADHD children--a time period rivaling the time parents spend with such children--teachers are in a position to inform clinical practice as much as they are informed by it. Particular to this is the authority teachers are

given as the suspects of ADHD. As indicated by the accounts of both parents and clinicians, teachers are the primary "whistle blowers," the ones who commonly begin the process of moving a child along the path to a formal ADHD diagnosis. Hence, the overall clinical picture that a lot of clinicians examine in diagnosing ADHD, involves the comments of teachers and/or consultation with them at SBT meetings. The role of teachers as suspecting parties reveals how some forms of clinical practice occur within the schools.

The conflation of the education practices found in school with the clinical practices found in the clinic, further reveals the mutually-informative relationship between clinician and teacher. As schools administer diagnostic tests, help administer medications and implement behavioral modification programs, it is clear that within the context of ADHD, schools function in more than a pedagogical capacity.

Resistance at the point of pharmacological treatment: case #3

The previous case of a parent resisting the initial recommendations of her child's teacher demonstrates the way interpretations of childhood misbehavior can be contested. These moments of disagreement also reflect the state of today's discourses on ADHD, namely, that the validity of the disorder remains mired in debate. In contrast to such cases of resistance are cases showing that the transition from the initial suspicions, characterized by those expressed by teachers, up to formal, clinical assessments of a child can be a smooth process. That is, the shift from semi-formal to formal suspicion is often shown to follow conventional channels, beginning within the school and culminating with a medical assessment, an ADHD diagnosis, and usually, a prescription for some kind of stimulant medication. The ease of the transition from semi-formal to formal suspicion was undoubtedly influenced by the perceived circumstances of the children in these cases. In all of the cases of ADHD I have examined, the children were considered markedly "off track" in some way, and this certainly made the process of convincing parents to seek medical assessment easier. In addition, a number of parents expressed in retrospect that they

wished that the school would have intervened earlier in order to treat the ADHD as soon as possible.

Within some cases that demonstrated a relatively smooth transition from initial suspicions to formal diagnoses, parents expressed resistance specifically at the point when the type of treatment their child would receive for ADHD was implemented. The case of "S," an eight-year old, grade 3 boy illustrates such a case. S demonstrated many behaviors characteristic of ADHD, especially ADHD with a stronger hyperactive component. His marks in school were within the top ten percent of his class, and he had just fallen shy of being accepted into his school's program for advanced students. His primary problems were seen in his incessant need to move about the classroom, spontaneously socialize with other students, and on one more than one occasion, fighting with other students. As the clinician, teacher and parent all conveyed in this case, S's ability to still perform at a high academic level led all parties to believe that his hyperactivity was a passing phase and not anything to become overly alarmed about. However, the hope that S would outgrow his hyperactivity vanished during one precipitating incident. His mother conveyed:

It was kind of like the fights to end all fights with S. I mean he had gotten into other things with kids, but this time it was serious, like he completely lost control of himself. He smashed a ball in his friend's face and then just started wailing on the kid. I don't know what led up to it, but this was just too much. I wasn't sure exactly what was wrong, but I was pretty sure that it was something beyond his control.

This incident culminated with a suspension from school and a conference between S's mother, his teacher, and the school psychologist the next morning. Though there was no intervention from an SBT, the presence of the teacher and the school psychologist, combined with the highly anti-social behavior S had exhibited, symbolized the seriousness of this situation.

From the account given by S's mother and teacher, the topic at that meeting concerned ADHD and how his teacher had been suspecting it for a while. Though the interviews do not

demonstrate that there was any meticulous documentation of S's problem behavior, the teacher's case for ADHD was accepted readily by S's mother. As his teacher conveyed:

When you see things like this, and you see how much they stand out against all the other kids, you have to see that this is something real. All kids have problems from time to time, but with S, I could see that he was not in control of himself (G 2/3).

Such an account mirrors the one previously given by his mother in which S's behavior is framed "outside of his control," therefore, symptomatic of a deeper psychological problem.

The teacher and school psychologist also imparted knowledge about ADHD to S's mother. According to his mother, that meeting was where she was referred to the book most often mentioned in the interviews with parents: Ratey and Hallowell's *Driven to Distraction* (1994). After reading this text, S's mother expressed a kind of revelation:

Well, I've read many other ones since then, but that was the book that really opened my eyes to ADHD. I still think ADHD is hugely misunderstood, people think that it's just a label for slower kids. But when I read that one, it made me see that ADHD is kind of a good thing. It may be one of the reason why he is so creative and smart. His brain is designed a different way and it gets him in trouble, but it also gives him a unique outlook on the world.

This excerpt demonstrates *Driven's* influence in solidifying a neurological perspective towards ADHD. In addition, this text has been largely embraced by parents of ADHD children because it spends considerable time removing the stigma associated with the disorder. After reading this text and others, S's mother became convinced that ADHD is an inherent, organic condition that remains largely misunderstood. Such a perspective paved the way for a medical assessment of her son.

This meeting at the school which culminated in a consensus about the possibility of S's condition being ADHD and the recommendation that S's mother read *Driven*, shows how the

presentation of initial suspicions are often "backed up," or given legitimacy. By imparting knowledge, in this case, referring S's mother to a widely-read book on ADHD, suspecting parties established themselves as connected to a larger body of literature, and hence, connected to other professionals with similar opinions. Such an exchange between school authorities and parents is also reflected in chapter eight, in which parents commonly conveyed that the beginnings of their knowledge of ADHD began in school settings.

After the consultation with school authorities, S was brought to a general practitioner who performed a complete physical exam. This was done, in the mother's opinion, to rule out any other possibilities that his behavior stemmed from something other than ADHD. After the exam, which revealed no abnormalities, S was referred to a Vancouver pediatrician who almost exclusively dealt with cases of ADHD.¹¹ Upon this consultation, described as "relatively routine" by the pediatrician, a positive diagnosis of ADHD was made according to the criteria of *DSM IV*, and a trial of 10 mgs. of Dexedrine per day was prescribed. Up to this point, S's mother appeared to be cautious, but accepting of the medical assessment of both her general practitioner and the pediatrician. After being convinced that S's behavior was caused by ADHD, she agreed to allow S to take Dexedrine.

Despite the Dexedrine, S's hyperactive symptoms persisted, in fact, according to his mother, there were other emotional side-effects to the medications: "Not only was he still acting up, but he was down a lot, just not himself." In response to this, the pediatrician made a "medication adjustment" and increased the dosage of Dexedrine to 20 mgs. per day. The symptoms of intense hyperactivity began to subside with this increase in dosage, but S's emotional flatness seemed to become more pronounced. Upon denouncing the effects of Dexedrine to the doctor, S was placed on Ritalin (10 mgs., two times per day). In response to Ritalin, there was an overall improvement in S's behavior and in his emotional state, but these improvements were not enough to defuse his mother's concerns. As she stated:

¹¹This particular pediatrician was mentioned repeatedly in my interviews with both parents and teachers and had seen many of the ADHD children the respondents discussed.

The bottom line is that I know my son. Better than anyone, I know him, and I know that these medications were not helping him. He was having problems sleeping, which he never had before, and he wasn't all that improved in his behavior problems. So, we gave it a good shot for about three months and it was time to look for some other way to help him.

Growing skeptical of amphetamines, S's mom talked to the pediatrician about non-medicinal types of treatment. As described in the interviews, this discussion was cordial, but was mildly antagonistic. Though S's mom believed that her son had ADHD, she wanted to abandon the conventional pharmacological treatment for the disorder. The pediatrician described that this type of conflict was not common, but had occurred before with other parents:

The reality is that not all children are going to respond the same to medications at first. I try to let parents know that there may need to be some adjustment (of the medications, dosages, etc.) to get the kids on track. But some parents, you know, they have already heard a lot about medications, that they're hazardous, or what have you. So, when a child starts having bad reactions, parents are pretty quick to try and get the child off of the medication and into something else. ...I don't try to discount all other types of treatment, but the medications have proven so successful that they really should be the primary plan of action (Pediatrician).

According to S's mother, the pediatrician agreed to lower the dosage of Ritalin and then entirely cease the administration of the drug.¹² S's mother reflected on these events after ceasing Ritalin: "I think there is a definite push to get kids on medication, and I don't think that it's always a bad thing. The other parents I know who have kids with this are strong backers of the meds. But in our case, we need to have something different."

¹²This is the common way to cease stimulant therapy for children. It is common clinical knowledge that Ritalin and other drugs cannot be suddenly removed from the child's system, but instead, should be reduced gradually, over a period of a few weeks, before being entirely ceased.

At the time of the interview, S's mom had consulted a family therapist and began a fairly structured regimen of behavioral modification therapy. Though it was arguably too soon to tell the effectiveness of such therapy, S's mother contended that her son was making improvements in his school behavior and remained a top tier student. In describing her son's condition and her experience with the medications, she stated: "Even though I strongly feel that S does have ADHD for real, I still think there are other ways to treat it. I think in his case, he just needs some reprogramming, kind of like learning some of those lessons that he wasn't able to process like most other kids." Such sentiment demonstrates an interesting conflation of neurological and psychodynamic perspectives towards ADHD. In stating that she felt her son truly had ADHD, S's mother conveys a belief that her son had a fundamental difference from other children. However, in seeking different types of ADHD therapy, S's mom simultaneously acknowledges that these differences can be minimized through a process of learning new behaviors and unlearning old ones.

S's mother's adoption of behavioral modification as the primary treatment method for her son opens up certain questions concerning the relationship between the perception of the nature of ADHD and the forms of treatment that are prescribed for it. For example, in this case, if the medication had not affected S negatively, and Ritalin was continued, would that have solidified a specifically neurological view towards her son's ADHD? That is, if the Ritalin had worked in the desired way, would that cultivate a framing of ADHD that follows the logic of neurology previously established, namely, that stimulants and the desired reactions to them reveal the truly organic nature of ADHD? By seeing how the adoption of behavioral modification coincided with the cessation of pharmacological treatments, S's case demonstrates how forms of treatment and etiology are inextricably linked in a dynamic relationship. This case reveals that the relative success of ADHD treatments can be a backdrop for validating an etiological stance towards the disorder.

A psychodynamic interpretation and treatment for ADHD: case #4

As the vast majority of parent respondents give their ADHD children medication (see chapter five), it may be deduced that a neurological position, though not universally adopted, is the predominant perspective taken towards their children's ADHD. Such a common practice with these parents shows neurology's power in influencing the treatment methods parents implement. The analysis of the ways in which parents (for example, the mother in case #3) question or resist conventional interpretations of their children's behavior further demonstrates the influence of neurology: the predominant way to view ADHD is through a physiological frame, and to deviate from this is considered by many to represent "denial," if not child neglect.

As can be anticipated from the dominance of neurological perspectives that are represented by these respondents, cases in which parents interpret their children's ADHD as mainly psychodynamic in nature are relatively uncommon. To adopt such an interpretation in the face of suspecting and diagnosing authorities represents a type of identity politics, in which parents make a conscious effort to seek non-neurological labels for their children. In these cases, parents show diligence in trying to thwart the efforts of those who would physiologically label their children and generate an alternative narrative to explain their children's social and academic struggles. Hence, there is little that is "smooth" about adopting a psychodynamic perspective towards ADHD. Adopting such a perspective in the wake of the dominance of neurology automatically connotes social conflict, more specifically, a denial of the legitimacy of neurological perspectives, the contexts within which these perspectives are maintained and the people who hold them.

The case of "B," a 10-year-old grade 5 girl, stands as an excellent example of the adoption of a psychodynamic perspective and the social conflicts and compromises that accompany it. B was described by her mother as an inattentive type of ADHD. She had not engaged in any anti-social behavior, but was a virtual non-participant in academics. As her mother, a 49-year-old flight attendant, claimed, B was all but forgotten in her class, left to "daydream in the back all day," and apparently received no individual attention. According to B's

grade 4/5 teacher, her mother was approached "more than once" about her daughter's academic problems and finally was asked to meet with the SBT. The circumstances surrounding the SBT meeting and previous meetings were described by B's teacher:

I believe we all (referring to members of the SBT) met with her mom. I was surprised at how much she did not want to look at what we were trying to say. It's not like we were trying to harm her little girl or anything like that. We were there trying to help, you know, trying to find a solution here. She was so far behind we were desperate to try and get her caught up, but without her (B's mom) help, it just wasn't going to happen (G 4/5).

The above excerpt elucidates that the suspicions of school authorities were not given credibility by B's mother. This lack of credibility denotes that the said intentions of the suspecting parties, and hence the roles they played in relation to B, were questioned. This is implied in the language this respondent uses. The statement, "It's not like we were trying to harm her little girl," for example, reflects the way the members of the SBT perceived themselves to be framed by B's mother. The exchange between B's mother and the SBT depicts two types of suspicion: the SBT's suspicions of B, and B's mother's own suspicions of the SBT. By instigating a "suspicion of the suspector," B's mother caused significant role conflict.

In describing her interactions with the school, B's mother articulated her disdain for the manner in which the SBT had prepared the meeting:

...I thought we would be able to have a conversation about what was going on, but there was none of that. The school had already made up their minds and it was this cut and dried thing. So, there I am trying to defend my daughter and they didn't even want to listen. I felt very frustrated by the way they approached this.

This excerpt denotes that B's mother was presented with the possibility of having a conversation with school authorities, but she argues that any conversation was an impossibility given the way they had designed the meeting.

In addition to her criticism of the manner in which the SBT meeting was held, B's mother took issue with the conclusions they had asserted about her daughter: "People were trying to put her into a nice neat box (referring to the suspicions of ADHD). But no one was acknowledging what a good kid she was. She gets along very well with other kids. She doesn't have any of the social problems a lot of other kids have." According to B's mother, school authorities were inaccurate in their suspicions of her daughter; in their haste to summarize B, they had missed a great deal of her good qualities. B's mother tied a great deal of these misconceptions and the trouble her daughter was having to flaws within the school system itself: "Another thing that kept nagging at me was why they never gave her any other options for her school lessons. They try to cookie-cutter the kids all the same. She has lots of things that she is very capable of, but they never took the time to try and help her with some of those: ...she was just completely bored with what they were offering there." Such sentiment represents a reversal of the suspicions school authorities leveled at B. Instead of viewing B's school failure as a result of her daughter's neurological impairment, B's mother frames this failure as a normal response to the stifling conditions of the school.

Despite her disdain for the school's initial suspicions of her daughter, B's mother consulted a clinical psychologist, who corroborated the suspicions of the school and concluded that B had a form of ADHD.¹³ She justified why she approached a clinical psychologist and not a medical doctor: "I didn't really want to take her to a pediatrician because I knew that meant they were going to try and put her on medication." Such a decision represents a compromise between the requests of the school and B's mother's beliefs about what was appropriate for her daughter. ADHD, from her mother's perspective, was an inadequate label for B, though it appeared to be the only way to categorize her struggles in school. B's learning problems were many, therefore ruling out any specific learning disability, and, given her "daydreaminess" in class, ADHD

¹³The fact that a clinical assessment of her daughter was sought in spite of B's mother's clear criticisms of the school, reflect, I believe, the perceived significance of the institution of education. Despite the argued inadequacies of B's school, clinical steps were taken to help enable B's success in this institution.

seemed to be the only diagnostic possibility. Inclined to look at her daughter's struggles as a result of the school failing to accommodate her personality type, B's mother shied away from neurological interpretations of her daughter's problems. Hence, assessments by people, such as physicians, who were typically supportive of neurological stances towards ADHD, were avoided.

The psychologist in this case was not entirely opposed to the use of medication, but felt that it was too frequently prescribed, and was given prior to the development of adequate psychological profiles of children. Though she declined to discuss B's case specifically, this clinician was candid about her perspectives on ADHD and how she felt it might best be treated: "I believe more in a family therapy approach to children's behavior issues. If we find down the road that medications are necessary, then we may try them, but I don't jump to them" (Clinical psychologist). Medications, she argued, can obscure larger problems with children and prevent therapies and behavioral modification techniques from working. In short, this clinician was weary of "external locus of control" complications that may arise with medications, namely that children and families become dependent upon medication for the maintenance of good behavior, rather than learning self-reliance and developing healthy family interactions. She continued: "You need to bring in the whole family when there are serious problems with one of the children. You can say it's a mental disorder, but it really is a family disorder."

This clinician's perspective towards ADHD is clearly psychodynamic, especially as it applies to this case. B, her mother, and her older sister all go to family therapy sessions in which they discuss issues that occur within the family.¹⁴ Though at the time of the interview they had only undergone family therapy for a little while, B's mother contended that her daughter's school performance had improved. More important for B's mother, however, was the notion that the quality of family life had increased.

Through negotiating her relationships with scholastic and clinical authorities, the actions taken by B's mother warrant a larger discussion of the way parents orient themselves towards

¹⁴B's father was divorced from her mother and was not participating in the family therapy sessions.

suspecting and diagnosing parties. In sum, clinician and teacher relationships to ADHD are professional, whereas parent relationships to the disorder are familial. It is a matter of course that parents have emotional investments in their children--something explicated in their testimony about finding out that their children had ADHD (see chapter eight). Of equal concern is the idea that parents wish their children to have their own emotional stability, that is, they do not want their children to harbor bad feelings about their greater social environments. Parents' testimony in chapter eight regarding feeling worried 'for' their children clearly represents these concerns. Concerns over their children's emotional state are also connected more pragmatically to ideas about the life success of their children. These are often the institutionalized forms of success characteristic of modern society. Parents, for example, want their children to have successful involvement in certain institutions, such as schools, but want to minimize and mediate their children's involvement with other institutions, such as medical clinics.

There is a clear disparity between the way that teachers and clinicians approach ADHD and the manner in which parents approach the disorder. In their familial capacity, parents must take into account the interests of their children and the professional interests of those who suspect and diagnose their children as having ADHD. Through the initial moments of suspicion, up to the point of implementing treatment for their ADHD children, parents must continuously mediate between the professional world and the world of their children. This implies a meticulous evaluation of the institutions of the school and the clinic and the way these institutions interact with their ADHD children. With regard to the school, parents must first critically examine the ways in which their children were suspected of having something fundamentally wrong with their mental state, and second, after the formal ADHD diagnosis and implementation of treatment, they evaluate how their children's performance in school demonstrates the efficacy of diagnostic and treatment measures. In examining the practices of the clinic, parents address the ways in which medications and behavioral modification regimens play themselves out in the behavior of their children. Particularly sensitive here is the issue of medications, how parents perceive these to affect children, and how the use of medications can

be connected to reducing their children's problems to neurological phenomena. Cases in which psychodynamic perspectives towards ADHD are adopted reveal parents who are attempting to avoid an over-arching description of their children and the medication that often accompanies such a perspective.

Concluding remarks

The way the ADHD experience is framed for someone is not exclusive to the relationship between a text and that person, and involves more parties than those who comprise a respondent group. The interplay between respondent groups in this sample is crucial in adding another component to the way that ADHD discourses make their way into practice. A subscription to a perspective about ADHD reveals as much about human interaction as it does about the dissemination of the information contained in texts. As Scheff (1984) argues, there are both individual and interpersonal systems that comprise the social condition of a mental illness. Individual and interpersonal systems comprise the "emotional/relational world"--a forum within which Scheff argues the key to a larger sociological understanding of mental illness can be found. At the individual level, we may analyze the psychological aspects of someone with a mental illness, or, for the purposes of this thesis, someone affiliated with ADHD through either professional or familial connections. This is epitomized in chapters six through eight. At the interpersonal level, we see how individual systems formulate the basis for interaction amongst the people associated with a mental illness. According to Scheff, an interpersonal analysis elucidates the social psychological dynamics of mental disorders, characterized by emotional exchanges and social role development.

These interviews reveal a crucial element to the individual and interpersonal dynamics of people associated with ADHD discourse. Foucault's extradiscursive dependency represents an interesting marriage between human interaction and text, in which the influence of discourse is seen through an examination of interaction. In order to provide a context for the interactions between respondents in relation to a case of a child suspected of having ADHD, it is important to

understand how the respective groups examined in chapters six through eight relate to a case of ADHD, and how this relationship to the disorder mediates the types of interactions these people will have as the ADHD case unfolds.

Of particular concern in this chapter is the relationship between the forms of suspicion and the types of resistance or skepticism that parents exhibit as these suspecting forces interact with parents. As suspicions move through their informal, semi-formal, and formal phases, it appears that there are decreasing levels of parental resistance to the conclusions of suspecting parties.

For example, in one-on-one interactions between teacher and parent, there is a potential for a greater degree of emotional exchanges, the "telling of two sides," and possibly, a discounting of teacher suspicions. As this thesis has focused entirely upon cases in which an ADHD diagnosis has been positively made, cases in which ADHD was suspected, but not diagnosed remain unexamined. Regardless, it can be fairly assumed that a greater proportion of positive diagnoses will originate from more formalized suspicion settings. Within these types of interactions, in which initial suspicions are leveled, there may be a potential for developing more general theoretical propositions about processes of suspicion.

At the level of semi-formal suspicion, characterized as a hybrid between educator and clinician roles, and seen most clearly in SBT meetings with parents, it may be asserted that resistance to suspicions and hence, to a particular conception of ADHD, become more pronounced. As cases for ADHD are methodically developed, and as such cases are presented in a structured way, the possibilities for alternative discourses to those being presented becomes sparse. Perhaps by controlling the communicative dynamics of the meeting between parents and suspecting parties, the SBT forum is fertile soil for the perpetuation of a discourse. Hence, this semi-formal environment is strongly implicated as the point at which parents begin framing their ADHD children in a particular way.

Both semi-formal and informal types of suspicion open up the door to formal forms of suspicion. It can be assumed that parents who are prompted to consult clinicians about gaining

deeper assessments of their children, already have a significant amount of ADHD knowledge. Reference to texts like *Driven To Distraction*, exemplify these information exchanges. The dissemination of knowledge, therefore, is much more crucial in the semi-formal context. Such knowledge provides the basis for parents to consult formal diagnostic authorities, and also provides some understanding as to why parents, despite their subscription to a neurological, psychodynamic or combined view of ADHD, would be willing to accept the ADHD label. Despite this acceptance of the ADHD label, however, there are cases in which parents specifically seek people in the formal realm (e.g. case #4) who frame ADHD in alternative ways. In this sense, parents "anticipate" a discourse. The choice of clinicians they consult may be mediated by ideas about which professionals believe ADHD is strictly neurological and requires medication, and who may see the disorder as connected to interactive contexts. The interactions between these three types of respondents, though often resulting in neurological perspectives towards ADHD, also have variation in their outcomes.

The next chapter will conclude this thesis by tying the contents of these chapters back into a theoretical framework and by illustrating where research of this kind may be furthered. Through describing some possible directions in which this research may continue, I hope to highlight a framework for a program of research and theory generation.

Chapter 10

Conclusions

When asked about my primary interest area in sociology, I readily invoke the topic of mental health, more specifically, the study of ADHD. The moment I mention the acronym "ADHD," I become embroiled in a larger conversation about the disorder. Such conversations are rooted in the fact that ADHD remains so contested in popular culture. Virtually everyone I know has heard about ADHD, and an equal number seem to have an opinion about the disorder. When people hear of my interest in the topic, the first question out of their mouths is: *Is ADHD real?* My response is much different today than it would have been 2 or 3 years ago. I previously regarded ADHD as a disorder fabricated by medical practitioners and pharmaceutical companies, and a catch-all typology for annoying, yet normal childhood behavior. I was completely sold on social constructionist understandings of the disorder. Today, I tell people: *The jury is still out.* I believe that the difference between the way I perceived ADHD years ago and the way I perceive the disorder today is a testament to the effectiveness of the methodology used in this thesis.

Asking whether or not ADHD is real reflects the deep skepticism people have about the disorder. The prevalence of public skepticism demonstrates the infiltration of contradictory ideas about ADHD into public awareness. These contradictory ideas are pitted against each other, one vehemently tearing the other down, and vice versa. People's informal discussions about the disorder mirror this antagonism: there is a strong pull to either know ADHD exists or know that ADHD is a sham. There are one of two poles people may find themselves on in understanding ADHD, one of which represents modern psychiatry, the other the perspective of social constructionism. One side argues for ADHD as a physical essence, while the other side conceives the disorder as a social invention. A middle ground between these two camps is absent from the debate. My unsure response to questions concerning the validity of ADHD shows how far removed from the validity debate I have become. The issue of whether or not ADHD is real in some palpable sense, was not the undertaking of this thesis. My intent was to contribute to the social study of ADHD in some alternative ways. This alternative perspective emphasized the role

discourse plays in the conceptions of ADHD as well the actions people take in relation to the disorder. Examining discourse as a foundation of social action was a way of supplementing classic deviance perspectives, primarily those originating from social constructionist stances.

The genealogical method and notion of the extradiscursive dependency drawn from the work of Michel Foucault have both been crucial in driving this research. Especially appropriate for the analysis of knowledge systems and the institutions they create, genealogy is a historical method that focuses on the role discourses play in developing an established body of knowledge. Genealogy allows us to retrace our steps from the point at which we "know" something to an earlier time in which that knowledge was not conventional, or was highly suspect. As a method for studying mental illnesses, it has been used brilliantly by both Ian Hacking in *Rewriting the Soul* (1995) and Allan Young in *the Harmony of Illusions* (1995).

As a category of illness couched in neurological terms, ADHD lends itself to a genealogical analysis. The acronym itself represents a collection of historical moments in which neurological nomenclature has outlined the causal factors which constitute ADHD, and, through its rhetorical devices and research resources, has fashioned these causal factors into a truism. A genealogical stance views these moments of dominance as representative of discursive politics, rather than reflections of truth, hence, in discussing both psychodynamic and neurological perspectives towards ADHD I have regarded these as research narratives (Young 1995). Such narratives are characterized by intense debate, always in play against each other always trying to achieve increasing legitimacy. The current era is characterized by people who commonly subscribe to neurology as the dominant perspective adopted towards ADHD. However, this dominance is subverted from time-to-time: disagreements about the nature of ADHD still persist both inside and outside neurological circles. The moments of disagreement give space to the existence of alternative discourses on ADHD, particularly psychodynamic ones.

The forces that propel some ADHD discourses and thwart others, are not textual, but social. This is why Foucault's extradiscursive dependency is crucial for understanding how actors negotiate between ADHD narratives and how subscription to these influences social interaction.

This dependency reveals how people's everyday experiences are influenced, if not directly formulated by discourse. The extradiscursive is a way of interpreting how people negotiate between systems of knowledge ("knowledge regimes" as Foucault asserts) and how the influence of those systems can be seen in the actions people take. At the extradiscursive level, ADHD is a mediated phenomenon; its interpretation is dependent upon the information one has acquired and on the social context in which ADHD is discussed. Within the extradiscursive dependency, exemplified in chapters six through nine, ADHD is a product of social roles--roles which are clearly influenced by discourses. Within each respondent group we saw a common thread in how they related to ADHD; it was an entity regarded pathological by clinicians, pedagogical by teachers, and familial by parents. The formulation of these relationships to ADHD were seen through the narratives these respondents adopted.

Revisiting social constructionism

It is important to demonstrate how this thesis supplements the work of social constructionist stances in the sociology of deviance. In order to do so, I will list some of the theoretical tendencies of social constructionists, especially found within previous discussions of hyperactivity by Peter Conrad (1975, 1976), and then I will argue the points at which this thesis has furthered these notions.

The articulation of colluding forces

Peter Conrad's (1975, 1976) study of hyperkinesis exemplifies the propensity of social constructionists to point fingers at particular social agents and hold them accountable for creating a false legitimacy for mental illnesses. From Conrad's perspective, ADHD is not a real neurological condition; it is a fabrication, both fashioned and maintained by the gross asymmetry in power between a collection of colluding forces (pharmaceutical companies, medical practitioners, and government agencies) and a naive public. It is fitting, therefore, that Conrad invokes Howard S. Becker's notion of "moral entrepreneurs" and also discusses the

encroachment of medical nomenclature upon the everyday social world. In the instance of moral entrepreneurship, Conrad (1975) discusses the role of special interests in creating a scare in lay people through specifying the morbid and epidemic proportions of childhood hyperactivity. Such a scare, according to Conrad, plays into the self-serving interests of these colluding forces. Clinicians, for example, step forward as the ones who do the most to treat the hyperactivity phenomenon and foster a public dependency upon their services. The same condition applies to pharmaceutical companies, who are argued to benefit economically from the mass-marketing of drugs only they can manufacture. Both the interests of medical practitioners and pharmaceutical companies are protected by government agencies who implement legislation on their behalf.

The greater public are believed to be entirely removed from discussions over the validity of ADHD. They are, effectively, victims of the collusion between the forces who gain from perpetuating the ADHD myth. Through this collusion, alternative perspectives on childhood hyperactivity are made impossible or are framed as non-scientific trivia. Because the public have been removed from the debate on ADHD, they are left with little options other than subscribing to what has become the dominant perspective on the disorder: ADHD is real; ADHD is underdiagnosed; ADHD is treatable through medication.

The dichotomy between the experts and the non-experts

One of the most significant presuppositions in social constructionist views of mental health is the stark contrast between the world of the knowledgeable and the unknowing. Such a dichotomy exemplifies social constructionist political analyses, typified by beliefs that there is an asymmetry of power between those who diagnose a mental disorder and those affected by it. In this power relation, it is argued that members of the lay public are passive in the face of the mental health apparatus. Because of the mental health industry's apparent omniscience, people accept the validity of mental disorder labels. Such labels, it is argued, may permanently damage self-concept. This damage may be left unaddressed because the "victims" of these labels have not been offered viable alternative perspectives on their condition.

The mental health experts are the agents that social constructionists say we approach to resolve problems in everyday life (Emerson and Messenger 1977). Therefore, Goffman's (1961) distinction between "formal" and "informal" forms of suspicion is not restricted to the total institutions he studied. The power relations associated with informal problems and their formal solutions happen at a variety of locations and embed themselves into the consciousness of lay social actors. We feel compelled to approach experts because they represent a beacon of clarity that we lack. Implied in social constructionist analyses of the appeal to experts is an underlying deception: the mental health apparatus is largely self-serving and its basic intentions are hidden from view. The self-serving nature of the system of mental disorder experts is something even hidden from practitioners themselves. Clinicians "buy into" their own expertise as much as the lay audience who utilize their services. Such self-deception further demarcates the monolithic nature of the mental health apparatus. The legitimacy of mental health knowledge is so overarching that it subverts the potential for external and *internal* critique.

Discounting discourse

As they focus largely on the agents whom lay people approach for resolution of their own and family members' mental problems, social constructionists do not examine discourses as a variable in the actions people take. Instead of examining the role of discursive systems in formulating the modality of the mental health enterprise, social constructionists focus upon these modalities in isolation. Despite offering social psychological commentary on how the mental health enterprise operates, social constructionists do not frame these social psychological relations (i.e., the process of labeling, the process of formal suspicion, the process of identity transformation, and so on) as connected to anything other than the mental health apparatus itself. Such an analysis depicts the agents of mental health diagnosis and treatment as the *originators* of mental health knowledge. This is perhaps one of the greatest pitfalls of social constructionist views on ADHD. We are led to believe that ADHD has been created in a test tube; that historical concepts related to ADHD are irrelevant. This is epitomized by Conrad's (1975, 1976)

discussions of hyperkinesis, where there are only trivial attempts to articulate an historical perspective on the disorder. The history of ADHD is treated as a stylistic necessity in research writing, a way of familiarizing the audience with the topic, rather than as a valid topic of inquiry unto itself.

Supplementing social constructionism: towards a synthetic methodology

Some of the perspectives of social constructionism briefly outlined here are not necessarily problematic to the social study of mental disorder. In fact, such positions can be valuable in raising awareness of mental illness, despite their shortcomings. The contemporary debate about the validity of ADHD is a representation of this. Certainly, it is plausible that some collusion between labeling agents has occurred throughout the history of ADHD, that ADHD implicates relations between experts and non-experts, and that ADHD experts contribute ideas that are novel to the study of that disorder. As they are presented here as shortcomings, social constructionist perspectives are places for improvement, rather than problems requiring unequivocal removal.

Through combining a discursive/genealogical analysis with everyday, qualitative accounts of the social actors surrounding ADHD, this thesis demonstrates a synthetic approach to studying mental disorder. Such an approach has combined the seemingly disparate worlds of social constructionism and discourse analysis. On the social constructionist end we have the interview data from parents, teachers, and clinicians. Such an analysis of data resonates very well with other qualitative accounts of mental disorder, for example David Karp's *Speaking of Sadness* (1996). On the discursive front, we have an analysis of the genealogy of ADHD and the contemporary discussions of the disorder, inspired by the work of Young (1995) and Hacking (1995). Taken in isolation from each other both methods can be said to have inadequacies. Genealogical analyses can be criticized as irrelevant, swimming aimlessly in the value-neutral world of texts. However, when combined with an empirical component, the analysis of discourse can be very fruitful. The everyday conditions of ADHD can be linked to the past and present

discussions of the disorder. ADHD, as experienced by lay actors, can be placed within a context that is more encompassing than that of the Goffmanesque "informal/formal" dichotomy. Conversely, the discourse that has comprised the knowledge of ADHD can be seen as an influential factor in the everyday manifestations of the ADHD phenomenon. Both discourse and everyday experience may be analyzed in their reciprocity, rather than in their separation from each other.

Discourse analyses and interview schedules as mutually influential

The relationship between discourse (reflected in textual data) and everyday experience (reflected in the interview data) is understood by Michel Foucault (1978) to be dialogical. This is best summarized by his position about the *extradiscursive* dependency, that describes the relationship between everyday social practices and the discourses that influence and are influenced by them (also see Barret, 1991). Social constructionism finds itself on one end of this dependency. Because it fails to address the larger discussions associated with a mental disorder, social constructionism analyzes the lived experience of people affected by such disorders in a discursive vacuum. Karp's *Speaking of Sadness* is a case in point. Biographical in nature, *Speaking* is rich with personal accounts of depression from the 50 respondents Karp interviews. However, the text is devoid of historical meanings of depression and has an equal paucity of contemporary discussions of depression; psychological and neurological discussions--phenomena certainly replete in the discourse of depression--are avoided entirely. We are left with a text that is personal and provocative, but one that makes no significant linkage between depression and discourse.

In analyzing both textual and interview data and drawing connections between them, it is essential to have a general idea about some of the major themes prevalent in the discourse of a mental disorder, and also to understand some of the informal discussion about such phenomena between lay actors. Themes teased out of discourse analyses, may influence the design of an interview schedule, and in turn, the conclusions reached from analyzing interview data may

prompt a deeper discourse analysis, which may again influence the interview schedule, and so on.¹⁵ For example, the inclusion of interview questions for parents about the behavior modification of their children was made after analyzing a sample of the ADHD parenting literature summarized in chapter 4. The understandings of the history and contemporary discourse about ADHD may influence the way everyday accounts of the disorder are solicited.

Inclusion of discourse in the analysis of interview data

Acknowledging the reciprocal relation between discourse and everyday experience opens up synthetic possibilities for the social study of mental illness. For the purposes of this thesis, such a synthetic approach includes combining the analyses from two qualitative types of data: textual and interview-based. Throughout the analysis of interview data in chapters 6 through 8 this thesis makes repeated linkages between the specific interview themes and their possible reflection of historical and current ADHD discourse. Allow me to address a few of the many examples of these linkages.

One example concerns the connection between the early discussion of the psychiatric sequelae of *encephalitis lethargica* that discussed children who had suffered from that disease later failing in school, and the framing by interview respondents that retains these conceptions of ADHD children. From the inception of the symptomatology of ADHD until now, children diagnosed with the disorder have been framed as institutionally-inept, especially within the school environment. This is strongly displayed in the teacher and parent interviews. By drawing the connection between early ADHD discourse and the contemporary framing of the disorder, the ADHD phenomenon is placed within a social and historical context. The staying power of the

¹⁵This dialogical process is an ongoing enterprise. Therefore, it would be difficult to state when the definitive point of ceasing the dialogue between the two should occur and findings presented. There is a push in medical sociology and anthropology to produce findings, to get conclusions printed in academic journals. This may constitute an element of recklessness in which a larger discussion of mental illnesses, for example, becomes obscured by the hasty inclusion of certain studies into the conventional wisdom.

discourse, that is, its ability to continue to hold its ground through the generations, becomes clear.

Another example stems from the analysis of clinician-based interview data and their relationship to neurological and psychodynamic narratives about ADHD. What is clear from these data is that clinicians often have a combined approach in understanding and treating ADHD. For example, very few clinicians were inclined to travel the "medication only" route for treating ADHD children. In the face of the massive amounts of Ritalin, Dexedrine, Cylert, and Aderall that are prescribed in North America, such responses denote that the process of treating ADHD is something that clinicians negotiate, and have a high degree of agency in constructing. The neurological narrative, as dominant as it has become, is not the only factor influencing how clinicians' approach the ADHD phenomenon.

With regard to addressing ADHD and family dynamics, today's clinicians practice treatment measures that seem antiquated by neurology's *avant-garde*. The discourse formulating the contemporary debate around ADHD reveals that the major dispute between psychological and neurological perspectives towards ADHD occurred in the early 1970's. Paul Wender's (1971) critique of psychology's treatment and understanding of minimal brain dysfunction was the major argument that broke the back of psychology and marginalized it in research circles. From the time of Wender's writings to now, neurology has reigned supreme in the ADHD research world. Regardless of this neurological dominance, many of today's clinicians view the etiology of ADHD as somewhat imbedded in family dynamics. This clearly demonstrates the longevity of discourses--even those that have been marginalized-- and the ability of opposing discourses to manifest themselves in the practices of one or more clinicians. More generally, these may also be regarded as paradigm dynamics not unlike those described by Thomas Kuhn (1962). In practice, psychological and neurological perspectives on ADHD can and do coexist.

Other examples that reveal the interrelatedness between discourse and social practice concern the framing of ADHD children as more volatile or less predictable than their non-ADHD peers. Such a framing of ADHD children is found in the data from all three respondent groups.

ADHD children, the data show, are prone to "flying off the handle" or may be inclined to respond in ways highly divergent from normal children. Such perspectives resonate very strongly with the clinical discussion of *encephalitis lethargica*, the psychoanalytic propositions of Melanie Klein and Anna Freud, and also, the discussion of such children's volatility in ADHD parental guidebooks. In this regard, the narrative of volatility can be said to be unrestricted in its influence, subscribed to by all three major social actors who find themselves associated--either through profession or family--with an ADHD child.

Clarifying some key findings of this thesis in relation to the specific phenomenon of ADHD

Through its application of a synthetic methodological approach, this thesis provides at least two substantial contributions to the study of ADHD. I believe that these contributions traverse disciplinary boundaries, especially those between the anthropology/sociology of mental health and psychology. Because this thesis avoids sociological accounts of mental disorder that cast modern psychiatry and psychology as self-serving shams (see Scheff 1984, Schrag and Divoky 1975, Breggin 1998, Walker 1998), it provides insights that people from different disciplines and lay people may find useful.

The contested nature of ADHD

This thesis has demonstrated that ADHD is by no means a mental disorder without controversy. At the core of the ADHD debate are the issues of what constitutes ADHD and what are the appropriate methods for dealing with it. The discourse that encapsulates the debate over the nature of ADHD has been heated and neurology has not emerged the victor in every round. Neurological perspectives towards the disorder also have internal debates that seem to persist. The differences between the work of Russell Barkley (1990, 1991, 1997) and Barbara Fisher (1996)--both authors regarded as "heavyweights" in ADHD research--stand as significant examples of this internal disagreement, each researcher implicating very different brain chemicals as causal factors in ADHD. The recent critique of American psychiatry by a Working

Party of the British Psychological Association is yet another example of how ADHD can be contested within psychiatric circles. Within such circles, ADHD is said to be too broad a category of disease, and its treatment, therefore, prescribed too frequently. From these and other examples of the contested nature of ADHD, it may be assumed that as the rate of ADHD diagnoses have increased so dramatically since the early 1990's, the debate surrounding the disorder's validity has been exacerbated.

The interview data from clinicians and teachers also provide strong examples of the contested nature of ADHD. Both of these respondent groups demonstrate concern over the validity of ADHD diagnoses. In addition, clinicians particularly questioned teachers' roles in the diagnostic process.

Clinician respondents demonstrated a marked skepticism about the APA's *DSM IV* criteria for ADHD. In many instances, clinicians used the *DSM IV* for want of some better diagnostic device, or avoided a direct application of its criteria. The criteria provided by *DSM IV*, many clinicians argued, did not account for the larger variables that influence childhood misbehavior. Family dynamics, many clinicians argued, were not highlighted by *DSM IV*, nor were dietary influences on children's behavior. Concomitant with the perceived inadequacies of *DSM IV*, many clinicians also expressed concerns over the implementation of the most conventional types of ADHD treatment: medications. These concerns again implicated the ambiguous nature of *DSM IV* criteria, specifically that the application of these criteria might lead to misdiagnoses and inappropriate medical intervention.

Though they were the respondent group who had the most uniformity in their assessments of ADHD, teachers also expressed some concern about the ADHD diagnosis. These concerns included the possibility that the ADHD label may be applied incorrectly, and cause the child undue stress. Teacher worries about incorrect labeling reveal that there are moments in which childhood misbehavior or academic failure may be due to reasons not readily explicable through neurological nomenclature.

In what represents a power struggle between educators and clinicians, 20% of clinician respondents stated that they thought teachers should not be in the business of diagnosing ADHD, and should instead emphasize teaching. Even though this perspective remains in the minority, it still conveys that teachers and clinicians are not unified against the "common enemy" of ADHD. Clinicians clearly have indicated that teachers do not always have the appropriate training to make definitive assessments of the neurological state of their students. This point of antagonism reflects some of the problems with the tendency to link certain mental illnesses to a process of collusion between social agents. Though there is certainly a degree of cooperation between teachers and clinicians (the administration of diagnostic instruments, such as Connors scales in schools being one strong example), there is also an element of disagreement and conflict. The desire on behalf of some clinicians to see less ADHD diagnosis in the school realm is a tell-tale sign that the disorder's "moral entrepreneurship" is not monolithic.

The processes of ADHD suspicion and the framing of ADHD children

Beginning with the discussion of imbecility and idiocy up through its contemporary neurological discussions, the history of ADHD represents a sometimes concerted, sometimes fractured attempt to typologize children with the disorder. Such historical and contemporary frames have conceptualized ADHD children in the following ways: 1) ADHD children are excessively extroverted; 2) ADHD children are excessively introverted; 3) ADHD children are socially immature in comparison to other children; 4) ADHD children need to be disciplined at the very moment they demonstrate inappropriate behavior, and with much less leniency than that afforded to normal children; 5) ADHD children are often academic failures; 6) ADHD children are highly distractible and require a more regulated environment; and 7) ADHD children are driven by impulses outside of their control, and for this reason should be regarded as volatile. Gleaning more from this thesis, this list is hardly exhaustive, however, these frames represent a solid depiction of how people often conceive of ADHD children.

These frames for ADHD promote the implementation of well-known ADHD treatment measures. The perception of the neurologically-impulsive nature of ADHD children, for example, facilitates the use of prescription medications. To paraphrase one clinician respondent: medication makes an abnormal situation with the brain normal again. The perception that ADHD children need immediate sanctions for their behavior fosters a reconstruction of both classroom and domestic environments, primarily through the implementation of behavioral modification techniques. The notion that ADHD children are very distractible also promotes a reconstruction of these environments and implies the necessity to regulate the ways in which ADHD children interact with other children. Where it may be perceived as normal for a non-ADHD child to have the occasional distraction by one of his/her peers during school time, for the ADHD child this can be seen as detrimental.

With an understanding of these frames for ADHD we are also able to analyze the process of suspicion. This is especially clear from the analysis of both teacher and parental data. Teachers often learn to recognize ADHD through the overt behaviors exhibited by unruly children, or may to a lesser extent recognize the disorder through some marked academic failure. Parents' suspicions are directly connected to teachers in that the concerns they harbor about their children are directly influenced by the comments of teachers. Repeatedly stressed in both chapters seven and eight is the educational specificity of ADHD. Hence parents' process of suspecting their ADHD children is already filtered through the experience of teachers. Teachers are often the ones imparting knowledge about ADHD to parents, and teachers are the ones who warn parents about what might happen if their children's ADHD is not quickly addressed.

The use of historical and contemporary frames for ADHD children represents another point at which the project of social constructionists like Peter Conrad (1975, 1976) can be expanded to include a more contiguous set of ideas. For example, the relationship between parents and teachers and ADHD suspicion expands the informal/formal dichotomy that permeates a large part of the literature that analyzes the institutional and social manifestations of mental health. The fact that teachers can be "semi-formal" in their suspicions of ADHD children

reveals that the division between experts and lay people is not that discreet. The technical, medical language that has framed the ADHD disorder has made its way into public consciousness, manifested visibly in the mutually informative relationship between parents and teachers. This condition, clearly present in the interview data, shows the power of a discourse in formulating the perceptions people have of each other. These perceptions need not be constructed through the active participation of a system of experts. People can be convinced that their children have ADHD without even consulting the medical establishment.

Suggestions for further research

This thesis has revealed that there is a much larger story to ADHD than the one told solely by neurologists, psychologists, or social constructionists. If taken in unison, these various perspectives on ADHD become a significant topic of analysis unto themselves. The story of ADHD is a result of the interplay between these various perspectives, demonstrated through the discourses embedded in older and newer texts, and also through the conveyed experiences of the social actors surrounding ADHD. This is not to say that ADHD is purely a result of the interplay of texts, for such a stance discounts the lived experience of ADHD, that is, how social actors demonstrate agency in making sense of the ADHD diagnosis, its effects upon identity, its reception in the greater community, and so on. For this reason, the way that ADHD can be understood need not be limited to one perspective, or one etiological paradigm.

In widening the perspective on ADHD, this thesis opens up some exciting avenues for further research. Four possibilities for further research come to mind, including: 1) longitudinal analyses of social actors surrounding ADHD; 2) additional empirical analyses of how knowledge about ADHD and other mental illnesses is shared and perpetuated amongst social actors; 3) a study of the mechanisms of suspicion and case-building, such as those demonstrated by school-based teams; and 4) an in-depth study of the subjective experiences of children diagnosed with ADHD.

The need for longitudinal analyses

Given an adequate amount of funding and time, a long-term analysis of ADHD respondents would be highly beneficial. Such an analysis might include interviewing the same collection of ADHD social actors (for example, the 60+ people interviewed in this study) at least twice within, say, a five year period.

Such an analysis would reveal more about the social psychology associated with ADHD, including changes in identity, changes in the way ADHD children are perceived, and how these changes relate to discourses about ADHD. A longitudinal analysis of ADHD parents, for example, would provide a dynamic perspective towards the processes associated with parents' conception of their family and its place within the greater community--perceptions which are inextricably linked to discourse. Interviewing respondents over a longer period of time would more adequately reveal the shifts in perspective people adopt towards ADHD over time, and the degree to which these changing perspectives reflect the most dominant narratives about the disorder.

As this research would chart the attitudes of social actors over time, such a perspective could more sharply identify points of tension and of intersection between competing discourses. One may research, for example, the shifts teachers and clinicians demonstrate over a five-year period in their perspectives on ADHD and the children this disorder is believed to afflict. Within these changes different discourses could be implicated and examined for their relevance. For example, one may ask why a particular clinician had begun a new treatment method for ADHD and see how this ties into the conceptual lineage of the ADHD condition. Changes in teaching strategy may also be examined, both as a cause to inquire about changes in curricula design and teachers' individual transformations.

The potential for in-depth empirical analyses of the transfer of knowledge

This thesis scratches the surface of an empirical analysis of the transfer of knowledge amongst social actors, and, in the context of mental illness, opens up a place for a much larger

analysis of this sort. As the legitimacy of knowledge and its points of origin have become increasingly suspect and viewed as political, it is becoming important to examine the way knowledge makes its way into professional and lay consciousness. This would imply an extension of this thesis's application of interview questions that solicit social actors' relationship to many different and often conflicting bodies of knowledge. For example, parents describing the major social agents responsible for informing them about ADHD--for the most part, these agents were school representatives--highlights how the transfer of information provides the groundwork for framing their ADHD children.

ADHD children become "known" through the subscription to information--information that is often framed as legitimate. Formulating the problem of this legitimacy would be a suitable place to begin an empirical analysis of the circulation of knowledge. The establishment of knowledge as legitimate and "valid" may reveal much about how "good" knowledge is distinguished from "bad." What would need further scrutiny in this regard is how the subscription to a particular knowledge perspective reveals the power difference between social actors and those who disseminate it, but also, how people who previously did not have knowledge about a particular topic establish themselves as knowledge resources for others. An example of the former may include something akin to a social constructionist analysis of the transfer of knowledge; for example, how ADHD parents, teachers, and clinicians utilized institutional resources to learn about ADHD, and how these social actors demonstrate these influences in everyday practices. Examples of the latter may include an analysis of how parents establish themselves as holders of valuable information for others (hence, revealing a reduction in the power asymmetry between themselves and the sources from which they initially learned about ADHD), how clinicians accumulate knowledge and find themselves moving into the "ADHD specialty," and how teachers may solidify a role as a hybrid between clinician and pedagogue. Finally, an analysis of ADHD knowledge from these and other potential respondents groups could be examined within a socio-economic context. For example, how would economic and

social class positions affect whether or not a respondent subscribes to a neurological, psychodynamic or combined approach to ADHD?

The empirical study of mechanisms of suspicion

Through the examination of interview data from the social actors who orient themselves to each other in response to a child suspected and diagnosed with ADHD, this thesis has opened the door for a more intensified analysis of the process of suspicion, especially those that occur within schools. This "sociology of suspicion" may involve examining the dynamics of the SBT, which clearly surfaced in the interview data as a significant means of propelling a child towards an ADHD diagnosis. As surmised in chapter nine, the levels of resistance to the forces of suspicion seem to dwindle as more formalized types of measures are taken to convince parents that their child may truly have ADHD. The reasons for why this resistance is less pronounced in the face of the SBT would form the parameters of new empirical analyses. Interviewing members of an SBT about the strategies they employ in an effort to convince parents of serious problems with their children, for example, would be a relevant and focused research inquiry.

This direction of study would imply a deeper exploration of how SBT's and similar organizations structure their social contacts with parents or other care-givers. Such social contacts would open up the examination of at least two further research avenues. First, it would begin an inquiry into how members of an SBT formulate narratives about parents who are skeptical of their claims. These narratives may speak to the mechanisms by which denial is socially-constructed through the SBT's contacts with parents and the perceived result of those contacts. A second research topic would examine how the process of case-building is used to "break denial" and persuade parents to accept SBT opinions as valid. Through looking at the process of case-building it would be important to examine the way the SBT asserts control over communicative dynamics and how this type of control influences the ways parents are able to respond to their suspicions.

Studying children

As this thesis has focused upon the manner in which both ADHD and the children diagnosed with this disorder are framed, it has operated under the presupposition that children are largely left out of this framing process. ADHD children may be construed as objects of knowledge with little influence over how they and their scholastic and social problems are ultimately perceived by adults. We may assume, then, that the perceptions children have of themselves are largely derived from the perception that adults have of them. This follows some of the basic tenets of symbolic interactionism, namely that conceptions of self and other are primarily derived from significant others, usually parents. Even though the self-perceptions of children are largely a reflection of the significant adults in their lives, their individual voices may still retain a unique character, and be worthy of future study. The actual language ADHD children use to describe themselves and their condition, for example, would be an enlightening data source.

A political analysis emphasizing the asymmetry between ADHD children and adults provides another possibility to continue the research undergone in this thesis. Through a qualitative analysis of the experiences of children, primarily through ethnographic methods, such a study may adequately illustrate how the subjective experiences of children are a reflection of or are opposed to the way adults have framed them. Medications may be a crucial topic at such a juncture. It would certainly be telling to observe ADHD children over a period of a year or two and allow them to convey how the medication affects them and to what extent their perspectives towards their medication differs from the perspectives of the adults in their lives. Such an analysis would be a pertinent exploration of the subjugated knowledges of ADHD children, primarily how their status as subjugated social actors stems from the way adults have cast them.

Final Remarks

In sum, the argument of this thesis points to a set of research possibilities that can illuminate the largely unexplored social dynamics surrounding the processes of ADHD diagnosis and treatment.

Through outlining the manner in which this mental disorder is negotiated through processes of suspicion and treatment, I have added a dimension to the study of ADHD that takes into account the attitudes of social actors, their sources of information, and how the allegiance to particular ADHD narratives influences outcomes in such cases. The conclusions drawn from this study should be treated as a supplement to perspectives in the sociology of deviance that rely heavily upon an analysis of the social agents who, through concerted effort, supposedly construct mental disorders into believable phenomena.

The discussion of ADHD discourse presented in chapters two through four represents a necessary context for the empirical component to this thesis. These chapters reveal that ADHD symptoms have been and continue to be subject to multiple interpretations. Such a condition in the literature about ADHD extends into the everyday accounts provided by lay persons. Respondents reveal a multitude of perceptions of the disorder, often leaning towards a neurological perspective towards ADHD, but, in a significant number of instances, embrace psychodynamic or combined approaches to the phenomenon. This clearly demonstrates that ADHD is not as "cut and dried" as many social critics may insist. Instead, I have shown that ADHD is a product of a social environment that is characterized by actors with varying relationships to ADHD discourse. The interpretations of ADHD-like symptoms are contingent upon social relations that are inextricably linked to discourse. Analyzing the relationship between the concepts of mental illnesses as they are represented by books, journal articles, and the like, and the social actors caught in the throes of such illnesses, holds considerable promise for the study of how these phenomena are actuated.

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Appendix I**Introductory Letter for Respondents**

Date: _____

Dear _____;

I am writing to you to request your assistance in my doctoral research in Sociology at the University of British Columbia. The study I am conducting concerns Attention Deficit Hyperactivity Disorder in children. I am interested in interviewing the parents, educators and clinicians of children with this disorder, and I wish to understand your experiences.

If you can spare about an hour of your time, I would like to discuss your experiences with ADHD. Please call me at the number below if you are willing to be interviewed. Of course, you may withdraw from this research at any time, for any reason whatsoever. Also, be assured that everything stated during the interview will be held strictly confidential, in that actual names of respondents will not be used in the thesis or associated with particular viewpoints or clinical/educational facilities. I sincerely hope that you can assist me in my research about ADHD, the results of which may be useful to the scientific and scholarly community, as well as to lay persons.

Sincerely,

Adam Rafalovich, M.A., Ph.D. candidate
University of British Columbia
Department of Anthropology and Sociology

study may be published. Any published material will strictly preserve the anonymity of participants.

Signature of Investigator

Date

Participant's Statement

The research described above has been explained to me, and I voluntarily consent to participate in this research. I have had an opportunity to ask questions and understand that future questions that I may have about the research or about the participant's rights will be answered by the Director of Research Services.

Signature of Participant

Date

Statement of Parental Consent

I hereby (consent/do not consent) to grant the investigator permission to speak with my child about his/her ADHD condition. Upon giving consent, I have been assured of my right to be present during the interview and that I can stop the interviewing process at any time.

Signature of Participant

Date

Copies to: Participant, Investigator's File

Appendix III**Interview Questions for Parents of ADHD Children**

- 1) What is your child's age? Grade? Gender?
- 2) How does your child measure up to other kids in his age group academically?
- 3) How does your child measure up to other kids in his age group socially?
- 4) Has your child expressed any kind of resentment at his/her school? Explain.
- 5) What were some specific incidents which led you to think that your son/daughter might have ADHD?
- 6) Where did these incidents take place?
- 7) Who first suggested that your child may have had ADHD?
- 8) In what capacity did you know this person?
- 9) Where and from whom did you learn the specifics of ADHD symptoms?
- 10) Was there more than one informational or defining source? Specify.
- 11) Could you briefly describe your feelings when you found out your child had the disorder?
- 12) Did you seek alternative diagnoses of your child's behavior? If so, from whom, and with what results?
- 13) Did you seek alternative treatment options to your child's ADHD diagnosis, and if so, what were the results? What is your opinion about alternative forms of treatment?
- 14) Have you incorporated any behavior modification techniques into your parenting practices? If so, what are these?
- 15) In your opinion, from where does the ADHD disorder originate?

Appendix IV
Interview Questions for Educators

- 1) In what way(s) do ADHD children differ from other children?
- 2) What are some of the disciplinary problems ADHD children have in your classroom?
- 3) Are these problems usually behavioral, or are they academic?
- 4) Do you believe these children are acting according to an unstoppable impulse, or can they control their behavior?
- 5) Whom do you usually first talk to when you think that a child might have ADHD?
- 6) What teaching techniques have you tried to use to educate children with ADHD?
- 7) Have you restructured your classroom to accommodate these children? If so, in what ways?
- 8) Are you aware of the diagnostic criteria for ADHD found in DSM IV? If so, are these criteria relevant or useful to you?
- 9) Do you feel that there is some consensus in your school about how to deal with ADHD children?
- 10) Do you have any concerns about the process of labeling which can result from a child being labeled as having ADHD?
- 11) What worries do you have if a child with ADHD goes untreated?
- 12) Do you know of any cases where ADHD went untreated? What happened in that case(s)?
- 13) What gender are most of the children with ADHD in your class? How do you account for this difference in gender, if there is any?

Appendix V
Interview Questions for Clinicians

- 1) How much time have you spent becoming familiar with the ADHD disorder?
- 2) From where or from whom do you usually hear the first suspicions of a child possibly having ADHD?
- 3) How much time do you spend with a child before providing a positive or negative diagnosis of ADHD?
- 4) Do you use the diagnostic criteria provided by *DSM IV*?
- 5) What are the customary lines of treatment you employ to deal with ADHD?
- 6) Do you see this line of treatment as accepted within your profession?
- 7) Could you describe any reservations you have about the use of Methylphenidate by ADHD children?
- 8) Based on your experience, how long should a person with ADHD take medication?
- 9) Are there periods of time in which medication should be ceased? Explain.
- 10) Do you find that there is any long-term treatment for ADHD which can eradicate or reverse the disorder?
- 11) What do you feel are the appropriate roles of educators in relation to ADHD children?
- 12) What do you feel are the appropriate roles of parents in relation to ADHD children?
- 13) Can you briefly describe the neurochemical structure of the disorder?