

**THE CONSTRUCTION OF 'ADHD' IN ONLINE INFORMATION FOR PARENTS
AND YOUNG PEOPLE: A DISCOURSE ANALYSIS**

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ABSTRACT

This study used a discursive psychology approach to analyse the construction of ADHD in a small sample of online materials produced by official sources (the National Health Service, Royal College of Psychiatrists, and Young Minds) aimed at parents and young people. Of specific interest was the constructed and constructive nature of discourse at a 'micro' level, with a particular focus on the factual accounting of ADHD, and analysis of rhetorical devices used. ADHD was constructed as an uncontested, uncontroversial and complex biomedical disorder, with environmental factors minimised or absent. A distinction was made between pathological and normal childhood behaviour, and the diagnostic process of distinguishing between 'normal' children and 'those with ADHD' a complex one requiring specialist assessment. The assistance of multiple professionals and specialist services was constructed as an integral part of help for parents and young people. The use of medication was constructed as an uncontroversial and essential part of treatment; and was the only treatment mentioned in two 'first-person accounts' of ADHD. Changes made to the first person account in one of the website's texts are discussed as an indication of the conscious and deliberate use of language in the official accounting of ADHD. Implications for clinical practice are discussed in light of the analysis.

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‘As a parent, it's natural to worry about your offspring. But sometimes it can be hard to work out whether your loud, naughty child is normal or showing signs of a behaviour disorder. In this section you can find advice to help.’

(www.netdoctor.co.uk/adhd/)

1.0 INTRODUCTION

‘Attention Deficit Hyperactivity Disorder (ADHD)’¹ is the most commonly diagnosed psychiatric disorder in children and young people. It has been described as ‘one of the most prevalent and intensively studied disorders in child psychiatry, and possibly the most controversial’ (Visser and Jehan, 2009, p. 127). Rates of diagnosis in the UK, along with most other Western countries, have risen sharply in recent years (Timimi, 2010); between 1996 and 2006, for example, there was a reported 700% rise in rates of diagnosis in England alone (Lloyd, Stead and Cohen, 2006). ADHD has been described as a ‘global phenomenon, spreading rapidly as a result of the increasing dominance internationally of US psychiatric models, the need for new markets for major pharmaceutical companies, the increasing use of the Internet by parents and professionals and changing approaches to schooling’ (Lloyd, Stead and Cohen, 2006, p. 2). This study takes a discursive psychology approach to the construction of ADHD in a small sample of online information materials aimed at parents and young people.

¹ The existence of ‘ADHD’ is contested and I do not use the term uncritically. However, for ease of reading I have not placed ADHD in inverted commas after the first occurrence in the text.

1.1 Researcher's position

In this section I introduce the reader to my position as a researcher and how my interest in this subject area developed, as qualitative research necessarily involves a degree of reflexivity about the values and assumptions one is bringing to the process (Burr, 2003).

My work experience prior to clinical psychology training was primarily with children and young people presenting with offending or anti-social behaviour, many of whom were diagnosed with ADHD or other behavioural disorders. When observing these children at school, during cognitive assessments, or individual therapy sessions, I noticed them behaving very differently in different contexts. A number of boys labelled with a diagnosis of ADHD showed excellent concentration and were able to sit still for considerable periods of time when receiving empathic individual attention or were particularly interested in a task. Yet this more positive behaviour tended to be framed by other professionals or parents as an exception; the focus remained on finding any examples of behaviour which could support a diagnosis of ADHD (and, in most cases, a prescription for stimulant medication).

In the course of my work, I also became aware of the challenging social and environmental factors that impacted on these children's lives. There were often significant difficulties in every system around them. These included living in socio-economic deprivation or chaotic home environments; being victims of abuse and neglect; and attending overcrowded and poorly resourced schools. Yet it was the individual children who were diagnosed and medicated for a psychiatric condition.

My first degree was in print journalism and I worked in the media for several years before re-training in psychology, so I have maintained a keen interest in how mental health difficulties are constructed in talk and textual materials.

I am critical of the dominant medical model of 'mental illness', and believe there is too much focus on biological or internal causes of distress as opposed

to social or environmental factors. I find this particularly indefensible when applied to children and young people, who occupy an especially powerless position in society.

I am primarily interested in working with children, young people and families after qualifying as a clinical psychologist, and I hope this study may contribute to a more critical body of literature concerning the most diagnosed psychiatric disorder in the UK's young people.

In the course of completing this study, I have become a parent. As the mother of a toddler, I spend much of my personal life managing rules and boundaries, and much of my time in social settings helping my daughter to negotiate behavioural norms and society's unwritten rules of conduct. Through this personal experience, I increasingly realise how parents are expected to exert discipline and control over their children in particular ways in UK society, teaching them to follow ways-of-being in the world which often seem arbitrary and culture-bound.

1.2 Literature review

When conducting my literature review for this study, I initially searched EBSCO, an international online database resource (all databases selected and all years available). I carried out searches using the following terms: 'ADHD'; 'ADHD and media'; 'ADHD and UK media', 'ADHD and media and discourse analysis'; 'ADHD information'; 'ADHD online information'; 'ADHD parent information'; 'ADHD child information'; 'ADHD adolescent information' 'ADHD young people information'; 'ADHD and discourse analysis'; 'ADHD and discursive psychology'; 'discursive psychology and mental health'. I searched through abstracts and then downloaded and saved full text articles that seemed particularly relevant. I also searched Google using similar terms, partly as a way of familiarising myself with ADHD-related materials that were 'out there' on a popular search engine (rather than confined to a subscription-only resource like EBSCO which is arguably used more by students and psy-professionals). I found both EBSCO and Google useful for directing me to relevant books and websites, as well as journal articles.

I carried out further searches on EBSCO and Google throughout the process of my research, in order to keep up to date with new material published. In subsequent chapters, I discuss the importance of remaining aware of new 'live' material when doing discourse analytic research on the internet, given my experiences during this study.

1.3 Diagnostic criteria for ADHD

Current diagnostic criteria for ADHD in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994, 4th edition) include nine features of 'inattention' ('often avoids, dislikes, or is reluctant to engage in tasks which require sustained mental effort, such as schoolwork or homework'); six features of 'hyperactivity' ('often has difficulty playing or engaging in leisure activities quietly'); and three features of 'impulsivity' ('often has difficulty awaiting turn'). Six or more 'symptoms' of 'inattention' and/or six or more 'symptoms' of 'hyperactivity-impulsivity' must 'have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level', with 'some impairment from the symptoms...present in two or more settings'.

1.4 Prevalence of ADHD

Because of uncertainty around definition, there is a huge range reported in prevalence rates even within the same country, from 0.5 % to 26% of children (Timimi and Taylor, 2004). Cross-cultural studies also show wide variations in the way professionals from different cultures and different ethnic backgrounds rate symptoms of ADHD (e.g. Hinshaw, Scheffler, Fulton et al, 2011; Timimi and Taylor, 2004; Brewis and Schmidt, 2003).

1.5 A brief history

In 1902, paediatrician George Still first described a group of children who displayed what he termed a 'morbid defect of moral control'. Still's work is often described by supporters of the ADHD biological model as the origin of the medical account of the disorder (e.g. Barkley, 2003). However, Rafalovich (2004) notes that Still's lecture might be better understood as a product of the

dominant medical discourse of the early 20th century, when ‘moral imbecility’ was conceptualised as a biological problem. Still’s lecture can be viewed as a ‘plea’ to his medical colleagues not to view ‘immoral’ children as less intellectually able than their more morally skilled peers. For Still, these children’s immoral conduct indicated a considerable degree of personal agency. Far from being unable to control their behaviour or understand the rules of society, these children *chose* not to obey them (Rafalovich, 2004). This important point on personal agency tends to be omitted in contemporary accounts of Still’s lectures, since one of the main points made about ADHD-as-medical-condition is that the children afflicted do *not* have control over the behaviours they display.

Following encephalitis epidemics in the US in 1917 and 1918, physicians became interested in children who survived these epidemics but displayed various behavioural difficulties similar to the ‘symptoms’ that Still had noted. This led to the development of the label ‘minimal brain damage’ and later ‘minimal brain dysfunction’ (MBD) which became more prevalent in the 1940s and 1950s (Singh, 2002).

In 1937, Charles Bradley, director of a child psychiatric hospital in Rhode Island, US, wrote of the apparent effectiveness of the stimulant Benzedrine in ‘treating’ problematic behaviours in children with MBD (Bradley, 1937). Twenty years later, Bradley’s successor, Maurice Lauffer, suggested that MBD be reclassified ‘hyperkinetic disorder’, as hyperkinesis (inability to stay still) appeared to be one of the behaviours most improved by medication. By the 1970s, hyperkinesis had become the most common childhood psychiatric diagnosis (Conrad, 1975). The 1970s also heralded more public criticism of children being medicated with psychostimulants, in keeping with that era’s increasingly outspoken anti-psychiatry movement (DeGrandPre, 2000). ‘Hyperkinetic disorder’ remained the popular label until 1980, when DSM-III reclassified it ‘attention deficit disorder’ (ADD). When DSM-III-R was published in 1987, the classification changed once more, to ‘AD/HD’ (attention deficit disorder with or without hyperactivity). This change was influenced by US researchers who claimed that it was primarily difficulties with inattention rather

than hyperactivity that separated 'ADHD children' from other 'difficult' children (Norris and Lloyd, 2000).

'Hyperkinetic disorder' remains the European ICD-10 classification system equivalent. However in the UK, now increasingly following the American model of psychiatry, the diagnostic framework and label of ADHD tends to be used (Timimi, 2005).

1.6 Biological / 'traditional' explanations for ADHD

Mainstream explanations variously given for ADHD suggest that it may be caused by brain dysfunctions, neurochemical imbalances, genetic defects, or pregnancy and birth complications (Barkley, 2003). Supporters of this conceptualisation of ADHD view increasing rates of diagnosis and medication as evidence of scientific progress, and argue that the disorder was simply 'under-recognised' in the past (Timimi, 2010). Some researchers have argued for a 'biopsychosocial' perspective which locates the aetiology for the 'disorder' not in one area but as arising from multiple interacting biological, psychological and social factors (Tannock, 1998). Notwithstanding this and the numerous critical perspectives which I discuss below, the biomedical model of ADHD-as-disease continues to dominate in Western society (Visser and Jehan, 2009).

1.7 ADHD and the psychiatric diagnostic system: a critical perspective

Critics of the concept of ADHD have described it as a social and cultural construct, noting that there are no medical tests to determine diagnosis and no specific cognitive, metabolic or neurological markers, despite years of extensive and expensive research (Timimi, 2006). As with other psychiatric diagnoses, there are inconsistent clusters of 'symptoms' and no clear distinctions between pathological and normal levels of 'hyperactivity' or 'restlessness' – thus turning diagnosis into an exercise of opinion based on subjective reports (Boyle, 2007). Even when researchers have a considerable vested interest in the diagnosis – as with the US National Institutes of Health at their Consensus Development Conference – it was noted that no reliable, valid, independent test for ADHD exists; that there were no data to implicate

brain dysfunction in ADHD; and that 'after years of clinical research and experience with ADHD, our knowledge about the cause or causes of ADHD remain speculative' (National Institutes of Health, 1998, p. 3).

Critical readings of ADHD have also placed it in the context of other psychiatric diagnoses (Moncrieff, Rapley and Timimi, 2010). Critics of the psychiatric diagnostic system view it as scientifically spurious and ethically problematic (Boyle, 2007; Bentall, 2003), the product of social, cultural and historical influences rather than genuine medical or scientific advancements (Norris and Lloyd, 2000). The several-times-revised Diagnostic and Statistical Manual of Mental Disorders (DSM), the psychiatrist's 'bible', is based on committee consensus and subjective opinion rather than concrete observable phenomena (Kutchins and Kirk, 1997). 'Mental illness' has been described as a metaphor for culturally inappropriate behaviours (Szasz, 1974) and the medicalisation of undesirable conduct as a means of social control (Foucault, 1977). With this overarching critical perspective in mind, I now explore some alternative theories for the construct of ADHD.

1.8 Alternative explanations for ADHD

Levy et al (1997), reporting results from a large-scale twin study, concluded that ADHD did not appear to exist as a discrete 'disorder' and that the so-called ADHD 'symptomatology' was present to different degrees across the whole population, and thus could best be described as a 'continuum'. This renders diagnostic cut-off criteria arbitrary, as indeed with any other psychiatric diagnosis.

Baker and Newnes (2005) suggest that there has been no overall change in children's behaviour over the last few decades, and that the rise in ADHD merely reflects a change in the 'dominant language used to describe conduct' (p. 36) – so disruptive children are now labelled as 'having' ADHD rather than as being disruptive, naughty or bored.

Breggin (2001) proposes that many of the 'symptoms' of ADHD are entirely normal childhood behaviours; for example, being easily distracted, having

trouble awaiting one's turn, or finding it difficult to play quietly. However, all of these 'symptoms' may also be classified by authority figures as undesirable behaviours which disrupt an orderly, controlled classroom environment.

Rowe (2005) suggests that a child exhibiting ADHD symptoms is actually displaying signs of fear, but the adults in a child's system – parents, teachers and professionals – may find it easier to label this as evidence of a behavioural disorder rather than emotional distress. To admit that a child is frightened would require more critical examination of what the child is frightened of, which could possibly implicate their own caregiving (or lack thereof).

Children who have suffered abuse, neglect or other trauma may display what is constructed as impulsivity, inattention and hyperactivity, as well as numerous other difficulties such as hyperarousal and sleep problems which may be attributed to a psychiatric condition (Rostill and Myatt, 2005). One study of mental health difficulties in the UK's looked after children population found that 45 per cent had been classified with hyperkinetic, conduct or emotional disorders. Twenty-one per cent of the children diagnosed with hyperkinetic disorders were taking stimulant medication (Meltzer et al, 2002). McLeer et al's (1994) study of children who had experienced sexual abuse found that almost half met the criteria for ADHD. Levine (1997) suggests that medication may 'mask a child's attempt to convey various forms of trauma [since] children frequently display behaviours that disclose experiences they cannot communicate through verbal language' (pp. 201-202). This theory has worrying implications for the many looked after children – and other young victims of abuse and trauma – currently taking stimulant drugs.

Another survey found that children with an ICD-10 diagnosis of hyperkinetic disorder were significantly more likely than those without a diagnosis to live in low income households in socially deprived areas; to have parents who were both unemployed or receiving disability benefits; and to have experienced two or more 'stressful life events' such as hospitalisation, parental separation or bereavement (Green et al, 2005).

At the other end of the socioeconomic spectrum, surveys of childhood stimulant use in the US show that it tends to be highest in affluent white communities where academic achievement is a high priority, and where there is the greatest gender gap in educational attainment favouring females (Timimi, 2006). Many of these parents now actively seek stimulants for their children because they feel they are otherwise at an educational disadvantage. High rates of stimulant prescription may indicate an increase in societal and parental expectations of children, particularly in the educational system (Hewlett, Hansen and Rapley, 2005).

ADHD has arguably become a diagnosis that people want to have, either for themselves or their children (Moncrieff et al, 2010). A medically sanctioned label may bring relief for parents because it absolves them of responsibility for their child's behaviour; provides what may appear to be simple, concrete solutions (whether pharmacological or psychological); and allows for the problem to be handed over to professionals (Horrocks, 2011). However, Graham (2008) has been critical of perspectives that implicate large numbers of parents in actively seeking a diagnosis for their children. Citing studies describing the 'pain and sense of being at blame' once parents receive an ADHD diagnosis (p. 14), she suggests that the actual percentage of parents seeking one is much smaller than is portrayed in both professional and popular literature.

Timimi (2010) suggests that the increase in diagnosis and medication for ADHD may reflect an interaction between a real increase in emotional and behavioural difficulties in children, due to cultural and environmental shifts in post-industrial societies; and changes in how these societies view childhood and child-rearing. Contributing factors may include an increase in parental working hours and less time spent with children; more family mobility with a breakdown in established communities; and the 'commercialisation' of childhood, leading to new profit-making opportunities such as the 'parenting' industry and the pharmaceutical industry.

DeGrandPre (2000) suggests that ADHD-like behaviours are developmental difficulties increasingly found in Western children exposed to a 'rapid-fire culture'; sensory overloading from a surfeit of TV, computers and other electronic media; and stressed, overworked parents. He proposes that children's brains may be adversely affected by this combination of excessive stimuli and impoverished caregiving.

Miller and Leger (2003) construct ADHD and Ritalin use as signs of a 'moral panic'; young people are a convenient *tabula rasa* onto which a nation's anxieties may be projected. Ritalin and other stimulant medication can be viewed as an easy means of turning children in danger of disrupting the social order into successful, productive individuals:

Positioned between birth and adulthood, holding both the promise of the future and the key to its potential corruption, youth are both 'at risk' and 'a source of risk'. They must be protected from harm by the family, society and educational institutions because they embody a threat to order and stability, as provided by those same institutions.

(Miller and Leger, 2003, p. 11).

Rose (1999) emphasises the cyclical nature of moral panics by constructing them as 'repetitive and predictable social occurrences', and describes how psy-professionals may contribute: 'Professional groups – doctors, psychologists, and social workers – used, manipulated, and exacerbated such panics in order to establish and increase their empires' (p. 125).

Some critics argue that the pharmaceutical industry has created and promoted the disorder of ADHD as a vehicle for prescribing stimulants (Breggin, 2002), otherwise known as 'disease mongering', which Moynihan and Henry (2006) describe as 'the selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments' (p. 1). From the 1960s onwards, the pharmaceutical industry invested heavily in promotion of stimulant medications for hyperkinesis, running prominent advertisements in medical journals and magazines, funding

conferences and supporting research into the disorder (Conrad, 2006). Children and young people can be seen to represent ideal target populations for pharmaceutical companies, as they already hold relatively powerless positions in society (Baldwin and Anderson, 2000). I will discuss the role of the pharmaceutical industry in greater detail in section 1.13 on stimulant medication.

1.9 The medicalisation of masculinity

ADHD is four to ten times more likely to be diagnosed in boys than girls (Timimi and Taylor, 2004), although in recent years diagnostic rates have been rising in girls, and some mainstream parenting literature describes ADHD as an 'equal opportunity disorder' (Nadeau, Littman and Quinn, 1999). Mainstream supporters of the biological explanation of ADHD suggest that girls may be more likely to manifest the 'dreamy, inattentive' form of the condition and thus the disorder is less likely to be noticed as their symptoms are less socially disruptive (Nadeau et al, 1999).

Notwithstanding this, boys are still overwhelmingly more likely to receive an ADHD diagnosis and a prescription for stimulant medication (Timimi and Taylor, 2004). Timimi (2006) suggests that in recent decades there has been an increasing 'feminisation' of care and authority in childhood, particularly in educational contexts, which may be adversely affecting boys and social perceptions of them. Childcare has become a professional, mainly female activity. The majority of teachers are now female, particularly in primary schools (when ADHD is most likely to be diagnosed) and more boys are being raised by single mothers, without a father or other significant male role model present. In almost all cases of children diagnosed with ADHD, it is adult females who first notice that a child's behaviour is 'abnormal'. Indeed, mothers and fathers frequently disagree about whether or not their ADHD-labelled child's behaviour is pathological (Timimi, 2006).

Educational methods currently used in the majority of Western schools tend to favour girls rather than boys (Burman, 2005) which may explain the now well-established trend in national exam results for girls to out-perform boys, even

in traditionally 'male' subjects. A disproportionately high number of boys in the UK are said to require special needs provision for poor reading, difficult behaviour or both (Timimi, 2006). Kindlon and Thompson (1999) suggest that the ADHD label may be applied to 'normal' boys who struggle to achieve in competitive, aggressive capitalist societies.

1.10 ADHD and schooling

Graham (2008) argues that the increase in diagnoses of ADHD in Western society may be due in large part to the introduction of mass schooling, and greater demands on children in educational environments. These include children entering school at younger ages, shortened break times, and a greater emphasis on academic achievement and 'seat work'. Furthermore she points to changing values in our society and a move from a production-based economy to a 'knowledge economy', resulting in fewer unskilled manual jobs and greater numbers of young people needing to stay on at school to gain higher qualifications. As she writes: 'The modern and increasingly *unnatural* demands of schooling have resulted in the rearticulation of *normal* childhood exuberance, curiosity and energy as "*unnatural*"' (pp. 23-24, emphasis added). I wish to highlight the use of 'unnatural' and 'normal' here because I think Graham's point illustrates aptly how the 'normality' and 'naturalness' (or otherwise) of a child's behaviour are entirely cultural and historical constructs. As she points out, 'If children were still working in the mines at nine years of age their energy levels would be considered a bonus' (p. 23).

Indeed it could be argued that the advent of mass schooling has not only shifted cultural expectations as to what constitutes 'normal' childhood behaviour, but as Foucault (1977) suggested, universal education operates as a means of observing and disciplining individuals. He described schools and other institutions as functioning like 'telescopes' or 'microscopes' through which citizens can be inspected and behavioural norms established. Rose (1999) has argued that the increasing social regulation of children, such as the advent of mass education and health care, came about not because society's powerful were necessarily concerned with their rights and wellbeing,

but because ‘they came to the attention of social authorities as delinquents threatening property and security, as future workers requiring moralisation and skills...’ (p. 125).

Breggin (2001) notes that ‘symptoms’ of ADHD often improve or disappear entirely during school holidays, and McHoul and Rapley (2005) suggest, ‘In the absence of the institution of the school, ADHD could hardly be a condition at all...the diagnosis may well be a way for the schooling system to cope with pretty much any form of unwanted conduct it may encounter’ (p. 421). A recent Canadian study found that children who were the youngest in their school year (born in December) were much more likely to be diagnosed with ADHD and subsequently medicated than their older January-born classmates (Morrow et al, 2012).

Schools are under increasing pressure to compete in national league tables with ever decreasing financial resources. A child with an ADHD diagnosis in the UK is eligible for a Statement of Special Educational Needs (SEN), which carries with it extra classroom assistance and extra funding for the school. A child described as merely disruptive, bored, or unhappy receives no such extra funding. Graham (2006) suggests that the label of ADHD may actually mask genuine learning difficulties in some children, preventing them from gaining access to the support they need: ‘problematic behaviour, and educational difficulties therein, become *managed*...not *supported* in the same way as educational difficulties arising from a “recognised impairment” within the learning disability/disability categories’ (p. 17).

1.11 ADHD, blame and responsibility

Boyle (2011) suggests that the biomedical model of mental distress operates to protect those in powerful positions in society – parents, teachers, adults, governments – from being held accountable for the distress of the less powerful. Thus, the construct of ADHD-as-disease absolves authorities and authority figures of blame and responsibility for children’s disruptive behaviours or emotional distress. Medical labels and technological solutions for social problems can be seen to directly benefit the producers of these

technological solutions (Timimi, 2006) – pharmaceutical companies, and what Ingleby (1985) termed the 'psy-complex': professionals in the disciplines of medicine, psychology and social work.

Timimi (2010) suggests that a key factor in the rise and rise of the ADHD diagnosis – and increasing emotional distress in the UK's child population (UNICEF, 2007) – is the expansion of neo-liberal free market capitalism, with its emphasis on freedom and individual rights at the expense of social responsibility, and a corresponding 'narcissism'-based value system:

When this system shows itself to undermine children's happiness, we distance ourselves from any potential feelings of guilt or assumptions of responsibility. Instead of asking ourselves painful questions about our potential role in producing this unhappiness, we view our children's difficulties as resulting from biological diseases that require medical treatment...thus biological psychiatry gives governments new ways of regulating the population, particularly in democratic societies where states must seek to rule by consent.

(p. 696)

Whether indicating medication or therapy as the most appropriate 'treatment', a biomedical discourse which constructs socially undesirable behaviour as individual pathology, and offers technological solutions for social problems, leaves little room for consideration of social, political or environmental causes of distress, or reflection on the complex reasons why children may be having difficulties at home or school (Lloyd, Stead and Cohen, 2006).

Visser and Jehan (2010), discussing the role of the psy-complex in the creation of ADHD-as-disease, write:

In order for the biomedical knowledge of ADHD to gain ascendancy over other competing discourses and to establish the value of absolute truth, such biomedical knowledge is channelled to the public by those people who are in a position of power, such as doctors and psychiatrists, who are perceived to create, sustain and convey the knowledge which crystallises what is deemed

to be 'right' and 'wrong', what is deemed to be 'normal' and what is 'deviant'... Because such truth about ADHD is produced as a result of 'legitimated knowledge' which is globally recognised for its mantra of reliability, objectivity and truth, the biological discourse inevitably gains the status of trust. As a result, the biomedical discourse is processed as a 'normalising discourse' which becomes the standard against which childhood is judged.

(p. 135)

1.12 Medicalisation, child-rearing and social control

'It has become the will of the mother to govern her own children according to psychological norms, and in partnership with psychological experts'.

(Rose, 1999, p. 134)

The medicalisation of undesirable childhood behaviours – as with other undesirable anti-social behaviours – is not a new phenomenon. By the end of the 19th century, children (along with the mentally ill, the disabled, criminals, and the poor) were being targeted for 'programmes of individualisation' by psychiatrists (Rose, 1999). Child-rearing as the domain of experts is also not a new phenomenon, although the categories of expert afforded specialist knowledge of this area have changed. From the 17th to the mid 19th centuries in Western society, members of the clergy were the dominant advice-givers to parents, with an emphasis on encouraging moral development in their offspring (Geboy, 1981). Towards the end of the 19th century, as the power of the medical profession grew, children's physical development and 'mental hygiene' became of greater concern. The allied disciplines of medicine and philanthropy, through the processes of 'normalisation' and 'moralisation' respectively, began to frame issues of moral conduct and the rearing of healthy children in medical terms (Rose, 1999).

As Rose (1999) points out, the mental hygiene movement of the late 19th and early 20th centuries could only be successful insofar as it was able to persuade parents voluntarily and willingly to discipline and 'moralize' their children. Thus the crucial concept of *normality* was introduced by psy-professionals, used to create a picture of the ideal child and family, and to

‘provide a more or less explicit set of instructions to all involved as to how they should identify normality and conduct themselves in a normal fashion, and to provide the means of identifying abnormality and the rationale for intervention when reality and normality fail to coincide.’

(p. 133)

In the 1920s and 1930s, following the success of Binet’s ‘intelligence test’, psychologists played a key role in creating childhood development tables and assessment scales, introducing the idea of developmental ‘milestones’, and thus establishing a ‘normative expertise of childhood’ (Rose, 1999, p. 153). These tables covered such areas as small children’s motor development, language skills, and social behaviour. Rose (1999) describes the wider impact of these assessment scales:

‘They provided new ways of thinking about childhood, new ways of seeing children that rapidly spread to teachers, health workers, and parents through the scientific and popular literature...In the space between the behaviours of actual children and the ideals of the norm, new desires and expectations, and new fears and anxieties could be inspired in parents, new administrative and reformatory aspirations awakened in professionals. With the rise of a normative expertise of childhood, family life and subjectivity could be governed in a new way.’

(Rose, 1999, pp. 153-154)

The 1920s and 1930s also saw the development of a psy-professional interest in the ‘problem child’, who might appear normal when compared to psychiatric patients of the 19th century, but showed defiance to authority figures (Miller and Leger, 2003). Following World War II, in an effort at early intervention and prevention of future social problems, a large number of community mental health services, child guidance centres, and child psychiatric clinics were established in the UK, with a correspondingly large number of psy-professionals trained to deal with the ‘problem families’ and ‘difficult children’ of the deprived working classes (Rose, 1999).

Timimi (2006) describes how in the post-war years, successful free-market economies led to greater worker mobility; more mothers working outside the home; and a breakdown of previously close-knit extended families and communities. As many families were now cut off from more traditional sources of parenting information, child-rearing manuals took on a new importance, 'giving professionals greater ownership of the knowledge base for the task of parenting' (p. 36).

Thus an increasing number of mental health experts in various spheres came to exert an influence on families, whether through popular publications or in community clinics. By the end of the 1950s, magazine columnists providing advice to parents (particularly mothers) tended to focus on two topics: 'discipline' and 'normalcy' (Singh, 2002). Children's psychological problems were compared to physical illnesses; mothers were expected to be able to distinguish between normality and pathology, but subsequent intervention was the job of the professional (Singh, 2002).

Thus, according to Rose (1999, p. 203):

The knowledge of what normal development is and how to ensure it has become esoteric; to have access to it requires reading the manuals, watching the television, listening to the radio, studying the magazines and advertisements. Normal development has become a problem, something to be achieved, necessitating continual nurturing and surveillance.

Almost a century after the birth of child development tables and standardised assessment procedures, it is still 'experts' who define normality and who produce standards to which families and individuals are supposed to aspire. Today more than ever, child-rearing is viewed as a task for professionals rather than parents, families or communities. Increasing numbers of 'experts' in mental health services, newspaper problem pages, internet websites and television documentaries offer specialist advice on the best ways to manage both 'normal' and 'problem' children (Timimi, 2006). Thus parents can choose from any number of titles in bookstores; a visit to one well-known central

London bookshop in 2012 revealed more than 500 titles on its Parenting shelves, including 11 ADHD-related titles (among them: 'All About ADHD: Symptoms, Diagnosis and Treatment', 'ADHD: How to Deal with Very Difficult Children' and 'The ADD & ADHD Answer Book: The Top 275 Questions Parents Ask'). Parents may also obtain information leaflets produced by organisations such as the NHS or NSPCC; read a newspaper advice column or magazine 'problem page' written by psy-professionals (Hansen et al, 2003); or watch TV documentaries in which a self-proclaimed 'expert' arrives at a family's home, Mary Poppins-style, to help them with 'difficult' children (e.g. *Supernanny*, *The House of Tiny Tearaways*).

The growth of the internet means this is one more arena where parents can easily seek advice; a 2011 Google search using the terms 'ADHD' and 'parenting' together yielded about 15,500,000 results. Hundreds of websites now offer advice on the diagnosis and management of ADHD. These include both official and unofficial sources of information; some of the less official websites include Facebook pages, support forums, and blogs written by parents and young people (adhdmommablogspot.com; myadddbog.com). Following trends in the US, there are now dozens of regional and national 'ADHD support groups' in the UK, most with their own websites.

1.13 ADHD and medication

Marge: *Good morning, honey. How is my special little guy?*

Bart: *I'm having side effects from the dope.*

Marge: *It's not dope! It's something to help you concentrate.*

('The Simpsons', series 11, episode 2: 'Brother's Little Helper')

'There is no clear clinical rationale for child and teenage prescribing of [methylphenidate], other than for *purposes of social control*' (Baldwin and Anderson, 2000, original emphasis).

It would be difficult to conduct any discussion or analysis of the subject of ADHD without also exploring associated pharmacological treatment. The diagnosis and the medication commonly prescribed alongside it are now

inextricably linked in popular culture. Indeed, as Singh (2002) suggests: 'In contemporary debates ADHD and Ritalin enjoy almost iconic status; they are a focal point of modern anxieties about children, parents, families, school, cities, civilization, and genetic futures' (p. 578).

Over 660,000 prescriptions for Ritalin and similar stimulant drugs were issued in 2010 to children under 16 in the UK, a 70 per cent increase in five years (Department of Health, 2011), although this figure is actually an underestimate of true prescription rates as Department of Health data does not include hospital and private practice scripts (Baldwin, 2000). By contrast, about 6000 stimulant prescriptions were issued in 1994 (Timimi, 2010) thus representing a 10,000% rise in 16 years. The global market for ADHD drugs was estimated to be worth \$US 4 billion at the end of 2008 (Shire, 2010).

Ritalin is the trade name for methylphenidate, an amphetamine-like central nervous system stimulant said by supporters of the drug to improve the 'symptoms' of inattention, hyperactivity and impulsivity in children with ADHD. Dexamfetamine and atomoxetine are two other drugs (a stimulant and anti-depressant respectively) commonly prescribed for ADHD in the UK (NICE, 2009).

Critics of the use of ADHD medication in children argue that stimulant drugs affect *all* individuals in similar ways, regardless of whether or not they are exhibiting 'symptoms' of ADHD (Breggin, 2001). Indeed as Baldwin (2000) writes, 'The supposedly desirable behavioural effects (including passivity, attention, reduced spontaneity) *are the primary toxic effects of psychostimulants*' (p. 457, original emphasis). Other reported cognitive effects include a flattening of emotional affect, otherwise known as 'the zombie effect'; a reduction in curiosity, initiative, socialisation and play; an increase in stereotyped, overly focused behaviours (Breggin, 2001); and depression, irritability, confusion and mood swings (Timimi, 2005). Well-documented physical effects of the drug include loss of appetite, weight loss, growth restriction, insomnia, accelerated heart rate, pituitary dysfunction, stomach aches, headaches, and dizziness (Timimi, 2005). The EMC Medicine Guides

website lists a total of 97 possible 'side-effects' of Ritalin; those listed as 'common' include 'abnormal muscle movements or problems', 'aggressive or hostile behaviour', 'heart problems', 'raised blood pressure' and, ironically, 'hyperactivity' (<http://www.medicines.org.uk/guides/ritalin/attention-deficit%20hyperactivity%20disorder>).

Timimi (2005) raises concerns about the lack of long-term studies into the effects of stimulant medication on developing brains, especially given that animal studies have demonstrated long-lasting effects of stimulants on the brain biochemistry of rats (Breggin, 2001). Baldwin (2000) similarly expresses concerns that UK prescription rates for methylphenidate are highest among 3-17 year olds, precisely the age group that is most vulnerable to central nervous system damage from the drug's effects. Furthermore, stimulant drugs (whether licit or illicit) are known to be highly addictive and prone to widespread abuse (Baldwin, 2000). There have been numerous reports of Ritalin abuse in the US amongst students and adults in high schools, including 'school nurses, "teachers of the year", and principals' (Miller and Leger, 2003, p. 24). University students obtain the drug illicitly to maximise studying efficacy, a practice now increasingly seen in the UK as well as the US (<http://news.bbc.co.uk/1/hi/7684963.stm>). When stimulant prescription rates fell by 60% in Western Australia between 2001-2008, largely as a result of campaigning by politician and activist Martin Whitely, there was a 50% drop in adolescent amphetamine abuse rates in the region (<http://speedupsitstill.com>).

It has been argued by numerous critics that any noticeable benefits from stimulants are short-term behavioural effects rather than improvement in academic achievement (e.g. Graham, 2008; Breggin, 2001). Recent evidence from longer-term studies demonstrates that even behavioural improvements are not sustained over greater periods of time. The Multimodal Treatment Study of Children with ADHD (MTA) concluded at their three-year follow-up that stimulant medication had produced no significant improvement in children's behaviour (Jensen et al, 2007), although the drugs initially had appeared to offer some short-term behavioural improvement, a result which was much-quoted in the mainstream ADHD literature. Furthermore, the

researchers found at follow-up that the children who had taken stimulant medication were significantly shorter and lighter, were in greater need of extra school services, and exhibited higher rates of 'delinquency' than children who had not taken medication (Timimi, 2011). The publication of these results is particularly notable as the study's primary investigators were strong supporters of medication with long-established financial links to the pharmaceutical industry (Timimi, 2005).

The Raine ADHD study, the first longitudinal study of its kind, was conducted by the Western Australia Department of Health and gathered data from 2868 families over 14 years. In children with a diagnosis of ADHD, no significant benefits were shown from long-term medication use on measures of attention, externalising behaviour, social functioning, depression and self-perception. Long-term medication use was actually associated with *poorer* academic performance, as well as raised blood pressure and altered cardiovascular function (Western Australia Department of Health, 2010).

Despite these long-term study findings, National Institute for Clinical Excellence (NICE) guidelines still recommend medication as a first-line treatment for 'severe ADHD', and as a treatment for 'moderate' ADHD in those 'who have refused nondrug interventions, or whose symptoms have not responded sufficiently to parent-training/education programmes or group psychological treatment' (NICE, 2009, p. 26). It is perhaps worth noting that over half of the Guideline Development Group (GDG) members responsible for developing the most recent NICE guidelines on ADHD had received either personal or professional funding from the pharmaceutical industry in the previous year. In all but one case this was funding from companies producing ADHD medication (NICE, 2009). 'What other men dare pretend to be impartial where they have a strong pecuniary interest on one side?' Shaw asked in *The Doctor's Dilemma* (1907).

Indeed - enter what Breggin (2001) terms the psychopharmaceutical complex. This includes the multi-billion-dollar pharmaceutical industry, one of the world's wealthiest and most powerful industries, and the American Psychiatric

Association (APA), creators of the DSM, who in the early 1980s entered into an 'economic and political partnership' with the drug industry to boost their financial resources and promote the medical model of psychiatry, in the face of competition from non-medical professionals (Breggin, 2001, p. 217). In the UK, Baldwin and Anderson (2000) suggest the huge increase in stimulant prescriptions is directly linked to pharmaceutical companies' marketing strategies and financial incentives. These include the funding of research trials, conferences, and 'parent support' groups; free product distribution in clinics; and adverts placed in medical journals. Shire and Novartis, two drug companies producing ADHD medications, have created 'educational websites' specifically for teachers, who often play key roles in the management of ADHD, through participating in the diagnostic process or as informal 'disease-spotters' (Phillips, 2006, p. 2).

Consider the following news item from the archives of the BIOS Centre for the Study of Bioscience, Biomedicine, Biotechnology and Sociology at the London School of Economics:

'On 12 November 2010, 200 psychiatrists, paediatricians, nurses and other healthcare professionals gathered for "Through the Looking Glass: A Child's Perspective on ADHD", a national educational meeting, organised by Shire, which seeks to explore the practical challenges experienced by healthcare professionals involved in the care of young people and children with ADHD'.

<http://www.kcl.ac.uk/sspp/departments/sshm/news/index.aspx>

The title of this 'national educational meeting' – 'Through the Looking Glass: A Child's Perspective on ADHD' – is the same as that of a film Shire produced, 'developed to help Shire's entry into the UK ADHD market'. The pharmaceutical company won 'top honours' at a 2010 healthcare communications awards ceremony for the film <http://www.shire.com/shireplc/en/about/awards>. Shire's 'International ADHD Marketing team', who also won awards that year, have evidently been doing

their jobs effectively: in 2011, Shire made over \$ US 1.3 billion in sales from Vyvanse and Adderall XR, its two ADHD drugs (Shire, 2012).

1.14 ADHD, media and popular culture

Now now now now now now now now bored

Hearing everything so faster

Now now now now now now now now bored

Giving myself a heart attack

Now now now now now now now now bored

I'm so bored I can't stand still

Now now now now now now now now bored

I'm so bored I can't think straight.

('ADHD' song lyrics by Blood Red Shoes. From 'Box of Secrets', 2008)

As rates of ADHD diagnosis rise in the UK and worldwide, so there has been increasing media coverage of ADHD, and growing public awareness of the disorder. Miller and Leger (2003) describe how in the 1990s ADHD became known as the 'diagnosis of the decade' in the US, such was the press coverage around the disorder, medication, and the controversy surrounding both. In 1996 there were just 24 mentions of ADHD in UK print media; by 2001 this figure had increased tenfold to 229. By 2006 there were 1083 mentions of ADHD in UK print media, and 1565 mentions in 2011 (as reported by the Nexis UK database, accessed 2nd April 2012). Norris and Lloyd (2000) propose that a two-way relationship may exist between the media and the rise of ADHD; contributing factors to increasing rates of diagnosis could be widespread media coverage and availability of information about ADHD on the internet.

ADHD has also entered the fictional world of entertainment. A 1999 episode of 'The Simpsons' cartoon ('Brother's Little Helper') featured Bart Simpson receiving a diagnosis of Attention Deficit Disorder and a prescription for a stimulant drug called Focusyn. Other TV programmes with UK broadcasts featuring characters with a diagnosis of ADHD include *The Sopranos*, *Neighbours*, *Desperate Housewives*, *South Park* and *King of the Hill*. Percy

Jackson, the young hero in Rick Riordan's best-selling series of books aimed at children and adolescents, has a diagnosis of ADHD: 'when the ADHD makes it hard to sit still in the classroom, it's just hyper-awareness that will keep him alive on the battlefield' (<http://www.guardian.co.uk/lifeandstyle/2010/feb/08/percy-jackson-rick-riordan>).

Online store Amazon.co.uk features music CDs by the band ADHD; a range of child and adult T-shirts bearing ADHD-related slogans; and a 'New Junior Air Stability Wobble Cushion' which claims to 'improve concentration of children with ADHD or difficulty sitting still' (http://www.amazon.co.uk/PhysioRoom-Junior-Stability-Wobble-Cushion/dp/B0057EQILE/ref=sr_1_sc_1?ie=UTF8&qid=1336322018&sr=8-1-spell). One hypnosis CD specifically designed for children with 'ADD and ADHD' has instructions which seem strikingly reminiscent of Aldous Huxley's *Brave New World*: 'simply play this CD after your child has gone to sleep and let the layered Theta frequencies and positive subliminal messages do their work' (http://www.amazon.co.uk/Child-ADD-ADHD-Childrens-Sleep-Hypnosis/dp/B000W8FW3K/ref=sr_1_8?s=music&ie=UTF8&qid=1336322114&sr=1-8).

The website for the National Attention Deficit Disorder Information and Support Service (ADDISS, www.addiss.co.uk), sells an impressive array of ADHD-themed merchandise: 'Whatever you're looking for in ADHD, we'll do our best to help'. 'ADHD supporters' can purchase ADHD-themed key rings, Christmas cards, a variety of 'toys for children and adults who like to fidget', and multi-coloured plastic wrist bands featuring the slogan, 'ADHD is real!' As befitting a capitalist culture, the disorder of ADHD creates creative opportunities for consumption – beyond the lucrative medication market and parent-training programmes – perhaps particularly apt as children and parents represent such a valuable market segment (McNeal, 1987).

1.15 Previous research on the construction of ADHD in media and texts

Lloyd and Norris (1999) identified two discourses in press coverage of ADHD, the discourse of 'experts' and that of 'parents'. They found that courses and books written by 'experts' aimed at teachers tended to explain the construct of ADHD with 'reductionist simplicity', and there was no mention of any controversy or professional disagreement surrounding the diagnosis.

Norris and Lloyd (2000) analysed 1990s newspaper coverage of ADHD and found three different expert perspectives about ADHD were located in the UK press. These were the biological perspective (by far the most frequently quoted); a second perspective that was largely biological but had some misgivings about reported prevalence and overuse of medication; and a critical perspective (least often represented in the press) that questioned the idea of ADHD-as-syndrome and considered the construct from a wider psychological and sociological perspective. Generally the strongest voices in the UK press sample tended to be parents and self-help groups who supported a biological construction of ADHD and were actually challenging the medical profession on their own ground, seeking more diagnoses, greater access to specialist services, and medication for their children. Parents were portrayed as 'reproducing the dominant discourse' and 'reinforcing the medical model' (p. 132). The authors noted that 'increased access by parents to information about "conditions" like ADHD and a growth in organised pressure...has created a more challenging client group, with an increased emphasis on a right to diagnosis' (Norris and Lloyd, 2000, p. 133).

Clarke (2011) used content analysis to examine popular magazine portrayals of ADHD, and found contradictory messages. Although doubt was frequently cast over the existence of ADHD-as-medical-disorder and medication use was often portrayed as problematic, the causes of ADHD were almost always authoritatively described as genetic or biological.

Schmitz, Fillippone and Edelman (2003) used Social Representations Theory to study ADHD in US newspaper media between 1988 and 1997. They noted that key aspects of representations included a bio-genetic understanding of

the cause; a dominant picture of young white males being most likely to receive an ADHD diagnosis; and an emphasis on symptoms of hyperactivity rather than inattention. They also noted that ADHD was objectified, with metaphors such as 'broken brain' and 'derailed concentration' used to describe the construct; and found that a diagnosis of ADHD seemed to exert a strong influence on young people's identity.

Horton-Salway (2010) analysed the construction of ADHD in UK newspaper media using discourse analysis. She identified two competing repertoires at work, the biological and the psychosocial. Although the repertoires appeared to describe ADHD in different ways, both constructed families as in need of interventions, whether medical or psycho-social. Horton-Salway related these findings to previous work on the construction of depression in the Australian print media (Rowe, Tilbury, Rapley and O'Ferrall, 2003) where apparently contradictory and competing biomedical, psychosocial and administrative/managerial discourses actually worked together to construct depression as individual pathology in need of professional management.

Rafalovich (2001) undertook a qualitative analysis of ADHD literature directed at parents, specifically parenting manuals. His work explored how texts 'provide frameworks for an administration of discipline in domestic life' and related the methods of behaviour modification described in these parenting manuals to Foucault's idea of Panopticism (1977). Rafalovich explains how, in Foucault's terms, the disciplined modern citizen is a product of Panopticism: 'We become "self-regulating" because we have been trained through a continuous response to the presence of being ever-sought, ever-seen' (p. 382).

Pajo and Stuart's recent study (2012) compared the information provided to parents of ADHD-diagnosed and non-ADHD-diagnosed children in popular self-help books. They found that both sets of children were described as exhibiting similar behaviours in similar settings – for example, throwing tantrums, interrupting conversations, and finding it difficult to go to bed at night or get up in the morning. The main difference seemed to be that the problems

'ADHD children' experienced were constructed as being more intense or more frequent in nature; and they were framed as experiencing more problems with academic performance, which appeared to be the main incentive for parents to seek help. Despite similar descriptions of difficult behaviour, the advice given to the two sets of parents was considerably different, with a focus on behavioural control in the ADHD books, and a focus on children's emotional wellbeing in the non-ADHD books.

In the same study, four out of five of the books aimed at parents of 'ADHD children' were supportive of the use of stimulant medication, emphasising the benefits and minimising side effects. The authors noted the treatment of medication in these self-help guides was generally a 'one-sided portrayal of the actual controversy on prescribing and using psychiatric drugs on young children' (Pajo and Stuart, 2012, p. 830).

Danforth and Navarro's (2001) research on the everyday language of ADHD identified two dominant discourses privileged by cultural norms, a school discourse and a medical discourse. The authors suggested that increasing public exposure to the dominant medical discourse used to describe ADHD has led to professional jargon becoming part of everyday 'lay' talk.

Hewlett, Hansen and Rapley (2005) analysed the construction of 'ADHD-as-brain-disease' in an Australian parliamentary inquiry, using membership categorisation analysis. Among their main findings was the explanation of ADHD using a disease framework and medical discourse; and the objectification and reification of ADHD. Of particular interest to the researchers were comments made by a school principal who appeared to suggest that children with a diagnosis of ADHD display innate behavioural patterns which cause them to react to particular situations in a predetermined manner, 'like bees to a honeypot' (p. 99).

McHoul and Rapley (2005) used a 'hybrid' discursive psychology approach informed by Conversation Analysis and Critical Discourse Analysis to examine an instance of naturally occurring talk between a paediatrician, a young boy

and his parents. Their analysis showed one 'local level' example of how easily and routinely a child with suspected 'ADHD' can be diagnosed and medicated even when parents show resistance to the diagnosis.

1.16 ADHD in the media: perspective of the psy-complex

Most research on construction of mental health problems in the media has been conducted from a traditional biomedical perspective. This has tended to emphasise the media's role in producing inaccurate and stigmatising depictions of 'mental illness' (Hansen, McHoul and Rapley, 2003). Psy-complex commentary on the media's portrayal of ADHD has also tended to follow this trend, criticising the publication of allegedly inaccurate information, or accusing the media of using scare-mongering tactics (such as questioning the validity of the diagnosis, or highlighting the risks involving in prescribing stimulants to children). Barkley et al's 'International Consensus Statement on ADHD' (2002), endorsed by a number of 'experts' in the field, expressed concerns regarding 'the periodic inaccurate portrayal of [ADHD] in media reports...We fear that inaccurate stories rendering ADHD as myth, fraud, or benign condition may cause thousands of sufferers not to seek treatment for their disorder' (p. 89). Timimi (2005) notes that several authors of this Consensus Statement have previously received funding from the pharmaceutical industry, as have a number of ADHD 'support groups' in the US which have published critical commentaries on 'misleading' media coverage that questions the existence of ADHD-as-medical-condition.

EnglandKennedy (2008) analysed media representations of ADHD in popular US TV programmes and concluded, 'Few media representations of ADD exist and most are inaccurate; they reflect and reinforce social concerns and negative stereotypes. Perceptions of ADD and people who have been diagnosed as "having it" reflect an overarching sociocultural belief that this is an illegitimate category of disability' (p. 112). In her study EnglandKennedy constructs ADHD as a bona fide 'disability', and expresses disapproval at the construction of ADHD as portrayed by 'cultural sceptics' (p. 112); that is, over-diagnosed and over-medicated.

Akram, Thomson, Boyter and Morton (2008) evaluated 22 UK websites providing information about ADHD and associated pharmacological treatment. They noted that most of the UK ADHD-related websites were aimed at parents and that generally information was 'limited', although 'websites by government and professional bodies appeared to have the best content, layout and organisation' (p. 698). They also found that '*no instances of wrong or misleading information were identified*' (p. 698, emphasis added) – thus illustrating an unstated but apparently positivist epistemological stance.

1.17 Development of the current study

I originally planned to undertake a discourse analysis of the construction of ADHD in UK media, including print, broadcast and online sources. However, when I returned to a review of the literature following some months away from my research, I realised that this area might be rather too broad.

I am particularly interested in the language of fact construction, which is why I have found discursive psychology approaches especially appealing. This study has been influenced not only by literature on ADHD but also the construction of other mental health problems, by professionals (Boyle, 2002); in the newspaper media (Rowe et al, 2003); online (Hansen et al, 2003); in patient information leaflets (Hansen et al, 2003) and by friends of the 'mentally ill' (Smith, 1978). I have also found other discursive work on the construction of factual accounts helpful (e.g. Potter, 1996; Wooffitt, 1992).

My interest in discursive psychological approaches, the construction of factual accounts, and my interest in the perspectives of parents and children, led me to consider the presentation of ADHD in more official sources of information, particularly given the psy-complex's often vocal criticisms of 'misleading' mental health coverage. As Hansen, McHoul and Rapley (2003) observe in a preamble to their analysis of mental health information pamphlets, 'It seems only equitable to work up a balancing account of this stand-off by subjecting the informational interventions of the psy-professions into public discourse to similarly critical scrutiny' (p. 147).

I decided to focus specifically on information which either explicitly or implicitly is directed towards parents and children with an ADHD diagnosis. In the case of ADHD diagnosed in children and adolescents, it is they who are primarily affected, often by decisions made by authority figures in which they have no say. Parents are recognized as the 'gatekeepers' to their children and the managers of their treatment (Pajo and Stuart, 2012, p. 828).

I chose to analyse electronic rather than printed sources of information because increasingly that is where information is most widely accessible and accessed by the general public. The internet is the fastest growing medium of communication in the UK and worldwide. Recent data suggests that 77 per cent of UK homes now have internet access, and 30 million UK adults use the internet on a daily basis (Office for National Statistics, 2011). Increasingly UK consumers are more easily and frequently able to access the internet using mobile devices. Thirty-five per cent of 12-15 year olds reportedly owned a 'Smartphone' in 2010 (Ofcom, 2011), and adolescents show higher rates of internet use than any other age group. Furthermore, most adolescents who use the internet report that they have looked up health information online (Edwards-Hart and Chester, 2010) and other research suggests that the internet is now a major source of health information for consumers (Hansen, Derry, Resnick et al, 2003). The current ubiquity of online media in this regard may increase the likelihood of two-way exchanges of information between parents and children. One study looking at the effects of the socio-economic 'digital divide' showed that children of less educated parents from lower socio-economic backgrounds were as likely or more likely to look up health information online than children of more highly educated parents. The author suggested that these children may be accessing online health information on behalf of their parents (Zhao, 2009).

1.18 Justification for the current study

To date there has been minimal research on the construction of ADHD in online media, or on the construction of ADHD in information for parents and young people. Given that parents and children are those most likely to be affected by increasing rates of ADHD diagnosis, and the information provided by psy-professionals, this seems an important area of study. Norris and Lloyd (2000), exploring the role of the newspaper media in disseminating information on ADHD, suggested that the internet might also play a key role, and proposed the exploration of ADHD in online media as an interesting avenue of research. Twelve years on from this suggestion – a long time in the history of the World Wide Web – internet growth has expanded exponentially, making this research idea even more relevant.

Historically, mental health professionals – including clinical psychologists – have failed to provide much of an outspoken alternative perspective to the ‘biopsychiatric rhetoric’ (Baldwin and Anderson, 2000, p.83) although Patel (2003) proposes that research in clinical psychology can and should be a political act. Previous discourse analyses on textual constructions of ADHD, and studies looking at ADHD in online media, have taken less of a critical or discursive approach. These have included approaching research from an unstated but apparently positivist epistemological position (Akram et al, 2008); appearing to accept at face value the construct of ADHD-as-disease (Horton-Salway, 2010) or explicitly claiming epistemological neutrality (Rafalovich, 2001). I propose that there is a place in this literature for a more critical, discursive approach to the construct of ADHD, as seen in studies using principles from discursive psychology and ethnomethodological conversation analysis to analyse naturally-occurring ADHD talk (e.g. Hewlett et al, 2005; McHoul and Rapley, 2005).

Boyle (2011) offers suggestions for critical practitioners and researchers in challenging the dominant medical model of mental illness. One of these is addressing the importance of language and linguistic devices in minimising the role of context in mental distress; for example, through critical research on talk and language in various settings. Furthermore, Gee (1996) highlights the

importance of mental health professionals taking a reflexive stance towards the linguistic construction of people's difficulties: 'When we unconsciously and uncritically act within our discourses, we are complicit with their values and thus can, unwittingly, become party to very real damage done to others' (p. 190).

This is one area where discursive psychology studies can play a crucial role. I hope that this study will contribute to a small but growing body of literature on critical constructions of ADHD in online and textual materials.

1.19 Research questions

The issue of whether or not to formulate research questions prior to analysis is a contested one among discourse analysts (Wooffitt, 2005). Harper (2006) proposes it is permissible not to construct pre-determined research questions, so as not to close down potentially worthwhile avenues of investigation. The general trend in studies using discursive psychology approaches is not to formulate research questions in advance (cf. Coulter and Rapley, 2011; McHoul and Rapley, 2005).

Rather than formulating explicit research questions, therefore, I would like to state the purpose of my study: to examine on a local level *how* ADHD is constructed in some online information for parents and young people; and the *function* of these constructions. A more detailed discussion of the methodology will follow in Chapter Two.

2.0 METHODOLOGY

In this chapter I first describe my epistemological stance, then describe the methodological approach I am taking. I then turn to a discussion of sampling and sample size in this study, before focusing on my approach to analysing the data collected.

2.1 Epistemology

My epistemological stance for this study follows a social constructionist approach. The classic text on social constructionism is *The Social Construction of Reality* by Berger and Luckmann (1966), which views practices, values, and knowledge as the product of social arrangements. This includes knowledge which has traditionally been viewed as 'factual' or the reflection of an objective reality, such as scientific knowledge. I am adopting a *micro* social constructionist approach (Burr, 2003) following the traditions of discourse analysis and discursive psychology (Edwards and Potter, 1992; Potter and Wetherell, 1987). This is a relativist approach, viewing the concepts of 'knowledge', 'reality' and 'truth' as human constructions, placed within particular historical and cultural frameworks (Tuffin and Howard, 2001). Micro social constructionism is described thus by Burr (2003, p. 21):

This sees social construction taking place within everyday discourse between people in interaction...Multiple versions of the world are potentially available through this discursive, constructive work, and there is no sense in which one can be said to be more real or true than others; the text of this discourse is the only reality we have access to.

2.2 Discourse Analysis

'Discourse' has been defined by Potter and Wetherell (1987) as 'all forms of spoken interaction, formal and informal, and written texts of all kinds' (p. 7). So 'discourse analysis' can be taken to mean any analysis of any of these types of discourse. Discourse analysis draws from observations and insights in ethnomethodology, the sociological study of scientific knowledge, conversation analysis, sociolinguistics, structuralism, speech act theory and literary criticism, and rhetorical psychology (Wooffitt, 2005).

Burr (2003) notes that 'texts' can be construed not just as material explicitly involving language, such as spoken interactions or written texts, but in visual images or the meanings encoded in some other object. Thus Burr (2003) suggests the metaphor 'life as text' may be particularly apt; all aspects of life carry meaning. Or as Wooffitt (2005) suggests, 'discourse brings the world into being' (p. 148).

Potter and Wetherell (1987) note that in closely studying language, discourse analysts are not concerned with linguistics or pragmatic language use, which might be the focus of more traditional research interests. Rather, discourse analysts are 'social psychologists expecting to gain a better understanding of social life and social interaction from our study of social texts' (p. 7).

2.3 Discursive Psychology

Discursive psychology is a type of social constructionist research that exists under the umbrella of discourse analysis (Burr, 2003). In traditional psychology research, following mainstream psychological models, language has been viewed as 'providing...a window upon stable underlying representations of the world' (Edwards and Potter, 1992, p. 8). Language is viewed as reflecting people's underlying mental states and cognitive processes, and it is these mental states and cognitive processes that are seen to drive social action (Wooffitt, 2005).

However, discursive psychology views language, or discourse, as a form of social action rather than a reflection of some objective reality. As Edwards and Potter (1992) explain: 'The focus of discursive psychology is the action orientation of talk and writing...the discursive approach focuses on how particular versions of reality are constructed in an occasioned manner to accomplish social actions' (p. 2). As with conversation analysis, discursive psychology's interest lies with the 'micro-processes of interaction' or the 'fine-grained' detail of talk and text to examine how this is achieved (Wooffitt, 2005, p. 129).

Discursive psychology approaches focus on three key features of discourse. Firstly, discourse is seen as *situated*: 'talk and texts are embedded in sequences of interaction' (Edwards and Potter, 1992, p. 3). Secondly, discourse is viewed as *action-oriented*: talk and text are seen as doing things, or *constructive*. Thirdly, discourse is understood to be *constructed* through various discursive practices (Edwards and Potter, 1992). Discourse's active properties mean that texts and language hold social and political implications (Potter and Wetherell, 1987).

2.3.1 Discursive Psychology and Factual Accounting

The study of factual discourse or factual accounting has become a key 'strand' of discourse analysis research (Wooffitt, 2005; Edwards and Potter, 1992) and discursive psychology seeks to examine how descriptions are constructed as factual in naturally occurring talk and text (Potter, 1996). This involves analysing the key aspects of factual or authoritative language that work to establish an account as factual or objective. As Edwards and Potter (1992) suggest, 'Factual accounts are social accomplishments...constructed as factual using a variety of discursive devices' (p. 105). Thus analysis might include unpacking the devices that are used to make one version of the truth seem credible and hard to undermine. Traditional psychological approaches have tended to assume that the use of descriptive discourse in reporting is a marker of 'objectivity'. However, as Edwards and Potter (1992) note, 'In every day discourse, descriptions and reports are often drawn on precisely when there is a sensitive or controversial issue at stake' (p. 3).

Given the popular and widespread controversy around the diagnosis of ADHD (notwithstanding the prevailing construct of ADHD-as-psychiatric-disorder) the study of so-called factual accounts of ADHD seems especially relevant as an addition to the body of discourse analytic research in this area.

In this study, therefore, from a discursive psychological perspective, I will be examining how ADHD is constructed; what are the techniques and devices used to construct ADHD in this way; and how do these devices accomplish

various activities? Such questions have been described as 'issues of construction and function' (Edwards and Potter, 1992, p. 27).

My methodological approach draws much from Potter's key text (1996) dealing with discourse analytic research in the organisation of factual language, as well as the 'hybrid' ethnomethodological conversation analysis – informed discursive psychological approach of McHoul and Rapley (2005), analysing phenomena at a 'local level' .

2.4 Critical Discourse Analysis

My epistemological stance in this study also features aspects of 'critical discourse analysis' (CDA) as developed by Fairclough (1995). CDA differs from some other forms of discourse analysis in that it starts from important social issues rather than making value-free choices about which materials to select for analysis. In providing guidance on how to go about adopting a CDA approach, Fairclough (2001) suggests, 'Focus upon a social problem which has a semiotic aspect...Of course, this raises the question: A problem for whom?' (p. 30).

Following Fairclough's lead, and the approach taken by McHoul and Rapley (2005), in their incorporation of CDA into an instance of naturally-occurring ADHD talk, I propose to view ADHD as a social problem – although not in the way that mainstream society and the psy-complex might dictate. Rather, I see the creation and maintenance of the discourse of ADHD-as-disorder as a social problem – or, one might say, I view the discourse of ADHD-as-social-problem as a social problem.

Social constructionism has been seen as acting as a critique of mainstream psychology (Burr, 2003); indeed, some researchers argue that the main goal for critical psychologists is to use social constructionism to 'subvert the more damaging or oppressive aspects of mainstream psychology' (Burr, 2003, p. 20). Insofar as mainstream clinical psychology is aligned with psychiatry, where the 'treatment' of ADHD is concerned, this study will hopefully make a small contribution towards this subversion.

2.5 Description of the sample

I will be analysing features of the factual accounting of ADHD in materials aimed at parents and young people from the following UK-based websites:

1. National Health Service (NHS) website

(<http://www.nhs.uk/Conditions/Attention-deficit-hyperactivity-disorder/Pages/Introduction.aspx>) (see Appendix 1).

This is the NHS website which has a section specifically devoted to ADHD, including a five-minute video of which I will be discussing extracts.

2. Royal College of Psychiatrists website

<http://www.rcpsych.ac.uk/mentalhealthinfo/mentalhealthandgrowingup/adhdhyperkineticdisorder.aspx> (see Appendix 2).

This is a website maintained by the Royal College of Psychiatrists. The website produces an online 'Factsheet' in their 'Mental Health and Growing Up' series on ADHD: 'Information for parents, carers and anyone working with young people'.

3. Young Minds charity website

(http://www.youngminds.org.uk/for_children_young_people/whats_worrying_you/adhd

and

http://www.youngminds.org.uk/for_parents/worried_about_your_child/adhd_children) (see Appendices 3 and 4).

This is the website of Young Minds, an organisation which describes itself as 'the UK's leading charity committed to improving the emotional wellbeing and mental health of children and young people'. Two different sections of the website are 'For Children & Young People' and 'For Parents', providing information on different kinds of 'mental health problems' and 'mental illness'. There is a sub-section on ADHD in both the

children's and parents' sections. The Young Minds information on ADHD has been described as 'particularly innovative' by quantitative researchers, 'making it suitable for young people and non-English speakers as well as adults with a limited education' (Akram et al, 2008, p. 698).

The benefits of using 'naturalistic' or naturally occurring records and documents, rather than researcher-generated interview data, have been discussed by Potter (1996) and Potter and Wetherell (1987) among others. Official documents or reports – or in the case of this study, websites - are 'features of the social fabric that the researcher has had no part in producing' (Potter and Wetherell, 1987, p. 162) therefore minimising the amount of outside influence on the data.

All websites involved in the analysis appeared in the top 10 results during repeated searches on different days in the internet search engine Google, www.google.co.uk. The terms 'ADHD', 'ADHD information', 'ADHD information for parents' and 'ADHD information for young people' were used. Therefore they are all sites that are easily accessible to people conducting internet searches on the topic of ADHD.

There are, of course, literally thousands of different ADHD-related websites I could have chosen for analysis. Therefore I needed exclusion criteria to narrow down my search! For the purposes of this study – a doctoral thesis based in the UK and funded by the NHS – I have chosen to include only a small sample of UK-based sites. The global nature of the internet means that websites based in the US and other countries are easily accessed by UK internet subscribers. However, I felt that restricting analysis to UK sites was keeping the study particularly relevant for UK clinical psychologists working with UK clients.

Some psy-professionals might argue that any analysis of online information materials is likely to yield much 'misinformation'; perhaps spurious websites that parents and young people might discover but that would be discredited in the doctor's or psychologist's office. However the sites I have chosen to

analyse in greater detail all represent 'official' sources of information. There is some evidence that when internet users are assessing the credibility of a health information website they primarily look for 'the source, a professional design, and a scientific or official touch' (Eysenbach and Kohler, 2002, p. 573). Furthermore, it is these sites that parents and young people are arguably more likely to be directed to for help and support. At least one NHS adolescent service features links to the Royal College of Psychiatrists and Young Minds web pages on their website:

(<http://www.simmonshouse.org/general-info/links.php>). I am interested in how ADHD is constructed in these more 'official' sites, precisely those that might be deemed more 'reliable' and 'valid' by psy-professionals.

Given that these sites would describe themselves as providing objective, factual information, my interest lies in analysing how these facts are constructed and the actions they are accomplishing.

2.5.1 Sample size

My approach to sampling draws on discursive psychology approaches and other discourse analytic studies on factual accounts, by focusing on relatively small text and video samples in a very small sample of websites. I felt that this would help me to conduct a detailed analysis of fact construction techniques, and what might be accomplished by these devices, rather than 'getting bogged down in too much data and not being able to let the linguistic detail emerge from the mountains of text' (Potter and Wetherell, 1987, p. 161). They also point out that a number of seminal discourse analytic studies have concentrated on a single text (e.g. Potter, Stringer and Wetherell, 1984; Smith, 1978). Other examples of discursive psychology research adopting this approach include Coulter and Rapley (2011), O'Byrne, Rapley and Hansen (2006), McHoul and Rapley (2005) and McCarthy and Rapley (2001). It differs from the position usually adopted in more 'traditional' or positivist psychology research, where sampling may focus on such issues as size and representativeness, in order to generalise findings to a wider population (O'Byrne et al, 2007).

It is important to note, therefore, that my study – in keeping with other discursive psychology projects – does not seek to generalise findings to a wider population, or draw inferences. That notwithstanding, if particular discursive practices are revealed in one small sample, they can reasonably be expected to be found elsewhere, too, thus revealing something about wider discursive practices around ADHD in similar texts. Such an approach follows the example of Nobel laureate and quantum physicist Feynman (n.d.): ‘As nature uses only the longest threads to weave her patterns, [so] each small piece of her fabric reveals the organisation of the entire tapestry’.

This approach to sampling is that suggested by conversation analyst Harvey Sacks (1992) who wrote that ‘in coming to understand a culture, one may profitably assume that cultures show *order at all points*... (Sacks, 1992, 1483-488, original emphasis). Schlegoff in Sacks (1992), commenting on the latter’s approach to sampling, suggests that ‘Order...is present in detail on a case by case, environment by environment basis. A culture is not then to be found by aggregating all of its venues; it is substantially present in each of its venues’ (p. xlvi).

2.6 Process

Potter and Wetherell (1987) emphasise that there is no concrete ‘method’ to discourse analysis as with some other forms of analysis, for example quantitative research using a statistics computer -software programme. Rather, they describe instead a ‘theoretical framework’ and a set of suggestions as to how discourse may be studied.

After identifying the websites from which I would draw materials, I searched the ADHD-related material available on these websites. I downloaded and printed relevant sections, so I could more thoroughly read and easily make notes on the printed copies, rather than viewing them onscreen. I also downloaded and printed the transcript from an ADHD-related video on the NHS website, as well as viewing the video a number of times.

Given the frequently changing nature and rapidly changing content of some websites, downloading documents for analysis has been recommended by some researchers (Strong and Gilmour, 2009). However when conducting analysis of online material, I suggest it is also important to return to the 'live' material on the website from time to time, precisely *because* of the changeable nature of material. Such changes may bring forth interesting new avenues of enquiry, as I discovered in the course of my study (see Chapter Three for more detail on this).

Initial analysis involved a 'manual' process of preliminary coding, doing repeated close readings of the text, highlighting particular words or phrases and making notes. I read and re-read the texts a number of times (over a number of days and weeks) trying to remain flexible and open to new ideas while doing so, as I was aware that close reading could reveal additional features or themes I had not considered. Tuffin and Howard (2001, p. 202) note that 'categories should emerge from the text, rather than being imposed upon it...similar instances of talk should be identified and grouped together.' My preliminary coding criteria specified that I was looking for examples of a. *how ADHD is constructed (issues of construction)* and b. *what these constructions are achieving (issues of function)*.

Following this process I had identified the following categories:

1. ADHD as disease: Biomedical discourse
2. Management of environmental factors
3. 'Normal' versus 'ADHD' behaviours
4. Constructing behaviour as abnormal
5. Psy-complex help required
6. Management of medication

I then carried out further close readings of extracts that had been identified as fitting with each of these categories, paying particular attention to rhetorical devices used, and trying not to 'take for granted' any features of the language. Potter (1996) explains the importance of specificity in discursive psychology approaches: 'to understand the way factual accounts are constructed, and the way they are bound up with activities, it is important to understand their specific features, and the way those features relate to the setting in which they are used' (p. 8). Or in the words of Sacks (1984), '*Detailed study of small phenomena* may give an enormous understanding of the way humans do things and the kinds of objects they use to construct and order their affairs' (p. 24, emphasis added).

It is important to note that this type of qualitative analysis is a subjective one. My analysis is dependent on the particular reading I brought to the texts, which would have been different had another researcher been analysing the same materials. This aspect of the research will be discussed further in my Critical Review in the concluding chapter.

2.7 Ethical aspects of the study

Ethical approval was sought from the University of East London, following doctoral clinical psychology research guidelines. However, it was not required from NHS or clinical ethics committees, as there were no participants involved.

All data analysed were taken from publicly available internet sites, therefore no special measures regarding confidentiality needed to be taken.

3.0 ANALYSIS AND DISCUSSION

In this section I present my analysis of extracts from three websites offering information on ADHD, produced by the following organisations: the NHS, Royal College of Psychiatrists (RCP) and Young Minds. I group these into the following category sections:

- ADHD as disease: Biomedical discourse
- Management of environmental factors
- 'Normal' versus 'ADHD' behaviours
- Constructing behaviour as abnormal: Oscar's and Ben's stories
- Psy-complex help required
- Management of medication

I discuss each of these in turn, by providing examples from the website texts and a short video.

3.1 ADHD as disease: Biomedical discourse

All the websites I analysed constructed ADHD unproblematically as a real medical condition, using biomedical discourse. I explore one such construction of this in more detail below. The following extract is from the NHS website's ADHD page.

Extract number: 1

001	Attention deficit hyperactivity disorder (ADHD) is a group of
002	behavioural symptoms that include inattentiveness, hyperactivity and
003	impulsiveness. Attention deficit disorder (ADD) is a type of ADHD...
004	<i>Causes of ADHD</i>
005	The exact cause of attention deficit hyperactivity disorder
006	(ADHD) is not fully understood. It is thought that ADHD is

007 caused by a mix of genetic (inherited) and environmental
008 factors.

009 *Genetics*

010 ADHD tends to run in families and, in most cases, it is thought
011 that inheriting the condition is the most likely cause. Research
012 shows that both the parents and siblings of a child with ADHD
013 are four to five times more likely to have ADHD themselves.

014 *Brain function and anatomy*

015 Although the exact cause of ADHD is still unclear, research
016 shows that the way the brain works in people with ADHD
017 differs from that of people who do not have the condition. It is
018 thought that chemicals in the brain that carry messages, known
019 as neurotransmitters, do not work properly in people with
020 ADHD. Also, people with the condition seem to display less
021 activity in the parts of their brains that control activity and
022 attention.

(NHS website)

As Boyle (2002) notes in her analysis of how ‘schizophrenia’ is constructed as a brain disease by the psy-complex, one of the most direct ways to imply that a social construct is a medical condition is simply to assert that it *is*. In the extract above, in lines 1-3, ADHD is presented without qualification as ‘a group of behavioural symptoms’ and ‘a behavioural disorder’, and attention deficit disorder ‘a type of ADHD’. The use of medical terminology such as ‘symptoms’ (line 2), ‘condition’ (lines 11, 17 and 20) and ‘factors’ (line 8) constructs ADHD as a disease, as does the emphasis on biological and genetic causes.

The device of *reification* is used (Potter, 1996) to conceptualise something abstract as a concrete, material thing; so ADHD becomes something that one can ‘have’ (line 12) and that ‘tends to run in families’ (line 10).

The qualifiers in the phrases ‘the *exact* cause of ADHD is not *fully* understood’ and ‘the *exact* cause of ADHD is *still* unclear’ (lines 5-6 and 15, emphasis added) work to construct the cause as something that is at least *generally* and *partly* understood, and as something that *will* be clarified at some point in the future, even if it has not been clarified yet.

In this extract, both genetic and brain-imaging research are mentioned, given their own separately headed sections. By funding and publicising research into biological and genetic causes of ADHD, an association is constructed between the disorder and bio-genetic causes, even if the research yields no significant results (Timimi and Radcliffe, 2005).

In their studies of scientists’ language use, Gilbert and Mulkay (1984) identified what they referred to as *empiricist discourse*. This involves, among other devices, impersonal grammatical constructions such as ‘it is thought that’, used several times in the extract above. Such linguistic devices work to construct what Potter (1996) terms as ‘out-there-ness’: the description is constructed as independent of the producer, and therefore functions to draw focus away from an individual person or organisation’s stake in the description (what they stand to gain or lose from describing something in a particular way).

Constructions such as ‘it is thought that ADHD is caused by a mix of genetic and environmental factors’ (lines 6-8) also represents a shift in footing in this extract. The website’s introduction to ADHD presents it as ‘a group of behavioural symptoms’, an uncomplicated fact. However the more contentious issue of what it is caused by is ‘*thought*’ to be caused by ‘a mix of...factors’; ‘it is *thought* that inheriting the condition is the most likely cause’ and ‘it is *thought* that chemicals in the brain...do not work properly’ (lines 9-10 and 16-17, emphasis added). Clayman (1992) suggests that shifting footing in this way works to portray the producer of the information as neutral, while also conveying controversy or sensitivity around the item in question. This construction works to distance the website’s producers from the source of the knowledge, thus removing them from responsibility for the facticity (or otherwise) of the proposed causes.

Another feature of the empiricist discourse is the agency attributed to experimental data, facts or evidence (Potter, 1996). In the extract above, the phrase 'Research shows...' appears twice (lines 10 and 14). Such a construct works to distance the website's producers from any part in fact construction: the research is seen to speak for itself.

What Edwards and Potter (1992) termed *systematic vagueness* is also present in this extract. The exact mechanisms by which the 'chemicals in the brain...do not work properly' are not explained, nor are the allegedly problematic 'parts of their brains' explicitly labelled (lines 18-21). Such vagueness makes undermining an account more difficult, yet provides enough details to infer (in this case) that ADHD is definitely a problem of brain chemistry. Vagueness may also be used by professionals with technical knowledge to imply that the factors are too 'complicated' to be fully explained to laypeople, thus reinforcing the 'expert' knowledge of the psy-complex (Rowe et al, 2003).

3.2 Management of environmental factors

Given the preponderance of biomedical discourse in the websites, I was interested in exploring how any environmental factors were managed in the construction of ADHD. I discuss this in further detail using the examples of three extracts below.

Extract number: 2

023 It is probably caused by problems in the part of the brain which
024 controls impulses and concentration, but other factors may also
025 have an impact.

(Young Minds for parents)

A biological explanation is given as '*probably*' the case, 'problems in the part of the brain which controls impulses and concentration' (lines 23-24) although it is suggested that 'other factors *may*' play a part (line 24-25, emphasis added). These 'other factors' are not explained in further detail, therefore the

emphasis lies with the primary malfunctioning-brain explanation. 'Other factors' is also an extremely broad category, thus allowing for any number of other potential explanations to surface without damaging the credibility of the website's producers.

Extract number: 3

026 It is not known what causes ADHD but it is thought that it runs in
027 families. It could also be an imbalance in the chemicals that transmit
028 nerve signals in the brain.

(Young Minds for young people)

This extract, from the young people's section of the same website, offers a different explanation. While first explicitly stating a lack of knowledge in line 26 – 'it is not known what causes ADHD' – a genetic theory is then offered, using a distancing impersonal construction: 'it is thought that it runs in families'. This is followed by a further possible theory, that it could be a chemical imbalance in the brain.

Harper (1999) explains how qualifications such as 'may' and 'could' (lines 24 and 27) function as a defence in factual accounting. Any challenge to a particular hypothesis 'can be met with the response that only a tentative hypothesis was being proposed, together with a flexible move onto another such hypothesis' (p. 134).

Extracts 2 and 3 above are biologically based, using empiricist discourse and systematic vagueness, either minimising non-biological factors or not mentioning them at all. However in other ways the two explanations, both from the Young Minds website, are noticeably different. Only the young people's section (extract 3) constructs the cause of ADHD as ultimately unknown, and offers a possible genetic explanation (lines 26-28). The young people's section does not mention any environmental factors implicated in ADHD, not even under the broad category of 'other factors' as seen in the information for parents (extract 2, line 24). This seems particularly regrettable given that

Young Minds bills itself as ‘the UK’s leading charity committed to improving the emotional wellbeing and mental health of children and young people’ (http://www.youngminds.org.uk/about/vision_mission_and_values). According to Levine’s (1997) research on young people with an ADHD diagnosis, ‘Very few children display awareness of the situational context in which their symptoms emerge. They tend to adopt the harmful cultural tale that there is a great deal wrong with them.’ (p. 202). Perhaps one contributing factor to any lack of contextual awareness may be the information provided specifically for young people on a website like this.

Why should there be such a discrepancy in explanations between two sections of the same website? Somewhat surprisingly in light of my analysis, Akram et al (2008) described the ADHD information on the Young Minds website as ‘particularly innovative’, but did not mention if they noticed this discrepancy at the time of their research. Different, biologically based, systematically vague explanations for ADHD are not uncommon across different websites, as I discovered while gathering material for this study. However, the presence of different explanations within the *same* website – ostensibly aimed at parents and children, theoretically members of the same family – seems more concerning. This may highlight the uncertainty even in supporters of the ADHD-as-disease model around key aspects of the diagnosis.

Extract number: 4

029	We do not know exactly what causes these disorders. ADHD can
030	run in families. It is more likely in children who have significant
031	traumatic experiences as a child. Sometimes parents feel blamed for
032	not having controlled their child, but there is no evidence that poor
033	parenting directly causes ADHD. However, it is important to note that
034	parents can play a crucial role in helping and managing a child with
035	ADHD.

(RCP website)

The use of the word 'we' positions the website's producers, the Royal College of Psychiatrists, as the holders of shared, expert knowledge (or lack thereof) around 'these disorders' (line 29). Although they say they do not know 'exactly' what causes them, two theories are mentioned: a genetic cause ('ADHD can run in families', lines 20-30) and environmental ('it is more likely in children who have significant traumatic experiences as a child, lines 30-31). This is notable as the latter was the only definitive statement in any of the websites I perused to make a link between social factors and what is constructed as 'ADHD'.

However, what may constitute these 'significant traumatic experiences' is not explained in more detail, and the next sentence (lines 31-33) works to exculpate parents from a blameworthy role: 'Sometimes parents feel blamed for not having controlled their child, but there is no evidence that poor parenting directly causes ADHD' (although the use of the qualifier 'directly' leaves open the possibility that *indirectly* 'poor parenting' may be implicated). Given that possible 'traumatic experiences' as a child can reasonably be said to include abuse, neglect and other adverse parenting practices, this sentence appears to contradict what has just been said. So although 'traumatic experiences' may be implicated in ADHD, 'poor parenting' is *not* a factor - thus the 'bad parenting hypothesis', a popular media and lay persons' explanation for ADHD, is summarily dismissed.

Boyle (2011) discusses how the medical model of mental distress operates to protect those in powerful positions in society - including adults, in the case of ADHD - from being held responsible for the distress of those in less powerful positions. This can include censorship of any theory that may hold parents or family systems responsible for children's distress or disturbance, claiming that such theories are simplistically 'blaming the parents'. Equally this could be said to apply to any theory that implicates other adults and adult-led systems - teachers, schools, pharmaceutical companies, governments - in children's difficulties.

The dismissal of the ‘bad parenting hypothesis’ in this extract could also be seen as a move by the website’s producers to get parents ‘on their side’, as the recruitment of parents to the expert project is then highlighted in lines 33-35: ‘it is important to note that parents can play a crucial role in helping and managing a child with ADHD’. This works as a means of dealing with environmental (parenting) factors by suggesting that they make an important and *positive* contribution to ‘helping’ and ‘managing’ children with the disorder, rather than contributing to the onset of ADHD ‘symptoms’. It also preserves the primacy of the biomedical model: the role of parents in ‘helping and managing’ their children is framed as if they were helping their children manage a physical illness such as asthma or diabetes.

Extract number: 5

Excessive exposure to television

036 There have been several studies that have looked at the relationship
037 between children watching a lot of television at a very young age and
038 the development of ADHD in later childhood. There is not enough
039 evidence to say that television is definitely a cause of ADHD, but
040 allowing children up to the age of three to watch several hours a day
041 could contribute to attention problems and ADHD in later life.

(NHS website)

This extract addresses the ‘TV hypothesis’, another popular environmental explanation for the cause of ADHD. The website producers carefully qualify the association between too much television and ADHD in lines 38-39 – ‘there is not enough evidence to say that television is definitely a cause’ – while leaving open the possibility that an extreme amount of television-watching *could* contribute to ‘attention problems and ADHD’.

The ‘TV hypothesis’ is arguably quite a non-controversial environmental factor to address as a possible cause of ADHD – an apolitical factor, one might say,

focusing on a feature of the individual's home environment that could be easily remedied (rather than, for example, more complex parenting dynamics, difficulties at school, or wider aspects of society). Regardless of where one stands on the existence of ADHD-as-disorder, 'allowing children up to the age of three to watch several hours [of TV] a day' (line 40) can reasonably be viewed as a negative parenting practice without inciting too much controversy or disagreement.

The possible environmental causes discussed in the extracts above all operate within the overarching framework of the biomedical model. Furthermore, it has been suggested that multifactorial explanations can function in a number of important ways. Firstly, if one theory is challenged, another can be brought in to continue to explain the individual's pathology. Secondly, multifactorial explanations frequently present different mechanisms as operating within a 'hierarchy', with biology at the core and other factors playing secondary roles. Thirdly, multifactorial explanations can function as a means of constructing the producer as flexible and open-minded – as with the so-called 'progressive' biopsychosocial model of psychopathology. Fourthly and perhaps most crucially, in any multifactorial explanation for ADHD-as-disorder (as with other psychiatric diagnoses) – the inherent distinction between pathology and normality is not challenged (Harper, 1999).

3.3 'Normal' versus 'ADHD' behaviours

In the following extracts I discuss how the line between pathology and normality is dealt with, given that many alleged 'symptoms' of ADHD also appear in 'normal' children.

Extract number: 6

042 Children naturally have a tendency towards the kind of behaviour that
043 ADHD causes, but this behaviour should not be confused with ADHD.

(NHS website)

Extract number: 7

044 Many children, especially under-fives, are inattentive and restless.
045 This does not necessarily mean they are suffering from ADHD or
046 hyperkinetic disorder. The inattention or hyperactivity becomes [sic]
047 a problem when they are exaggerated, compared with other
048 children of the same age, and when they affect the child, their
049 school, social and family life.

(RCP website)

In the extracts above, one of the popular anti-ADHD-as-medical-condition arguments – that ADHD ‘symptoms’ are simply normal childhood behaviours – is summarily dismissed. In the first extract, ‘naturally’ occurring children’s behaviour is described as distinctly different from behaviour ‘that ADHD causes’ (lines 42-43), although this is not explained in further detail. Here ADHD is again ascribed with agency, as a concrete entity that ‘causes’ behaviour.

In lines 44-46 of the second extract, the common criticism that normal children are also ‘inattentive and restless’ is dealt with by explicitly making a distinction between those children and ones ‘suffering from ADHD or hyperkinetic disorder’. The subjective nature of an ADHD diagnosis is evident here, as ‘inattention or hyperactivity’ is seen to become a ‘problem’ when it is ‘exaggerated, compared with other children of the same age’ (lines 47-48). It is not specified exactly how ‘exaggerated’ these difficulties have to be to meet the diagnostic criteria (unsurprising given the criteria’s arbitrary nature). ‘Inattention or hyperactivity’ are given a considerable degree of agency and ‘the status of first causes’ (Boyle, 2011) : they are framed as something that will ‘affect the child, their school, social and family life’ (lines 48-49), rather than viewing a family, school, or social environment as contributing to such difficulties in the first place.

These extracts can be viewed as a form of *stake inoculation* (Potter, 1996). That is, the producers of these websites – the NHS and the Royal College of

Psychiatrists – could be constructed by sceptics as not merely objective, disinterested parties, but as standing to gain from describing ADHD as a medical disorder, or as having a ‘stake’ in describing things in a particular way. One common criticism of ADHD-as- disease is that the ‘symptoms’ are merely normal childhood behaviour. These extracts work to explicitly discount that argument. While conceding that ‘many children’ ‘naturally’ have a tendency towards overactivity, restlessness and other ADHD-like behaviours, such ‘normal’ behaviours are constructed as different from, and indeed ‘should not be confused with’, *real* ADHD.

3.4 How behaviour is constructed as ‘abnormal’

3.4.1 ‘Oscar’s story’

In this section I focus on how behaviour in children with a diagnosis of ADHD is constructed as abnormal. I first discuss an extract from a five-minute video on the introductory page of the NHS’s ADHD website. This is titled, ‘Children with ADHD’ and presents what are apparently interview extracts (presented as monologues) with a ‘consultant child and adolescent psychiatrist’; a boy ‘with ADHD’, Oscar; and his parents, Paul and Helen.

Before discussion of this extract it seems important to highlight that, as with any documentary-style video, the editors are in full control of the material presented and the final cut. They can edit interviews and juxtapose footage to support or undermine particular perspectives; this is an important aspect of fact construction in broadcast media (Potter, 1996). We can be sure, then, that the material presented here was consciously chosen by the producers to achieve particular aims. We also remain unaware of the questions put to the interviewees, the ‘briefing’ they may have been given, and indeed if they were presented with scripts to follow. However, I am not concerned here with whether the footage is a strictly accurate version of everything said by Oscar, his parents, and the psychiatrist. Of interest is what the ADHD talk is accomplishing, and how it is doing this.

Extract number: 8

050	Oscar's mother:	I think we knew quite early that he had a problem with
051		concentrating. Even when we were thinking about
052		primary schools, we realised it would be quite difficult
053		for him to sit in a class with 30 kids and understand
054		what was going on and take part in the lesson.
055	Oscar:	I fidget, think about other things a lot. I do like running
056		around. For some strange reason I do it way more than
057		everyone else.
058	Psychiatrist:	The symptoms of ADHD can range from very mild to
059		very severe. At the severe end children might not even
060		be able to stay sitting down for more than a couple of
061		seconds. They might run everywhere, even when it's
062		completely inappropriate. There may be some children
063		who are not particularly overactive and restless, but it's
064		really that they can't concentrate.

In this video extract, important work is done by all three interviewees – Oscar's mother, Oscar himself, and the psychiatrist – to construct Oscar's behaviour as 'abnormal'.

Firstly, visual footage is presented over the voiceovers of Oscar bouncing a ball with a tennis racket in what appears to be a living room – certainly an indoor room (see Appendix 5). This image succinctly shows us evidence of Oscar's difficult behaviour. He is behaving in what can be viewed as a socially inappropriate and overactive manner by bouncing a ball with a tennis racket *inside* the house. Oscar shown using the ball and racket on a tennis court, or sitting in a living room reading, would not have the same effect in constructing an 'ADHD' identity.

In lines 50-51, Oscar's mother sets the scene when she says 'we knew quite early that he had a problem with concentrating'. The use of the word '*even*' in

the sentence 'even when we were thinking about primary schools' (lines 51-52) alerts the audience to something extreme or abnormal – emphasising that they knew Oscar had a 'problem' from a very young age. Oscar's mother is describing a normal task of British parenthood, 'thinking about primary schools'. In the words of Sacks (1984) one might say Oscar's mother is 'doing being ordinary', constructing herself and Oscar's father as normal parents like any other. In lines 52-54, she follows with a three part list (Jefferson, 1990) – 'we realised it would be quite difficult for him to sit in a class with 30 kids and understand what was going on and take part in the lesson'. This list can be seen as a comprehensive account of what is considered normal and appropriate behaviour for a primary school child – and the fact that Oscar would apparently find this 'doing-being-a-normal-school-child' difficult alerts us to his difference.

Oscar's account of his behaviour in lines 55-56 also includes a three part list – 'fidget[ing]... thinking about other things a lot...running around.' By contrast to the appropriate behaviour described in lines 52-54, this is worked up into a comprehensive account of *abnormal* behaviour – typical ADHD behaviour, one might say. Presumably the 'other things' he is referring to when 'thinking about other things a lot' might be those classified by authority figures as 'things not relevant to the task at hand'. Oscar also uses the word 'do' when talking about running around, emphasising his preference for this activity.

Fidgeting, daydreaming and running around could be viewed as normal childhood behaviours – and indeed critics of the ADHD diagnosis would argue that they are normal behaviours, rather than symptoms of a disorder.

Therefore the key to the 'abnormalising' work is in the last sentence of Oscar's account: 'For some strange reason I do it way more than everyone else' (line 56-57). As Smith (1978) points out, what counts as normal or abnormal is indexical. Thus Oscar saying he likes to run around is not sufficient in itself to convince the audience that there is something pathological about his behaviour. However, doing it '*way more than everyone else*' constructs his behaviour as extremely different to the norm, using extreme case formulations (Pomerantz, 1986). The underlying motive for the 'running around' also needs

to be made explicit to further abnormalise it – or rather the lack of motive. Although Oscar has told us he likes running around, it is '*for some strange reason*' he does it so much compared to other people. This implies a lack of agency on his part: the running around behaviour is not under his control but instead is caused by some 'strange' other, outside the bounds of normality. This works to pathologise what could be viewed as an ordinary childhood activity, giving credence to the theory that Oscar's behaviour is the manifestation of a disorder over which he has no control, rather than behaviour he engages in 'way more' than other people because (for example) he really enjoys it.

The 'consultant child and adolescent psychiatrist' then speaks, using medical terminology to provide information about the 'symptoms' of ADHD, which we are told can range from 'very mild' to 'very severe' (lines 58-59). It is worth noting that the professional opinion offered throughout this video is not just that of any doctor but a 'consultant child and adolescent psychiatrist', therefore can be seen to add extra weight by using *category entitlement* (Potter, 1996). That is, certain categories of people, in particular contexts, are treated as being especially knowledgeable about particular things. Their knowledge or expertise is thus seen as taken-for-granted without having to ask how that person knows something: 'their reports and descriptions may thus be given special credence'. In Western society it is taken-for-granted that doctors are entitled to impart knowledge about illness, and that child and adolescent psychiatrists are particularly entitled to impart specialist knowledge about mental health problems in children and young people. A 'consultant' is a highly specialised and experienced doctor; this title increases the plausibility of the information even further, adding weight to its veracity. It could also be viewed as indicative of the taken-for-granted nature of ADHD-as-disease (as with other 'mental illnesses') that the professional is a doctor, without any explanation necessary as to why she is specially qualified to give an opinion on socially undesirable conduct.

The psychiatrist uses a number of extreme case formulations in lines 59-62 to indicate the abnormality of the behaviour she is describing: 'at the severe end children might not *even* be able to stay sitting down *for more than a couple of seconds*. They might run *everywhere, even* when it's *completely inappropriate*' (emphasis added). As in the accounts of Oscar and his parents, there is a contrast structure at work here to explicitly pathologise behaviour. It is not enough to say 'they might run everywhere' – it could be argued that engaging in a lot of running may seem like normal (if exhausting) childhood behaviour. Therefore the second part of the sentence, 'even when it's completely inappropriate', constructs the running as not just childish energy, or disobedience, but as *pathological* behaviour, as a 'symptom' of a mental disorder, as it is not operating within the limits of what is 'appropriate'.

This contrast structure highlights neatly what critics might view as the nuts and bolts behind 'mental disorders' – the medicalisation and pathologisation of socially undesirable behaviours. One could ask, who decides when and where it is 'completely inappropriate' to run around? Here, a child who does not comply with social rules around running behaviour is constructed not as strong-willed, naughty, energetic, a free spirit, or any other description one might come up with, but as exhibiting signs of a biological disorder.

Indeed, as the psychiatrist goes on to say, even if a child does not appear to be outwardly flouting social convention there may be a problem: 'There may be some children who are not particularly overactive and restless, but *it's really that* they can't concentrate' (lines 62-64, emphasis added). The construction 'it's really that' positions the psychiatrist as the authority on the symptoms of this disorder, providing us with the truth behind complex anomalies in ADHD cases (such as children not exhibiting symptoms who actually do 'have' ADHD). This could be viewed as a form of stake management, pre-empting people who might criticise the diagnosis being over-inclusive and applied to children with 'normal' levels of activity and restlessness. However it also broadens the diagnostic field to potentially include *any* child suspected of 'having ADHD', indicating that a lack of exhibited symptoms may not prevent a diagnosis.

3.4.2 'Ben's story' part one

I continue the accounting of abnormal behaviour with discussion of the following extract from the website of the Royal College of Psychiatrists. It is titled 'Ben's story', and is presented as the first-person account of an 11-year-old boy diagnosed with ADHD.

I originally downloaded this extract in September 2011 (see Appendix 7). However in the ensuing months, some physically minor but important changes to the text have been made which I will discuss in greater detail later. The extract below is from the original downloaded version.

Extract number: 9

065 I was always getting into trouble at school. The teacher used to tell me
066 off for not sitting still, I'd try to sit down but it was hard – I would just
067 want to get up and walk around. I was always getting into trouble for
068 talking. The other children in my class would sit still and finish their
069 work but I found this hard.

070 Mum and dad said I had a lot of energy. Sometimes my friends would
071 tell me I was over the top. Mum says she couldn't take me anywhere
072 when I was younger because I was so noisy and always on the go.

There is much important work done in this extract. The experience of ADHD is presented as an allegedly first-hand account using direct reported speech – a powerful device (Woofitt, 2005). In their study of the construction of depression in print media, Rowe et al (2003) noted how the supposedly authentic accounts of lay people tended to be supportive of medical expertise, often acting as a device to 'buttress' the dominant biomedical discourse.

There are numerous extreme case formulations here that work Ben's behaviour up as abnormal. He describes himself as '*a/ways* getting into trouble at school, *a/ways* getting into trouble for talking, *a/ways* on the go'

(lines 65, 67 and 72, emphasis added); his parents describe him as having ‘a lot’ of energy (line 70), ‘so’ noisy and his mother as not being able to take him ‘*anywhere*’ (line 71, emphasis added).

A contrast structure is used in the following sentence to further highlight the abnormality of Ben’s behaviour: ‘The other children in my class would sit still and finish their work but I found this hard’ (lines 68-69). Without the comparison to other children, Ben’s behaviour could be viewed as that of a ‘normal’ student. Many children do have trouble sitting still in class to finish their work, and there may be any number of reasons why this is so. It may be the end of the day; a subject or teacher they don’t find particularly interesting; they are tired or hungry or too hot – whatever. However, the description of other children works to construct Ben as being different, outside the norm – not only do the other children (apparently *all* the other children) finish their work but they do it while sitting *still*.

Crucially in lines 66-67, the reason Ben gives for not sitting down when he is told to, and for not finishing his work, is that he found engaging in these more socially acceptable classroom behaviours ‘hard’, implying some degree of effort on his part to try to ‘do the right thing’: ‘I’d *try* to sit down but it was *hard* – *I would just want to get up and walk around*’ (emphasis added). The implication is that Ben is not being ‘naughty’, or deliberately disobeying the teacher; there is some involuntary, underlying process at work. So ‘just want[ing] to get up and walk around’ is constructed as an action beyond his control, something he has *tried* not to do. This does important work in constructing Ben’s difficulties as being beyond his control (i.e. a biological disorder) rather than as within his own free will.

The numerous perspectives involved in this account – those of Ben himself, his mum and dad, his teacher, and his friends, all work as part of a *consensus and corroboration* device (Edwards and Potter, 1992). If many different people notice and agree on something then this adds weight to a factual construction. *Category membership entitlements* (Potter, 1996) are employed too – not only has Ben (as the ‘sufferer’ of ADHD) noticed that it is ‘hard’ for him to sit down

and finish his work, but both his 'mum' and 'dad' also report problems with his behaviour. People in certain categories are afforded particular kinds of knowledge, and the category of 'mum' or 'dad' indicates that the parent in question possesses special knowledge of their child (and perhaps other children) without further explanation required. Similarly the opinion and actions of a 'teacher', as the classroom authority, carries a particular kind of weight. Ben *always* getting into trouble with the teacher, at school, carries more weight than if he were getting into trouble with a shopkeeper for talking too loudly in a shop, or with a layperson sitting on a bus next to him.

One of the most important pieces of work is accomplished in lines 70-71: 'Sometimes my friends would tell me I was over the top'. As Potter (1996) notes: 'One of the features of the everyday use of the category "friend" is its implications of positive feelings and loyalty; friends are people you stick by' (p. 128). In Smith's seminal 1978 paper 'K is mentally ill', K's difficulties are described by someone who counts herself a 'close friend' of K's, which works powerfully to establish the facticity of the account and confirm that K's behaviour is, indeed, strange and troubling. From a young person's point of view, teachers and parents may often present as dissenting and rule-enforcing authority figures who disapprove of normal childhood mischief. However the fact that sometimes even Ben's *friends* used to tell him he was 'over the top' – that he is seen as being different even within his peer group - work to construct his difficulties, again, as definitely outside the realms of normal childhood behaviours.

In this relatively brief extract, then, work is done to construct Ben's difficulties as being present in home, school and social contexts. Indeed, as Ben's mother reported she couldn't take him 'anywhere', it could be argued this is constructing his behaviour as difficult to manage in *all* contexts.

Why is so much work going on, to construct this account of Ben's difficulties? Given the popular argument that ADHD is just a label for bad behaviour, without the work done to establish Ben's behaviour as abnormal, it might be easy for the reader to write him off as a badly behaved child. Many children

sometimes get into trouble at school, are reprimanded by teachers for talking out of turn, or find it difficult to finish their work. Many children are also often energetic, noisy and 'on the go' (this latter expression, as well as being colloquial, is also part of the DSM-IV list of hyperactivity 'symptoms'). The devices used here work hard to establish that something is not right with Ben – he is in need of professional help. Pomerantz (1986) writes, 'The social order essentially is a moral order. Extreme case formulations propose behaviours are acceptable and right or unacceptable and wrong...part of justifying a course of action may involve portraying the precipitating circumstances as *necessitating* the action' (p. 227, emphasis added). In Oscar and Ben's cases the 'course of action' to be justified is ultimately medication. As discussed in Chapter One, this can be viewed as a controversial treatment. Thus the extreme case formulations (and other rhetorical devices) in Oscar and Ben's stories can be seen as working up the severity of their difficulties to suggest that medication is required.

3.4.3 'Ben's story' part one - revisited

I wish to add a follow-up to the account of Ben's difficulties, which came about when I returned to the 'live' material on the RCP website in April 2012. This was about six months after I first downloaded text from the website; I noticed there had been various slight changes made to the content. When I looked at the copyright notice on the website I saw it had been updated only one month before, in March.

It is beyond the scope of this thesis to mention all the changes in the website text, but what particularly struck me were the subtle changes made to 'Ben's story' – supposedly a first-person factual account. Perhaps the least notable point to make is that these changes arguably confirm that 'Ben's story' is not a real first-person account, but one constructed by the RCP website's producers. This is something one might already have suspected. More relevant for the purposes of this study is how the changes help to illustrate the expert project of the factual accounting of ADHD. (See Appendix 7 for print outs of the original and revised versions of 'Ben's story').

One of the original sentences in 'Ben's story', as discussed above, reads as follows:

068a The other children in my class *would* sit still and finish their work but I
069a found this hard.

The revised sentence reads thus:

068b The other children in my class *could* sit still and finish their work but I
069b found this hard.

(emphasis added in both examples)

The substitution of the word 'could' for 'would' in line 68 does important work in this contrast structure, in that it emphasises not just the fact of the 'other children' sitting still (in contrast to Ben) but that they were *able* to sit still. Thus even more of a contrast is built up between them and Ben, who in the second part of the sentence says he found sitting still difficult. The implication is made even clearer that in contrast to his classmates, Ben's inability to sit still is *out of his control*.

In section 3.6 on 'Management of Medication' I will discuss further changes that were made to Ben's story, to the account of his being prescribed medication.

3.5 Psy-complex help required

In this section I discuss how the websites construct the role of the psy-professionals in the 'diagnosis' and 'management' of ADHD.

Extract number: 10

073 There is no single, simple, definite test for ADHD. Making a diagnosis
074 requires a specialist assessment, usually done by a child psychiatrist
075 or specialist paediatrician. The diagnosis is made by recognising
076 patterns of behaviour, observing the child and obtaining reports
077 of their behaviour at home and at school. Sometimes a
078 computerised test may be done to aid the diagnosis. Some children
079 also need specialised tests by clinical or educational
080 psychologist [sic].

(RCP website)

The fact that there are no objective physical tests available for ADHD arguably casts doubt on the construct of ADHD-as-medical-condition. However, the assertion that there is no 'single, simple, definite test for ADHD' (line 73), rather than throw doubt on this construct, works up the complexity of the disorder and the professional help required. In the absence of a 'single' test, a full diagnosis requires a 'specialist assessment', not just by any doctor but by an expert: a 'child psychiatrist or 'specialist paediatrician' (lines 74-75). To further construct the process of ADHD diagnosis as a complex one, possible diagnostic options of a 'computerised test' or 'specialised tests' are introduced - the latter to be administered by a different psy-professional, a 'clinical or educational psychologist'.

Jefferson (1990) has suggested that a three-part list can indicate completeness, or the normative status of a class of objects. Thus the three-part list in lines 75-77 can be seen to define, normalise and make routine the business of making-an-ADHD-diagnosis: 'recognising patterns of behaviour, observing the child and obtaining reports of their behaviour at home and at school.' The use of the word 'recognising' suggests that the 'patterns of behaviour' exhibited are ones with which the specialist will already be familiar,

and emphasises that there is something noticeably *different* about the behaviour of children-with-ADHD versus children-being-ordinary.

To summarise analysis of the extract above, the absence of a ‘single, simple, definite test’ for ADHD – a point which could weaken the construct of ADHD-as-disease – is here constructed as a sign of the *complexity* of the disorder and the complex professional help required. The possible involvement of four different professionals, ‘computerised’ and ‘specialised tests’, and a ‘specialist assessment’ involving ‘recognising patterns of behaviour’, ‘observing the child’ and ‘obtaining reports’ are all constructed as necessary on the road to an ADHD diagnosis.

Extract number: 11

- 081 If you are worried that you might have ADHD then you should talk to
082 someone you trust and go to see your GP.
- 083 There is no test for ADHD and so a specialist such as a psychiatrist or
084 specialist paediatrician would talk to you and maybe your parents
085 about your difficulties to find out the best way to help.
- 086 A variety of approaches including medication, behavioural therapy,
087 individual counselling, family meetings and special educational
088 provision can be effective for children and young people with
089 ADHD.

(Young Minds website for young people)

This extract, aimed at young people, introduces the idea of *worry* around suspecting oneself of having ADHD (line 81) – the implication being it is something to be worried about. As a perusal of the ‘symptoms’ of ADHD show that the line between pathology and normality is subjective rather than objective, it appears inevitable that in order to determine which side of the line one’s experiences lie on requires professional help. That is made explicit in lines 81-85: ‘You should talk to someone you trust and go to see your GP...There is no test for ADHD and so a specialist such as a psychiatrist or

specialist paediatrician would talk to you and maybe your parents about your difficulties to find out the best way to help’.

Lines 86-88 illustrate the complexity of the professional help available, with five different ‘approaches’ mentioned: ‘medication, behavioural therapy, individual counselling, family meetings and special educational provision’. The ‘help’ available for a young person’s difficulties are all technical solutions focused on changing the individual, albeit two of them framed as more ‘systemic’ approaches (‘family meetings’ and ‘special educational provision’). Indeed, this five-part list arguably represents the expert project of ADHD ‘treatment’.

Furthermore, seeking help requires a conversation with a ‘specialist’ who, on the basis of this conversation, will ‘find out the best way to help’ (lines 83-85). Therefore the type of help required is framed as something that will be ‘discovered’ by the expert, rather than, say, a mutual agreement between young people, parents and professionals.

Extract number: 12

090 If you think your child may have ADHD, it is important to talk to your
091 child’s school or nursery and to contact your GP. You can be referred
092 to a specialist such as a paediatrician or child psychiatrist who will be
093 able to assess your child, and take into account all the factors which
094 might be affecting your child’s behaviour. Only a specialist can make a
095 diagnosis of ADHD.

(Young Minds website for parents)

It is notable that a ‘nursery’ is mentioned in line 91 as a possible site of concern for a child’s behaviour. It is mentioned in an unremarkable way - ‘it is important to talk to your child’s school or nursery’ – which suggests that it is considered an ordinary event that a parent of a two- or three-year-old might think their child ‘has ADHD’. And indeed it might be a normal event, with growing public awareness of the symptoms of ADHD-as-disorder. In one

study 40 per cent of mothers described their four-year-olds as hyperactive (De Grand Pre, 2000); following current ADHD criteria, this could suggest that 40 per cent of mothers of four-year-olds should be contacting their GPs.

The nursery as site-of-concern is somewhat at odds with parental information given elsewhere on the Young Minds website, which states,

Most toddlers and young children are restless and excitable. This is normal...

How is a parent supposed to distinguish between 'normal' 'restless and excitable' behaviour and that which involves a talk with the nursery and contacting one's GP? The answer lies with the psy-complex – educational and medical professionals (lines 91-92) who hold special knowledge to help parents separate the ordinary from the pathological in their children. As Rose (1989) writes, 'The almost inevitable misalignment between expectation and realisation, fantasy and actuality, fuels the search for help and guidance in the difficult task of producing normality, and powers the constant familial demand for the assistance of expertise' (p. 132).

Lines 94-95 describe the one specified end of the process of thinking-your-child-may-have-ADHD: a 'specialist' making a diagnosis. The mention of 'all the factors which might be affecting your child's behaviour' (lines 93-94) implies that there might be reasons apart from ADHD for problematic behaviour, but these 'factors' are not explained in further detail, thus leaving dominant the ADHD explanation. Despite the suggestion of initial contact with lower-level professionals, the diagnostic process is now constructed as the business of experts, taking management of ADHD out of the realm of the parent, lay person, teacher, or even ordinary doctor: 'You can be referred to a specialist...only a specialist can make a diagnosis of ADHD' (lines 91-95).

In the extracts above, 'making a diagnosis' is constructed as almost a foregone conclusion once a child visits the doctor. This observation supports the work of McHoul and Rapley (2005) whose analysis of talk-in-interaction

showed how 'routine and mundane' it is for children to be diagnosed with ADHD (and subsequently medicated) simply by presenting at the doctor's office to explore the possibility of the disorder.

Extract number: 13

096 Teachers and parents may need to use behavioural management
097 strategies like reward charts. Parents/family may find parent training
098 programmes helpful, especially in managing the defiant behaviours
099 which may arise from their hyperactivity.

(RCP website)

In this extract, some of the help on offer is described, in the professional language of technological solutions: 'behavioural management strategies' and 'parent training programmes' (lines 96-98). In lines 98-99, 'defiant behaviours' caused by 'hyperactivity' are targeted as a specific site of intervention. As Breggin (2001) points out, arguably the most problematic aspect of so-called ADHD behaviours is the challenge they present to authority figures (Breggin, 2001). Such descriptions continue to work up the complexity of the disorder, with associated professional interventions available.

Graham (2008) suggests that psychologists have gained a role as 'key players' in managing and treating ADHD, alongside psychiatry, because medication has not provided a satisfactory solution to the ADHD 'problem'. Therefore 'psychologists have successfully argued for a multi-modal approach to the treatment and management of ADHD through behaviour modification techniques and management programmes...thus have secured a legitimate place in the space surrounding the "behaviourally disordered" child.' (p. 19).

3.6 Management of medication

In this section I discuss how the issue of medication is constructed and managed. First, I present the original extract of 'Ben's story' which deals with medication (the one downloaded in September 2011). I also present my analysis of this extract, which I wrote before seeing the March 2012 updated version on the website. I originally considered deleting the aspects of my analysis which dealt with the old version, but then thought it would be a useful 'real life' example of just how a few words can significantly alter a discursive psychology analysis.

3.6.1 'Ben's story' part two

Extract number: 14

100 In the end, mum and dad took me to a clinic for children who have
101 problems. They said I have ADHD and talked to my parents and
102 teachers about how to help me. They gave me some medication –
103 Ritalin. My mum and dad think it helps. I don't seem to get told off so
104 much and can do my school work better.

The scene-setting construction 'in the end' (line 100) implies that Ben's parents did not take him to a clinic as a 'quick fix', or as soon as his difficulties started, but possibly as a last resort; the difficulties had been going on for a long time before they sought help. 'A clinic for a children who have problems' (lines 100-101) constructs the problems as being something internal to the children, a part of them – not as occurring within the family, wider environment or society. 'They said I have ADHD' (line 101) employs the dominant biomedical discourse – ADHD is something one can 'have', like measles or mumps. The unnamed 'they' are also positioned as experts, the purveyors of knowledge – it is they who make the diagnosis and provide helpful information to Ben's parents and teachers. It is important to note that this is constructed as help for Ben – 'how to *help me*' (line 102, emphasis added) – rather than help for Ben's parents and teachers, who are arguably the people who find Ben's behaviour most problematic. This works to suggest that all involved –

the unnamed professionals, parents and teachers – are intervening for *his* benefit, rather than their own.

This work to establish the motives of those in authority is important, as the next sentence tells us that the help ‘they’ gave Ben is ‘some medication - Ritalin’. It is interesting that this brand name of methylphenidate is specifically mentioned, given the controversy surrounding it and indeed the ‘almost iconic status’ of the drug (Singh, 2002, p. 578). For many people, ‘Ritalin’ is synonymous with the over-medication of young people. Perhaps this is why it’s specifically mentioned: Ritalin may have received a bad rap elsewhere, but according to Ben’s account, this is what’s helped him. Or rather, *other people* seem to think it has helped Ben – ‘my mum and dad think it helps’ (line 103). Given that parents are the named audience of this particular website text, this works to position Ritalin as a helpful treatment from the point of view of ‘ADHD parents’. Ben also says he doesn’t *seem* to get told off so much and can do his schoolwork better. This works to construct Ritalin as offering further help for Ben, allowing him not only to escape behavioural sanction but achieve academically.

However, we are not told directly whether *Ben* thinks it helps him. He says that he doesn’t ‘seem to get told off so much and can do [his] schoolwork better’ (lines 103-104), but this is not the same as feeling that the medication helps *him*, Ben. However, if ADHD behaviours are viewed as a problem of social control and medication the solution (Baldwin and Cooper, 2000) then in those terms, Ritalin is achieving its aims. The notion of academic improvement, however, may be somewhat misleading, since a number of studies have demonstrated that use of stimulant medication does *not* lead to better educational outcomes (e.g. Timimi, 2011; Western Australia Department of Health, 2010).

The statement elsewhere on the RCP website that ‘not all children with ADHD will need medication’ (line 125, discussed below) could be seen as ‘stake inoculation’ against the sceptics’ interpretation that, of course, a website run by psychiatrists will focus on the benefits of medication. And other non-

pharmacological treatments are described on the website. However, this supposedly first-person account constructed in a young person's own words, not those of a medical professional, ascribe the improvement in ADHD 'symptoms' to taking Ritalin. Given the acknowledged power of direct reported speech in factual accounting (Wooffitt, 2005), this first-person account may arguably carry quite a lot of weight with readers. Furthermore, in 'Ben's story', medication is not just presented as a successful treatment but as the *only* treatment.

3.6.2 'Ben's story' part two – revisited

As with the first part of 'Ben's story', the revised RCP website featured some apparently minor but important changes in text which I will now discuss (see Appendix 7 for the original and revised printed versions).

The original text read as follows:

100a	In the end, mum and dad took me to a clinic for children who have
101a	problems. They said I have ADHD and talked to my parents and
102a	teachers about how to help me. They gave me some medication –
103a	Ritalin. My mum and dad think it helps. I don't seem to get told off so
104a	much and can do my school work better.

The revised text reads as follows:

100b	In the end, mum and dad took me to a clinic for children who have
101b	problems. They said I have ADHD and talked to my parents and
102b	teachers about how to help me. They gave me some medication
103b	which I take every day. Everyone thinks it helps. I don't seem to
104b	get told off so much and I can sit and do my school work now.

My analysis of the original text (seen above) expressed surprise that the controversial brand name of 'Ritalin' was mentioned (line 103a). It has been deleted from the revised version of 'Ben's story', replaced with the phrase 'which I take every day' (line 103b). As discussed, 'Ritalin' has secured a place in popular culture as an indicator of the over-medication of children, and the medicalisation of social problems. It is therefore perhaps unsurprising that

the RCP website producers would wish to remove this controversial brand name from their page. They have instead chosen to describe the medication as one which, in Ben's words, 'I take every day'. This constructs him as unproblematically compliant with his medication, which he takes on a daily basis, thus setting up the business of taking-medication-for-ADHD as a routine regular activity, like brushing one's teeth.

In the original version, I suggested that membership categorisation devices were used to work up 'Ritalin' as something Ben's 'mum and dad' think is helpful (line 103a). 'Mum and dad' has been replaced with the extreme case formulation 'everyone' (line 103b). Thus now the medication (with controversial brand name removed) is seen as helpful by *everyone*, rather than just Ben's parents. What Ben himself thinks of the medication is still not made explicit in this revised version – although the suggestion that he is compliant with the daily dose is perhaps seen as evidence enough by the website's producers.

The revised version has replaced 'can do my school work better' (line 104a), with 'can sit and do my school work now' (104b). This new version adds an extra dimension to the success of the medication. It has not only given Ben the ability to do his school work better, but to *sit* and do it – 'sitting still' being a crucial part of appropriate classroom conduct that we were previously told Ben found difficult compared to his peers. Furthermore, by the replacement of the word 'better' with 'now', this constructs Ben as having the ability to do his school work at all - the implication being he was entirely unable to do it before commencing medication.

I now discuss an extract from 'Oscar's story' on the NHS website video which deals with the issue of medication.

3.6.3 'Oscar's story'

Extract number: 15a

105 Psychiatrist: Medication can definitely help some children,
106 particularly those who've got more severe difficulties
107 where it's really holding them back at home and school.

Emphasis is added to the psychiatrist's account with the use of 'definitely' (line 105). Work is then done to contextualise exactly when medication might help – with 'those who've got more *severe* difficulties where it's *really holding them back at home and school*' (lines 106-107, emphasis added). The use of 'severe' and 'really holding them back' contributes to an extreme case formulation, and sets out what a child might be faced with – obstacles to success in multiple contexts. Furthermore, the child's 'difficulties' are given the 'status of first causes' (Boyle, 2011) and constructed as the cause of problems at 'home and school' – rather than, for example, family disturbance or inadequate teaching leading to problems for the individual in home and school settings.

Extract number: 15b

108 Oscar's mother: It was his school that first raised the issue and then we
109 saw a paediatrician. And I think the argument that the
110 paediatrician made that was most powerful was, 'You
111 can either carry on without and he'll struggle to
112 concentrate at school as he is now, or you can get him
113 taking Ritalin and it will allow him to concentrate and
114 he'll make much more of his schooling.

Quite a lot of important work is done in this extract. Oscar's mother tells us that it is Oscar's school 'that first raised the issue' (line 108) – the issue at hand is not specified, but in the context can be inferred to be the topic of 'prescribing Oscar medication'. They then turn to their visit to the 'paediatrician' (line 109), drawing on the category entitlement of this particular

kind of person – a doctor who specialises in treating illnesses in children – as adding credibility to their account. Holt (1996) suggests that direct reported speech is often used when it seems especially important to provide evidence of what a person said on a particular occasion. Given the popular controversy around ADHD medication use in children, the parents are arguably absolving themselves of blame for the decision to medicate by using the paediatrician's speech to construct the importance of 'Ritalin'.

In lines 109-110, 'the argument the paediatrician made that was the *most powerful*' (emphasis added) suggests that this was only one of several powerful arguments in favour of medication, this being the *most* influential. The choice the paediatrician gave the parents is presented in stark terms: either they do not give him medication and 'he'll struggle to concentrate at school as he is now' (lines 111-112), or they 'get him taking Ritalin' and 'it will allow him to concentrate and he'll make much more of his schooling' (lines 112-114). Ritalin is afforded agency here – it becomes something that will *allow* Oscar to concentrate – and academic attainment is constructed as the most 'powerful' reason to administer the drug. That this does not require further explanation highlights the importance of academic achievement in Western society, although as noted in my discussion of 'Ben's story', section 3.6.1, the research evidence supports no link between medication use and improved school performance (e.g. Timimi, 2011; Western Australia Department of Health, 2010).

Extract number: 15c

115	Oscar:	The Ritalin makes me feel... [hesitation] It does help with my
116		concentration, yes, but I don't really like the idea that I'm taking
117		drugs. It hasn't really changed many of my hobbies, actually. I
118		still like to do the same things.

Oscar begins his account by starting to say how the Ritalin makes him feel – a sentence he does not finish. It is unclear in the video if this was a natural hesitation on Oscar's part, followed by an unfinished sentence, or if the clip has been edited so it just looks like an unfinished sentence but in fact Oscar

went on to say something else. One could infer that the adjective he was looking for (or used in an unedited version) might have been a negative one, as he goes on to say, 'It does help with my concentration, yes, *but I don't really like the idea that I'm taking drugs.*' (lines 115-116, emphasis added). Here Oscar is agreeing that although the Ritalin helps his concentration he does not like the idea of the means to an end – of 'taking drugs'. Oscar then works to construct himself as unchanged by the medication: 'it hasn't really changed many of my hobbies, actually. I still like to do the same things' (lines 117-118). Would this include running around, one wonders? The key message given at the end of Oscar's talk seems to be 'I'm still me', despite 'the drugs' – a message that might seem important to put across to young people watching the video.

Although non-pharmacological treatments were discussed in the main text of the websites, It is notable that in these two first-person accounts, medication is the only treatment mentioned – despite the most recent NICE guidelines (2009):

Drug treatment is not indicated as the first-line treatment for all school-age children and young people with ADHD. It should be reserved for those with severe symptoms and impairment or for those with moderate levels of impairment who have refused nondrug interventions, or whose symptoms have not responded sufficiently to parent-training/education programmes or group psychological treatment' (p. 26).

These guidelines may help to explain why Ben and Oscar's difficult behaviours are constructed as so extreme and abnormal in the above accounts. Arguably the implication is that they are experiencing 'severe symptoms and impairment', thus justifying the use of medication in these first-person accounts without reference to non-pharmacological treatments.

3.6.4 Management of medication in text extracts

I conclude this section with consideration of two short text extracts below.

Extract number: 16

119 Medications can play an important role in managing moderate to
120 severe ADHD. Medications can help to reduce hyperactivity and
121 improve concentration. The improved concentration gives the child
122 the opportunity and time to learn and practise new skills. Children
123 often say that medication helps them to get on with people, to think
124 more clearly, to understand things better and to feel more in control of
125 themselves. Not all children with ADHD will need medication.

(RCP website)

The 'important role' of medication is discussed here, with agency ascribed to medication as something that can 'manage' 'moderate to severe ADHD' (lines 119-120). 'Not all children with ADHD will need medication' (line 125) could be seen as a form of stake inoculation (Potter, 1996) against the popular criticism that doctors are over-medicating children. However this statement follows a four-part list describing the positive things 'children often say' about taking medication (lines 122-125); therefore the complete effect is to portray medication as something not always *necessary* perhaps, but quite *desirable*. By describing what 'children often say' about the (positive) effects, this extract appears to take a 'child-centred' approach to the controversial issue of medication. It is not medical professionals, teachers, or parents who are constructed as advocates for pharmacological intervention, but *children themselves* who report that medication improves their social skills, thinking and comprehension, and self-control.

The issue of controversy around medication use and possible ambivalence is discussed in the following extract, from the Young Minds information for young people:

Extract number: 17

126 Some people feel the medication is too strong for children. Other
127 people think it is really helpful. Talk about it with your parents or carers
128 and get the doctor to explain all about it. Ask any questions if you are
129 not sure about anything. You should have regular reviews, which is
130 the case with most medications, so if you don't feel happy taking it
131 then you can always bring it up with your doctor at a later date.

(Young Minds for young people)

At first glance, this extract could be seen to even-handedly present both 'sides' of the medication debate in ADHD. We are told that 'some people' feel the medication is 'too strong for children' (line 126) and 'other people' think medication is 'really helpful' (lines 126-127). However I would argue that 'too strong' is not an accurate countering description to 'really helpful'. A more appropriate countering statement might read, 'Some people feel the medication is really unhelpful' or 'Some people feel the medication is really harmful'. 'Too strong' implies that some people view the medication as inappropriate for children because it produces a very intense effect or is intense in its efficacy – rather than it being considered by some to be of clinically insignificant efficacy at best and toxic at worst (Timimi, 2005; Breggin, 2001). Furthermore, the addition of 'for children' (line 126) implies that even its critics might accept ADHD medication is appropriate for adults or adolescents.

The word 'children', when applied to adolescents, can arguably be viewed as a rather pejorative description. I can imagine many teenagers I know (including myself, once upon a time) reading that sentence and exclaiming indignantly, 'But I'm not a child!' Given that adolescents or 'young people' are as likely to be reading this website as younger children, and given the oft-quoted strong desire of adolescents to be treated as young adults, arguably many of the readers could write off that counter-argument as inapplicable to them: 'The medication wouldn't be too strong for me because I'm not a child anymore'. Discounting something as inappropriate for small persons – 'too

strong for children’ – can be seen as a typical ‘grown-up’ perspective, and arguably constructs ADHD medication as falling into the category of too much junk food or TV.

In lines 127-129, young people are encouraged to ‘talk about it with your parents or carers’, ‘get the doctor to explain all about it’ and ‘ask any questions if you are not sure about anything’. The use of the singular *doctor* implies that there is one medical professional young people are expected to consult if they have doubts about taking the medication, rather than second or third opinions. This advice positions the young person as in a position lacking knowledge or certainty, while the doctor is able to answer questions and ‘explain all about’ the condition and medication. The end result of knowledge-seeking and lack of certainty is framed as inevitably one of taking medication: ‘You should have regular reviews, which is the case with most medications, so if you don’t feel happy taking it you can always bring it up with your doctor at a later date’ (lines 130-131). Here the young person taking the medication is presented as a *fait accompli*, with the proviso that the young person ‘can’ bring up any concerns with the doctor ‘at a later date’, in one of the ‘regular reviews’, which constructs ADHD as like any other prescription drug.

To summarise, this extract could be viewed unproblematically as addressing issues of controversy over medication, and reminding young people of their right to ask questions and seek information. However, it could also be viewed as adding weight to the view that medication acts intensely and effectively; that some people feel it is inappropriate ‘for children’ but its use in adolescents and adults is uncontroversial; and that the natural end result of uncertainty around medication use is a prescription.

4.0 CONCLUSION

I begin the final chapter of my thesis by offering a summary of my analysis and discussion, and comparing my findings to some of those from the literature. I then discuss implications for clinical and research practice. Lastly I present a critical review of this study, before ending with some final reflections.

4.1 Summary of analysis and discussion

I return first to the initial aims of the study. These were to examine on a local level how ADHD is constructed in some online information aimed at parents and young people; and the function of these constructions.

Firstly, and perhaps most importantly, this analysis suggested that the fine-grained use of particular words and rhetorical devices may be crucial in the factual accounting of ADHD in official information. This is at odds to the perspectives of traditional psychology models which view language as incidental in descriptions of mental health difficulties, particularly those produced by more official or 'objective' sources. That this is not an unconscious process, and that language is chosen carefully and deliberately, may be illustrated in the two different versions of 'Ben's story' (allegedly a first-person account) constructed by the Royal College of Psychiatrists.

In all website texts, ADHD was constructed uncontroversially as a medical condition, using biomedical and empiricist discourse to work this up as a real, concrete, psychiatric disorder. Environmental factors, if mentioned, were positioned as vague, or as secondary to biogenetic factors, and constructed within the framework of the biomedical model.

Abnormal behaviour was constructed in the website's 'first-person accounts' using a variety of rhetorical devices. These devices constructed ADHD-labelled behaviour not just as problematic but pathological; as signs of a disorder outside a young person's control. Generally, childhood behaviour was constructed as existing on either side of a pathology/normality divide. That this distinction is unclear; that there are no tests for ADHD; and that it

appears impossible for the layperson to distinguish between 'normal' and 'ADHD' behaviours; were used to add to the *complexity* of the disorder, the diagnostic process, and the treatment required, once a diagnosis was made. The confusion around ADHD symptoms, therefore, was evidence of the need for expert assistance, constructed (to put it in psy-professional terms) as complex multi-modal treatment requiring a multi-disciplinary approach. Arguably the primary intervention for ADHD was constructed as stimulant medication (descriptions of other interventions notwithstanding). This was evidenced by first-person accounts on different websites which constructed medication as being not just the most desirable treatment but the *only* treatment. Negative feelings towards medication, voiced by one young person, were left unexplored (cf. 'Oscar's story'). The success of ADHD medication was measured by others' judgement, rather than the young person's in the other first-person account (cf. 'Ben's story').

There was some variability in accounts both between and within websites. This was most striking on the RCP website, when as discussed, two different versions of a so-called first-person account appeared on the website at different times. There was also notable variability on the Young Minds website, which featured different explanations for the causes of ADHD in the separate sections for parents and young people. Members of the same family looking at this website could be forgiven for remaining somewhat confused as to the 'facts' on ADHD.

4.2 How my analysis compares to other studies

The findings from my study echo a number of those from similar literature which I discussed in Chapter 1. Firstly, the dominance of biomedical constructions of ADHD in the media (Norris and Lloyd, 2000; Schmitz, Fillippone and Edelman, 2003) and in naturally occurring talk and text (Hewlett et al, 2005; McHoul and Rapley, 2005) has been well documented. My findings also reflect the study of Hewlett et al (2005) in that the behaviour of children with ADHD was constructed as being outside their control, therefore giving credence to the construct of ADHD-as-disorder.

Lloyd and Norris (1999) noted that expert discourse in press coverage of ADHD did not indicate any controversy or professional disagreement surrounding the diagnosis, which was also true of the officially produced material in this study.

In my analysis, expert professional assistance was constructed as necessary in the 'treatment' of ADHD, as discussed by McHoul and Rapley (2005) . The need for professionally designed 'technological interventions' to treat ADHD, such as behavioural management and parent training, was also noted in the work of Pajo and Stuart (2012) and Rafalovich (2001), authors who analysed the construction of ADHD in self-help parenting texts. Furthermore, Pajo and Stuart (2012) also observed the dominance of pharmacological treatment in ADHD constructions.

4.3 Implications for clinical practice

4.3.1 Popularisation

Potter and Wetherell (1987) describe various models for the practical application of discourse analytic findings. One of these is popularisation, or giving the knowledge away freely (Miller, 1980). Atkinson (1984) suggests that an audience made aware of the use of rhetorical devices in discourse may respond to speeches in a more critical manner. Similarly, if the uses of rhetorical devices in 'mental health' information were publicised, this might facilitate an audience viewing such texts with a more critical eye.

4.3.2 Working with parents and children

Baldwin (2000) notes that some parents who refuse medication for their ADHD-diagnosed child may find themselves under pressure to conform (cf. McHoul and Rapley, 2005) and we can be alert to this as critical practitioners. If necessary, clinical psychologists could support such parental decisions in the face of pressure from biomedically minded psy-colleagues. It could be argued that more critical members of the psy-complex have a moral duty to ensure that young people and parents are aware of the risks inherent in stimulant medication, and research evidence that does not support

its widespread prescription (cf. Jensen et al, 2007; Western Australia Department of Health, 2010). My analysis suggests that official information available to parents and young people constructs ADHD in particular limited ways; therefore critically minded psy-practioners working with them could signpost alternative, more critical sources of information. This could include American psychiatrist Peter Breggin's website addressing child psychiatric medication practices (http://www.breggin.com/index.php?option=com_content&task=view&id=38) or the writing of UK psychiatrist Sami Timimi (e.g. *Naughty Boys: Anti-social behaviour, ADHD and the role of culture*, 2005). Such information would at least provide a 'balancing' perspective to the dominant 'biopsychiatric rhetoric' (Baldwin and Anderson, 2000, p. 83).

4.3.3 Making context of paramount importance

How clinicians talk to parents and young people about difficulties is crucial. This talk, in assessment, formulation and intervention, should continually emphasise the role of environmental and social factors in their experiences (Baker and Newnes, 2005).

Boyle (2011) notes that challenges to the biomedical model of mental illness often emphasise the importance of environmental and social factors in causing a particular disorder. However, these challenges still employ biomedical terms such as 'symptoms' or 'disorders', thus the debate becomes one about the causes of mental disorder rather than the construct of 'mental illness' itself. Rather, Boyle suggests that clinicians emphasise the 'intelligibility' of emotional distress and difficult behaviours, making context paramount, in 'every presentation of distress, in theory, research, teaching, case discussions, media presentations and everyday conversations between service users and professionals' (p. 40). Indeed, one task for critics of the construct of ADHD-as-disorder may be to demonstrate how in many ways these children are just 'doing being ordinary', based on their lives, relationships and experiences, and the wider society in which they are growing up.

4.3.4 Lobbying for change, and political action

On a small, local level, lobbying for positive change could include ensuring that one's community library held copies of more critical ADHD literature, in addition to the mainstream ADHD parenting books.

Another possibility, on the basis of my findings, is to lobby websites such as Young Minds to provide clear information on the following:

- Acknowledge the considerable controversy around the ADHD diagnosis (and other mental disorders)
- Clearly acknowledge and implicate environmental influences on childhood distress, including findings from published research
- Provide clear information on controversy linked to medication use, which would mean not only listing side effects but include research demonstrating no long-term benefits and increasing concerns over long-term effects.

This approach could be used with other providers of mental health information. Moynihan, Heath and Henry (2002) suggest that ideas of 'informed consent' should be broadened to include 'information about controversy surrounding the definitions of conditions and diseases', rather than implying to the general public that the existence of ADHD (or any other mental health condition) is as uncontroversial as the existence of a physical illness such as cancer or diabetes.

Critics of the dominant construct of ADHD could also work with (or borrow tactics from) other detractors of the medical model of 'mental illness'. For example, the Inquiry into the 'Schizophrenia' Label (ISL) is 'an independent inquiry into the usefulness of "schizophrenia" as a diagnosis and medical condition...supported by national and international organisations, groups and individuals' (www.schizophreniainquiry.org). This campaign has partly gained endorsement through its presence on the internet; supporters of the ISL are encouraged to 'Facebook' or 'Tweet' details of the inquiry on social networking

sites. Perhaps in the future www.adhdinquiry.org could be a viable webpage with similar support.

One success story for campaigning against the ADHD diagnosis and stimulant medication is Western Australian politician and former teacher Martin Whitely. He was elected to the Western Australian parliament in 2001, when ADHD prescribing rates in the state capital Perth were among the highest worldwide. His activism helped to cut child stimulant prescribing rates in Western Australia by 60% in seven years, at a time when ADHD prescription rates in other parts of Australia and other Western countries, including the UK, were rising rapidly. This led to a corresponding 50% decrease in adolescent amphetamine abuse rates in the region (<http://speedupsitstill.com/>).

Beyond the ADHD diagnosis, Timimi (2010) suggests critical psy-practitioners need to become involved in

‘wider social and political debates about children’s development, mental health, protection, and their relationship to economy, adversity, culture and inequality’...[and] support policies likely to promote more pro-social value systems, reduce social inequality, and forge stronger more cohesive families and communities’ (p. 702).

4.4 Implications for research

4.4.1 Analysis of more specific features in official ADHD discourse

Given practical considerations such as time, space and word counts, there was a limit to the amount of material I could present in this thesis. I was aware while writing it up that there was a considerable amount of material on the websites that I could not present in detail. My analysis presents specific examples of some of the most salient features on the websites I perused, examining how they were constructed. Suggestions for future research include studies focusing specifically on how *one* aspect of ADHD is constructed in official information, such as behavioural interventions, or medication side effects.

4.4.2 Analysis of other sources of ADHD information

A similar discursive psychology approach could be used to examine constructions of ADHD in numerous other texts. This could include the construction of ADHD in discussion threads on internet forums; in online blogs; or parenting programmes on TV.

4.4.3 Involving young people and parents

This study did not involve participants as active members of the research process or in analysis of the material, thus obviously privileging my interpretation of the texts over interpretations made by the intended audience. A future study could invite young people to deconstruct official information on ADHD to see what sense they make of these constructions. Clark et al (2008) conducted similar research, led by young people, exploring how young people are portrayed in the media. A related study could involve asking parents of ADHD-diagnosed children to deconstruct the same information.

4.4.4 Mothers and fathers, boys and girls

Future research could investigate ADHD constructions specifically directed at mothers versus ADHD constructions directed at fathers in textual material. Alternatively, a discursive psychology approach could be used to examine naturally occurring talk from mothers and fathers to see how their talk compares. Some suggestions for source material include the NHS video from my study featuring commentary by both Oscar's mother and father; a *Supernanny* episode dealing with ADHD; or internet support forums where the separate voices of mothers and fathers can be discerned. Future research could also examine constructions of ADHD in boys versus ADHD constructions in girls, in naturally occurring texts or talk.

4.5 Critical Review

There are numerous aspects of my research that could be examined critically; however, due to space limitations I have chosen to examine a few specific points in more detail. I then turn to an appraisal of the quality of my study.

4.5.1 The digital divide

The analysis of online texts raises questions about the socioeconomic 'digital divide', and whether my study is privileging analysis of texts that may only be accessed by select groups in society. Recent research suggests that although 99% of professionals own a home computer, only 65% of the long-term unemployed do (Office for National Statistics, 2011). I would argue that this latter still seems a relatively high number; furthermore, increasing numbers of people are accessing the internet using mobile phones. There is also widespread free internet access in school and libraries. The issue of the 'digital divide' appears more relevant across age groups – over 65s are less likely than younger people to regularly access information on the internet or feel confident doing so (Office for National Statistics, 2011).

Furthermore, all the texts were deliberately chosen for their status as mainstream, official material; therefore one could reasonably expect them to strongly resemble the printed information provided at GP surgeries and Child and Adolescent Mental Health Services (CAMHS).

4.5.2 Parents, children and gender

I have referred to information aimed at 'parents' rather than specifically 'mothers' or 'fathers' throughout this study, because this is how information was framed in the texts. However, it has been suggested that even in societies where there have been significant changes in gendered parenting practices, a persistent culture of mother-blame still exists (Malacrida, 2001). By this rationale, professionals may well view a 'difficult child' as an indicator of maternal pathology, particularly in relation to the ADHD diagnosis which has been constructed as partly relating to, from a historical perspective, 'the intimate association between a problem boy and his problematic mother' (Singh, 2002, p. 580). Timimi (2006) notes that mothers and fathers frequently

disagree about whether or not their ADHD-labelled child's behaviour is pathological (Timimi, 2006). In section 4.4.4 above I discussed how possible differences between mothers and fathers could be addressed in future discursive psychology studies.

I have also referred to 'children' and 'young people' rather than 'boys' or 'girls' throughout the study, despite much higher diagnosis and medication rates in boys (Timimi, 2006). There are a number of different theories for this, as discussed in section 1.9. I chose not to engage specifically with the issue of gender in my analysis as the information on websites was all purportedly directed at the non-gender-specific categories 'children' and 'young people' (although, unsurprisingly, both 'first-person' accounts were from the perspective of boys). Again, in section 4.4.4 above I suggest ways this could be addressed in future research.

4.5.3 'Micro' versus 'macro' approach

There was a wide selection of potential materials to analyse, as discussed in section 2.5. I deliberately took a 'micro' approach to text analysis, which necessarily meant I focused on *depth* at the expense of *breadth* in my approach. This is consistent with a 'hybrid' discursive psychology approach (cf. Hewlett, Hansen and Rapley, 2005). However, an alternative approach would have been to conduct a discourse analysis on more of a 'macro' level (cf. Horton-Salway, 2010) thus searching many more websites looking for broad interpretative repertoires.

Each approach has its strengths and limitations. However, had I conducted this study using a broader analytic approach, I would have been more likely to miss the subtle but important changes made to 'Ben's story' on the RCP website. This was an important aspect of my findings: the very deliberate use of language in professionally constructed information, and the evident careful editing which produces different versions of reality to the public at different points in time.

4.5.4 Generalisability

As with any discourse analytic research, I am not seeking to generalise my findings to wider populations, as is the aim of quantitative investigation. However, returning to the words of Schlegoff in Sacks (1992) which I discussed in section 2.5.1: 'Order...is present in detail on a case by case, environment by environment basis. A culture is not then to be found by aggregating all of its venues; it is substantially present in each of its venues.' Therefore, as with other 'local level' analyses (cf. McHoul and Rapley, 2005) the material presented here – extracts from three official UK sources of information, easily accessed on the internet – can reasonably be expected to be found elsewhere and on a wider scale. Certainly my perusal of various officially produced ADHD-related websites, for the purposes of this study, suggest that the material I have presented is not an isolated cluster of unusual texts (cf. the quotation at the beginning of my study, from www.netdoctor.co.uk).

4.5.5 Reflexivity and language

Reflexivity is a key issue in discourse analytic research (Wooffitt, 1992), and as Potter and Wetherell (1987) suggest, 'Arguments about the constructive nature of language use apply also to [researchers'] own writings, including the discourse through which such observations are made...' (p. 182). While writing up this study, I have been reflecting on my own use of spoken and written language. For example, in this thesis I am aware that I have used rhetorical devices to analyse others' rhetorical devices – extreme case formulations and three part lists, to name two. However, Potter and Wetherell (1987) also point out that making such observations about one's own 'discourse on discourse' does not invalidate or undermine the work:

'It is possible to acknowledge that one's own language is constructing a version of the world, while proceeding with analysing texts and their implications for people's social and political lives. In this respect, discourse analysts are simply more honest than other researchers, recognising their own work is not immune from the social psychological processes being studied'.
(p. 182)

On that note, it is important to point out that this analysis has been actively constructed by me (Harper, 1999) and is presenting one version of a small part of the world. As Stainton-Rogers (1991, p. 10) proposes, 'I am not telling it "like it is", but rather saying "look at it this way"'.

4.5.6 Quality

Antaki, Billig, Edwards and Potter (2003) suggest a number of key areas in which discourse analysis of talk and texts can be lacking. I now summarise these points and clarify how I have tried to avoid these shortcomings in my study.

1. Under-analysis through summary

I felt one of the benefits of conducting a 'micro' level analysis was the necessary focus on specific words and phrases, asking myself, 'What is that *doing* there?' This helped to avoid the issue of merely presenting the text as a prose summary, or of summarising general themes, without giving specific examples and explaining the function of the language.

2. Under-analysis through taking sides

Given my position as a researcher (as stated at the beginning of Chapter One) this could have been a relatively easy pitfall. I was not approaching this research from a more positivist neutral perspective. Antaki et al (2003) note that evidence of 'the analyst's own moral, political or personal stance...*on its own* is not discourse analysis' (emphasis added). Therefore although there may be evidence of my personal stance towards the construction of ADHD in these materials, I have not let that stand as analysis *in itself* but rather have supported my position with an analysis of material in the text.

3. Under-analysis through over-quotation or through isolated quotation

I aimed for a balance of quotations interspersed with my commentary throughout the analysis. I was careful to analyse each extract I presented rather than (for example) stand-alone sentences. Although I was not presenting the website contents in their entirety in my analysis, I was mindful of not taking extracts out of discursive contexts.

4. The circular identification of discourses and mental constructs

I have not framed 'ideologies, repertoires or discourses' in the texts as being produced by ideologies, repertoires or discourses, which would be circular identification. Rather, my approach examined the construction of ADHD through an analysis of the specific use of language.

5. False survey

I have stated that my findings are not generalisable to a wider population, as per discursive psychology design. At the same time, I am suggesting (cf. McHoul and Rapley) that one *may* reasonably expect to find similar constructions of ADHD elsewhere in professional materials. This proposal is qualified, however, rather than trying to claim absolute generalisability.

6. Analysis that consists of simply spotting features

I would have been doing this had I simply pointed out, for example, 'a three part list and two extreme case formulations were used in the extract', without further explanation. Although I have specifically named rhetorical devices used, I have explained in each case what the rhetorical device was accomplishing in the particular context, rather than just 'spotting features' of the discourse.

4.6 Final Reflections

This has been an absorbing but sobering area of study for me, especially as I hope to work with children and families after qualifying as a clinical psychologist. Newnes (2011) writing on 'toxic psychology' and ADHD, describes the role of clinical psychologists in actively 'assessing and labelling' people (p. 221) including children 'with' ADHD: 'This is perfectly in step with child psychiatrists who then prescribe medication in order to suppress the conduct' (p. 222). Newnes describes few clinical psychologists speaking out against such harmful practices, and many who appear to maintain the 'status quo of assessment and treatment in the context of such services' (p. 222). The business of doing this research, de-constructing some official information on ADHD designed for parents and young people, has made me think seriously about how I want to work as a critical clinical psychologist, and how I may help to challenge the status quo.

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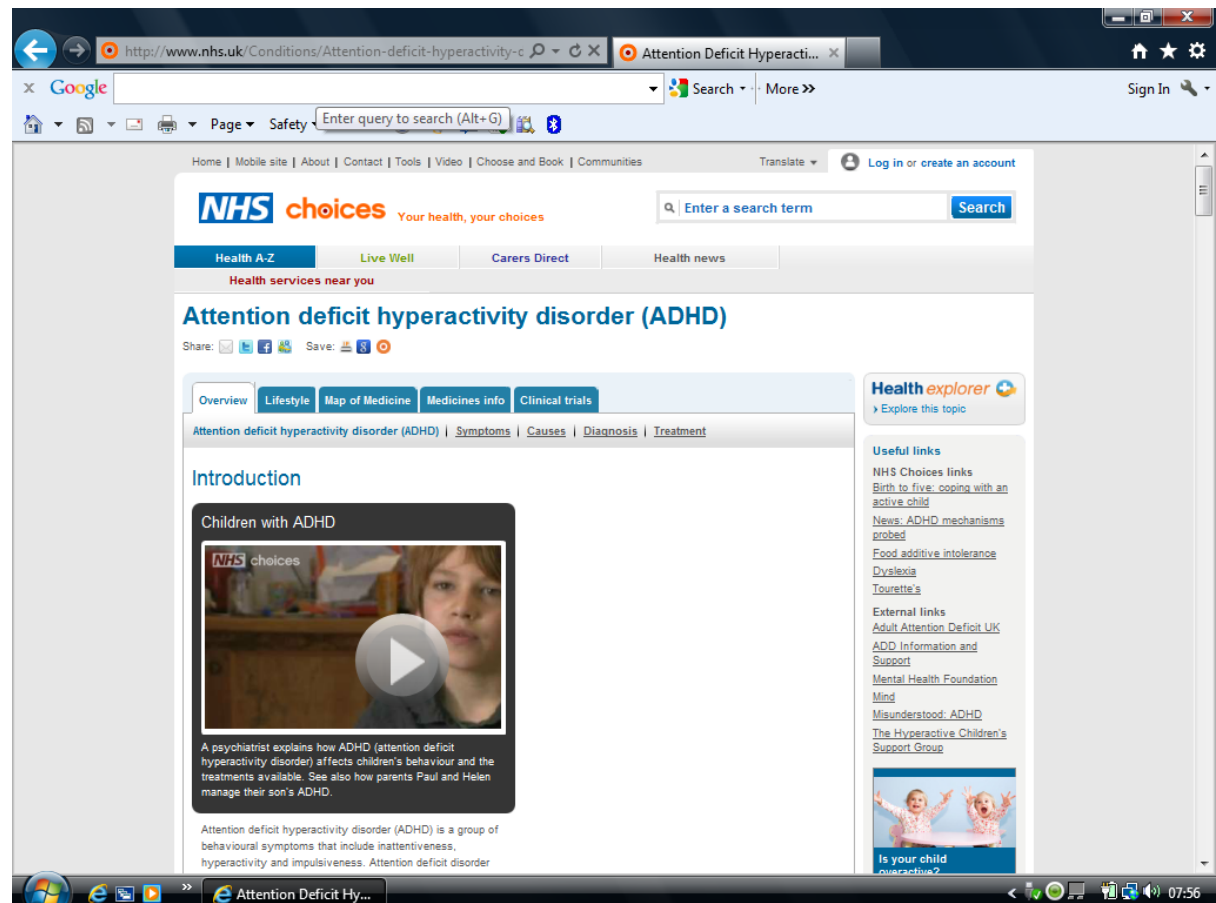
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APPENDIX 1:

SCREENSHOT OF NHS WEBSITE



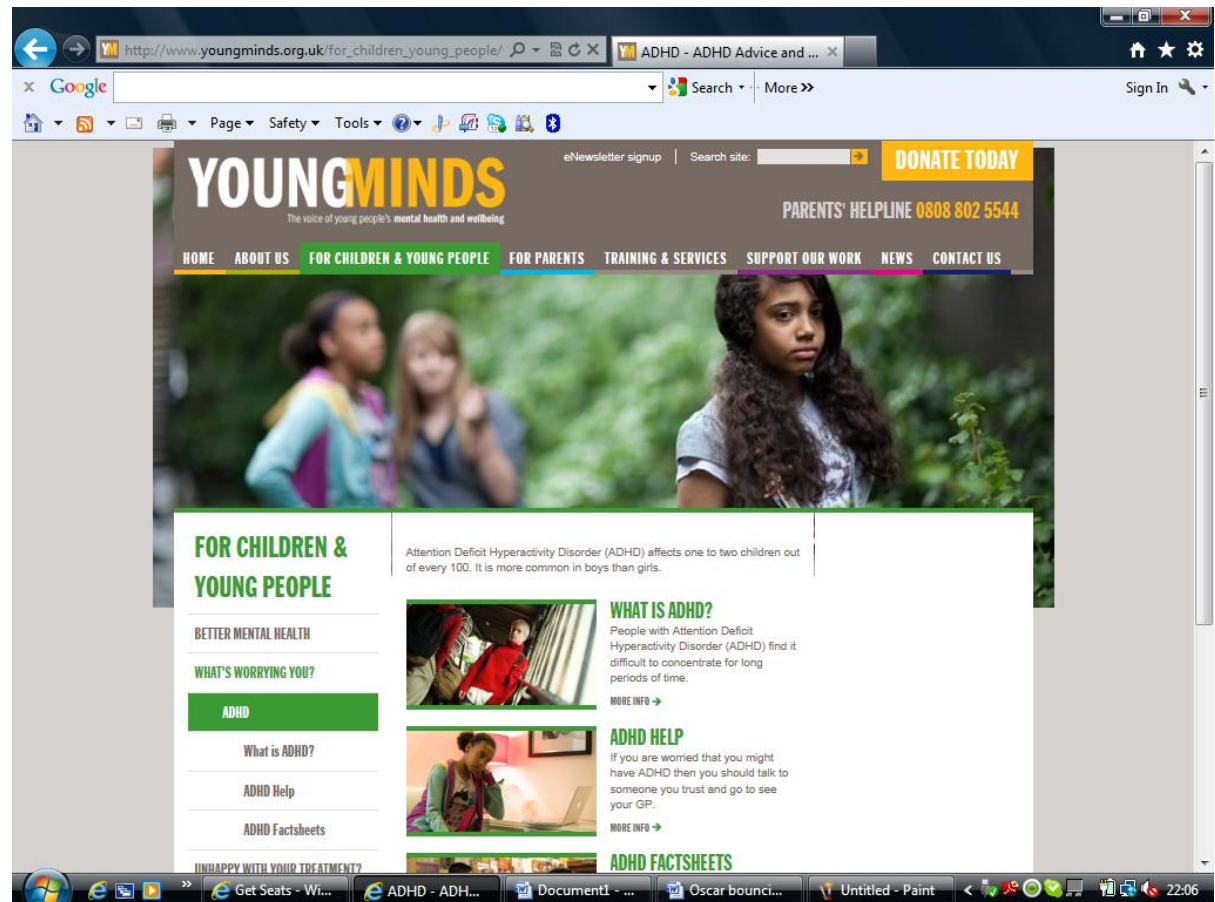
APPENDIX 2:

SCREENSHOT OF ROYAL COLLEGE OF PSYCHIATRISTS (RCP) WEBSITE

The screenshot shows a web browser window displaying the Royal College of Psychiatrists (RCP) website. The address bar shows the URL: <http://www.rcpsych.ac.uk/mentalhealthinfo/mentalhealthan...>. The search bar contains the text "royal college of psychiatrists adhd". The website header features the RCP logo and the text "The Royal College of Psychiatrists" with the tagline "Let Wisdom Guide". A navigation menu includes links for Home, Mental Health Info, Members, Specialities, Training, Examinations, Careers, Publications, Quality, Events and Courses, Press, and Policy. A sidebar on the left lists various topics under "Problems", "Treatments", "Young people", and "Campaigns", with "ADHD hyperkinetic disorder" selected. The main content area is titled "Mental Health and Growing Up Factsheet" and "Attention-deficit hyperactivity disorder (ADHD): Information for parents, carers and anyone working with young people". It includes a section for "Ben's story (11)" and "About this factsheet". The "About this factsheet" section states: "This is one in a series of factsheets for parents, teachers and young people entitled *Mental Health and Growing Up*. The aims of these factsheets are to provide practical, up-to-date information about mental health problems (emotional, behavioural and psychiatric disorders) that can affect children and young people. This factsheet helps to understand what attention-deficit hyperactivity disorder (ADHD) is and also offers some advice about what is helpful and where to get help." The "Introduction" section explains that 'Attention deficit (ADD)', 'attention-deficit hyperactivity disorder (ADHD)', 'hyperkinetic disorder' and 'hyperactivity' are various terms used by people and professionals, and that these differences in terminology can sometimes cause confusion. The "What is ADHD (attention-deficit hyperactivity disorder)?" section is partially visible. The right sidebar contains a "Google Custom Search" box, a "Support us" button, and links for "About our leaflets", "Order our leaflets", "See also", "Related Information", "Excitable and restless child", "Who's Who in CAMHS", and "Translations". The bottom of the screenshot shows the Windows taskbar with several open applications: "Get Seats - Window...", "ADHD and hyperkin...", and "Document1 - Micro...". The system clock shows the time as 22:12.

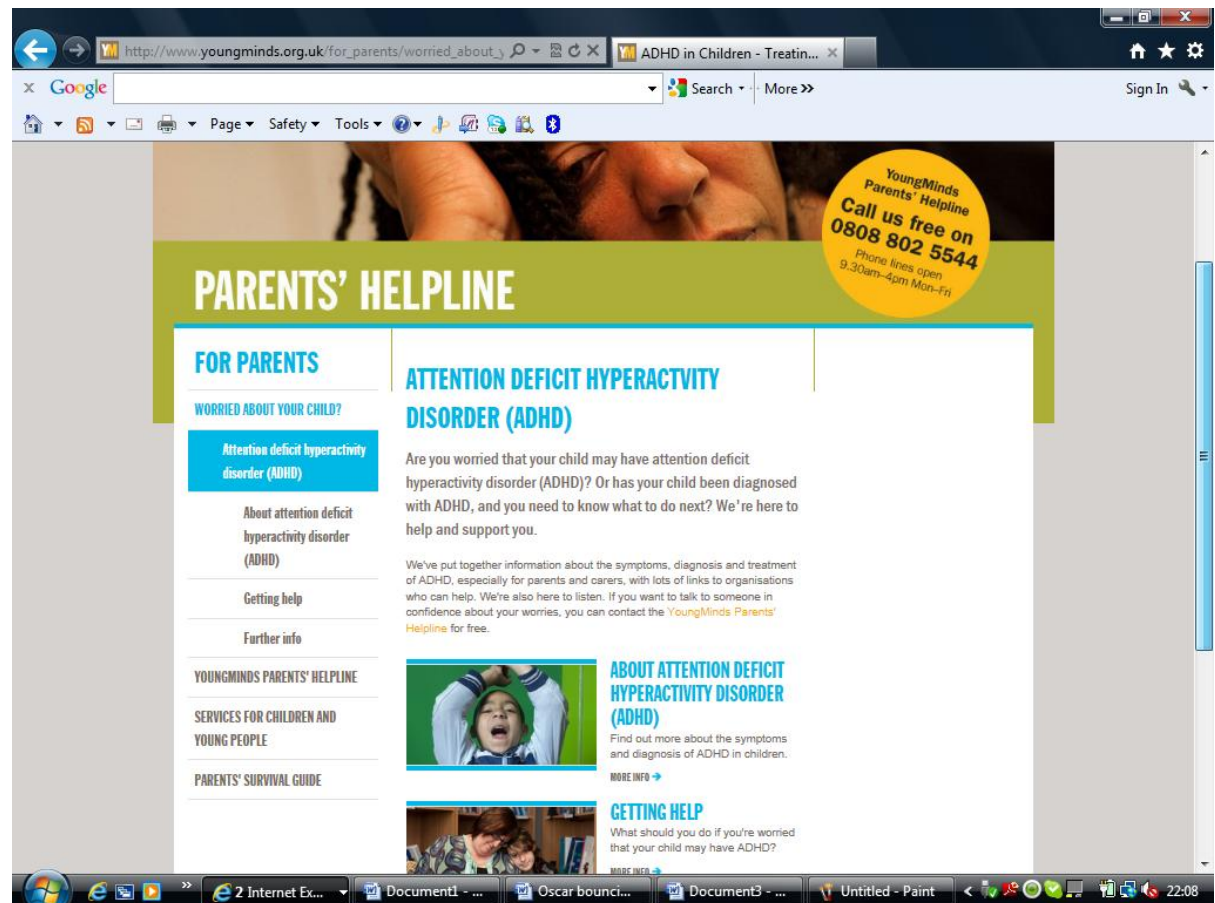
APPENDIX 3:

SCREENSHOT OF YOUNG MINDS WEBSITE (CHILDREN AND YOUNG PEOPLE'S SECTION)



APPENDIX 4:

SCREENSHOT OF YOUNG MINDS WEBSITE (PARENTS' SECTION)



APPENDIX 5:

SCREENSHOT OF NHS WEBSITE VIDEO ON ADHD (OSCAR BOUNCING A BALL IN THE HOUSE)



**APPENDIX 6: WORKED EXAMPLES OF TRANSCRIPTS – SEE
OVERLEAF**

NHS Website – Oscar's story

(Psychiatrist)

Medication can definitely help some children,

particularly those who've got more severe difficulties

where it's really holding them back at home and school.

(Parents)

It was his school that first raised the issue

and then we saw a paediatrician.

And I think the argument that the paediatrician made

that was most powerful was,

"You can either carry on without

and he'll struggle to concentrate at school as he is now,

or you can get him taking Ritalin

and it will allow him to concentrate

and he'll make much more of his schooling."

(Oscar)

The Ritalin makes me feel... [hesitation?]

It does help with my concentration, yes,

but I don't really like the idea that I'm taking drugs.

emphasis

extreme c.f.

extreme c.f.

multiple contexts

school as site of dx.

med. or ADHD?

category membership

rhetoric...

one of a number of powerful arguments

brand name

allows Oscar - agency

emphasis on school achievement

? edit or natural hes.?

Young Minds for parents website

as if it can be seen
no explanation
qualifier

Significant levels of ADHD are found in around one to two children out of every 100.

It is more common in boys than girls. It is probably caused by problems in the part of the brain which controls impulses and concentration, but other factors may also have an impact. biological

vague
repeating
brain

If you think your child may have ADHD, it is important to talk to your child's school or nursery and to contact your GP. You can be referred to a specialist such as a paediatrician or child psychiatrist who will be able to assess your child, and take into account all the factors which might be affecting your child's behaviour.

enlist
parents

not explained
qualifying
language

Only a specialist can make a diagnosis of ADHD.

not explained - vague

I need
help of
professionals
professionals
give

expert
help

not
just
only
professional
- needs
specialist assistance

- biological framework
- professional help / specialist help
- vagueness
- environmental / "other" factors hinted at but not explained

**APPENDIX 7: 'BEN'S STORY', ORIGINAL AND REVISED VERSIONS
(ROYAL COLLEGE OF PSYCHIATRISTS WEBSITE, SEPTEMBER 2011
AND APRIL 2012) – SEE OVERLEAF**

Ben's story (11)

extreme
c.f.

contrast structure

trying
to sit
down
eff

"I was always getting into trouble at school. The teacher used to tell me off for not sitting still, I'd try to sit down but it was hard – I would just want to get up and walk around. I was always getting into trouble for talking. The other children in my class would sit still and finish their work but I found this hard.

Mum and dad said I had a lot of energy. Sometimes my friends would tell me I was over the top. Mum says she couldn't take me anywhere when I was younger because I was so noisy and always on the go.

In the end, mum and dad took me to a clinic for children who have problems. They said I have ADHD and talked to my parents and teachers about how to help me. They gave me some medication – Ritalin. My mum and dad think it helps. I don't seem to get told off so much and can do my school work better."

but does Ben think it helps?

[Home](#) | [Mental Health Info](#) | [Members](#) | [Specialties](#) | [Training](#) | [Examinations](#) | [Careers](#) | [Publications](#) | [Quality](#) | [Events and Courses](#) | [Press](#) | [Policy](#)

Problems

Treatments

Young people

Campaigns

[ADHD hyperkinetic disorder](#)[Ben's story](#)[Alcohol & drugs parents](#)[Autism and Asperger's](#)[Behavioural problems](#)[Bipolar affective disorder](#)[Bullying and emotion](#)[Child abuse and neglect](#)[Chronic Fatigue Syndrome](#)[Chronic physical illness](#)[Dealing with tantrums](#)[Death in the family](#)[Divorce and separation](#)[Domestic violence](#)[Eating disorders in young](#)[Good parenting](#)[Learning disability](#)[Medically Unexplained symptoms](#)[OCD in children and young](#)[Parental mental illness](#)[Psychosis parents](#)[Restless & excitable child](#)[Schizophrenia](#)[Self-harm in young people](#)[Sleep problems in childhood](#)[Soiling or wetting](#)[Specific Learning difficulties](#)[Traumatic stress in children](#)[Worries and anxieties](#)[Who's who in CAMHS](#)

Web links

Multimedia

Translations

Top 10 leaflets

Viewpoint

More information

Keyfacts

Debt & mental health

Get well soon cards

SURF and Carers' Forum

Book Reviews

Minds on Film Blog

Work and Mental Health

Books for the Public

Ben's story (11)

"I was always getting into trouble at school. The teacher used to tell me off for not sitting still. I'd try to sit down but it was hard – I would just want to get up and walk around. I was always getting into trouble for talking. The other children in my class could sit and finish their work, but I found this hard.

Mum and dad said I had a lot of energy. Sometimes my friends would tell me I was over the top. Mum says she couldn't take me anywhere when I was younger, because I was so noisy and always on the go.

In the end, mum and dad took me to a clinic for children who have problems. They said I have ADHD and talked to my parents and teachers about how to help me. They gave me some medication which I take every day. Everyone thinks it helps. I don't seem to get told off so much and I can sit and do my school work now."

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