The medicalization of behaviour in children diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD)

by

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A thesis submitted in fulfilment
of the requirements
for the award of the degree of

Doctor of Philosophy

Faculty of Education and Social Work
The University of Sydney
March, 2010

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SYDNEY

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Faculty of Education and Social Work
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This is to certify that:

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Date: March 2010

Acknowledgements

Many before me have travelled the path of embarking upon doctoral research and most, it seems, recognize the key factor in reaching completion as being largely determined by one's persistence to do so. Having reached this point of completion, I share their sentiments. Such determination may not have been possible, however, were it not for the generosity of so many, some of whom I make mention of here.

I begin with my sincere thanks to my husband David John Hill, for his loving interest and encouragement throughout. His patience in awaiting the opportunity to see this work at its completion will long be remembered.

It is doubtful that this study would have proceeded had it not been for the confidence and heartening support of my supervisors, Professor Trevor Parmenter and Professor Barbara Fawcett, each of whom stood by my side throughout, ever-available, ever encouraging and ever wise. I thank you Barbara, in particular, for the gift of your insightful words when you said: " begin by looking at 'perspectives".

I pay tribute to the many scholars, past and present, who continue to engage the world with their legacy of knowledge, most of which would have remained a mystery to me had it not been for the curiosity this study stirred within. In particular, I am grateful for Peter Conrad whose work has had a profound influence on me.

On a practical note, I express my appreciation to the librarians in the Petherick Reading Room in the National Library, Canberra, and to Philippa Crosbie in the Fisher Library, University of Sydney. Their assistance in facilitating access to vital resources was invaluable.

I thank my sons, my extended family, and my friends. They did not grow weary from asking, "Have you finished yet?" Their encouragement balanced the loneliness often associated with sole research. I especially mention my youngest friend Ng Kai Lai from Hong Kong, whose cheers could be heard in Australia.

My furry friends, 'Ming' and 'Little Turk' also deserve a mention. By sleeping in a pile across the base of my chair, they kept me at my desk for long periods of time - and the shy wattle bird by my window - she showed me, through her delicate extraction of nectar, that much can be gathered from little.

I close by reflecting on my childhood, when the idea of studying at The University of Sydney was a dream I could but dare to have. Dream I did. I am most grateful.

Dedication

I dedicate this dissertation to the memory of my late parents Jean and Ronald Lloyd Wright. My mother, Jean, raised in an orphanage, and my father, Ron, having had the opportunity to complete only primary school, would be pleased with their achievement borne in the efforts of this their daughter.

And to my sons, Steve, Matt and Paul, I share with you my finished work to show that your "little ma" did indeed do it.

Abstract

In recent decades, Attention Deficit Hyperactivity Disorder (ADHD) has achieved a high profile in academic and popular culture alike, evidenced in several competing perspectives across a variety of sectors. As the social processes at work in objectifying a child as 'ADHD' are not well understood, this dissertation draws on the tenets of the sociology of mental health to explore the diagnostic mechanism by which social forces encapsulated in medical, family and educational agencies synergize to construct ADHD. In short, this study aims to examine the social processes by which a child 'like any other' comes to be understood as 'being ADHD'.

Despite the dominance of biochemical and neurological explanations of ADHD and in the absence of pathological evidence, the identification of ADHD predominantly relies on individualistic interpretations of human behaviour. One view gaining attention is that ADHD is situated within a broad global trend that redefines perceived 'abnormal' social behaviours and non-medical problems as illnesses and mental disorders requisite of medical intervention. It is argued that the mounting categorization of children as mentally disordered and the escalating use of psychotropic medication alongside images of deviant adult-ADHD behaviour contextualizes the ADHD phenomena as a contemporary moral panic worthy of further investigation.

From a social constructionist standpoint and utilizing aspects of symbolic interactionism, I adopt a qualitative approach to investigate four case clusters in an Australian context, comprising the mothers, the doctors and the teachers surrounding eight child participants diagnosed as having ADHD. Unstructured in-depth-interviews provide rich data in which the social processes at work are illuminated.

The findings suggest a shift from the more established view of teachers being dominant actors in the launching of the medicalization process to that of the mothers. Relief from mothering stress is implicated in the mothers reaching a 'tipping point' and fear of the consequences of disengaging with ADHD diagnoses appears to be the major reason for the maintenance of the children's passive patient state. Mother-doctor partnerships reveal much about the power of social interactions and perceptions in achieving ADHD diagnoses.

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Preface

In thinking reflexively about my engagement with this study, and in examining my purposive process of unravelling 'becoming ADHD', I contemplated the roots of my beliefs. Attitudes to health and illness in the industrial city of Newcastle, New South Wales in the late 1960s and 70s, according to my childhood memories, seem vastly different from those of today. Far more so than one might expect given such a relatively short passage of time.

In those days, physical disability and illness were somehow fused, sometimes with notions of deprivation such as portrayed by images of 'poor little Barnardo children' in callipers. In contrast, the state of 'being healthy', or experiencing 'well being' as we say these days, was perhaps best represented by images of extraordinarily active children; rose cheeked 'happy little vegemites' [1] as they were known, displaying behaviours more akin to 'Louis the fly' before his fateful dose of insecticide. As far as I can recall, there was no mention of ADHD in those days.

Medication was a part of life, even then; to make us 'better'; to prevent something 'bad' from happening. We children, for example, were shepherded, from time to time, into classrooms where the presence of white coats signalled 'medicine time' rather than spelling drill. In a strange resemblance to 'taking communion', we filed by with outstretched tongues to receive the sweet drop of Sabin vaccine; our 'salvation' from becoming like 'the poor little Barnado children' in callipers. We complied, relieved to escape 'the needle' which seemed as thick as the javelin in the sports shed. We trusted in those who 'knew what was best'. We had no choice.

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[1] The term 'vegemites' refers to images of children consuming or associated with a food product marketed as 'vegemite' (similar to marmite in Britain), which some people consider an Australian icon.

Somehow, medication seemed simpler in those days. We children, for the most part, were kept healthy with vegemite sandwiches, free school milk and the odd dose of decongestant. Sick people, like my third grade teacher with diabetes, took medicine of all kinds and colours. Strange people, 'the loonies', were locked away in a prison-like mental hospital on "the hill". They wore striped flannelette pyjamas. Their cries and moans could be heard by passers-by who were brave enough to pass by, and by girls from the private church school, also on "the hill", passed by on their way to swimming lessons at the baths. We, the girls, didn't know if the 'inmates' took medicine but guessed that they were probably *made* to take 'tablets'. They, we thought, were 'psycho'.

As the years passed, notions of a future world less needy of medication were to be the fruit of our obedience to systematic immunization and the advance of 'science'. Perhaps 'tablets' would replace food, we thought. We were wrong. We could not have believed that ensuing decades heralding the 21st century would attest unprecedented expansion of medicine for what were to become newly perceived 'medical problems' once associated with everyday life. The 'poor little Barnardo children', it seemed, were replaced by fatness, baldness, shyness, forgetfulness and aging and some of we 'happy little vegemites' could be called "ADHD".

Somewhere between being a school child and becoming a teacher of children with disabilities, I became aware of 'ADHD', or ADD as it was also called. In the 1980's, ADHD became part of my everyday experience. As I had 'special' qualifications, I was expected to be able to explain ADHD to others and to solve perceived learning and behaviour problems that far exceeded my confidence to do so. Even though most people, it seemed, had an opinion about what ADHD was and almost everyone knew someone who "had it", exactly what 'it' was, was never completely clear to me. Why was it that I could understand, at least partly, what it meant to have limited vision, acquired brain injury and cerebral palsy, for example, yet remain perplexed by what it meant to "have ADHD"?

As a teacher and later, as a special education consultant, I frequently encountered children who were "ADHD". They were mostly boys. Some reminded me of the boys I knew when I was a child, the ones who pinned blowflies to the windows, and the ones who ate glue. The ones I played with. What puzzled me now, however, was how the behaviour of children labelled in this way, varied so, particularly from one environmental setting to another, and why opinions about them varied so. ADHD, whatever it was, seemed to me to be highly contingent upon environmental factors, and opinions, yet the treatment was similar: psychotropic medication.

I read books on the topic commonly found in school staffrooms. Most were by well known authors such as Barkley (1981, 1995; 1990b); (Green & Chee, 1997) and Hallowell (1995). Each confirmed the notion that ADHD was a 'real' neurological disorder, yet I maintained my curiosity about how the diagnostic process really worked. I was aware that comments by teachers on 'checklists' for doctors and counsellors, reminiscent of rating quizzes found in the popular *Women's Weekly*, varied according to the mood of the moment. I knew first hand how much difference a cup of tea and a biscuit made to my own responses to such things, depending on whether the refreshment came before or after the 'what do you reckon?' task.

Over the ensuing years, across a range of schools in Australia, UK and Hong Kong, the answers to my perennial questions eluded me. Indeed, they seemed to magnify along with the number of 'cases' I encountered. This may be why I thought more and more about the effects of growing up as 'being ADHD' for children so diagnosed; of being called 'psycho' by other children; of being summoned to the office via the school-wide intercom to be 'medicated', only to be left waiting by overburdened 'office ladies' and missing play. I asked questions about what these children so diagnosed were really learning, learning about themselves, learning about their 'identity'. No text that I read on ADHD seemed to answer these questions, not even *ADHD for Dummies* (Strong & Flannagan, 2005).

In 2004, my curiosity peaked when I visited several schools in the United States claiming to specifically cater for children with ADHD. Staff at these schools explained that their enrolments had been 'adopted' from traditional educational settlings where, despite medication, the 'ADHD children' had continually failed. They claimed that these same children were now not only 'medication free' but potential candidates for the 'Ivies'[2].

While the veracity of this declaration remained untested, at least on my short visit, my impressions of happily involved children (almost outnumbered by their teachers) suggested, at the very least, that 'ADHD' was for them, little more than school 'branding'.

Today, as a researcher, I bring my thoughts of these experiences to this study. While many of my questions of old remain, my interest has shifted from seeking a 'definition' of understanding of 'ADHD' as a 'condition', to more about the experiences, views and beliefs surrounding 'becoming ADHD'.

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[2] The term 'Ivies' refers to the Ivy League Universities, a group of eight high ranking/prestigious higher education institutions located in the north-eastern region of the United States.

1 Introduction

In this introductory chapter, notions of ADHD and 'medicalization' are presented as two key areas of interest and connectivity. Although each is introduced separately, they are drawn together by viewing ADHD through a medicalized lens. This chapter closes with an outline of the dissertation's chapter by chapter structure.

Introductory comments

Attention Deficit Hyperactivity Disorder (ADHD), formerly known as the Hyperkinetic Syndrome of Childhood and Minimal Brain Dysfunction[3] (and other nomenclature), is a 'condition' that attracts significant interest across disciplines. This is arguably so because ADHD elicits a range of social responses, rendering it a controversial topic.

The diagnosis of ADHD was initially confined to childhood. This is no longer the case. Today, through a series of redefinitions in previous decades, ADHD knows few constraints in terms of its candidature. It now accommodates adults of all ages, gender and ethnicity, although most remain male. Nevertheless, the topic of ADHD continues to be of particular concern to those interested in child and adolescent mental health: an age group where its prevalence continues to rise.

There is significant variation in social responses to issues and practices relating to 'ADHD' (see Chapter 2). For example, some view the rapid escalation of ADHD

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[3] The term 'minimal brain dysfunction', a precursor to ADHD, was frequently used to describe a range of learning and behaviour problems. Put another way, if one was unsure of a 'diagnosis', then one could say that the individual has minimal brain dysfunction (or MBD). As such, MBD was not used exclusively to describe ADHD 'symptoms' (Parmenter, 2009)

diagnoses as unremarkable, believing it to be a consequence of modern medicine's prowess in identifying and treating a range of physical and mental health 'conditions'. Others, in contrast, view ADHD fatalistically, as an inevitable outcome of modern living. Still, others describe ADHD as a 'spoof', a conspiracy, where labelling and medication are used to exploit the socially vulnerable. Whatever one's standpoint, few disagree that more and more people are increasingly being identified as 'ADHD'. This may be why Morely (2004, p. 1) says that ADHD is: "the disease du jour".

Indeed there has been increasing representation of ADHD diagnoses in very young children (Auerbach, Benjamin, Faroy, Geller, & Ebstein, 2001; Lahti, et al., 2005; Landau, Amiel-Laviad, Berger, Atzaba-Poria, & Auerbach, 2009) and, perhaps surprisingly, elderly people (Cetkovich-Bakmas, Gleichgerrcht, Torralva, Lischinsky, Roca, Manes, 2008; Wassertein, 2005). Therefore, while the specific reasons for the ADHD controversy are unclear, it is of interest that the literature remains weighted towards presenting ADHD as a mental health 'condition' requiring medical treatment. As such, less is known about the social processes at work in objectifying children as 'ADHD'. On this basis, this dissertation intends drawing on the tenets of the sociology of mental health to qualitatively explore social processes implicated in the transformation of 'a child like any other', to a medically treatable 'ADHD object'.

Introducing ADHD

As stated, notions of ADHD are as varied as they are contentious. Even so, biochemical and neurological explanations characterizing ADHD as a psychiatrically derived 'disorder' continue to dominate academic publications and media representations alike (Coghill, 2005). Despite this, there is mounting disquiet surrounding ADHD 'realities', rendering it a topic which some describe as "divisive" (Hildebrand, 2007).

While this thesis lays no claim to espousing or refuting the 'truth' of 'ADHD', its 'presence', viewed socially and/or medically, cannot be denied. Indeed, the term itself is detected in numerous mediums. From the world's largest medical library, the National Library of Medicine (2009) to on-line medication data bases in 'the cloud'[4], and from popular magazines in supermarkets, to books in my local bookstore (which stocks no less than eighteen books of various kinds including *A kid friendly ADHD and autism cookbook* (Compart & Laake, 2009), ADHD takes its place.

It is, however, ADHD's listing in the *Diagnostic and Statistical Manual of Psychiatric Disorders*, now in its fourth revision and soon to be fifth (American Psychiatric Association, 2000) and the more limited ICD-10 (World Health Organization, 1993)[5], which is of particular significance. Although there are no definitive pathological 'tests' to determine the nature or presence of ADHD (Chacko, Wakschlag, Hill, Danis, & Espy, 2009; Kupfer, Baltimore, & Berry, 2000; Rubinstein, Scrimshaw, & Morrissey, 2000), ADHD's medical 'reality' is nonetheless therein endorsed and subsequently formally recognized by the powerful institutions of education and law. Therefore, without ADHD being 'legally' ratified in sources such as these, the process of medicalization would be impotent.

Arguably, ADHD's 'absoluteness' is further solidified, if only by association, through various strands of medicine. Some medically oriented research cites, for example,

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4 ADHD features in the Untied Kingdom's seemingly well utilized on-line medical encyclopaedia for General Practitioner Analysis of September 2008 traffic statistics show that 50% of UK GPs access GPnotebook at least once a week (McMorran, 2009).

5 The classification of ADHD as a mental disorder or mental condition is contentious. In the USA its classification as such is widely accepted while in Britain, it is less so. However, the USA categorization of ADHD is the dominant position and is adopted in Australia. Further information detailing differences is found in the British Psychological Society's booklet (1996) entitled Attention Deficit Disorder: a psychological response to an evolving concept.

genetic causation (Cooke et al. 1995; Waldman et al. 1998). Others seek to 'prove' ADHD with neuro-imaging and biomedical techniques (Barkley, Cook, & Diamond, 2002; Castellanos & Tannock, 2002; Faraone & Biederman, 2000). Being neither well defined nor reliable (Aronson, 2007; Cohen & Leo, 2004; Furman, 2008; Pittelli, 2002) or replicable (Brookes et al. 2006)[6], none, thus far, even using 'state of the art' techno-tools or novel computer game 'tests' (Philips, 2010), have succeeded in pinpointing ADHD. This may explain why poorly correlating teacher-parent checklists (Furman, 2008; Rubinstein, et al., 2000) and parent managed "trials" of medication, spurious though they may be, remain the more common form of 'evidence-based' "evidence" of enigmatic ADHD.

Although few, some noteworthy investigations of ADHD, from a sociological perspective, have been undertaken since Peter Conrad's original study (Conrad, 1976b). These include, for example, Claudia Malacrida's comparative study of mothers' reactions to ADHD (2004) and Adam Rafalovich's study which culminated in his book *Framing ADHD children: A Critical Examination of the History, Discourse and Everyday Experience of Attention Deficit/ Hyperactivity Disorder* (2004). Other studies have been conducted in Australia, which include Brenton Prosser's two book publications (2006a, 2006b), and Linda Graham's (2007) series of papers focusing on schools and ADHD using a Foucauldian framework.

The issues raised by these contrasting approaches to the sociology of ADHD are far from being exhausted or resolved. Indeed, it seems that much remains unknown in the

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[6] Some cite genetic, neuro-imaging and other biomedical techniques as sufficient proof (Barkley, et al., 2002; Castellanos & Tannock, 2002), others strongly claim the findings of such studies to be unreliable emanating from methodologically unsound research (D. Cohen & Leo, 2004), and some , for similar reasons, question the use of bio-medical imagery as legal evidence of mental illness (Aronson, 2007).

area explored in this study, intent on illuminating the social processes at work in 'becoming ADHD'.

Introducing 'medicalization'

'Medicalization', a term which emerged in the 1970's through the work of Conrad (Conrad, 1975), refers to the phenomenon whereby nonmedical problems are identified and then redefined and treated as illnesses and/or disorders. Before this, notions of medicalization were already conceptually underway by sociologists interested in theorizing *social control*.

Underpinned by influential works such as the writings of Durkheim, who directed attention towards the role of social institutions (namely family and religion) in constraining individuals' self-directed tendencies, various schools of thought emerged[7]. These include a move to define deviance in terms of illness (Parsons, 1951), and assertions that social reactions to behaviour constituted constructions of deviance (Scheff, 1966); the theoretical development of psychiatric social control (Szasz, 1963, 1974); medical institutional control of illness and madness (Foucault, 1965b, 1973) and medicine as an institution of social control (Zola, 1972); exposition of identity transformation, labelling and stigmatization in the 'career' of the mental patient (Goffman, 1962); and, the medicalization of life in its entirety (Illich, 1975).

Following Conrad's seminal work (and several ensuing publications), he, with Schneider, published the influential book *Deviance and medicalization: from badness to sickness* (1980). Since then, there has been interest across an array of topics. Some examples of this include female menopause (Lowy & Gaudilliere, 2006; Meyer, 2003) and male menopause (Marshall, 2007; Watkins, 2007); male sexual

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[7] These ideas were not necessarily attached to Durkheimian thought. A comprehensive analysis of the emergence of social control is found in Jesse Pitts' (1968) exposition.

performance (Rosen, 1996) and women's' sexual libido (Gracia-Arnaiz, 2007); body image (Monaghan, 2007) and eating issues (Gracia-Arnaiz, 2007); alcohol consumption (Lunbeck & Tracy, 2007); shopping behaviour (Lee & Mysyk, 2004); gambling (Rossol, 2001); social behaviour (Conrad & Potter, 2000); sleeping (Armstrong, Previtera, & McCallum, 2000; Williams, 2002b); conception (Heitman, 1999) and childbirth (Fox & Worts, 1999); of ageing (Kaufman, 1994) and dying (McCue, 1995) and of life itself (Hartley, 2009). Indeed, it seems that little remains 'immune' from being interpreted through a medicalizing lens, for even 'life in cyberspace' is today viewed through a medicalized lens (McMillan, 2009).

To add to the complex nature of interpreting disease and illness, 'medicalization' of particular "disorders" is itself not static. Some 'conditions' are 'demedicalized' and then 'remedicalized' (Conrad, 2007). For example, homosexuality, once believed to be an illness, and then a lifestyle right, is now once again viewed medically through psychobiological portrayals of the "gay gene" (Annicchiarico, 2009; Conrad & Markens, 2001; Mustanski, et al., 2005). Moreover, the term 'medicalization', more recently, has been 'replaced' by the emerging term 'biomedicalization', a term associated with:

> The greater use of techno science in biomedical treatments, practices and health to produce transformations of identities, bodies and life itself (Clarke, 2009),

While numerous examples of the infusion of medical technology in what may have once been considered 'private' or 'commonplace' may be cited, there is perhaps no more poignant example than that of human conception and ante-natal development itself. The once mysterious place of the womb is, it seems, becoming 'ever marketable', 'ever virtual' and 'ever available' as the following example of an online advertisement suggests:

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> Bundles Baby Ultrasound allows mothers-to-be, family and friends to see an unborn baby's expressions such as smiling and yawning on a large plasma screen using the latest 3D/4D ultrasound technology from just $150... with unlimited downloads of your images to share in other locations around the world (Bundles Baby Ultrasound, 2009).

The merging of medical technology and 'mothering', captured here by the image of a foetus, implicitly epitomizing bodily perfection, engaging in the social symbol of approval, 'a smile', exemplifies more than semantic difference. Perhaps 'medicalization' as a term is becoming inadequate in accommodating the enormity of the porous nature of medical-technological, political-economic and socio-cultural boundaries confronting sociologists today.

This aside, returning to the notion of 'ADHD' as a mental disorder, and 'medicalization' as a social phenomenon, the connectivity achieved in Conrad's sociological analysis of ADHD, though not without its critics (Whalen & Henker, 1977), stands as one of the few outstanding studies using a 'medicalizing' perspective. Although research studies in this vein remain sparse, there is evidence of renewed interest in viewing ADHD as an example of medicalization[8], with a possible emphasis within popular culture. A search using the terms 'medicalization' using the term 'ADHD' separately and then, in combination, shown in Tables 1 and 2, demonstrate this trend.

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[8] A comprehensive review of the emergence of medicalization is provided by Peter Conrad (1992).

Table 1 A comparison of searches on the terms 'medicalization' and 'ADHD'

Note: Each term is applied independently.

For ease of comparison, the term 'medicalization', (including the terms medicalize, medicalization (spelled also with "s") is printed in black and 'ADHD' (including the terms attention deficit hyperactivity disorder; attention deficit; ADD; hyperactive; hyperactivity) is in blue.

Publications before 1970		
Social Science Citation Index	zero	52
Medline	zero	230
Newspaper Articles	zero	zero
Publications between 1971 and 1980		
Social Science Citation Index	19	629
Medline	34	2,268
Newspaper Articles	zero	79
Publications between 1981 and 1990		
Social Science Citation Index	53	1,235
Medline	117	5,001
Newspaper Articles	90	4,252
Publications between 1991 and 2000		
Social Science Citation Index	209	5,557
Medline	269	9,062
Newspaper Articles	2,038	39,945
Publications between 2001 and January 2008		
Social Science Citation Index	255	7,882
Medline	289	13,170
Newspaper Articles	5,060	92,251

Note: These figures do not necessarily represent sociological studies

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Table 2 Combined searches on the terms 'medicalization' and 'ADHD'

Note: In this table, various forms of the words were not used, in order to avoid an unnecessarily complicated set of results

Prior to 1970	
Social Science Citation Index	zero
Medline	zero
Newspaper Articles	zero
1971-1980	
Social Science Citation Index	zero
Medline	zero
Newspaper Articles	zero
1981 – 1990	
Social Science Citation Index	1
Medline	1
Newspaper Articles	1
1991 – 2000	
Social Science Citation Index	4
Medline	3
Newspaper Articles	7
2001 and January 2008	
Social Science Citation Index	8
Medline	5
Newspaper Articles	238

Although, as stated, the results of these searches are limited, they nonetheless suggest some points of interest. Note that Table 1 confirms ADHD's strong representation in medically oriented writing (consistent with its medical roots, see Chapter 2), well before 'medicalization' appeared. Note also that 'medicalization', though its representation is comparatively small (in keeping with its introduction through the work of Conrad in 1970s, presents with a similar marked increase in the medium of news media. Moreover, in combination, Table 2 suggests a similar pattern. This may reflect growing concerns about medical solutions being applied to children's behaviour in general, or it may relate to ADHD specifically. Either way, it is in the broad context of increased social interest that this study is conceived.

Dissertation structure

By drawing on the association between 'ADHD' as a mental disorder, and 'medicalization' as a social phenomenon, and in the interactionist tradition utilized in Peter Conrad's sociological analysis of ADHD, this dissertation unfolds in eight chapters. Following on, Chapter 2 presents aspects of the complex nature of ADHD through a description of some contrasting perspectives of ADHD and Chapter 3 places ADHD within the sociology of deviance, where social reactions to children's behaviour. Following on, Chapter 4 presents the research design and methodological approach. The findings relating to the analyses of the data are discussed in Chapters 5, 6 and 7. Finally, Chapter 8 provides a conclusive discussion, and Chapter 9 presents recommendations for future research.

2 Characterizing ADHD

As suggested in Chapter One, the concept of ADHD is both complex and contentious. This chapter contributes to laying the foundations for this study by reviewing aspects of the emergence of ADHD in greater depth. In addition, some current issues relating to ADHD are discussed and major perspectives are explored. The main purpose of this chapter is to establish that ADHD is 'understood' in different ways.

Introduction

Being a "dog-lover", Hoopmann's (2009) picture book *All dogs have ADHD* captured my attention. Her intention, it seems, is to present a range of behaviours commonly thought of as symptomatic of ADHD. The compilation of real-life photographs of mischievous, adventurous and misunderstood puppies in action, with attached captions, is likely to entertain even the most canine averse person (see Appendix I).

The novel approach of this book, perhaps aimed at promoting acceptance of children diagnosed as having ADHD, belies a significant feature about ADHD; that is, behaviours of all kinds may be conceptualized in endless ways. However, when applying such categorizations to people, there is a stark contrast between somewhat comical, 'ADHD puppy' behaviour and that of children. Often, overactivity, poor concentration and impulsivity in children rarely amuse. Perhaps it depends on the views of the onlooker, as the well known "Fidgety Phil" poem of old exemplifies (Hoffman, 1845) (see Appendix II).

For the most part, it is reasonable to assume that behaviours, like excessive fidgetiness for example, have long caused irritation to others. This seemed especially so for parents in an Anglo Celtic context in the early 1900's, for such cases of child unruliness both demanded and claimed the attention of acclaimed medical academicians (Still, 1902). Ironically, the treatment for these 'little' psychiatric curiosities came in the form of advice: apply a dose of 'good' discipline (Still, 1902).

Today's 'ADHDscape' is no longer confined to images of fidgety children falling off chairs. Trans-generational images flood popular culture, from 'ADHD creator' (with entrepreneurial style) to 'ADHD troublemaker'. Indeed, ADHD's enigmatic characteristics seem to apply as much to crying babies as to forgetful grannies. With the recent expansion of ADHD definitions (Conrad, 2007), the key question to pose becomes *how* and in what *ways* is ADHD 'understood' and acted upon?

Chameleonic ADHD

ADHD, cast in myriad faces, gives rise to arguments and counter arguments reflected in numerous 'definitions' of ADHD and having defined it, responses to it. For this reason, I introduce the term 'chameleonic ADHD', as it suggests that beliefs about ADHD can be seen as 'adapting' to the views of its 'host', much like the way in which a chameleon's environment informs its appearance. To further explain, just as a reptilian chameleon 'reflects' traits or conditions in reference to its environment, the very same chameleon could potentially appear quite differently, and be described quite differently in another. If then, ADHD is likened to a chameleon's 'ability' to 'adapt' to its surroundings, it can be reasoned that ADHD 'perspectives' are, similarly, in 'sympathy' with the *social surroundings* in which they are understood. In this way, ' chameleonic ADHD' views are neither static nor easily compartmentalized.

According to my own interactions with people, mainly through everyday conversations, ADHD elicits views and opinions awash with emotion. Examples of these are found in my field notes where answers to the opportunistic question, "In your opinion, what is ADHD?" include:

> It's the poor kids with no father. It stuffs them up. They get a bad start in life. Then they give them bloody pills to sort them out. It's disgusting. (Male Plumber age 42)
>
> They are the hyper ones. It's in their genes. It's the same as bi-polar.' (Female Hairdresser age 19)
>
> They are misunderstood bright kids. They need the medicine or they'll end up on the streets or even worse. (Mother of a teenager with ADHD, age 57)
>
> It's the food they eat. It's all the additives. It makes them spin out. (Female U.K. Tourist, age 39)
>
> It's observed behaviour in children which disrupts everyone around. I have no idea what causes it. (Male Academic, age 56)
>
> Kids like this have always been around. I remember them when I was at school. They were the bad kids, the naughty kids. Today they'd probably be diagnosed with ADHD. I don't reckon ADHD exists. They've just thought up a name for naughty kids. (Female Union Organizer, age 36)
>
> It's where a child has a constant need to be entertained and finds it hard to focus on any one thing for an extended period of time. They are born with it. (Male University student, age 24)
>
> It's just bad behaviour caused by parents who don't discipline their kids. There's no routine, too much TV and the parents are out too much leaving their kids alone with too much fast food. Someone should do something about bad parenting to fix ADHD. (Female schoolteacher age 37)
>
> They have brain damage. It's all in the wiring. We'll understand what's wrong with their brains one day. (Male engineering scientist age 63)

> It's pollution. It's the mercury in the water. It's the power lines. Heavy metals are everywhere. It's making our kids hyper. I believe in natural therapies. (Mother of 8-year-old child diagnosed as having ADHD, age 42)

These comments reveal a range of ADHD views derived from premises including:

- Neurological abnormality of genetic and/or environmental origins
- Unsatisfactory parenting (including diet)
- Inappropriate labelling of 'naughty' and/or 'clever' children

Such 'variegations' (in association with the term 'chameleonic') however, are met with the prevailing 'hard science' absolutism exemplified by Australian paediatrician and author, Mark Selikowitz (2004). In his concise book entitled *ADHD: the facts*, he attempts to authorize a single-minded psycho-neurological view. He is not alone. The gamut of medically oriented literature echoes a similar refrain.

In order to grasp the power of the dominant medical response to children's behaviour, it is useful to consider the source of ADHD's emergence. As historical accounts of ADHD (and previous nomenclature)[9] have already been conducted (see for example, (Rafalovich, 2004; Timimi & Leo, 2009), repetition here is unnecessary. However, as this study is primarily interested in links between perspectives and actions, I draw attention to sociological angles of interest concerning medical responses involved in controlling human behaviour.

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[9] Various accounts trace ADHD's earlier nomenclature, including encephalitis, minimal brain damage; minimal cerebral palsy; mental retardation; minimal brain dysfunction; hyperkinesis; attention deficit disorder without hyperactivity (ADD).

ADHD and morality

The term 'ADHD' is commonplace[10]. It is recognized and used in everyday language in numerous countries (Scot Danforth & Navarro, 2001a) where, as previously stated, it often provokes debate. Evidence of disputes about the prevalence and treatment of ADHD abound in the media although research studies are sparse in viewing ADHD as a 'moral' dilemma. One exception to this is Blum's scrutinizing of ADHD through the concept of 'mother-blame' (2007). Another is Miller and Leger's examination of the ADHD medication Ritalin™ and its role in generating 'moral panics' (2003).

While much could be explored in relation to ADHD and 'moral judgement', for the purpose of this study, I draw on a single illustration that extends beyond etiological argument. In a recent news report by the Australian Broadcasting Corporation (ABC) (ABC, 2010) a twenty four year old single mother of two young children was rejected as a candidate for her second liver transplant. She, a heroin addict, was 'judged' by the Western Australian Health Minister, Kim Hames, to be unfit for a "second chance" of another liver transplant (her first having failed) because she was a heroin recidivist. He argued that it would be "patently unfair" that she be given yet another liver, only to potentially 'abuse' it once again, causing others in need to "miss out". It was counter-argued, however, that her diagnosis of ADHD, made when she was a child of twelve years, and its treatment, *caused* drug dependency and led to her subsequent liver damage. For this reason, she argued that, being a child and having no say in the matter, she was not responsible for her condition. Indeed, she held 'society' accountable for her current state of impending loss of life.

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[10] Please note that although ADHD nomenclature has changed over the decades, it is still possible to encounter other terms such as ADD and Hyperkinesis. It is reasonable to assume that the ADHD label may also change in the future.

This interesting case could be investigated and 'moralized in a number of ways. Indeed, social reactions to the image of a terminally ill young single mother with two children provoked extraordinarily different responses, evidenced by more than one hundred on-line responses to the news article within a twenty four hour period following its publication. For some, she an 'irresponsible addict', deserved no more than palliative care for the few months before her imminent death. For others, her story attracted sympathy for a 'child victim' subjected to socio-medical forces that inflicted upon her an ADHD diagnosis and psychotropic medication. Although the polarisation of views is clear, so too is the inevitability of moral debate. Amongst the questions posed is whether ADHD's connection with 'moral judgement' is a recent phenomenon, or whether it can be traced to its very beginnings.

Today, 'ADHD' is a catchword. However, unlike other universally accepted terms, "supersized" ADHD emerged from far less 'consistent' beginnings than the "global hamburger". The first point to be made is that current medical definitions of ADHD are directly traceable to some of the earliest descriptions of diseases and deficiencies documented in the London Bills of Mortality in the 16th century. This was the forerunner of the International Classification of Diseases (ICD), which in 1893, after multiple revisions and various pathways of classification, led to today's ICD-10 (World Health Organization, 1993) and related documents (World Health Organization WHO, 2007), where ADHD is mentioned today. While admittedly this connection is relatively weak, it nonetheless roots ADHD in the *practice* of medical classification.

The second piece of evidence is that ADHD's heritage is found in the annals of medical research history, evidenced in a series of lectures by a medical academic, George Still (1902). In a series of lectures delivered to the Royal College of

Physicians in England, ADHD was first 'branded' as "volitional inhibition". Its cause was attributed to "defects in moral control"

Interestingly, these earliest conceptions of ADHD can be visualized as an 'heirloom', evoking, differing responses. Barkley (1990a, 1997), for example, refers to Still's notes as an indication of the root of the perennis of ADHD whereas Breggin (1995), uses the same example as a reason to dispute ADHD's medical validity and its very existence. Although these viewpoints represent either end of the ADHD spectrum, it is undisputed that Still (1902) interpreted the behaviours of the children referred to him in the context of Victorian England at the time of the implementation of the Lunatics Act and the Asylums Act (both of 1845). These Acts provided a comprehensive national system of certification of 'idiot' children and adults known as the 'pauper insane'; those who were also seen as morally deficient. While the emphasis here is on people who appeared to have 'low intelligence', the point to be made is that people with various 'deficiencies' became prevalent as "scientific" inquiry grew after the Enlightenment era, and especially in the 19th century. Therefore, while the specificity of the diagnosis came much later, the relatively recent phenomenon of ADHD, as it is 'understood' today, fits within in a long history of diagnosticians trying to put labels on different aspects of human behaviour.

The referential link between ADHD and morality (evident in the eugenics movement in the late 19th and early 20th centuries) is, therefore, extremely important. It provides insight into current ADHD discourse because the introduction of 'idiocy' and 'imbecility' provided one of the first known opportunities for doctors (and psychologists) to medicalize behaviours deemed 'morally' inappropriate within the cultural context of the day.

Drawing on these two elements of ADHD's historical roots, ADHD (although identified using earlier nomenclature) was arguably born in a period of human history when 'behaviours' were commonly justified as warranting exclusion from mainstream society. Some may propose that little has changed. Either way, there is little doubt that this was a period when "putting away" 'undesirable' family members (including children and infants) and when "moralizing" behaviour was prevalent.

Cravens (1993), for example, in investigating the "child saving" movement in the late 19th century in the United States, reported that people with perceived 'learning difficulties' were believed to be "feebleminded" (Cravens, 1993). A link can be made to the then esteemed psychologist and chief administrator of the Vineland Training School, New Jersey USA, Henry Goddard, in 1890, who referred to "feeblemindedness" as a social evil causing individuals to be criminals, paupers, dependents and other "bad sorts" (Cravens, 1993). While these descriptions are not strictly 'ADHD-like' behaviours, others are. Take, for example, the records of a child accepted as a private inmate of the Earlswood Asylum, England, who, in the late 19th century, was referred by a domestic servant on the grounds that he[11]:

> Cannot dress or feed himself, that he eats ravenously & (sic.) bolts his food; that he is inattentive to the calls of nature; that he is restless and destructive" (Certificate for insanity for James Allen (Wright, Gronfein, & Owens, 2000).

Overall, this trend continued throughout the western world during the ensuing century attracting, in particular, the attention of sociologists and philosophers. Michael Foucault's exposition on institutions such as mental asylums, hospitals and prisons, for example, led to theoretical postulation of the power of medical interpretations of

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[11] No one knows how long the child would have been institutionalized but it is likely to have been no less than six years according to the practice of the day.

behaviour in objectifying those deemed to be socially unacceptable (Foucault, 1965a, 1977, 1980). Yet, despite ensuing theoretical development of the sociology of medicine and social control, the medical interpretation of ADHD strengthened.

Post World War 1, ADHD behaviours were interpreted as being caused by a virus manifesting in the disease Encephalitis Lethargica: a condition with symptoms of 'defiant' and/or 'immoral' behaviours (Rafalovich, 2004). Ironically, Barkley (1990) later referred to this condition as a possible neurological trigger of ADHD and the link between morality, neurology and ADHD was, perhaps unwittingly, made.

Later, 'dopamine' deficiency was believed to be the cause of chemical imbalance in the prefrontal cortex[12]. It was the dopamine deficiency argument, sometimes referred to as 'chemical imbalance', which, even though its empirical validity was strongly contended[13], formed a very important bridge between psychiatric discourse and notions of a chemically treatable brain[14].

Discussions along these lines could continue in depth, beyond the scope of this study. While much could be said about ADHD's heritage, in sum, the key point is that ADHD has emerged primarily through a fusion of mental health and neurological discourse. This is important to note because it could explain the complexity of a 'condition' enmeshed in what may be described as a continuum of thickly woven strands of medical and sociological 'tug-o-war'. At one end of the spectrum, the 'ADHD brain' is viewed as *treatable* and at the other, as *controllable*.

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12 Psychotropic treatment was purported to be capable of restoring dopamine levels.

13 Even with the neurological field, the dopamine argument is considered a paradox because it suggests an 'under activated' rather than an 'overactive' brain (Levy & Swanson, 2001). An earlier experimental study (Rappaport,1978), tested the effects of administering psychotropic medication to children diagnosed as having ADHD as well as to those who did not have ADHD and found that both groups reacted similarly with increased attention with subdued physical activity. These findings presented evidence diminishing the value of the dopamine deficiency conjecture.

14 Although experimental research in genetic studies examining dopamine genetic studies has gained momentum, criticisms and counter arguments continue Langley et al. (2005) as an example of contemporary 'dopamine' counter argument.

Current issues

Since its earliest days, ADHD has been conceptually complicated. It can be argued that its clarity of definition has, throughout the decades, been neither diminished nor crystallised. This is so despite increasingly sophisticated 'state of the art' medical technology. As a result, it is reasonable to say that ADHD's geographic and intra-generational trajectory remains medically and socially ambiguous.

Being contentious, as it is, there are numerous ways in which ADHD can be problematized. I have briefly addressed two interrelated areas of interest as a way of non-specifically contextualizing the participants in this study. These are, firstly, matters concerning the diagnosis of ADHD and its consequential so-called 'prevalence' and secondly, the medical treatment administered to those deemed to 'be' ADHD.

Diagnosis and prevalence

In general, illnesses and disorders (of numerous kinds) are 'legitimized' by pathological evidence. Hand in hand with such diagnoses, treatment records indicate the rates of prevalence or particular diseases.

Pathology is less relevant in relation to mental health disorders, where 'patient' history and a behavioural assessment legitimize a variety of conditions (Silver, 2003). In these cases, it can be argued that 'medical treatment', usually in the form of *psychotropic medication*, provides an important *symbol of legitimacy*.

ADHD, viewed as a mental disorder, is no exception. In the absence of biological measures, 'qualified' medical professionals "officialise" ADHD, not so much on the basis of neurological imaging or genetic coding or any other biological means (all of which have failed to definitely pin-point ADHD (Jay, 2004; Pittelli, 2002)), but by practitioner *interpretation* of human behaviour, as is the case with most psychiatric conditions. At the same time, practitioners' ways of gathering 'evidence' varies. One commonly used method is the perusal of completed checklists and questionnaires, such as the Conners' Rating Scale (Conners, 1997). These are usually completed by non-medical personnel such as parents and teachers and are poorly correlated (Green, Wong, & Atkinson, 1999)[15]. As discussed earlier, underpinning these however, is the *Diagnostic and Statistical Manual,* now in its fourth and soon to be 5th (American Psychiatric Association, 2000) (see Appendix III) which provides (particularly in the United States and Australia) the 'official' 'interpretive' tool.

Despite the *Diagnostic and Statistical Manual* being used worldwide in courts of law, the list of ADHD symptoms specified therein utilize non-robust terms, such as "careless" and "forgetful", and "often", which is used no less than fifteen times (as seen in Appendix III). These non-measurable terms are used as 'quantifiers' of behaviours that are thought to contravene 'social expectations' typically required in western classrooms.

As the "gold standard" of medical interpretation of ADHD, it is not surprising that ADHD is described similarly in other sources. The World Health Organization's most recent attempt to describe ADHD, for example, uses "all" and "few" with "active", "hyperactive'" and overactive", in its 'official' description, as shown:

> Attention Deficit Hyperactivity Disorder: All children are active, but a few are overactive and considered hyperactive. They may sleep only a few hours at a time. When awake, they are impulsive, constantly in motion, darting from one activity to another, often failing to sustain attention in simple tasks or games (World Health Organization WHO, 2007).

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[15] These 'scales' are either cited as "proof" of the neurologically dysfunctional ADHD brain, or evidence of ADHD 'tomfoolery'.

If imprecise descriptions such as these provoke scepticism, then it is of little surprise that escalating rates of diagnoses[16] raise significant variations in social responses to 'ADHD'. This is evidenced in the media, and in turn, in socio/political organizations, even though there are rare examples of de-escalation of ADHD prevalence due to lobbying)[17]. Overall, reports of ADHD prevalence are inconsistent[18] and consensus cannot be reached despite attempts to synthesize opinions from scores of writers (Goodman & Poillon, 1992)[19].

Medical treatment

The rapid increase in ADHD diagnoses and associated treatment is not necessarily confined to the condition of ADHD alone. Further, such escalation attracts a range of responses, particularly with regard to ADHD medication. There are, not surprisingly, opponents and proponents. Whatever one's point of view, however, it is possible that medical treatment for ADHD may have attracted negligible attention were it not for a growing awareness of the risks associated with it (Vitiello, 2008; Wigal, 2009; Winterstein, Gerhard, Shuster, & Saidi, 2009). Arguably, it is not that ADHD medication is 'new'[20] that is cause for concern, but that ADHD medication, and its possible serious side effects, is now being increasingly administered to very young

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[16] This is so, especially in developing countries (Kuruppuarachchi & Wijeratne, 2004), and also in the toddler and preschool age range (Hale & Deceglie, 2009).

[17] De-escalation is reported in Western Australia following a stream of political lobbying (Western Australia Policy Forum, 2009)

[18] Some reports suggest a threefold worldwide diagnostic increase in ADHD between 1993 and 2003 yielding an average of 5% of the world population and a disproportionate ninefold increase in spending on ADHD medication with some reporting as much as US $ 2.4 billion (Scheffler, Hinshaw, Modrek, & Levine, 2007). It is reported that between 1990 and 1997 there was a 700% increase in ADHD prescriptions for children in the U.S. (Diller, 1998) and in England, a 600% increase in filled prescriptions between 1994 and 2004 (U.K. Government, 2004).

[19] The Diagnostic and Statistical Manual of Mental Disorders -Text Revision (American Psychiatric Association, 2000) reports 3%-7% of school aged children as having ADHD yet other sources show rates as high as 15.2% in Israel (Brook & Boaz, 2005),17% in United States (Scahill & Schwab-Stone, 2000), and 20.4% in Columbia (Cornejo, et al., 2005). In contrast, in Europe they are as low as 2% to 5% (Buitelaar, et al., 2006).

[20] ADHD medication is reported as being introduced when Charles Bradley, in 1937, observed that amphetamine drugs like Benzedrine had a dramatic effect in subduing behaviour (Bradley, 1941; Bradley & Bowen, 1940).

children (Chacko, et al., 2009; Fanton & Gleason, 2009; Greenhill, Posner, Vaughan, & Kratochvil, 2008; Zito, et al., 2000). It also appears that growing concerns about the impact of such medication on young developing brains, which some say is tantamount to child abuse (Breggin, 1998, 2000), may be overshadowing the well documented negative social consequences of 'being ADHD'. Moreover, negative social consequences long associated with those so diagnosed, such as stigma and social exclusion (Coleman, Walker, Lee, Friesen, & Squire, 2009; Jastrowski, Berlin, Sato, & Davies, 2007; McMenamy & Perrin, 2008; Pescosolido, et al., 2008; Peters & Jackson, 2009) are juxtaposed with contrasting moral questions relating to arguments favouring ADHD medication for 'suffering children' (Barkley, 1990a; Faraone, Biederman, Morley, & Spencer, 2008; Hallowell & Ratey, 1995)

Adding to the complexities surrounding the medication debate is the role of consumerism borne out by the growing choices in modes of bodily delivery. Recently, for example, the Food and Drug Authority (FDA) in the United States approved a transdermal patch, Daytrama™[21] for children using stimulants such as dextroamphetemine, methylphenidate and pemoline (Rosack, 2006). Such convenience is believed to have directly boosted the already established multi-billion dollar industry (Mintzes, 2006)[22] overshadowing concerns regarding the possible side effects of decreased appetite, insomnia, stomach ache, headache, irritability tics and height and weight suppression[23] (Faraone, Biederman, & Spencer, 2009).

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[21] This is a "bandaid" style sticky patch applied to the child's skin. It can be concealed under clothing. It delivers a formulation of methylphenidate in increments from 10 to 30 mg doses and is replaced daily.

[22] Some reports indicate that as many as three million children are diagnosed as having ADHD, representing 10% of all 10 year old boys in the U.S. and 1.5 million adults (Kirkey, 2006; Nissen, 2006); 1.9 million prescriptions for ADHD stimulants were processed by Canadian pharmacies in the 12 months ending April 30, 2006. (Kirkey, 2006).

[23] Few disagree that ADHD medication decreases children's weight and height growth although there is much disagreement about the degree. For a comprehensive review of the literature on the effects of

Despite debate and media attention highlighting the possible negative consequences of ADHD medication, and notwithstanding the claims of social critics and psychiatric researcher Jackson (2009, p. 278), who says:

> The era of the psychostimulant marks a reprehensible period in the history of modern medicine (G. E. Jackson, 2009),

the seeming dismissal of side effects evidenced by burgeoning ADHD medication sales, remains unexplained. It may be because parents and medical practitioner alike have been influenced by rhetoric designed to convince otherwise, as the following excerpts from well-known ADHD 'experts' declare:

> Treatments we now use in the treatment of attention deficit disorder can dramatically improve the quality of an individual's life just as glasses help the nearsighted focus (Hallowell & Ratey, 1995)
>
> It is extraordinary how many false rumours swirl around...the fact is that when Ritalin and other medication are used properly they are very safe indeed (Hallowell & Ratey, 1995)
>
> Stimulants are remarkably free of side effects (Green & Chee, 1997, p. 143)
>
> ...unfounded fear of these drugs is unfortunately perpetuated by some physicians' requirement that parents sign a consent form ...If your doctor asks you to sign such a form don't assume it means the drugs are dangerous (R. Barkley, 2000, p. 217)

Around a decade after claims such as the above were made, on May 26 2006, the drug Safety and Risk Management Advisory Committee of the Food and Drug Administration (FDA) recommended a "Black Box Warning" for all ADHD

ADHD medication on children's height and weight development see Faraone, Biederman, Morely and Spencer (2008).

medication (Gorman, 2006; Kirkey, 2006)[24]. Despite this, and disputes relating to it, many so-called 'ADHD medical experts' are still found to be pointing out the benefits of ADHD medication, while sparingly acknowledging the growing body of evidence claiming that it can be harmful[25].

Much of the media attention concerning ADHD medication refers to the potentially fatal heart and liver damage of ADHD medications. Specifically, questions are raised about the use of Ritalin™, whose chemical properties (although quantities and mode of delivery differ) are similar to illicit drugs such as cocaine (Ashton, Gallagher, & Moore, 2006; Cardo & Servera, 2008; Timimi & Leo, 2009, p. 27; Vastag, 2001); Dexamphetamine, which shares the same pharmaceutical family as crystal Methamphetamine, commonly known as Speed and Ice (Shearer, et al., 2001); and Strattera®, where suicidal ideation is becoming increasingly reported. Furthermore, social problems surrounding ADHD medication extend beyond individual children. Other matters, such as the over prescription of ADHD medication (Calver, Sanfilippo, Preen, & Bulsara, 2007) and illicit drug trading of ADHD medication (Crime and Misconduct Commission, 2002) are but a sample of conflicting social pressures for policy makers to address.

Indeed, media attention to the use and 'abuse' of ADHD medication can be seen as attracting political reactions. On July 2007, for example, the then minister for Health and Ageing in Australia, Tony Abbott proposed relaxing government subsidies to include atomoxetine hydrochloride (packaged as Strattera ®) [26], saying that adverse academic and social behaviours associated with ADHD would be better managed

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[24] This was based on direct causal links with potentially fatal cardiovascular illnesses

[25] I attended the CHERI conference in 2007 where I noted Dr Paul Hutchen's berating of those who raised questions about the safety of ADHD medication (Hutchins, 2007).

[26] Tony Abbott sought for this medication to be added to the list of subsidised drugs through the Pharmaceutical Benefits Scheme (PBS) at an expected cost of $101 million over the following 3 years.

children themselves, are in one way or another, submersed in a range of conflicting social messages about ADHD, and its treatment.

ADHD Perspectives

As previously highlighted, examination of the ADHD phenomenon unveils a range of contemporary belief systems that discuss ADHD in a variety of ways. Some critics, such as Breggin (1995, 1998) completely reject the notion of ADHD, believing it to be a scandalous fraud. Cohen (2006), for example, thinks of ADHD and its common form of treatment, Ritalin™, as a marker of the psychiatric colonization of childhood. Others, such as Carey (2002) and Diller (1998), allow for the possibility that such a condition is legitimate, in a descriptive sense, for some children, but that current treatment practices have strongly diminished the value of ADHD's identification. Still others, such as Armstrong, (2006, p. 34) suggest that ADHD is a postmodern condition reflecting what he describes as a "short attention span culture". Social critic, Conrad (2007), directs comment on the legitimacy of ADHD in a biological sense, to examination of the sociological impact of its presence in the broader context of the medicalization of society.

The following outline of ADHD perspectives, therefore, is not intended as definitive, as an exhaustive list of opinions and beliefs about ADHD is no more possible than practical. After all, perspectives of ADHD could be accounted for and sub-divided in numerous ways using differing combinations of non- standardized terminology. As foundational to this study, I introduce two primary standpoints from which ADHD 'meanings' may be discussed. These are the *bio-neurological perspective* (with *'psycho-neurological' and 'psycho-enviro' sub-perspectives*) and the *social constructionist perspectives.* As the psycho-neurological and psycho-enviro sub-through increased access to medication (Abbott, 2007). However, others, like Martin Whitely, member of the Australian Legislative Assembly in Western Australia, drew attention to ADHD diagnostic 'fraud'. He stated:

> I have been lobbying to fix the over diagnosis/over prescription problem in this country for 16 years. I used to think that it was an over diagnosis problem but after looking into it as much as I have, I am convinced that I don't believe in ADHD at all any more. We've had some doctors over here in this state prescribing with no evidence of it. We had one character serving on a government enquiry into the over diagnosis problem and then we found out that he was in the pocket of one of the drug companies so we got rid of him. This ADHD thing is a sham. The problem is the medical world is more organized than those of us who want to shine some light on what's going on. We need to be more organized. ADHD is just wrong (Hill, 2008),

All the while, teachers were required to act as medication managers, as the following directive shows:

> A frequent intervention for children diagnosed with ADHD is the prescription by medical practitioners of stimulant medication (typically Dexamphetamine or Methylphenidate). Some children may need to take medication during school hours and this requirement would need to be included within the child's management plan. The Education Department's Administration of Medication Policy (1997) stipulates that schools are obliged to comply with reasonable requests for assistance in the administration of medication. (Western Australian, 2006)

Central to the medication argument, therefore, are the degree to which parents, medical professionals, teachers and society at large, is willing to trade the possibility of social and physical side-effects for 'placid children'.

While issues such as these could be debated at length, in summation, it is clear that the participants in this study, be they teachers, parents, medical professionals or the perspectives share the commonality that ADHD is essentially *caused* by a dysfunctional brain, they provide a distinct contrast to the social constructionist position.

Each of these 'grande' perspectives informs the analysis of this study. The bio-*neurological perspective,* being anchored within a medical model of ADHD, is of critical importance, because it suggests the likely standpoint of the doctor participants. Further as the parents (and perhaps teachers) engage with the doctors in the diagnostic act, it is likely to be instrumental in the enactment of the diagnostic process and the 'legitimization' of the ADHD 'patient' and therefore may assist in illuminating participants'' views of ADHD as a medical 'condition'. However, as this study attempts to illuminate *how* medical jurisdiction actually takes hold in the lives of children whose behaviour is judged as troublesome, the psycho-neurological perspective alone may not suffice in informing the social processes at work in 'becoming ADHD'. Therefore, perusal of a *social constructionist perspective* of ADHD is of equal importance, especially as it resonates with the interactionist approach adopted in this study. Therefore, the arguments presented in this thesis will ultimately draw on both psycho-neurological and social constructionist perspectives of ADHD.

Before interrogating specific perspectives in detail, however, it is important to establish the notion that perspectives influence action. This idea is central to social enquiry. Charon (2007) explains that perspectives comprise a blend of assumptions and moral judgements. These function to 'texturize' an individual's view of the world.

Understanding 'knowing', however, is not simple, as philosophers across the centuries have long espoused. Debates about 'realities' are far too complex to accommodate in this dissertation, however Immanuel Kant's (1724-1804) views of the power of perspectives to illuminate 'knowing' ought not be omitted (although admittedly loosely adapted here). In light of his premise that 'perspectives' are windows into *aspects* of reality and, in particular, that 'hard science' (akin to the dominant psycho-neurological perspective of ADHD), inculcates the belief that objective truth is attainable, the medical model of ADHD not only seems less robust, but ADHD 'realities' are incalculable.

The neurological perspective

The neurological stance towards ADHD forms the central pillar of the dominant medical model. This perspective, in simplistic terms, epitomizes a 'hard science' approach to the aetiology of ADHD. Although complicated by competing strands within, it unequivocally adheres to neurological dysfunctionality, purporting technologically enhanced techniques to 'expose' ADHD.

The neurological perspective is arguably the most influential perspective of all because it influences policy-making at various levels. It is notable that some earlier neurological studies conducted by Barkley (1991, 1997), for example, have been used to inform definitions and government policy on ADHD.

Those who have challenged this position have encountered strong defence. For example, an excerpt from the International Consensus Statement (2002) found in Barkley's *'official ADHD Site'*, demonstrates this point. It reads:

> We, the undersigned consortium of international scientists, are deeply concerned about the periodic inaccurate portrayal of attention deficit hyperactivity disorder (ADHD) in media reports. This is a disorder with which we are all very familiar and toward which many of us have dedicated scientific studies if not entire careers. 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. It also leaves the public with a general sense that this disorder is not valid or real or consists of a rather trivial affliction.
>
> We have created this consensus statement on ADHD as a reference on the status of the scientific findings concerning this disorder, its validity, and its adverse impact on the lives of those diagnosed with the disorder as of this writing. (R. Barkley, 2006)

Barkley adds further weight to the psycho-neurological position using analogies like " virus...HIV/AIDS" and "smoking...cancer" to emphasise if not alarm his audience. Furthermore, he 'recruits' powerful institutional organizations of his persuasion to support his counter attack. He states[27]:

> The views of a handful of non-expert doctors that ADHD does not exist are contrasted against mainstream scientific views that it does, as if both views had equal merit... In fact, there is no such disagreement—at least no more so than there is over whether smoking causes cancer, for example, or whether a virus causes HIV/AIDS. The U.S. Surgeon General, the American Medical Association, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the American Psychological Association, and the American Academy of Paediatrics, among others, all recognize ADHD as a valid disorder (Barkley, 2006).

While the work of Barkley remains influential[28], scrutiny of the psycho-neurological viewpoint reveals numerous endeavours to provide reliable empirical evidence of ADHD. Although several strands within this overarching standpoint continue to attract research interest, none have successfully captured ADHD thus far. Despite there being no 'official' names or established 'list', I briefly describe influential 'sub-perspectives' within the broad psycho- neurological scope detailed below.

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[27] It is also interesting to note that Russell Barkley, on the same website, attempts to exonerate himself from accusation of being personally funded by pharmaceutical companies.

[28] Russell Barkley's writing is not confined to professional or academic genres. It extends to several 'easy read' self-help books such as Taking Charge of ADHD (2000) nominated by the retailer AMAZON™ as a 'best-seller'.

Psycho-neurological perspective

The psycho-neurological sub perspective of ADHD can be described in terms of a 'medical model' in its purist sense. Within this framework, ADHD is commonly constructed as an inheritable disorder of the brain as an organ, which directly affects the behaviour of the person 'suffering' from it.

Arguably, the *genetic perspective* of ADHD, which more recently has largely emanated from the mapping of the Human Genome, could be described as yet another sub perspective in its own right because infuses several others. However, I concentrate on its role as both the cornerstone of the psycho-neurological perspective and a common thread in various strands within.

Although few disagree that no definitive genetic links to ADHD have yet been established (Furman, 2008; Joseph, 2000, 2006)[29], perceptions of ADHD's genetic origins persist.

The genetic interpretation of ADHD attempts to specifically locate ADHD genetic coding, as is the case for other mental illness conditions like schizophrenia (Chapman, 1991; Heston, 1970; Orourke, Gottesman, Suarez, Rice, & Reich, 1982; Pedrosa, et al., 2009; Remschmidt & Theisen, 2005)[30] [31]. Interestingly, like ADHD, schizophrenia is a similarly contested 'condition'. Indeed, aside from evidence contradicting genetic causes for people exhibiting 'symptoms' of schizophrenia

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[29] The Abstracts for the XIth World Congress of Psychiatric Genetics in 2003 (Barden, 2003), showcased numerous research findings relating to associations and genetic markers attributed to ADHD but as yet no genetic link has moved beyond hypothesis.

[30] Some of the earliest studies attempting to link behaviour with genetic characteristic came from studies of identical and fraternal twins conducted in 1929 with a study on 'criminal twins' (Lange, 1930). Since then, numerous twin and adoption studies have failed to show a genetic predisposition towards any form of antisocial behaviour, however, 'antisocial' may be defined. An in depth critique of the literature on this subject is found in Jay Joseph's chapter 8 in his book The Gene Illusion (2004).

[31] DNA micro array technology attempts to make direct causal links between psychiatric disorders, including ADHD within complex gene patterns.

(Tienari et al. 2004) and confusion in alleged comorbidity with other 'conditions', such as substance addictions (Dixon, 1999), the actual 'existence' of schizophrenia itself is increasingly chalenged (Read et al. 2004). Moreover, alternative psychological explanations offered by those experiencing 'symptoms' consistent with 'schizophrenia' (Hornstein, 2009; Romme et al. 2009) have added to existing concerns about the credibility of the Diagnostic and Statistical Manuel (Mosekwitz & Corstens, 2007) in categorizing mental illnesses. Furthermore, schizophrenia's recent absorption into Psychosis Risk Syndrome in the 5th edition of the Diagnostic and Statistical Manuel (Ross, 2010) is akin to Conrad and Potter's (2000) assertions of diagnostic elasticity associated with medicalizing distress in its many and varied forms.

Overlaying popular beliefs of ADHD's genetic origins, and despite criticisms of it, various bio-technological techniques have emerged. I have described these as the *neuro-transmitter perspective*. These include scanning techniques, such as positron emission topography (PET), electroencephalogram brain waves (EEG) and functional Magnetic Resonance Imaging (fRMI), each attempting to provide a visual map of ADHD 'at work' in an individual's brain. Findings from several studies utilizing techniques such as these have been strongly criticized on several counts. These include: small sample sizes; heterogeneous and non-comparable control groups; lack of replication; use of cross-sectional rather than longitudinal data; and the lack of distinction between results that show an association and those that show cause and effect.

One example typifying the failure of techniques such as these is (Kovatchev, et al., 2001) study of neurotransmitter activity in adolescents diagnosed as having ADHD. The research findings from this study were accused of merely measuring blood flow rather than actual brain activity (Jackson, 2006). Moreover, neurological scientist, Leo and sociologist Cohen (Leo & Cohen, 2003), criticized a review of 30 neuro-imaging studies implicating ADHD's influence on the brain's neural circuitry (Giedd, Blumenthal, Molloy, & Castellanos, 2001), because none of these studies reported on whether the participants were medicated at the time of testing.

Another term which I introduce as the *psychostimulant-impact perspective* claims that behavioural changes induced by ADHD stimulant medication verify ADHD's existence. Put another way, if the consumption of medication results in behavioural change, then this in itself 'proves' the sufferer to 'be ADHD'. This is so, even though it is well known that stimulants cause behavioural changes in animal and human behaviour whether or not there is a prior condition of mental illness[32].

Psycho-enviro perspective

This position proposes that ADHD is caused by interplay between environmental conditions (social and/or physical) and a 'pre-existing' neurological problem in an individual. The spectrum of possible environmental factors believed to expose or 'activate' ADHD is endless making classification near impossible. Moreover, the reasons why some favour certain circumstances over others are unclear. Interestingly, Rafalovich (2005a), in interviewing clinicians, found that paediatricians and general practitioners tended to approach ADHD from a neurological standpoint whilst clinical psychologists, psychiatrists and family therapists placed more emphasis on taking into account the enviro-social context of the child[33].

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[32] For a comprehensive review of several key meta analyses of the serious flaws in deranging ADHD 'meaning' from the use of medication I refer the reader to David Cohen's chapter Critiques of the ADHD enterprise (D. Cohen, 2006) where he comments on the US Agency for Health Care Policy and Research (AHCPR) findings amongst other broad reviews.

[33] Perhaps this is because each view supports respective professions.

An excellent example of the psycho-enviro perspective is evidenced in the work of medical practitioner and paediatrician turned allergist, Ben Feingold. In his book *Why Your Child is Hyperactive* (1975), certain foods, food additives and food processing techniques associated with the modern fast-food industry are reported to cause an allergic reaction or 'poisoning' which, in turn, is thought to interact with an individual's ADHD predisposition.

Feingold (and those of his persuasion) has played a significant role in destabilising the neurological view[34]. This is borne out by popular Complimentary Alternative Medical (CAM) therapies. Researchers such as Rojas and Chan (2005), for example, although criticized by some as "disease mongering" (2006), argued that 'natural' remedies could be substituted for psychotropic pharmacology to treat ADHD [35].

Diller (1998) and Furman (2005) typify yet another strand of thinking which implicates family dynamics and traumatic life events as being possible triggers for ADHD. This view is reminiscent of earlier 1920's ideas that connected childhood neurosis with childhood misbehaviour. Those of a Freudian persuasion popularized *psychoanalysis* in children and the ADHD debate shifted to interpretations of unwanted social behaviour as an outcome of the psyches' adjustment to latency (Freud, 1946)[36].

Comparatively, an important distinction between the psycho-environmental and the psycho-neurological perspectives is the *treatment* of ADHD. The former accepts the role of pharmacology to degree, yet allows for the possibility of improvement in

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[34] The Feingold position is considered to be related to a social constructionist view because Feingold conceptualized ADHD as a 'new' social phenomenon.

[35] Rojas and Chan (Rojas & Chan, 2005) claimed that essential fatty acid supplementation, yoga, massage and homeopathy were very useful in treating ADHD.

[36] 'Latency is a term used by Freud to identify a developmental period of mental maturity starting around the five up to the age of puberty. Psychoanalysis, though indirectly, strongly influences certain therapy approaches to ADHD today although it is not without its critics, especially from those from a neurological persuasion.

It is reasonable to assume that such complexities, as noted by Burr, could apply to numerous 'conditions', making a social constructionist approach well suited to the exploration of social orientations of ADHD. However, while this may be the case, a closer review of contemporary disagreements surrounding this broad sweeping term, 'social constructionism', suggests that doing so may be more challenging than one may initially expect. This may be at least partly because, as Lock and Strong point out, "there is no one school of social constructionism" (2010, p. 6).

Popularized by Berger and Luckmann (1966), and, according to Hacking (1999), deeply rooted in Kantian philosophy, this is not perhaps surprising as social constructionism is reported to have emerged through several schools of thought. Lock and Strong (2010) trace its development through, for example, the broad existential tradition of the French philosopher Maurice Merleau-Ponty (1962); Foucault's (1965) discursive 'self'; Mead's (1939) notions of 'self, other and I' and, in no way exhausting the list, Goffman's 'performance' of social roles (1959).

It is widely held, however, that it was the sociological critique of 'social problems' in the 1970's, which brought 'social constructionist' ideology (and the rising interest in phenomenological sociology), to the fore (Best, 2002). This was largely due to the theoretical work of Spector and Kituse (1977) who are attributed to have steered social *enquiry* towards a focus on the 'social conditions' that underpin perceptions of 'social problems'. The ensuing decades that followed showed a trend towards social researchers asking *how* and *why* particular social problems had, in the first instance, become 'popularized' (Loseke & Best, 2003). Moreover while contemporary 'meaning-making' rhetoric labelled as 'social constructionism', intensified and, at the same time, broadened (Denzin & Lincoln, 2005; Holstein & Gubrium, 2008), it was symptoms through therapy and or environmental management including pedagogy and family therapy whilst the latter focuses on treating the brain as an organ. The latter relies heavily on psychotropic treatment alone.

Social constructionist perspective

In contrast to previously discussed 'perspectives', this section differs. Rather than simply presenting alternative views to the dominant neurological position, the tenets of social constructionism turns the focus to the *notion* that perceptions of ADHD are related to the social experiences and beliefs of actors, rather than mere descriptions of such perceptions. As such, the 'social constructionist perspective' represents an approach to the exploration of ADHD 'meanings', the social actors who may be involved, and their social reactions to it. For this reason, as 'medicalization' is in itself a constructionist 'idea' (Conrad & Potter, 2000), consideration of views deemed to reflect a 'social constructionist perspective' may be useful in exploring underlying beliefs and reactions connected with it.

Indeed, numerous sociological studies indicate the adoption of a social constructionist standpoint when investigating a broad range of social problems. This is exemplified in Burr's (1995) exploration of 'illness and disease'. Here, multiple layers of human experience are implicated. She states:

> Defining illness and disease is not simply a matter of identifying the presence of pathology. It is a deeply social matter involving the interpretation of our experience within our particular cultural context of assumptions, norms and values as well as the economic structure of our society. It is also a matter of power relations. The bodies 'deficiencies' only show up as such when persons are constrained to live in environments designed to suit the needs and activities of others' (Burr, 1995, p. 40)

perhaps to be expected that research studies claiming to have drawn on a social constructionist perspective reflected quite different research topics. These varied, for example, from 'realty television' exposing crime (Cavender, 2003) to the theorizing the social organization of deviance (Best & Luckenbill, 1994). Closer to the topic under investigation in this study, Singh (2004) utilized a social constructionist stance to uncover numerous ambiguities surrounding ADHD 'meanings' and Conrad and Potter (2000) framed their investigating of the expansion of medicalizing categories. Constructionist thinking on the process of medicalization is demonstrated as follows:

> Psychiatric and medical diagnoses are the product of socio-historical circumstances and the claims-making of particular interest groups. New diagnoses rarely emerge simply as a result of new scientific discoveries. Medicalization studies have demonstrated that agents such as self- help and advocacy groups, social movements, health-related organizations, pharmaceutical companies, academic researchers, and clinicians can be central in creating specific diagnoses.(Conrad and Potter, 2000)

A further example of the effectiveness of interrogating social problems from a social constructionist perspective is found in Pawluch's (2003) analysis of the changing characterisation of the "new paediatrics". She found that social actors performing the role of paediatricians "oversee not only children's physical growth and development, but their emotional, psychological, social and even, as some paediatricians have interpreted it, their spiritual well being" (p. 219).

Yet another example of sociological enquiry into cultural definitions of 'disease' is found in Zola's (1966) comparative analysis of differences in interpreting symptoms between 'patients' of Italian and Irish ethnic origins. This study showed that "socio-cultural background may lead to different definitions and responses to essentially the same experience" (Zola, 1966, p. 630). It therefore highlights the importance of *social interpretations* of abnormality.

Applying some of the principles discussed thus far, if one assumes the position that the social world is the product of social processes (Burr, 2003), then a social constructionist approach to ADHD would suggest that the varied 'meanings' of ADHD, even meanings derived from the psycho-neurological and psycho-environmental perspectives, are a direct perception of multiple ADHD realities. It further suggests that social reactions to such meanings could include medicalizing actions. Therefore, returning to the task of relaying a social constructionist perspective of ADHD for the purposes of this study, this standpoint steers attention towards exposing social responses to ADHD 'meanings', rather than *describing* 'meanings' of ADHD per se.

Beyond challenging medical domination, social constructionism is also used to explain social phenomena. Such an example is found in Armstrong's article, *Canaries in the Coalmine* (Armstrong, 2006). Here, Armstrong suggests that the global community of today is itself in the process of developing a collective 'short attention span'[37]. Likewise, Grandpre in his book, *Ritalin Nation* (1999),views ADHD as a product of a modern "rapid fire culture" within a contradictory world of virtual and actual realities. Grandpre claims that vulnerable ADHD individuals are the ones who are unable to cope with it. Still others conceptualize ADHD as a symbol of pharmaceutical enterprise (Stead, Lloyd, & Cohen, 2006) and Conrad (1997) suggests that the neuro-scientific approach acts symbiotically with the alluring power of the media's involvement, to shape public perceptions. Interestingly, according to Norris and Lloyd (2000), the topics of medication, criminality, genetic studies, educational

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[37] Thomas Armstrong draws upon classical ideas of Pavlovian conditioning to develop his theory of commercial exploitation. He outlines an analysis of media intent in 'jolts per second', representing sudden or novel stimuli, to explain the emergence of the ADHD phenomenon. He claims that an increasing number of stimuli 'hits' are required to attract audience attention.

exclusion and examination accommodation are amongst the most popular aspects of ADHD featured in newspapers.

In sum, a social constructionist standpoint reveals there can be no objective *ADHD fact*. Therefore, it can be argued that the leverage social constructionist thinking has within the broad range of ADHD perspectives, is its facilitation of ADHD as an object with which people interact. Social constructionist ideas, therefore, form a natural conduit to the exploration of social reactions to human behaviour through the formation of moral judgements.

3 Medicalizing appropriation of deviance

In this chapter, notions of deviance and its links to the process of medicalization are addressed using a social constructionist approach. While each are different, the points of connection are explored because, as highlighted earlier, ADHD is primarily defined in terms of troublesome behaviour with associated mental disorder designation. Moreover, for the most part, ADHD is responded to through a medical paradigm.

The purpose of this chapter, therefore, is to propose a conceptual framework relating to how children's behaviour comes to be understood as deviant and subsequently allotted a mental disorder category, so named *ADHD*. In this respect, ADHD is viewed as an ambiguity attracting social responses not dissimilar to those produced by mental illness generally which, as Bracken and Thomas (2005, p. 59) remark, reflects "a paradox between care and control".

Introduction

Sociologists have long been interested in studying human behaviour. Making sense of children's behaviour, a task central to the focus of this study, draws wide interest across several disciplines. A search conducted 6 October 2008 using the key words 'behaviour' and 'child' using the academic search engine *web of science*, for example, yielded 44,298 peer reviewed journal articles alone from fields including psychology, psychiatry, paediatrics and disability studies. Researchers clearly want to know 'something' about children's behaviour, especially problematic behaviour; how to measure it, how to control it, how to understand its causes and social impact and how to define it.

Children's behaviour is central to this study because ADHD is predominantly framed in terms of problematic social *behaviour* (see appendix III for behaviours defined in 'clinical' terms as being evidence of ADHD). Even though ADHD has more recently 'officially' extended to include adults, in the case of my enquiry, those diagnosed as having ADHD are *children*.

As stated previously, ADHD is reported in academic literature and popular culture in markedly diverse ways. Everyday images are strikingly different, and vary from the Lancashire episode noted below (see *Image multiplicities and audience reactions*) to clichés and images of binge-drinking footballers (Daily Telegraph, 2004), forgetful and physically unsteady grannies (Clevenger, 2006), eccentric entrepreneurs (Gilbertson, 2003), cantankerous toddlers (Byrne, Bawden, Beattie, & DeWolfe, 2000) and suicidal adolescents (GalÈra, Bouvard, Encrenaz, Messiah, & Fombonne, 2008).

Some claim an authoritative stance exuding 'expert' knowledge of ADHD's pathology (Barkley, 2000; Biederman & Farone, 2004; Selikowitz, 2004). As noted earlier, ADHD, remains an enigma that most people have a definite opinion about; a 'condition' which blankets the globe in all manner of ways, leaving most who would analyse the wide variety of views sure of little more than to be ADHD is to be "different".

Is the existence of human difference enough, however, to explain the many faces of ADHD? Is it sufficient to make comprehensible the mass use of psychotropic medication to control the behaviours of those who have been so named "ADHD"? While these questions create an assortment of oddities to brood over, I leave the debate of definitions and divisions to others, for the critical aim of my study is to explore *how* an infant, born with the straightforward identity of 'child', is somehow transformed to 'ADHD incarnate'.

With this in mind, my intent is very much about burrowing beneath perspectives to expose glimpses of foundational anchor points to which ADHD is attached. One such cementation is, without a doubt, to notions of the unconventional, the peculiar, the troublesome and some may say, the deviant.

While I intend neither comprehensively reviewing the sociology of deviance nor theorizing ADHD, I am nonetheless aware that by situating ADHD within the realms of deviance I am creating links, as Conrad (1976b) did several decades ago, with a field of unclear origins. One which, some say, has petered out giving way to 'a sociology of censure' (Sumner, 1994, pp. 7-20). Even so, I am hopeful that a social constructionist perspective of deviance will illuminate much about how children's behaviour comes to be viewed in clinical terms because, by the very nature of constructionism, 'absolutes' are precluded.

As discussed earlier, social constructionism points to the importance of *meanings* attached to or derived from social interactions. As Adler and Adler (2003, pp. 3-4) explain:

> Constructionists argue that deviance is thus lodged in the eyes of the beholder rather than in the act itself. This creates the possibility of multiple definitions of acts simultaneously existing applied to people's behaviour or conditions that is rooted in the interaction between individuals and social groups. Those who have power to make and apply the rules onto others control the normative order.

I therefore proceed, not by reciting historical accounts and definitions of deviance *per se,* but by highlighting paradoxes and conflicts surrounding the *object* of ADHD to which actors react and interact. In this way, I probe the mobilization of ADHD as both a resource 'carrying' an individual to a 'new' place and as the destination.

Sociological orientations of 'becoming'

This study is primarily focused on the *process* of "becoming", that is, "becoming ADHD".

In order to understand more completely, how individuals or social groups 'become' socially identified, it is useful to consider the *meanings* and *processes* of social delineation and categorization through social symbols. Put another way, if one takes the position that the identification of ADHD can be 'seen' in terms of it being a form of deviance, then it stands to reason that "actions" relating to social responses to that deviance, so named ADHD, is valuable.

It could be argued that societal reactions to deviance vary as greatly as the social contexts in which they are studied. Power imbalances relating to social and economic status and institutional power include the endorsement of deviance by social control agencies like law enforcement, hospitals and schools (Grisso & Underwood, 2003), gender and social-psychological marginalization processes (Heimer, 1996) and social forces at work in the diagnoses of mental illnesses in children through parents and peers (Heimer & Matsueda, 1994). These are but a sample of the broad range of areas attracting research interest akin to this central idea.

Closer to the field of this study, albeit broad in itself, strong sequential links have been made between societal reactions to numerous forms of troublesome behaviour (Rosenfield, 1982) frequently described as an outcome of low intelligence and attention deficiencies (Grisso & Underwood, 2003)[38]. It is interesting to note, however, that only a few studies, actually link ADHD directly with the topic of deviance even though its 'official' status relies on descriptions of deviant behaviour rendering mental illness categorization (American Psychiatric Association, 2000). This is one reason, why the work of (Conrad, 1976a) provides a significant contrast to the vast gamut of research utilizing a psycho-neurological perspective. Conrad (1976b, p. 49) showed that almost all children who were identified as deviant in one social system, either school or family, "were defined as a medical problem in the same social system". This was, and remains, a very important clue to understanding the medicalization process, because it suggests a strong association between the identifying agent, the identification of deviance and the trajectory of diagnostic achievement.

Other research, influenced by the work of Conrad has since come to the fore. More recently, Rafalovich (2004), in his analysis of ADHD discourses in clinicians, teachers and parents, highlighted various ways in which ADHD is "framed" (or constructed) by these same powerful social agents. Rafalovich's work is particularly useful in showing how perspectives influence the actions of those who direct children's experiences of 'becoming ADHD'.

Many scholars have examined the *modus operandi* of deviance. Before progressing further, it is worth pointing out that I use deviance to mean identified behaviour that is considered "abnormal" or socially undesirable by a given audience. Even so, accepting ADHD as a 'type' of deviance is not necessarily my main concern. Rather, I emphasise that identification and responses to deviance may be explained (though

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38 These are commonly associated with screening and assessment tools designed to deliver 'evidence' to legitimize disorders such as ADHD (Yelich, 2001).

admittedly an oversimplification) through two primary stances influencing perspectives: the first is a *positivist* framework and the second, an *interactionist.*

Perspectives guided by a positivist approach to deviance support the objective 'existence' of deviance. For example, medical perspectives are generally positivist because ADHD is explained through aetiology and this viewpoint is consistent with interventions aimed at "fixing" the defective object. In contrast, an interactionist persuasion explains behaviour through the outworking of social and cultural forces working together to create social meaning. From this position, ADHD is a social construction dependent on human interactions.

I therefore begin by drawing on ideas found within the sociology of deviance where rich discourses concerning social responses to behaviour are already well documented. I point out at onset, however, that the overall subject of deviance, having emerged from scholarship in the early part of the 20th century[39], has drawn less interest from sociologists in recent decades. Indeed, some go so far as to say that it is no longer a serious stance in its own right. The decline of the sociology of deviance is largely thought to be the outcome of criticism of its shortcomings to incorporate numerous social injustices because, by the mid twentieth century, criticism of the conceptual framework of deviance began to emerge[40]. I refrain from interrogating the veracity of such claims but note with interest the idea that the demise of the

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[39] For an overview of the historical development of social understandings of deviance see Chapter 2 of Tannenbaum's Crime and the Community (1938) and Matza's Becoming a Deviant (1969): in particular chapters 1 and 2, major themes surrounding the emergence of deviance within several schools of thought are discussed.

[40] Though not necessarily explicit, Foucault is one such example of prominent discussion, which symbolizes the demise of the sociology of deviance. In his eminent book *Madness and Civilization* (1965b), Foucault draws attention to the state's control of morality through economic and political control of individuals within society.

sociology of deviance reportedly lays in its inability to satisfy the fundamental question relating to 'benchmarking' deviance (Sumner, 1994)[41].

In terms of empirical studies, aside from Conrad, few have studied ADHD through an interactionist deviance lens, although some have conducted related studies (Malacrida, 2003; Rafalovich, 2005b). Prior to Conrad's (1976b) seminal study, other notable scholars had attempted to explain human behaviour in terms of deviance (Becker, 1963; Erikson, 1962; Goffman, 1962, 1963, 1968; Kitsuse, 1962; Matza, 1969; Scheff, 1966) following the earlier work of Lemert (1951), Tannenbaum (1938) and Sumner (1906)[42].

The pioneering work of Tannenbaum (1938) is of particular interest to me because his work shows that the process of identifying deviance has long been contentious. In his rebuke of an 'absolutist' position, espoused by people such as Parsons (Parsons, 1926), Tannenbaum (1938, pp. 8-9) draws attention to social *reactions* to behaviour (in this case criminal behaviour). He asserts that the 'criminal' is constructed through *moral judgement* and contextualizes the criminal state by referring to the *power* of the symbol of 'the group' to which the individual is attached. He writes:

> The criminal *is* a social human being, he *is* adjusted, he is not necessarily any of the things that have been imputed to him... the issue involved is not whether an individual is maladjusted to society, but the fact that his adjustment makes him maladjusted to the large society because the group he fits into is at war with society. (Tannenbaum, 1938, pp. 8-9)

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[41] A comprehensive analysis of the demise of the sociology of deviance is found in Colin Sumner's book *The Sociology of Deviance: an obituary* (1994).

[42] William Sumner's classic book Folkways describes the consequences of violating three distinct aspects of life which he called folkways, that is, everyday customs, mores or broad societal matters of morality and laws or statutory and enforceable social sanctions applied to those who defy such stipulations. He devised a theory of deviance that was closely linked to crime though deviance and crime are seen as overlapping categories in themselves.

If Tannenbaum were to comment on ADHD today, his response may be no less controversial. Although set in a different era, well before ADHD was popularized, his contention is readily transposable, as I demonstrate:

> The 'child so diagnosed as being ADHD' (insertion) is a social human being, he is adjusted, he is not necessarily any of the things that have been imputed to him… the issue involved is not whether an individual ' child so named ADHD' (my insertion) is maladjusted to society, but the fact that his adjustment makes him maladjusted to the large society because the group he fits into 'being those diagnosed as having ADHD' (insertion) is at war with society ('representative of the social group in which he is situated, being home or school). (Tannenbaum, 1938, pp. 8-9)

There are, of course, shortcomings with my adaptation. In the first instance, does it not seem excessive to contemplate ADHD as representative of a *group* at 'war' with society, albeit figuratively speaking? On the other hand, few would disagree that individuals diagnosed as having ADHD are not only set apart and objectified as 'ADHD' but, by the strength of social meanings attached to the symbol of ADHD, join the group of those so identified *as* "ADHD".

Criticism of a positivist approach to deviance has generally always arisen from the *process* of *identification*, as Tannenbaum's (1938, pp. 7-8) comments suggest:

> The imputation of physical or psychic abnormality has this crude "scientific" basis, that it derives from measurement, testing, calculation…the fact that the qualities measured are intangible, that the traits examined may be irrelevant, has not prevented the process from finding wide acceptance and considerable acclaim, and in some instances, even legislative sanction…the projection of normal or good is merely the passing of a moral judgement upon our own habits and way of life…unless we exclude him and set him apart from the group, the whole structure of our orderly life goes into pieces (Tannenbaum, 1938, pp. 7-8)

These pithy words expressed more than seven decades ago allude to two fundamental social agents embedded in social understandings of deviance; that is, medicine (more specifically psychiatry) and law (Kirk & Kutchins, 1992)[43], each traceable, in a variety of ways, to antiquity (Sedgwick, 1982). Today, ADHD is primarily determined as a formally designated mental disorder (although the diagnostic process of ADHD is not limited to the jurisdiction of psychiatry[44]) and bears the watermark of psychiatrically branded criteria. As such, it may be likened to other mental illness categories, and therefore open to similar controversies and inconsistencies evident in diagnostic psychiatric processes (Fawcett & Karban, 2005; Kirk & Kutchins, 1992; Sedgwick, 1982; Sumner, 1994; Timimi, 2002). Some, even from within the ranks of psychiatry itself, go so far as to claim that the process connected with the diagnoses of ADHD is so flawed, by eluding biological explanation that, in itself, it provides evidence of medicalizing childhood (Timimi, 2002). This may explain why the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000), relied in the legal verification of ADHD diagnoses (Kirk & Kutchins, 1992), presents caveat upon caveat on what actually constitutes 'mental'.

Such confusion is readily understood from an interactionist perspective. In reference to, the question "deviant from what?" reliance on *moral judgement* is clear. What is unclear is how moral judgements are formed, and why they are ascribed *medical meanings*.

Moral judgement: contradictions, absurdities and inconsistencies

> So where in the bloody hell are you?

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[43] By medicine, I mean a medical response to behaviour, operating in various ways but mainly through the jurisdiction of psychiatry; by law, I mean the formalized social framework whereby rules are devised to describe the individual as a social law breaker (Becker, 1963) and used in the judicial system to judge criminal liability.

[44] Diagnosis of ADHD and the prescribing of ADHD psychotropic medications may be conducted by paediatricians and general practitioners.

(Slogan of the Australian Tourism Campaign, 2006)

When Australia's then Tourism Minister, Fran Bailey, was confronted by the actions of Britain's Advertising Clearance Centre in banning the Australian Tourism advertisement, people's reactions varied (Roberts, 2006). Tony Blair, the then Prime Minister of Britain, for example, reportedly joked as he stepped from his plane onto Australian soil saying: " So where in the bloody hell am I?" For others, it appeared 'right' for Australia to be condemned for its cheekiness with a ban to be imposed.

This poses questions as to why reactions varied so. Perhaps it was the act of breaching 'social boundaries' that attracted applause or disgust, or the image of a bikini-clad girl saying "bloody hell". Whatever the case may be the protest resulted in the demise of an AUD 180 million campaign. While questions and answers may be interesting, or otherwise, few would disagree that there is no simple answer. This is because social interactions, of all kinds are, by definition, dependent on beliefs and values. Indeed, it is reasonable to say that the power of moral judgement, albeit person-to-person or system-to-system (and every other possible combination in between), is inextricably linked to a complex interplay between social interactions, perceptions and subsequent actions embedded in social norms.

From this standpoint, one may ask whether individual or collective social reactions, as exemplified in the Australian tourist campaign, differ from reactions to children's behaviour? To test this question, consider an image of a child running amok in a supermarket. What might people's reactions be? Is he, for some, entertaining, being high-spirited, while for others, annoying, being unruly? What of his carer? Are her overt attempts to calm his rowdiness to be applauded or is she to be admonished for imposing unrealistic expectations on him? Is the child to be pitied, relieved, reviled, confined, soothed or medicated and his carer extolled, or should it be the other way around? Further, it begs the question as to whether reactions will vary according to the gender of the carer.

The variety of answers springing from immeasurable combinations of social contexts, demonstrate the unpredictability of determining people's views of children's behaviour in general and interpretations of ADHD in particular. It is this very notion of the *unpredictability* of audience's reactions that presents as the first of several ironies surrounding ADHD. If one interprets the child running amok in the supermarket as deviant, what form might that deviance take? Might he be 'ADHD', or something else, like 'Aspergers'[45]?

When it comes to identifying ADHD, given the range of possible reactions to behaviour, it could be said that the process of "becoming" ADHD is more to do with *informal* diagnoses than the acquisition of a formal ADHD label. Indeed, it may even be that behavioural indicators such as those prescribed by the Diagnostic and Statistical Manual (American Psychiatric Association, 2000), fade into insignificance in comparison to audience perceptions of the object of ADHD. As such, if one were bold enough to modify the Australian tourism slogan by asking of ADHD, not "where" but "*what* in the bloody hell are you?" behaviours, more or less fidgety, excessively talkative, forgetful, careless or inattentive, defy pathological interrogation and give way to near infinite meanings of ADHD through the process of *moral judgement.*

Questions of morality flowing from audience reactions to ADHD, therefore, underpin the full range of perspectives relayed in Chapter 2, including those that appear to be

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[45] Asperger's Syndrome is a disorder within the autistic spectrum. It is marked by its comparatively increased language and cognitive development contrasting to other forms of autism. More complete appraisal of 'Asperger's' may be found in Tony Attwood's comprehensive text the complete guide to Asperger's Syndrome (2007).

objectively contrived; even Selikowitz's boldly titled little book, *ADHD: the facts* is in itself but one type of audience reaction, albeit dressed in 'certified organic packaging'. Media representations of ADHD such as this, in turn, arguably invoke further audience reactions responsible for a variety of ADHD realities inclusive of the need for medical intervention.

The primary point to be made here, from a social constructionist perspective, is that if one accepts that deviance is interpreted as a *process* dependent upon societal moral attitudes, the central argument cannot be confined to simple bifurcation as to whether a child 'ends up' being 'ADHD' or, 'Aspergers'. Rather, a social constructionist angle provides a way to illuminate social meanings of ADHD, which not only flow from, but also lead to the act of *deciding* that another is socially unacceptable and that such unacceptability be understood as ADHD. In this way, ADHD is well placed to benefit from aspects of the sociology of deviance, which Sumner (1994) aptly defines as the science of moral ambiguity.

Albeit that contradictions abound surrounding the many faces of ADHD, from benign childhood fidgetiness to socially harmful criminality, the important question remains: how did such a range of views and beliefs arise? Without being waylaid by historical and contemporary socio-political forces at work, exploration of the emergence of ADHD is useful in attempting to address this broad question for reasons that follow.

Entering deviant territory

Many childhood fairy stories tell tales of innocent infants venturing into territory beyond their scope. In the case of ADHD, adulthood entered childhood territory heralding the broadening application of ADHD to adult deviant behaviour. Aside from school, few institutions and activities have defined 'childhood' better than child

Humphrey (2006) explains that deviant behaviour is usually formalized in litigation of so-called *predictable* patterns of behaviour. Descriptions of this 'behaviour' are primarily conveyed through language. However, the postmodern view of language is that it is always in a state of process, rather than referring to something that is 'real'. As such, language and the meanings attached to particular terms describing behaviours of various kinds are expressed like 'rules'. Therefore, over time, it is not surprising that language usage changes; it adapts to a number of factors based on social definitions "which vary from place to place and from time to time" (Tittle, 2003, p. 19). Nevertheless, I proceed to discuss subtle changes in the way in which ADHD is "officially" characterized because it exemplifies the dilemma of 'scientifically' interpreting human behaviour that takes place in social contexts.

Evolving nomenclature

To return to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* in its sixty year history it has been revised four times, the latest version being the current DSM-IV-Revised, with the fifth revision on the way[46]. ADHD, has appeared throughout, beginning in the 1950's as a diagnosable category in its own right[47] (Kirk & Kutchins, 1992; The British Psychological Society, 1996). Throughout the ensuing decades, ADHD broadened its scope. The most significant shift occurred in 1980 with the "new" biologically oriented DSM-III. The change in emphasis, from the psychoanalytical to the biomedical (Conrad, 2007; Kirk & Kutchins, 1992) occurred midst socio-political struggles in relation to mental illness categorization of contentious issues such as homosexuality (Kirk & Kutchins,

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[46] Controversy surrounding the criteria for diagnosis of disruptive behaviours continues, despite the revisions. Lauren Wakschlag's book chapter appraises calls for improvement of the DSMIV diagnostic criteria (Wakschlag, Leventhal, Thomas, & Pine, 2007).

[47] During this period ADHD was referred to as Minimal Brain Dysfunction.

1992); the vogue biological approach to mental illness promised an advancement in socially acceptable interventions. One of the promoters of the of the new DSM version, Klerman, who, according to Kirk and Kutchins (1992), was the highest ranking psychiatrist in USA when the DSM-III first appeared, proclaimed that it was 'science' in the service of 'healing' (Klerman, 1984).

The significance of this shift in relation to 'understandings' of ADHD relates to the *application* of ADHD: that is, the subtle description of ADHD's *usual* rather than *absolute* restriction to childhood[48] took its course *beyond* childhood. As such, it could be argued that this paved the way for today's DSM-IV Revised version, where fidgety childhood behaviour characterized by hyperactivity was redirected in two ways; the former, I suggest, being predisposed to the latter. Firstly, *'inattention'* was added to the list of traits and, secondly, possibly as a consequence, ADHD descriptors are now suited to adult deviant behaviour. Symbols of ADHD have indeed changed. Today, ADHD is reported as having a life-long impact (Biederman, Faraone, et al., 1998; Biederman & Farone, 2005; Manuzza, Klein, Bessler, & Shrout, 1998; Riccio, et al., 2005; Seidman, et al., 2004) delivering adult sized social rule-breakers (Becker, 1963) who fail to "attend" to the social laws and mores set by their moral judges (Lemert, 1942)[49].

Whichever way ADHD's 'chameleonic' rise is explained however, it is, by definition, undisputable that ADHD *has* officially breached the confines of being age defined. Today, even the elderly people may be diagnosed as having ADHD (Cetkovich-Bakmas, et al., 2008). Such developments have rendered ADHD a confusing status.

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[48] The history of the emergence of ADHD itself is well documented by others*. Of particular interest is Adam Rafalovich analysis of ADHD's psychoanalytic and neurological heritage(Rafalovich, 2001).

[49] If so, this could at least partly explain the expansion of symbolic meanings of ADHD underpinning a smorgasbord of ADHD perspectives, and its negative impact on the wider community (GalÈra, et al., 2008).

specified illnesses or disorders (Prior, 1992). ADHD was, in the past, one such disorder which, relegated to childhood, defined the restless "wriggling" child. While this study does not focus on ADHD in adults, in viewing ADHD in a 'deviant' framework it stands that ADHD has morphed from a relatively benign 'childhood disorder' believed to peter out during adolescence, to one which accommodates the entire life span.

There are many suggestions as to why ADHD's footprint has escalated. Some say that the primary reason is associated with pharmaceutical companies who find ADHD a profitable market. This argument is supported by reports from drug companies who boast of new ADHD marketing frontiers. In a press release provided by the Chief Executive Officer of Shire Pharmaceutical Company on October 29 2008, new medications targeting adult ADHD were announced as being responsible for increased sales:

> Shire had another very strong quarter across its business. Product sales were up 31% and Non GAAP earnings per ADS rose 88%, compared with the same period last year. Our new products continued to underpin this growth, generating revenues of $276 million, representing 39% of our total product sales ... The launch of VYVANSE® (lisdexamfetamine dimesylate) - Attention Deficit and Hyperactivity Disorder ('ADHD') for adult ADHD in June 2008 has helped to make VYVANSE the third highest prescribed ADHD product in the US. For the nine months to September 30, 2008 VYVANSE, net sales totalled $215.6 million. These products will continue to deliver strong growth, driven in part by our geographical expansion into the important emerging markets...with an excellent portfolio and pipeline for future growth, developed around our focused specialty biopharmaceutical strategy (Russel, 2008)

As stated several times earlier, I re-emphasize that one may come to explain such 'success' differently. For some, ADHD's magnification is proof of a world 'out of

Social responses are equally perplexing. Despite intentions for "science" to bring "healing", remnants of former approaches to naughty childish behaviour continue to call for corporal punishment (Harris, 2009) and adult ADHD offenders goad the intervention of powerful mental health and law enforcement agencies.

Symbols and ADHD image multiplicities

The Lancashire Episode and beyond

On 15th March, 2005, a BBC news report entitled *Police Fight Attention Disorder*, describes a joint intervention project between two powerful agencies: child mental health and the Lancashire police department. The purpose of their union was to bring under control what could be conceived as a 'moral panic' surrounding public havoc caused by adults with ADHD. In a flurry of interviews, representatives of the justice system had this to say:

> If we can treat and identify ADHD we could stop people entering the criminal justice system. Sergeant Steve Brown, Lancashire Police Department (M. Jackson, 2005)
>
> If behavioural difficulties are detected early and children are referred to the right people they have a chance of leading a better life and are likely to keep out of trouble. Inspector Anderton, Lancashire Police Department (M. Jackson, 2005)

According to Graham Pattinson of the East Lancashire Child and Adolescent Mental Health Services, a joint effort with the Lancashire Police Department in terms of both *process* of *identification* and *treatment* of ADHD is necessary because it is, in effect, like:

> Putting a fence at the top of the cliff rather than having ambulances waiting at the bottom. Graham Pattinson, East Lancashire Child and Adolescent Mental Health Services (Jackson, 2005)

control': a global society willing to colonize childhood. For others, ADHD is a symptom of modernity (T. Armstrong, 2006) and, yet for others, ADHD's heightened profile is evidence of long awaited recognition of a condition which has been ever-present (R. Barkley, 1998, 2000), is frequently misunderstood and one which can be relieved by psychotropic medication (Barkley, 1990a; Barkley, Murphy, O'Connell, & Conner, 2005; Biederman, Spencer, Wilens, Prince, & Faraone, 2006).

ADHD is not the only condition, however, which has rapidly expanded. Several authors, (Mandell, Thompson, Weintraub, DeStefano, & Blank, 2005), showed a similar trend in the diagnosis rates for Autistic Spectrum Disorder. Furthermore, not all illnesses or behavioural disorders have progressed in a similar trajectory. For example the 'treatment' of homosexual behaviour, once considered a mental illness, has more recently been "de-medicalized" (Conrad, 2007). At the same time, responses to deviant behaviour concerning crime are, at least in the western world, now more readily associated with medical intervention.

The medicalization of behaviour can, therefore, said to be crossing socio-political boundaries. It does not relate to medical practitioners alone, as earlier writings in medicalization reported (Illich, 1975). Rather, socially discriminated behaviour, like ADHD, may attract medical solutions that are historically, culturally and legally situated.

Legitimizing ADHD as deviance

Scheff (1966, p. 32) in his seminal work on *Being Mentally Ill, suggests*

> ...Deviance can be most usefully considered as a quality of people's response to an act, rather than as a characteristic of the act itself...

Here "fences" and "ambulances", *symbols* of confinement and medical intervention, are used to evoke strong images of intent to act. The purpose is twofold: firstly, to engage moral betterment in the children so named ADHD and secondly, to protect society evidenced by the stated goals: ' (of them) keeping out of trouble' and 'leading a better life''.

For the social researcher, this example of the public face of ADHD highlights certain anomalies. On the one hand, ADHD presents as a 'condition' characterized as relatively benign educational underachievement associated with inconsequential annoying childhood behaviours exhibited by those who (for at least six months) fail to present as attentive focused children, eager to comply to teachers' requests (American Psychiatric Association, 2000). On the other, ADHD is constructed as a disorder eliciting troublesome, even criminal behaviour and one that demands the attention of the law enforcement, mental health and medical institutional systems to bring it under control.

This then promotes a return to the pivotal question of what then is ADHD, and to the various views expressed. To recapitulate, some may consider ADHD to be a harmless childish fidgetiness while others may think of it as dangerous adult recklessness. Some may describe ADHD as a mental illness, either genetically or environmentally induced, or, as Armstrong (T. Armstrong, 2006) suggests, a 'by-product' of our modern age. Whatever one's position, surely, to portray ADHD in terms of deviance is extreme, for does not the term 'deviant' bring to mind a strangeness far too distant to apply to the four thousand or more toddlers and pre-school children who, currently in Australia, have been formally diagnosed and medicated? Former images of wriggling little boys in the classroom "calling out in class" have given way to accommodate adult behaviours like "often acts before thinking".

I suspect that the broadening definitions of ADHD have provided the necessary scope for ADHD's swift rise infused with 'variegated' symbols, including that of 'public havoc creator'. This then provokes the question, if ADHD is tagged by multifarious symbols including those which would suggest a less than satisfactory adult image, to what extent do such symbols influence the way in which a given audience reacts to a child ADHD suspect?

Of course the answers are largely unknown, but this question remains useful. It could be surmised that ADHD's newfound mobility into adulthood, transiting through adolescent years could explain an audience's compulsion to 'take charge' of ADHD. At the very least, I reason that in order for a particular child to qualify as a candidate for diagnosis, that child must, by the very nature of the act, have first entered a position of suspicion or embarked upon the role of "suspect".

While the nature of suspicion may be strongly influenced by one's perspective, the act of *suspecting* links all perspectives regardless of the symbols adopted. For those whom a formal diagnosis is achieved, the act of suspicion could be seen as a conduit, transporting the child from being 'a child like any other" to being *identified* (perhaps as ADHD, or perhaps as simply "different") and subsequently "groomed" for diagnosis. In this way, the first moves towards "becoming ADHD" are inescapably linked to processes of *moral judgement* as a springboard of ADHD suspicion. Conrad and Schneider's (1980) ideas remain particularly influential because, as they say, the moral code associated with medicine is quite dissimilar to that of wickedness. In this way, medical meanings ascribed to deviant behaviour cast a very different moral light for the individual whose behaviour is judged as being problematic.

Filtering these ideas through a symbolic interactionist lens, it is possible to see that *symbols* attached to an individual's perceived 'condition' might strongly influence an audience's actions. Applying this principle to this study, it could then be that a medical or clinical perspective of ADHD applied to a child's behaviour is likely to result in a medicalizing action. This, however, as useful as it may be, is insufficient in explaining the *impetus* for the medicalization process; it falls short in illuminating *drive* towards a formal diagnostic achievement. Are there further clues, I ask, to be found in not only establishing that ADHD is symbolized in numerous ways, but that such symbols are weighted by the emotions they conjure? To explore this question I finalize this chapter by probing the notion of *moral panic*.

Social reactivity: from moral to medical

In order to explore aspects of social reactions to deviance and ADHD, I draw on earlier material (albeit applied slightly differently) including Conrad's (1975, 1976b) earlier works, which established links between *perceptions* and *categorizations* of deviance. Specifically, Conrad & Schneider (1980, p. 1) posited that deviant behaviour, "once defined as immoral, sinful or criminal, has been given medical meanings". Once again, however, the question of process comes to the fore.

Some clues are found in notions of the morally 'wrong'. Goode & Ben-Yehuda (1994), suggested that:

> "moral panic involves social reactions to…some form of moral wrongdoing – deviant behavior was seen to be responsible for the problem. Some specific individuals were targeted as deviants (Goode & Ben-Yehuda, 1994, p. 19)

Therefore, if one were to view social reactivity to ADHD as a form of moral panic[50], as Miller and Leger (Miller & Leger, 2003) did in their paper *A very childish moral panic: Ritalin*[51], then elements of process may be examined.

According to Cohen (1972), moral panic comprises five stages in its 'life'. In the first stage, a given audience perceives and *identifies* 'something' as a threat: a destabilizing force affecting existing moral values or social mores. In the second stage, the 'something' is *objectified* in a visible and discernible way (typically by the visual and print media). In the third stage, a rapid escalation in public concern is evident and in the fourth stage, governing bodies typically develop policies and

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[50] I first encountered the concept of 'moral panic' when reading the groundbreaking work of the 'founder' of the term, Stanley Cohen (1972).

[51] In Toby Miller and Marie Claire Leger's paper entitled A very childish moral panic: Ritalin(Miller & Leger, 2003)51 the construction of ADHD and the use of Ritalin as a social control tool and ensuing moral panics are examined. I highly commend this paper's attempt to theorize ADHD using exiting theories of moral panics.

intervene. Finally, in the fifth stage, the state of moral panic is subdued by social change. Although ADHD could be conceptually overlayed across Stanley Cohen's entire process, I draw on the first of these stages: that is, when ADHD, a social object, is interpreted as a *threat*. Returning to the Lancashire episode above, in terms of perceptions of 'threat', it could be that the symbol of ADHD invokes the intervention of medical and law enforcement agencies: an excellent example of control through the medicalization of behaviour.

Following on from this, it is noteworthy that current research literature on the social consequences of ADHD, may itself add credence to the notion of ADHD as 'public havoc instigator'. The list of ADHD induced offences seems endless. These include, for example, significantly higher substance addictions of nicotine (Tercyak, Lerman, & Audrain, 2002; Topert, Barratta, Brown, & Brown, 2002; Upadhyaya, Brady, & Wang, 2004) illegal drugs and alcohol (Biederman, Wilens, Mick, Faraone, & Spencer, 1998; Collins, Levin, Foltin, Kleber, & Evans, 2006; Topert, et al., 2002). People with ADHD are accused of being more likely to cause social unrest and conflict in family and workplace environments (Hornig, 1998; Marks, Newcorn, & Halperin, 2001; Wassertein, Wolf, & LeFever, 2001) and have a higher propensity to engage in criminal acts such as homicide (Lindberg, et al., 2004)[52], assault and battery, domestic violence. Further, there are claims of a higher representation in completed suicides and self injurious behaviours (DiScala, Lescohier, Barthel, & Li, 1998) with a four-fold higher representation of being hospitalized for suicide attempts and self harm (Lam, 2005). If extreme behaviours are not sufficient to stir public fear, reports that people diagnosed as having ADHD are responsible for four times the number of road accident incidents may suffice (Barkley, et al., 2005).

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[52] This is a particularly interesting study because it investigates links between childhood sleep patterns and adult criminal behaviour

Such portrayals contextualizing ADHD raise questions relating to the medicalization of deviance so named ADHD. Such questions bring to this endeavour an awareness of the broadening scope of 'ADHD symbols' possibly influencing those audiences who, through everyday social interactions, define ADHD realities.

With this general idea in mind, and more specifically, in drawing on the notions of their being a variety of perspectives of ADHD as discussed in Chapter 2, and the legitimization of deviance as 'ADHD' outlined here in Chapter 3, I now embark on the execution of this study.

Indeed, burgeoning portrayals of life-long inflictions and consequences (Barkley, et al., 2005; Biederman, Faraone, et al., 1998; Ferguson, Lynskey, & Horwood, 1997) are then used to justify the use of psycho stimulant medication (Weyandt, 2005; Wilens & Dodson, 2004) to control and manage a genetically disordered brain[53] (Barden, 2003; Barkley, 2006; Faraone & Biederman, 2000; Levy, Hay, & Bennett, 2006).

With the expansion of ADHD symbols, it is easy to see why parents of children who are "suspected" as having ADHD, may, in response to wide-spread fears associated with ADHD, act in a medicalized way as the following except shows:

> Today's parent lives in an era of diagnosis...fear often lurks in the back of a parent's mind, put there partly by a drumbeat of persistent media coverage...sometimes it seems treatment is struggling to catch up and adapt to this fast-changing and expanding group of children. Health professionals seemingly worry about everything: misdiagnosis, under diagnosis, over diagnosis and use of medication (Nyhan, 2008)

These words portray similar themes to the Lincolnshire episode above. Words such as: media portrayal; parents; health professionals; children; treatment; fast-changing; and expanding situate 'fear' with medical dependency in an everyday sense for 'ordinary' parents. Moreover, at a global institutional level, ADHD 'screams' back at parents with its declaration that ADHD is a bone fide mental health condition. A 'condition' which, if left untreated, is expected to wreak havoc on a youngster's sense of self-esteem, interfere with his/her ability to perform well at school, to make friends, and to get along with siblings and parents (World Health Organization WHO, 2007).

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[53] Farone and Biederman claimed that molecular genetic research implicated several genes as being responsible for an individual's susceptibility of ADHD (see 2000, p. 572)

Others (briefly mentioned in the Preface), include my professional experiences of 'ADHD' in a range of contrasting circumstances. For example, I attended complimentary dinners provided by pharmaceutical companies intent on "educating" its audience about the benefits of 'ADHD' while in other settings, I heard 'ADHD' decried; I was involved in the interpretation of school reports for children diagnosed as having ADHD and I myself wrote such reports; I observed the work of advocates seeking improved learning conditions for children diagnosed as having ADHD; I was introduced to children as 'ADHD' rather than by their actual names; I heard them being called derogatory terms such as 'psycho' and, in contrast, witnessed sensitive and respectful interactions with these same children, occasionally by the same people who had ridiculed them.

To be sure, although a range of 'disabilities' and 'disorders' have been part of my professional and everyday life experiences for a very long time, I cannot recall more inconsistencies or social interpretations with any other 'condition'. Therefore, while some claim that qualitative research beckons an 'open mind', I am acutely aware that I bring to this study my own continually reconstructing views of ADHD.

The research aim and questions

As stated, the central purpose of this study is to examine the social process at work in the identification and subsequent medical diagnoses of children whose behaviour is believed to be evidence of the presence of 'ADHD'. I have therefore problematized ADHD in terms of the appropriation of a medical lens by powerful social agents, namely the mothers, the doctors and the teachers, to illuminate the medicalizing journey of children diagnosed as having ADHD.

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powers of this technique, particularly in delving into the views of those experiencing the situation or topic of interest.

According to Mason the research question/s form the 'backbone' of any research design (1996): being the essence of the enquiry, it serves 'to establish the boundaries of what will be studied' (Strauss & Corbin, 1990a, p. 25). While McLean claims that the *refinement* of a broad question is an important part of the process (2006), Creswell (2007) makes the important point that research questions, particularly in qualitative studies, continually evolve.

With this in mind, I use a central compound question in an 'open-ended' style with a series of sub-questions as follows:

Central question

What social processes are involved in a child becoming understood by significant actors as 'being ADHD' and why is it that a medical solution is sought in response?

Guiding sub-questions

- What are the contextual conditions involved in the identification of behaviour suspected as 'being ADHD'?
- To what extent do underlying perceptions contribute towards the initiation of the process of achieving formal ADHD diagnoses?
- Who or what is responsible for the initiation and achievement of diagnostic status?

Conceptual paradigm

Few disagree that empirical social research draws on a variety of long-established traditions in the quest to study and conceptualize society. There are, therefore, many possibilities from which to choose when embarking on a qualitative study such as this. Some caution that commencing a qualitative research study in accordance with a

4 Research design

Following the former introductory chapters, this chapter begins by introducing the approach taken and by stating the research aim and questions. Following this, the main body of this chapter comprises three separate sections detailing the research methodology, the methods and aspects of the research experience. Part 1 refers to the procedures and experiences involved in the procuring of the participants; Part 2 presents information relating to the qualitative interviewing experience; and Part 3 conveys the approach taken in analysis, the influence of the early stages of analysis, and the evolving nature of the study.

Introduction

In conceptualizing the task of illuminating ADHD as emerging 'realities', I found Crotty's (1998) four elements of research design: epistemology; theoretical orientation; methodology and methods, a useful framework from which to begin. Having a well thought out epistemological and ontological position in approaching a research problem is, however, not the only consideration (Bryman, 2008). Various other factors may influence the way in which a research problem is designed and managed. These may include, for example, a researcher's educational background and training (Goodwin & Goodwin, 1984) and interpersonal skills (Somekh & Lewin, 2005). In addition, the research experience may be affected by time and resource availability (Strauss & Corbin, 1990b).

In the case of this research study, I nominate, in particular, my primary methodological training in qualitative research methods[54] as an influential factor.

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[54] I once used qualitative interviewing to illuminate mothers' experiences in having a child with sudden onset acquired brain injury and through this, I experienced the extraordinary investigative

particular theoretical base may prejudice the researcher's attempts to draw from the data itself. This view is posited, in particular, by Glaser and Strauss' in their grounded theory approach (1967). In addition, Bryman (2008 p. 7) cautions researchers to avoid "dressing up" a research project in "theoretical clothes" and Silverman (1993) warns of both over and under using theory, although he appears to be less clear about how this may be assessed.

To add to the problem, as stated earlier, sociological studies of ADHD from which to draw are relatively sparse. Even fewer explicitly convey their theoretical base. Some recent exceptions include Graham's (2007) doctoral thesis and Bennett's (2007) use of Foucauldian, and feminist epistemologies to explore mothering subjectivities. Aside from these, as previously mentioned, Rafalovich (2004) draws on a variety of social theories of mental health and deviance in his analysis of ADHD discourses, building on Conrad's (1975, 1976a) interactionist paradigm. An overview of the literature therefore confirms the notion of many social 'meanings' of ADHD, an idea that fits within the broad interpretivist tradition.

According to Rogers (2005), a social constructionist perspective accommodates the possibility of multiple, sometimes contradictory, social realities and is therefore a popular approach for those interested in exploring the way in which people, individually and collectively, construct and reconstruct their social worlds (Holloway, 1997)[55]. Indeed a social constructionist orientation has been used insightfully in fields related to this topic, including: mental illness (Weinberg, 1997; Williams & Collins, 2002); deviance (Richman, Mercer, & Mason, 1999; Victor, 1998); ADHD discourse (S. Danforth & Navarro, 2001b; Martin, Pescosolido, Olafsdottir, & McLeod, 2007);

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55 Rather than engaging in a detailed analysis of social constructionist theory in this thesis, I refer to Vivian Burr's excellent book Social Constructionism for a comprehensive analysis of Social Constructionism (2003).

and a range of "medicalizations", from menopause (Oudshoorn, 1997; Palmlund, 1997) to snoring (Williams, Seale, Boden, Lowe, & Steinberg, 2008b).

One clear advantage of this approach is that it allows for a continuum of merging and sometimes overlapping perspectives. For example, in investigating teachers' perspectives and ADHD, Rafalovich (2004) showed that they, just like everyone else in the community, are influenced by their own degree of acceptance of the validity and meaning of ADHD. Rafalovich (2005a) extended the argument further, once again from a social constructionist position, by contending that the inability of neurological discourses to substantiate certain key assertions exposes the inadequacies of both neurology and psychology in sociologically conceptualizing ADHD. Such clinical uncertainty surrounding the diagnosis of ADHD, also demonstrated by Shaw et al.(2002) and in Ball's survey of the views of Australian General Practitioners' (Ball, 2001), exemplifies Zola's (1966) emphasis of the importance of socio-cultural interpretation of 'meaning', and the benefits of adopting a social constructionist position. Moreover, as highlighted in Chapter 2, and in alignment with Blumer's (1969) claim (and those who built on his work), key social agents within a group influence one another's' 'meanings' and 'interpretations' of a social situations.

Symbolic Interactionism

Further narrowing the broad social constructionist platform, it can be argued that whatever an individual beliefs of 'ADHD' may happen to be, the language of 'ADHD' arguably functions as a *symbol* evoking numerous social responses. Based on an interactionist position that the key actors in this study are likely to 'act' towards the symbol of ADHD (and one another) according to the meanings they derive from it, I consider a symbolic interactionist approach to be well suited in further refining the exploration process. By illuminating the 'assigned' social meanings relating to 'ADHD', it may be possible to investigate factors driving the process of medicalization. Put another way, if ADHD 'things', be it the children so diagnosed, or be it the 'condition' of ADHD itself, assume the role of 'social objects' to be acted upon, then the exposition of the beliefs and perceptions of those interacting with such symbols (Charon, 2007) may reveal the power of social interactions. Moreover, the justification and advantage of taking such an approach, despite its susceptibility to inconsistencies in researcher interpretation (Meltzer & Manis, 1972)[56] is, as Goffman (1962 p. 2-3) states:

> It is a fact of our human condition that, for most of us, our daily life is spent in immediate presence of others...our doings are socially situated... The trick, of course, is to differently conceptualize these effects, great or small, so that what they share can be extracted and analysed, and so that the forms of social life they derive from can be pieced out and catalogued sociologically, allowing what is intrinsic to interactional life to be exposed thereby (Goffman's address 1962)

Furthermore, the identification of symbols within human interactions provides an effective means of producing data for analysis (Hunt & Miller, 1997). This has been demonstrated as being effective in studies such as Friese, Becker, and Nachtigall's enquiry of older mothers' reproductive identities (Friese, Becker, & Nachtigall, 2008); Loe and Cuttino's (2008) investigation of the attitudes of university students diagnosed as having ADHD; Rossols'(2001) examination of the medicalization of compulsive gambling; and Cahill's (2003) comprehensive review of studies theorizing aspects of childhood. However, I point out that I differ from these in that I intend drawing on symbolic interactionism in a conceptual rather than a 'methodical' sense because I am interested in illuminating the overall process of medicalization,

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[56] Bernard Meltzer, in critiquing of George Mead's foundational principles for symbolic interactionism, claimed them to be too fuzzy and vague for scientific explanation.

Data Generation

(Marsh, 1988, p. 42) points out that data is "produced" rather than "found". Adopting this being the case, the qualitative researcher is functionally involved in the generation and identification of data.

One of the strengths of a qualitative approach is the accommodation of the researcher's informal analysis from the onset of data generation. The transformation of raw data to 'findings' involves a continuum of discovery, encapsulated within multiple layers of data collection and field experiences.

In the case of qualitative interviewing, researcher interpretation begins with the first stages of transcription as data filters through the researcher's own particular epistemological framework (Miles & Huberman, 1994). Therefore, as I approach the data, I acknowledge the inevitability of *interpretation* in the formulation of what *constitutes* data and the *meaning* attributed to that data, each of which are deeply intertwined (Denzin & Lincoln, 1994).

Data management

Mason (2002) emphasises the distinction between *sourcing* and *spawning* data, (Mason, 2002) but not all agree that qualitative research requires meticulous organization of data. Burns (1994), for example, implies that quantitatively derived data is more demanding in this respect, although how such a claim is 'quantified' remains unclear. Creswell (2007), on the other hand, points out that if it were not for mastery of practical tasks such as recording information, resolving field issues and storing data effectively, enacting data instrumentation would be of little use.

rather than in a micro-analysis of potentially numerous layers of meanings attached to ADHD as an end in itself.

Methodology

I use the term 'methodology' to encompass not only the epistemological and ontological foundation of this study, discussed above, but also the research procedures employed to execute the enquiry. In keeping with the conceptualization of this study, to restate, I use qualitative approach because, according to (Mason, 1996, p. 24):

> Qualitative research is essentially exploratory, fluid and flexible, data driven and context sensitive.

Moreover, it is known to produce data described as 'thick and rich' (Strauss & Corbin, 1990a), and is capable of revealing shared complexities in human interactions (Somekh & Lewin, 2005). It is therefore particularly useful when explanations of processes and experiences are sought (Miles & Huberman, 1994). A qualitative approach is, therefore in complete alignment with the nature of this enquiry.

This said, there are many ways to gather qualitative data. Corbin and Strauss (1990a) outline a vast array of methodological approaches. This point is made obvious by numerous qualitative studies addressing similar topics. For example, Judge's analysis of attitudes towards people diagnosed as having psychosis employed *narratives* as the means of data generation (Judge, Estroff, Perkins, & Penn, 2008), whereas Wong and Fu (2007) [57], chose *semi structured interviews*: each of these well regarded qualitative studies proved to be insightful.

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[57] Each study varied in its goal but they are sufficiently similar to make the point.

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Part 1 Research strategy

In considering possible qualitative approaches for this study, I first developed a research 'map' as shown in Figure 1. I found the conceptualization of the medicalizing terrain indicated by the shaded area useful in identifying significant social agents[58] surrounding an 'ADHD child'.

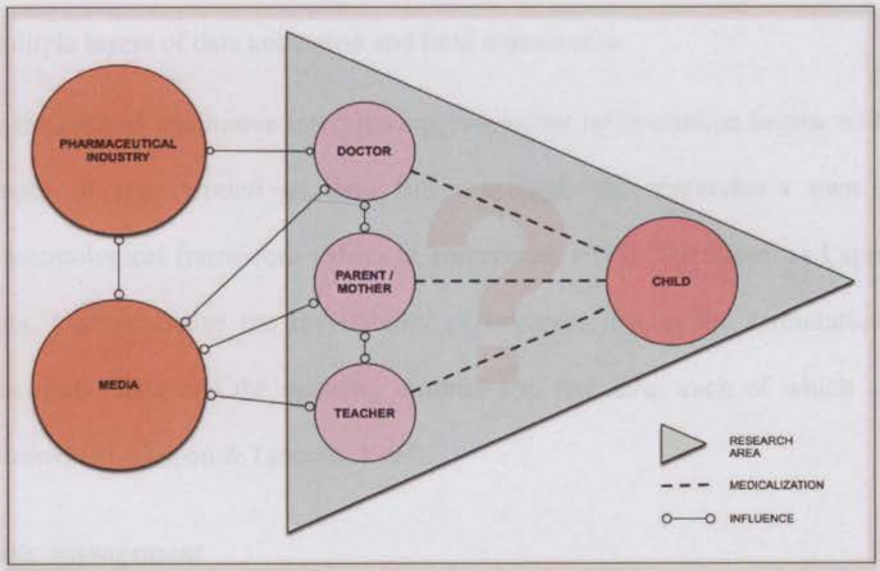

Figure 1: The conceptualization of the research parameters

Here in Figure 1, three central actors are shown as possible significant candidates in a child becoming identified as 'ADHD' and, in due course, diagnosed as having ADHD. The media and pharmaceutical industries at this point are included as possible influencing factors outside the research area.

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[58] Please note that while I have anticipated certain influencing connections outside the research area, I do so to contextualize the study as I see it.

Within traditional approaches to the management of voluminous material (typically generated by qualitative methods), there are few organizational protocols (Knafl, Webster, Benoliel, & Morse, 1988). More recently, task-specific computer assisted software has come to the fore (Bazeley, 2007; Davidson & Jacobs, 2008; Richards, 1999). NVIVO® is one such example.

I chose to use NVIVO (versions 8 and 9) to assist me in the task of data management, because it promised to provide a way of not only collecting and organizing information, preparing the way for it to be transformed into usable data, but also the attachment of field notes, memos, and related research documentation [59]. In this way, NVIVO could act as an electronic filing cabinet and analytic system (Davidson & Jacobs, 2008) although the actual data analysis remained my (as researcher) sole responsibility. Although NVIVO has the capacity to manage qualitative data in several different modes, I used it, primarily, to develop codes and themes.

Thematic analysis

Creswell (2007, p. 244) defines a thematic approach as the task of "aggregating information into large clusters of ideas". However, even though definitions such as these can be found, *thematic analysis*, as a term, is not necessarily a clearly identifiable technique in itself (Bryman, 2008) despite its use by numerous social researchers (using a variety of approaches) when discussing their findings. Furthermore, the term 'theme' or *thematic analysis* is often criticized for its 'loose' application and unsatisfactory explanation; a term which raises suspicion (Bazeley, 2007). Perhaps this explains why numerous well known authors expounding a gamut of qualitative research methods, such as Jupp (2006) for example, omit referring to

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[59] Bazeley's book Qualitative Data Analysis with NVIVO (2007) and Richards' book Using NVivo in Qualitative Research (Richards, 1999) provided a comprehensive guide to NVIVO as a research tool.

the term 'theme' and why Crotty (1998), although writing about the importance of 'themes', appears to avoid defining it.

Nevertheless, as (Miles & Huberman, 1994) indicate, a symbolic interactionist perspective, although one of several frameworks capable of doing so, is well suited to the identification of themes. While adopting this recommendation and in adopting Creswell's definition of 'theme', I intend approaching the data in not dissimilarly to the familiar task of detecting themes and motifs in musical works. To do this, I intend drawing on my paraphrase and adaptation of Lloyd's explanation of thematic analysis in music (shown in parentheses),

> " a theme may be seen in merely a progression of chords (utterances) out of which spins many strands of melody (meaning or 'reality')...the job of the composer (the researcher) is to show the many possibilities that lie hidden in the them" (Lloyd, 1968, p. 592).

Qualitative interviewing

Renowned social theorists such as Husserl (1964), Blumer (1969) and Goffman (1962), advocate that researcher *submersion* in the empirical world is essential in sociological enquiry. As worthwhile an aspiration as this may be, the researcher must nevertheless select from within a range of possibilities, an effective means of doing so. One mode of data instrumentation is qualitative interviewing (Rapley, 2004) or in-depth interviewing as it also called (Minichiello, Aroni, Timewell, & Alexander, 1995).

According to Mason (1996, p. 62), the core features of qualitative interviewing include the following: an interactional exchange of dialogue between researcher and participant/s; a relatively informal style; a thematic and/or topic focus; and a belief that knowledge is situated and contextual. On this basis, qualitative interviewing is a 'natural' means to accessing information (Gubrium & Holstein, 2001) relating to individuals' beliefs, experiences and perceptions of a topic or situation (True, 1989). This, however, as pointed out by Bryman (1988), is sometimes interpreted as over-dependence on researcher interpretation and, therefore, potentially unreliable. Furthermore, effective qualitative interviewing requires researcher *rapport* (Creswell, 2007), *sensitivity* (Strauss & Corbin, 1990a), *experience* (Mason, 1996) and *skill* (Miles & Huberman, 1994) to achieve optimal data. As such, qualitative interviewing is not necessarily a straightforward exercise for the beginning researcher, who may be further daunted by the vast array of techniques, each promoting a 'recipe' for success (Babbie, 1989) such as:

> Active, biographical, collaborative, conversational, depth, dialogical, focused, guided, informal, life-history, non-directed, open-ended, oral-history, reflexive, semi-structured (Rapley, 2004)

Indeed, given the range of approaches, it is not surprising that the meaning ascribed to specific interviewing approaches varies considerably[60]. In this study, I use the term and approach of 'unstructured qualitative interviewing' to represent a series of interactions with the participants, largely guided by the participants themselves. In this way, 'unstructured qualitative interviewing' is conducive to the revelation of information that the participants *themselves* 'see' as being important; information that may have otherwise remained 'hidden'[61]. This may be why this approach is widely used in investigating human interactions and the processes at work, as is the case in this study.

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[60] Mason's preference for the term 'semi-structured' over 'unstructured' is justified on the basis that the latter suggests a somewhat 'mythical' absence of research direction while, on the other hand, 'structured interviewing' presents as little more than a veiled questionnaire (Mason, 1996). As such terms are not standardized, it is useful to examine the actual approach on a study by study basis

[61] Therefore, rather than directing conversations through a pre-determined set of specific questions, I chose to 'probe' the views of participants; I used broad guiding questions related to my research question, in response to unfolding conversations. In this way I hope to identify social interactions between relevant actors (Rapley, 2004) .

Sampling

Within the seemingly endless gamut of research terminology, 'sampling' is yet another term requiring clarification. I use *sample* to refer to a representation of the population that fulfils the criteria of the topic under investigation (Burns, 1994). Once again, like Jennifer Mason, I believe that this process should effectively 'generate data which will advance your (one's) understandings' (Mason, 1996, p. 127).

While there are numerous approaches to sampling, *purposive sampling* (Holloway, 1997; Mason, 1996; Oliver, 2006), sometimes referred to as judgemental sampling (Babbie, 2008), is commonly used to select participants directly related to the *purpose* of the research (Patton, 1990). Although, purposeful sampling may be prone to researcher bias (Oliver, 2006), its success in targeting participants capable of providing relevant information may explain its popularity (Somekh & Lewin, 2005).

Numerous researchers have utilized purposive sampling based on the characteristics of the population in relation to the purpose of the study. Scott's (2008) doctoral thesis on the mental health experiences of adolescents is an excellent example of this. Similarly, purposive sampling is well suited to this study contingent on the pre-existence of a diagnosis of ADHD in child participants and relevant actors. As such, I utilize purposive sampling to not only select children who have been diagnosed as having ADHD but also to construct the social network surrounding the child diagnosed as having ADHD.

As stated previously, such a network could have included several key agents but, as Figure 4 indicates, the significant actors believed to be of interest in this study are the parent/mother, teacher and doctor/clinician.

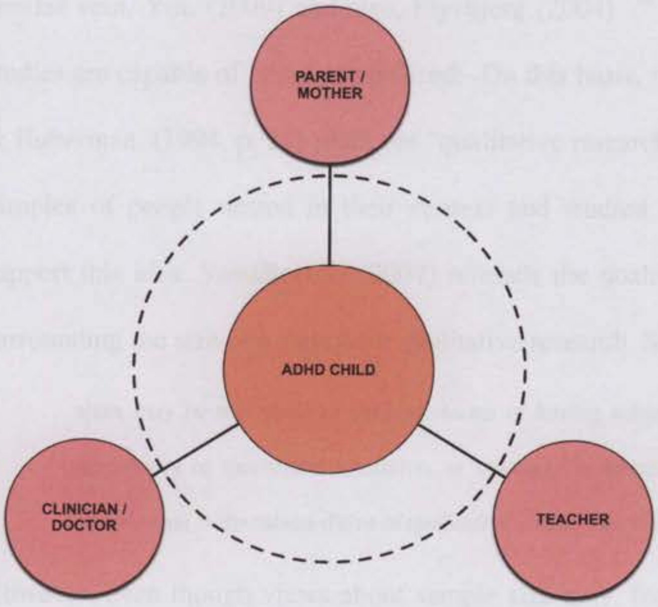

Figure 2: A representation of participants in the medicalization process indicative of the scope of participants sought for this study

Sample Size

According to Marshall (1997), the common misapprehension that generalizing is the ultimate goal of 'good' research questions the usefulness of studies that utilize a relatively small sample. However, as Bryman (2008) emphasises, that there are no 'rules' on sample size specifications in qualitative studies, although time and cost may influence a researcher's final decision. Morse (2000), suggests two guiding principles worthy of comment; firstly, the *nature* of the investigation and secondly, the *type* of the data sought. Furthermore, if the approach is well suited to the aims of the research, then it is likely that fewer participants may be required (Morse, 2000). In a similar vein, Yin, (2009) and also, Flyvbjerg (2004) [62] assert that even single case studies are capable of being generalized. On this basis, it is not surprising that Miles & Huberman, (1994, p. 27) point out "qualitative researchers usually work with small samples of people nested in their context and studied in depth". Even so, not all support this idea. Sandelowski (2007) reminds the qualitative researcher of tensions surrounding the size of a sample in qualitative research. She states:

> sizes may be too small to support claims of having achieved either informational redundancy or theoretical saturation, or too large to permit the deep, case-oriented analysis that is the raison-d'etre of qualitative inquiry (p. 179)

However, even though views about sample size may, for some, implicate a study as unsatisfactory or inadequate, the selection of a sample size is, according to Myer (2000), nonetheless guided by the researcher's intent on describing the world of human experience. Therefore, ultimately, the number of participants in any research study is, like most other aspects of the design, usually at the discretion of the researcher (Sandelowski, 1994).

Sample Recruitment

I approached the data collection process one case cluster at a time, within the limitations of time and resources, until I considered that I had gathered 'sufficient' data. I intended searching for participants by distributing information brochures (see Appendix IV) and using both targeted and arbitrary distribution. Venues to be directly reached were educational institutions, medical centres and ADHD parent support groups; the distribution was opportunistic and included shopping centres, cafes and members of the public.

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[62] Bent Flyvbjerg, a Danish Philosopher (1952-), argued that case-study research was commonly undervalued and misunderstood. He challenged popular views about the lesser usefulness of case-study research through five areas which he identified as 'misunderstandings'.

Participants in this study fulfilled the following criteria:

- Child participants were officially diagnosed as having ADHD by suitably qualified medical practitioners; they were enrolled in registered Australian schools.
- Parent participants gave full written consent for their child/children to participate. In addition, they approved of and facilitated the procuring of other relevant adult participants. Based on these requirements, the role of the gatekeeper became apparent.

Gate keeping

The broad term "gatekeeper" is often used to identify an individual, or an institution that exercises its social power to enable or deny certain social interactions or actions. For example, a flight attendant can perform the role of "gatekeeper" in using her/his designated authority to deny a "suspicious" passenger from boarding an aircraft. While 'gate keeping' in research studies can apply to actors in various ways, it is also worth noting that the role of 'researcher – gatekeeper' as highlighted by Trinch (2007) influences the generation of the data itself by accepting or denying potential participants. Therefore, for a range of reasons, the identification of 'gate keepers' can be important in any study. Minichiello et al. (1995, p. 171) lists the following preparatory questions for researchers to ask:

> How do you gain permission and from whom? How do you represent yourself? How much detail or information about the research project?; Is your study an overt or a covert one?; To what extent does the manner in which you present yourself influence your ability to gain access to the informants and or the setting?

With research involving children, those legally responsible for the children must provide their consent. Therefore, the last of these questions I found to be particularly thought provoking given my own personal experiences in encountering children diagnosed as having ADHD across settings. As mentioned in the introductory section of this chapter, I was aware from the onset that the language associated with ADHD frequently stirred emotions and or triggered expressions of opinion with seemingly little provocation. Therefore, rather than using the formal title of this thesis, I preferred to explain the project in terms of seeking information about the experience of navigating one's journey with ADHD.

Beyond initial expressions of interest, I anticipated two primary gate keeping roles: firstly, the mothers as gatekeepers to their children and their children's clinicians and teachers and secondly, representatives of organizations (such as ADHD parent support groups) and medical practices as gatekeepers to the mothers.

Ethical considerations

The term 'ethics' in research usually pertains to judgements of morality in conducting the research study itself. Ethical judgement, being a complex topic, refers not only to matters directly relating to participants, but also, as Mason (1996 p. 201) says, to:

> …the ethics and politics of your arguments, analyses and explanations, and of the way you are presenting them to a wider audience.

In this study, I paid particular attention to Babbie's (2008) suggested points of consideration in social research as a whole. These include the necessity of voluntary participation; the ensuring that no harm comes to participants; the preservation of participants' anonymity and confidentiality; and the determination of clear communication to participants relating to the nature and arrangements of the study avoiding any forms of deception. However, as can be seen in a later section headed 'conducting the interviews', ethical considerations occur throughout the process of data collection.

All aspects of this study complied with the human ethics protocols as approved by the University of Sydney (Human Research Ethics Committee, 2008) (see Appendix XX).

Part 2: The data collection experience

A methodological framework was established at onset, as detailed in Part 1. However, as this study was essentially exploratory, the process of investigation allowed for adaptation, as is often the case in qualitative studies involving direct engagement with people (Strauss & Corbin, 1990a).

Procuring the sample

As intended, I utilized purposive sampling technique. Mindful of ethical matters concerning potential coercion or intrusion of privacy, preparation for the research project including to the procuring of respondents, progressed through a series of stages as follows:

Stage One

As a first step towards obtaining suitable participants, I produced approximately 200 information brochures introducing this study and calling for expressions of interest (see Appendix IV). The language used in the brochure was intentionally neutral to avoid influencing potential participants. As mentioned, I used two different strategies to distribute the brochures: opportunistic and strategic.

I placed brochures in various locations in Canberra, Australian Capital Territory (ACT) and Sydney, New South Wales (NSW). Styles of locations included noticeboards in supermarkets, cafes and food stores. I initiated contact with various people who I thought might have access to parents and teachers of children diagnosed as having ADHD. These included medical centres, the Director of Education in the Department of Education and Training, (ACT), and several ADHD parent and community support groups in the ACT and NSW (See Appendix V). With regard to medical centres, I located these through the Yellow Pages and subsequently visited several. On each occasion I approached the front desk and asked to speak with the centre manager and in most cases, I was able to explain the project and leave brochures. In some instances, I was able to speak directly with doctors about this study.

In speaking with representatives from each organization, I supplemented my brochure with a verbal explanation and a written letter of introduction. Some time afterwards, I received invitations to address parent and community groups and social and health workers forums (see, for example, Appendix VI).

Expressions of interest were quite different to my expectations. Surprisingly I received no responses from my direct approach whatsoever. In contrast, my opportunistic approach provided several promising initial enquiries: three mothers contacted me (having seen my brochure on a supermarket notice board, in a coffee shop and at a fruit and vegetable market) (see for example, Appendix VII). In due course, each of these mothers subsequently became participants in this study. A fourth mother responded to this study after obtaining my contact details from her friend who had come into possession of a brochure.

Stage Two

This study, as previously documented, initially envisaged individual child participants surrounded by a network of powerful social agents (see Figure 2).

I had not anticipated family clusters. It eventuated that seven of eight child respondents shared families. That is, there were multiple children with a diagnosis of ADHD in the same family and therefore, for the most part, they shared the same network of powerful social agents such as medical practitioners and teachers[63]. This gave rise to four *case clusters.* The unexpected benefit of this situation was that besides providing increased economy of time and resources, I suspected that this might provide some insight into family belief systems.

After establishing that all potential child participants had been formally diagnosed as having ADHD by suitably qualified medical practitioners, I provided further written information in two versions, one being a version suitable for child participants [64] (see Appendices VIII and IX respectively)[65].

Stage Three

Following all four mothers' affirmations of their and their children's intent to participate, I arranged a further meeting with them, inclusive of the children, at which time they could seek further clarification[66]. On this occasion, I attempted to gauge the degree to which the child participants may be able engage in the interview process[67]

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[63] Some of the teachers had taught each of the children from the same family at different times because the children typically attended the same school.

[64] I explained to mothers that the simplified version for children was intended to be both read by (where possible) and read to the children at their discretion.

[65] I asked the mothers to speak with their children about this study, to read the introductory letter with them, consider their children's' responses and contact me should they and their children want to proceed.

[66] I met with each child and his mother separate to his siblings.

[67] I informally 'assessed' the child participants, based on my own teaching experience, to determine likely response capabilities in engaging in qualitative interviews.

and to explain their rights of unconditional withdrawal. Further, bearing in mind Cousins and Milner's (2007) claim that obtaining consent from children is 'a thorny one', I sought signed consent from the mothers and also from the children in order to heighten each child's awareness of their rights and involvement in this study.

To further explain, the 'informed consent' of the mothers with regard to their own participation, which reasonably demonstrated their appreciation of the nature of the research, needed to extend to their children. This extension had important implications for the consent procuring process, not only because this study involved 'children' per se, but also, because the children had been diagnosed as having a disorder categorized as a 'mental illness'. As such, even though clinical descriptions of ADHD do not necessarily imply diminished intellectual capacity, the fact that the children had been 'diagnosed' as having 'a disorder', heightened the importance of the mothers' effective delivery of the 'age-appropriate' information material intended for the children. Therefore, even though the children's act of 'signing' could be said to be both redundant and legally impotent, it was nonetheless one means of both *emphasizing* and, to the extent possible, *ensuring* that the children had received the benefit of such information. After due reflection in light of the participant criteria all four case clusters were accepted.

Stage Four

Having established mother and child participants, stage four involved extending contact to the relevant medical practitioners and teachers. In line with my expectations, mothers proved to be the *gatekeepers*. Not only did the mothers provide the introductory information that I had requested, they directly requested their involvement and gave their permission in writing for the disclosure of information concerning their children (see Appendix X). Furthermore, the mothers followed through with further requests according to need. In some cases, the mothers sought out and made contact with the teachers involved with their children at the time of their children's diagnoses, as some had relocated to other locations. In short, without the cooperation, initiative and support of the mothers (see, for example Appendix XI) the procuring of additional participants for each case cluster would have been unlikely.

Stage five

Following being informed by the mothers of their successes in contacting the doctors and the teachers, I proceeded with my own attempts to make direct contact (See Appendix XII). At this point, however, I encountered my first significant obstacle in completing each case cluster; a second layer of gatekeepers unexpectedly appeared in relation to the doctors.

The doctors' secretaries/office managers, in all four cases, appeared to control my access to the doctors. Without exception there appeared to be overt reluctance from the secretaries to pass on information on the basis that the doctors were "too busy to get involved". In an effort to find a solution, I began 'on the spot' unplanned negotiations with the secretaries offering modifications such as brief interviews within strict time parameters and or telephone interviews. Even so I met with varying degrees of resistance from one outright "no" to comments like: "I'll get back to you but if you don't hear anything, it means that doctor is too busy".

Having had no further reply from either the doctors or their secretaries for several weeks, I contacted the mothers once again and explained my difficulty in reaching the doctors. All four mothers, without hesitation, indicated that they would contact their respective doctors once again requesting their participation. Following this, I (see, for example, Appendix XIII). Each of the interviews commenced with a re-statement of their rights to discontinue the interviews at any time without recourse and assurances of confidentiality.

Careful consideration was given to the choice of venues for the interviews. In the interest of both the child and the researcher's protection all interviews with the children took place in the children's homes where ease of access to the children's parents was ensured (Williamson, Goodenough, Kent, & Ashcroft, 2005). It was appreciated that, as Gillham (2005) suggests, it is important to obtain mutual agreement between the researcher and the parents with regard to the safety and well being of the children being interviewed[69]. Adult interviews were conducted at the locations nominated by the adult participants[70].

With regard to the duration of the interviews, the timing was deliberately flexible so as to be sensitive to the needs of the participants as it was appreciated that the topic being discussed may have resulted in emotional responses and or fatigue (Cowles, 1988). It transpired that most interviews were between sixty to ninety minutes, with the exception of a telephone interview with a doctor participant, which, in this instance, lasted just fifteen minutes (see Doctor 2).

The day following the interviews, with the exception of the doctor and teacher participants, the participants were contacted to provide the opportunity for further questions or comments[71]. It is of interest that, without exception, the mothers' indicated their appreciation in being able to express their view. No problems were

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[69] Whilst parents were not always in the room when the child was being interviewed, the door to the interview location remained wide open throughout the entire course of the interview and in full view of the parent who may be called upon should a need arise.

[70] Three of four of the mother participants chose to be interviewed in their homes and one in a café. One doctor was interviewed in his professional rooms and the remainder by telephone. Teacher participants were interviewed in vacant classrooms after school hours and all children were interviewed in their homes.

[71] In the cases of child participants, I spoke with each child's mother rather than the child.

received phone calls from three of four doctors' secretaries indicating that the doctors had agreed to participate in this study: two agreed to telephone interviews and one doctor agreed to a face-to-face interview. The fourth doctor's secretary claimed that he declined to participate on the basis that "he doesn't get involved in research". At first I thought that this fourth cluster, given this refusal, would not serve my research but after discussing this with my supervisors, it was decided that it would be included.[68]

Only two of the teachers who were present at the time of diagnoses were contactable (as the diagnoses had occurred several years prior to this study). Therefore, current teachers provided a substitute. The absence of the original teachers for all case clusters was noted as a possible weakness in the completeness of the data.

Producing the data

With four case clusters in place, I collected data on a case-by-case basis. I decided that further arising expressions of interest would be filed for access at a later date on a needs basis because, according to Bryman's (2008) comments, its difficult to know exactly how many interviews may be useful.

The final number of cases considered sufficient for this study remained open pending evidence of the richness of the data and time and resource constraints.

Conducting the interviews

Twenty qualitative interviews were conducted between February 2007 and October 2007. The interviews for each case cluster were recorded in an interview schedule

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[68] It is unclear whether the doctor actually ever heard about this research; it may have been the secretary's decision to exclude him. Nevertheless it is interesting that of all four doctors, the mother said that this doctor relied on scientific evidence of 'malfunctioning brain waves' using fRMI scans to detect ADHD in her child which he had subsequently described as 'mild'. So this doctor, attributed to being engaging in 'the latest research and medical technology' was reported to have avoided participation in this study because 'he doesn't get involved in research'.

reported. Each of the mothers said that it was the first time that had been able to "tell the story".

It was interesting to note, however, that two of the four mother participants indicated to me that the interview process had provided them the opportunity to reveal to their children, for the very first time, that they had been diagnosed as having ADHD years earlier. This being the case, it can be said that these mothers used their children's participation in this study as a way of disclosing to their children their diagnosis of ADHD. These revelations reportedly occurred immediately or soon after their children's interviews with me. I learned of these occurrences when I telephoned the mothers soon after interviewing their children to seek the mothers' responses as to the 'well being' of their children and to express my impressions that their children did not appear to have seen themselves as having being diagnosed as having ADHD. The mothers' explanations of their children's 'vagueness' about 'experiencing' ADHD was thereby explained by the mothers. This situation raised questions about potential distress and/or other emotional responses of the children, as a result of learning of their earlier ADHD diagnoses of which they had previously no reported knowledge. In enquiring about such responses with the mothers, I was assured by the mothers that the children had suffered no adverse effects.

Returning to the interview process, with regard to recording the conversations, all of the interviews were retained on a digital voice recorder and, as an extra measure, a conventional tape recorder. All data was stored on a password protected computer and copies of transcripts (see, for example Appendix XIV) and additional storage devices were stored in a fireproof safe which was both digitally and key locked at all times.

Part 3: Formative analysis

The early data derived from the interviews with the mothers showed that across cases, six of the eight child participants were diagnosed as having ADHD well before school age. Therefore, earlier concerns regarding lack of access to the teachers who were present at the time of the children's' diagnoses, as noted above in *Stage Five*, proved to be less important as the teachers did not have a direct role in directly initiating the diagnostic process[72].

These initial findings stood in contrast to numerous other studies, in Australia and elsewhere, implicating teachers as being directly involved in the first stages of ADHD identification (Graham, 2007, 2008; Prosser, 2008; Rafalovich, 2005b; Sciutto, 2004; Sciutto, Nolfi, & Bluhm, 2004). Indeed my own experience in schools influenced my own belief of this being the case, so much so that the initial working title of this study was: *The mechanism and impact of the medicalization of behaviour in children diagnosed as having Attention Deficit Hyperactivity Disorder: A sociological study of teachers in Australian Schools* (Ethics application, 2006). As my preconceptions were challenged soon after the first interviews with the mother participants, my focus shifted from the teachers to the mothers' and their reactions to their children's problematic behaviour. I began considering the data with a particular interest in the mothers' interactions with other key actors, as described in Figure 1.

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[72] As the teachers were not significant actors in the process of medicalization, their conversations, although interesting, were not used in the analysis of this study.

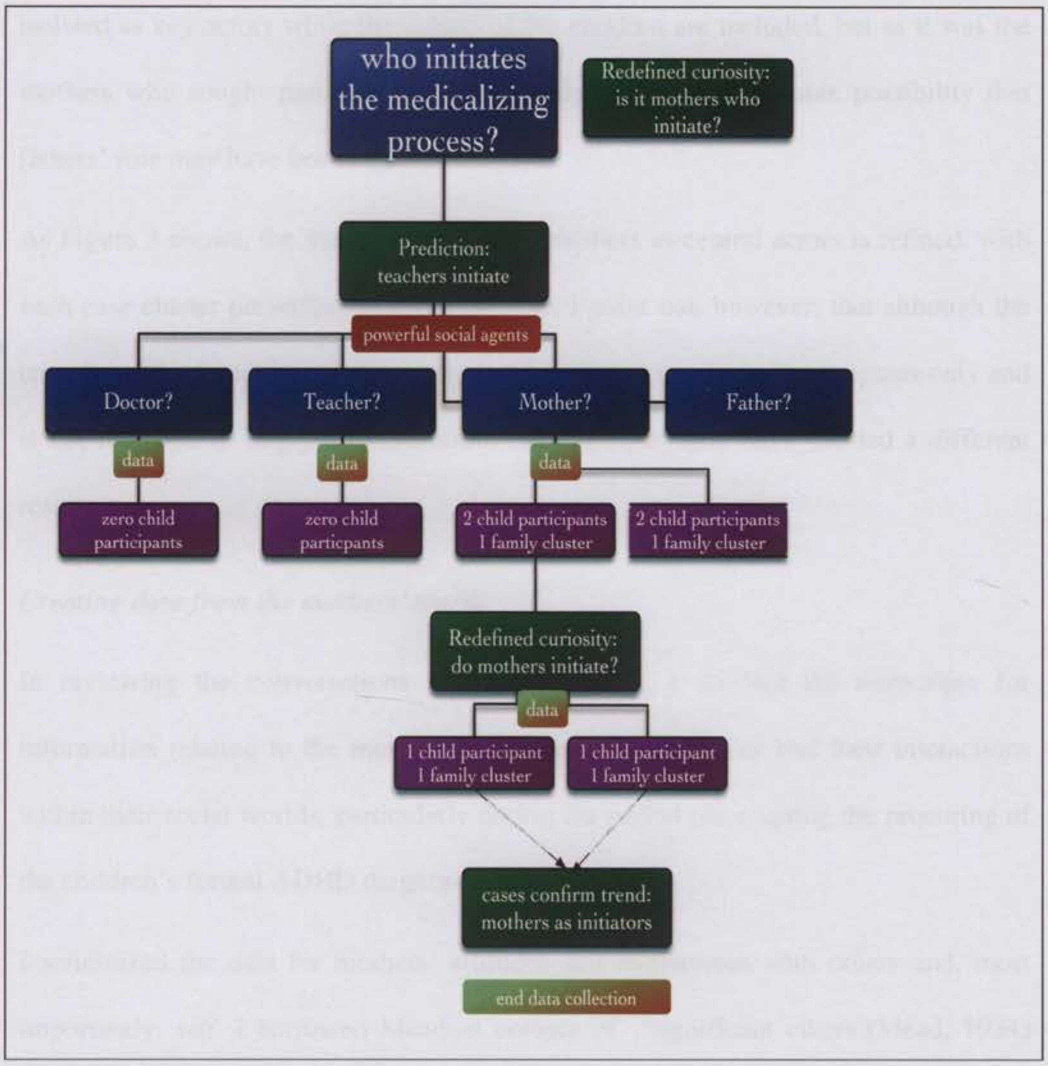

Figure 3: The process of formative analysis in determining the initiation of the process of medicalization, and its influence on data collection.

As indicated, the identification of the key actor/s involved in the initiation of the process of medicalization forms a critical starting position for the early stages of analysis. This question is important because it provided a point of entry in probing the social meaning and conditions that could have influenced the beliefs and actions of key social agents.

Following through in this line of questioning, Figure 3 indicates three actors of interest: the teacher, the doctor (or related clinician) and the mother. The teachers are isolated as key actors while the fathers of the children are included, but as it was the mothers who sought participation in the study, it was a reasonable possibility that fathers' role may have been indirect.

As Figure 3 shows, the identification of the mothers as central actors is refined, with each case cluster presenting in a similar way. I point out, however, that although the term "trend" is used, it is in the context of the limited number of participants only and is not intended to imply generalization. Further cases may have yielded a different result.

Creating data from the mothers' words

In reviewing the conversations with the mothers, I scoured the transcripts for information relating to the mothers' contextual circumstances and their interactions within their social worlds, particularly during the period pre-empting the procuring of the children's formal ADHD diagnoses.

I scrutinized the data for mothers' attitudes and interactions with *others* and, most importantly, *self.* I borrowed Meadian notions of 'significant others'(Mead, 1934) and used it, as either an individual or a collective group (functioning in a sense as 'one'), with whom mothers engage: that is, those whose views or behaviours may have had influence in the formation of the mothers' perspectives, and perhaps less obviously, the media and broad community. In this way, significant others, in a collective sense, 'become' social objects to which the mothers interact (see Figure 4).

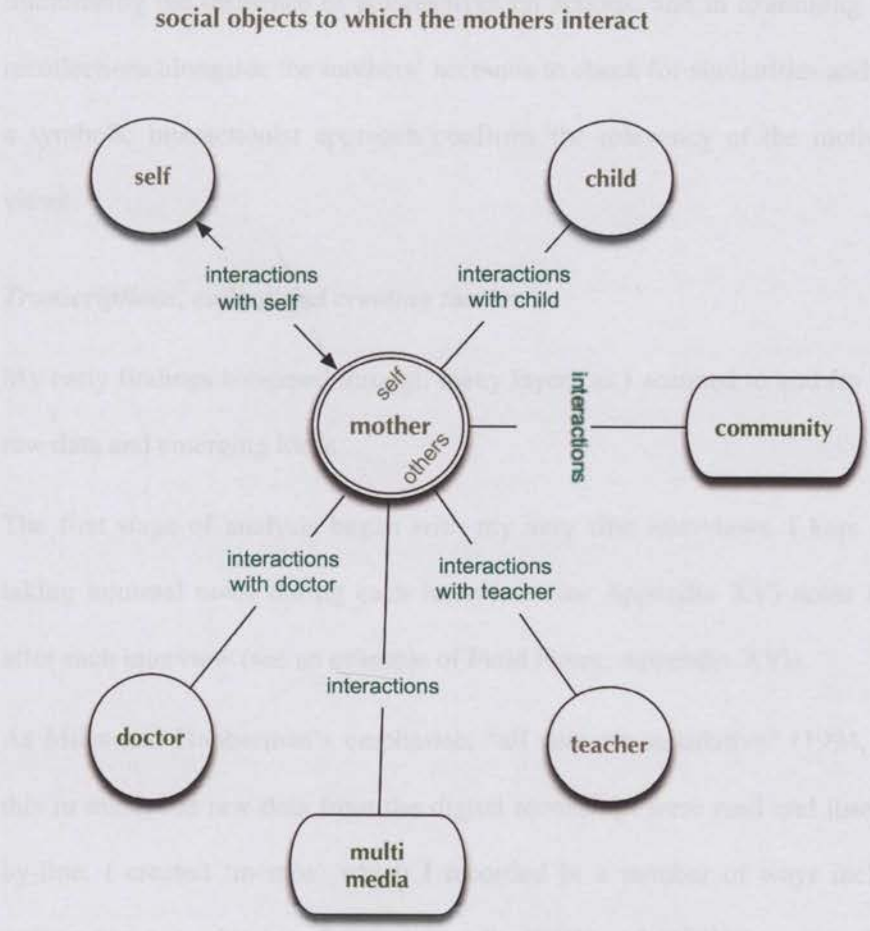

Figure 4 Possible 'objects' with which the mothers interact

Validity

I use Jupp's definition of validity as " the extent to which conclusions drawn from research provide and accurate description of what happened or a correct explanation of what happens and why" (Jupp, 2006, p. 311). In addition, I acknowledge possible weaknesses in the reliance on the mothers' past recollections, however, a symbolic interactionist perspective reaffirms that the meanings the mothers attach to experiences inform their present realities. Therefore, as my enquiry intends illuminating the influence of perspectives on actions, and in examining the doctors' recollections alongside the mothers' accounts to check for similarities and differences, a symbolic interactionist approach confirms the relevancy of the mothers' present views.

Transcriptions, coding and creating themes

My early findings traversed through many layers as I scanned to and fro between the raw data and emerging ideas.

The first stage of analysis began with my very first interviews. I kept a record by taking minimal notes during each interview (see Appendix XV) notes immediately after each interview (see an example of Field Notes, Appendix XVI).

As Miles and Hubberman's emphasise, "all data are qualitative" (1994, p. 9). With this in mind, the raw data from the digital recordings were read and listened to line-by-line. I created 'memos' which I recorded in a number of ways including hand written notes, a whiteboard (see Appendix XVII) and NVIVO memos. Through the synthesis of various sources and modes of recording, I began creating 'free nodes' relating to the first and second case clusters. I then progressed with interviewing participants from the third and fourth case clusters[73].

Coding analysis: capturing and linking codes

After multiple readings of the interview transcripts, re-listening to the recordings of the interviews and reflecting on an array of emerging free nodes, I noted emerging trends. Returning repeatedly to the words of the participants, I attempted to verify my

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[73] I was aware that my formative analysis was influencing my research experience. Informed by the ongoing refinement of ideas emerging from the data, I probed participants' views in second round interviews. I was aware of the possibility of steering the participants' conversations towards my emerging 'tree nodes' and attempted to avoid this by maintaining the unstructured interviewing approach and repeatedly reflecting on the transcripts.

analyses. Using NVIVO software, I eliminated free node duplications, set aside irrelevant free nodes and proceeded to create 'tree nodes' (see Appendix XVIII).

This was a complicated task made more manageable by producing ongoing tree node coding reports, once again using NVIVO (see, for example, Appendix XIX). I soon realized that organizing data and conceptualizing emerging themes had less to do with the capacity of NVIVO to assist in the organization of complicated material and more to do with the richness and texture of voluminous data and my interpretation of it. At this point, I found that frequently returning to the focus of this study conceptualized in my research question was critical to avoiding tangential diversions [74].

Having undertaken a thorough approach to establishing a coding framework relatively early in the process of analysis, my strategy was well suited to the ensuing case cluster interviews. As thematic categories began to emerge, second round interviews with the mothers were particularly useful in further exploring emerging themes[75].

The use of thematic terminology magnified my own construction of meaning. According to symbolic interactionism, language is a powerful symbol in itself, capable of conveying a range of meanings. In addition, some themes, such as 'blame' were unexpected. Therefore, further investigation of the literature, including notions of mothering found in feminist literature was noted as requiring further investigation.

Final remarks

I point out that rather than deconstructing each case cluster individually, I synthesized the data and refer to individual cases to illustrate similarities, differences or points of interest. I began this chapter by clarifying my intention to approach the raw data from

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[74] Although not all nodes were immediately useful, I retained several versions in case they became relevant in the future.

[75] For practical purposes and in the interest of time efficiency, interviews were over the telephone.

a social constructionist perspective. I constructed numerous codes and tentative categories arising from symbolic interactionist sensibilities.

While I expected to 'see' emerging themes readily, to the contrary, I encountered a bewildering array of possibilities; rather than providing clear 'themes', my coding approach appeared at first to produce tangled layers of overlapping ideas. Grappling with this problem, I began to interpret my codes, as Kathy Charmaz (2006) in her approach to theoretical sampling suggests: strategically, specifically and systematically. Rather than following an explicit procedure, I used NVIVO software to assist in organizing links between perspectives and actions reflective of the mothers' interactions towards self and others. I focused, in particular on the mothers' contextual circumstances around the period when their children were fist identified as being 'different' or perhaps, 'deviant'. I scoured the data for indications of the perceptions and actions relating to the act of diagnosis and its relationship between the many 'meanings' of ADHD held by the powerful social agents: the mothers, the doctors and the teachers.

As discussed previously, determining whether sufficient data has been achieved is not necessarily straightforward. Although some social researchers refer to 'data saturation' as the primary means to determine the point when sufficient data has been obtained (Guest, Bunce, & Johnson, 2006) in exploratory research such as this, the focus is primarily on the illumination of the phenomena of interest. After completing four case clusters, it was clear that the raw data was sufficiently dense for me to cease the procuring of further material. I then proceeded to the final stages of my analysis as detailed in the ensuing Chapters 5 and 6.

5 The initiation phase

In this chapter, the findings relating to the period *preceding* the achievement of formal ADHD diagnoses are explored. Data relating to this stage of the process of medicalization reveal much about the perspectives, interactions and actions relating to its launching. Hence, I have named this period the *initiation phase.*

The discussion of the findings is arranged in two parts. The first section, Part One, condenses information gleaned from the mothers' conversations relating to their contextual circumstances, both past and present, providing a foundation to the discussion that follows in Part Two, where the grande theme of *blame* which can be seen to characterize the 'initiation phase'.

Introduction

The search for meaning surrounding how it is that children come to be interpreted as ADHD is much like unravelling a multi-coloured-textured skein of twine of unknown origin. Formative analysis of the mothers' conversations show, in particular, the initiation phase to be a period dominated by the mothers' disappointments occurring much earlier than I had first anticipated; that is, when their children are infants or toddlers. The mothers' interactions, particularly with self, reveal both defence and accusation in connection with lamenting their social and environmental circumstances, compounded by tensions emanating from their perceptions of their children's unsatisfactory 'baby performance'. In this sense, mothering judgements deliver the first signs of perceptions of deviance[76] in their children, as Mother 3's comments exemplify:

> My first child, he slept twenty minutes a day. From the time he was born…I knew there was something wrong there (Mother 3)

This alone, however, is insufficient in explaining why the mothers proceed along a medicalized pathway nor does it show why, in due course, they interpret such deviance as being evidence of ADHD. This curiosity is of particular interest, especially since the mothers' descriptions of their children's early "irritant" behaviours (such as crying and tantrums) have little resemblance to the behavioural indicators of ADHD as stipulated in the Diagnostic and Statistical Manuel (American Psychiatric Association, 2000, p. 2) [77] detailed in Chapter 2.

Informed by feminist writers on aspects of mothering, and sociologists interested in deviance and medicalization; further analysis capturing the mothers' interpretations of their children as ADHD shows rich contextual clues as to how the mothers make sense of their social worlds. In fact, evidence found in the mothers' reactions to their children's' behaviour reveal entrenchment in a medicalized world long beforehand.

Indeed, like most western women, the mothers in this study have long been accustomed to engaging in partnership with medical professionals in a context of culturally oriented medicalized thinking. This not only pertains to reproductive health through the medicalization of menstruation (Lee, 2002) and conception but also medical jurisdiction throughout gestation in pregnancy (Rothman, 1994), where screening technologies preside over the detection of imperfection in developing foetuses (Petchesky, 1987) through 'real life' images (Michaels & Morgan, 1999)

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[76] Deviance meaning behaviour outside mothers' expectations of normality.

[77] This is perhaps expected since these have been criticized as being specifically reflective of contra-classroom behaviours according to teachers' expectations of ideal behaviour

fostering a culture of self- determined reproduction (Landsman, 2003; Williams, 2005). Expectations and moral dilemmas surrounding the production and sustenance of the "perfect child" or possible demise of the imperfect (Bliton, 2003; Williams, 2005) naturally leads the debate into the disability arena where considerations of the social construction of disability and embodiment abound (Barton, 2007; Goggin, 2005; Hughes, 2007; Hunt, 1998; McKeever & Miller, 2004; Oliver, 1996, 1999; Parmenter, 2001; Priestly, 1998; Shakespeare, 2005; Swain, French, & Collins, 2003).

Mothers in this study are situated within such complexities: a social world where medical control is assumed (Copelton, 2004)[78]. It is in this context that the mothers come to understand their children as being imperfect and eventually, as being ADHD and it is therefore perhaps not surprising that mothering discontent emerges as *blame*. Indeed, mothers in this study invoke different forms of blame to defend, to accuse, to explain and to resist their children's perceived imperfection.

I therefore nominate *blame* as the overarching dominant theme at onset and one that continues to pervade the entire study, being overshadowed only by degree by the additional rising themes of *relief* and *fear*, which appear to dominate later in the process of medicalization (see Chapters 6 and 7). Moreover, blaming perspectives appear to give rise to actions consistent with a medicalized thinking. Therefore, although the initiation phase is not designed to pinpoint a moment in time when the process of medicalization 'commences', it nonetheless represents the period leading to and including the mothers' earliest recollections of 'performing' mothering. The parameters of the initiation period, although loosely defined, reveal a complex array of mothering tensions and emerging ADHD sensibilities.

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[78] Mothers in my study may be viewed as part of the western medical domination of childbirth, especially evident in the past two centuries.

Part 1 Contextualizing the mothers

The roots of medicalizing action

The initiation period is predominantly characterized by the mothers' feelings of stress situated within everyday life experiences. The mothers' contextual circumstances are later 'crimped' by confusion and misalignment between the mothers' expectations of being "the good mother" of the "the perfect child". One mother captures the commonly shared view of all when she describes her 'pre' and early mothering experiences as "awful".

However, it is important to note that, as discussed in chapter 4, the interviews with the mothers relate to perceptions and events at least a decade earlier to the time of the interviews. While this may raise questions of validity [79], a symbolic interactionist perspective reassures that the meanings the mothers attach to past experiences inform their present realities, so the longevity of memories is part of today's 'truths'. However, as my enquiry seeks to illuminate the relationship between perspectives and actions, I have reviewed the doctors' recollections alongside the mothers' accounts to check for similarities and differences.

As a means of socially situating each case cluster, each of the mother participant's situations at the time of interviewing, and their recollections of the period leading up to the diagnosis of the children as ADHD, is profiled below[80]. Note that the mothers' actual names are not used. Instead, the mothers are referred to numerically in order to comply with the ethical standard of informed consent to participation (Mason, 1996).

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[79] I use Jupp's (2006, p. 311)definition of validity: " the extent to which conclusions drawn from research provide and accurate description of what happened or a correct explanation of what happens and why"

[80] Information was obtained through an open interview style rather than through the asking of specific questions.

The Mothers' profiles

The information presented is gleaned from the mothers' conversations recorded in field notes (derived from informal conversations with the mothers) and, for the most part, interview transcriptions. Notwithstanding the uniqueness of each case cluster, the mother participants' present with some similar characteristics[81], particularly in the following areas:

- Marital status
- Number, ages and gender of children
- School enrolment
- Employment status
- Ethnicity
- Socio-economic status
- Educational level of achievement
- Spoken language
- Age
- Level of educational achievement and socio-economic status.

To explain in greater detail, all of the four mother participants appeared to be between forty and fifty years, were of Caucasian appearance possibly from an Anglo-Celtic ethnic background and spoke English as their first language. Three of the four were born in Australia and the fourth in the United Kingdom. The mothers appeared to be

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[81] I did not systematically gather this information, for this was not my purpose. However, the mothers' conversations 'naturally' revealed these features.

of a 'working/middle class'[82] background and resided in homes and neighbourhoods reflecting this.

Without exception, the mothers had graduated from secondary school and three of four had achieved tertiary qualifications. According to the mothers, both parents were in full time employment at the time of interview and all of the mothers spoke of being employed, at least in a part-time capacity, throughout their mothering years.

It was noted that each family cluster had three sons relatively close in age with no daughters. With regard to the children's schooling, six of eight child participants attended government schools and two attended Catholic schools.

Despite the number of similarities, some differences were noted. Although perhaps fewer, they presented greater potency of interest. The most striking difference was the mothers' degree of ADHD disclosure. ADHD 'secrecy' featured strongly in two of the four cases, even to the extent that two of the child participants remained uninformed of their ADHD diagnostic status during their participation in this research study[83]. In providing clarification as to the circumstances of this, one of the mothers explained that her child's daily ADHD medication had been deliberately portrayed to the child as essential medication for a 'mythical' kidney complaint to avoid the stigma and negative outcomes of her child being identified as being ADHD, especially at school. Consistent with this, the child's teachers were, for the most part, similarly unaware of the child's diagnostic state. While the second mother had not replaced ADHD with another fictitious condition, she nevertheless chose to conceal from her

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82 This is my interpretation rather than a reflection of the mothers' words

83 As the mothers had agreed to participate in this research study concerning 'ADHD' I was surprised to find that, during the course of interviewing the children, they appeared to not 'know' that they had been so diagnosed. In seeking clarification of this with the mothers, the mothers revealed that this was the case and that they had considered their children's participation in this study as a useful means of 'revealing' to their children that they had been diagnosed and treated for ADHD for a number of years.

child and his teachers (with the exception of the teacher at the time of his diagnosis) his ADHD identity.

The other two mothers, in strong contrast, conveyed their intent from onset to advocate their children's ADHD: their children were portrayed as the victims of ADHD. As such, rather than 'disguising' their children, these mothers indicated that they were impressing on their children and the teachers, the symptoms of ADHD and the necessity for behavioural 'accommodations' across environments.

Further, some curiosities emerged which were not easily categorized as either similar or different, one example being marital attitudes towards the veracity of the ADHD diagnoses. Three of the four mothers spoke about their husbands' disagreement of their children being diagnosed as having ADHD. Although further mentioned below in 'he-blame', it is useful to summarize at this point that the mothers who advocated their children's ADHD diagnoses also seemed to speak most about their husbands' opposition to the same. It was noted that Mother 3, possibly the strongest advocate of her children's ADHD 'condition' to the wider community, referred frequently to her husband's hostility and his 'inapproachability' not only to his sons' ADHD diagnoses but also the topic of ADHD in general.

Overall, as the interviews were unstructured, the degree to which the mothers disclosed various aspects of their present and past life situations varies. I have therefore organized the following content loosely. While it could be argued that some of the material bears little relevance to my analysis, it nonetheless serves to contextualize the mother participants in their social and physical environments.

Mother 1

Current situation

Children

Mother 1 had three school-aged sons aged eleven, twelve and fourteen years of age at the time of interview. Two of the three boys, the eldest and the youngest, were diagnosed as having ADHD. The youngest child, when four years of age, was the first in the family to be diagnosed as having ADHD. The eldest child, at age six, was diagnosed as having ADHD soon afterwards. Both children diagnosed as having ADHD were interviewed. While Mother 1 spoke of each of her sons and ADHD, she made greater reference to her experiences and attitudes in relation to her youngest child's ADHD diagnosis.

Husband

Prior to this study, Mother 1 stated that she had not disclosed to her sons that they had been diagnosed as having ADHD. She justified this action by describing it as acting protectively towards in avoiding stigma associated with 'being ADHD'. Mother 1's husband was interviewed. Interestingly, he spoke more about his eldest child. In relation to both children, however, he stated that he did not find his sons' ADHD diagnosis credible. Nevertheless, he claimed to have remained supportive of his wife's views and continued to comply with his wife's 'kidney disease' story. Although he remained concerned about the ADHD medication treatment, he stated that he had chosen to submit to his wife's approach. However, in order to 'compensate' for this and to curtail the 'symptoms' of ADHD, he said that he actively promoted the benefits of physical activities such as competitive sport. In addition, although perhaps not related, he stated that he actively shared in home and childcare duties.

Employment

At the time of interview, Mother 1 was in full time employment. She worked as a checkout operator in a supermarket while also studying to be a primary school teacher by distance education. Her husband was also in full time employment in the public service.

Although presenting as a dual income family, both parents stated that they had limited financial and material resources. Their financial lack was partly attributed to the need to draw on their finances to curtail the limitations imposed on their children by "ADHD". This included additional tutoring which, despite the relatively high expense, had not apparently made any difference to the children's behaviour or academic achievement[84].

Home environment

Externally, the home itself presented as comparatively modest in the context of its suburban location. Inside, it appeared to be sparsely furnished and decorated. Mother 1 commented that the home environment had been restricted by financial limitations and to accommodate boisterous behaviour and minimize further loss of property: one child had recently accidentally set his bedroom on fire. This was attributed to him 'being ADHD'.

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[84] Mother 1 referred, in particular to the DORE® programme for which she claimed to have outlaid "thousands' of dollars.

Background

Mother 1 met her Australian born husband in the United Kingdom. Some time later, they married in her hometown. They had three children in relatively quick succession.

The family migrated to Australia eleven years before being interviewed, when the youngest son was just three months old. Mother 1 said that she was ill prepared for the event because (at the time) she was of the impression that her family (she, her husband and her three children) was coming to Australia for a brief period only, to visit to her terminally ill mother-in-law. They stayed longer than planned because her mother-in-law's illness extended. In due course, her husband consequently sought and gained employment and before long, the family were residing in Australia permanently.

Referring to this period she recalled feelings of isolation, financial hardship and dismay (especially as she was separated from her extended family on whom she had relied in a number of ways). Although English was her first language, she stated that communicating with others was a difficult task. She says:

> It took me a long time to come out of my shell when I came here I think – to get confidence in this country and all that sort of thing… I had to re-learn the language and everything when I came here… it was *very difficult* and I had no idea where to even start looking for help (Mother 1)

At first residing in her father-in-law's home, where minimizing the children's 'noise' was required, she ventured out of the home with the children as often as possible into an 'unknown' environment. She found this to be very stressful as she recalls:

> It was *awful* (long pause) oh dear, it was awful. I was in a new country and could speak the language but couldn't actually understand anybody. At the time we were living with (husband's) parents' house. I would get up in the morning very early and

> take the boys (her three young children) out just to get out of the house. But I was always frightened of getting lost. So I used to walk in a square, just in case I got lost because I was terrified I might have to talk to somebody. You feel very alone. You feel very on your own. *Very* alone. I felt like an intrusion. I'm an independent person and to suddenly get into the situation where people were telling me what to do I found that *very* hard. *Very hard.* I had to learn to bite my tongue (Mother 1).

Within the ensuing twelve months, Mother 1 said that her baby changed into a "monster". By preschool, he was diagnosed as having ADHD and immediately afterwards, the eldest child was similarly diagnosed. They were both immediately treated with ADHD medication. The youngest child continues to take medication.

Mother 2

Current situation

Children

Mother 2 had three sons aged eleven, fourteen and fifteen at the time of interview. The youngest of whom was diagnosed as having ADHD at four years of age and he immediately commenced taking ADHD medication. This continues to be the case to date. In addition, within a few years and in the context of ongoing difficulties at school and at home, he acquired a further diagnosis of Asperger's syndrome at age seven while retaining his ADHD status. Mother 2 states that his two older brothers express resentment about him having the growing list of disorders. Less parental attention and the requirement for them to make 'excessive' accommodations for his troublesome behaviour were cited as the reasons for their grievances.

Husband

Mother 2's husband declined participating in this study, although he reportedly encouraged his son and wife to do so. Mother 2 stated that her husband was not convinced about the veracity of ADHD as a 'condition' but that he did not strongly object to his son having this diagnosis. He reported as being minimally involved in home and childcare duties, leaving the decision-making relating to home affairs (which included the children) to his wife.

Employment

Mother 2 was currently in full time employment although she stated that this had at times worked on a part-time basis. Her husband was employed full time.

Home environment

Externally, the home was typical of the middle-class suburb in which it was situated. In contrast to Mother 1's home, internally, the home presented as well organized with high quality furnishings.

Background

Mother 2 described her life before her youngest son's birth as being characterized by marital discord. Marital disharmony was further exacerbated by Mother 2's feelings of physical exhaustion. She attributed her weariness to working extensive hours while taking full responsibility for home duties and for the childcare of her two pre-school aged children whilst expecting her third child. Around this time, she and her husband separated. The couple were reconciled just a few weeks before their third son's birth.

Soon after the apparently uneventful birth, she stated that her infant had presented as having sleeping and feeding difficulties. Mother 2 recalled feeling extremely isolated by the baby's crying behaviour; she voluntarily avoided socialising with others including her immediate family and, as early at just a few weeks of age, believed that her infant son's behaviour was 'abnormal'. She states:

> Then (baby's name) came along. We (my husband and I) were back together then (after our separation), but yeah that (baby's name) made things *difficult*... So it was kind of an unsettled time... (name of child) 's behaviour even as a baby was not what I'd say normal (Mother 2)

By toddler-hood, Mother 2 spoke of her ongoing difficulties in manageing her child's behaviour, which she described as being "clingy". She states:

> I had to drag myself away from him (when leaving him at pre-school). He'd hold my legs and didn't want me to ever leave him. It was terrible. (Mother 2)

Soon afterwards, in early childhood, he was diagnosed as having ADHD.

Mother 3

Current situation

Children

Mother 3 had three sons who, at the time of interview were aged twelve, fourteen and seventeen years of age. Each of the boys was diagnosed as having ADHD around two to three years of age and have taken ADHD medication ever since. In contrast to Mothers 1 and 2, Mother 3 said that her reflections about ADHD related mainly to her eldest child and also, to a slightly lesser extent, her second child. Her current distress, however, related to her experiences of ADHD with her youngest child. All three children were interviewed.

Husband

Mother 3's husband declined participating in this study. As he reportedly strongly disagreed with the veracity of ADHD and as 'ADHD' is, according to Mother 3, a 'taboo' topic between them, the extent to which Mother 3's husband was aware of his wife's participation in this study was unclear.

Interestingly, Mother 3 appeared to be convinced that her husband's opposition to 'ADHD' could be best explained by her belief that he himself 'was ADHD'. She reasoned that even though she had advised her husband of his ADHD 'condition', he had rejected her claim, believing that neither he nor his sons has ADHD. Therefore, she reasoned that it as 'ADHD itself' that was preventing him from 'seeing' the 'truth'.

According to Mother 3, her husband rarely participates in childcare or home duties and, like Mothers 1 and 2, relinquishes home affairs and the decisions associated with this to her.

Employment

Mother 3 works full time as a primary school teacher, a position she had held full time since before the birth of her children. Likewise, her husband has maintained full time employment throughout the years. At the time of interview, he was self-employed in his own business.

Home Environment

Externally, the home presented as typical of the middle- class suburban area in which it is situated. The interviews took place in the lounge and kitchen areas of Mother 3's home. It was modestly furnished and unlike Mothers 1 and 2, was seemingly quite disorganized, being cluttered with various materials.

Background

Mother 3's recollections of the period leading to the diagnoses of her first and subsequent children reveal feelings of isolation, financial strain and sadness, especially upon her resumption of employment soon after her first child's birth. In particular, she spoke of her disappointment in her husband's absorption in home renovations, which she believed to be untimely, disruptive and 'stress inducing' for her and their infant. She states:

> I went back to work when he was six months old, which was *really awful*. I cried every day on the way to school… I didn't want to (go)… the reason was the money, and the fact that I would have to leave the super fund that I was in, I'd have to lose my position… my husband was ADHD, he was ADHD so he used to get pretty frustrated and he did things at 100 miles an hour… his extreme frustration with different things… he would do the renovations and throw it together. He started just before our baby was born and he spent the whole 6 weeks (after the baby was born) digging so rather than helping with the baby he was digging. It was extremely disappointing (Mother 3).

Following on, as subsequent children were born, Mother 3 spoke of feeling disempowered and guilty when her family members reported their difficulties in manageing her children while she attended her employment. Weary from matters of domesticity and in full-time employment, she had this to say about a typical day:

> I had to get up at 5.30 in the morning. It used to take the best part of an hour to hang the washing out because I used to have to take the children with me and they used to climb all over things and would climb all over things and get into difficult positions…I was extremely tired…my husband would come home and expect everything to be done and everything wasn't done. I'd cry for half the time going to work because I wanted to stay home and look after my children and it was a battle for my mother every day trying to get them off to sleep (Mother 3).

A significant event occurred when Mother 3's second child, aged five months, contracted a serious illness. Following this, Mother 3 suspected that he and his toddler brother had ADHD at which time she 'informally' diagnosed them as such. Similarly, in due course, she believed her third and youngest son to be ADHD. All three sons, around three years of age, were subsequently diagnosed as having ADHD and treated with ADHD medication. They continue to take medication to date.

Mother 4

Current situation

Children

Mother 4 had three sons relatively close in age. At the time of being interviewed, the children were aged eleven, fourteen and sixteen years.

Mother 4 had informally diagnosed all as having ADHD in toddler-hood. The two older children were formally diagnosed as having ADHD by pre-school age and the youngest child soon after commencing school. As noted below, Mother 4 had long anticipated her offspring as 'having ADHD'.

The two youngest children were interviewed (as the eldest child was not available). Mother 4 spoke most about her youngest child and ADHD.

Husband

Mother 4's husband was interviewed. While he expressed some uncertainty about ADHD in general, he affirmed his sons' ADHD diagnoses and treatment. He indicated strong participation in home and childcare duties but also spoke of deferring home affair matters to Mother 4, seeing her as the primary decision maker.

Employment

Mother 4 has maintained full time employment since the birth of her children as a community based early childhood nurse. Likewise, her husband has also been continually employed in the public service.

Home environment

Mother 4 was interviewed in the lounge room area of her home situated in an affluent middle class suburb. The home setting presented as moderately furnished and presented as being exceptionally cluttered with various materials and a menagerie of animals.

Background

In contrast to the other mother participants, Mother 4 differed in that she informally diagnosed herself as having ADHD well before having children. She indicated that she first became aware of ADHD when studying nursing. Then, early in her career as a school nurse, she spoke of witnessing children diagnosed as having ADHD being victimized by teachers and peers. She stated that the mothers of these children were characterized as having inadequate parenting skills. Mother 4 apparently assumed that, based on her own inherited ADHD, it was inevitable that her children would also have ADHD. She extended her expectation to not only the ADHD 'condition' itself impacting her children but also the subsequent problems at school including the inevitability of her being judged as an inadequate mother. This, she said, created a contextual anxiety as she contemplated parenthood.

Moving on to her present day experiences of ADHD and consistent with her beliefs about the 'symptoms' of ADHD, Mother 4 describes herself as lacking in a number of ways including matters of domesticity, as she says:

> This place was always a mess… I lack organizational skills, my distractibility is a real negative part of what I am and I relate probably quite a bit of that to ADHD…we live in a chaotic household which doesn't foster good organizational skills…I keep wanting to say organization because I fear that's what we lack is structure and tidiness (Mother 4)

Linking present realities to her early experiences when her children were first diagnosed as having ADHD, the data indicates that Mother 4 was already well entrenched in applying medical meanings to her social experiences. Perhaps more importantly, however, her self-appraised ADHD symptoms, such as 'untidiness', appear to have influenced her interactions with self. Just as she had predicted, she felt judged as an inadequate mother by others.

Mother 4's children, suspected as having ADHD during pregnancy, were all subsequently officially diagnosed as having ADHD, the first two in early childhood and the youngest in the first year of school. The extent to which they continue to be treated for ADHD was unclear.

Summarizing the mothers' contextual circumstances

Table 3 provides a general idea of key factors or contingencies that the mothers' conversations reveal, as they discuss their earliest memories of encountering their children as 'ADHD'.

Table 3 An overview of mothers' expressions of circumstances causing them stress prior to their children's' diagnoses of ADHD

Mother Participant	**Contextual stressors**	**Blame directed towards**
Mother 1	Social isolation caused by unintended migration: language barrier; living with in-laws; feeling	Environment: foreign and anxiety inducing

	an intruder; caring for 3 young children including infant; emotional context of mother-in-law's terminal illness	Husband: cause of ill-prepared/unwanted migration; husband's mother ill; difficulties residing with husband's parents Mothering role: 3 young children
Mother 2	Marital separation: discord and re-union; stressful pregnancy; baby behaviour/health: screaming, not sleeping, poor feeding; mother not sleeping	Environment: re-negotiating living with husband Husband: marital conflict Mothering role: newborn baby with problems
Mother 3	Unsupportive husband; undesired employment to relive financial hardship; unwanted isolation from baby; reliance on child care for baby with difficult to manage behaviours	Environment: home in disarray; Financial hardship; work demands Husband: emotional and physical unavailability; disrupting home with renovations Mothering role: child care, babies with problems
Mother 4	Personal difficulties in keeping home in order; time management difficulties; fear of teacher reprisals against self and future children; self appraisal as having inadequate parenting skills	Environment: disorganized home; unsympathetic workplace Father: perceived genetic source of ADHD Mothering role: problems mothering dues to being "ADHD" herself; difficult to manage infants

Part 2 Thematic analysis

Introduction

As stated previously, the core of qualitative research is the exploration of social phenomena. However, when it comes to the process of analysing data, and, as the heading of this section suggests, creating a thematic analysis of the data, certain assumptions are inevitably made. One such assumption is that data 'found' is *useful* in addressing the research aim. Another is that the *interpretation* of the so-assumed 'useful' data is conducted with skill and integrity. This beckons the question as to why any given researcher's analysis itself should be considered worthy of contributing to the existing body of knowledge.

In the case of this study, as stated in Chapter 4, I chose to employ a thematic analysis approach to my analysis of the transcripts and I did so, primarily, by comparing and contrasting the interview transcripts. More importantly, however, I did so with an acute awareness that my own views of ADHD would inevitably interact with my interpretations, as would my experiences in the data collection process itself. Such an acknowledgement is, however, insufficient justification for the presentation of useful findings.

In an attempt to achieve my goal of presenting insightful findings relating to the research questions, I used techniques employed by others. These included diarizing my thoughts and writing memos about ways of categorizing data (Field & Morse, 1985). Further, by immersing myself in the data through multiple readings of the transcripts (Berger, 1989) I engaged in extensive open coding (as discussed in Chapter 4) which I believe assisted in safeguarding my analysis from possible pre-existing assumptions about ADHD. Moreover, as my open coding informed the development of 'tree nodes' (see Chapter 4), I began to recognize the ways in which the mothers had positioned themselves in legitimizing their 'understandings' of ADHD in the lives of their children, through the 'positions' that they had decided to take.

Moving on to the following analysis of the findings, I begin by pointing out that an overview of the mothers' contextual situations suggests that the mothers' stressful circumstances coalesce with blaming perspectives. In adopting the term 'blame', I clarify that I utilize this term in several ways. Firstly, I use 'blame' to mean 'fault' and to mean 'cause'. While this may pose some confusion to the reader, each of these meanings interact and overlap to the extent that the task of delineation would likely lead to misrepresentation of the mothers' views. Besides this, it is my intention to focus on the *function* of 'blame'. That is, the act of 'blame' appears to function as a means of *explaining* the children's troublesome behaviour. This can be said to add to the mothers' apparent struggle with myriad contradictions concerning *who* or *what*, through their eyes, was, and possibly continues to be, deserving of blame. Reconstruction of the mothers' conversations suggests that the mothers act as both *perpetrators* and *victims* of blame in what could be described as a battleground of emotion, awash with mothering insecurities.

One way of interpreting the mothers' accounts of blame was to explore the extent to which *mothering stress* functions as a possible *catalyst* igniting *blaming perceptions.* While exploration of this could take many forms, I have conceptualized two primary blaming frameworks emerging from the data.

The first of these is the mothers' act of blaming the 'environment' in which they are socially and physically positioned. I call this *enviro-blame.*

Two aspects of enviro-blame are explored. Firstly, the act of apportioning blame to significant male figures. I call this *he-blame*. Secondly, there is a strong indication in the data that the mothers point to their infants' behaviour as the cause of their distress. I call this *baby-blame*.

Although each of the blaming frameworks overlap, as the analysis unfolded, I identified a second tier of blaming strains. The first of these I have introduced as *monster-blame;* a phrase directly extracted from the transcripts and one which refers to the act of blaming the child, I suggest is apt in describing the intensification of the mothers' feelings of stress. I have also identified *brain-blame*, which is a progression of the blaming theme, emerging towards the final stages of the initiation phase just before the achievement of formal diagnoses.

Framing blame

Enviro-blame

Although the act of mothering is tied to the mothers' relationships with their children, it is significant that the mothers speak of aggravating conditions just before and around the time of the birth of children. In this sense, enviro-blame can be described as the social circumstances in place when the act of mothering 'engages'. This, therefore, raises its level of importance.

Moreover, even though the data reveal that each of the mother participants' situations is unique, it is evident, across cases, that the mothers hold the belief that their aggravating environmental circumstances were imposed on them from external sources. From this stance, the initiation period may be seen as being marked by the mothers' feelings of powerlessness flowing from their beliefs of a diminished capacity to influence their everyday circumstances. For Mother 1, for example, she immigrated to Australia, not by planning to do so, but by default. For Mother 4, she did not intend being 'born' with ADHD but, once again, had her 'condition' imposed upon her through her father's genes. Each of the mothers' stories carry a similar thread of powerlessness.

The main point of interest is, therefore, not so much the actual circumstances, but that the mothers declare their pre-mothering states of felt stress.

Moving on to the early period of motherhood, the mothers add that their infants exacerbated their feelings of stress and henceforth, mothering stress became the dominant characteristic of their everyday mothering experiences.

It is also of interest that, simultaneously, significant male actors were also held responsible for contributing to their felt stress, both prior to and at the onset of mothering. Although the subject of gender is not a key aspect of this study, it does not go unnoticed that mothers' projections of blame early in the initiation phase were attributed, in part, to significant male figures; sometimes fathers of mothers, but especially husbands and infant sons. I call this phenomena *he-blame*.

He-blame

The mothers' conversations indicate that notions of ADHD were contemplated as a possible cause of their mothering troubles quite early in their relationships with their infant sons. Further, three of the four mothers adopted 'ADHD' as a categorizing symbol for other significant male figures their husbands or their father. In this respect, the symbol of 'ADHD' appears to function as an interpretive mechanism used to partly explain, partly accuse and/ or partly excuse male behaviour.

When referring to the broad scope of related literature, I found several studies which pointed to a common theme of women's' dissatisfaction associated with their husband's performances, particularly in matters of child rearing, domesticity and emotional bonding (Madden & Janoff-Bulman, 1981). The point of interest in this study, however, is that the mothers not only express varying degrees of dissatisfaction with male performances as fathers but also attribute this as being caused by 'ADHD'.

The 'he-blame' framework therefore provides an additional layer of complexity to the social interactions and mothering identities evident in the data. Mother 3's blaming of her husband for contributing to her 'mothering stress' highlights this point. At one level, she interprets his home renovating activities (see Mother 3 contextual profile presented earlier in this chapter) as an act of deliberate emotional and physical absenteeism. As such, her words suggest that she constructed a *martyr-mother* identity inferring her husband's child-like dependence on her:

> He (husband) did not connect with (infant's name) when he was a baby and he couldn't connect very well …I knew that I would be the major one to take care of the children (this baby and those to come) and him as well. (Mother 3)

Further, Mother 3 defends herself against her husband's criticisms of her domestic incompetence:

> It was difficult…my mother said I deserved a sainthood…(it was stressful) because my husband thought I couldn't deal with them (the children)…all the toys were on the floor (and he would come home and say) "look at the house. It's a mess" blah blah blah yeah and I would say "well look after them for a day. Find out what it's like!" (Mother 3)

However, Mother 3 contends that her husband's behaviour can be explained. She claims that his abdication of husband/fatherly duties and his inability to "cope" is evidence of his true ADHD identity and infliction. She says:

> He thinks that it's just the mother's role to deal with the children, a traditional role. That's because *he* can't cope with dealing with the children because he's ADHD himself (Mother 3)

Here Mother 4, on the other hand, provides an interesting contrast. As highlighted earlier, unlike the other mothers, Mother 4 believes that she herself was ADHD, a source of both distress and acceptance to the extent that it infuses her very being making her "her". However, ADHD, she says, is a result of her genetic inheritance from her father, which her sons, in turn, inherit from him, through her. In her children, the presence of ADHD is without a doubt believed to be the cause of her maternal worries as she interprets her children's social and academic achievement as lacking.

For Mother 4, her informal diagnosis of her father as being ADHD provides a way of interpreting not only her own father's behaviour, but also hers, which she characterizes as being disorganized and inadequate in a variety of ways. She states:

> People have always accused me of being disorganized and being quite distractible and I see a lot of behaviours in my dad like that...he can never stand still for a minute... I look at my dad; I've inherited that (Mother 4)

Mother 4 and Mother 3's *he-blame* differences diminish in the light of similar mothering insecurities and while their views of their husbands were dissimilar (in that Mother 4's husband is not mentioned as having ADHD), both husbands were portrayed as in need of her protection from *troublesome* ADHD children. As such, Mother 3 and Mother 4 speak of acting in mothering identities of *mother-gatekeeper* and *mother-peacemaker* by buffeting male figures, that is ADHD fathers and ADHD sons, from one another.

Mother 1's husband, also informally diagnosed by her as being ADHD, differs yet again by way of circumstances. However, Mother 1 attributes her chronic mothering stress as being an outcome of her husband's decision to attend to his ill mother (see Mother profiles). When Mother 1's physical environment morphs into residency in a foreign land, her "perfect baby" transforms into a "monster": a state she later explains as being caused by him having inherited ADHD from his father, as she says:

> Oh I think it comes from the father – still do – good old (name of husband) gets it all, I think they (the children) were born with it. (Mother 1)

Mothers 1, 2 and 3 blame their husbands for their children's ADHD inheritance, so it is perhaps not surprising that the mothers' informal diagnoses of husbands and infant sons is not dependent on their husbands' agreement of such, as Mother 1's husband's words indicate:

> I think it (the diagnosis) was wrong. I thought it was wrong all along... I personally believe (my son is an example) of misdiagnosis... Mother 1 and I, we disagree about things (like our sons' ADHD diagnoses), but we both have the best intentions (Husband of Mother 1)

While the reasons for husbands' rejection of their wives' views of them as 'being ADHD', and similarly, of their sons, were not completely clear, their seemingly tacit compliance to the mothers' actions in the medicalization of their sons' behaviour is nonetheless of interest. The mothers achieve formal diagnoses without overt opposition: their sons are medicated and they maintain an ADHD status for many years and their fathers remain informally diagnosed as 'being ADHD', being characterized within the family as such. One possible explanation for this could be that mothering identities may be understood not only in terms of *mother-martyr, mother-gatekeeper* and *mother-peacemaker*, but also as *mother-expert*, capable of informally diagnosing sons, husbands and fathers alike.

In association with this analysis, the data also indicates that the mothers' child-care decisions take precedence in relation to each family's day-to-day operational child-care activities, with the he-blame acts serving to weaken the male position. Put another way, the mothers hold the decision-making power concerning child management.

Mother 2, for example, following her separation from her husband during her pregnancy and subsequent reunion midst escalating tension, overrides her husband's suggestions as this account suggests:

> There'd be conflict, like (my husband) would say oh, just leave him (the crying baby), and I would say well, if I just leave him, then he won't get any sleep and then tomorrow he'll be much worse (Mother 2)

Mother 2's words show her child-focus. She acts to soothe her crying infant so that he, the child, will feel better the next day (having slept). Although this may at first glance seem a minor point, it demonstrates that although mothers may perceive their positions as powerless, through a *he-blame* frame they emerge as powerful agents presiding over the decision-making process within the realm of child-care. In this sense, the imperfect babies 'remain in the bathwater' of mothering discontent, eventually functioning, with other males, as destabilizing agents of "good mothering" intentions.

Baby-blame

Baby-blame can be seen to represent the transition from mothers' perceptions of *perfect* baby to *troublesome* baby. Across cases, all of the mothers had once hoped for a "perfect child". 'Perfection', however, is soon replaced with notions of 'abnormality'. Mother 2, for example, first constructs her child's deviance, apportioning blame to her marital situation, work place tensions and managing a household in the context of having a baby that she believes to be abnormally unsettled, as she says:

> (Name of infant) wasn't a settled baby right from the beginning... I knew that how he was, was not usual and it was definitely much more challenging and difficult but I didn't know why...The fact that you are planning on having another baby and you've got other kids as well and you're trying to work on a relationship as well trying to have your mind in all those spaces at the same time was challenging. Then after the baby is born, there's all those everyday life things and when you have a child that is difficult - he just takes so much time..., he didn't sleep, and when I say didn't sleep, I mean he literally didn't sleep. And he had feeding issues and all that. So, right from the beginning we were kind of seeing people like paediatricians... And the screaming, (name of child) just used to scream, so not just cry, scream. And it would be for hours. And he wasn't settled, he would never be happy. (Mother 2)

The period of transformation seems to be a relatively short in time, yet powerfully long lasting in its influence on the mothers' medicalizing actions. This is possibly because the mothers perceive their children's behaviour to be anxiety inducing from very early in the mother-child relationship. *Baby-blame*, as the name suggests, therefore begins in infancy and continues through to toddlerhood and then to pre-school age where it morphs into *child-blame*.

It is difficult to say when, on the continuum of everyday mothering experiences, that mothering stress is at its most intense. Although parental anxiety in caring for newborn infants is commonly thought of as not unusual[85], what *is* apparent is that problems emerging soon after birth, when infants exhibit sleeping difficulties, have a lasting impact on the mothers in this study. Moreover, mothering anxiety appears to have a strong influence in shaping the direction of their perceptions of deviance.

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[85] Further, it is also well known that parents of newborn infants commonly anticipate several problems like: "sleepless nights, financial burdens and vexations" (Wilson, 1993, p. 3).

There is abundant evidence in the data to show that the mothers recall their infants' sleep patterns as being significantly problematic. Indeed, sleeping problems appear to be one of the major sources of mothering distress. Even when, for example, some babies later develop life-threatening health disturbances, such occurrences rate a fleeting mention in the mothers' conversations in comparison to the frequency and degree of emotion apportioned to problematic sleeping patterns. Mother 3's baby, for example, had a serious febrile convulsion at twelve months of age requiring hospitalization, but this was only given a passing comment whereas everyday sleeping difficulties were not only spoken about disproportionately frequently, they were considered an indicator that "something was wrong" with him.

The reason as to why such weight is given to the infants' sleeping patterns by most of the mothers is nonetheless clear although admittedly, the topic of sleep in newborn babies is evidenced in numerous studies addressing various aspects including, for example, Sudden Infant Death Syndrome (SIDS). Nevertheless, for the mothers in this study, sleep issues feature in the mothers' interactions with self, providing amongst the first evidence of the mothers' developing perceptions of something being amiss in their children. The mothers, however, do not restrict their concerns to sleep matters alone. They come to believe their children to be atypical in a number of ways as the infant progresses to toddler-hood and then, too early childhood.

Without focusing on the nature of their complaints at this point, I have concentrated on the interactions between self and others that appear to influence their perspectives. I have identified three measuring tools found in mothers' conversations comprising 'performance comparison', 'moral judgement' and the role of 'mothering qualifications'.

The mothers firstly *compare* their *mothering performances* and their *baby performances* with others. Secondly, the mothers make *moral judgements,* about that which they believe others are making of them: the mothers use terms such as "good", "perfect", and "terrible" to qualify such performances with terms such as "terrible mother" featuring significantly. Thirdly, the mothers draw on past mothering experiences (which sometimes include when they themselves were mothered), to *promote* their own expert mothering *credentials,* to perhaps counteract a mire of mothering insecurities reinforced by countless social interactions with self and others, as Mother 1's comments illustrate:

> You are thinking that *you've* done something wrong – *I've* done something wrong- what am I doing that's not right? (Mother 1)

Of these three tools, performance *comparison* is perhaps the most prevalent. Indeed numerous examples illustrate this, as these mothers say:

> He (the child) was *completely different* to the other boy. My other boy and even (name of child), although my other boy shared a lot of his tendencies, name of child was *extreme* – he was this *monster* that we had created and like yeah "oh my god what happened" you know we felt that we were the *same*, we were the same parents to these boys…we had no idea of what had happened – or what had we done wrong – you know- where had we go wrong with this one when the other two boys were (long pause) *very* different- but yet you know they weren't out of control like this child and such a *tiny person* and you think how can you get in this state with such a *tiny person?* (Mother 1)

and,

> I was lucky he was my third child…I think if you were a first time mother, it would have been quite daunting…I (already) had two children, I've worked with children, I worked in early childhood for years, and plus, we'd always had babies in our house

> from when I was young. I knew that there was *something different* there, but I didn't know what it was. (Mother 2)

The way in which "difference" as a term is mirrored in these examples shows an interesting interchange in application. In one instance, 'difference' is used to describe troublesome children and in another, it refers to those children who are less problematic. This is an excellent example of the power of perspective at work. This point is further made by the data that indicates that the mother participants (with the possible exception of Mother 4, who had adopted a fatalistic attitude towards ADHD) had anticipated "perfect" children. Soon after the birth of the children, the mothers' changing perceptions of their children can be seen as instrumental in their transformation from babies to "monsters".

Continuing with the analysis, the data indicate that the mothers' *belief* about the status of their children changes. This is not necessarily as the result of a single act or event (although some situations have a significant impact), but through everyday mothering experiences. Evidence supporting this is found in the accounts of Mother 2 and 3 where their babies unwanted screaming behaviour is seen as being 'normal' for the first few weeks after birth but when it persists, Mothers 2 and 3 begin *view*ing their babies differently as Mother 2's words show:

> I remember (name of child) was not a settled baby right from the beginning and I guess you, like with any new baby, you think the first couple of weeks you know ...once you get past that first normal 3 or 4 weeks and things haven't improved you think maybe there's something wrong (Mother 2)

Here it can be seen that Mother 2 interpreted something as "wrong", not with the environment, nor necessarily with herself. Although the "something wrong" is not qualified here, later it becomes clear that the problem, it seems, is with her child. Therefore, the process of change, at the core of this investigation, appears to occur in conjunction with the transformation of Mother 2's *perceptions* of her child in accordance with her *interactions with self.*

These early perceptions of abnormality give way to mothering actions. As such, it could be argued that the mothers' *reactions* to their perceptions cause them to *act.* Initially, troublesome baby behaviour is met with acceptance and, therefore mothering *inaction.* However, as the troublesome baby behaviour persists, the mothers' perceptions of normality appear to shift towards a growing suspicion that something is "not right". As such, the mothers' *expectations* of normality are *breached* and, figuratively speaking, the children are born once again, as "monsters". Therefore, from the earliest constructions of deviance, although not yet necessarily defined as ADHD, the drive to medicalize the children's behaviour appears to smoulder.

The data indicates that soon after reconstructing their views, the mothers *do* act; the first steps towards medicalization *are* taken. More specifically, it is significant that such actions, from the onset of mothering troubles, involve seeking medical advice, as Mother 3 says:

> I knew there was something. I took him to the doctor, I took him to the speech pathologist, I had his hearing tested, I started him on occupational therapy, so I knew there was something not, *not right*, I knew there was something (Mother 3)

These words are particularly interesting from a symbolic interactionist standpoint, because they show that the mothers now begin interacting with their infant as an *object* that requires repair. However, once again, such objectification is not so simple for the mothers' emotional involvement persists via the mode of comparison. The mothers not only continually compare their infants with other children, but they do so with regard to their own mothering performances, as Mother 3's comments reveal:

> I was telling myself that I was a big failure at it (parenting), everyone else seemed to be in control of their children and their children had sleeps and they would have a lovely time with their children it was my fault because I wasn't disciplining them properly – all the parents, all the parents in shopping centres myself as well because I didn't feel in control of the situation… all the parents would think I was a terrible mother... they'd be thinking you must be a bad mother (Mother 3).

This telling excerpt reveals, the gamut of issues in the "stew" of mothering contentions. Key words symbolizing various ideas emerge including failure; control in relation to sleep; and mother-power (through disciplinary control) contextualized in the everyday event of shopping and the way in which Mother 3 invokes moral judgement on herself.

Much like Goffman's (1962) dramaturgical portrayal of front stage behaviour: the shopping centre scene reveals the intensity of self-blame interactions at work. Mother 3 imagines "all" the other well-rested parents, not only having a "lovely time" with their well-behaved and well-rested children, they become to her, a vitally important audience to her and her child. She perceives this audience as intent on judging her morally and concluding that she is "bad". As such, aspirations of being a "good mother" crumble and the pain of a "terrible mother" identity comes to the fore.

This analysis channels mothering actions further along the course towards a child-focus, if for no other reason than to gain relief through absolution. Although each of the mothers' stories vary, there is evidence to suggest that all of the mothers search for that "something that is wrong", for to find "it" is to find a way of subduing it.

In this vein, mothers fervently 'perform mothering' in the pursuit of success, for to fail is to suffer the perpetual blame directed at the self, from the self and from others, as Mother 2 illustrates:

> ...(You feel) guilty and blamed and that *you're* not doing a good job and if only you would do these things differently, you could *fix* the child.

As the medicalizing journey proceeds, yet another mothering identity of 'mother-fixer' emerges. The mothers react to this identity by venturing even deeper into the medical world, using medication to control their infants' sleeping behaviours despite its failure to deliver the relief they so desperately desire:

> It was an unsettled time and ... (I took my child to) the paediatrician, they were saying 'oh, we think it's reflux', so he went on all the reflux medication, and that's probably because he's not sleeping, he's agitated blah blah blah, after a period of time, you could obviously see that, well, the medication wasn't making any difference (Mother 2)

Consistent with Thurer's (1995, p. xii) comment that "good mothering is not a formulaic procedure" rather than finding alternatives to the initial medical solution of medication, mothers continue to spiral deeper into a gulf of mothering insecurities where their infants become ever-present living symbols of mothering failure through two powerful institutions: the family and medicine. The intertwining of these social forces evokes further determination to problematize the child, as Mother 2 explains:

> And you get a lot of, like, family, and even like clinic nurses and that, they'll say, you know, they look at the *parenting* so you get a lot of *pressure*, like, you know, with the whole sleep thing, "do you do this, do you do that"? So it comes down to a lot of what *you're doing*...the focus really wasn't on 'well what's with the child that's making *him* cause this behaviour? (Mother 2)

As Mother 2's blaming perspective hones in on her infant, her actions follow suit; she proceeds to manipulate the repertoire of medical advice by *taking control* using her "mother-expert" identity, as Mother 2 continues:

> I think I was lucky he was my third child, because I'd already learnt by that stage that you take all this advice with a bit of, a grain of salt. So I was kind of able to sift

> through stuff and take out what I wanted to use and ignore other stuff that I didn't kind of agree with (Mother 2)

All the while she is ever-hopeful that:

> with a bit of time he'll improve… he'll get that little bit older again and it'll get that bit better (Mother 2)

Eventually, however, her hope, like that of other mother participants, turns to despair because, as she says:

> Nothing ever worked long term. I just sort of struggled through. I kept living with the hope that, people say, "when he's six months old, and he's sitting up, it'll be much better. When he's one year old and he can walk or he can do this, he'll be much better. When he's two – " you kind of live from stage of development to stage of development, you know? A lot of people suggest, "once he can talk, he won't be so frustrated" (Mother 2).

It seems that as Mother 2's infant develops into a toddler and onwards, her mothering troubles change in accordance with the social response of disapproving onlookers. The analysis appears to support the notion that seemingly unsettled infants are metamorphosed from symbols of 'normal' problems, attracting reactions of expected improvement, to objects of *deviance,* especially in the context of expanding social exposure.

Interestingly, increasing social rejection, in turn, appears to stir conflicting reactions in the mothers. On the one hand, as Mother 2's words, show, the mothers generally disapprove of the judgement of others while questioning its validity as they judge their mothering performances. In addition, the escalation of social rejection of their children stirs protectiveness, as Mother 2's account illustrates:

> If you've got a difficult baby people are more *accepting* of that because it's a baby… people are a bit more *compassionate* but when that behaviour changes from that baby

> type behaviour and you get more into like, you know, the tantrums or the screaming when they are a bit older, that's when I found the real *shift* in how people reacted because they don't accept it, that's just not accepted and that's when I felt more pressure that I wasn't either disciplining him enough … maybe I'm not doing things how I should be doing them maybe I'm too busy with the other kids and that's when I felt the pressure more because people are more likely to openly disapprove of that behaviour (Mother 2)

As the mothers continue to interact with their children, now moving through from infancy to toddlerhood, broader social contexts appear to call for more clearly defined interpretations of deviance and abnormality. This can be seen to take shape in a process of 'naming and blaming'.

Monster-blame

> It's horrible, it's devastating, I go grey, you know, why can't my child just be normal? (Mother 2)

These words are telling. Here Mother 2 speaks using catastrophic language in framing the rhetorical question "why can't my child just be normal?"

The position of blaming the child, which I call *Monster-blame*, and one which I use interchangeably with the term 'child-blame', is a critically important aspect of blame. It is significant because it represents the enveloping of mothering tensions between mother and child 'identities'. If the child is believed to be *perfect*, it could be reasoned that, given his troublesome behaviour, his mother must be "terrible". However, if the child is believed to be *deviant*, then his mother may still be 'good': perhaps a 'good mother'. Perhaps she is indeed worthy of "sainthood", as Mother 3's mother claimed, having borne the pain of the 'monster-child'.

Therefore, a shift in perceptions, from perfect to monster, provides the means for the child to be blamed, not only for causing mothering stress, but also for his own unsettled and cantankerous misery. As such, blame of the child provides both the "understanding' of, and also the alleviation of mothering guilt.

Child-blame may, therefore, be defined as both a period and an aspect of blame. It is a *period* because it emerges as the child grows in size and physical power taking him into new social situations not encountered when he was an infant. It is an *aspect* because his growth is accompanied by an escalation of unwanted behaviour, forcing his mother to attempt to control him in a greater variety of settings: as social encounters widen, social rejection deepens and public shame, based on her ongoing interactions with self, mounts, for as Mother 1 says:

> You know the last thing you ever want to admit to everyone is I've done the wrong thing (Mother 1)

Although the construction of deviance is arguably a *process* and not merely a single event, the following description is an excellent example of the construction of deviance at work. Using catastrophic language to portray the transformation of her *perfect baby* to *monster child* (at approximately twelve months of age), Mother 1 had this to say:

> He was gorgeous as a baby - he never cried he just was the perfect baby you know and then this *thing* happened... (Name of infant) had been such a gorgeous such a beautiful *beautiful* baby and then suddenly you know he hit one and this *monste*r appeared (Mother 1)

Here Mother 1's words show that the baby's state of perfection and beauty is described in terms of what he does not do: cry. To extrapolate, the baby's perfection is thought to be so because his 'baby performance' is pleasurable to his mother. In contrast, when he is a little older and demonstrably more demanding, his mother's "understanding" of him acts to transform his state: he "becomes", through her eyes, *imperfect*, a deviant, a *monster*, an object of blame.

It is important to note, however, that his mothers' self-image is not necessarily altered by his new identity nor does she directly *act* on this basis. As Mother 1's description of an outing to the zoo shows, her public embarrassment appears to be most distressing.

In this account, Mother 1 casts herself as a victim and her child as all-powerful. In this respect, the theme of 'child blame' can be seen as being overlayed with what appears to be a focus on 'control'. In a matter of a few sentences, the complexity of inter-relational power between the mother and the child can be appreciated:

> He was just a small (boy), he wouldn't do anything, there was nothing I could get him to do, but yeah, we went to Sydney for a weekend and I had to carry him all the way... he refused to walk anywhere and he would only go if I carried him on my back.
>
> For a weekend I carried him around Sydney – he wouldn't have my brother, (name of his older brother) or his Dad carry him. It had to be me... I think that was the last straw...I was just never going to take him anywhere again (Mother 1)

Here, Mother 1 emphasises his size and his smallness, it seems, magnifies her sense of defeat and her justification for blaming him. Her subordination to her child, by yielding to his demands in the presence of various social audiences including her family, shames her and frames her as weak and compliant, imaging her as a demoralized mother incapable of mastery of her dual role as rule maker and rule enforcer (Becker, 1966). From a symbolic interactionist perspective, her resolve *to act* to gain control by sanctioning future outings provides evidence of the link between perspectives and actions.

Although unachievable, strictly speaking, social withdrawal is a common response shared by all of the mother participants. Mother 2's near seamless account (included in its entirety despite its length) provides remarkably fertile data showing the process of problematizing not only her child's behaviour but also of her interaction with her social context. As such, this passage demonstrates connections between her *perspectives*, her *reactions* to her child's behaviour and her actual *actions*. Note that she primarily operates through modes of defence and protection:

> When (name of child) was 2 or 3 I used to feel like if you go to people's house for morning tea and stuff like that you'd kind of feel…it's not spoken all the time…you don't get invited again… you would just see people through their body language the way they react they obviously felt – they didn't approve of the behaviour and then you think to yourself well what do they think I should be doing… I used to try and plan, if I was going anywhere I would try to plan, as much as I could do that it would be more likely to be successful …quite often I wouldn't go to things because I knew that it wouldn't work and that it would be stressful more for me I guess and that's where that sense of aloneness comes from because when you kind of choose – like if your child wasn't *different* then there'd be many more things I would have done but because of that I chose not to do it so you get a sense of missing out on doing things because of that and that's when you feel a bit more lonely and situation because you make those choices because you think it would be easier for the child because you are avoiding a situation you know will end in disaster and also because you are protecting yourself because you don't have to go through that because you don't put yourself in a position where you feel you are going to be judged. You carry around a sense of responsibility for the other people… (Mother 2)

Her words "you think to yourself well what do they think I should be doing" stand as a beacon illustrating the way in which Mother 2 *interacts* with herself on the basis of what she believes others would have her *do* to be a "good mother". Void of answers, vulnerable, lonely and unable to control her child's behaviour to satisfy her own expectations (formed by her perceptions of the expectations of others), Mother 2 takes action. Like Mother 1, she employs *social avoidance* because, as she says, "you are protecting yourself because you don't have to go through that because you don't put yourself in a position where you feel you are going to be judged" (Mother 2).

Mother 2's response fits with Denzin's (1994) definition of socially constructed deviance: the child, from his mother's perspective, violated her social behavioural expectations, attracting the judgement and consequential rejection and sanctions of others, so that she perceives herself as "never (being) invited back again". Not only does this belief cause her to feel alienated, she *interprets* the judgement of others as being an attack on her child's image; an image which is enmeshed in her own mothering identity (Chodorow, 1978):

> The strongest thinking was trying to protect the child. Number one, being put in a position that you know they aren't going to be able to cope with and then being put into a position where because it it is not only you that gets judged, it's that child and then you know people perceive your child, as a mother you don't want people to think oh you know, he always does this- he always does that –oh no not (name of child) coming…there's a big sense of not only protecting yourself but also protecting your child from these sorts of judgements. (Mother 2)

Overall, the mother participants' utterances relating to perfection abound in one form or another. They are typified by this telling rhetorical question:

> Every mother wants to have the perfect child, don't they? (Mother 2)

Infused with contradictory views and desires, the mothers wrestle with *child-blame.* They desire it and they resist it. They are clear about it and they are confused. In the constant search for meaning about what it is to be 'normal' and with overtones of moral judgement, Mother 1 explains:

> You feel you were doing something *wrong* and all these people are *perfect*, and people are very judgemental about what they see (of my child) and what they hear (others say about him) (Mother1)

These words can be considered in terms of Goode's comments on the importance of an individual's interactions with 'self'. He writes:

> It is difficult to maintain one kind of self image in the face of a unified conflicting view from those with whom we interact...In short, the self is continually reflexive (Goode, 1978, p. 71)

Child-blame is therefore not so much an accusatory stance taken by the mothers but one which extends, through defence and protectiveness of self and of the child as Mother 3's words further confirm:

> I'd tell them (other people) to go and take a running jump, really. Because I think they're making judgements, they don't know anything, they don't know... that's what breaks my heart with kids like this because people do not bother to look any further than that little bit of behaviour that they saw over there for that five minutes. And yeah, they make a judgement (Mother 3)

The mothers' interactions with self and others are complex, especially in their reactions to their children being "blamed". They appear to assume several acting roles. In the excerpt above, Mother 3 could be interpreted as performing the role of *mother-protector*, reversing the roles to accuse those who make judgements, because, in her role as *mother-expert*, she asserts that her child's accusers "know nothing". In this way Mother 3 becomes a *moral entrepreneur* (Becker, 1966) by re-writing the rules of normality: for her, 'normal ADHD' means behaving as an ADHD child is 'expected' to do so from a medical standpoint, rendering those who "judge" to be ignorant.

Mother 1's analysis of her sons' typical behaviour at pre-school[86] offers much insight into similar ideas when she relays the way in which she comes to "understand" her son's behaviour. Note that while Mother 1 does not deny that her child behaves in a way that evokes social rejection, she nonetheless explains his behaviour. Put another way, his deviant acts are confirmed though excused. I draw attention to the way in which she infuses his behaviour into his actual personal identity when she says: " This *is* (name of the child)":

> He was punching. He punched people. That's what he did. He punched people. This is (name of the child). He tended to greet people by punching them. He would bear hug everyone he met. He was a loving loving little boy -still is. Very very loving little boy but you know. Yeah he'd punch people when he met them for the first time – punch them in the tummy - Not meaning any malice but that was his way of saying hello but children just got angry with that so I had to stop taking him to places (Mother one)

In this text, Mother 1 juxtaposes deviant behaviour with a neutralizing re-phrase: " He punched people...he would bear hug everyone he met". By explaining her child's breach of social behaviour in greeting people as a 'miscue' of his expression of friendliness, Mother 1 transforms her child into a victim making the point that he, as a result of his misunderstood behaviour, experienced the rejection of his peers. Her triangulated interaction between her 'self', her child (through her interpretation of her child's behaviour) and his peers (through her beliefs concerning their reactions), shows the act of constructing deviance, from a child-blame perspective, at work.

The data suggest that the mothers, no longer able to avoid the "terrible mother" image by social withdrawal, experience an intensification of the pain of perceived rejection. Alongside this, as a parallel theme, the mothers' determination to gain control

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[86] Pre-school refers to a preparatory educational centre for children aged from 3-5 years.

likewise intensifies. Utilizing retrospective interpretations of their children's baby behaviour (Schur, 1971), the mothers activate the *process identification* of "something". It could be argued that this very act is, in a sense, an act of *creating* deviance.

Moving on, as *baby-blame* shifts from mothering and child performances to child defectiveness, the mothers, previously guilt-ridden and disempowered, become formidable social agents driving the mechanism of diagnosis onwards. However, absolution comes at a price. Reciprocity of attachment between mothers and children (Chodorow, 1978) beckons mothering responses of defence, not only of themselves, but of their *monster-children.* Therefore, based on notions of mothering defence, or, mothering protectiveness, however one may view it, I reason that if the mothers are to be truly "good", then monster child absolution makes absolute sense; to achieve this is to remove blame from the child and replace it with something for which he cannot be blamed: his brain. Indeed, the perception of "the problem" as being genetically sourced and unwittingly passed on by central male figures, absolves all, leaving but one remaining source to be blamed: those who fail to understand and accommodate.

Brain blame

Moving forward to blame of the child's brain, the child is yet again transformed; the child metamorphoses, in his mother's eyes, from deviant to victim. However, even with the benefit of rationalizing that the 'dysfunctional brain' is the source responsible for causing the mothers to feel stressed, mothering dilemmas nevertheless remain unsubdued. This may be because the mothers, despite the re-framing of their situation, continue to encounter two major difficulties: firstly, their perceptions of the relentless onslaught of the judgements of others persist, and secondly, whether in private or for public display, their failure to control their children's behaviour continues. In fact, the struggle for power becomes increasingly serious, sometimes being described in terms of physical abuse. This is exemplified by several of the mothers' accounts of injuries inflicted on them by their children, as Mother 4 illustrates:

> I can remember one of them kicked me in the shins and I got this massive bruise ...I did feel then like I wasn't doing a good job...everyone thought I let my kids run all over me,,. I've always been teased about being a very child-like parent and letting my kids run all over me (Mother 4)

It is of interest that Mother 4 uses this experience as an indication of her mothering failure: she shows how the opinions of others influence her self-assessment. Mother 1, on the other hand, fears harming her child as seen in this account:

> He was young, he was young, he wasn't even at preschool, not even at preschool, and I pushed him that was what finally, I was miserable, I was miserable, life was a constant *constant*, constant battle with him...I pushed him one day, he just was pushing and pushing and pushing and I physically pushed him over and that just snapped for me, that was the last time...I mean, that was frightening, that was frightening... I sat down and said at that point, this three-year-old is wrecking me... I said there must be some help somewhere, what am I doing, and then I started thinking about what was going on, putting everything in perspective... that made it easier. (Mother 1)

Furthermore, the mothers fear losing control of their own behaviour and perhaps even their mental well being. In the following excerpt, Mother 2 talks about the depth of her need for relief and the strategies she employs in attempt to remain in control:

> Sometimes you just have to go away from it (the crying child). I remember sometimes if (name of child) was screaming or whatever and nothing would work and he'd be in a safe place like his cot I remember I would just go to the laundry and

> close the door for a bit it was that 'time out' for me I didn't get a lot of time out and it goes back to mother guilt and all that too 'cos I felt that I was the best one to deal with (name of child) but then I couldn't do it all the time and you think if I can't do it and I'm his mother how can I expect other people to do it? …I had two other children and it kind of impacts on everything so I used to go into the laundry or out the back door and I used to have a cigarette like that lady on the television and she'd go out the back and her family's all inside and she'd sneak out the back and have a cigarette (Mother 2)

Seemingly tormented by her belief that she, as expert-mother, is the most qualified to subdue her child, yet, according to her experiences, unable to do so, she finds temporary relief by means of escape; she withdraws to the laundry, soothes herself with a cigarette and feels afresh her defeat in her self imposed 'time-out".

As she continues, her risk of injury from her small child, her enforced separation in her interchangeable "time-out" pattern of escape and the emotional drain on her mental state of well being sets the battle-ground scene of which she speaks:

> It's a constant battle to be - I found it was a constant battle all the time to keep yourself calm and to try – you know, to keep yourself calm and no get too emotive about the behaviours and continue on with the way your are going to manage it and what you are going to do and sometimes you know your strategy was at the time OK putting them in the room for time out just getting them to the room for time out can be quite stressful mentally as well as physically like if they're kicking and screaming and trying to bite you and whatever, it's a constant ah like a constant self talk all the time to try to keep calm (Mother 2)

Mother 1's words, "putting everything into perspective…that made it easier", illuminates how the process of medicalization soothes. Marked by moments of extreme frustration, Mother 1's own words show the ways in which she finds the relief she so desperately seeks. She begins by "*thinking* about what was going on" and she knows that "there must be some help out there".

The pathway towards diagnostic achievement, as documented in other studies, is not a linear chain of events (Lazarus, 1984). It involves multifaceted experiences interpreted and re-framed in numerous ways. For Mother 1, her "thinking" coincides with her need for a solution for much is at stake. So intense are her interactions within the family that the connection between physical abuse and emotional strain are seen as threatening (Lazarus, 1984) the entire family by the monster-child to the extent that requests for another baby sibling to be added to the family are met with a firm "no" for fear that she may produce yet another monster:

> You know if you are at the end of a brick being thrown it is not particularly nice and I think I remember the boys saying to me I think we'll have another baby but the only answer you could give was 'well you might have another (name of child)' and that was the end of it (Mother 1)

This mother's words reveal the enormity of her own suffering as she questions her very survival and the preservation of her own sanity. The battle lines are then drawn as she resolves to gain control:

> I think, you get to that stage where sink or swim you know – this child is either going to drive me mad or we are going to do something about it, we are going to find something out and try and help

Blaming the child's brain therefore offers a way of drawing on external resources: medical resources. Even so, mother-blame seems inescapable, for coming to terms with an officially recognized 'imperfect child' is not, according to Mother 4, without its problems:

> Every mother wants to have a perfect child don't they? If they're diagnosed with something, you kind of feel like you've failed because they've got a condition (Mother 4)

Though details vary, the data reveals that all mothers reach a "tipping point" where, as a matter of personal survival, they must find respite, as mother 2's candid account reveals:

> Sometimes you reach a point where you think I just can't do this any more. Sometimes you just reach a point and actually, I really don't *want* to do this any more. That's the scarier bit… it can be quite scary when you start having feelings and thoughts about not *wanting* to do it any more and kind of wishing that you didn't have to and that things were different and that this is when I felt that I was out of control and that I just couldn't do it any more (Mother 4)

The tipping point: escaping-blame

At the "tipping point', it appears that the mothers make a *connection* between their prior 'knowledge' about ADHD and their children's behaviour. For some, this takes the form of a progressive 'realization'. For Mother 4, for example, it is her sense of ADHD inevitability while Mother 1's account indicates an "a-ha" moment. She expresses a revelation when she says:

> I was reading something and I thought 'Oh my god that's (name of child) it was like everything clicked – that was him! (Mother 1)

It is noteworthy that Mother 1 does not so much think of the portrayal of ADHD as descriptive of her child. Rather, ADHD, as "it", *is* her child. Put another way, her child "is" *ADHD:* that is, ADHD *personified.*

I visualize the mothers' revelation as a fire-lighting match. Just as friction is required for ignition, so too the mothers' contextual circumstances may be likened to dry tinder dipped in the combustible material of pre-existing knowledge of ADHD. When the friction caused by the children's problematic behaviour strikes (albeit the striking moment is neither consistent nor entirely clear) the medicalizing pathway *ignites* and illuminates the passage of the canoe so named 'ADHD", with the mothers 'paddling' and the children in tow.

Linking blame and relief

Associations between blaming beliefs is apportioned and the mothers' search for relief can be drawn from a number of passages within the transcripts. One such example is found in Mother 1's words below. Here she makes clear that she is motivated by the need to find a means of preventing her family's destruction. Doom avoidance, she believes, is achieved by identifying that which makes her child a monster and relieves her of mothering guilt. She says:

> We were looking for something cos at the time (name of the chid) was *ripping* the family apart and we were looking for and yeah I think we were even looking for – yeah we were looking for a label something to say that this was it

Moreover, across cases, the data suggests that the act of "seeing" ADHD provides a means of "understanding" and "relieving" mothering anguish. As such, the mothers' ADHD 'realities' appear to provide that which they have sought from the earliest stages of detecting deviance evidenced by troublesome infant behaviour: a means of *relief.* Moreover, it seems that their newfound feelings of being 'in control', channels the mothers' towards an engagement with intent to achieve *formal diagnoses*, as Mother 3 explains:

> Before the diagnosis, everything's out of control, it's a panic situation, isn't it? Anything that you don't understand or is out of your control (Mother 3)

By implication, Mother 3 achieves control through the act of diagnosis.

As an aside, I note that passages such as this illuminate the merging of the initiation period with the ensuing diagnostic achievement phase, detailed in Chapter 6.

Final Remarks

My interpretation of the data in the initiation phase suggests that the mothers' stressful circumstances, together with their pre-existing knowledge of ADHD, provide fertile ground where 'deviance' is first conceived and identified as being ADHD. I contend that when the mothers, already feeling stressed by their respective life situations, encounter their children's irritable baby behaviour and unmanageable toddler behaviour, their felt need for relief engages with their pre-existing knowledge of ADHD. The medicalization stream of action is activated and their children begin their medicalized journey as silent passengers.

6 The achievement phase

This chapter presents a discussion of the findings relating to the formal steps in 'officialising' ADHD. Data revealing links between the medical act of diagnosis by the doctors and the ubiquitous search for relief by the mothers are exposed. In addition, evidence that the mother-doctor *partnership* empowers the ultimate objectification of the child as 'ADHD' is presented.

Introduction

Data relating to the achievement phase are found within a relatively brief time-span, 'sandwiched' between the former *initiation* phase, and the period of *maintenance* of the patient state. Therefore, the transition from the initiation phase remains a focal point, especially in the first sections of this chapter.

It concludes by showing that the doctors' attitudes of acceptance of the mothers' 'informal diagnoses' and the mothers' actions in partnering with the doctors in the act of 'formal' diagnosis are central to the empowerment of transformation of the child from "monster" to 'patient'.

The achievement of medically diagnosed 'ADHD' is made visible by the decisive actions of the mother and, most importantly, which result in the child being formally diagnosed as 'being ADHD'. In this way, the *achievement* of diagnosis, as an act, is unambiguous. Even so, it is no less complicated by layers of mother-doctor interactions within the diagnostic experience, and flanked by actions associated with the mothers' diagnostic pursuit and the management of the medication that follows. For this reason, the achievement phase illuminates a variety of ways in which ADHD acts as a symbol to shift the emphasis from 'blame' to 'relief'.

During the achievement phase, various 'meanings' of ADHD become particularly noticeable through the interpretation of ADHD symbols. Once again, as these could be organized and arranged in numerous ways, I have selected three that appear to be important in driving the process of medicalization. These are symbols of *understanding*, *enablement* and *transformation*. The mothers and the doctors appear to interact with these various 'faces' of ADHD, to empower their actions.

One such example is found in Mother 3's words that show how ADHD is seen as a symbol of transformation. She says:

> Before the diagnosis, everything's out of control, it's a panic situation, isn't it? Anything that you don't understand or is out of your control (Mother 3)

These words suggest that Mother 3 draws on ADHD's power to transform, to realign her situation. The diagnosis helps her "understand", and 'understanding' yields "control". I point out, however, that similar links between 'diagnosis', 'control' and 'understanding' are reported in other studies (particularly disability studies) reporting on quite different 'conditions', therefore it is reasonable to assume that other 'conditions' may be similarly symbolized.

Using the same excerpt, ADHD can also be interpreted as functioning as a symbol of *enablement*. Mother 3 convinces herself of the 'truth' of ADHD using an 'all or nothing' framework; that is, *before* the "the diagnosis", "everything's out of control" and "a panic situation". The diagnosis, therefore, is perceived as being the antithesis of "panic". It is a symbol of "understanding", and means to escape *all* of the "panic".

Ultimately, ADHD is a symbol of *power*. It provides power to subdue and transform the child "monster", much like the way commercial toys called "transformers" reconfigure, for example, a car to a robot. So too 'ADHD' symbolizes the reconfiguring of the child's identity, from "monster" to 'patient'. Moreover, the term

"ADHD", as she understands it, progresses from the *general* to the *particular*, that is, to her particular child.

Framing relief, connecting ADHD

While perspectives are neither fixed nor static, the mothers in this study, without exception, recall having 'known' about ADHD some time in the past. Note that the mothers refer to ADHD (such as 'hyperactivity' and 'ADD') using earlier nomenclature when speaking of their earliest recollections. As these references pertain to a knowledge' of ADHD well before *experiencing* it in their lives, it seems to be reminiscent of the Kantian idea of a priori knowledge (1934), or knowledge outside one's experience. In this sense, it may explain why the mothers somehow accept ADHD as a universal truism.

Not surprisingly, information concerning the actual source of the mothers' knowledge of ADHD is scant, since the mothers' recollections relate to a period at least ten years previously, making specific times of encountering ADHD impossible to substantiate. Alternatively, it could be argued that *because* all of the mothers speak of 'knowing' about ADHD, the importance of its embedment in popular culture, as described in the following accounts, is heightened:

> Before I had kids it (ADHD) was on TV. It was ADD then. Then when I read about it later. I already knew about it, from somewhere... off the TV I think... but I had a bit of general knowledge of it ...I had some sort of inclination of it (Mother 1)

and,

> I had definitely heard about it and knew a bit about it (ADHD) before (name of child) was born ...I did have a general idea ... like you hear things on television, stories, newspaper, you read articles about it...and as he moved into preschool I had more

> thoughts about ADHD, the picture you get in the media is more school aged kids… I definitely knew about it. (Mother 2)

and,

> That hyperactivity thing, I had heard about that bandied about sort of thing way before (name of child) was born… I'd known about that for quite some time…I'd read about it in newspapers and stuff and magazines more than television. (Mother 3)

These excerpts confirm the indirect influence of the media of the day (as suspected in the depiction of the research design Figure 1). Therefore, comments relating to a general knowledge of ADHD are perhaps not particularly remarkable. The critical point to be made with regard to this study, however, is not the generality of knowledge, but the particular application of it. My data show that at some point, along the continuum of everyday experiences, the mothers make a *direct connection* between their *general* knowledge and their *particular* situation, as the following excerpts show:

> … Then later, I remember when I read about it in Christopher Green's book it was more a match. What I read about I could see in (name of child) (Mother 1).

and

> I definitely knew about it (ADHD). By the time he got a little bit older, by the time I got to that stage, I was well and truly on the path of thinking this is what it is. I'd already kind of been, he got that little bit older and I started making the connection (Mother 2).

and,

> I read the book 'Hidden Handicap'…he was just around two (years old) then I cried and cried because I realized how hard life was going to be for him (Mother 3).

Mother 3's reflection, above, shows an apparent connection between her 'understanding' of ADHD, formed through her interpretation of the printed material mentioned, and her infant's life course of inevitable suffering. When this association is made, Mother 3 feels the pain of her belief that her toddler will inevitably suffer throughout his life.

A particular kind of 'knowing'

Although I am unable to determine the perspectives of the mothers in their earlier exposure to ADHD, it is clear that at the time of being interviewed all of the mothers, without exception, held rather similar medical perspectives of ADHD, believing it to be a genetic condition inherited through the male line.

Mother 3's definition of ADHD typifies the mothers' construction of ADHD:

> ADHD is a difference in the composition of the fluid between the brain cells which means that the waves going through the brain go intermittently rather than constantly and medication used to help this actually makes those waves go faster. Doesn't make them constant again, but it makes them go a lot faster, so that they can understand better what's going on...I read lots of literature on it I started with the 'Hidden Handicap' (Mother 3)

It is noticeable that the medical perspective incorporates a belief in the benefit of medical intervention; that is, ADHD medication. Mother 3's medical view of ADHD is steeped in medical jargon, such as brain functioning, fluid between the brain cells, brain waves, and accelerating brain waves. Moreover, the 'ADHD brain" is, she believes, improved in its functioning through medical treatment; that is ADHD medication.

A particular kind of 'timing'

Unlike other studies, which emphasise the direct importance of the role of school personnel in facilitating the process of diagnosis, the mothers in this study particularize ADHD before their children are of school age. In the case of Mother 3, this occurred when her first child was around eighteen months old. The data show that Mother 3 sought the advice of the same obstetrician who had provided medical treatment during her pregnancy and had also presided over the birth of her 'soon to become' problematic infant. This doctor, upon her seeking his advice about the child's sleeping and related behaviours, evidently pointed her to Krane's (1980, p. 15) book, *The hidden Handicap* (Kranes, 1980, p. 15), as she says:

> Oh (I first learnt about ADHD), by reading, by reading lots of literature on it (ADHD). I started with the hidden, I started with the 'Hidden Handicap', my doctor, my GP asked me to read it when my (infant) was about 18 months old or about two years old...he's almost eighteen (years old) now. (Mother 3)

Once again, I draw attention to the apparent connection between the particular mentioned text and its authorisation by the doctor. While there is no way of knowing the *influence* of this social interaction at a time when her mothering stress was escalating, it is clear that Mother 3 indeed acted on her doctor's advice. She read *The Hidden Handicap* forthwith and was influenced by its contents which is typified by the following excerpts:

> The only thing these so-called slow learners learn fast is failure. Often they are considered so academically hopeless that they are not only excluded from higher education, but most often drop or are thrown out of secondary school programs. No other group of children suffers more in self-esteem or feels more frustrated (Kranes, 1980, p. 15)...Under the heading "learning disabled," this population is more lost than ever...not retarded and not quite normal (Kranes, 1980, p. 32)

and,

> The assault to the child's organism may occur either in the genetic development, the prenatal, the peri natal, or postnatal, or during birth...the MLD's difficulties may not

> be apparent immediately…presently the diagnosis of brain damage in the young child may be tied up with disordered behavior, short attention span, defective work habits, impulsiveness and specific learning disorders (Kranes, 1980, p. 44)

The data show that Mother 3's perceptions of her child changed as a result of the interaction she had with self and the object of ADHD as her words repeat the link between absorbing the 'meaning' of ADHD and applying this to her child. :

> Mother 3: I sat down and read it (*The Hidden Handicap*) and I cried [her eyes fill with tears as she speaks].
>
> Researcher: I sense a bit of emotion when you think about it even now
>
> [Mother 3 weeps]
>
> Researcher: Just take your time…when you feel that emotion, what is it you're feeling? …. Can you tell me about that?
>
> Mother 3: Yes, the sadness, really, that their lives aren't going to be … (long pause then a whispering voice she sobs) easy.

Note that Mother 3 expresses strong emotion when she says *"their lives"* even though, at the time of reading this book, she had just one child, her first child. While this may have been nothing more than a miscue of language, in due course, Mother 3 had three sons in total; all of who acquire ADHD diagnoses before school age. While not necessarily overemphasising semantics, the question of whether it could be that Mother 3's views were already well established when her subsequent children were born, has to be considered. More importantly, even though I emphasised earlier that such connections were made without school intervention, I now draw attention to the way in which school life is projected through the text above.

Following on from particularizing ADHD, the mechanism of diagnosis appears to be activated. In fact, just six months afterwards and around her tipping point, Mother 3 takes action. She initiates a consultation with yet another paediatrician known to her and one who had previously attended her child for another serious matter requiring hospitalization. In the first consultation, Mother 3's child, now just two and a half years of age is subsequently diagnosed as having ADHD and treated with Ritalin the very same day. Some sixteen years after the fact, he still takes Ritalin. In this, Mother 3 retains her medical perspective of ADHD and remembers reading the original source that she believes to be responsible for guiding her thinking.

In sum, Mother 3 "understands" ADHD in medical terms derived not only from popular culture, but also as facilitated through the doctor who is, and had been, in control of her reproductive health. She states:

> Well, my GP was my obstetrician as well, so he already knew about my pregnancies and all that sort of thing (Mother 3)

Therefore, although it is clear that the medicalizing baton passes from one doctor to the next, the process of medicalization is nonetheless not easily unravelled: determining 'who did what first' does little to explain the complexities of the child's journey from the womb, to babyhood, childhood and beyond. Moreover, while cases vary in detail, the mothers in this study share similar trajectories from the general to the particular, as Mother 1's comments demonstrate:

> I was reading something about someone else (diagnosed as having ADHD) and I thought 'Oh my God that's (child)' you know it was like everything "CLICKED" *that* was *him* (Mother 1)

Even though it can be established that the mothers in this study personalize the object of ADHD, much remains unknown about the drive which energizes the search for 'relief' the role that the achievement of ADHD diagnoses plays in delivering such relief or the quality and sustainability of 'feeling relieved'. To uncover more about these matters I consider once again the tipping point, because it is here where the mothers' sense of 'needing' to gain control of their 'felt stress' takes hold.

The tipping point revisited

In reviewing the tipping point, two primary functions appear. Firstly, the tipping point provides a window into the intensity of mothering stress. Secondly, it underscores how the mothers conceptualize the 'place' of relief and the benefits it may bring.

Assuming that the state of 'feeling relieved' is relative to 'feeling desperate', it stands to reason that the tipping point forms a reference or 'set of coordinates', from which the pathway to the 'place' of relief may be mapped. Most importantly, as the mothers' feelings of desperation appear to intensify at the tipping point, further probing of the data uncovers social interactions that may be responsible for influencing both the direction and impetus of the flow of medicalizing action.

One of the most interesting developments characterizing the tipping point is the mothers' sense of impending disaster, evidenced in a number of ways across cases. The findings relating to the mothers' feelings of desperation and doom are contextualized case by case as follows:

Mother 1

Mother 1's discernment of her situation at the tipping point appears to strongly focus on matters of survival: her primary emotion appears to be fear, associated with her prediction of imminent family-unit disintegration. Interactions with *self* reveal beliefs impressing upon her a *compulsion* to act to avoid impending disaster. She states:

> Honest to god I doubt if my family would have survived if we had gone on the way we were before this (ADHD) diagnosis ... before (my husband) and I found out what was going on, you could have ripped us apart as a family unit... we would have been

> separated, all of us… the situation couldn't have gone on the way it was, quite simply couldn't have, we would have been finished, the family unit would have been split, in some way or it would have been just a disaster (Mother 1)

Words like "ripped", "finished", "split" and "disaster" provide insight into he depth of emotion driving Mother 1's felt-need to preserve her family-unit. While the phrase "found out what was going on", when considered in isolation, could suggest that the act of diagnosis pre-empted Mother 1's perceptions of her child being ADHD, scrutiny of the overall data more likely refers to the act of the doctor providing *confirmation*, as these words show:

> I think the (ADHD) diagnoses are made pretty easily because they (the doctor) just take what we say (as the basis of diagnoses)…She (the paediatrician in diagnosing our son as having ADHD) basically just agreed with what I thought were the symptoms (Mother 1)

Amidst mothering tensions and a growing conviction that ADHD is the cause, the *place* of relief becomes clear: "this diagnosis", as she says, is related to "finding out what was going on" which, in turn, is accounted for in officialising the child as ADHD.

Therefore, the progression from the "initiation" phase following on from the tipping point demonstrates connections between perceptions, action and *emotion*. Mother 1's words in the following excerpt show not only the escalation of her desperation but also her determination to act, as the battle line is drawn between her and her child. She states:

> I think you get to the stage where you sink or swim you know. This child is either going to drive me mad or we are going to do something about it (Mother 1).

Here, in the context of catastrophic terms relating to 'drowning' and being driven "mad", enveloped in catastrophic images like "ripped" and "finished", Mother 1's comments offer an excellent example of the *process* of 'moving on' from the tipping point: she takes medicalizing *action* to relieve the stress she feels.

Mother 1's 'place' of relief is described in two ways. Firstly, the achievement of an ADHD diagnosis positions Mother 1 as "controller" of her small challenging child and secondly, it provides her and her family with a 'safe' haven, thus facilitating the preservation of her sanity. Here the process of medicalization can be seen as *interacting with self* through processing phrases such as "getting to the stage" alongside contrasting imagery of "sink or swim" and "drive me mad or do something". Put another way, Mother 1's actions could bifurcate: she either acts (and this will prove to be to achieve an ADHD diagnosis for her child) or she yields to insanity.

Mother 2

Although circumstances vary, a similar thread is detected in Mother 2's account of moving on from her tipping point. With a background of sleeping difficulties and toddler "clinginess", which incidentally bear no resemblance to the indicators of ADHD as stipulated in the DSM, Mother 2 seeks a solution:

> I was looking for answers...within the first two or three weeks of preschool it was quite obvious child's name) wasn't coping within the environment...we had separation anxiety issues...he didn't want to let go and he'd say "oh I don't want to go to preschool" and I'm saying "you *have* to go to preschool you *need* to go to preschool" he needs to go to preschool to give me a couple of hours break. I felt awful... (Mother 2)

These words show, on the one hand, that her child's clinginess is likely to be connected with his anxiety in being separated from his mother. On the other, being desperate for "a break", Mother 2's filters her interpretation of her child's behaviour through her social interactions with self and others, including those of her own mother. In this way Mother 2's mother, a lay 'expert', acts as a symbol of deviant verification in the child. She says:

> … My mum's a foster-mum, and she's been a foster-mum for years and years, so she's got a lot of experience with babies, so I was asking her for a lot of support, you know? She'd try lots of different things, and she even took him for a couple of nights to see if she can sort things out, you know, like – but of course, you know, even all her skills and things, like, nothing ever worked long term (Mother 2).

So, with "nothing ever" working, Mother 2 reaches her tipping point. She says:

> I think at that stage we were really in crisis point, I mean, the (pre) school placement had broken down, everything wasn't really working (Mother 2).

As such, other possible explanations for her child's behaviour, such as his anxiety, are discarded in favour of applying her 'general' knowledge of ADHD in order to explain her monster-child. She states:

> Mother 2: around three, ADHD had definitely been discussed…(I was) just speaking about it (ADHD) with family and friends, and just saying things like, oh do you think it (the cause of my child's troublesome behaviour) could be like ADHD, and obviously finding a little bit of information about it (ADHD) and thinking OK (it's ADHD)…mum had heard the term before, just with her experience with kids, and I think some of my friends too.
>
> Researcher: So can you remember a specific moment where you first heard 'ADHD'? Was it just 'in the air', and then you sort of delved into it a little bit more for information?
>
> Mother 2: Yeah. That (ADHD) was kind of around. But I guess, too, that at that stage I was kind of looking for answers.

Mother 2 says that she was "looking for answers". While the question of 'why ADHD?' and not some other condition, is not completely explained, the important point is that Mother 2 *found* her solution; she informally diagnosed her child as having ADHD and in so doing, she is relieved from feeling:

> Guilty and blamed and that you are not doing a good enough job, and if only you could do things differently you could fix the child. (Mother 2)

So, having interpreted her child as ADHD, and labelled him accordingly, she 'fixes', not so much her child, but more so her mothering troubles. She says:

> It (the problematic behaviour) is labelled then… it's controlled (Mother 2)

While this may sound simple enough, it is nonetheless far from being a straightforward progression; a symbolic interactionist approach to analysis reminds the researcher of the interconnectedness between actors and their social environments. Closer scrutiny of the data reveals, much like it does for Mothers 1 and 3, that the flow of medicalizing action is not merely about 'finding' a condition' and applying it to one's situation. More to the point, the mothers are already well accustomed to seeking medical solutions as a general pattern to mothering stress as the following account of medical immersion demonstrates:

> Right from the beginning we were kind of seeing people like paediatricians and, like, going to, like there's a place called (name of hospital clinical), and they help with family support, like sleeping and feeding and all that. So, I guess over those first years, before he started pre-school, I guess what the health professionals were saying was oh, it's reflux, it's this, it's that, so it was like there's lots of other reasons that could be causing this behaviour (Mother 2)

Therefore, lest one assume that medicalizing begins in babyhood, the data implicate medicalizing patterns connected with mother-blame as far back as her pregnancy as Mother 2's words infer:

> When we were talking about it (her child's problematic behaviour), it is probably because you were stressed in the pregnancy (Mother 2)

In fact, in a similar way the other mother participants, Mother 2's interactions and apparent partnerships with doctors, immediately following her child's birth, demonstrates the first indications of medicalizing interactions imbued on her child. This being the case, one could question whether ADHD is but a 'part' of a continuum of medicalizing patterns of behaviour, rather than the pinnacle. Mother 2 revealed that within a few years of achieving an ADHD diagnosis, she pursued a further diagnosis of Asperger's Syndrome. She stated that she preferred that her child be 'known' as 'Asperger's' as this attracts more government funding for him in his educational setting. Further, she stated that his behaviours in the classroom, although no change has been noted in them, are now considered 'normal' Asperger's behaviour. This, she said, has led to greater increased tolerance of his once intolerable behaviours.

Mother 3

While much had been already said about Mother 3's contextual circumstances earlier in this chapter, I focus here on Mother 3's description of the eve of her pursuit of medical intervention for her first child[87]. As outlined previously, Mother 3's tipping point, in a similar to way to Mother 2, is closely associated with perceptions of her infant son's apparent sleeplessness and excessive waking activity and her interactions with others. Her mother, for example, portrays her as one to be pitied in having had a monster- child. She says:

> My mother said I deserved a sainthood (Mother 3)

Interestingly, Mother 3 forms a 'collective view' of her infant as being troublesome to the extent that his behaviour is potentially detrimental to her sister's well being. She states:

> My older sister said he was nearly her undoing because he would never go to sleep (Mother 3)

Once again, this provides an excellent example of the influence of perceptions on subsequent actions in that, as a result, Mother 3 forms the view that "something" is "wrong" with her child. That "something', she reasons is *identifiable*. She states:

> My first child slept for twenty minutes a day from the time he was born and then quarter hourly at night so I knew there was something wrong...he was like a whirlwind...he was into everything... I knew there was *something* because I took him to the doctor (Mother 3)

While not overemphasizing the semantics of her words, her final comment does not go unnoticed; "I knew there was something *because* I took him to the doctor", hints that the *act* of seeking medical verification in itself provided *evidence* of the "something" to which she refers. One could extrapolate from this that the "doing", that is, taking the child to the doctor, in itself verified "the something".

Mother 4

As her pathway to formal diagnostic achievement differs, Mother 4's prediction of ADHD provides an interesting case contrast. Further analysis suggests that Mother 4 is well accustomed to the institution of medicine. She attributes her professional training as a nurse, before her becoming a mother, as the period when she first formulated her views of ADHD. She says:

> I became aware of ADHD as a professional before I ever became aware of it as a personal issue (Mother 4)

Yet her understanding of ADHD allows greater flexibility of definition, as her attempt to do so in the interview suggests:

> It (ADHD) was something that just happened to you, like you might be a diabetic or you might be a schizophrenic that it was probably in your family history (Mother 4).

Note that Mother 4 informally diagnoses numerous family members as having ADHD, and in doing so, her medical perspective of ADHD is tailored to accommodate a "normal bunch of people with a label", as she says:

> People have always accused me of being disorganized and being quite distractible, and I see a lot of behaviours in my dad like that ... I see a lot of parallels in a number of members of my family, cousins and siblings and so in a sense that's kind of reassuring, that they made it ok and so (my children) will be ok... I've just kind of considered (my family to be) a normal bunch of people with a (ADHD) label, and not felt that we had a condition, to the point that it's always been a joke that my kids have had ADHD amongst me and my friends, you know, and that I've got ADHD (Mother 4).

While at first it may seem that 'being ADHD' is inconsequential, further discussion with Mother 4 reveals that she too reaches a tipping point. As an aside, I point out that Mother 4 refers mainly to the diagnosis of her youngest child so my analysis of her tipping point is situated in relation to this event. I assume that she may have experienced earlier 'tipping points' in relation to the diagnosis of her older children as there is no reference to these experiences in the transcripts. In relation to her youngest son, however, this appears to occur when her child's early childhood teachers advise her of his academic underachievement. She explains:

> The teachers, in his final year of preschool, the teachers recommended that I held him back. And I was *devastated*, because I was never given the impression that he wasn't level with his peers (Mother 4).

As such, school personnel play a role in triggering Mother 4's tipping point although it cannot be said that school personnel characterize the child as being ADHD.

Although Mother 4 speaks elsewhere of struggling to manage her child's reportedly violent behaviour, it seems that her decision to seek a formal ADHD diagnosis is strongly connected with his perceived poor school achievement and "worrying about him (her child)" intensifies. Unlike Mothers 1 and 3, Mother 4 appears to have had no pre-existing relationship with the diagnosing paediatrician but had a recommendation from a close friend whose children had been diagnosed as having ADHD. When her child's underachievement persists, Mother 4 proceeds to choose a paediatrician who uses "brain-imaging" as a diagnostic tool and subsequently achieves an official ADHD diagnosis. She states:

> (My sons' underachievement makes me feel) sad in a way, and that's why I wanted to make sure, if I got these kids medicated, would they achieve that (expected academic achievement)? And I wanted to make sure that I didn't feel guilty because I didn't have them medicated because I didn't want to medicate my children, and (then) they (would have) missed the opportunity to be academic... I look at all three of my boys, none of them are stupid, but I don't think any of them have achieved academically what they're capable of (Mother 4).

Here Mother 4's comments show a significant link between contrasting images of academia and stupidity, and the relief that medication promises in alleviating guilt associated with mother-blame.

The diagnostic event

I begin by pointing out that details surrounding how the mothers and the doctors consultation came to be, in a practical sense, was not at first of particular interest. In reflection I have, however, come to appreciate the benefit of an unstructured interview approach because this revealed points of interest relating to the circumstances surrounding "choosing" the diagnosing practitioner as has been discussed in the earlier section entitled *The Tipping Point Revisited.* In terms of the mechanism of diagnosis, however, the 'moving on' from the 'tipping point' can be described as a straightforward series of steps culminating in the diagnostic event.

Even so, such actions are wedged within a complex array of social interactions related to the mothers' and the doctors' *perspectives* and their synergy. In summation, across cases, there are clear links between mothering dilemmas, the pursuit of control, existing patterns of medicalizing thinking, particularizing ADHD, official diagnostic achievement and ADHD medication. Trawling of the data pertaining to the actual diagnostic event itself shows the encapsulation of the mothers and the doctors in a medicalizing contract securing official transformation.

Practically speaking, the act of formally diagnosing the children as being ADHD appears to take a relatively short period[88]. While Mothers 1 and 3 specifically mention pre-existing relationships with the doctors, Mother 4 is an exception in that she appeared to have had no such relationship with her choice of diagnosing paediatrician. She does make comment, however, that she followed the recommendation of a friend of hers whose children had been diagnosed as having ADHD.

Another point worthy of comment is that, with the exception of Mother 4, whose child was at first administered a brain scan, ADHD diagnoses are achieved in a single consultation. This 'event' includes the administration of psychotropic medication. Overall, it follows an uncomplicated trajectory (see Figure 5).

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[88] Most accounts indicate that the children were diagnosed in less than a period of thirty minutes. In the case of the consultation I observed (as noted in the Prologue), the diagnosis was achieved in less than thirteen minutes.

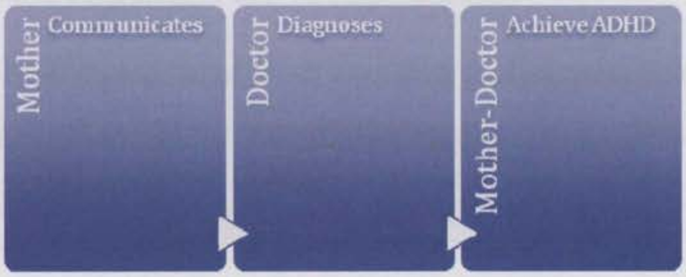

Figure 5 The trajectory of the diagnostic event

In this study, the evidence points to the diagnostic scene unfolding as follows: after the mother makes her case of troublesome behaviour in the context of stressful everyday circumstances, and expresses her belief of such behaviour being indicative of ADHD, the doctor agrees, pronounces the child as being a case of "ADHD", subscribes psychotropic medication with some instructions and after a relatively brief encounter, the mother and the child exit, the child now being a fully-fledged "ADHD".

According to the mothers' accounts, the 'surface' conditions of the medicalizing stream on which they traverse appears calm; official diagnoses and medical treatment are readily available. The overwhelming question which emerges surrounds why the doctors appear to provide such 'rapid-fire' diagnoses, especially to young pre-school aged children. Beneath the calm, the data reveal many currents worthy of further exploration, much of which is uncovered in investigating the doctors' perspectives. Therefore, before proceeding further with the analysis, I insert information relating to the actual interviewing experiences with the doctors attached to each case[89].

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[89] The mother and the doctor participants are numerically associated.

Background Information: interviewing the doctors

Three of four doctors, all of whom were paediatricians, participated in this study. The following accounts convey contextual information relating to the interviews with the doctors.

The doctors varied in gender. Doctor 1 is female and the remaining doctors are male. While I did not enquire about their ages or years of experience in practising medicine, my impression was that they had been doing so for several decades.

Although I intended face-to-face in-depth interviewing in keeping with my research plan detailed in Chapter 4, this proved to be impossible to achieve. As discussed in Chapter 5, the doctors' secretaries[90] acted as 'gatekeepers'. In contacting the doctors' consulting rooms, the secretaries took the calls. I introduced the research study to them and requested that letters and other related information which had already been sent to the doctors' rooms, be made available to them (see Appendix XVI). Generally speaking, the secretaries appeared reluctant to provide assurance that information relating to the study would be passed on to the doctors. I overcame this perceived difficulty by discussing this research study in detail with the secretaries and by offering alternative interviewing arrangements for the doctors. It transpired that a series of interviews were arranged, with the exception of Doctor 4, who declined to participate. I point out, however, that the interviews with the doctors were, by comparison with the mothers, limited in duration by the doctors' time constraints. In addition, the interviews were conducted differently: while the mothers were interviewed in their homes face to face, two of the doctors were interviewed on the telephone and one was interviewed in his consulting rooms. Despite such differences,

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[90] Or administrative staff

the interviews with the doctors, summarized below, produced dense, readily accessible data, which I interpret using a symbolic interactionist approach.

Doctor 1

Doctor 1 is the diagnosing paediatrician for two of the child participants from the same family. Doctor 1 had diagnosed the children approximately seven years prior to the time of interview and continues to refer to herself as the 'family' doctor. According to Mother 1, contact is limited to the provision of ADHD prescriptions for ADHD that are authorized for maximum "repeats" which, according to Mother 1, are sufficient to supply two years of continual ADHD medication without the need for further consultation. Doctor 1 confirmed this to be so. Moreover, she reported that she had not provided consultation for the past two years.

As an alternative to a face-to-face interview, a telephone interview was arranged at an agreed time. When I called at the appointed time, however, my call was redirected to her home telephone[91]. At the commencement of the interview, Doctor 1 stated that she had refreshed herself about her experiences with the child participants by referring to her notes. She stated that although she rarely saw the children, she believed Mother 1 to be capable of managing the children's ADHD 'condition', including the administration of ADHD medication with minimal, if any, oversight from her. With few guiding prompts, Doctor 1 spoke extensively about a number of aspects of ADHD. These included her general definition, other examples of her experiences and beliefs of children with ADHD in school environments, her interactions with Mother 1 and the children themselves.

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[91] At the commencement of the interview, the doctor stated that she was in her own home "with her feet up relaxing with her dog and having a cup of tea" with the children's' case notes in front of her.

Doctor 2

Doctor 2 was the diagnosing paediatrician for Mother 2's youngest son. He provided a concise telephone interview. In fact, the doctor unexpectedly initiated the call to me, following my introductory contact with his secretary. He stated that, though he was in a "hurry", he was keen that the interview be conducted immediately, that is, 'on the spot'. As his call was impromptu, I was not well prepared with recording facilities. I nevertheless agreed to the interview because I was not convinced that the opportunity to do so would be available again.

I also point out that Doctor 2 insisted that the interview not be audio-recorded because:

> I might be misinterpreted. I don't believe in tapes unless you are at the police station being interrogated.

I agreed to his requirements and instead of audio-recording the interview, I took notes throughout and wrote extensive notes immediately afterwards.

Despite the brevity of the interview and the unusual circumstances, rich data were obtained.

During the interview, Doctor 2 said that he had seen the child of Mother 2 just once, some four years before our conversation. Mother 2 independently indicated that her child had since been diagnosed as having Asperger's Syndrome although her child retains his ADHD diagnosis and continues with ADHD medication.

Like Mother 1, Mother 2 takes complete responsibility in manageing her child's ADHD medication. She indicated that she obtains prescriptions from yet another doctor, the family's general practitioner, and once again, she continues to request further prescriptions by contacting the doctor's secretary as the need arises.

Doctor 3

Doctor 3 is the diagnosing paediatrician of three child participants (from the same family). He was interviewed face-to-face in his professional rooms. The setting was informative in itself. I observed several children of varying ages with their mothers in the waiting room who appeared at the time to be awaiting consultations and whom I later learnt were awaiting their diagnoses. I was offered an impromptu opportunity to directly observe one such diagnosis in process: I refer to this experience in the preface of this study.

Although Doctor 3 continues to prescribe ADHD medication for the children, he said that he had not seen any one of them "for years", as he leaves the management of medication to Mother 3. The means of obtaining prescriptions of ADHD medication for the children was not clear. Further, Doctor 3 commented that he had "over one thousand ADHD cases on his books" and was "run off his feet" being unable to "see" them all[92].

The interview itself continued for approximately thirty minutes interrupted by the cries of awaiting children and his secretary's prompting for him to conclude speaking with me. The doctor ended the interview with an invitation for me to return by saying:

> It's about time these bloody universities sent people to learn about ADHD. Please come back and I will tell you more (Doctor 3).

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[92] The doctor gestured to numerous files lining the entire wall in the entrance of his surgery implying that they all referred to cases of ADHD.

Doctor 4

Doctor 4, according to his secretary, declined the invitation to participate in this study. When Mother 4 heard of this, she told me that she made several requests to his secretary seeking his reconsideration; she said to me that she was surprised because she believes him to be an acclaimed published author of a 'famous' ADHD book and an "ADHD world authority". I have since obtained a copy of his publication; I refrain from citing it because it would divulge his identity, but I make mention that it seems to me to be a concise text that conveys ADHD as a genetic disease caused by a dysfunctional brain.

Mother 4 contacted me to enquire as to whether Doctor 4 had "changed his mind" given that she had apparently asked his secretary several times for him to reconsider. Still, despite her further requests, according to his secretary, Doctor 4 declined. Interestingly, Mother 4 appeared to be surprised by this as she had anticipated that in an interview, the "brain scans" to "prove" the existence of a 'damaged' ADHD brain, for which Doctor 4 was well known, may have been explained[93]. In any case, I therefore have only the transcripts revealing Mother 4's opinions' about Doctor 4, and her recollections of the diagnostic process, from which to refer.

Having contextualized my experience of interviewing the doctors, I now present my findings by incorporating the doctors' perspectives in a mother-doctor interactional framework. The following section of this chapter outlines several elements of interest, which I have interpreted as aspects of power. While this in itself is substantive, it also lays the foundations for further analysis of additional sub-themes of relief, discussed towards the end of this chapter.

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[93] She had evidently not been provided with a either copy of the scans conducted on her own child (several years earlier), or an adequate explanation.

Mother-doctor partnerships: the paradox of power

It is evident that the mothers and the doctors form a robust connection, borne out by its sustainability for years to come. The data show that the mother-doctor unions are rooted, for two of four mothers, in pregnancy and childbirth and in all cases, are well established by toddler-hood. Indeed, it could be argued that the 'birth event' gives way to the 'diagnostic event': the former delivering a 'child', the latter delivering a reconfigured ADHD child.

Within the fertile ground of the diagnostic event, several paradoxes emerge relating to the *power of* and the *empowering of* the diagnostic event. Several aspects of 'power' are examined. These include: the negotiation of *control* in the mother-doctor 'ADHD agreement'; the power generated by overlaying perceptions (particularly the doctors' perceptions), of the object of ADHD, the 'good mother' and schools; and the role of *medical treatment* as the diagnostic 'prize'. Such notions are identified although the data generated by particular conversations are, broadly speaking, enfolded within the grande theme of relief.

The power of diagnosis: negotiating control

While the history and background of each actor, individually and collectively, forms a backdrop for the diagnostic event, it is reasonable to assume that it is the doctors, as custodians of medical institutional authority, who are ultimately 'all-powerful' in officially recognizing and legitimizing the children as ADHD. Such a claim, while plausible, is nonetheless an oversimplification of an extraordinarily complicated set of social interactions impinging on the 'diagnostic event': an event that substantiates the presence of mental illness by categorizing the child as "ADHD". While this may be partly the case, such an assumption falls short of explaining why mother 2 enters the diagnostic event confident that:

> I knew (when I took my child for his consultation) that he (the paediatrician) would agree (with me) that it (the source of my child's behaviour) was ADHD (Mother 2)

In contextualizing the accounts of the mothers and the doctors in this study, I begin by surveying sociological enquiry concerning the process of 'illness authentication': an area which is neither new nor confined to a particular discipline [94] but one which gravitates to the tenets of medical sociology. Although medical sociology is a domain far too broad to discuss at length within the scope of this thesis, it is within this broad scope of interest that phenomena surrounding how ADHD is officialised emerge. More specifically, the theorizing doctor-patient relationships have already gained significant attention during past decades and interest continues to grow in accordance with shifting trends. As the 'patients' in this study are children and as they, from a functional point of view, have a minimal role, for the sake of discussion I adapt ideas relating to doctor-patient relationships to the mothers[95].

According to the early pioneering work of Parsons' (1951) theoretical modelling of the doctor-patient relationships, the doctor and the patient performed polarized roles. The doctor dominated the diagnostic experience from a platform of superior 'expertise' and 'experience' and the patient from an 'inferior' position of 'need'. In this way, Parsons argued that the patient and the doctor formed an *agreement* of 'role performance' where the patient performed the 'sick' role, and the doctor took an 'expert' interventionist position.

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[94] More specifically, factors connected with the impact of science and economics in medicine are implicated in the diagnostic practices of physical and mental illnesses. For an excellent overview of social change and medicine see the work of Ray Fitzpatrick (1997).

[95] I point out that in discussing 'the patient' I am referring in the main to 'the mother' as acting functionally as the patient, in her child's stead.

While this may have been the trend in the past, a recent analysis of the sociology of diagnosis by Morgan (2003) shows a shifting trend towards 'mutuality': that is, an approach to diagnosis whereby doctor-patient relationships are more likely to be conceptualized as 'client-doctor' partnerships, being defined by shared meanings of illness and shared expectations in treatment delivery. This model therefore goes a step further to Parson's thesis by presenting the diagnosis of illness as and overall patient-doctor *partnership.* Perhaps even these ideas can, however, be seen as outdated, being superseded by trends in wellness as the vogue human rights and self diagnosis as the outcome of a "super-self expert" model. Furthermore, 'evidence' is sometimes overridden by the need to relieve competing social pressures (Summerskill & Pope, 2002), which may also explain why not all doctors lament the escalation of 'doctor-self patients' as co-partners (Young & Flower, 2002) as Duttweiler (2007, p. 1) so aptly puts it:

> To have problems is not an everyday matter any more, while therapy is becoming an everyday issue, because investing in one's own health has turned to be a social obligation.

Even so, rather than assuming that doctors are totally disempowered and somewhat obsolete, others postulate that doctors remain as powerful as they ever were, being the gatekeepers to medical intervention as Tassano (1995, pp. 26-27) asserts:

> The medical profession towers in moral stature above the rest of human society having... absolute control of medical technology, thus being able to make the difference between medical comfort, or between death or life,

Amidst the confusion of swaying between accepting or denying the veracity of such trends when confronted with numerous combinations of doctor-patient models, the existence of exclusion of the patient in favour of doctor supremacy cannot be denied. On the one hand, the mothers in this study appear to spearhead the diagnostic process and the data overwhelmingly reveals this to be the case. On the other hand, the children in the study have no say in either the diagnostic label of ADHD or the consumption of psychotropic medication. In this respect, the mother-doctor partnerships stand as both the verifiers and social controllers of childhood deviance.

With the richness of texture evident in the sociology of diagnosis in mind, I focus on the idea that the mothers in this study are situated amidst competing operational models. Whatever the case may be, it is clear that the mother and the doctor participants engage in an interesting 'dance' of *reciprocity*. While there is little doubt that the mothers remain 'in need' of the doctors' gate keeping power of access to psychotropic medication, the mothers at the same time hold the *power of diagnostic reception* on behalf of the child. This brings to light the circular nature of diagnostic control for on the one hand, the act of officialising the child as ADHD draws on the power of the institution of medicine by 'highly' trained medical practitioners who subsequently authorize the administration of 'powerful' psychotropic medication and on the other, is 'powerless' without the mothers' *initiation* and *receptiveness.* These sobering peculiarities are further discussed in the concluding Chapter 7, but retaining the idea of the mothers' role in the diagnostic process at this point, some likely facilitators of the mothers' influence could be the fact that medical 'knowledge' is no longer confined to doctors alone. Voluminous information is readily available en mass via the Internet (Frode & Aksel, 2009), often using shared medical sites such as *Medical.JustAnswer.com*, ("Just Answer," 2009). Perhaps factors such as these explain why the 'expert doctor' of old is at risk of 'dying' in a mire of 'clinician uncertainty' and 'diagnostic ambivalence'(Rafalovich, 2005a).

The power of 'the evidence': determining ADHD

Making a case for ADHD, or verifying the medically treatable 'condition' known as ADHD as it occurs in this study, is characterized by an apparent paradox best framed by the question: how is it that 'medically' defined ADHD, cloaked in dysfunctional brain rhetoric, rely on such little psycho-medico 'knowledge'? Put simply, the question of what conditions form the basis of diagnostic judgement remains.

In terms of the mothers in this study, one way of interpreting this process is to liken the mothers' acquisition of ADHD knowledge or, 'knowing ADHD', well before they have need of it, to that of purchasing a tool from a hardware store before one has need of it. When a problem arises, it may be that one searches one's toolbox, sees the tool and utilizes it to "fix" the problem at hand. In a similar way, it could be that the mothers 'have' ADHD buried amongst a clutter of possibilities but it so happens that at a moment of need, it is found to be the very tool needed. Unlike the mothers who may have a number of tools from which to choose, one could assume that the doctors have only one tool in their 'toolbox', medication.

Drawing on my interpretation of the data, I find that the doctor participants show a pattern of determining ADHD not through a 'scientific' evidence based framework but rather, through their own perceptions. In other words, they 'make sense' of the mother and child before them. For example, one such perception appears to revolve around the doctors' judgement of the capabilities of the mothers' as 'women', as Doctor 1's words suggest:

> (Mother 1) is a very thoughtful woman and well-read and well-educated woman, and I have a lot of confidence in her ability (Doctor 1)

Although Doctor 1 does not explain what is meant by the words "her ability", these comments are made in the context of Mother 1 relating her beliefs of the child's poor baby performance as the cause of her mothering troubles and her beliefs about her child being ADHD. Doctor 1 focuses, it seems, on the 'good mother' before her: the educated, well-read and thoughtful woman with a 'monster-child'. Curiously, she appears to deliver an ADHD diagnosis perhaps empathetically, rather than 'expertly', which may explain why Mother 1, somewhat ironically, interpreted the acquisition of a formal diagnosis as having been given "very little", as she says:

> With ADD she (the paediatrician) really had very little to give us – very little to give us- and it's been the same since then – she basically just agreed with what I thought were the symptoms and what *I* saw were the problems...You expect these people (doctors) to know better than you do. You expect these people to have, I don't know, *more awareness* than you do (Mother 1).

Although Doctor 2 discusses his diagnosis of Mother 2's child with an air of clinical forthrightness, his reliance on his perceptions of Mother 2 are in some ways similar, as his account suggests:

> Doctor 2: In (Child's name) case it (ADHD diagnosis) was very straightforward. He (the child) had behaviour problems. He had ADHD. It was straightforward. It (diagnosing ADHD) is not always straightforward but in his (child participant's) case it was.

Paradoxically, on the one hand, Doctor 2 says unequivocally that Mother 2's child was a "straightforward' case of ADHD yet perceptions of the home life over which Mother 2 presides clearly influences his judgement, as the following excerpt demonstrates:

> Researcher: You say that it (diagnosing ADHD) is not always straightforward. Can you say more about what you mean by 'not always' straightforward?
>
> Doctor 2: Some children have dysfunctional families and so their behaviour reflects that. Their difficult behaviours in school might stem from a dysfunctional family. This was not the case with (child's name) He had ADHD. It was straightforward.

Here Doctor 2 reveals some important clues concerning how he constructs ADHD. Firstly, Doctor 2 makes connections between "dysfunctional families", "difficult behaviour", "school" and "ADHD", and secondly, he diagnoses the child, not by clinical symptoms but by his perceptions of a 'functional' home life. In this way, Doctor 2 uses the absence of dysfunctionality as a diagnostic tool. Ironically, Mother 2 spoke in her interview with me of her troubled marital relationship that she believed had contributed to her mothering stress evident at her 'tipping point'. However, even allowing for the possibility of Doctor 2 drawing on an array of additional stimuli unknown to the researcher, this example evokes questions relating to the role of *moral judgement*, and *diagnostic intent* in constructing an ADHD 'reality'.

The power of perception: schools, toxicity and salvation

A symbolic interactionist position emphasises the significance of perceptions in influencing action. This principle is demonstrated in the example above, where Doctor 2 reveals links between his generalized perceptions of school and home environments. In probing the doctors' conversations, it seems that negative images of schools is a common. Even though the child participants in this study, at the time of the diagnostic event, are not yet of school age, and in the case of Mother 3, the child was just eighteen months of age, two fundamental beliefs about school environments emerge. These are, firstly, the belief that schools are hostile places for children with learning difficulties and secondly, that teachers 'know' very little about ADHD and are therefore unsympathetic to children who may 'have' ADHD. If these beliefs are responsible, at least to some extent, for activating the doctors' engagement with the plight of the mothers, then it can be said that the doctors' perceptions of school serve to connect the institutions of medicine, education and family, in medicalizing action.

Take, for example the words of Doctor 1 who, when asked to specifically explain her diagnostic decision making process, states:

> (I treated a boy with ADHD who) had real problems writing, writing short stories and was quite shy and anxious about this and he was asked by an English teacher, and I will raise that this has always stuck in my mind and because it was astonishing… (He was told by the teacher) to read his two-minute speech that he's written, and that *shattered him*, … I couldn't help but think how bloody stupid that was and I didn't really understand why somebody would do that to somebody who had a significant learning problem but I just use it to represent the sorts of things I heard from teachers who get very frustrated and I've heard of children having their incomplete, again, work demonstrably torn up in front of other children or the child, I remember one little boy if you're going to behave like rubbish, you can be like rubbish, this was a child in kindergarten, go and stand in the rubbish bin and that's the sort of, they're the sorts of things that still occur in the school environment because people are perhaps not well educated about the effect of impulsivity, poor impulsivity, problems with focusing, and *indeed all learning* problems on a child. (Doctor 1)

Although lengthy, this uninterrupted excerpt, relays two detailed images which capture Doctor 1's beliefs and emotions and the flow of Doctor 1's thought processes; I point out that she spoke rapidly, without hesitation and even though the interview was conducted over the telephone, she seemed to be eager to express her opinions about ADHD. Doctor 1 cites examples of "stories" she had heard about the suffering of children who encounter hostile "perhaps not well educated" teachers who are willing to publicly shame and humiliate children.

The gamut of descriptors of the children's problems is generalized. Note that in the first example, Doctor 1 refers to an adolescent child with "learning difficulties" and in the second, a little boy in kindergarten who is personified by his teacher as the essence of "rubbish" itself, and who is then made to publically stand in the rubbish bin. Doctor 1, at no time mentions ADHD as a specific condition, but implies its connection in the mentioned traits of "impulsivity", "poor impulsivity" and yet she attaches her concern to "indeed *all* learning problems".

She continues, admitting quite clearly her difficulty in attaching children's suffering at school to a disease or mental disorder label:

> These sorts of things I found quite astonishing… I find it really difficult to tease out all the symptoms and to try and understand what the cause is …I don't know that there's a solution to this, quite frankly, but I do think that you can be quite, you can really be harmful to children if you make an example of them in front of a classroom when they've got any sort of disability but particularly a learning disability or problems with impulse control (Doctor 1).

Here Doctor 1 not only questions whether an adequate medical solution can be found but implicit in her words is her intent to counteract potential "harm" inflicted on vulnerable children. The solution that she turns to is to diagnose and medicate, possibly pre-empting the inevitable imposition she believes will at some stage appear, as her continuing dialogue suggests:

> I believe that in fact parents are told that if their children don't have an assessment and treatment then it's a pill treatment and usually that's usually not trialled, then their child is either not going to be allowed back in or will continue the same behaviour and will be expelled from school, so there's certainly an implied threat, and that's happened with high school children and also with primary school children, and I'm not sure just how that's presented to parents, but I've heard it from a number of different parents, from a number of different sites, and I'm pretty sure, though I wasn't there, that parents have been told that there's got to be a pill that their child can take, and I've had a sense of that from schools, too (Doctor 1)

When Mother 1 entered the diagnostic scene with her monster-child in tow, Doctor 1's rapid-fire diagnosis may have eventuated, not on the basis of 'expert knowledge' of ADHD symptoms, but on the strength of her *moral judgement*, with her perceptions of toxic school environments overlaying Mother 1's exhortation of her child exhibiting difficult behaviour. The following account of what she remembers Mother 1 saying in the diagnostic event and Doctor 1's response to my probing questions is revealed as follows:

> Doctor 1: his mother brought him along because he was really so *active*, far busier than his two older siblings, and there were also some really out of the family behavioural activities such as violence. He was quite violent to his siblings I think. There was a physical violence, generally easily frustrated and angry and quite *disobedient*, quite noncompliant... so she was wondering if this might possibly be attention deficit hyperactivity, and I was quite impressed by (mother's name) because she had done a lot of reading (about ADHD) prior to coming to see me
>
> Researcher: So his mother, having read about something concerning ADHD wondered, "Is this my child?" and came to you?
>
> Doctor 1: Yes. Yes.
>
> Researcher: So you went through the various steps such as talking to her, and did you actually see any of the behaviors (of ADHD) yourself when he was there (in your surgery) with you?
>
> Doctor 1: Look, I didn't record that I had... oh I've got here he (the child) was very busy at the surgery so we did make a note of it.

It is possible that, by emphasising the word "disobedient", Doctor 1 not only projects the child's fate in schools, but also engages with Mother 1's need for control. With little hesitation, Doctor 1 'officialises' the child as 'ADHD' and prescribes psychotropic medication decisively and swiftly, as Mother 1's account shows:

> The decision was made very quickly and easily. There was no prolonged diagnostic procedure; we just went up there (to the doctor's consulting rooms). Next day he was on it (ADHD medication). We saw a paediatrician. Next day he was on the tablets (Mother 1)

One way of understanding the apparent paradox of the evidence as the basis on which ADHD diagnoses take form, is to liken the diagnostic event to that of a live musical performance. If the doctor actor is thought of as a sole performer playing to an audience of one (that is, the mother actor), she presents in her performance a well practised, personally interpreted score. In the event that she welcomes participation from her audience, the mother actor, then she may hear a request like: "can you play 'ADHD'?", who likewise has her own 'score' in mind.

This analogy, applied specifically to Mother 1 and Doctor 1, continues such that the sole person in the audience presents as:

> A very thoughtful woman and well-read and well-educated woman (Doctor 1)

a self-taught musician. Both actors therefore can be seen as coming to the diagnostic event, each bringing to it their own unique interpretations, which, as it turns out, appear to harmonize. Mother 1 brings to the diagnostic experience her perceptions of her 'monster-child' and her fear of losing her sanity. Doctor 1, brings her image of a 'good mother', and a 'monster-school' awaiting a 'victim-child'.

Further examples of the power of perception are found in the case of Mother 2, who enters the diagnostic experience believing that Doctor 2 "will agree" with her opinion of her son being ADHD. The following excerpt of my conversation with Doctor 2 provides evidence of clinical forthrightness alongside diagnostic uncertainty:

> Researcher:
>
> So, would it be feasible that a child could end up with a different diagnosis depending on the course of action or thinking of the people who first identify the behaviour as outside the normal range? Might their decision or choice of referral make a difference to the diagnostic outcome?
>
> Doctor 2:

> Ah, I suppose so. Yes, it is possible. Yes. But just because there is no specific test for ADHD – well that's OK I can live with that.
>
> Researcher:
>
> If you don't' mind me asking Doctor (name), how is it that that's OK?
>
> Doctor 3:
>
> Well I don't need a piece of paper with a test result on it to diagnose a disease. I don't need that piece of paper. After all, we were treating Pneumonia long before we were looking down microscopes. I have no difficulty with ADHD – it is very clear-cut.

Here Doctor 2 admits that the way in which the child is 'framed' pre-diagnosis may well influence the diagnostic outcome and he further admits that there is no substantive evidence on which he may depend in being certain that the child does in fact 'have' ADHD. Moreover, Doctor 2 states that he "can live with" the uncertainty of his diagnosis. He attempts to justify his position using medical language, like "test-tubes", by associating the diagnosis of ADHD with the testing of "pneumonia". He boasts of doctors' abilities to diagnose without the benefit of evidence or "seeing it". His lack of need for a "piece of paper" because ADHD is so "clear-cut" is a clear paradox. Throughout my conversations with Doctors 1 and 2, neither demonstrates a well-formed "scientific" view of ADHD as the conversation with Doctor 1 suggests:

> Researcher: what is the source of ADHD? From a medical professional point of view, where do you think ADHD comes from, how do you think one acquires it?
>
> Doctor 1: Look, I'll put it very simply because I don't know the answers to this, and I'd say that we probably don't know the answers to this yet, but there are a lot of studies going on looking at the genetic and therefore the neurochemistry basis for this, and I put that in terms that a parent might understand, talking about the messages between cells and how they're chemicals in the brain and so on, and how

> something is *different*, and that some people are really really good at focussing and they can really just track just one thought right along and then there's a whole group of people around that who are very very similar, maybe not as well-focussed, and then I talk to people about the bell curve and some folk down here, might be 3 percent of the population, might be 6 percent of the population, are not so good with focussing but they might be good at some other things, they might be good at juggling several things at once, so that's as I try and describe it to people (Doctor 1)

Here, it is noticed that Doctor 1's attempt to define ADHD is awash with medico-jargon. She says, for example, "I don't know the answers" and then proceeds to claim that there are "studies" linked to "genetic"; "neurochemistry"; "chemicals in the brain" and so on. One interpretation is that her caveat of simplification "for parents" is in fact a reflection of her own 'mixed up' view of ADHD. Indeed, amidst such a cocktail of chemically oriented language, the phrase "something is *different*" stands as a beacon. In this way, "difference" itself could be viewed as an object to which Doctor 1 attaches ADHD, as she contextualizes the child, once again, in toxic school environments. She continues with her explanation of ADHD as follows:

> Also put in the fact that nowadays that we expect children to be put into situations where they've *got* to focus, and perhaps that didn't happen 3 or 4 or 5 centuries ago so that nowadays we expect children to be in a situation that's a little bit artificial, and we call it school and then school's that, because there are this many children and this many teachers, then children who are outside those normal limits will then come to attention, and then we expect children to learn some of the things that we create for them, so in essence it's an artificial situation for probably what is probably an evolutionarily normal person, and we're asking them to perform in a certain way, and so that's as I put it.
>
> Researcher:
>
> So modern day living and modern day cultural expectations have changed to that extent?

Doctor 1:

I think so, yes, I think at least that fits in with my belief system – I think that that's what we do and what we expect of children and that's why I think we get so many referrals from schools to put children on stimulant medication.

From a symbolic interactionist standpoint, Doctor 1's words reveal aspects of her "belief system" and the way in which this influences her perceptions and her actions. The certainty of ADHD as a clinical condition is, it seems, at best overshadowed by Doctor 1's concern for the well-being of the children in the school environment and at the least, completely inconsequential.

Doctor 2 expresses similar school-based awareness, as an excerpt from our conversation suggests:

Doctor 2:

The child has to perform in a structured environment. Maybe we wouldn't see ADHD if it was free range. The (school) structure helps us to see it.

Researcher:

Are you saying then, that the environment has a role in our interpretation of the existence of ADHD?

Doctor 2:

Interpretation? [LONG PAUSE] – well the environment certainly brings it out – yes it brings out the ADHD – but that doesn't mean that ADHD doesn't exist – it is just that we might not see it if we didn't have the structure (of the school).

These words suggest that Doctor 2 interprets ADHD through the lens of the school, and he draws on the power of medical intervention, namely ADHD medication, to connect and empower medical jurisdiction as he says:

Doctor 2: medicine is better able to detect ADHD

> Researcher: How is it that medicine is better able to determine the presence of ADHD given that there is no well-defined pathology?
>
> Doctor 2: Well medication is a good diagnostic tool. We can trial it and see if it makes a difference and if it does, it is useful in confirming ADHD

As such, an official ADHD diagnosis, by providing the means to utilize medication to justify the medicalization of behaviour, in itself suggests yet another paradox: the assessment of the veracity of medication's authenticating power is in the end left to the mothers. The mothers, are left, unsupported and unchallenged, to 'assess', the benefits of medication by means of their perceptions of changes in their children's behaviour; that is, if their monster-children are suitably subdued and brought under control, then this 'proves' that the children are indeed "ADHD".

In examining the mother-doctor partnership, it seems that a model of mutuality is at work. Yet, somewhat ironically, the synergy between the mother and the doctor gives way to the 'expert doctor' whose 'evidence' barely resembles anything "scientific", but rather, is based on interactions with *self*: an ability to "pick it", revealing the ultimate "expert", as Doctor 3's concluding remarks in our interview indicate:

> Teachers? No those comments are not worth the paper they are written on. I don't bother asking them (the teachers) any more. They don't know. It is a waste of time... I can pick it (ADHD)...it is (my) experience that counts. After all these years I can pick it (ADHD) straight away...it's experience. (Doctor 3)

The power of medication: normalizing ADHD

In discussing the role of medication in this study, it is important to clarify that medication, albeit a potent form of medical technology, is for the most part a consequence of diagnostic legitimization, not necessarily the means to it (Conrad, 1992). This is not to say that medication, particularly psychotropic medication, is not a powerful technique in controlling human behaviour. Equally, ADHD medication is not the only drug capable of facilitating medical social control. Recent studies in the sociology of sleep, for example, have not only highlighted a sharp escalation in medically defined sleep related 'conditions' but also a marked increase in the use of medication to control the behaviour of people deemed to have sleep disorders (Williams, 2002a; Williams, Seale, Boden, Lowe, & Steinberg, 2008a). For example, a recent study investigating the sociology of sleep and the use of the drug Modafinil, found a marked expansion in designated 'disorders' and 'illnesses' to which Modafinil could be legally used. Indeed, from a limited number of conditions including narcolepsy, Modafinial has been continually re-defined to seemingly accommodate an ever-growing list of sleep disorders as different as Shift Work Sleep Disorder (SWSD) and Restless Leg Syndrome (RLS) (Coveney, Nerlich, & Martin, 2009).

Of even greater interest in the sociology of medicalization is the phenomenon where Modafinil continued beyond illnesses and disorders into the arena of lifestyle enhancement. More specifically, Modafinil has become conceptualized as a medication to enable wakefulness in 'normal' and 'healthy' people desirous of extending their waking hours (Coveney, et al., 2009). These findings are relevant to the analysis of this study in that they demonstrate the extent to which links may be made between *expectations* of a 'deserved' life-style and the power of individuals' beliefs *in* medication to achieve the control of self and others. As such, it can be argued that the Modafinil study shows a trend toward medical enhancement, a topic that has already attracted attention in the use of ADHD medication. Therefore, notwithstanding the fact that individuals throughout the ages have long engaged in 'enhancement' techniques to 'improve' culturally defined expressions of bodily expectations (Conrad, 2007), Coveney and her colleague's provocative study on Modafinil (Coveney, et al., 2009) is useful to those interested in the sociology of medication because it not only redefines 'wellness' , it makes medical inroads into the medicalization of medicine itself.

As an aside, I point out that, although possibly coincidental, the topic of 'sleeping' features throughout this study; the mothers in this study identify deviance in their infants primarily through their perceptions of 'normal' sleeping patterns in infants. More to the point, however, is the notion that the mothers in this study are well accustomed to a strong association between diagnosis and medication. This is borne out in Mother 2's action as follows:

> (I went to the paediatrician) not just the diagnosis, but for medication... Yeah. He (the paediatrician) was for medication...(The paediatrician was) reassuring. And like he said we can trial it...Well, I kind of left there (the paediatrician's consulting room) feeling like okay, this is the answer. So, this is the answer, we'll get the medication, we're going to tell everybody yep, it's definitely ADHD, he's going to be medicated, and now we can do "blah blah blah", and things'll get better (Mother 2)

These words provide insight into Mother 2's perceptions of the role of medication in the context of her partnership with the doctor. She explains her intent in terms of a diagnostic-medication package. Here Mother 2's words suggest that she initiated her contact with the doctor in order to obtain ADHD medication. She indicates that Doctor 2 was "for the medication". The diagnosis of ADHD, it seems, is almost incidental: she 'sees' her answer not in terms of the diagnostic label of ADHD, but in that which it enables – the medication. Mother 2's intent is therefore satisfied by her partnership by the reassuring and compliant Doctor 2. In short, Mother 2 describes her satisfaction derived from a medical solution for her child's unwanted behaviour. The ADHD medication symbolizes "the answer" that she can "tell everybody", thereby alleviating mother-blame. Moreover, as her child's behaviour is controllable, "things'll get better".

While these words follow a recognizable trajectory of absolution contextualized within her social setting, the comments which show a conduit channelling the flow of diagnostic power are: "It's definitely ADHD, he's going to be medicated". In other words, the illness is officially identified and the treatment is applied. On the basis of this example, it is clear that Mother 2, being both an extension of her child, the patient, and a powerful social force in her own right, is an active participant in the process of medicalization.

From the doctors' perspective, they appear to rapidly make generalized connections between schools, parents and medication. The following example shows how Doctor 1's expectations of the school's expectations of parents, energizes her engagement in the process of medicalization:

> Parents have been told (by schools) that there's got to be a pill that their child can take (Doctor 1)

Here Doctor 1's words suggest that the 'pill' symbolizes a *resource* believed by schools to be effective in achieving social control. In response to this belief, Doctor 1 takes the following action as a matter of practice, as she says:

> So, the normal procedure for me is to try it (ADHD medication) before they're actually at the school (Doctor 1)

While it may at first seem that Doctor 1 is using ADHD medication as no more than a diagnostic tool, it may also be seen as a step of avoidance. That is, Doctor 1's seeming collective experience of stories about schools may be interpreted as her justification for acting as 'saviour'. Doctor 1 can be seen as 'saving' Mother 1 from her "disobedient" and "violent" 'monster-child', and, at the same time, 'saving' the 'victim-child' from the "humiliating", "poorly educated" teachers and 'bully-like' school principals who want a "diagnosis" and a "pill" to socially control deviant children. Ironically, Doctor 1 is quick to provide such a "pill".

In any case, however, this may be interpreted, the point of importance is that the 'mother-doctor partnership', as an object of power, activates the power of diagnosis and medication to 'control' the perceived 'toxic' school environment. Mother 1 explains:

> He has medication to get him through the school day. That is what he has medication for. He has medication to control himself, to be in an environment because the environment doesn't support him to be (name of child) (Mother 1)

At the symbolic level, the purpose of medication is clear. It is a symbol of control, which, when applied to the uncontrollable self, brings relief associated with survival of a hostile environment, unsupportive of the essence of the self: "the environment (of the school) does not support him to be him". At an interactional level, however, Mother 1 displays curious disappointment or insecurities in what may have been a perception of clinical ambivalence embroiled in self-talk of gullibility as she says:

> The first option and only option we were given especially for (name of child) was to put him on Ritalin. We weren't given any other option. We didn't know about any other option. We were gullible and not knowing anything at the time, we did put him on it straight away (Mother 1)

At an operational level, the paradox of the "pill' presents a disparity between the *ease* in which such powerful psychotropic medication is delivered and the diagnostic uncertainty surrounding such actions. It seems that Mother 1 detects this anomaly when she says:

> You expect these people (doctors) to know better than you do. You expect these people (doctors) to have, I don't know, more awareness than you do. And at first, he

> was basically on the tablets before we got the chance to think about it, which is probably my fault. Not that I blame myself or anything like that but you take them to the doctor and that was the option we were given, that was the only options we were given. (Mother 1)

Yet, Mother 1, together with all mother participants, is situated within a broad sociological context where individualism is valued and where medicine reaches into ever-expanding frontiers of human existence. For this reason, the complexity of the mother-doctor partnership, in terms of the power of medication is almost impossible to completely unravel because medical treatment is embedded within the mothers' life experiences including their own, as Mother 4 indicates:

> I've been suffering with depression for years...I've been on medication because I know it evens my mood out (Mother 4)

And in the experiences of teachers, as this teacher's comments show, when she says:

> There's a lot of teachers on depressants. A lot of teachers are on medication themselves. I am. You know, to get through (Teacher of Mother 1's children)

These words show an interesting parallel between the doctors, the mothers and the teachers: each sees "medication" as a way of "getting through". Ironically, "the pill" Doctor 1 speaks of can be visualized as a mechanism bridging each of the three powerful institutions: medicine, home and school. A bridge which becomes 'well trodden, but a bridge which is far from perfect, as Mother 2's comment suggests:

> There was going to be no magic pill. Ritalin was not a magic pill (Mother 2)

Yet, it is the only bridge capable of keeping the monster-child at bay, as Mother 2 eludes:

> He's still on the Ritalin because when he's not, it is much worse (Mother 2)

In finalizing my analysis of the role of medical treatment, I bring attention to three points of interest. These are: firstly, that the doctors appear to make their diagnoses and prescribe ADHD medication relatively rapidly, that is in just one consultation and with negligible external input other than the mothers' accounts expressed at the time of consultation; secondly, in three of four cases, the doctors entrust the management of psychotropic medication to the mothers and as far as the children are concerned, they appear to do little more than provide written prescriptions for the replenishment of more drugs as the mothers require. Mothers 1 and 3 stated, by way of example, that they arranged to obtain replenishment of ADHD medication by speaking with the doctors' secretaries over the telephone. Quite specifically, Mother 1 stated that Doctor 1 provided her with sufficient 'repeats' to ensure replenishment of ADHD medication for two-yearly periods at a time. Cross checking this with Doctor 1's transcript, this was confirmed.

Furthermore, there appears to be minimal, if any, follow-up to such medical action other than a somewhat vague request from the doctors that the mothers 'watch out' for particular side-effects cause by the medication. There is no evidence, it seems, to suggest that the mothers 'understood' how to conduct, record, interpret or report such observations.

Finally, I point out that psychotropic medication was prescribed to the children in the first consultation. Moreover, some seven to thirteen years after the fact, all appear to remain 'medicated', their mothers having sustained their role as medication managers throughout the entire period, with relatively little contact with the doctors.

Aspects of relief

In the transition between the tipping point and the achievement of formal ADHD diagnoses, I posit that the mothers seek relief from their aggravated state. While a number of impressions of relief have already been mentioned in this chapter, further sub-themes gleaned from social interactions throughout the achievement phase are presented. Mother 1's expression of the 'monster-child' demonstrates, firstly, the objectification of ADHD as a sanctuary or haven from feelings of frustration and impending doom. Secondly, the function of ADHD in normalizing the monster-child is discussed. Limited by the scope of this study, there is no intent to theorize or generalize claims of the following 'relieving themes', although the highlighting of curiosities that may prove to be useful for future research are not overlooked.

`Sanctuary'-relief

As seen in Chapter 5, 'stress' and 'blame', viewed in differing ways, are interpreted as driving the mothers to search for a solution to their aggravated state of conflict with their 'deviant' children. With this in mind, I propose that ADHD diagnoses provide a way for the mothers to reconfigure perceptions of 'monster-children' and 'bad mothering' to create '*normal* ADHD children' and 'good ADHD mothering'.

I suggest that the mothers authenticate themselves as 'good' ADHD mothers through their changing perceptions that enable the objectification of their children as 'ADHD'. Consequently, their actions towards their children change from *rejection*, of notions of 'bad mother' to *acceptance* of self as 'good mother'. Such acceptance yields *accommodation*, which, in a circular fashion, reinforces their own transformed image as a 'good ADHD mother', as Mother 4's comments suggest:

> I could now (that I know that they have been diagnosed as having ADHD) handle them (my children diagnosed as having ADHD) better than if they'd been born into another family (Mother 4)

Such mothering transformation is not limited to the mothers but is extended to the family, which was once threatened by being "finished". Now, the home, once a battlefield between the mothers and their "sleepless" deviant infants (as discussed in the initiation phase) through the process of medicalization passes through a metamorphosis to a 'safe place', a sanctuary, a haven for both mother and child, as Mother 1's words suggest:

> This (the home) is his safe place ... it doesn't matter what has happens in the world, this is the safe place where they (my children diagnosed as having ADHD) can be themselves here (Mother 1)

Mother 1's words, "be themselves", elude to the newly 'understood' ADHD self or the 'true self'. In this way the object of ADHD transports the mother-child relationship deeper and deeper into safety extending even beyond the physical constraints of the home to the self, where the monster- child, now 'understood' is soothed by his mother's transformed view of him.

More importantly, Mother 1's words show how ADHD facilitates reframing the way in which the child is viewed, such that ADHD and the child come to be identified as one in the same:

> We technically don't see him in that (ADHD) light because that (ADHD) is him – take him or leave him –you know - this (ADHD) is his safe place... it (ADHD) *is him*, the ADHD in (child's name) *can't be separated* – they're there together – they're (child's name) and for him to be allowed for him to be (child's name) (Mother 1).

As such "ADHD" *relieves* by granting 'permission' for "the child to be seen differently, not only in the home in his infancy, but also into places extended by time and space including the school, as Mother 4 indicates:

> I pointed out to him (the teacher) that if he (her son) didn't have ADHD, he wouldn't be him (Mother 4).

ADHD, therefore, brings about acceptance. The child's behaviours, once creating his 'deviance', originally interpreted by mother 1 as "*ripping* the family apart", are now viewed as 'normal' expressions of being ADHD. Through an ADHD lens, behaviours which are considered intolerable by others, are passively accepted by the 'good ADHD mother as Mother 4's words demonstrate:

> They (my sons diagnosed as having ADHD) would get really, deeply angry and lose control. And often that would involve hitting or shoving, and at times that would end up hurting me. Yeah. I can remember one of them kicked me in the shins. Everyone was so horrified, how can you let your child do that to you? And even now I can't even remember what the fight was over, and I can't remember making a big deal out of it, and I only remember the bruise because of everyone else's reaction to it. So I just took it as oh well, you've lost your temper, and dealt with the temper loss, and moved on from it (Mother 4).

Mother 2's comments explain the process of acceptance even further when she says:

> Before I saw it (the behaviour) as a problem that we needed to fix. Now I see it as just something that I have to accept (Mother 2)

Mother 1 states that before she "understood" her child as being ADHD life with her monster-child was a battlefield as she says:

> He was young, he was young, he wasn't even at preschool, not even at preschool, and I pushed him that was what finally, I was miserable, I was miserable, life was a constant constant battle with him (Mother 1)

Further, when Mother 1 was asked if knowing that her child was ADHD changed her views of him, she says:

> Yeah, I think it does, I think your heart goes out to them a bit more, I think you understand how difficult things are for them, and you understand that if changes could only take place, that life would be so much easier for them (Mother 1)

Normalizing ADHD

Prior to the achievement of ADHD diagnoses, the mothers' conversations are flooded with words lamenting their children's apparent abnormality. In the early stages of identifying the children as 'deviant', evidence is found in mother participant's conversations that suggest a form of lamentation revealed by words like:

> It's horrible, it's devastating, I go grey, you know, why can't my child just be normal? (Mother 2)

and,

> You want them to be normal don't you? You want them to be involved and included (Mother 1)

Although the data are reliant upon interpretation, I suspect that as ADHD is predominantly defined behaviourally, the transformation of the deviant child to an ADHD state delivers the 'normality' the mothers seek: the children become, in a sense "normal ADHD's". Moreover, in achieving ADHD diagnoses, becoming a 'normal' ADHD provides an *explanation* of the difficulties the mothers are experiencing in manageing their children's behaviour, as Mother 2's words infer:

> It's (ADHD is) labelled then…at the time, yeah. It was like there is, this is why, it was like the cause…Yeah, and it's not me, it's not what we're doing wrong, this is the cause. It was kind of like, it gave an explanation (Mother 2).

An explanation of the monster child as 'ADHD' provides 'normalizing relief' as the following excerpt of my conversation with Mother 1 shows:

> Mother 1: …she (the paediatrician) basically just agreed with what I thought were the symptoms and what I saw were the problems
>
> Researcher: Tell me about how you felt about that when she (the paediatrician) agreed (with you) and the diagnosis was made.
>
> Mother 1: There was a bit of relief there actually, you know this, oh well you know there was a reason for it - which is a relief –

The relief Mother 1 speaks of is the re-conceptualization of her child from "monster" to "ADHD" as her continuing account reveals:

> Mother 1: Yeah that you hadn't actually created a monster, you know, there was an excuse maybe - maybe that's it – there was an excuse – there's a label to excuse his behaviour. 'Cos you don't want your children to be "monsters", you know you really don't, obviously, you know that, but yeah no just that sense of relief that this is what it is and this is what we need to do about it and this will make it better – you know that will bandaid syndrome

Words such as " a reason"; "a label"; "an excuse" show how the achievement of ADHD diagnoses negate "the monster" thereby relieving Mother 1 from her self blame attributed to her role in creating "the monster" (as discussed in Chapter 5). Further, phrases like "this is what it is", " this is what we need to do about it" and "this will make it better" are evidence of the interactive nature of *perceptions* influencing *medicalizing actions*, which, perhaps in hindsight, are somewhat ironically nonetheless considered little more than a "bandaid".

Mother 1's choice of the medicalized term: "bandaid syndrome" is telling. It conveys the temporal nature of achieved relief, which is imbued with confusion and contradictions. It seems that mothering tensions, despite initial feelings of relief, are not necessarily sustainable. At first, Mother 1 speaks of "needing an excuse" but later in her conversation, she wrestles with the ADHD label. While acknowledging her child's fusion with ADHD 'personified', she appears conflicted by such acceptance of 'normal behaviour' and therefore, 'accountability', as she says:

> He is what he is and to separate him (from ADHD) you couldn't...he doesn't need an excuse. He doesn't need to say I misbehaved this morning because of my ADHD. If you misbehave whether you're ADHD or autistic or whatever it might be, if *you're doing the wrong thing*, you're doing the wrong thing, there's no excuse. There's no label to excuse that (Mother 1)

Such sentiments highlight the ongoing struggles of the mothers, in dealing with their disappointment in the phase that follows the act of diagnosis.

Maintenance: a "can of worms"

Before moving on from the 'achievement phase', I turn to the third phase that I call 'maintenance'. I emphasise, however, that there are limited data as this final aspect of experiencing ADHD was not central to the original research question. However, some of the mothers' comments evident in the transcripts are worth highlighting, as they provide insight into how the mothers relate their current life situations to their recollections about the period when they first 'knew' that their children were ADHD.

I use the term 'maintenance' as this term implies ongoing 'preservation' of the identification of the children as "ADHD". Following on from the achievement of ADHD diagnoses, and the initial relief that the mothers say they gained, in the longer term it appears to be unsustainable. Mother 1 states:

> Oh well you know there was a reason for it (the "monster") - which is a relief – but it basically opened a can of worms (Mother 1).

Across cases, the mothers all express their own "can of worms" stories about their ongoing experiences of their children 'being ADHD', as Mother 2 indicates:

> I remember kind of coming out (of the doctor's consulting rooms at immediately after the diagnosis) feeling really relieved and kind of thinking right, well, we've got this medication, everything's going to be fixed. And how wrong I was...whilst you might get a label, that's what it is, you've still got to live with it whether it's called whatever it's called or whether it's called 'nothing', you're still living with that child or that behaviour. (Mother 2)

Without exception, the mothers convey that their children's behaviour continues to be problematic and their academic achievement poor, despite their children's diagnostic status and/or their use of ADHD medication. Mother 1 goes so far as to say:

> No, I feel the diagnosis was wrong, I feel that putting him on tablets that weren't going to help him was wrong (Mother 1).

While the data is not entirely sufficient to expand further on this point, one possibility influencing the 'maintenance' of ADHD could be the mothers' *fear* that should their children's medication be withdrawn, along with the 'medical' explanation, the continuing troublesome behaviour and poor school performance may escalate. More so, without the symbol of medication, little would remain to explain their children's ongoing seemingly inadequate if not worsening 'performance' and even less to restrain the reappearance of the "monster" and the return of mothering guilt.

The role of fear

Throughout the maintenance phase, the grande theme of *blame*, which pervades the entire findings but which is most noticeable in the *initiation* phase, appears to shift in intensity from the range of blaming themes mentioned in Chapter 5, to *teacher-blame* and the rising grande theme of *fear*.

Aspects of 'fear' appear on a number of fronts but, for the most part, for the mothers it is associated with fear of catastrophic school failure, which, inturn, is interpreted by the mothers in a number of ways. Whatever form 'fear' may take, however, it seems that the ADHD diagnosis and the mothers' administration of ADHD medication is seen as of greater necessity than ever, in order to minimize the effects of 'toxic' school environments imposed on the 'victim' children. Mother 1 exemplifies this when she says:

> It's (the taking of medication) for school…it's difficult – he has a lot of trouble with the classroom – and it' completely and utterly dependent upon the teacher in the classroom to the extent I would never have believed possible. (Name of child) was hauled up in front of the class and told he was the worst speller in the school– I mean what does that do to a child's self confidence – seriously - …I think his dad forgot to give him his tablet one morning and his teacher said "oh god he's been horrible today" and I went oh god he's probably didn't have his tablet (Mother 1).

"The tablet", is symbolized as the means of survival, for without it, the "horrible" 'monster' can be seen to reappear.

The notion of *learning* and *behaviour* 'fusion', or perhaps 'confusion', appears repeatedly throughout the mothers' conversations. Mother 3, for example, goes so far as to suggest that her child's experiences at school have shaped his 'moral identity'. She states:

> (Name of child) went to intensive reading throughout primary school, he still can't read very well (and his is now in Year 8)…from his year 2 class, this year 2 class, got this bad reputation, all the way through (to today)…ADHD adds an extra dimension because they suffer so much…his (her child's) behaviours grated against her (the teacher). His impulsiveness, his – maybe she had to work harder to get him to do what she wanted, like, you know, to get him to achieve (Mother 3).

Words such as "suffer" and "grated" are situated in proximity to the teaching having to "work harder" to "get him to achieve". Once again, as if a mirror of Mother 3's earlier difficulties in controlling her infant son's behaviour, she 'sees' his teachers' difficulties in a similar way as she, the teacher endeavoured to "get him to do what she wanted".

Likewise, Mother 4 found neither the ADHD label nor its treatment prevented her child's school failure. Referring to a time approximately four years after the achievement of an ADHD diagnosis for her child, and in the midst of a complete school placement 'collapse' Mother 4 indicates the next tier of medicalizing action. She states:

> I felt I had no time because, you know, well obviously the school placement had already been broken down, we'd been to the behaviour centre, this time – this is what, through all the different people coming in and out, we now had okay, we think there's ADHD, we agree, like, we all had (agreed), the ADHD thing was there and accepted (the diagnosis), but now there's more…so we'd better get on with it (to diagnose 'it'). Like, can't wait twelve months, like, that's a whole year. What's going to happen in a year? So I rang her (a recommended psychologist who specializes in Aspergers Disorder) and she agreed and diagnosed (the child as having Aspergers) (Mother 4)

Once again, feelings of desperation lead to Mother 4 initiating medicalizing action. On this occasion, she pursued an 'Aspergers' diagnosis for her child. Similarly, the child was diagnosed as having Aspergers syndrome in just one consultation, this time by a Psychologist 'specializing' in 'Aspergers'. As a result, Mother 4 reported that the medical diagnosis of Aspergers once again provided relief as her social interactions with this 'new' condition appear to provide 'more' for the "something more" that was to be found. She explains:

Mother 4:

Well, this is where I see the big difference between the two (diagnoses of ADHD and Aspergers). Once you've got the diagnosis of Aspergers, there's a lot more support. And a lot more readiness maybe for the school then to change a few things…it's the same behaviour, mind you, nothing's really changed, but they (the school) weren't going to change things when it was just ADHD or when it was 'nothing', but more changes seemed to come about once he was diagnosed with like, an autism disorder, there seemed to be more, um, that seemed to be more of a catalyst for change in their approach.

Researcher:

Can you tell me some examples of what you've noticed?

Mother 4:

Expectations weren't the same of (name of child). (Having been diagnosed as having Aspergers) it wasn't expected that he would be able to like, say, do work for long periods of time. It wasn't expected that he was necessarily going to be able to share and all that stuff. Now the STA (Special Teaching Assistant) was there (assigned to the child) so he got more hours (of direct support). More support and um well, it's kind of like more time was put into maybe teaching (name of child) those skills. Whereas when it was just ADHD flowing around, you know, they still expected him to sit down there.

Researcher:

Why do you think that is?

Mother 4:

Um, I think it's from a lot, kind of unfortunate myths, just about ADHD and about how easy it is to get diagnosed and about how easy it is to get medication, like it's the easy way out… Yeah, because – so they don't – I think it's just, you know, that's what I'm getting at, I think it's ignorance. Like, I don't think people really know…now he is diagnosed (as having Aspergers and ADHD) it is a far better place.

> And I think, kind of having the dual things, I think it's right, I do agree with both things, so the support of the medication (is needed)

Mother 4's beliefs that her child has 'benefited' from an alternative diagnosis do not, however, diminish her belief that her child has ADHD and did not influence her, or any of the medical professionals involved, to curtail or withdraw his ADHD treatment. As such, her child continued to be treated with medication for 'ADHD', but his ADHD identity was traded for the possibly more fashionable 'Aspergers', along with its lucrative benefits. Interestingly, Mother 3 conveyed her beliefs about an 'Aspergers' as being preferable to ADHD when she says: " having Aspergers (in comparison to ADHD) would be "OK" (Mother 3).

The example of "same behaviours" yet 'different label', clearly demonstrates the power of symbolism. I emphasise the seeming phenomena that the 'same child' with the 'same behaviours' is, according to Mother 4, treated very differently, indeed with greater social acceptance it seems, by significant others, than had been the case when he was 'known' as "ADHD".

While the 'maintenance phase' suggests fertile ground for further research, in summation, one of the most interesting aspects of this phase is the mothers' ongoing disappointment in the lack of relief provided by the ADHD. Their ongoing battles appear through blurred expectations of 'ADHD normality' and wavering blaming frameworks. For the most part, inadequate teaching instruction and teacher ignorance are pinpointed as the primary cause of their lack of 'relief'. Speaking of her child's ongoing "frustration" as if it were her own Mother 3 speculates that in an ideal educational setting:

> (The children diagnosed as having ADHD) wouldn't be so frustrated because they'd have, the teachers would be able to give them their instructions one by one, so they

> could follow them properly and not be lumped into five instructions, like, 'blah blah blah blah blah', so they couldn't understand them, they got lost after instruction number one.

This idea Mother 3 suggests that her children's 'ADHD may not be so easily recognizable. She says:

> ...Well, the boys would be, not just the boys, well, it would be boys because the girls have to stay home, but they'd be the hunters, they'd be out there doing. They wouldn't be out there listening badly. Terribly. The restrictions of school and um society, they are still developing strategies to deal with their, their ADHD and being able to channel it (Mother 3).

The role of the mothers

The mothers' actions have been considered throughout this chapter. The analysis of the data shows that, through mother-doctor 'partnership', the act of diagnosis itself is swift, goal-driven and direction oriented, that is, towards 'officialising' the 'condition', ADHD. At this point, the dominant theme of blame, prevalent in the 'initiation phase', gives way to the rising theme of *relief* in the 'sanctuary' of ADHD and in its 'normalizing' effects that reconfigure the 'monster-child' to a 'normal ADHD' patient.

However, following the 'achievement phase', the mothers' feelings of relief appear to be unsustainable. Conflicted by their perceptions of 'normal' ADHD behaviour and the disappointments associated with ongoing school failure, the mothers begin to blame 'the teachers'. Alongside this, the evidence point to yet another rise in mothering stress characterized by disappointment in the power of the ADHD 'label' to convince significant others, such as the teachers, of their children's 'patient state'.

Essentially, this gives way to an overwhelming *fearfulness* associated with the return of "the monster".

The ultimate twist of the achievement phase is not only its brevity represented by the action of the diagnostic event, but also to the extent of the relief it brings the mothers. The experience of the achievement phase, therefore, is largely one marked by dissatisfaction, as Mother 1's descriptive statement captures so well:

> The diagnosis opened a can of worms (Mother 1)

Final remarks

According to the analysis of the data, and in terms of the flow of medicalizing action, the 'achievement phase' can be described as a consequence of the first phase, 'initiation', and a generator of the next phase, 'maintenance', where the 'patient state' of the child is perpetuated. As such, the 'diagnostic event', being a symbol of medical achievement, forms a clear landmark in the medicalizing journey. For this reason, the achievement of formal ADHD diagnoses may be ultimately described in terms of its functionality; as a bridge between initiation and the maintenance of the patient state. To illustrate, the achievement phase can be likened to a sandwich 'filling', of a sticky and pungent kind. Thinly spread (in terms of duration), as Vegemite™ (to rekindle a term used in the preface) in a sandwich often is, the achievement phase's 'stickiness' binds the former and latter phases in a barely noticeable way. Yet despite this phase's brevity, its strength of 'pungency', once again, like Vegemite™, reflects its *binding* and *activating* capabilities. The achievement phase 'binds' the 'mothers' and 'doctors' in partnership with the act of 'initiation', 'activates' the children's 'ADHD' state and transforms not only 'child' but also 'mothering' identities. Since the 'ADHD' children *are* no longer 'monsters' but *normal* 'ADHD's', the 'saviour doctor' and the 'pitied mother' can be seen as meeting one another's needs. The 'ADHD patient' is delivered.

7 Mothering stress

The association between 'mothering' and 'stress', as previously stated, is significant in this study. However, as neither topic was anticipated at the onset, this chapter provides a brief return to the literature to explore some possible ties or associations between 'mothering', 'stress' and, where possible, 'medicalization'. While this does not extend to an in-depth review of the literature, a broad sweep approach exposes some links between the findings of this study, related studies and theories of 'mothering'. Although, towards the end of this chapter, elementary application of the literature leads to some discussion, its primary purpose is to prepare the way for more detailed discussion of the findings in Chapter 8.

Introduction

Exploration of the notion of 'stress', in a broad sense, reveals a subject steeped in rhetoric representative of medicine/biology, psychiatry and popular culture, to mention the least. According the material I have read, today's notion of 'feeling stressed' largely stems from the theoretical work of Seyle (1956) which laid the foundations for the merging of 'biology' and 'psychiatry' to deliver today's "biologic stress" (Cooper, 1983, p. 2). Not at all straightforward, being fused with Freudian interpretations of 'stress' in connection with familial relationships, and a gamut of psychiatric interpretations of 'stress' in relation to mental illness, numerous forms of so-called "stress" have arisen. From these earlier beginnings, so popular has the meta-domain of 'stress' become, that Cooper's (1983) expectations of its longevity, as a topic, are likely to be accurate. However, such views are counterbalanced by others, such as Bracken and Thomas's (2005, p. 97) challenge to Cooper's purportedly overly simplistic view of the 'self' as being little more than the 'the sum of its biological reactivity'. In contrast, they posit the 'self' to be:

> A site of struggle; deeply layered, complexly textured,

From this position, which I take to be harmonious with a social constructionist approach, the entanglement between interpretations of 'mothering stress', and subsequent reactions to it, is not only plausible, it seems to be inevitable.

As stated, re-visiting the literature at this point is purposefully brief. Honing in on the emerging issues in the analyses of this study in the context of broad-based medicalizing trends (Conrad 2007), I note with interest burgeoning research investigating coping strategies for myriad forms of stress disorders (Bright, Hayward, & Clements, 1997). Indeed, voluminous material reflecting the rise in 'stress related conditions' suggests that the mothers in this study are situated within a general trend towards the medicalization of everyday problems (Aho, 2008; Ballard & Elston, 2005; Conrad, 2007) and that 'mothering stress' is but one mode in which this occurs. However, relating this broad context to the findings in this study provides little more than contextual possibilities for even various 'condition' types are associated with 'stress' inducement in differing ways. Studies relating to the social and biological impact of 'stress', for example, vary from reports of the benefit of stress, such as increasing one's motivation and vitality for life (Weaver, 2009), to it being detrimental. Some go so far as to claim that the neuro-chemical responses associated with 'stress' is not only an outcome of 'conditions' but is actually responsible for causing illness itself (Brown, et al., 2009; Sowden & Huffman, 2009) and a range of mental disorders (Fosu, 1992; Lazarus, 1966).

However, despite the variation of positions on 'stress', in narrowing the exploration of the topic of 'stress' further, it is nonetheless of interest that the literature appears to indicate that stress related mental health disorders are, and always have been, weighted towards women (Rogers & Pilgrim, 2005). Moreover, reports of 'stress' in women are commonly associated with 'mothering stress' and implications of moral judgement concerning what causes it, what stress itself causes, and who or what is to blame for the presence and effects of 'mothering' stress.

Indeed, 'blame', in various guises, appears to be central to the discussion of 'mothering stress'. Some go so far as to link 'stress' experienced in the antenatal period of pregnancy with the presence of emotional problems in babies and children (Rice, Jones, & Thapar, 2007). Others claim that 'stress' in pregnancy is responsible for inducing Asperger's syndrome (Epstein, Saltzman-Benaiah, O'Hare, Goll, & Tuck, 2008) or 'ADHD' in the offspring (Van den Bergh & Marcoen, 2004). Studies such as these exemplify the grounding of 'stress' in women's reproductive health and produce strong connections with moral judgement leading to constructs of *mothering guilt*.

Mothering-stress, madness and mothering-guilt

The mothers in this study spoke of fearing "going mad". Placing these fears in the context of broad social trends, I note with interest several studies associating 'women' and 'stress' are commonly couched in mental health language. Whether it is 'psychological distress' (Romito, Saurel-Cubizolles, & Lelong, 1999) or its more palatable antonym, 'psychological well-being' (Baker, Blacher, & Olsson, 2005) 'mothering stress' is not only *pathologized* in mental health terms (McKeever & Miller, 2004) but it enters the realm of 'mothering madness'.

Yet, another critical point of relevance to this study is the connectedness between 'mothering stress', 'morality' with medical outcomes. One need only examine the connection between the *conduct* of mothers during *pregnancy* for example, and the accusation of negative outcomes for their children, to establish this inclination. However, from a sociological point of view, it is not so much that the child is affected biologically that is in question. Rather, it is the power of perception to accuse the mother as perpetrator of her child's 'misfortune'. The notion that 'mothers' are to be blamed for their offspring's' 'conditions' is a powerful one (Caplan, 1998; Hays, 1996). Even so, it is nonetheless a plausible view when examined through a medical lens, which may explain its popularity. More importantly, it may well be largely responsible for setting social 'tone' of 'mothering guilt' a theme of significance in the findings of this study.

The notion of 'mothering guilt' is responded to in the literature in numerous ways. Several studies set out to 'defend' 'mothers while others report on mothers' defence of their 'mothering' by nominating their children's 'problems' as the root of their 'mothering stress' (Beagan, et al., 2005; Landsman, 1998). Mothering children with disabilities commonly reported as being highly likely to impact negatively on 'mothering identities' (Burton, Lethbridge, & Phipps, 2008). Some extend the 'cause and effect' argument by reporting that children's 'conditions' may be responsible for declined physical health in the mothers (Burton, et al., 2008). Studies such as these, however, are also criticized as presenting biased results and erroneous impressions (E.

A. Byrne & Cunningham, 1985). While the work of Oliver and Sapey[96] (1983) and McKeever (2004) express a range of views and issues relating to the effects of mothering children with disabilities, studies such as Read's (1991) and Ryan and Runswick-Cole's (2008) investigation of children with intellectual disabilities, make the important point of numerous belief systems impinging on 'being a mother'.

While the literature is rich with material on the subject of 'mothering performance', a topic of long standing (Lumsden, 1981) and one of particular relevance to this study, I draw on Diquinzio's (1999) comprehensive work on mothering *differences*, and Chodorow's (1978) theorizing of the *role* of women in mothering. These works, although theoretically complex, provide important foundational concepts in determining the relationship between *performance*, *mothering goals* and *self-appraisal* to measure concepts of 'mothering success'. Such ideas are useful, even if used in a rudimentary way. They can be used to review the mothers' perceptions of 'mothering success' (or lack thereof), in relation to their perceptions of 'normality' especially as the mothers frequently speak of feeling frustrated and anxious about the ceaseless nature of mothering troubles. Moreover, as these are conceived and defined within their social contexts, it is arguably the case that the behaviours of the children 'become' problematic to the mothers in accordance with their expectations. Put another way, the children's behaviours are *assessed* by the mothers as being unacceptable to them through the mode of *comparison* and *self- appraisal.*

Once again, such determination is not straightforward. The act of 'judgement' is, according to the views of the mother participants, directed at them via broad social norms and, more specifically, the views of significant others. This is consistent with

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[96] See in particular chapter 4 of their comprehensive book Social work with disabled people (1983)

Thurer's (1995, p. xv) view that "performance" is central to constructions of mothering. She writes:

> Motherhood- the way we perform mothering – is culturally derived. Each society has its own mythology; complete with rituals, beliefs, expectations, norms and symbols...our particular idea of what constitutes a good mother is only that, an idea, not a verity. The good mother is reinvented as each age defines anew, in its own terms, according to its own mythology (Thurer, 1995, p. xv)

Although 'mothering performance' is not defined by the mothers in this study as a static list of duties, their children's performances nonetheless serve as a social 'barometer' by which the mothers judge themselves and feel judged by significant others and broader social norms. It is reasonable to assume this to have been the trend for decades, if not longer. Although Smith's (1995, p. 21) analysis of mothering in the 1950s refers to mothering practices decades previously, it as if these words were referring to the beliefs of the mothers in this study. She states:

> Women were judged by the standard of their mothering. If children's behaviour, manners, dress, cleanliness, sometimes even health, were less than perfect, it was mothers who were held accountable. They could be censured by the wider community through the medium of the church, school or social groups or, at a personal level, by critical relatives. Husbands too were quick to criticize. Dirty children or naughty children were their mothers' failure. For these reasons, out of loving pride, most mothers cared a great deal about how their children looked and behaved...motherhood could resemble an endless public and private test, which women were obliged to pass.

While 'mothering performance' may not necessarily evoke a state of 'stress' for *all* mothers across society, the mothers in this study repeatedly report feelings consistent with those reported elsewhere, including 'exaltation, despair and many other emotions in between' (DiQuinzio, 1999, p. viii).

While the literature 'boils' with material intent on reporting mothering tensions (Armstrong, et al., 2000; Bright, et al., 1997; Miller, 2005; Romito, et al., 1999) it is not so much *that* 'mothering stress' is common, but more so that it is the act of striving to *perform mothering perfection* that drives the mothers' actions. This may also explain, in part, why a perceived lack of 'mothering success' leads to poor self esteem, desperation, and or 'blame'.

According to (Romito, et al., 1999), 'stressors', however sourced, impact mothers' perceptions of their self worth and may lead to maternal depression. Maternal depression, when seen as being an indeterminate "cause and effect" 'trap', is sometimes defined in terms of it being a hindrance to maternal success (Aisenberg, Trickett, Mennen, & Saltzman, 2007; Bright, et al., 1997). An excellent demonstration of this idea is found in Mother 2's cyclic association between 'being depressed'[97] and the identified stressor, this being a combination of her 'difficult to manage' infant, physical exhaustion and medical treatment. She recalls:

> I had a period when I was quite depressed. I was taking antidepressants. He was under a year old. You are so tired. You've got this child that's so difficult to manage. Before he was diagnosed it was sheer exhaustion. (Mother 2)

While the 'biology' of tiredness is plausible enough, the focal point of this comment are the links, in one simple string of sentences, which associates the context of a medical solution to the mother 2's "depression" in the form of psychotropic medication, the child's behaviour being "difficult" and the solution, that is, "he was diagnosed".

In examining related studies, some of which are based mostly on mothers' perspectives (see Malacrida, 2004; Singh, 2004), it is of interest that Bennett (2007)

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found that mothers' of children with ADHD often report feelings of guilt, believing that others *blame* their poor mothering for their children's socially unacceptable behaviour (Bennett, 2007). In addition, Malacrida's (2003) personal experience of mothering a child diagnosed as having ADHD and the experiences of others (Blum, 2007; Kendall, Leo, Perrin, & Hatton, 2005; Malacrida, 2004; Taylor, Houghton, & Durkin, 2008) relays the intensity of mothers' claims of ongoing perceptions of feeling 'judged' in a negative light by others. This is also echoed in Singh's (2004) investigation of mother-blame and ADHD.

In this study, I find significant links between 'mothering perceptions' and medicalizing action. The analyses of the data presented in Chapter 5 and 6 show that across cases, mothering performance features from the mothers' earliest recollections of mothering experiences and it is on this basis that the mothers act. Mother 1, for example, associates her newborn "perfect baby" as evidence of "good mothering" and speaks of her 'mothering demise' by contrasting her earlier success with his toddler "monster" state when, before his diagnosis as ADHD, she feels a failure. Likewise, although Mothers 2 and 3's newborn infants' unsettled behaviours evoked perceptions of 'inadequate mothering performance' from onset, they also attempt to achieve 'good mothering' by following the doctor's instructions. Curiously, when "nothing (that the doctor suggested) ever worked" (Mother 2) the mothers doubted their mothering performance, rather than the medical solution itself. One way of explaining this is found in Thurer's (1995, p. xvi) insightful words:

> The all importance of mother-love has been fuelled by a giant collective wish for perfect mothering.

However, when the attainment of mothering perfection repeatedly fails, 'blame', a topic well represented across qualitatively oriented studies (particularly women's studies, disability studies and family studies), is a relatively common outcome. Moreover, across the breadth of literature, studies concerning the topic of 'blame' as a general theme are prolific. A basic search using 'blame' as a keyword in the University of Sydney's 360-search engine for academic papers, for example, yields 35,760 entries (search undertaken 10 September 2008).

Like most (if not all) qualitative studies relating to the topic of 'mothering-stress', the segregation and categorization of the mothers perceptions of blame is open to interpretation. Furthermore, the condition in which mothering discontent emerges is not always clear. Notwithstanding this, in so far as the mothers' in this study is concerned, the projection of 'self' to their infants, and the struggle between blaming 'self' and blaming 'the child', as highlighted, can be further explored through the work of feminist theorist Chodorow (1978) in her pioneering work of 'mothering'. Chodorow based much of her thinking on the basis that a child's very existence is tied to the source of his emotional and physical sustenance: his mother and her sense of mothering 'success'. Although Chodorow drew on a variety of mothering dilemmas in theorizing mothering and child satisfaction, a specific aspect of her work is of interest in relation to this study. She found that reciprocally, the child's mother seeks reassurance that she is her child's "good mother" largely based on the *performance* of the child. Put another way, when the child is "wrong", for whatever reason, 'mother', in her core 'self', is inadequate. These ideas bring to my mind the importance of the interactive interpretations espoused by the symbolic interactionist approach of Cooley (1902) and his 'looking glass self'.

Few argue that 'doing mothering' is 'all consuming' and relentlessly demanding (Miller, 2005; Wilson, 1993) but Thurer (1995) extends this idea even further by suggesting that unrequited fulfilment of mothering goals in the context of mothering intensity, whatever the context, is the single most powerful agent of *blame.* 'Blame', in turn, is held responsible for spiralling mothers deeper into intensive mothering identities and behaviours. However, Swanson and Johnston (2006) add that mothers actively *alter* their own version of mothering intensity by reconciling it with competing demands within their selective control. In this way, 'mothers' can be seen as changing the emphasis from mothering passivity to assertiveness. While I cannot make any strong case for this from the data in this study, these ideas provide some insight to further extend Thurer's (1995) idea that *mothering stress* invokes perceptions of blame and perceptions of blame lead to actions shaped by those perceptions.

This being the case, in applying some of these general theoretical ideas of mothering to the porous mother-medico interconnectedness so evident in this study, it is reasonable to assume that the mothers' perceptions give rise to actions consistent with the medicalizing framework which endorses medical jurisdiction over their own reproduction and childbirth experiences. After all, according to the mothers' conversations, they have already had their reproductive health subjected to medical scrutiny and continue to respond to their infants through a medical lens, just as they did through pregnancy. Moreover, when the goal of achieving the social status of being a "good mother" is hindered by "imperfect babies" and "monster children", and their growing perceptions of mothering failure mounts, the mothers could be interpreted as selectively reconciling mothering control, an idea in alignment with Swanson, to achieve mothering satisfaction. In a complex interplay between *power* and *dependency*, layered with possible overtones of mutual 'benefit' in the child being diagnosed as having "ADHD", it can be argued that the mothers alleviate themselves of mothering guilt attached to their beliefs of producing a "monster". In this way, through shared *power* in the mother-doctor partnership, the 'blameless mother' and the 'ADHD patient' are re-born.

8 Medicalizing action

This chapter begins by emphasizing the notion of medicalization as a "journey" and concludes by providing a succinct overview of my interpretation of the flow of medicalizing action. In this final section, I have put forward a visual presentation of particular 'milestones' in the children's journey of 'becoming ADHD' by focusing, in particular, on identifying contingencies, contextual circumstances and significant actions. Although I have alluded to several possible social systems at work in influencing mothering ideologies, I have deliberately oversimplified the process of medicalization in this chapter, in order to emphasize a certain simplicity about 'becoming ADHD'.

Introduction

> I read the book 'Hidden Handicap'...he was just around two (years old) then I cried and cried because I realized how hard life was going to be for him (Mother 3).

I lead in to the final discussion of the analysis of this study by repeating these telling words of Mother 3. For me, this excerpt powerfully captures the essence of the findings of this study.

Using Goffman's dramaturgical approach, these words create the medicalizing scene. The 'front stage' is sparsely set. Note the absence (in physical form) of a doctor. A significant prop dominates the stage. Its form is of less interest, however, than the meaning it conveys; it is a popularized 'medical-style' book, symbolizing the power of 'knowledge' and the 'truth' of ADHD. A weeping mother, having adopted such a 'truth', holds it.

In this scene, the weeping mother is not alone. Cradled, not in her arms, but in her 'belief', is her toddler son, barely two years of age. His infancy is no barrier to her certainty of him having a "hard life". He, she believes, is "ADHD". His medicalizing journey has begun.

Continuing the journey

It has been repeated, several times, that the process of medicalization is complex. Throughout the discussion thus far, various images have been used to capture some aspects of the social stratum spotlighted in this study. I proceed with this final discussion by returning to the visual image (introduced in Chapter 5) of a "canoe" named "ADHD", being 'paddled' along a stream of water named "medicalization" and with cargo bearing the 'make-shift' label "ADHD".

A mother paddled the canoe. She alighted, relieved of her 'mothering stress' and affirmed in her 'mothering performance', for she, according to her interactions with self, had not produced "a monster", but an "ADHD". Her child, now reconfigured, was in need of medical assistance and she was intent on "doing something about it" (Mother 1). As the analysis of the data unfolded, in Chapter 6, the stream of medicalization flowed to the banks of "medical officialdom" where a doctor actor awaited the one who paddled. The one believed to be "the expert".

Developing this image a little further, in conclusion, I draw on the characteristics from the natural world to apply to the social world in the following way: a physical stream would be likely to bear a certain course or direction according to the conditions at the time of its emergence and then, throughout its entire existence. In fact, for the stream to exist at all, several factors are likely to have given way to its origin. Rather than such conditions controlling the stream forevermore, however, a symbolic interactionist perspective would suggest that the stream takes on 'a life' of its own', continuously interacting in synergy with its surroundings, yet influenced by the topography and dynamic conditions in which it flows.

Returning to the image of the mother and the canoe, as tantalizing as it may be to blame or applaud the 'mother', depending on one's point of view, the evidence shows that such stream is likely to have emerged from a deeply layered social landscape. This being the case, it is useful to examine the 'groundwater' from which such a stream may have sprang, namely 'mothering stress' and 'mothering performance'.

It has been said several times now, that the mothers operate within their own unique social systems. Their social interactions and actions cannot be analysed in isolation nor can they be generalized. This said, one of the most interesting findings of this study, albeit based on a relatively small sample, is that across cases, the mothers perform the role of 'mobilizing' actors in the process of medicalization. For example, the mothers are the 'first': to 'see' their children's behaviour as problematic; to interpret the child as 'abnormal' and/or 'deviant'; to respond by seeking medical solutions; to instigate, maintain, and in some cases, enforce medical treatment; and, to promote their children's disease label, even if using an 'alias' designation. Indeed, based on the evidence, the mothers' pro-activity in the process of medicalization is indisputable. While some may argue that a formal medical diagnosis could not be achieved without the doctors and diagnostic certainty never has been guaranteed, the data, across cases, indicates that the mothers directly initiate contact with the doctors.

However, it has already been established that the mothers are not isolated 'controllers' in the process of medicalization. They are situated within the broad social context in which they live and the specific conditions that make each of their life experiences and perspectives unique. Therefore, the critical question for a sociological enquiry such as this remains, at least in part, concerned with broad social trends underpinning the mothers' beliefs and actions. Even so, much can nevertheless be gained by reviewing the actual journey of 'the canoe' from onset to diagnostic achievement and, to the extent that it is possible to do so from the data, beyond. As this task involves particular actions, I assign it the name 'the mechanism of diagnosis'.

The mechanism of diagnosis

In determining the course, that is, the 'direction' of medicalization as it presents in this study, the continuum of mothering perceptions and actions could have divided and subdivided a seemingly infinite number of ways. To recapitulate, in Chapters 5 and 6, I presented the findings two of three overlapping 'phases': *initiation, achievement* and *maintenance* and, in Chapter 6, I introduced aspects of the third phase, 'maintenance'. Each phase was interpreted through corresponding grande themes, as shown in Table 4.

Table 4 Corresponding sequential phases and associated grande themes

Phase	Initiation	Achievement	Maintenance
Theme	Blame	Relief	Fear

The progression of these phases, refined through a process of cross checking the mothers' and the doctors' accounts and comparing cases for similarities and differences, provides an overview of the flow of medicalizing action, or, put another way, the 'mechanism' of diagnosis.

The depiction of social 'action' as a 'mechanism', however, may seem contradictory to an interactionist oriented research study. The incongruity, perhaps suggested by language with 'hard science' overtones, such as 'mechanism', lies not in the attempt to do so, but in the nature of defining and isolating particular actions and assessing their importance. Nevertheless, it is one way of synthesizing the data relating to the journey of transformation from 'child' to 'ADHD' object. To this end, the term 'mechanism' need not imply an engineering-style approach, but may be used, as I do, in much the same way as Charon's (2007, p. 128) description of the 'stream of action'. He states:

> When we say that interaction influences our definition of the situation, we mean that, as actors act towards each other, the action of each becomes part of the situation that each actor is defining, and thus each actor becomes a social object to the other. The acts of each are influenced, and the stream of action of each is influenced.

In a similar vein, the mothers' actions, as discussed in Chapters 5 and 6, are inextricably tied to the many ways in which they define their life situations, and, in particular, their children's behaviour.

Synthesizing the flow of action

Given the mothers' interpretation of their contextual circumstances, their medical perspective of ADHD, and the links they have made between their children and "ADHD", their actions are perhaps as straightforward as they are predictable. Indeed, they may be traced through a series of clear steps. These include making an appointment with the doctor, physically taking the child to the doctor's consulting rooms, 'framing' the 'problem' and conveying it to the doctor, remunerating the doctor financially for his service, visiting the pharmacist, making payment for the medication and, for years to come, purchasing ADHD medication and supervising the administration of the medication.

In two of four cases, it also involves the mother actively denying the child knowledge of his diagnosed 'condition' and the nature of the medication he is being administered and in one case, lying to the child, throughout the ensuing years, about the type of medication, and its purpose.

Indeed, if one were to summarize the 'mechanism of diagnosis' as an act of consumerism, then perhaps one could say that 'becoming ADHD' is as simple as the mother 'pays' and the doctor and the pharmaceutical industry 'deliver'. While it is not suggested that all medical professionals behave in this way, it is nonetheless the case that this belief is becoming a popular one, even amongst medical professionals themselves. One doctor, with reference to his colleagues said: "some doctors are nothing more than human Ritalin vending machines" (General Practioner, Sydney, November 2009). Such a linear view of 'consumption' would, however, overlook the possibility of various 'currencies' and deliverables being sought and achieved, and multiple streams of action at work in the process of medicalization, as suggested in Chapters 5 and 6.

Returning to the flow of action and putting aside possible paradoxes, the data nevertheless point to two straightforward contingencies underpinning the apparent 'ease' of transformation. The first of these involves feelings of "stress" and the second, the mothers' and, through the mothers, the doctors' reactions to children's behaviour.

Although individual circumstance of the mothers vary across cases, from 'blindly' migrating to Australia, recovering from marital separation, experiencing marital discord or 'expecting' one's child to be born ADHD midst the chaos of one's own "disorganized" 'ADHD state', it is significant that each of the mother participants recall feelings of "stress" just prior to the birth of their children.

Simultaneously, whilst in a state of feeling stressed, it is noteworthy that the mothers speak of an existing set of beliefs of the 'condition' ADHD.

With these two points in mind, and while it may be assumed that the mothers may have 'knowledge' of other disorders, it is nonetheless conspicuous that the mothers convey their knowledge of ADHD revealing a *medical* perspective, which they say they absorbed from a range of multi-media sources and societal trends, is conspicuous.

Therefore, in formulating 'the mechanism of diagnosis', these two elements; firstly, 'stressful circumstances' and, secondly, 'pre- existing' medical perspectives of ADHD (and its less clear links to the media), may have provided fertile ground for the formation of 'the stream' of medicalization so named 'ADHD'.

At this point, it is reasonable to say, however, that 'the stream', although it may be directed towards 'ADHD', lacked momentum. The first signs of actual medicalizing 'energy' appear when the mothers' encounter difficulty *controlling* their infants' behaviour as depicted in Figure 6. To recapitulate, although it may be of interest that this takes the form of sleeping behaviours, the description of the behaviour is not considered to be as important as the mothers' belief of their children's abnormality, which, in due course, the mothers identify as evidence of 'deviance', is interpreted as requisite of a medical solution.

Moving on, and in the context of the mothers "tipping point", feelings of desperation and the search for relief appear to empower the 'stream'. It rapidly gains momentum as the mothers gain control of "the monster", and, reconfiguring him as an "ADHD", they 'paddle' towards the doctors and the medication they 'promise' to provide.

Proceeding to the 'achievement phase', the data provide evidence of a clear 'engagement' or 'partnership' between the mothers and the doctors. The doctors, as if waiting on the bank of 'the stream', welcome the mothers' momentary pause of diagnostic affirmation. In this study, the doctors admit relying solely on the mothers' accounts of the children's behaviour. Even though such accounts seem mostly inconsistent with the indicators of ADHD found in the DSM IV, the doctors nonetheless formally diagnose the children as having ADHD and, at the same time, prescribe ADHD medication.

The mother-doctor partnership does not 'end' at this point. The doctors appear to elevate the mothers' role to 'medication manager', or "pseudo-nurse". While such a role may be commonplace across a range of illnesses, the importance of this point centres on the nature of the medication: psychotropic medication, prescribed the to child participants of pre-school agree. Not only are the mothers relegated the duty of administering such medication, but they are left to 'assess' its benefits and to, at call, request repeat prescriptions when they deem it necessary. In this way, the mother continues to define 'ADHD'.

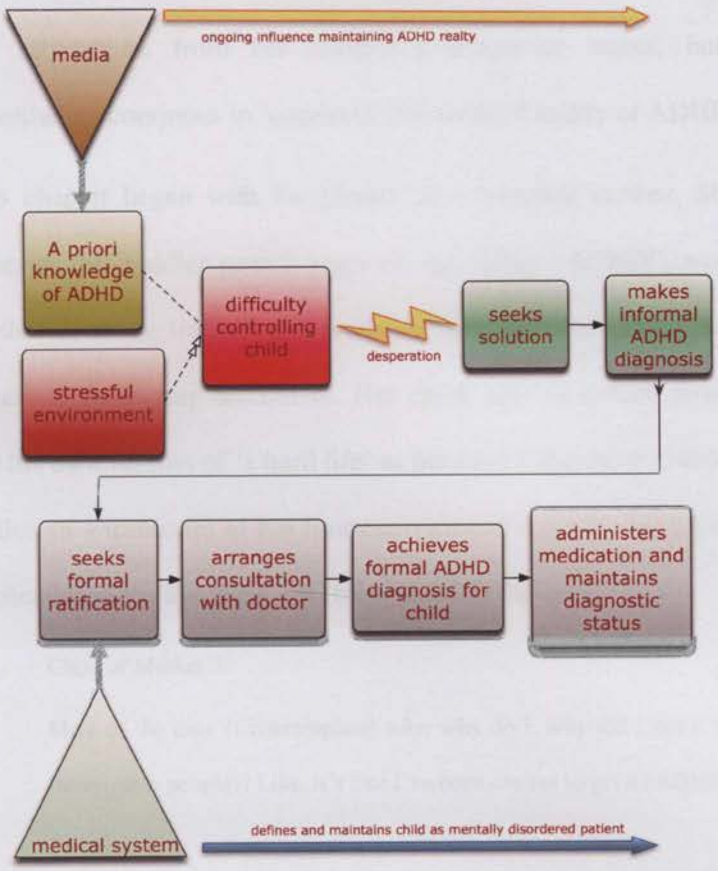

Figure 6 The mechanism of diagnosis illustrating influences directing the course of action in the process of medicalization.

While Figure 6 highlights the process of medicalization with greater clarity in terms of front stage behaviour of 'the mother' as central actor, it does not encapsulate the multitudinous perspectives and interactions of key actors in influencing the flow of action. The analyses in Chapters 5 and 6 discuss particular themes alluding to several possible avenues, I contend that all is irrelevant without the mothers' pronouncement of "ADHD" in her interactions with self, which is the 'decisive moment' authorizing the child's objectification and subsequent transformation.

In concluding, it is worth re-visiting Mother 1's "the can of worms" experience as she reflects on 'paddling the canoe'. Like the other mothers, she enjoyed neither relief nor satisfaction from her children's diagnostic status, but, with her doctor, nevertheless continues to 'construct' the medical reality of ADHD.

This chapter began with the picture of a weeping mother. She wept because she believed that toddler near 2 years of age, being "ADHD", would have a hard life. Mother 3, at the time of this research, continues to 'paddle the canoe' through the waters of mothering discontent. Her child, now seventeen years of age, has indeed had his own version of 'a hard life' as have her subsequent children. I conclude with a section of a transcript of her fourteen-year-old son who has been treated with ADHD medication since age three. Of 'being ADHD' he says:

> Child of Mother 3:
>
> Most of the time (I contemplate) *why*, why do I, why did *I* get it (ADHD) and not them (other people)? Like, it's like I've been *chosen* to get it (ADHD).
>
> Researcher:
>
> And what's the answer to that? Who chose you? What's behind that?
>
> Child of Mother 3:
>
> It's like just someone's, like, someone's just like *chooses*, like, chooses who *lives* and *dies* [long pause] has like chosen that *I* have this *disease* and *they don't* have it.
>
> Researcher:
>
> Who's that someone?
>
> Child of Mother 3:
>
> Probably God, if there is God [long pause]. It's like, when, like I was *chosen*, like, when I was injected with something saying they're (me and other children so diagnosed) going to have this disease and let's see how they go with it. Yeah, like it's an experiment to see if I get treated *different* or something.

While the transcripts of each of the mothers' children, relating to their experiences of "being ADHD", await detailed analysis and possible exploration in future research, my conversations with the children thus far suggest similar sentiments of disappointment, if not despair, in their journey as silent passengers in the canoe so named "ADHD".

9 Conclusions and Areas of Future Research

This short concluding chapter highlights the contribution that this study has made to the understanding of the social processes at work in 'becoming ADHD'. Some tentative contentions, implications and limitations of the findings, and suggestions for further research are presented.

Limitations

Before highlighting the achievements of this study, I begin by pointing out that, like all studies, this study is not without its limitations. The comments which follow do not claim to be a critique of such, for qualitative studies characteristically can, and do, approach the gathering and analysis of data in very different ways, not to mention the range of possible approaches and interpretations by individual researchers. I do make mention, however, that the data, which could be described as being ' rich and dense', does relate to a relatively small sample, with families drawn from varying social backgrounds and with varying degrees of engagement in participation. Therefore, as stated, it would be inappropriate for generalizations to be made. Clearly, the arguments presented require further empirical investigation to confirm possible trends. Furthermore, in drawing conclusions concerning the views of the participants, it is also worth noting that the 'diagnostic event' occurred several years before the time of the interviews. The point has been made, however, that recollections such as these are nonetheless valid, as they 'exist' in each of the participant's current reality.

Contentions and future directions

With regard to this study's adding to previous sociological enquires of ADHD, it can be said that the qualitative approach taken and the use of qualitative interviewing as a technique, has exposed aspects of complexities entwined in the multi-dimensional social creation of ADHD 'meanings'. Moreover, the analysis of the data shows that these 'meanings' are involved not only in the obvious transformation of the children so diagnosed, but, perhaps as importantly, to influence the formation of mothering identities.

More specifically, I begin with the contention that the notion of 'mothering identity transformation' is one of the key 'openings' of the findings of this study. While numerous possibilities for further exploration await, it is the transformation from a 'mothers of *monsters*' to 'mothers of *ADHD patients'*, that is perhaps the most important conjecture to be made. This being the case, the unexpected finding of the role of the mothers as 'initiators' (rather than the teachers as was first thought to be the case) provides the pivotal point of contrast to existing trends placing schools in this role. Moreover, it serves as an excellent example of the *research process* at work (as explained in Chapter 4), where a shift in the focus of this study was required. This important finding could represent a shift from school/teachers to 'mothers'. Further empirical evidence could provide clarity on this point.

Further, related to the notion of the transformation of mothering identities, the findings suggest that the 'condition' of 'ADHD' acts as a powerful symbol of 'normalization', as seen in Chapter 5. While this can be seen as an interesting 'twist' to conflicting portrayals of ADHD as a mental health 'condition', the importance of the notion of a designated medical problem or 'disability' acting to 'normalize' an individual ought not be overlooked. Indeed, this possible phenomena could be further played out by making links with other disciplines, such as is found in the vast volume of theoretical work found within the domain of disability studies[98].

Honing in on the evidence found in this study, I find it plausible that 'ADHD', as a symbol of transformation, may have been used by the mothers and the doctors to objectify the children in order to reconfigure and disempower 'the monster' and conversely, empower the mother and the doctor partnership. This idea is underpinned by my interpretation of a shift in the blaming themes of 'mother-blame' and 'he-blame' 'child-blame' to 'brain-blame', and underscores the relationship between 'ADHD's' transformational 'power' and actors' interpretations of it. In drawing on feminist writings, such as Chodorow's (1978) idea of the child as an extension of the mother figure, and my own speculation that ADHD medication may be seen as an extension of self-medication for the mothers, some exploratory links could be made to mothering ideologies.

In addition, although this study focused on the social processes at work in 'becoming ADHD', the importance of 'ADHD', as a specific mental disorder label, could be investigated to reveal more about the 'power' of transformation. Additional research could reveal more about whether any one particular disorder, such as ADHD, is of the essence, or whether another disease label could also achieve similar social results. Put another way, the notion that the 'canoe' so named "ADHD" could be interchanged with another label such as "Aspergers" and achieved similar transforming properties could be very interesting. Taking the examples of Mother 4's narrative of her experiences with the additional "Aspergers' diagnosis, and Mother 1's contriving a pseudo-disease label of 'Kidney Disorder' in preference to 'ADHD' could be drawn

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[98] My general reading of the discourse relating to theorizing social interpretations of disability (Hughes, 2007; M Oliver, 1996; Shakespeare, 2005), and 'identity transformation' discussed by Swain and French (2000) and Swain and Cameron (1999), suggest that this may be useful.

on to examine possible wide spread of beliefs concerning social reactions to different forms of physical illnesses, disabilities and mental illnesses. Moreover, the notion of whether there exists a 'hierarchy' of social inclusion/exclusion of particular disease labels could provide the basis of future studies.

Finally, even though much has been said in relation to the motives/role of the doctors and the 'mother-doctor partnership', many questions remain. The doctors interviewed in this study arguably use their power of 'pronouncement' in the diagnostic process, not so much to identifying and treating 'illness' per se, but as means of social support. A possible shift in the 'doctor-expert' model to 'mother-expert', alongside perceptions of 'toxic' school environments, may suggest that 'medicalization' provides a means of 'protecting' children who appear to be 'different', while, at the same time, alienating them. In this respect, making a case for ADHD, or verifying the medically treatable 'condition' known as ADHD as it occurs in this study, appears to be characterized by an apparent paradox whereby a 'medically' defined and treated ADHD, cloaked in 'dysfunctional brain' rhetoric, relies neither on pathological 'evidence' nor on psycho-medico 'knowledge'. Rather, it relies on the strength of the mother-doctor partnership and the social interactions therein.

Although several questions are enfolded in the discussion thus far, I draw this study to a close by presenting the following questions as the basis for future research as follows:

- With regard to Conrad's (2007) assertion of 'ADHD' as an example of the expansion of medicalization in various directions, what sociological changes have taken place that may have contributed to this being the case? In relation to this question, have the parameters/'understandings' of "childhood" itself, once largely defined by institutions such as education and medicine, shifted?

Further, if 'ADHD' continues to diversify, could this be understood in terms of other changing social trends?

- Drawing on orientations from postmodern feminism in relation to 'mothering', what factors influence 'good mothering' perspectives in relation to perceptions of offspring 'imperfection'? Can any links be made to fundamental issues and conceptualization/s of 'disability', the embodiment of 'perfection' and social behaviour?
- What are the social outcomes of medicalizing women's reproduction? What are the social and ethical outcomes of characterizing particular social groups as genetically defective? Is it possible to theorize reproductive identities using a 'medicalization' paradigm?
- To what extent does bio-medical technological development and accessibility of information influence interpretations of human difference? In what ways is this responsible for shifts in 'power' via the role/ determination of the "expert"?

One final question remains, but not before restating that the central tenet of interactionism, that is, that 'meaning' is derived by the interactions with 'self' and 'others' has proven to be a most appropriate framework for this study. It has enabled the sociological exploration or certain ironies involving the actions of significant actors, each of whom appear to be unaware of the possibility of having been influenced by their own unique social construction of ADHD. Finally, if one were to conceptualize the enactment of an ADHD diagnosis using Goffman's dramaturgical approach, one is likely to visualize three actors engaging in social interactions within the setting of the doctor's consulting room; the actors being the mother, the doctor and the child. Scrutiny of the scene may, however, suggest more likely a two-person front stage act involving only the mother and the doctor. The child participant being a silent actor with no 'lines' to say: that is, one who 'enters' the diagnostic 'stage' as an ADHD 'prop'. This sets the scene for my closing question:

- What are the social ramifications of having been diagnosed with a 'condition' such as ADHD, for the individual concerned? How can the rights of the child be further explored?

Final remark

This qualitative study, as highlighted, has been a process 'at work' in itself. My thinking, as researcher, has likewise evolved. The analysis of this study presents a 'glimpse' of the social complexities surrounding ADHD, some of which may have otherwise gone unnoticed. In particular, it has shown much about the power of social interactions and perceptions in initiating, achieving and, to some extent, maintaining ADHD diagnoses. The diverse nature of the questions that remain, suggest a broad range of enquiry possibilities including theorising 'mothering' and exploration of social directions in 'medicalization'.

Epilogue

> Whenever a doctor cannot do good, he must be kept from doing harm. Hippocrates 430 BC

I reflected on this ancient quotation, attributed to arguably the most memorable physician of all time, whilst sitting in a doctor's surgery directly observing the diagnosis of a fourteen-year-old boy. It was November 2007 and I was gathering data in my role as a doctoral researcher.

The diagnosis was quick, especially in view of what was to come. It lasted just 13 minutes, from entry to exit. In this time, the boy acquired, in the official sense, a new identity: he was 'ADHD'.

Having witnessed the boy with his mother in the waiting room prior to their consultation, I wondered whether the diagnosis had already been made, at least informally, some time before the doctor's appointment was even made. The boy, in asking his mother why he was visiting the doctor, was told:

> 'You've got ADH...it's something wrong with your brain. I saw it on the Internet. You've definitely got it. You got it from your father. The doctor will tell you too...your wiring just isn't right in your head'

The consultation began with the doctor listening to the boy's mother describe how stressful life was for her, a restaurant operator working long hours in a fledgling business. She described the fourteen year old as lethargic most of the time and how this made life very difficult for her. She said that he did not want to do his homework and that he did not want to do anything at all except in play on his computer. Her son silently stared, his pimply face turned towards his feet scuffing the carpet. After administering for the next six weeks. If she was surprised to have not been given a prescription, she did not show it. The event was over. Mother was right. Doctor agreed. An 'ADHD child' was born, there in the doctor's room, before my eyes, swiftly and definitively.

Immediately afterwards, I was invited to speak with the doctor alone. I asked him about additional information or evidence on which may have influenced him in favour of an ADHD diagnosis. He confirmed that there was none, saying that he relied on his ability to 'pick it". With more than one thousand children currently on his ADHD caseload, all of whom he himself claimed to have diagnosed as having ADHD, he said that so much more was to be done about 'the problem' as he was busy diagnosing children as ADHD, he had barely enough time to monitor those whom he had already diagnosed.

The doctor farewelled my visit by saying:

> It's been good that you came. We need to get the word out about ADHD. Come back another day and I'll tell you more.

Vividly etched, thoughts of this unique experience as a researcher remain; on the basis of the mother's account of her perceptions of her son's behaviour as being indicative of ADHD, and without further enquiry or assessment by the doctor, the child, in my presence, was formally diagnosed as having ADHD.

In addition, medical treatment was administered via trial packs of psychotropic medication, sufficient for daily use for a period of six weeks. The mother, the assessor, would report on its success.

This case of an ADHD diagnosis led to my perception of this being a powerful example of the process of medicalization. That is, a mother's account of her listening, with still not a word from the boy, the doctor asked his mother what she thought the problem was. She replied without hesitation:

> I reckon he has "ADH".

The doctor paused; cast his eyes on the boy who was still looking downwards and then leaned forward. The boy glanced at the doctor whose penetrating stare through thick black-rimmed glasses captured his attention. With stethoscope dangling, as if dividing the two, the doctor said:

> Yeah I think you're right. He has ADHD.

He went on to draw a simple sketch of three horizontal parallel lines broken in the middle and not matching up.

> Look, I'll explain it like this. The messages in your brain aren't matching up. They are starved of the chemicals they need to work properly. We need to feed them and then things will be better. I will give you some medicine which will feed the neurons in your brain. Let's give it a go.

The doctor turned to the mother saying 'I can see courage in his eyes'. Apart from a shrug, the boy did not immediately respond. His mother smiled. "He's quiet" the doctor added, having not heard the whispers between mother and son just moments before, whilst he was busy on the floor, with his head buried in his cupboard rummageing for sample boxes of pills.

> Mum this stuff won't hurt my brain will it? Like, it won't do anything bad to me will it?

His mother quickly replied:

> No, doctor wouldn't give us anything that was bad for us. Would he?

The boy's mother clutched the quickly hand written doctor's note which described the escalating dosage combinations which she was given the responsibility of

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perceptions of her child's deviant behaviour as being ADHD, and the doctor's reliance on her account, led to her son being categorized as having a mental illness or disorder of an ADHD kind.

Despite various claims relating to the malady of children's behaviour so named "ADHD", the extraordinary rise in the prevalence of ADHD continues. It does so, along with numerous other problems identified as syndromes, illnesses or disorders relating to behaviour, learning, psycho-intellectual states or matters concerning the objectified body in the continuum of life experiences. As the Chinese poet 屈原 (Qu Yuan) said, in his famous poem〈離騷〉 路漫漫其修远兮、吾将上下而求索 [lù màn màn qí xiū yuǎn xi wú jiāng shàng xià ér qiú suǒ]:

> Long, long had been my road and far, far was the journey; I would go up and down to seek my heart's desire. The way stretches endless ahead, yet I shall search though heaven and ground.(Qu, 270 BC approx)

So too, the mothers in this study are today still paddling the 'canoe', with their cargo in tow. In a sense, you, the reader, and I, have surveyed the landscape of their journey, from the vantage point of this study.

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Appendix I

An image of a dog portrayed as having ADHD

An excerpt from All dogs have ADHD (Hoopmann, 2009, p. 2)

An ADHD child may not sleep as much as his parents would like.

Reproduced with the permission from Jessica Kingsley Publishers, 116 Pentonville Road, London N1 9JB, United Kingdom.

Appendix II

An image of a the poem Fidgety Philip

The Story of Fidgety Philip (Hoffman, 1845), by Henirich Hoffman

Second Stanza:

See the naughty, restless child,
Growing still more rude and wild ,
Till his chair falls over quite.
Philip screams with all his might,
Catches at the cloth, but then
That makes matters worse again.
Down upon the ground they fall,
Glasses, bread, knives forks and all.
How Mamma did fret and frown,
When she saw them tumbling down!
And Papa made such a face!
Philip is in sad disgrace.

Obtained from the public domain
http://images.google.com.au/images?q=fidgety+philip&oe=utf-8&rls=org.mozilla:en-US:official&client=firefox

Appendix III

Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder

Excerpt of the diagnostic criteria for Attention Deficit Hyperactivity Disorder (American Psychiatric Association, 2000)

Either (1) or (2):

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

Inattention

1. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
2. often has difficulty sustaining attention in tasks or play activities
3. often does not seem to listen when spoken to directly
4. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
5. often has difficulty organizing tasks and activities
6. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)

7. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)

8. is often easily distracted by extraneous stimuli

9. is often forgetful in daily activities

2. six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

1. often fidgets with hands or feet or squirms in seat

2. often leaves seat in classroom or in other situations in which remaining seated is expected

3. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)

4. often has difficulty playing or engaging in leisure activities quietly

5. is often "on the go" or often acts as if "driven by a motor"

6. often talks excessively

Impulsivity

(g) often blurts out answers before questions have been completed

(h) often has difficulty awaiting turn

(i) often interrupts or intrudes on others (e.g., butts into conversations or games)

2. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

3. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

4. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

5. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Code based on type:

314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criteria A1 and A2 are met for the past 6 months

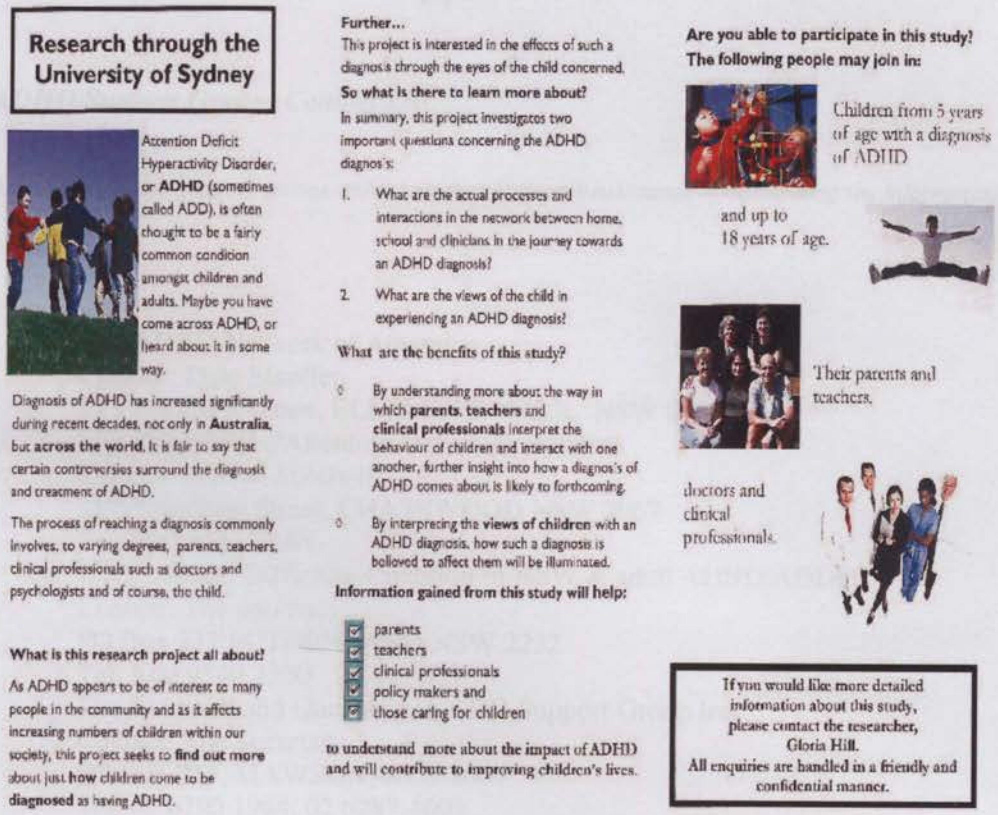
314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if Criterion A1 is met but Criterion A2 is not met for the past 6 months

314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months

Appendix IV

A brochure produced to invite expressions of participation interest

A reproduction of the inside cover of the brochure I produced in 2007 used to introduce this study.



Research through the University of Sydney

Attention Deficit Hyperactivity Disorder, or **ADHD** (sometimes called ADD), is often thought to be a fairly common condition amongst children and adults. Maybe you have come across ADHD, or heard about it in some way.

Diagnosis of ADHD has increased significantly during recent decades, not only in **Australia**, but **across the world**. It is fair to say that certain controversies surround the diagnosis and treatment of ADHD.

The process of reaching a diagnosis commonly involves, to varying degrees, parents, teachers, clinical professionals such as doctors and psychologists and of course, the child.

What is this research project all about?

As ADHD appears to be of interest to many people in the community and as it affects increasing numbers of children within our society, this project seeks to **find out more** about just **how** children come to be **diagnosed** as having ADHD.

Further...

This project is interested in the effects of such a diagnosis through the eyes of the child concerned.

So what is there to learn more about?

In summary, this project investigates two important questions concerning the ADHD diagnosis:

1. What are the actual processes and interactions in the network between home, school and clinicians in the journey towards an ADHD diagnosis?
2. What are the views of the child in experiencing an ADHD diagnosis?

What are the benefits of this study?

- By understanding more about the way in which **parents**, **teachers** and **clinical professionals** interpret the behaviour of children and interact with one another, further insight into how a diagnosis of ADHD comes about is likely to forthcoming.
- By interpreting the **views of children** with an ADHD diagnosis, how such a diagnosis is believed to affect them will be illuminated.

Information gained from this study will help:

☑ parents
☑ teachers
☑ clinical professionals
☑ policy makers and
☑ those caring for children

to understand more about the impact of ADHD and will contribute to improving children's lives.

Are you able to participate in this study?
The following people may join in:

Children from 5 years of age with a diagnosis of ADHD

and up to
18 years of age.

Their parents and teachers.

doctors and
clinical
professionals.

If you would like more detailed information about this study, please contact the researcher, Gloria Hill.
All enquiries are handled in a friendly and confidential manner.

Appendix V

ADHD Support Groups Contact List

A list of the ADHD support groups which I contacted to seek assistance in distributing the information brochures.

1. The ADHD Network of Australia
   Contact: Dale Stauffer
   12 Chehalis Avenue, ELERMORE VALE. NSW 2287
2. The Hyperactive/Attention Deficit Association
   Contact: Roslyn Mitchell
   15/29 Bertram Street, CHATSWOOD NSW 2067
   Tel: (02) 9411 2186
3. The Learning Difficulty Coalition of NSW & adult ADHD:ADDult
   Contact: The secretary
   PO Box 472 SUTHERLAND NSW 2232
   Tel: (02) 9540 3300
4. The Canberra and Queanbeyan ADD Support Group Inc.
   Contact: The Secretary
   PO Box 717, MAWSON, ACT 2607
   Tel: 02 6290 1984, 02 6287 4608

Appendix VI

An invitation to speak about this research in process to health professionals

A copy of email correspondence from Himali W (2008) taken from my computer.

From: Himali W <ihimali@yahoo.com.au>
Date: Friday, 9 May 2008 10:25 PM
To: Gloria Hill <gloriahill@learnsol.net>
Subject: Re: ADHD speaker request

Dear Gloria

You're very welcome !! I have already found an alternatve time. We are having the Baulkham Hills children's interagency at the Baulkham Hills Council, would you be available to present about ADHD at this interagency?
It's on 22nd May at 9.30 -12.30. You can present for about half hour (knowing that you must be very busy).

Let me know if you will be available. It would be a great pleasure and honour for us to have you, If you can come let me know about the outline of your presentation. The workers hardly get access to medical related information so it would be very useful for them I know they co suffer not having access to much information on ADHD and having children who are medicated through wrong diagnose etc. So it would be great if you could inform them about your research information.

Hopefully that you will be free with warm regards
Himali

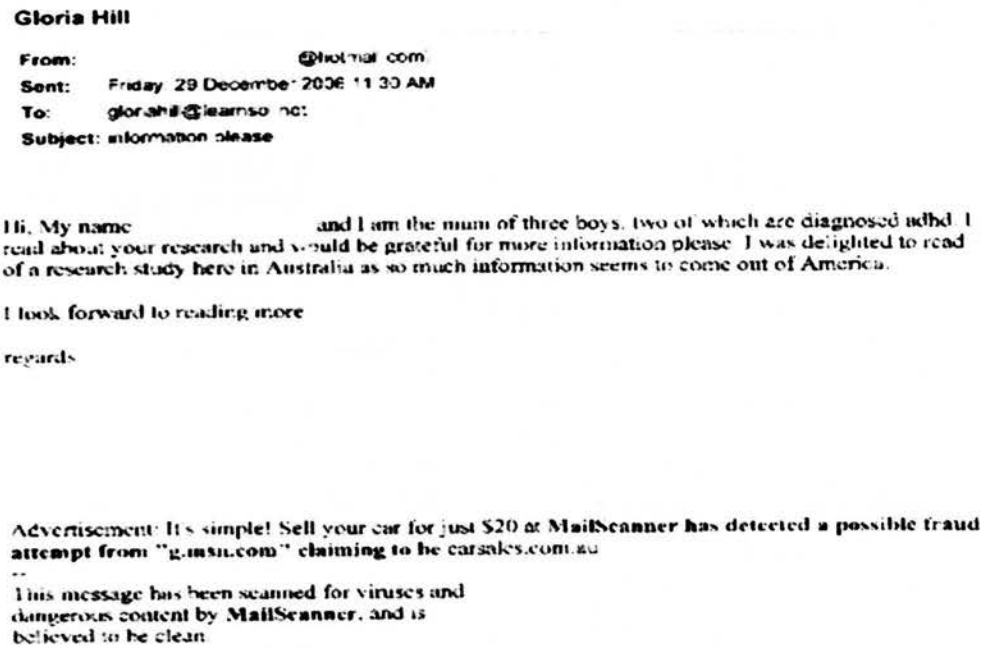
Gloria Hill <gloriahill@learnsol.net> wrote:

> Thankyou for your kind words Himali ' I would be my pleasure to make a presentation some time in the future.
> Gloria
>
> On 21/04/08 5:27 PM, "Himali W" <ihimali@yahoo.com.au> wrote:

Appendix VII

Communication by email from Mother 1: expression of interest

An email from Mother indicating her interest in participating in this study



Gloria Hill

From: @hotmail.com
Sent: Friday 29 December 2006 11:30 AM
To: glorahill@learnso nc:
Subject: information please

Hi, My name and I am the mum of three boys, two of which are diagnosed adhd. I read about your research and would be grateful for more information please. I was delighted to read of a research study here in Australia as so much information seems to come out of America.

I look forward to reading more

regards

Advertisement: It's simple! Sell your car for just $20 at **MailScanner has detected a possible fraud attempt from "g.msn.com" claiming to be** carsales.com.au

--
This message has been scanned for viruses and
dangerous content by **MailScanner**, and is
believed to be clean.

Appendix VIII

Parent/guardian participant information Statement

NSW 2006 AUSTRALIA

Faculty of Education and Social Work A35
College of Humanities and Social Sciences

PARENT/GUARDIAN PARTICIPANT INFORMATION STATEMENT RESEARCH PROJECT

The mechanism and impact of the medicalization of behaviour in children diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD:
A Sociological study of teachers and networks in Australian Schools

You and your child are invited to participate in a research study concerning Attention Deficit Hyperactivity Disorder (ADHD). Consent is voluntary.

The research study is being conducted by Mrs Gloria Hill, a post graduate student of the University of Sydney, and will form the basis of a Doctor of Philosophy degree under the supervision of Professor Trevor Parmenter and Professor Barbara Fawcett, Faculty of Education and Social Work, University of Sydney, NSW, AUSTRALIA.

The purpose of the study is to explore the way in which children come to be diagnosed as having ADHD. Further, this study aims to contribute towards a more complete understanding of the role of the school in this process and the impact of experiencing an ADHD diagnosis for the child.

To achieve this, you and your child and those connected with your child in respect to the diagnosis, are invited to participate in this study. The study will involve two approaches:

1. Individual interviews with you, your child and up to three other adults who may include your child's teacher/s or school personnel and clinical practitioners such as doctors and psychologists.
2. With your permission, access to documents relating to the ADHD diagnosis such as reports and notes held by yourself, the school and your child's clinicians for the purpose of viewing and note-taking.

Your participation in the study and that of your child will involve one and possibly two interviews each of approximately one hour duration. If your child is better able to manage shorter time intervals, such as three twenty minute intervals, this will be arranged with you and deemed to total one complete interview. The total interview time for he second interview may be requested if and only if the researcher considers that the results of the study will be enhanced by a second interview.

Each interview will be conducted on an individual basis, where beliefs and recollections about ADHD will be explored. Although inaudible to you, you may be in full view of your child's interview or alternatively, you may nominate a friend or relative to take your place, to offer support or assistance should the need arise. With your permission, the researcher will also have a colleague in full view of the interview, although the interview will also be inaudible to this person. You will be informed of this person's identity prior to the interview.

The interviews for you and your child will take place in your home or if this is not suitable, a mutually agreed place which you deem to be safe, comfortable and private. During the interview, you and your child may be asked some questions by the researcher, intended to assist in revealing personal views and opinions about the process of being diagnosed as having ADHD and the impact of having such as diagnosis. There are no right or wrong responses and no compulsion to answer any questions.

With your permission, each interview will be audio recorded on a small voice recorder and hand written notes will be taken in relation to the interview. All aspects of the interview/s are entirely confidential except as required by law. At no time will your child's identity or your identity be divulged. The information will be kept in a secure place. Mrs Gloria Hill, Professor Trevor Parmenter and Professor Fawcett are the only ones to have access to the information. In the event that a research report about the research findings is submitted for publication in an academic journal, no individual participants or his or her personal details will be identifiable in such a publication.

Although not expected, if at any time you or your child express discomfort with the interview experience, you or your child may withdraw straight away without negative consequences. In the highly unlikely event that discussing personal issues or feelings about experiencing ADHD cause you or your child to feel distressed, please express this to the researcher, Gloria Hill, who can assist you in obtaining counseling support if required.

When you have read this information, Gloria Hill will discuss with you any further questions you may have. Following this, if you would like to know more, please feel free to contact Gloria Hill on tel.: + 61 2 61617879 or
+ 61 (0) 409905691, or alternatively, Professor Trevor Parmenter on tel.: + 61 2 88780500 or Professor Fawcett on tel. + 61 2 90369316.

Yours sincerely,

Gloria Hill
Researcher
September 5, 2006

This information sheet is for your personal reference. It is yours to keep.
Any person with concerns or complaints about the contact of a research study can contact the Manager, Ethics Administration, University of Sydney on + 61 (2) 9351 4811

Appendix IX

Child Participant Information Statement

This is the child version describing this research project and is similar in content to the parent/guardian information statement.

NSW 2006 AUSTRALIA	**Faculty of Education and Social Work A35** College of Humanities and Social Sciences	
		Telephone +61 2 9351 2791 Facsimile +61 2 9351 4580

CHILD PARTICIPANT

RESEARCH PROJECT

Behaviour in children diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD)

Instructions for Parent/Guardian: *This document is designed a supplement to assist your child in understanding this research project. It would be helpful if you could provide the opportunity for your child to either read this document or listen to it being read, or both. While the terminology has been simplified, it may still be too difficult for younger children to read or understand and may take further explanation. Please contact Gloria Hill if you require assistance or have any questions (details below).*

This is a research study about Attention Deficit Hyperactivity Disorder, or ADHD. This means that we are trying to understand more about ADHD and more about what it is like to have ADHD.

Being part of this study is voluntary. That means that you can choose whether you join in or not. It is completely up to you and your parent or guardian to decide if it is OK for you to do it. You do not have to agree.

The research study is being done by Mrs Gloria Hill, a student of the University of Sydney, and will form the basis of a Doctor of Philosophy degree at the University of Sydney. Two other people, Professor Trevor Parmenter and Professor Fawcett, also from the University of Sydney, will help make this study work well.

To do this study, Mrs Hill plans to talk with children between the ages of 5 and 18 years, who doctors say have ADHD, about what ADHD is like for them. She also plans to talk with four other adults around each child. These will include parents, teachers and doctors and people like these. This means that if you become a part of this project and everyone agrees that it is OK to do so, Mrs Hill will talk with you, your parent/s, your teacher/s and your doctors. This is because people around you may have some important things to say about ADHD. The talks will be with one person at a time and will be private.

So, if you agree, you will be asked to talk with Mrs Hill. You do not have to write anything down. It is not a test. It is just talking. This is called an 'interview' and it may take about one hour. Another interview might happen if Mrs Hill thinks that it will help and if you agree. If it is better for you, shorter talks can be done making up about one hour in total. During the talking time, you will be asked about what you think of ADHD in your life.

To help Mrs Hill remember the things you say, the interview will be recorded on a small voice recorder and Mrs Hill will write some things down, if you and your parent or guardian agree. There are no right or wrong answers. It is all about what you think. You do not have to give an answer if you do not want to.

The interview will be in your home unless you, your parent or guardian and the researcher think of a better place for you. The interview/s will be between you and Mrs Hill with no-one else able to listen, but you will have your parent or guardian or a friend nearby in case you need them for something. They will be able to see you all of the time while you are with Mrs Hill. Mrs Hill will also have someone nearby to help her if she needs something. This person will not be able to hear the things you say.

Everything about the interview is private except if needed by law. This means that your name and all the things about you including your family, your doctor and your school will not be told to other people. The voice recordings and notes will be kept in a very safe place by Mrs Hill. Professor Trevor Parmenter and Professor Barbara Fawcett are the only ones who will see or listen to these things and they will not tell other people anything about you either.

If Mrs Hill finds out some important information about ADHD by doing this research, a story about it may be sent to an academic journal. This is like a special magazine or a paper in a library or on the internet where other people can read things to try to learn more. Even if they read it, no-one will know that it is about you.

If at any time you or your parent or guardian feels uncomfortable or unhappy with the interview experience, you can stop straight away without anything bad happening. Also, you can tell Mrs Hill about how you feel and she can help you, if you like, by giving some information about other people who can help you.

After reading this, I will answer any questions you may have. If you do not have any questions, that's OK too. Also, if at any time you want to know anything at all about this project, you can easily contact me on tel: (*insert University Office number when this becomes available*) or + 61 (0) 409905691 or Professor Trevor Parmenter on tel.: + 61 (2) 88780500 or Professor Barbara Fawcett on el. + 61 (2) 9036 9316

Gloria Hill
Researcher
September 5, 2006

This information sheet is yours. It is for you to keep.

Any person with concerns or complaints about the conduct of a research study can contact the Senior Ethics Officer, Ethics Administration, University of Sydney on + 61 (2) 9351 4811 (Telephone); (02) 9351 6706 (Facsimile) or gbriody@mail.usyd.edu.au (Email).

Appendix X

Parental Consent Form

NSW 2006 AUSTRALIA	**Faculty of Education and Social Work A35** College of Humanities and Social Sciences

PARENTAL OR GUARDIAN CONSENT FORM

I, ... hereby agree to participate in this research project and hereby permit my child ...., who is aged .... years , to participate in the research project entitled:

Behaviour in children diagnosed as having
Attention Deficit Hyperactivity Disorder (ADHD)

The medicalization of behaviour in children diagnosed as having ADHD

In giving my consent I acknowledge that:

1. I have received and read the Participant Information Statement for Parents and Guardians and understand the time involved for my and my child's participation in the project. I have assisted my child in reading the Child Participant Information Statement and I acknowledge that this has been read aloud to my child. The researcher, Gloria Hill, has given me the opportunity to discuss the information and ask any questions about the project and these have been answered to my satisfaction.
2. I understand that I can withdraw my child from the study at any time for whatever reason without prejudice to me or my child's relationship with the researcher/s now or in the future.
3. I agree that research data gathered from the results of the study may be published provided that neither my child nor I can be identified.
4. I understand that if I have any questions relating to my child's participation in this research I may contact the researcher who will endeavour to answer them.
5. I agree to the involvement of my child's educators and clinicians being in this project and to the researcher, Gloria Hill, viewing and making notations about from confidential documents provided by myself, the school or clinicians.
6. I confirm that my child has a formal diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) by a qualified medical practitioner.

....	....
Signature of Parent/Guardian	Date

....

Please PRINT name

....	....
Signature of Child	Date

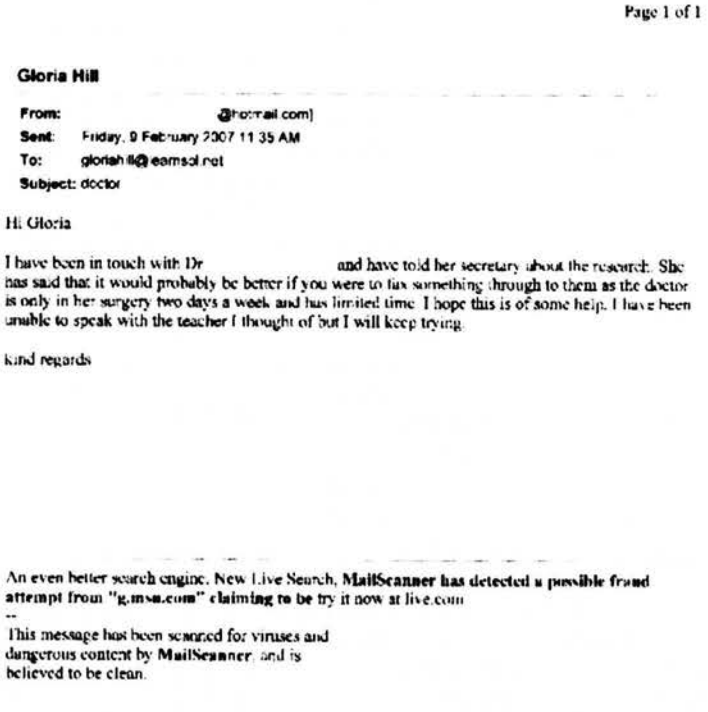
....

Please PRINT name

Appendix XI

An email from Mother 1

An email from Mother indicating her initiative/support in seeking the participation of the doctor and the teach



Page 1 of 1

Gloria Hill

From: @hotmail.com]
Sent: Friday, 9 February 2007 11 35 AM
To: gloriahill@eamsol.net
Subject: doctor

Hi Gloria

I have been in touch with Dr and have told her secretary about the research. She has said that it would probably be better if you were to fax something through to them as the doctor is only in her surgery two days a week and has limited time. I hope this is of some help. I have been unable to speak with the teacher I thought of but I will keep trying.

kind regards

An even better search engine. New Live Search, **MailScanner has detected a possible fraud attempt from "g.msn.com" claiming to be** try it now at live.com

--

This message has been scanned for viruses and
dangerous content by **MailScanner**, and is
believed to be clean.

Appendix XII

Clinician/doctor participant information statement

NSW 2006 AUSTRALIA

Faculty of Education and Social Work A35
College of Humanities and Social Sciences

CLINICIAN PARTICIPANT
RESEARCH PROJECT

Behaviour in children diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD)

Dear Dr XXXX,

I understand that XXXX, mother of XXXX, has agreed to participation in this research project concerning Attention Deficit Hyperactivity Disorder (ADHD) and has requested your participation also, giving full permission for you to discuss with me matters concerning Matthew, should you wish.

This introductory letter is intended to provide information about the project. Your consent is voluntary.

The research study is being conducted by myself, Mrs Gloria Hill. I am a post graduate student of the University of Sydney, and this study will form the basis of a Doctor of Philosophy degree under the supervision of Professor Trevor Parmenter and Professor Barbara Fawcett, Faculty of Education and Social Work, University of Sydney, NSW, AUSTRALIA.

The purpose of the study is to gain further understanding about the mechanism of diagnosing ADHD in relation to communications between teachers, parents and clinicians and also, the impact of such a diagnosis on the child from the child's perspective. As you are involved with XXXX, I wish to understand your experiences of ADHD and your experiences of XXXX in particular and your communications with others, if any, concerning XXXX.

Your participation in the study will involve a private interview with me. During the interview, you may be asked to share your thoughts, revealing personal views, opinions and recollections about ADHD and XXXX. There are no right or wrong responses and there is no compulsion to answer any questions.

Appendix XIII

Sample Interview Schedule

An example of record keeping for Interviews

If convenient to you and with your permission, the location of the interview will be at your practice, at a time convenient to you. If this location is unsuitable, for whatever reason, another mutually agreeable location may be nominated.

With your permission, each interview will be audio recorded on a small voice recorder and hand written notes will be taken. If at any time you wish to withdraw from the interview experience, for whatever reason, you may do so without negative consequences.

Further, with your permission and if applicable, I also seek access to documents such as reports and notes held by yourself or your practice concerning ADHD and Matthew for the purpose of viewing and note-taking. Such access follows full written permission from XXXX. I will view these documents at your practice or another agreed location and in the presence of yourself or a person nominated by yourself if you so desire.

All aspects of the research project are entirely confidential except as required by law. At no time will your identity or the child's identity be divulged. The information will be kept in a secure place. Mrs Gloria Hill, Professor Trevor Parmenter and Professor Fawcett are the only ones to have access to the information. In the event that a report about the research findings is submitted for publication in an academic journal, no individual participants or his or her personal details will be identifiable in such a publication.

I sincerely hope that you are able to assist in this research about ADHD, the results of which may be useful to the educational, scientific and scholarly community as well as to parents and lay persons.

When you have read this information, I will discuss with you any further questions you may have. Please feel free to contact me on tel.: 0409905691, or alternatively, Professor Trevor Parmenter on tel.: + 61 2 88780500 or Professor Fawcett on tel. + 61 2 90369316.

Yours sincerely,

Gloria Hill, M Ed. (Special Education), PhD. candidate
Faculty of Education and Social Work, University of Sydney
June 13, 2007

This information sheet is for your personal reference. It is yours to keep.

Any person with concerns or complaints about the conduct of a research study can contact the Senior Ethics Officer, Ethics Administration, University of Sydney on + 61 (2) 9351 4811 (Telephone); (02) 9351 6706 (Facsimile) or gbriody@mail.usyd.edu.au (Email).

Confidential information: No permission is given for any form of media reproduction

Interview schedule

Case Name: Network

Actors:

Mother:
Father:
Eldest son (of 3):
Youngest son:

Silent party
Middle son:

Location: Goulburn NSW

Interview date	**Actor**	**Comment**	**Transcribed**
11/01/07		present	Y
11/01/07		present	Y
22/01/07			
22/01/07	, and		
07/03/07	Dr	Telephone	
14/03/07			
14/03/07	Teacher:	School	

Appendix XIV

Sample transcript

An excerpt taken from the transcript of an interview with Mother 3

Researcher

I wonder, as we begin, could you just explain to me or in your own words, what you think ADHD actually is.

Mother 3

Um, it's a difference in the composition of the fluid between brain cells, which means that the waves going through the brain go intermittently rather than constantly, and medication that is used to help this actually makes those waves go faster. Doesn't make them constant again, but it makes them go a lot faster, so that they can understand better what's going on.

Researcher

So medication helps a lot?

Mother 3

[She nods 'Yes']And it leaves the door open to then teach them different skills that they wouldn't necessarily learn particularly social skills.

Researcher

Now with that definition of ADHD then, can you remember how you came to understand that? Where did you learn about it?

Mother 3

Oh, by reading, by reading lots of literature on it. I started with the hidden, I started with the 'hidden handicap', my doctor, my GP asked me to read it when my…

Researcher

That's a book?

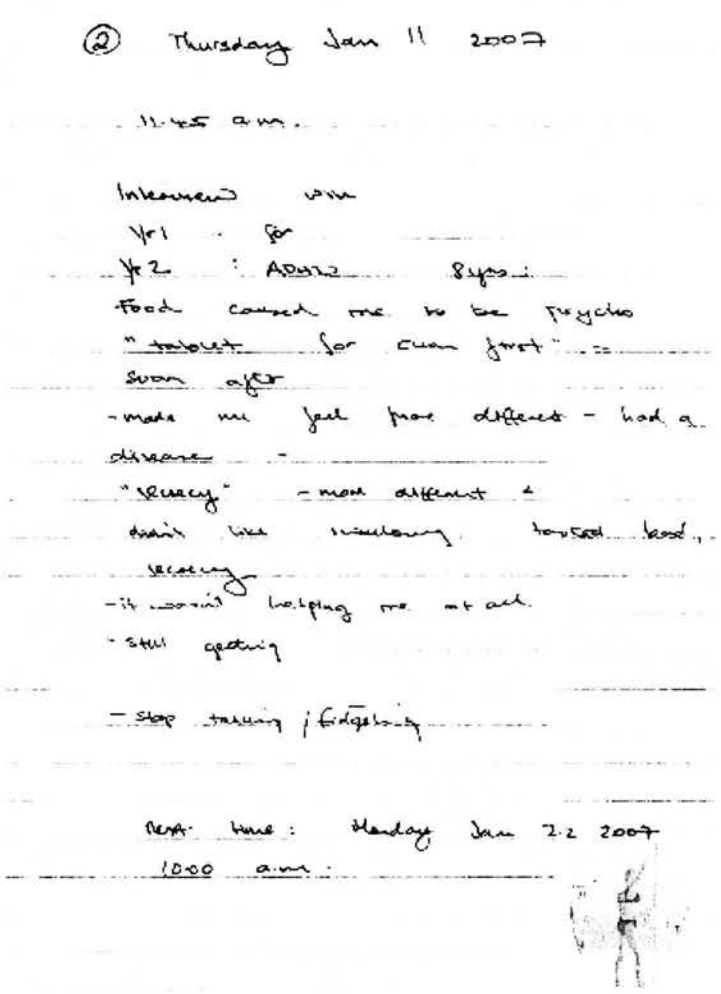
Mother 3

Yes, I can't remember who wrote it now, but my GP asked me to read it when XXXX was about 18 months old - about two years old.

Appendix XV

Sample interview notes

An excerpt from a small notebook used during the qualitative interviewing process. Key points only are noted, to support the digital recordings, as eye contact with participant was maintained as much as possible throughout the interview. This example relates to an interview with Mother 4.



② Thursday Jan 11 2007

11.45 a.m.

Interview with
Yr 1 . for
Yr 2 : ADHD 8yrs.
Food caused me to be psycho
"tablet for [illegible] first"
Soon after
- made me feel more different - had a disease -
"scary" - more different &
[illegible] like swallowing, tasted bad,
[illegible]
- it wasn't helping me at all.
- still getting

- stop talking / fidgeting

Next time: Monday Jan 22 2007
10.00 a.m.

Appendix XVI

Sample Field Notes

Date: 10.00 A.M. Thursday January 11, 2007

Place: Outside Mother 1's home, NSW Australia

Occasion: Immediately following my first interview with M1

Relevant Information: Checkout manager at local supermarket. Husband helps in the supervision of the children. Does p.m. shift so that sons always have a parent home. Born and raised in UK. Has been in Australia ....years. Came to Australia when husband's mother was terminally ill so that husband could spend time with his mother. During this period of some months, husband (Australian) found work and the family decided to stay. Said that she found settling into Australia as very difficult task and took longer than expected to settle. Missed father quite a lot and spoke regularly with him on the telephone.

Interview experience: This was my very first of all interviews! M1 was very welcoming. She invited me into her lounge room. This is where the interview was conducted. The room was sparsely decorated with evidence of children's toys and books and well worn furniture. After a few minutes of friendly chat, I restated the purpose of our getting together. The recording instruments were set up and neither she nor I appeared to take any notice of this from then on.

The conversation flowed freely. M1 appeared to be keen to speak about her experiences.

I was surprised by the extent to which she seemed to feel comfortable in sharing her thoughts and feelings, especially as she said that she was not accustomed to speaking about ADHD/children with anyone outside the family. She expressed quite a lot of emotion and was visibly upset when she recalled her early mothering experiences and her more recent experiences with teachers, most of whom she disapproved. At the end of the interview, she thanked me, saying that this was the first time that anyone had asked her about 'her story'.

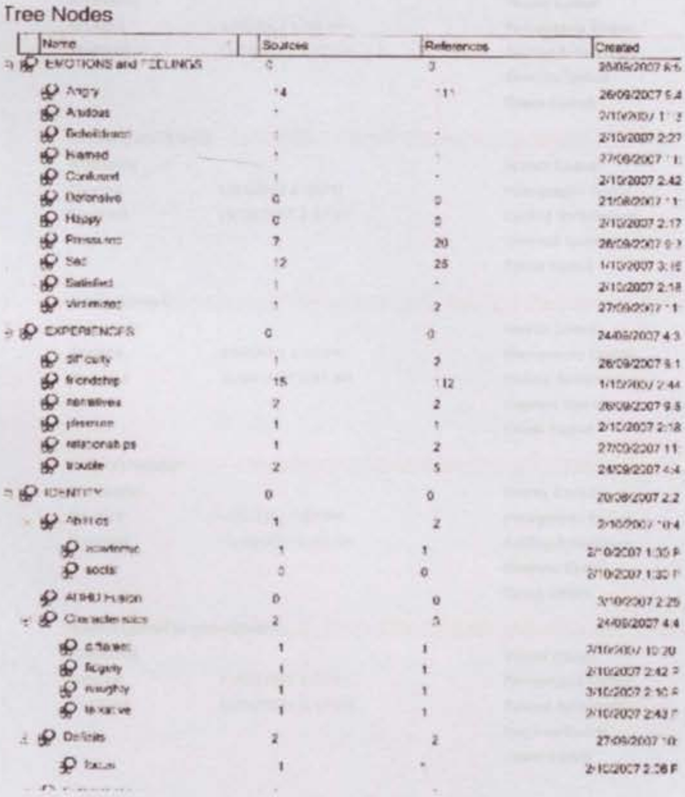
Appendix XVII

An image of my whiteboard indicating preliminary and merging ideas (and a drawing of encouragement by son Matthew)

Appendix XVIII

Sample coding: Tree nodes

Sample 1: An image of tree node coding using NVIVO



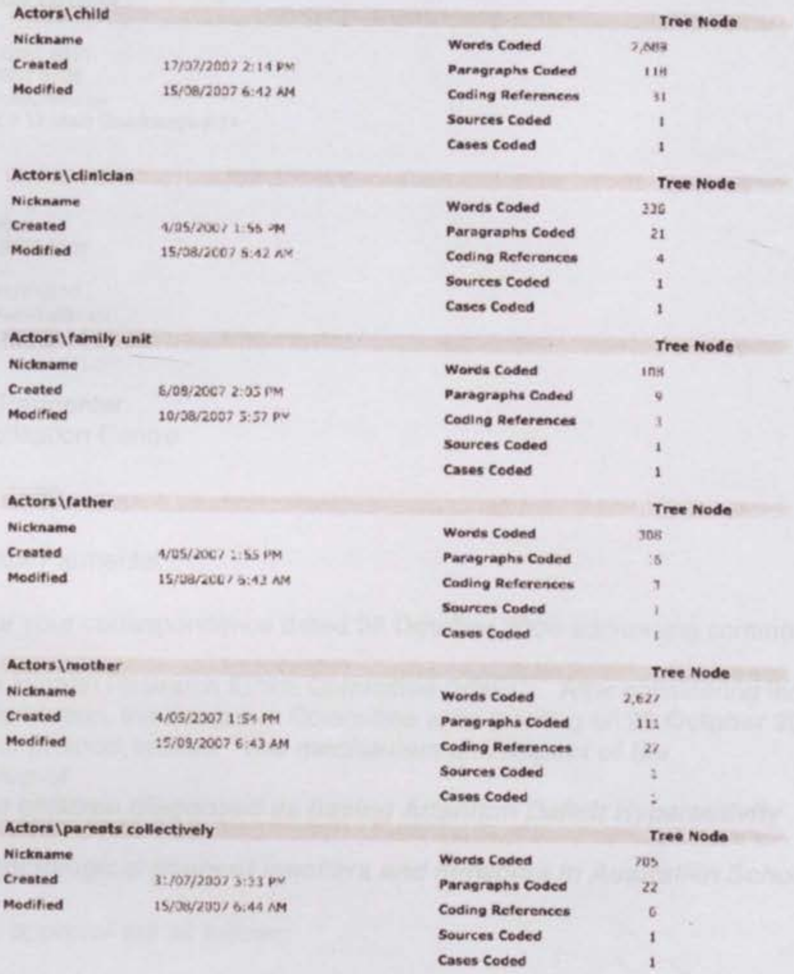
Tree Nodes

Name	Sources	References	Created
EMOTIONS and FEELINGS	0	3	20/08/2007 8:5
Angry	14	11	26/09/2007 5:4
Anxious	1		2/10/2007 1:3
Belittled	1	1	2/10/2007 2:27
Blamed	1	1	27/09/2007 11
Confused	1	1	2/10/2007 2:42
Defensive	0	0	21/08/2007 11
Happy	0	0	2/10/2007 2:17
Pressured	7	20	26/09/2007 9:3
Sad	12	25	1/10/2007 3:16
Satisfied	1	1	2/10/2007 2:18
Victimized	1	2	27/09/2007 11
EXPERIENCES	0	0	24/08/2007 4:3
difficulty	1	2	26/09/2007 5:1
friendship	15	112	1/10/2007 2:44
narratives	7	2	26/09/2007 9:5
pleasure	1	1	2/10/2007 2:18
relationships	1	2	27/09/2007 11
trouble	2	5	24/09/2007 4:4
IDENTITY	0	0	20/08/2007 2:2
Abilities	1	2	2/10/2007 10:4
academic	1	1	2/10/2007 1:35 P
social	0	0	2/10/2007 1:30 P
ADHD Fusion	0	0	3/10/2007 2:25
Characteristics	2	5	24/09/2007 4:4
different	1	1	2/10/2007 10:20
fidgety	1	1	2/10/2007 2:42 P
naughty	1	1	3/10/2007 2:10 P
talkative	1	1	2/10/2007 2:43 P
Deficits	2	2	27/09/2007 10
focus	1	1	2/10/2007 2:38 P

Appendix XIX

Sample coding report

An excerpt from a full Coding Report created using NVIVO



Actors\child			**Tree Node**
Nickname		**Words Coded**	2,689
Created	17/07/2007 2:14 PM	**Paragraphs Coded**	118
Modified	15/08/2007 6:42 AM	**Coding References**	31
		Sources Coded	1
		Cases Coded	1

Actors\clinician			**Tree Node**
Nickname		**Words Coded**	336
Created	4/05/2007 1:56 PM	**Paragraphs Coded**	21
Modified	15/08/2007 6:42 AM	**Coding References**	4
		Sources Coded	1
		Cases Coded	1

Actors\family unit			**Tree Node**
Nickname		**Words Coded**	108
Created	6/08/2007 2:05 PM	**Paragraphs Coded**	9
Modified	10/08/2007 5:57 PM	**Coding References**	3
		Sources Coded	1
		Cases Coded	1

Actors\father			**Tree Node**
Nickname		**Words Coded**	308
Created	4/05/2007 1:55 PM	**Paragraphs Coded**	16
Modified	15/08/2007 6:43 AM	**Coding References**	7
		Sources Coded	1
		Cases Coded	1

Actors\mother			**Tree Node**
Nickname		**Words Coded**	2,627
Created	4/05/2007 1:54 PM	**Paragraphs Coded**	111
Modified	15/08/2007 6:43 AM	**Coding References**	27
		Sources Coded	1
		Cases Coded	1

Actors\parents collectively			**Tree Node**
Nickname		**Words Coded**	705
Created	31/07/2007 3:33 PM	**Paragraphs Coded**	22
Modified	15/08/2007 6:44 AM	**Coding References**	6
		Sources Coded	1
		Cases Coded	1

Appendix XX

Ethics Committee letter of approval

Human Research Ethics Committee
www.usyd.edu.au/ethics/human
Senior Ethics Officer:
Gail Briody
Telephone: (02) 9351 4811
Facsimile: (02) 9351 6706
Email: gbriody@usyd.edu.au
Rooms L4.14 & L4.13 Main Quadrangle A14

Human Secretariat
Telephone: (02) 9036 9309
(02) 9036 9308
Facsimile: (02) 9036 9310
Email: bdeleon@usyd.edu.au

27 October 2006

Professor T Parmenter
Royal Rehabilitation Centre
PO Box 6
RYDE NSW 1680

Dear Professor Parmenter

Thank you for your correspondence dated **25 October 2006** addressing comments made to you by the Human Research Ethics Committee (HREC). After considering the additional information, the Executive Committee at its meeting on **26 October 2006** approved your protocol entitled ***"The mechanism and impact of the medicalization of behaviour in children diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD): A sociological study of teachers and networks in Australian Schools"***.

Details of the approval are as follows:

Ref No.: 10-2006/9478
Approval Period: October 2006 – October 2007
Authorised Personnel: Professor T Parmenter
Mrs G S I Hill
Professor B Fawcett

The HREC is a fully constituted Ethics Committee in accordance with the *National Statement on Ethical Conduct in Research Involving Humans-June 1999* under *Section 2.6.*

The approval of this project is **conditional** upon your continuing compliance with the *National Statement on Ethical Conduct in Research Involving Humans.* We draw to your attention the requirement that a report on this research must be submitted every 12 months from the date of the approval or on completion of the project, whichever occurs first. Failure to submit reports will result in withdrawal of consent for the project to proceed.

Chief Investigator / Supervisor's responsibilities to ensure that:

(1) All serious and unexpected adverse events are to be reported to the HREC as soon as possible.

(2) All unforeseen events that might affect continued ethical acceptability of the project are to be reported to the HREC as soon as possible.

(3) The HREC is to be notified as soon as possible of any changes to the protocol. All changes must be approved by the HREC before continuation of the research project. These include:-

☐ Notifying the HREC of any changes to the staff involved with the protocol.
☐ Notifying the HREC of any changes to the Participant Information Statement and/or Consent Form.

(4) All research participants are to be provided with a Participant Information Statement and Consent Form, unless otherwise agreed by the Committee. The Participant Information Statement and Consent Form are to be on University of Sydney letterhead and include the full title of the research project and telephone contacts for the researchers, unless otherwise agreed by the Committee and the following statement must appear on the bottom of the Participant Information Statement. *Any person with concerns or complaints about the conduct of a research study can contact the Senior Ethics Officer, University of Sydney, on (02) 9351 4811 (Telephone); (02) 9351 6706 (Facsimile) or gbriody@usyd.edu.au (Email).*

(5) The HREC approval is valid for four (4) years from the Approval Period stated in this letter. **Your approval will expire on 31 October 2006**. Investigators are requested to submit a progress report annually. **Your first progress report will be due on 31 January 2007**.

(6) A report and a copy of any published material should be provided at the completion of the Project.

Yours sincerely

Associate Professor J D Watson

Chairman
Human Research Ethics Committee

cc Mrs Gloria Hill, 35 Morgan Place, Curtin ACT 2605

Encl. Parent/Guardian Participant Information Statement
Child Participant
Teacher/Clinician Participant
Parental or Guardian Consent Form
Teacher/Clinician Participant Consent Form

Semi Structured Interview