PROBLEMATISING YOUNG PEOPLE

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PROBLEMATISING YOUNG PEOPLE

A Critical Ethnographic Investigation of ADHD

BY

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INVESTOR IN PEOPLE

For Anna, Aonghus and Georgia

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About the Author

Charles Marley has been part of the Section of Clinical Psychology at the University of Edinburgh since 2010. He is currently the Programme Director for the MSc in Mental Health of Children and Young People: Psychological Approaches. His research is interested in the application of critical theory to children and young people's mental health and well-being and focuses on how cultural, political and economic factors interact with local contextual factors to inform the everyday practices regarding children and young people's mental health and well-being.

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Preface

Overview of the Investigation

The investigation presented in this book utilised an ethnographic approach, and the scholarship of Michel Foucault, João Biehl, Nikolas Rose and Carol Bacchi to reconnect the wider social, political and institutional factors that were influential in the formation of a particular form of ADHD-related health care. By utilising various strands of their theoretical and empirical material, the investigation aimed to reconnect the nexus of elements that conditioned the possibility for the everyday social practice of ADHD to be in place within an NHS region in Scotland in the present moment.

An overarching aim was to consider ADHD from outside its dominant biomedical explanation by examining the wider context and processes that conditioned the possibility for the emergence of a local social practice of ADHD diagnosis and treatment. The investigation made use of the ethnographic approach of *Vita: Life in a Zone of Social Abandonment* as a methodological guide. *Vita* reconnects the nexus of elements – the 'invisible machinery' – that allowed for the subject of the project to be represented as mentally defective in the present. This project attempts a similar methodological reconnection of the invisible machinery that conditioned the present, but with the social practice of ADHD as the focus.

The analytic approach made use of the concept of 'problematisation', which captures a two-stage process – the questioning of how and why certain 'things' become a problem, but also how these 'things' are shaped as the objects that they become. Objects are not considered as things that previously did not exist being created by discourse, but as things that become what they are because of their interconnected 'apparatus' – the totality of discursive and non-discursive elements that introduce them into the play of true and false. The object of interest for this project was 'young people' and how they were problematised and shaped as the target of certain knowledges. It was through this process, the *how* of their construction as a problem, that the project made the connections that provided the authority for particular problem explanations to be installed as 'real' over other possibilities.

The fieldwork was conducted in a small geographical region in Scotland and consisted of several periods in health and education services. Along with extended periods in these domains, further ethnographic tools utilised included observation of clinical appointments, document analysis, interviews and archival research. Multiple sources of information formed the qualitative data for the investigation, including audio recordings/transcription of clinical appointments, clinical case notes, health service management team meetings and health and education policies and guidelines. The different layers of qualitative material – from individual appointment to national policy – allowed for reconnection of

the discursive field in which the current practice of ADHD emerged. The material was engaged with horizontally and vertically within and across the different layers of material, allowing for the examination of the changing discursive background and the problematisation of young people within education and health domains. The analysis revealed discontinuity in how the 'problem' of young people was constructed across time, what was legitimated as solution to these problems, what effects were created and what followed from these effects.

The study is considered a Foucauldian-inspired ethnographic 'case study'. The thesis uses the various chapters to construct a genealogical account of the emergence of the local social practice of ADHD, one that maps and makes visible the multiplicity of events implicated in the construction of young people as particular types of problems and which conditioned the possibility for the social practice of ADHD to become the current means by which young people become known as problems. The account offered provides a theoretical redescription of the rise of ADHD diagnosis and treatment locally, one that aims to trouble accepted explanations by revealing the wider complex network from which the social practice emerged.

Connecting Analysis across Chapters

In Chapters 1 and 2, I establish the frame of reference for this investigation and outline the methodological plan that guided the investigation in the field. Chapter 1 is offered in place of a 'literature review'. My rationale for not providing a 'review' of the ADHD literature is because I take the position that reviewing this material would be nothing more than a reproduction of the 'scientific truth value' of ADHD. Rather than viewing the material as providing access to a 'real' account of ADHD, I consider it as constructing a rhetorical truth value, based on an enactment of procedures of objectivity, that provides ADHD its authority and which allows it to remain a dominant way of constructing young people considered problematic. Instead, what is offered in place of a literature review is a brief account of the positivist literature and an expansion of the ontological and epistemological grounds for the rejection of this literature. The remainder of the chapter provides an account of the theory and concepts that underpin the approach that guided this investigation. This theoretical account is then expanded in Chapter 2, which is presented in two sections. In the first section, I expand the theoretical account, providing a detailed theorising of the main analytical concept that guides the investigation – the apparatus. The concept is then placed within an account of methodological precautions and analytical steps. In the second section of Chapter 2, I provide a detailed account of the procedures for enactment of the theoretical account offered in first part of the chapter.

In Chapter 3, I provide an overview of the changing politico-economic background of the region and the changing requirements of the young person within the new societal order that emerged from this process. The chapter documents the decline of industry in the region; the removal of traditional forms of

employment for young people in the area; and the emergence of technologies for disciplining young people towards active citizenship, a form of subjectivity in which the young person would self-improve through vocationally focused learning in order to 'fit' with the emerging post-industrial society. This chapter was made possible by the analytical focus that informed Chapter 4: specifically, the emergence of disadvantage and poverty as a strategic aim the apparatus of education, something that was prominent throughout my discussions with educational professionals in the region. Its visibility in discussions took the form of accounts of the impact of disadvantage locally and 'on' the behaviour of children. These discussions connected to my consideration of 'additional support needs' and its role in solving the impact the 'problem' of 'social exclusion' and 'disadvantage' had on learning. My previous unquestioning acceptance of local disadvantage was disrupted through a conversation with an educational professional, which was made possible by the critical focus on social exclusion in Chapter 4. As such, there was a requirement to extend the critical focus further to understand some of the elements that conditioned the possibility of the problems social exclusion came to represent. The chapter is presented in two sections: one section is offered as a genealogical/topological account of the elements considered important in conditioning outcomes and effects implicated in the emergence of the local procedures of ADHD and a second section where the effects are considered in detail.

The analysis in Chapter 4 was situated within educational sites and documents the conditions that allowed for psychiatric knowledge to play a role within the school. The chapter considers the changing discursive background of 'learning disability', the emergence of the category of Additional Support Needs from within this discursive space, the role this category played in constructing young people as requiring 'support to learn' and how this opened up a discursive space in which psychiatric knowledge and technologies would function. This chapter was made possible by the analysis in Chapter 5: one of the pressing issues, and one that offered legitimacy to the procedures that allowed for psychiatric knowledge to become dominant in CAMHS, was the 'problem' of increased referrals from schools. The question in this chapter was to understand what was 'done' with regard to problems in school and to understand what conditioned the possibility for ADHD to become a solution. As with the previous chapter, this chapter is presented in a similar way: a genealogical/topological account of the elements considered important in conditioning outcomes and effects and a more detailed consideration of these effects.

The analysis in Chapter 5 documents the shifting explanation for young people's behaviour within the Child and Adolescent Mental Health Service (CAMHS) through analysis of clinical case files and team meeting minutes. The analysis documents the conditions that allowed for the emergence of the everyday practice of ADHD within CAMHS, connects this to wider shifting health and education reforms and highlights how this was able to connect to the local schools through the concept/policy agenda of 'well-being promotion' and 'multidisciplinary working'. This was the starting point for the investigation. The single question that informed the entire investigation was 'how it was possible to

do what was done with regards to ADHD in the service in the present moment?' I was aware of tensions in the service regarding ADHD, but yet the procedures for management of the problem appeared to be unquestioningly accepted and enacted. My aim was to attempt to understand what made this possible. As with the chapters above, this chapter is presented in two sections: the first section documents the initial steps of the analysis, highlighting the shifting background within the case notes and meeting minutes that highlight the emergence and influence of the procedures of ADHD that came to form the everyday social practice of diagnosis and treatment. The second section provides an analysis of the discursive background that allowed for the emergence of the procedures and which provided the invisible lines of authority upon which they were legitimated.

The analysis in Chapter 6 offers a conceptualisation of the medication review through the Foucauldian lens of disciplinary power. The chapter highlights the disciplinary process enacted through the 'elements' that formed the medication review by using Foucault's account of panopticism to frame the process as a form hierarchical observation in which normalisation was enacted through discipline. This chapter was made possible through observing ADHD medication reviews, a required procedural component of the diagnostic process. Through these observations, I located a tension between the 'ADHD presentation' represented by formal institutional knowledges and the everyday 'problems' that came to be represented by ADHD. Another tension was the 'treatment' of ADHD. Formal institutional knowledge provides an account of the 'action' of the medication on the source of the 'symptoms', resulting in the behavioural symptoms being 'treated'. The everyday reality of ADHD treatment in the service was at odds with this account, however. This chapter aimed to provide an account of the means by which ADHD continued to be fixed on the young person despite these tensions.

Chapter 7 concludes the investigation by drawing together the elements of the apparatus and situating these within a discussion of the merits of critical ethnographic approach informed by poststructuralist theory. The chapter leaves the investigation open by highlighting the changing nature of the problematisation of young people through the emergence of ASD as the new explanation for problematic behaviour. This new form of problematisation is situated within the elements of the apparatus that allowed for ADHD to emerge.

Summary

The investigation documented in this book relates to the mental health and well-being of children and young people. I am interested in how the knowledges and practices that structure everyday social action relating to mental health and well-being emerge from within an 'apparatus' of interconnected cultural, political, and economic factors. What is offered is a critical ethnographic 'case study', one that connects everyday social actions to a multitude of influencing historic and current social, institutional, political/policy factors and which documents their role in conditioning the possibility of these everyday practices to be

possible. The investigation was influenced by and overlaps with an emerging area within global mental health studies. There have been calls within this theoretical domain for approaches that consider cultural, political and economic factors and their interaction with local contextual factors. The approach I adopt is an 'at-home' ethnography, one that utilises the constructs and theoretical approach emerging within the global health movement to explore how contemporary 'problems' have come to be understandable as they are currently known.

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Chapter 1

Establishing the Research Frame of Reference

Attention deficit hyperactivity disorder (ADHD) is the most extensively studied area of child psychiatry and the most common psychiatric status ascribed to children worldwide. Since first appearing in the *DSM-II* as 'Hyperkinetic Reaction of Childhood', ADHD has undergone multiple changes in nomenclature and nosology, with advocates arguing that this reflects the increasingly sophisticated understanding of the pathophysiology provided by research from neuroimaging studies (see: de Mello et al., 2013); twin studies (see: Kuntsi et al., 2013); adoption studies (see: Harold et al., 2013); and genetic studies (see: Hawi et al., 2013). This evidence is argued to highlight that ADHD is a 'biologically driven, brain-based neuro-developmental disorder', the 'most heritable psychiatric disorder', arises from the 'interplay of environmental risk factors and multiple susceptibility genes' and is 'associated with both structural and functional brain deficits' (see: Faraone et al., 2005; Fischman & Madras, 2005; Seidman, Valera, & Makris, 2005).

The above representation of ADHD is not the only one, however. A brief review of ADHD literature highlights that there are as many critics as there are advocates, a whole range of competing possible causes of the 'symptoms' (see: Armstrong, 1996; Atkinson & Shute, 1999; DuPaul, McGoey, Eckert, & VanBrakle, 2001; Powell & Inglis-Powell, 1999; Shanahan, 2004; Smelter, Rasch, Fleming, Nazos, & Baranowski, 1996; Walker, 2004), as well as multiple alternative explanatory frameworks that would allow for ADHD to be known in a completely different way (see: Baldwin, 2000; Baughman, 2012; Breggin, 2002; Conrad & Schneider, 1980; DeGrandpre, 1999; Ideus, 1995; Prior, 1997; Slee, 1995; Tait, 2006). Even if a brief review were to be confined to only positivist experimental psychiatric and psychological research, there would be as many articles regarding the methodological failings of the 'evidence' as there are articles claiming to provide 'evidence' for ADHD. As means of an example, contrast the questions asked of ADHD neuroimaging studies (see: Castellanos et al., 2002; Fox et al., 1995; Sowell et al., 2003; Walker, 1998), twin studies and adoption studies (see: Joseph, 2000, 2002, 2004, 2006) and genetics studies (see: Arcos-Burgos et al., 2004; Bakker et al., 2003; Bakker et al., 2005; Fisher, Franks, McCracken, & McGough, 2002; Hebebrand et al., 2006; Langley et al., 2004; Mill et al., 2005; Van der Meulen et al., 2005) with the previously mentioned studies in each of these areas regarded as 'evidence' for ADHD.

Given that ADHD has attracted trenchant criticism from many professionals within the field of child and adolescent mental health, as well as commentators and critics outside that field, and that increasingly sophisticated biomedical investigations have failed to produce conclusive evidence of genetic, biological or neurological indicators, why does diagnosis and treatment with stimulant medications continue apace? My aim with this investigation was to consider this question; however, rather than entering the debate for and against ADHD that characterises the mainstream psychological and psychiatric literature, I approach the question from a Foucauldian-inspired sociological perspective. Thus, my approach does not subscribe to modernist assumptions of knowledge as cognitive representation of 'what is the case' in the 'real world' arrived at through positivist-inspired research based on rationality and empiricism. To take this approach would imply that the symptoms of ADHD are naturally occurring phenomena embodied in the sufferer and that the diagnosis is globally and trans-historically applicable, 'out there' independent of its observers and awaiting discovery through objective observation and by experts.

Instead, my position throughout this book assumes infinitely many potential 'reality-versions', each of which promotes the interests of some as opposed to other interest groups. Reality-versions are considered to be constituted at intersections of societal structures and are socially manufactured through legitimation practices into 'knowledges'. The reality-versions that I am interested in are 'psy-complex' reality-versions: 'the heterogeneous knowledges, forms of authority and practical techniques that constitute psychological expertise' (Rose, 1999, p. vii). As such, I do not consider psychological and psychiatric knowledges, such as ADHD, as a description of 'real' phenomena but as constituting them and, in the process of so doing, individualising, psychologising, essentialising and naturalising as inevitable what are contingent socially constituted and so reconstitutable features of particular politico-socio-economic arrangements.

ADHD and the various categories and concepts associated with these psy-complex reality-versions are considered socially sanctioned ways of understanding the world. By producing 'positive knowledges' and 'plausible truth claims' through 'apparent dispassionate expertise', these psy-complex reality-versions have not only made it possible for humans to understand themselves and others in ways that we have come to view as 'psychological' – personality, intelligence, self-esteem, behaviour, etc. – but also made it difficult for humans to be conceived in ways outside of these knowledges. These knowledges have come to enjoy the privileged position of 'truth' within our current historical and cultural period and have provided everyday social practices that reinforce their status as knowledge as well as reinforce the positions of the institutions that enact them. These knowledges, with their implicit norms, regulations, controls and various methods for shaping the individual in the image of the knowledge, have enwrapped us, influencing our thinking and judging, and how we act and interact.

Our current dominant system of truthing structures truth as scientific knowledge; in this sense, ADHD, as an object of psychological and psychiatric knowledge, with its filtering through 'objective' scientific methods and with its enunciation of and enunciation by multiple connected knowledges and practices – such as

medical, psychiatric, psychological, educational – and as enacted by various positions of authority – such as psychiatrists, psychologists, teachers – has come to enjoy the privileged status of 'truth'. The rules, according to which the true and the false are separated within the regime of 'truth' of ADHD, evident in the debate between the 'International Consensus Statement on ADHD' (Barkley et al., 2002) and the 'Critique of the International Consensus Statement on ADHD' (Timimi et al., 2004), focus on the rules and procedures that enact 'objectivity' and 'methodological rigour', with conceptualisations that do not attend to these procedural requirements being assigned the status of 'false', or at best 'methodologically flawed'.

Established as truth within our present culture and historical period, ADHD has become embedded within laws, policy, training, 'interventions' and everyday language; these various elements are assembled together into apparatuses which produce, inscribe, examine, debate, analyse, theorise and, with the results, form further elements. It is within these apparatuses of psychological truth that human subjects are 'assembled', constituted as objects of psychological knowledge through various 'techniques of the self' – the various 'ways of thinking, judging and acting upon themselves' (Rose, 1999, p. xvi) articulated by the understandings presented by 'psy' knowledges that enwrap the everyday life of human beings.

'Truthing' ADHD through Psychiatric Research

From its inception as the DSM in 1957, the number of categories of classification has more than tripled, increasing from 112 to 374 in the *DSM-IV-TR*; with the release of the new edition, the *DSM-V*, further concepts and categories have been introduced. ADHD and the multitude of other categories are further divided into 'subtypes' and 'symptomology', allowing for an increasingly nuanced categorisation of human subjects. They have also become embedded in various forms into everyday life, through the internet, through television, through newspapers and magazines, transforming family relations by urging observation ('watchful waiting') (NICE, 2008, p. 15) and readiness to respond to the 'signs of disorder' by placing the child in front of an 'expert'. And with the embedding of ADHD and other categories in policy and guidance, professional relations have also been transformed, with the role of pre-school assistants, classroom assistants and teachers extended into new areas of social management. The techniques for managing difference have also burgeoned with the most common, psychostimulant medication, being the most controversial. However, many further techniques are applied which, although less obvious, are no less insidious. Take any guidance regarding 'treatment' of ADHD or other childhood disorders, and you will have a stepwise approach to the management of difference refracted through a psychiatric lens.

The 'discovery' of ADHD is attributed to George Frederick Still. During the Goulstonian Lectures to the Royal College of Physicians in 1902, descriptions such as 'passionateness', 'spitefulness', 'cruelty', 'jealousy', 'lawlessness', 'immodesty',

'sexual immorality' and 'viciousness' (Still, 1902, p. 1009) were presented as signs of a 'defect of moral control' in children who were deemed too intelligent for the behaviours to be associated with 'disorders of intellect'; the 'defect of moral control' was considered a 'manifestation of some morbid physical condition' (Still, 1902, p. 1165). These descriptions have been presented by mainstream literature as early 'proof' of ADHD before being refined by the 'progress of clinical practice' and 'scientific investigation', both by advocates (see: Barkley, 1990, 1991, 1997) and critics (see: Armstrong, 1995; Breggin, 1998) of ADHD. However, if one were to consider this from a position informed by critical theory and a critical approach to knowledge production, it could be argued that the emergence of this particular object of psychiatric knowledge was not 'discovered' but was constituted through an interconnected nexus of discourses, knowledges, practices and procedures.

As highlighted by Rose (1999), the conditions of possibility for 'psy' knowledges, such as ADHD, to emerge are 'themselves practical and institutional, involving the collection of persons together in particular places, their organisation within particular practices and the grids of perception and judgement that are thrown over conduct and competencies as a consequence [...]; psychological phenomena [...] are thus the outcome of a complex process of production, requiring the alignment of entities, forces, gazes and thought' (p. xv). This is apparent in the series of meetings held between 1948 and 1951 and published in the *Journal of Orthopsychiatry* between 1949 and 1952 (see: Healy, 1949). These publications detail a series of discussions between representatives of the institutions of psychiatry, paediatrics and criminal justice; the focus in the meetings was the applicability of the category of 'psychopath', an object of a moral discourse, when applied to children. It is argued that these meetings paved the way for judgements of morality to slide into obscurity and be replaced solely with a psychiatric judgement; the particular 'alignment of entities, forces, gazes and thought' within these meetings allowed for 'psychiatric' judgements to be 'thrown over the conduct and competencies' of certain groups of children and conditioned the possibility for the emergence of the 'organicity of hyperkinesis', the category from which the modern concept of ADHD emerged.

The 'truthing' of 'hyperkinesis' as 'biological' in origin and as an 'organic child psychiatric disorder' allowed for conduct and competencies that were previously considered a moral concern and for emergence of the rhetorical 'scientific-ness' of ADHD upon which the current battle over truth is fought; once this 'truth' was established, brought into existence, further explored, dissected, analysed and classified, a 'family of descriptions' that formed one version of reality to the exclusion of other versions of reality emerged. And once this 'family of descriptions' took hold, the production of other 'families of descriptions' was closed off as forms of research and investigation followed one path at the expense of others (Rose, 1999, p. xvi). The family of descriptors that currently provide the intelligibility of ADHD is provided by the biomedical discourse, which upturned the psychodynamic discourse that dominated psychiatric knowledge in the *DSM* in which Hyperkinetic Reaction of Childhood first appeared. This shift in 'aetiological focus' emerged from controversies and disputes over the 'truth' between a 'neo-Kraepelinian' paradigm and a 'psychodynamic

paradigm' between the second and third editions of the *DSM*; through this confrontation, the concept of 'reactions' associated with the 'psychodynamic paradigm' was replaced by descriptors of the expression of disorders and claims of being 'atheoretical with regard to aetiology' (Klerman, 1978, p. 7). It is through this shift that the principles of the descriptive classification system of Emil Kraepelin and the concept of 'biological aetiology' was reintroduced to psychiatry, which allowed for burgeoning of research in order to establish the biological origins of psychiatric disorders; the 'family of descriptions' and associated practices that have taken hold are connected to the modernist scientific discourse, allowing ADHD to be constituted as a 'biologically driven, brain-based neuro-developmental disorder'.

The Rise of ADHD

Despite the dubious origins of 'scientific-ness' of ADHD and being considered the most controversial child psychiatric disorder, the number of children receiving the diagnosis, and the resulting treatment with stimulant medication, has risen exponentially in recent years. For example, in the UK, a recent report on the safe management of controlled drugs (see: CQC, 2013) highlighted that prescriptions of methylphenidate increased by 236,937 between 2007 and 2012 in National Health Service (NHS) settings in England, an increase of 56% on the 2007 figure. Scotland saw a similar increase in the prescription of methylphenidate. According to the Information Services Division (see: ISD, 2012) of the NHS National Services Scotland, the number of prescriptions of methylphenidate increased from approximately 43 defined daily doses (DDD; per 1,000 of the 0–19 population) to approximately 91 DDD (per 1,000 of the 0–19 population) which, based on the Scottish populations of 0- to 19-year-olds for 2002 (1,210,000) and 2011 (1,172,000) (see: GROS, 2013), was an increase of 54,600 prescriptions (an increase of 105% on the 2002 figure). However, these figures only cover the NHS prescriptions for methylphenidate in England and Scotland; they do not include Northern Ireland and Wales, prescriptions for ADHD drugs other than methylphenidate or private prescriptions. A wider view is provided by the International Narcotics Control Board (see: INCB, 2012); in 2011, the UK had a prescription rate of 0.06 per 1,000 inhabitants per day on all forms of medical amphetamine: at the 2011 census population estimate of 63.2 million, this suggests approximately 3.79 million people were taking a form of medical amphetamine in 2011. This increasing diagnosis and treatment with stimulant medication has also been mirrored in Australia; the number of boys diagnosed increased from 2,200 to 20,800 between 1988 and 1998, with the number of girls diagnosed doubling in the same period. Between 2000 and 2011, prescriptions of stimulant medication increased by 72.9%, making Australia the third-highest prescriber of stimulant medication behind Canada and the USA (see: Graham, 2008; Stephenson, Karanges, & McGregor, 2012).

As highlighted above, ADHD is a global phenomenon; its visibility as explanation for children's behaviour has become more and more prominent, to the exclusion of multiple alternative explanations. It is now common parlance, appearing in newspapers; television shows; radio shows; popular magazines; the internet; on leaflets in GP surgeries and schools and even as an 'app' available for smartphones and tablets.[1] It also appears to be accepted without question by those who are the focus; in my role as a clinical psychologist in a Child and Adolescent Mental Health Service (CAMHS), many of the families I met had requested appointments to discuss whether their son or daughter 'had' ADHD. This was not confined to families with young children: families of teenagers would request appointments, teenagers themselves would request appointments, professionals working with young people would request appointments. What makes this extraordinary is that, whilst ADHD has been available as an explanation in various forms since the 1950s, the rise of the current epidemic of ADHD commenced in the mid-1980s, with a continued rise from its initial emergence. This is evident in the diagnosis rates listed previously, but also highlighted clearly in Figure 1. The chart was constructed using 'Google Books Ngram Viewer', which charts frequency of appearance of specified words in books printed between 1800 and 2008. Figure 2 is focused on the period between 1980 and 2008.

This begs the question: why then? What was significant about this period that allowed for the explanation offered by psychiatric discourse to become so dominant? The answer provided by proponents of ADHD is that the condition is better recognised due to improved training for health and education professionals, improved screening tools, better treatment regimens and the accumulation of knowledge regarding the anatomy and structure of the brain. The implicit proposition here is that lack of awareness, poor training, unprecise screening tools, unwillingness to accept diagnosis due to poor treatment options

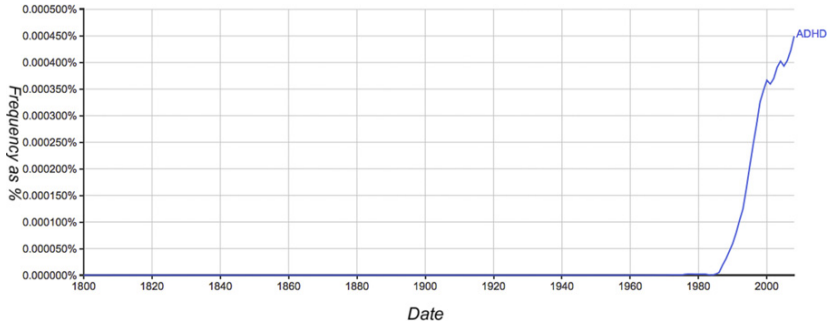

Figure 1: Frequency of Appearance of 'ADHD': 1800–2008.

[1]See: ADHD Psychopharmacology by SoftPsych or *ADDitude Magazine* by New Hope Media.

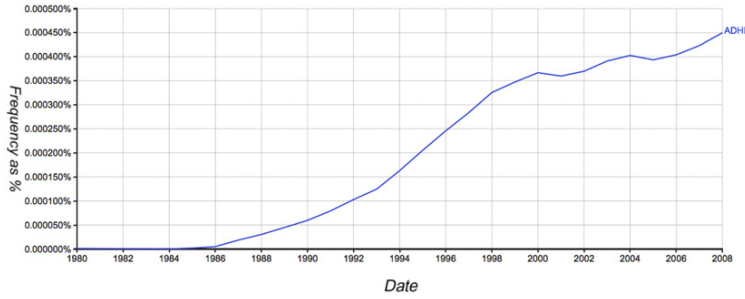

Figure 2: Frequency of Appearance of 'ADHD': 1980–2008.

and lack of knowledge and technology for understanding the origins of the condition have led to an underdiagnoses of the disorder until now. In this book, however, I will offer an alternative account.

Problematising ADHD Diagnoses

The aim of the investigation that I will outline in this book was to question the rising diagnosis rates and the explanations offered for this rise from a Foucauldian-inspired standpoint. The rising diagnosis of ADHD has not gone unquestioned; a recent critique of the expansion of the disorder cited several factors, including a transnational pharmaceutical industry; Western psychiatry; increasing usage of the *DSM* diagnostic criteria; ease of access to online screening checklists; and advocacy groups. I do not dispute these factors as contributing to the rising diagnoses rates, but my point of focus will be different; instead of considering the vehicles that may have allowed for the concept to become more accessible, I aim to consider how the everyday social practice of ADHD has contributed to the burgeoning of usage and, thus, contributed to the rising rates of diagnoses.

To do so, my investigation utilised the concept of problematisation. The concept relates to Foucault's focus on what he called 'the history of thought', which was described as an analysis of the way 'institutions, practices, habits and behaviours become a problem for people who behave in specific sorts of ways, who have certain types of habits, who engage in certain kinds of practices, and who put to work certain types of institutions'. Utilising the concept involves analysis of 'the way an unproblematic field of experience, or set of practices, which were accepted without question, which were familiar and "silent", out of discussion, becomes a problem, raises discussion and debate, incites new reactions, and induces a crisis in previously silent behaviour, habits, practices, and institutions' (Foucault, 2001, p. 74). Thus, my investigation aimed to examine, and call into the question, the gathering together, characterisation, analysis and management of young people through ADHD. To do so, my aim was to examine the interconnected nexus of discourses, power/knowledges, practices and procedures through which young people were constituted as 'having' ADHD.

Discourse, Power and Knowledge

The concept of discourse within Foucault's writing is particularly elusive and difficult to define, mainly due to the different ways in which the concept was used in different stages of his writing; for example, sometimes it was considered to represent a 'general domain of all statements', sometimes it represented an 'individualisable group of statements' and other times it was considered as a 'regulated practice that accounts for a number of statements' (Foucault, 1972, p. 8). For the purposes of this book, discourse is referring to the way it is used in the third definition above: that discourses consist of multiple statements that cohere and produce meaning and effects in the 'real' world. By referring to 'real' in inverted commas, I am not suggesting that reality does not exist, but that the material things to which the categories and concepts that structure our world refer have their meanings inscribed upon them by these categories and concepts and that these categories and concepts gain their specific meaning from the discourse to which they belong. Thus, discourse is considered as a group of statements that belong to a single formation of knowledge and which 'systematically form the objects of which they speak' (Foucault, 1972, p. 54). However, discourses should not be considered as an expression or representation of reality; not only do they produce the objects of which they speak but they constitute particular realities over other realities through defining and establishing what is considered 'truth' at particular historical moments through a 'whole series of particular mechanisms, definable and defined, that seem capable of inducing behaviours or discourses' (Foucault, 1996, p. 394). Thus, the inscription of meaning by discourse constitutes reality, fixing particular understandings and their associated ways for thinking, talking and acting, thereby legitimating the practices and consequences of ordering our world in that particular way.

It is these 'discourse effects', the structuring of the commonly accepted understandings of our world, and the practices and procedures that have been produced in relation to these effects, that were of particular interest to me. As I mentioned earlier, the discourse of ADHD structures commonly accepted understandings about young people, and it has become common practice to problematise young people's behaviour through this particular form of knowledge. As such, various forms of difference are constructed as 'behavioural symptoms' – for example, being 'unable to sustain attention or follow through on instructions', being 'easily distracted', having an 'inability to inhibit response', having an 'excessively high level of activity' – and management of these behavioural symptoms through psychological and psychiatric 'treatments' has exponentially increased as a consequence of these effects. Discourses are able to achieve these effects, to specify 'what is' and 'what is not' in the 'true', through being entwined with power/knowledge. Discourses are historically variable ways of specifying 'truth', with knowledge being produced by effects of power and considered as 'truth'; thus, power functions through discourse, it is constitutive of and is constituted by discourse, thus enabling the fixing of reality through the effects it creates and the 'truths' it establishes. This fixing of reality should not be considered complete, however; we can question our current