THE UNIVOCITY OF ATTENTION: ADHD AND THE CASE FOR A RENEWED SELF-ADVOCACY

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A DISSERTATION SUBMITTED TO
THE FACULTY OF GRADUATE STUDIES
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

GRADUATE PROGRAMME IN
SOCIAL AND POLITICAL THOUGHT
YORK UNIVERSITY, TORONTO

JANUARY 2023

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Abstract

This dissertation uses multi-sited ethnography and socio-philosophical analysis to answer the following questions: What is the current state of ADHD's onto-epistemological status in contemporary discourse? Is an equivalent to critical autism studies possible for ADHD? Specifically, is it possible to refigure ADHD's ontology as an affirmative difference rather than a deficit? Drawing from my own experiences living with ADHD, as well as anecdotal and ethnographic accounts from my engagement with ADHD self-advocacy communities, I put various critical social scientific theories "to the test," including Hacking's looping effects, structuralist-functionalist's medicalization and social control, Foucault's and Rose's theories of subjectification and governmentality, Deleuze and Guattari's concept of becoming, the fold and related antipsychiatry approaches (e.g., in mad studies literature), and historical materialist theories of the pathologies of late-stage capitalism. My findings indicate that there is something specific about ADHD's symptoms that pushes back against the often-totalizing nature of these critical theories. I also draw from science and technology studies to conduct an ethnographic study of an ADHD clinic in Japan, to explore how this specificity of ADHD "travels" in cross-cultural contexts without being reduced to biology or culture. The results of my research indicate that the ontological legitimacy of ADHD (what qualifies it as existing, and what it means for it to exist) in contemporary discourse has little to do with its purported neurobiological or genetic underpinnings. Instead, popular ontological beliefs appear to "swing" between two poles of what I call the "dialectic of medicalization": in one direction, a belief in the ontological primacy of identity (a disease entity, human kind, brain type, medical label, and so on); in the other direction, a belief in the ontological primacy of individual variation (neurobiological diversity, "human distress," statistically-associated symptoms, genetic correlates, and so on). I show how this dialectic keeps ADHD in conceptual purgatory, helps to explain the history and current state of ADHD discourse, and contributes to ADHD misrecognition and harm. Borrowing from Deleuze's *Difference & Repetition* (1994), I call for a renewed ADHD self-advocacy that breaks free from this dialectic by reformulating ontologies of ADHD in terms of its "difference in itself." My dissertation arrives at a position compatible with critical disability studies and critical autism studies, though in a way that speaks to the specificity of ADHD's affirmative differences rather than reducing them to the generality of neurodiversity.

For Nymph and Clara

Both born on the twilight of my doctoral studies

Acknowledgements

I am indebted to my supervisor Aryn Martin for helping me make this dissertation readable and coherent. Without her excellent comments, suggestions, and criticisms over the years, it would have remained a chaotic mess. Aryn has also gone above and beyond by connecting me with other projects during my time as a PhD student, namely my discourse analysis work with the Canadian Blood Services on the gay blood ban, and our collaborative work on chronic traumatic encephalopathy in Canadian hockey. No doubt, if not for her passion for STS, her long list of reading suggestions for my comprehensive exams and beyond, and her mutual appreciation of both theoretical and ethnographic work, I would not have had the same opportunities that are currently afforded to me (most of all, I am indebted to her for helping me secure my upcoming postdoctoral position in neuroethics at the University of Washington). Hélène Mialet has also been a wonderful influence on the direction of my thought for this project. I originally intended to have an additional chapter connecting her work to ADHD via her theory of the distributed centered subject; but time and space limitations cut that short. Her ethnographic methods were certainly an inspiration for my work in Japan, and will continue to inspire my future work. I would also like to thank Philip Walsh for agreeing to join my committee at a later stage, for his excellent commentary on my sociology chapter, and for his kind comments on my later drafts. Finally, I must acknowledge my long-term mentor and friend Thomas Kemple. Without Tom, I would never have made it into graduate school in the first place, nor be introduced to social theory. His persistent encouragement that I continue in academia and never give up theory turned out to be good advice. Whenever I had doubts about academia or my future, Tom was/is always there to remind me why I love academia in the first place, and how I'd go crazy without it.

I would like to give thanks to Veronika Reichert for being my supportive friend and colleague over the years, for teaching me so much about political theory and history, and for constantly reassuring me that deep, close, theoretical work is absolutely necessary if public education is to have a viable future. I also want to acknowledge my family for their ongoing support over the years. Mom and Dad, Alicia and Warren, Stefan and Emily, and Gornel have always been a guaranteed safety support net for me no matter how weird, annoying, or moody I am. Knowing that they will always be there for me has helped me get through some of the darkest months and years of my life. My old cat Mozart was also an amazing buddy for many years during my time in Toronto. I've had many friends come and go over the years. It's hard to know where to start or who to include, but really I am thankful to anyone who I've had the pleasure of knowing and chatting to. The older I get, the more friends disappear, and the more I realize how important it is to hold onto good friends. I'd like to specially acknowledge everyone that kept in contact despite my often asocial and sometimes abrasive/impulsive personality. In particular, my high school friends never disappeared from my life, and for that I am eternally grateful. Despite most of them living across the country, playing video games with them online helped me stay sane through rough times, especially during the pandemic: Justin, Dylan, Donald, and James. More recently, my brother's "tech friends" have included me in their milieux, which I am also grateful of: Alex, Denise, Gareth, Kaleim, Kino, and Tristan. Academic-wise, I would like to thank Justin Kong

and Vlad Cristache in particular for being great conversationalists and long-lasting friends. Special shout out to my good friend Madison Trusolino for resurrecting me from the dead a year and a half ago. Her brilliant insights into the social reproductive dimensions of academic work, and her ability to live what she writes, continue to be an inspiration. Her persistent encouragement, interest in my work, and supportive superpowers were absolutely essential in getting me back on track to finish my dissertation, apply for postdoc positions, and move forward with my life at a time when I was completely lost.

I would also like to acknowledge my graduate programme in Social and Political Thought for being so accommodating of weird projects and people. Never have I felt such a sense of belonging than in those first few years at York University. Thank you to everyone who was a part of that. Special thanks to Judith Hawley for being a world class graduate program assistant. And a shout out to several professors who I either had the honour of taking courses with, or were inspired by in other ways: Eve Haque, David McNally, Lorna Weir, Terry Maley, Robert Latham, and more. Thanks to Maggie Toplak and Jessica Jeong for helping me carry out part of my research with the York University Psychology Clinic. A huge thank you to CUPE 3903 for being the best union ever and helping us all stay sane.

This research was funded by an Ontario Graduate Scholarship and a Canadian Graduate Scholarship (CGS) Doctoral award by the Social Sciences and Humanities Research Council of Canada (award number 767-2016-2578). Without this funding, there is no way this dissertation would have ever been finished.

Table of Contents

Abstract……ii
Dedication……iii
Acknowledgements……iv
Table of Contents……vi

THE UNIVOCITY OF ATTENTION: ADHD AND THE CASE FOR A RENEWED SELF-ADVOCACY i

PART ONE: THE PROBLEM WITH ONTOLOGICAL GENERALITIES, AND THE SEARCH FOR ONTOLOGICAL SPECIFICITY 1
Glossary: Key Concepts for Part One 1

Introduction: Critical ADHD Studies? 2
Preliminary Arguments 10
1: The Predominant Form of ADHD Harm Is Misrecognition 10
2: The Concept of Neurodiversity Is Insufficient for ADHD Self-Advocacy 16
3: Psychiatric Power Is Anemic for ADHD Self-Advocacy 20
Overall Argument and Chapter Outlines 24
Limitations 30
Methodology 32

Chapter One: Looping Effects and the Question of Specificity 35
Memoro-Politics and Multiple Personality Disorder 41
Script-Flipping, Inaccessible Kinds, and Autism 49
ADHD and the Logic of Care: A Case for the Syndrome's Inaccessibility to Discourse 54
Conclusion 68

Chapter Two: Against Critical Therapy 69
The Medicalization of Structural-Functionalist Discourse 72
The Transfusion of Structural-Functionalist Discourse into Everyday Consciousness 77
From the Therapeutic State to the Therapeutic Market 82
The Contraindications between Critical Therapy and Symptomatic Specificity 84

Chapter Three: A Case Study of an ADHD Clinic in Japan 96
The Fieldsite: The ADHD Research Centre 96
The Biomedical Presence of ADHD in Japan 97
The ESSENCE of ADHD 100
How ADHD Is Diagnosed at the Clinic 108
How does ADHD "Travel" to Japan? How Is it "Translated"? 113
What Exactly about ADHD Is "Inaccessible" to Cultural Discourse? 121
The Dopamine Transfer Deficit (DTD) Theory 128
The Implementation of the New Forest Parenting Programme (NFPP) in Japan 135
Conclusion 144

PART TWO: PHILOSOPHICAL INTERVENTIONS 147
Glossary: Philosophical Terms Used in Part Two 147

Chapter 4: The Dialectic of Medicalization 150
Initial Foray into the Problem of ADHD Skepticism and Misrecognition 150
A Preliminary Outline of Key Concepts 156
The Historical Emergence of the Dialectic of Medicalization 160
Aristotle's First Ontological System (Top-Down Determination) 162
The Equivocity of Disease 167
Aristotle's Second Ontological System (Bottom-Up Determination) 169
Deleuze's Critique of Aristotle's Proposed Solution 176
How the Dialectic of Medicalization became Institutionalized in the Anatamo-Clinic, and Why the Idea of "Biological Reality" Is Historically Insufficient for Foucault (and for ADHD) 180
Conclusion 185

Chapter Five: Difference in Itself 187
Part One: The History of the Highest Identity of Disorder 191
The Different Ontological Roots of ADHD Harm and Autistic Harm 199
Part Two: Difference in Itself and the Second Aspect of Indifference 204
Intuiting and Feeling ADHD's Difference Despite Having No Concept of It 204
Difference in Itself According to the Second Aspect of Indifference 207
Part Three: The Philosophers of White Nothingness 210
How the Specificity of Autism Calls into Question the Totalizing Character of Rose's Theory of Subjectification 219
Why Autism's Concept of Difference in Itself Is Insufficient for ADHD 225
Conclusion 228

Chapter Six: Breaking Barkley: The Drive to a Univocity of Attention 232
Part One: Barkley's Theory of ADHD 234
Barkley's Implicit Critique of the Dialectic of Medicalization 234
How Barkley's Theory Constitutes a Concept of Difference in Itself 238
Why Barkley's Theory Folds Back into the Dialectic of Medicalization 245
Part Two: A New Theory of ADHD's Difference in Itself 251
Prelude: Is There Anything Positive about ADHD? 251
The Drive to a Univocity of Attention 254
Attention Surplus and Oversensitivity 256
Creativity 261
Productivity 266
Treatment 268
Conclusion 272

Conclusion 276

Bibliography 280

Part One: The Problem with Ontological Generalities, and the Search for Ontological Specificity

Glossary: Key Concepts for Part One

Discussing ADHD academically proves chaotic for conceptual clarity. The term "ADHD" can signify completely different things for different people. The following concepts—though alien-sounding at first—are designed to clarify these discussions in Part One (a more robust, sophisticated conceptual toolbox is provided in Part Two). Please note, the examples provided are not meant to be comprehensive, nor indicative of what *I* believe or plan to argue.

ADHD's Ontology	What it means for ADHD to exist. Constitutes an ontological specificity (or specificities) and/or an ontological generality (or generalities).
Ontological Belief	A particular belief someone holds about what ADHD is.
Ontological Specificity[1]	That which specifies—at least on a conceptual level—whether someone has ADHD or does not have ADHD. Some possible examples: (1) an "ADHD brain"; (2) an ADHD diagnosis.
Primary Ontological Specificity[2]	That which is *most* specific to ADHD. In layperson terms, what ADHD "really is." ADHD can have multiple ontological specificities—a diagnosis, a brain type, etc.—but only one can be primary. For example, *if it is believed* that ADHD's primary specificity is an "ADHD brain," then it follows that everyone who has this specific brain type has ADHD, *regardless of whether or not they have been diagnosed with ADHD*. An ADHD diagnosis, *in practice*, distinguishes ADHDers from non-ADHDers, yes, but ontologically speaking such differentiation is subordinate to what "really" specifies ADHD in an individual.
Ontological Generality[3]	That which generalizes the existence of ADHD to something other than its specificity. Some possible examples: (1) mental distress; (2) normal childhood behaviour; (3) neurodiversity.
Ontological Traversal[4]	Believing that ADHD exists *simultaneously* as an ontological specificity and an ontological generality; *or* habitually switching back and forth between believing in one or the other. For example, sociologists tend to believe that ADHD is a generality (really nothing more than normal childhood behaviour), but exists *also* as a specificity (a label or diagnosis that has "real effects" on the individual).

[1] In Part Two, ontological specificity is shown to constitute "identity" and "categorical differences."

[2] In Part Two, replaced by the more radical and expansive concept, "difference in itself."

[3] In Part Two, ontological generality is shown to constitute "individual variation" and "individual differences."

[4] In Part Two, corresponds to "the dialectic of medicalization."

Introduction: Critical ADHD Studies?

We take a beating for being interested in ADHD. -Clinical Psychologist, Interview

The current state of *autistic self*-advocacy presents a burning sociological question: why is there no equivalent for ADHD? Autistic self-advocacy takes power away from the institutions of psychiatry, psychology, and medicine by asserting control over discourse on autism. Self-advocacy books like *Autistic Disturbances* (Rodas 2018), *Authoring Autism* (Yergeau 2018), and *War on Autism* (McGuire 2016) are just a few recent examples of the plenitude of academic works constituting the field of what some call "critical autism studies" (Roscigno 2021). Critical autism studies subverts psychiatric power and control of autism while simultaneously embracing autism—not as a disorder, but as an affirmative difference. *Critical yet affirmative.*

The phrase "psychiatric power" refers to the scientific production and control of truth about "mental illness," a kind of "power-knowledge" developed not by individual patients, but by those who hold clinical power—pediatricians, physicians, psychiatrists, psychologists, neurologists, and more—both in therapeutic practice and research (Foucault 2008: 341-346). I use the adjective "psychiatric" as shorthand for the *strategic outcomes* of the institutional alliances of psychiatry, psychology (in the case of ADHD and autism, developmental and behavioural psychology especially), medicine (pediatrics in particular), pharmacy, neuroscience, and genetics. The American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual* (DSM) is a key example of a strategic outcome of these alliances. Importantly, to subvert psychiatric power does not mean a complete rejection of all these institutions, but rather a rejection of their *discursive control*. For example, autistic self-advocates embrace

neurobiological and genetic framings of autism, yet reject any psychiatric discourse that attempts to control such framings in order to justify medical intervention (Rivières 2021: 40).

ADHD's critical-yet-affirmative voice, in contrast, is scarcely to be seen—a blog post here and there but almost nonexistent (Huijg 2021; Meadows 2021). Instead, it is almost always assumed that to criticize psychiatric power and control *is* to criticize ADHD, to discredit and disregard it. Put differently, it is widely assumed that to be ADHD-affirmative is to be *uncritical*. ADHD has, in a way, become a contemporary emblem for psychiatric power. For instance, York University's own Critical Perspectives on Mental Health research cluster—an interdisciplinary group of critical scholars writing on mental health and mad studies—state that "the diagnosis of ADHD [can be used] to uncover the ways in which psychiatric power operates to shape the conceptualization, diagnosis, and treatment of mental distress" (Morrow et al. 2021: 4)—as if that is the limit to ADHD's utility in critical thought. Some critical scholars have even gone as far as calling its diagnosis an act of violence (Sjöberg 2021). Why has ADHD remained so fused with the image of psychiatric power whereas autism has managed to escape psychiatric control? Why has there been so much written from a critical-yet-affirmative autistic perspective but virtually nothing through a critical-yet-affirmative ADHD perspective? Why is ADHD's critical voice virtually nonexistent?

I open with these questions because they serve as an introduction to the kinds of underlying problems facing ADHD discourse that I want to make explicit in this dissertation, problems that have, historically, been almost entirely overlooked and ignored by social scientists. Namely, the conceptual, practical, and ethical problems that arise for ADHD from the sociological conflation of all psychiatric disorders into a singular, *generalized ontology*, an *ontological generality*.

By "ontology" I mean beliefs surrounding what it means for something to exist. Sociological critiques of medicalization, to take a key example, assert that psychiatric disorders all exist in the same way: as medicalizations *of* some generalized ontology. Sociologist Nikolas Rose, for instance, argues that the term "mental disorder" should be replaced with "mental distress," and that "distress, anxiety, feelings of inability to cope, guilt, even despair and self-loathing, are actually rather *common human experiences*" (2018: 188). Even a disorder as well-established as schizophrenia is called into question by Rose. He contests "the traditional psychiatric view that [hearing] voices should be understood as 'auditory hallucinations,' which are symptoms of severe mental illness.... Voice hearing is actually quite widespread in the population" (2018: 188). Rose's basic point here is that we have much more to gain from refiguring psychiatric disorders as a normal part of *human existence*—a generalized ontology—than we do from conceptualizing them as existing as distinct entities—like the way we conceptualize disease. We need, Rose argues, "to expand our understanding of... the 'bandwidth' of ways of being human.... Difference is not pathology" (2018: 188). This sociological move to generalize disorders into human difference is rooted in an ethics that seeks greater freedom for individuals who are otherwise stigmatized, stereotyped, disciplined, and coerced by cultural practices of diagnostic psychopathologisation. The problem is that this approach does not work for ADHD, for reasons I will explain below.

ADHD self-advocacy, almost by definition, rejects any ontological generality put forward to explain what ADHD is. To advocate for ADHD is to advocate for its ontological *specificity*: a unique genetic or neurobiological deficiency (or difference): an "innate impairment," a "different kind of brain," etc. Suggestions that ADHD is nothing more than "common human experience" is seen as an affront to ADHD self-advocacy, a lack of recognition of its specificity. Autistic

self-advocates, in contrast, have never seemed too concerned about framing autism as an ontological generality. Indeed, they even developed their own philosophy of one, represented in the concepts of neurodiversity and neuroqueerness: natural human variation that transgresses or queers overly-restrictive normative values in society. They have also, however, developed their own philosophies of autism's ontological specificity. Critical autism studies scholar Remi Yergeau, for example, argues that "rhetoric is ontological," and autism is a "rhetoric unto itself"—a specific, unique, distinct ontology: "a way of being in the world through invention, structure, and style [that] may at times be advantageous" (2018: 6, 205). Notably, Yergeau does not reject autism's ontological generality; they embrace neuroqueerness. Autistic self-advocates are able to effortlessly traverse the line between ontological generality and specificity without concern.

Once again I ask, why is this the case? Why have autistic self-advocates been successful in laying out, popularizing, and traversing their own ontologies—both specific and general—while ADHD's ontology remains in psychiatric care? Why are ADHD self-advocates so afraid of leaving this ontological asylum? Why do they fear ontological generalities?

Of course, there are significant differences between the histories of autism and ADHD self-advocacy. While mothers of autistic children have been advocating for autistic rights since the 1960s (Douglas 2016: 5), autistic self-advocacy did not begin—at least not explicitly—until the early 1990s. Borrowing from civil and disability rights movements, early autistic self-advocates, such as Jim Sinclair (1993), came together as a community to challenge psychiatric discourse that views autism as a "deficit," and questioned the ethical validity of clinical therapies like Applied Behavioural Analysis (ABA) that aim to "fix" autistic behaviours.

In contrast, ADHD self-advocacy was initially formed as a challenge to ADHD's pedo-ontology: the widely accepted belief that ADHD was a childhood disorder that did not persist into adulthood. This challenge was first made in popular discourse in Edward Hallowell and John Ratey's 1994 book *Driven to Distraction*, which included several descriptive accounts of ADHD in adults, far exceeding the limited criteria found in the DSM. Importantly, both Hallowell and Ratey claimed to have ADHD themselves. The birth of ADHD *self*-advocacy: a discourse around ADHD that was developed by ADHD individuals.

Make no mistake, however, *Driven to Distraction* is not a work of critical scholarship. Hallowell and Ratey are both psychiatrists. Ratey is a professor of psychiatry at Harvard Medical School. They were not trying to challenge or question psychiatric discourse or control of ADHD; they wanted to raise awareness in the public that ADHD persists into adulthood, and that ADHD individuals can be successful at life if it is caught and treated. As Hallowell puts it in the opening of the documentary *ADD & Loving It*, "it can be devastating. *Without a proper diagnosis*, ADD can ruin your life. Okay having said that, the tremendous good news is, *if you get the diagnosis*, and you get *proper* treatment, not only can you avoid all those disasters, you can achieve spectacular success" (in Green 2009; emphasis added).[5] Hallowell is not challenging the idea that ADHD is a "deficit"; rather, he suggests that through submission to psychiatric power—getting diagnosed and adhering to treatment prescribed by professionals—the positives of ADHD can then shine through (i.e., one can find success in neoliberal societies).

The popularity of *Driven to Distraction*—no doubt spurred on by a 300% increase in ADHD diagnoses following changes to the DSM criteria in 1994—provided a template for a specialized

[5] A list of names and photos of "successful" ADHDers then appear on the screen, including two businessmen, a professional golfer, an actress, a comedian, a television show host, and an NFL player (Green 2009).

self-help subgenre to emerge: the birth of the ADHD self-help industry. From this newly-burgeoning industry grew ADHD self-help communities—parent support groups and adult ADHD support groups, both online and offline—with similar templates. In these groups, members share experiences of hardship ("case studies" of themselves), and come up with strategies to overcome these hardships. Sometimes the "positives" of ADHD are talked about, but never at the expense of psychological framings. ADHD continues to be primarily understood as a deficit, but a deficit that can be treated (see Figure 0.1).

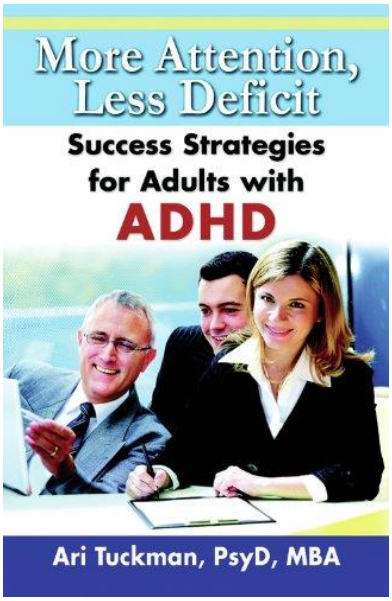

Figure 0.1: The successful, neoliberal, ADHD subject illustrated on the cover of Ari Tuckman's self-help book (2009)

In summary, *autistic self*-advocacy began in communal spaces that were *independent from and averse to psychiatric power*, whereas ADHD self-advocacy was initiated *by psychiatrists* and developed into an *industry*. This set the tone for all future ADHD self-advocacy: one that is always *reliant on* psychiatric power. If an ADHD individual wants to discuss self-advocacy, they discuss it within this self-help framework.

Another key difference between autism and ADHD self-advocacy is how the ontology of these disorders are framed. The ontology of autism is discussed and debated between various autistic communities and scholars. Some argue that autism is strictly a social construction, but they do so in a way that still presents autism as an affirmative identity to be respected (Woods et al. 2018: 976). This is not the case for ADHD self-advocacy. When it comes to neuropsychological and medical discourse, one of the main criticisms of ADHD is that it is a "cultural construct" and therefore "not a genuine medical disorder" (Timimi et al. 2004). Similarly, in the social sciences there are decades worth of research articles and books criticizing ADHD as a harmful category, identity, or diagnosis (Harwood 2010; Hacking 1999; Rose 1990; Conrad 1975). In popular media ADHD has been portrayed as a "fictitious epidemic" made up by the pharmaceutical companies (Robinson 2010). Even the fields of bioethics and human rights studies argue against the power of the ADHD industry (Rogers 2014: 166). It should come as no surprise, then, that ADHD self-advocates rely heavily on framing ADHD's ontology in biological terms, as they believe that asserting a social constructivist view of ADHD risks playing into the hands of the critics they are so wary of.

Importantly, studies that criticize ADHD, almost without exception, make no effort to engage with ADHD self-advocacy communities or voices, and therein lies much of the problem. Critical-minded individuals who get diagnosed with ADHD inevitably become drawn to whatever critical discourse on ADHD is available to them. For instance, in a newsletter on York University's Critical Perspectives on Mental Health, a PhD student writes about recently being diagnosed with ADHD; in response to his new diagnosis, he decides to perform an analysis of ADHD using a Foucauldian biopower perspective, and cites popular ADHD skeptic Sami Timimi (Joseph 2021: 11). He makes no mention of ADHD self-advocacy discourse.

Without a *critical ADHD studies* that engages with ADHD self-advocacy while also encouraging critical thought and reflection, critical-minded individuals will no doubt become skeptical of their ADHD diagnosis. They have little choice but to disown their ADHD, to repress the idea of it, and in latent cases of critical self-awakening, to be ashamed and embarrassed about ever having believed in it. They become, for all intents and purposes, ADHD skeptics, even if they still take medication for it.[6]

This dissertation, to some extent, is about reversing that process. As someone with ADHD myself, I have pushed myself over the past eight years to keep an open mind despite my disciplinary training in critical theory and critical sociology. I want to convince other critical-minded ADHDers that there is radical potential in identifying with and fighting for ADHD as a legitimate category. *Solidarity* should be the first goal of a critical ADHD studies: to offer our hand out to critical ADHD individuals who we—ADHD self-advocates—have abandoned; and, in the other direction, to listen to and consider ADHD self-advocacy voices that we—critical scholars and thinkers—often dismiss as uncritical.

The second goal of a critical ADHD studies should be to develop radically new strategies for reducing ADHD harm in all its forms. This dissertation is about establishing a theoretical ground upon which the path to achieving these goals can *begin*. That is, it is about explicating and clarifying the problems in contemporary ADHD discourse, and providing a rationale for why a critical ADHD studies that centres ADHD self-advocacy voices is desperately needed. It also means showcasing a potential alternative to dominant theories of ADHD. In other words, I

[6] As ADHD self-advocate Mary Solanto puts it, the "ADHD skeptic" is "The Patient in Denial" (2017: 48-49).

develop a critical-yet-affirmative ontology of ADHD—not as a definitive answer or solution to all the questions or problems, but as a starting point for imagining radical alternatives.

Preliminary Arguments

1: The Predominant Form of ADHD Harm Is Misrecognition

Studies that criticize ADHD do not do so out of malice; their approach is rooted in the desire to minimize one particular kind of ADHD harm: that which is perpetuated *by the social construction of ADHD*. Sociological criticisms of ADHD, for example, tend to be framed either through the framework of "labeling theory" or through a critique of "medicalization" (Rafalovich 2002: 11). Labeling theory traces the many harms inflicted on individuals (especially children) due to being labeled as "ADHD." *Psychiatric* discourse does this too—maligns social burdens that might come with the diagnosis—but tends to argue that "stereotypes" or "prejudices" are to blame for the hurtful effects of labeling (the APA calls this kind of harm "stigma"; it can also include "self-stigma" and "institutional stigma") (Borenstein 2020).

Sociologists, in contrast, blame this kind of harm on the power structures inherent in institutional administrations of the label. They also emphasize how labels can intersect with already-existing social inequalities. For example, sociologist Valerie Harwood describes a case in which a nine-year-old child who was suspected of having ADHD by his teacher (one kind of "labeling") was forced into a "mobile asylum," where he was not allowed to attend school until he received an official diagnosis from a psychiatric assessment, which took four months to obtain, four months of him staying at home all day because his single-mother had to work, making him "horribly depressed and suicidal" (2010: 444). Sociological critiques of medicalization, on the other hand, address the oppressive structural forces that problematize or

give rise to ADHD-like symptoms (social control, underfunded classrooms, pharmaceutical profit, etc.), and the oppressive apparatuses of psychiatric power that veil these forces in favour of psychological or biological explanations. This family of critiques redirects focus from *individuals* (who are medicated in order to be cured) to the *systems and institutions* which, if re-ordered or abolished, would eradicate ADHD. It might be said that these sorts of critical takes on ADHD employ a politics of anti-oppression and recognition—but not *for* ADHD. They do not view ADHD as an "identity" that entails fighting for one's rights in the same way that, say, being Black does.

ADHD self-advocates, in contrast, do employ a politics of recognition for ADHD, though *not* a politics of anti-oppression. Their fight for recognition is a fight to have their *deficiency* recognized (see Figure 0.2). Recognition here includes the usual claims made by groups with disabilities—institutional accommodations, healthcare coverage, and government support—but it also means recognition in the sense of not being *misrecognized*.

Figure 0.2: ADHD self-advocate Pina Varnel's comic illustrating the desire for ADHD's deficits to be recognized (2019).

Misrecognition is a key concept throughout this entire dissertation. One definition is "failing adequately to respond to the person and their normatively significant features" (Martineau et al.

2012: 3). ADHD individuals—as is the case for any disability—must create new norms for themselves to adapt to their environment (Canguilhem 2012: 183, 186). When these new norms are not recognized by others, ADHD behaviours are inevitably *misinterpreted or misread* by others.

For example, popular social media gurus and ADHD self-advocates Jessica McCabe and Brendan Mahan describe a common experience of ADHD individuals having to spend more time than usual to begin a task. This is because, they claim, ADHD individuals have to emotionally prepare themselves to "climb the wall of awful"—the emotional wall that demotivates them from doing a task they have previously failed at time and time again.

> The kid is taking forever to get their binders out of the backpack, the parent comes over, grabs the binders, puts them on the table, and goes "do your homework!" Typically what happens then is the kid snaps, and starts yelling at mom or dad.... The kid was climbing the wall.... They just needed a bit of a longer runway. (McCabe and Mahan 2019)

The "normatively significant features" in this case is that the kid normally needs longer to prepare to do a task he or she does not want to do. Climbing the wall of awful is a "new norm" that the kid has created to adapt to this emotional blockade. The parents who rush (rather than gently nudge) the kid are engaging in misrecognition of ADHD: they are not acknowledging or accommodating the kid's specific ADHD-related differences.

For analytical clarity, it is important to distinguish between the concepts of ADHD stigma and ADHD misrecognition. Sociologist Erving Goffman defines stigma as a mark on the

individual that makes others treat him or her as "not quite human" (2009: 5). Conventionally, as is the case with any "mental illness," stigma occurs as a result of the *label* and its associated stereotypes and prejudices. As some studies show, being labeled "ADHD" contributes to negative attitudes toward the individual from (a) the individual him or herself; (b) the family of the individual; (c) the individual's teachers; and (d) the individual's primary care practitioner (Bisset et al. 2022: 537-538). Notably, these studies focus on how *children* with ADHD can be greatly impacted by the label.

However, and *this is really important*: in a recent systematic review of academic studies looking at *community* attitudes (i.e., *not* family members, teachers, or medical professionals) toward ADHD, Bisset et al. write, "findings suggest that negative attitudes are only associated with ADHD-related *behaviours*, not the *label* of ADHD" (2022: 544). They state that "there was general agreement across studies in the current review that knowledge, recognition of, and familiarity with ADHD tends to *protect* against negative attitudes.... It is not so much the symptoms that influence the acceptance, *but whether or not they are attributed to the person or to ADHD itself*" (2022: 544; emphasis added).

Misrecognition, then, refers to negative attitudes toward ADHD behaviours that are attributed to the *person* (e.g., a deficiency in the person's character) and *not* to ADHD's normative features. As one user on ADHD coach Pete Quily's self-advocacy website writes, "I do things unknowingly sometimes, and it is very painful emotionally because people don't understand and just think I have 'no tact.' But when I say, 'I'm sorry I have ADD,' they just shrug their shoulders, roll their eyes and completely dismiss what I just said" (in Quily 2015a). This is an example of ADHD misrecognition: others are attributing the behaviour to the person (she has "no tact"), not the ADHD. Even when ADHD individuals try to *be marked*, or make

their mark known, others refuse them that mark (contra stigma). This refusal stems from a belief that the individual is bearing a mark falsely—trying to use it as an *excuse*. In effect, the behaviour is misinterpreted or misread through a social-normative lens rather than an ADHD-normative lens. It is unsurprising, then, that one of the dreams of ADHD self-advocacy is for the public to recognize ADHD's normative features *as social norms* (see Figure 0.3).

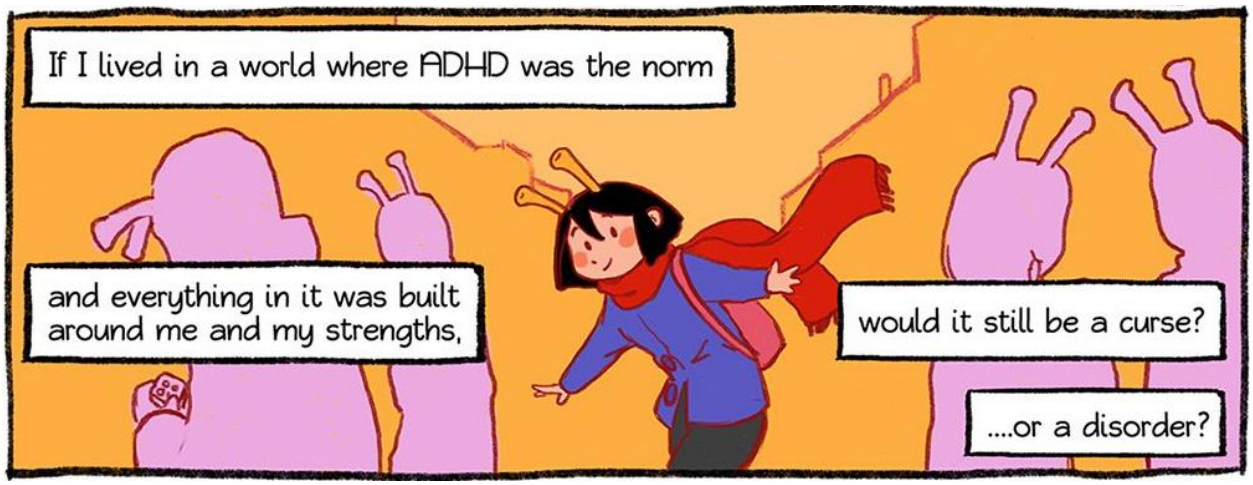

Figure 0.3: Varnel imagines what the world might look like if ADHD's normative features *were* social norms (2019).

There are endless examples of ADHD misrecognition that I could draw on: an ADHD individual who zones out during a conversation is misinterpreted as not caring about what the other is saying[7]; an ADHD individual who hosts a dinner party but forgets to take the groceries out of the car in the morning (and consequently has no food to offer her guests) is misinterpreted as disorganized (Matlen 2014: 35-36)[8]; an ADHD individual who is momentarily distracted and forgets to set a cooking timer ends up burning a pot on a stove, and is subsequently misinterpreted by roommates as immature, incapable of being left unsupervised in the kitchen. In

[7] Those "with ADHD might seem to lack empathy toward others' feelings and points of view, but often [they are] simply too distracted to notice others' feelings" (Matlen 2014: 136).

[8] While ADHD individuals are often disorganized, in this case it was simply a momentary lapse of attention that led to the food being spoiled in the hot car, not disorganization; in fact, this individual was highly organized: she planned and hosted a dinner party and bought all the required groceries.

all these cases, misrecognition arises precisely because ADHD symptoms are misinterpreted as normal human behaviours, particularly behaviours that signify bad qualities about the person (a lack of care, disorganization, and immaturity). As Hallowell and Ratey write, "people don't know how else to make sense of this kind of behaviour, so they attack it as being beneath adult standards" (1994: 114).

ADHD misrecognition can have far-reaching consequences especially when it occurs on an institutional level. In a study of career outcomes of ADHD individuals with a post-secondary degree, it was found that they are still at least twice as likely to be laid off (33% to 13%), 1.5 times as likely to be fired (61% to 43%), and earn $8,900-$15,400 (USD) less per annum than their non-ADHD counterparts of equal educational background (Solanto 2011: 9). They are also four times less likely to hold a "professional job" than those without ADHD who hold a similar degree (Kuriyan et al. 2012: 38). There *might* be a bit of ADHD stigma going on here, but most ADHDers know not to disclose their diagnosis to employers (Fellman 2022). And given that these ADHD individuals were able to complete a post-secondary degree, it seems unlikely that these career discrepancies are strictly a consequence of ADHD's purported "innate impairments." Clearly, these individuals know how to effectively manage and overcome their impairments in a particular complex environment (higher education). So why then the discrepancy in measures of professional success between them and non-ADHD individuals? These discrepancies are, in all likelihood, a consequence of the complex interplay between misrecognition, discreditation, and spiraling self-doubt.

In summary, recent analyses of the literature indicate that while ADHD stigma—labeling effects, etc.—is still a significant issue for ADHD children (stereotypes and prejudices held by family members, teachers, and family physicians), it is much less of an issue—if an issue at all—

for ADHD adults. Children may experience institutional stigma (e.g., an underfunded school system streaming them into overpacked alternative classrooms full of "undesirables") or self-stigma (a self-fulfilling prophecy of feeling and being inadequate) (Harwood 2006: 122-140). ADHD children may also experience ADHD misrecognition, though I am unsure how it compares for them in severity to ADHD stigma (statistically speaking). In any case, recent literature indicates, and my research and experience affirms, that when it comes to adults with ADHD, the pervasive form of ADHD harm is misrecognition, where ADHD's normative features are attributed to their personhood rather than their disorder. This kind of harm can have significant consequences for a person's social relationships, self-esteem ("self misrecognition"), and career prospects ("institutional misrecognition").

As a final point, misrecognition is a kind of harm that is perpetuated whether or not the label "ADHD" is present or known to those who misrecognize the behaviour, or even to the ADHD individual. Critical-minded ADHDers who disavow their diagnosis or distance themselves from identifying with ADHD are still just as vulnerable to ADHD harm: not harm from the label, but from misrecognition.

2: The Concept of Neurodiversity Is Insufficient for ADHD Self-Advocacy

The ADHD self-advocacy subreddit, with 1.4 million subscribers, prohibits "promotion of neurodiversity" ("ADHD" 2021). Why? In the statement made by the subreddit's moderators, there is one key point that is repeated again and again: ADHD is an "innate impairment," and the framework of neurodiversity overlooks that when it asserts that "mental health disorders are just 'differences in cognition'" ("Position on Neurodiversity" 2021). In philosophical terms, the moderators view ADHD as a primary ontological specificity (an "innate impairment") that is being trampled on by the generalized ontology of neurodiversity. According to the

neurodiversity framework, neurodiversity represents a heterogeneous range of cognitive differences in humans that happen to transgress social norms. These transgressions are medicalized by psychiatry as "internal pathologies" or "innate impairments," but the neurodiversity movement rejects these framings. The ADHD subreddit moderators, in contrast, embrace them. Why do they do this?

I want to emphasize two approaches to answering this question: the socio-historical approach and the socio-philosophical approach. In the former approach, the answer is that ADHD self-advocacy is historically rooted in psychiatric power and modeled after the ADHD self-help industry. As a result, ADHD self-advocates believe that the "medical model [is] a necessary foundation that enables the treatment of ADHD" ("Position on Neurodiversity" 2021). They believe that psychiatric control of ADHD helps to legitimize it in the eyes of other institutions such as schools and workplaces, helping ADHDers combat ADHD harm and acquire accommodations, government support, and healthcare coverage.

The socio-philosophical approach answers the question from a different angle. It asks, what are the dominant ontological beliefs surrounding ADHD? What is it about these beliefs that makes psychiatric power so appealing for ADHD self-advocates? Why would they reject the progressive, affirmative, generalized ontology of neurodiversity in favour of a self-demeaning, negative ontology of an "innate impairment"? Why are they so averse to ontological generalities? My argument is that self-advocates recognize—implicitly—that the root of ADHD misrecognition—the predominant form of ADHD harm, at least for adults—derives from the belief that ADHD can be reduced to a generalized ontology of humanhood.

The most obvious example of this is when people claim that ADHD does not exist. In a recent study out of Germany, for example, 20% of participants believed that ADHD was not a

"real disorder" (Speerforck et al. 2021: 785). In their view, ADHD individuals are just normal human beings that have been misdiagnosed, or diagnosed in order to have an excuse for their personal failures, or to get medicated.

However, to be an ADHD skeptic does not necessarily entail a total disbelief in ADHD's ontological specificity. In a meta-analysis of studies from 2000-2010 of attitudes of general practitioners (GPs) in the UK, Australia, and Iran, the majority of GPs felt that ADHD was overdiagnosed and a "fashionable diagnosis" (Tatlow-Golden et al. 2016: 10). In their view, it might be a legitimate disorder, sure, but it is certainly overdiagnosed. Similarly, in a more recent study of Australian public attitudes, 78.3% of participants believed that too many children are diagnosed with ADHD when they do not really have it (Partridge et al. 2014). These studies suggest that even if one believes that ADHD has an ontological specificity—say, that it corresponds to a "different kind of brain," an "innate impairment," an "internal pathology," or that it is "real"[9]—that this is often accompanied with a belief in an ontological generality as well.

Why does believing ADHD is overdiagnosed entail a belief in an ontological generality? As ADHD self "advocate" Gabor Maté writes, "fueling skepticism about its actual prevalence is the [belief][10] that no feature of ADD is so unique that it cannot be found, to one degree or another, in any number of people among the non-ADD population" (2000: 21). Everyone, at times, gets distracted, acts impulsively, loses track of time, arrives late, has emotional outbursts, forgets where they put their phone, experiences self-doubt, and so on. The belief that ADHD symptoms are so indistinguishable from normal human behaviours is what leads people to believe the

[9] For some, ADHD is only "real" if it has a *biological* specificity.

[10] He writes "fact" but I refute that in Chapter Six. Maté, a physician, is a controversial figure in ADHD self-advocacy. Discussions of his work are forbidden in the ADHD subreddit (primarily because he argues that ADHD has a social-environmental etiology).

disorder is overdiagnosed, and this belief fuels ADHD skepticism. It is a belief in a generalized ontology of ADHD that, in most cases, overshadows its ontological specificity.

What it also does is perpetuate ADHD harm. To recognize ADHD behaviours as normal human behaviours *is* to misrecognize ADHD's normative features. ADHD skepticism and ADHD misrecognition are two sides of the same coin. This predominant form of ADHD harm—misrecognition—stems from the reduction of ADHD to a generalized ontology of humanhood. Wives often complain about their ADHD husbands being *like children* (Maté 2000: 38). Husbands often accuse their ADHD wives "of being 'frigid'... or involved with someone else," when in actuality they just have trouble paying attention during sex due to their ADHD (Hallowell and Ratey 1994: 117). These are examples of misinterpreting ADHD's normative features through a social-normative lens.

Neurodiversity characterizes ADHD as a part of normal human diversity. As a political strategy for combating *stigma*, this framing makes sense. But when it comes to combating ADHD misrecognition, adopting the ontological framework of neurodiversity makes little sense. It risks attributing "disorderly" behaviours to the *human being*, and not this internal pathology we call "ADHD." I would argue that this, more than anything, is why many ADHD self-advocates, such as the ADHD subreddit moderators, do not promote or embrace neurodiversity.

While it is of course beneficial for ADHD self-advocates to *ally* with the neurodiversity movement, and while there is no immediate harm in ADHD individuals identifying themselves as both ADHD and neurodiverse—which many certainly do—my key point is that neurodiversity as a philosophical and political framework is not a viable starting point, let alone an end point, for establishing a critical-yet-affirmative discourse on ADHD that can effectively combat ADHD misrecognition.

3: Psychiatric Power Is Anemic for ADHD Self-Advocacy

In the years and decades following the publication of the DSM-III in 1980 and the rapid decline of psychoanalysis, psychiatry's new "'destigmatizing' strategies... [sought] to convince us that mental distress is, or arises from, diseases like any other, [thereby] liberating individuals from responsibility, guilt, and blame for their condition" (Rose 2018: 189). Indeed, one of the strongest attractions of psychiatric power is that it provides ADHD individuals with a pathological explanation for their struggles that does not put the blame on the individual (or on society), but on this internal pathology instead. ADHD self-advocacy's servitude to psychiatric power is largely premised on the idea that acknowledging ADHD's deficiencies as being biologically rooted helps to boost the individuals' self-esteem *and* alleviate moral condemnation from others. As the title of one ADHD self-help book puts it, *You Mean I'm Not Lazy, Stupid or Crazy?!* (Kelly and Ramundo 2006). Or, as the lyrics of a pop song (with over 144 million views on YouTube) instructs, "blame it on my ADD, baby" (Red Bull Records 2014). In short, psychiatric power is said to effectively combat ADHD stigma and misrecognition by allowing individuals to disclose, without shame, that they have a medical disability.

However, these psychiatric strategies have never been very successful at destigmatizing mental distress (Rose 2018: 189). As the APA states on their website, "while the public may accept the medical or genetic nature of a mental health disorder, many people still have a negative view of those with mental illness" (Borenstein 2020). ADHD harm is still widespread throughout society (Bisset et al. 2022).

I disagree with contemporary ADHD self-advocates who believe it is imperative that we continue to allow psychiatric power to control ADHD discourse. My argument here is twofold: relying on psychiatric power to combat ADHD misrecognition is a losing strategy because (a)

ADHD's proposed ontological specificities (an "innate impairment," a "different kind of brain," a "medical disorder," etc.) do not actually refute public beliefs in ontological generalities. Continuously insisting over the past thirty years that ADHD is "genetic," for instance, appears to have done little to dissuade widespread beliefs that ADHD is overdiagnosed. And (b) behind the scenes, psychiatric power asserts a generalized ontology for ADHD anyway, and could very well pull the plug on ADHD in the near future.

The phrase "psychiatric power" is not meant to represent a singular vision of ADHD by everyone involved in psychiatry, psychology, medicine, pharmacy, neuroscience, and genetics. Researchers and clinicians have a range of disciplinary backgrounds, theoretical orientations, personal belief systems, preferred methodologies, and so on. But part of the strategy of psychiatric power is insisting that there is a "consensus" on ADHD and that its institutional legitimization is stable. The 2002 "International Consensus Statement on ADHD," for example, spearheaded by prominent ADHD researcher Russell Barkley and signed by 86 psychiatrists, psychologists, and pediatricians, asserts several possible ontological specificities for ADHD: "those with ADHD... demonstrate relatively smaller areas of brain matter"; "one gene has recently been reliably demonstrated to be associated with this disorder"; and ADHD is a "failure of... a psychological mechanism that is [otherwise] universal to humans" (Barkley et al. 2002: 90, 89). While there is a marked lack of consensus on the precise mechanism, the statement is meant to perform consensus that an underlying mechanism exists.

In his own work, however, Barkley simultaneously frames ADHD's existence as an ontological generality: "ADHD [is not] a disease entity, but... a matter of degree in what is otherwise a characteristic of typical children" (2006: 95). He toes this double line to sustain ontological coherency in the face of criticism from his colleagues. For instance, two years after

the consensus statement was published, child psychiatrist Sami Timimi and 33 co-endorsers replied with a critique, pointing to the lack of "cognitive, metabolic, or neurological markers for ADHD and [the lack of] a medical test for this diagnosis" (2004: 60).[11] To offer a bit of philosophical clarity to my argument, I am not suggesting that simultaneously asserting an ontological specificity and generality for ADHD is a contradiction. Rather, the problem in psychiatric discourse is the *agnosticism* shown towards ADHD's ontology—that is, the lack of clarification as to whether its specificity or generality is ontologically *primary*. Is it the case, following the view laid out by Barkley et al. above, that what is most specific to ADHD is its purported smaller brain, genetic marker, or psychological deficiency? And that this specificity then modifies the generality of childhood behaviour in a way that pushes it over the DSM criteria's threshold? A biological specificity *modifying* the generality of humanhood, leading to a specific diagnosis? *Or* is it the case that the generality of humanhood is ontologically primary, that it is *not* modified by specificities, but "lawless" in its endless neurodiversity? And that ADHD's specificity is nothing more than a DSM-informed interpretation and enclosure of neurodiverse traits? There is always a back-and-forth between ontological specificities and generalities when thinking about what ADHD is, but what ultimately defines someone's belief is the starting point and direction: which side of this dynamic is taken as ontologically primary, and which side secondary?

The problem with psychiatric agnosticism is that ADHD discourse becomes stuck in an ontological circle that has crisscrossing starting points or, amounting to the same thing, no

[11] It might be said that ADHD is a biological specificity when the narrative of "scientific progress" is asserted (the idea that its biological specificity will soon be proven by science), but a behavioural generality (with specific diagnostic thresholds) when the narrative of "scientific skepticism" is asserted (the accusation that, if it did have a biological specificity, surely a reliable biomarker would have been discovered by now).

starting point at all. Given this ontological circularity, asserted by even its most esteemed experts, it is no surprise that the disorder remains highly controversial amongst medical professionals. Many physicians still feel uncomfortable diagnosing it, many psychologists, neuroscientists, and geneticists scoff at colleagues who research it, and many clinicians ardently oppose it. As ADHD coach and self-advocate Pete Quily writes, "I know people who work in the mental health fields who have ADHD and went public [with it] and got harassed and discriminated by psychiatrists, psychologists, and doctors at work. Then they went back to hide in the ADHD closet" (2015b).

From what I can tell, such discrimination from *within* the institutions of psychiatry, psychology, and medicine *is* on the decline, but *not because ADHD's biological specificity is becoming more accepted*. Rather, such discrimination is *forcing the category of ADHD to be reduced to a generality*. Only when it is taken as a generality do these "professional skeptics" lay off the discrimination. Indeed, this whole shift in public discourse surrounding psychiatric disorders that we have seen in recent years—recognizing neurodiversity, talking about spectrums—*coincides* with a shift going on behind the scenes (out of the public's eye) in psychiatric discourse and politics: a growing movement to turn away from the DSM for classification purposes, and to develop a new classification scheme based on ontological generalities. The popular Research Domain Criteria (RDoC) is precisely this alternative (Insel et al. 2010). One idea behind RDoC is that psychiatric disorders like autism and ADHD "could be better conceptualized as lying on an etiological and neurodevelopmental continuum, rather than being defined as discrete entities," and this follows a "general trend" in psychiatric discourse of placing disorders on a spectrum (Morris-Rosendahl et al. 2020: 69, 68). In other words,

psychiatric discourse is gradually moving to replace ADHD's biological specificity with a *biological generality*.

To conclude, ADHD self-advocates rely on psychiatric power to combat ADHD harm *not* because it works. Rather, they cling on to this idea *that it works* because that is the strategy of psychiatric power. The strategy is to present—at least to self-advocates—ADHD as *primarily* a biological specificity. It dichotomizes this discursive "truth" against purported "untruths" about its generality: it encourages self-advocates to interpret ADHD skepticism as "anti-science," and anti-psychiatry or critical sociology as "misinformation" or "pseudoscience" ("ADHD" 2022). It deploys these strategies to maintain control over ADHD. It presents itself as ADHD's saviour from skepticism, stigma, and misrecognition when in actuality it perpetuates these problems just as much as anti-psychiatry or critical sociology discourses do. And behind the scenes, psychiatric discourse contributes to the reduction of ADHD to ontological generalities just as much as it constructs its ontological specificities. This is why psychiatric power is *anemic* for ADHD self-advocacy. Like a vampire, it befriends and guides self-advocates during the day (when public-facing), but sucks the blood and oxygen out of them at night (in esoteric, academic discourse that remains inaccessible to them).

Do not get me wrong: I do not call for ADHD self-advocates to abandon psychiatry, psychology, and medicine. Criticize them and take away their *control* of ADHD discourse, yes, but not abandon. Without psychiatry and medication I would not be writing this dissertation right now. But my fear is that if we continue to allow these institutions to control ADHD discourse, its ontological *primacy* will be pushed further into the ground of generality, and that the problem of misrecognition will continue to permeate the lives of ADHD individuals.

Overall Argument and Chapter Outlines

In its most succinct form, my overall argument is as follows. First, the predominant form of ADHD harm (misrecognition) is rooted in an ontological fracture inherent in the practice of medicalization. Second, the practice of medicalization is dialectical: it sustains itself as habits of thought that effortlessly traverse from ontological generalities to specificities and vice versa. Third, this dialectic of medicalization is perpetuated both by psychiatric power *and* social scientific discourse. Fourth, that in order to effectively combat ADHD misrecognition, ADHD self-advocacy must seek to escape this dialectic by asserting its own critical-yet-affirmative ontologies of ADHD that can effectively *put an end to* this ontological back-and-forth between generality and specificity. And fifth, that one such ontology can be developed by synthesizing Russell Barkley's negative theory of ADHD with positive, descriptive accounts of ADHD's symptomatic specificity in self-advocacy discourse.

Evidently, there are many branches to this overall argument, and each chapter aims to strengthen a particular branch. This dissertation, however, is also more than the sum of its parts. Each chapter is written as a standalone piece that can be read apart from the broader dissertation argument put forward in this introduction. Yet, for thematic cohesion, I outline each chapter below in relation to *this* broader argument, rather than describing the precise arguments put forward by the chapters on their own terms.

Chapter One asks, what does it mean to start thinking about ADHD in its specificity *outside of biological identity*? In other words, what makes a specificity capable of ontological primacy if not biology? The problem with the biological specificities of ADHD asserted by psychiatric discourse is that they are "technologies of the self." In other words, biological framings of ADHD are themselves *discursive techniques of power* (Rogers 2014: 167). In layperson terms, pointing out that ADHD has no reliable biomarkers does not mean it is "not real"; the *belief* that

it *is* biological, no matter how tenuous the evidence, still imparts "real effects" on the believers. In turn, *for those who are critical* of psychiatric power, the *tenuity-yet-power* of ADHD's biological framings only serves to reinforce *their* beliefs in an ontological *generality* of psychiatric power: the belief that all psychiatric disorders—ADHD or otherwise—fundamentally exist as powerful discursive constructs. Yet, what these critiques tend to overlook, I argue, is the *symptomatic* specificity of disorders, and how *those* specificities—rather than biological specificities—call the generalizability of these critiques into question.

In this chapter, then, I analyze philosopher Ian Hacking's theory of looping effects as a particularly well-cited example of a critique of psychiatric power. The case of multiple personality disorder (MPD), the basis of Hacking's theory, has no *primary* specificity because whatever specificities it does have—namely, its *specific label* and the *specific effects of being labeled with MPD*—are quite malleable, open to psycho-social discursive influence. This makes it a "perfect" example of looping effects. I point to the problems that arise for Hacking when he tries to apply his theory to another disorder, namely autism. He becomes confronted by the immutability of autism's symptomatic specificity, what Hacking calls its "inaccessibility" to looping effects. In particular, then, the specificity of autism seems to be something more than it is for MPD. I argue that Hacking is ultimately forced to abandon his theory of looping effects *for autism* once he starts examining autistic self-advocacy literature. Although he does not put it this way, it is almost as if he understands that there is something specific about autism that *precedes discourse about autism*. A specificity that is *prediscursive* yet also, at least in its ontological primacy, *not necessarily biological*. I suggest that this might also be the case for ADHD. In short, Hacking helps to clarify a starting-point for thinking about what makes a specificity have

ontological primacy: not whether or not it is biological, but whether or not it is *inaccessible to discursive effects*.

Chapter Two changes gears by addressing my argument that ADHD misrecognition is perpetuated by a reduction of ADHD to ontological generalities—not just by psychiatric power but by *sociological discourse*. In particular, I point out how structural-functionalist perspectives in sociological and public discourse reinforce this kind of ADHD harm. The sociological critique of medicalization assumes ADHD symptoms to be recognizable patterns of social dysfunction that emerge from social problems: underfunded classrooms, overzealous and strict teachers, intensification of time-management under capitalism, and so on. The structural-functionalist solution is to enact social reform, to eradicate these social problems and restore society to "good health." I argue, however, that the side-effect of structural-functionalism is a widespread belief in public discourse that ADHD is reducible to such an ontological generality: that ADHD symptoms are nothing more than normal human psycho-physical reactions to social issues.

As this "sociological ontology" of ADHD continues to be bolstered and popularized in Canadian and American media, and especially in discussions surrounding education (c.f. Robinson 2010), more ADHD individuals are turning to critical discourse for therapeutic guidance. This connects back to the point I made about the allure of studies that criticize ADHD: ADHDers who are critical of psychiatric power tend to look toward critical discourse—or its public-facing variants—for self-understanding. The problem with this therapeutic approach, however, is that it provides self-understanding but not solutions. It overlooks the helpful psychotherapeutic techniques that address ADHD's *symptomatic specificity* in favour of viewing one's symptoms as nothing more than an ontological generality.

Chapter Three dives into an ethnographic case study of an ADHD clinic located in Okinawa, Japan. I chose this lab because the biomedical model of ADHD is relatively "new" in Japan, and so questions of the interplay between ADHD and culture are readily on the minds of the lab's clinicians (who all speak English and are trained in Western models of neuropsychology). If the Western biomedical model of ADHD can "travel" to a foreign country, how do these clinicians conceptualize this mobility? Do they strictly figure ADHD's specificity as *biological*, and "therefore" *universal*, case closed? To answer this, I interview clinicians to try to get a better understanding of what aspects of ADHD are accessible, and which are inaccessible, to *cultural* discourse—Japanese belief systems, cultural norms, childrearing practices, and different standards of behavioural conduct and etiquette in both family and classroom contexts. My findings indicate that each clinician believes in one, two, or all three of the following primary specificities proposed for ADHD: a biological specificity, a psychological specificity, and a symptomological specificity. I also encounter and document instances of what I call "ontological traversal" in the expressed beliefs of various clinicians, or between different clinicians. Experts do not always operate with a consistent, clear, and articulable concept of what ADHD "is". Finally, I argue that, at least in the context of cultural discourse, it appears that psychological and biological specificities are not as inaccessible as these clinicians claim them to be. Similar to my findings in Chapter One, the only consistent aspect of ADHD that remains truly inaccessible to discursive effects is its specific symptoms.

Chapter Four aims to unearth the *common root* of the habit of reducing ADHD to ontological generalities that is shared by both psychiatric discourse and social scientific discourse. It also aims to explain why, on a philosophical level, discourses surrounding ADHD—with the exception of ADHD self-advocacy discourse—have so little issue traversing ontological

specificities and generalities. I call this common root of the problem the *dialectic of medicalization*. I argue that medicalization represents dialectical *habits of thought* that are constantly trying to fix an ontological fracture: the incoherency of ontological specificities in the face of ontological generalities that ground them, and vice versa. The result is a never-ending conceptual back-and-forth between specificity and generality. The dialectic of medicalization is what allows ADHD to be both institutionally *sustained and stabilized* as a specificity, and institutionally *criticized and destabilized* as a generality. It is what churns the research industry surrounding ADHD, a continuous exploitation of its ontological undecidability. It also, of course, perpetuates ADHD misrecognition: allowing ADHD to *persist as a legitimized category and diagnosis* while simultaneously encouraging people to *recognize its symptoms as common to all humans.*

Chapter Five argues, against the backdrop of my philosophical argument in Chapter Four, that the ontological histories of ADHD and autism should not be conflated. Their predominant sources of harm emerge from different directions. I use philosophical genealogies to argue that autistic self-advocacy has put forward a sort of "difference in itself" for autism (Deleuze 1994: 28). I reinterpret the concepts of the autism "spectrum" and "neurodiversity" through this demedicalized, ontological framework. I also argue that autistic self-advocacy calls into question the totalizing character of various theories of subjectification, most particularly that of Nikolas Rose. I conclude by pointing out why, given the differences in ontological histories (and forms of harm) between ADHD and autism, on a philosophical level, ADHD cannot follow in autistic self-advocacy's footsteps. I reiterate that ADHD self-advocacy is at a crossroads: either it succumbs to the self-defeating argument that it is nothing more than medicalized individual variation, scientifically legitimized only by a series of genetic and neurobiological

reconfigurations that have had very limited success (surely a *precarious* position to be in); or it tries to reimagine itself through its own ontological specificities, a socio-philosophical intervention.

Chapter Six develops a new critical-yet-affirmative ontology of ADHD. I draw from ADHD self-help literature, Russell Barkley's psychological theory of ADHD, and philosophy to try to parse out what I call the "univocity of attention," ADHD's difference in itself. It is a new way of understanding the *specificity* of the disorder that does not slide back into the dialectic of medicalization. It provides a philosophical basis for the possibility of a renewed self-advocacy, one that can more effectively fight against ADHD misrecognition, and determine its own ontologies in a way that is inclusive of critical ADHD voices beyond just my own.

Limitations

One type of ADHD harm I failed to mentioned is the harm that occurs when other aspects of a person's identity—the intersections of race, ethnicity, gender, sexual orientation, and so on—interfere with recognition of ADHD. Consider the follow statement from PhD student Rudolph Reyes II:

> One semester in college, I received back a final paper with great expectation. I was trying to synthesize two ideas in a novel way. When I got back my paper, my excitement turned to shock, anger, and disappointment. There was positive feedback, but I could only focus on one comment. The comment read: "There are a lot of grammatical errors, but I assume this is because English is not your first language." English is my first language. The only

> Spanish I knew was my family's idiosyncratic use of Spanglish. My ADHD way of writing was not attributed to my neurodivergence, but to my racialized identity. (Reyes II 2021)

This is an example of *racialized misrecognition of ADHD*. Other examples include the common practice of diagnosing Black and Indigenous youth with fetal alcohol syndrome while *white-passing* youth are diagnosed with ADHD (Charlesworth 2021: 4; Ergun et al. 2021; Oldani 2009); or clinicians diagnosing Black children with conduct disorder but white children with ADHD (Harwood 2006: 24). Tackling racialized ADHD harm is absolutely essential to critical ADHD studies, and I certainly do not do this type of harm justice in this dissertation. I mention it here because it is a major issue, has had very little research done on it, and has a distinct complexity to it compared to non-racialized ADHD misrecognition.

Another limitation to this dissertation is that, with few exceptions, I do not deploy a politics of anti-oppression to analyze how individuals can be harmed by the social construction of ADHD. Though I argue that ADHD does have an ontological specificity beyond the label or diagnosis, I also accept that, as a DSM-constructed psychological category, many aspects of ADHD are socially constructed, and done so in ways that can perpetuate already-existing oppressions (again, this appears to be especially true for ADHD children). Nevertheless, given that there is already a well-established field that researches this type of harm—the interdisciplinary field of studies that criticize ADHD—I see no reason for me to have to retread this ground.

In this dissertation, I also risk mischaracterizing the complexities and tensions within autistic self-advocacy movements, both historical and contemporary, as my research into these

movements is far from complete. While I am continuously trying to learn more about autistic self-advocacy, I remain, for the time being, singularly focused on ADHD. My research and interpretations of autistic self-advocacy is guided by the differences I observe between it and ADHD self-advocacy, and I hope this approach has not led me too astray from accurately depicting autistic self-advocacy.

Finally, in the early days of this project, I considered diving into epigenetics and neuroplasticity in order to better understanding how ADHD individuals' biological make-up and brain is directly impacted by discursive forms and practices. I could have tried to understand the complex interactions between biological materiality (genetics, brain synapses, etc.), historical materiality (capitalist transformations of time, work, education, and so forth), and discursive power. And I think that would be a project worth pursuing. However, although I tinker with these ideas, I ultimately decided to take a different approach, one that strikes me as timely and more relevant to ADHD self-advocacy—where my heart is at—even if at the risk of avoiding, for now, complex and inviting questions about biosocial materialities.

Methodology

This project utilizes multi-sited ethnography (Marcus 1995: 102) including open-ended interviews, participant observation, auto-ethnography, and qualitative content analysis across a variety of field sites. I do not only "follow the people" involved in ADHD communities, but also psychological and neurobiological knowledge (passed along and de-technicalized), commodity chains (stimulant drugs, self-help books), and narratives of conflict (such as overcoming ADHD harm and fighting for recognition).

My research includes over 20 extensive interviews with ADHD professionals working in psychology across Canada, the United States, and Japan. I also interned at an ADHD children's

clinic for ten weeks where I observed glimpses of diagnostic practices in a clinical setting, asked questions about the process, and engaged in challenging conversations about the implicit assumptions and biases experts sometimes hold. Further, I have spent several years participating in ADHD communities and volunteer work, including attending five different ADHD support groups across Canada; presenting at workshops aimed to educate the public—mainly teachers and parents—both in Canada and Japan (a live translation of my speech was provided in the latter); organizing an ADHD Booth at a well-attended "Youth Conference" in Vancouver; and developing and co-facilitating my own ADHD "strategy group" to undergraduate students at York University, funded by the psychology clinic on campus. Ethics clearance from York's Ethics Review Board was obtained for my ethnographic interviews (and consent given by interviewees) as well as for the student strategy group, which was video recorded and transcribed with consent of the members. I have also given numerous conference presentations on ADHD and have benefited from many casual conversations with ADHD individuals and parents.

In addition to these physical ethnographic sites, I have also spent much of my time investigating *textual* sites. This includes self-help books, online internet forums, blogs, videos, and other media through which individuals with ADHD share their experiences and thoughts publicly. Conventionally this might be called "content analysis," but I include it in my broader ethnographic approach. As sociologist Chloe Silverman writes in her work on autism, "archival sources read in parts like ethnography, as I describe social practices as symbolic systems and seek to illuminate how participants understand the meanings of their actions" (2011: 2). Similarly, in her work on Alzheimer disease, sociologist Margaret Lock claims that her arguments are "illustrated throughout by means of excerpts taken from both interviews *and written sources*" (2013: 21-22; emphasis added).

I try to follow the approach of sociologists Silverman and Lock, as well as science and technology studies (STS) scholar Annemarie Mol in not reducing their analyses of these disorders or diseases to Foucauldian analyses of power and knowledge. My angle is particularly influenced by STS, a field which emphasizes rather than disregards the scientific study of *materiality*. STS generally recognizes that scientific "facts" are not mere constructs or the products of discursive apparatuses of knowledge, but emerge directly from laboratory work (a non-positivist theoretical perspective that stretches back at least as far as French philosopher Gaston Bachelard's writings in the early-to-mid twentieth century). More recently, many feminist philosophers in STS have gone to lengths to transcend outmoded dichotomies like "social constructivism" versus "reality," or "nature" versus "society." I follow in their footsteps, though through an alternative framework built from my own observations of the specific issues of philosophical misrecognition facing ADHD.

Chapter One: Looping Effects and the Question of Specificity

"Vyvanse, has anyone tried Vyvanse?" A man looking in his thirties wanders around a large room asking people whether they have tried Vyvanse, a relatively new stimulant medication commonly used in the treatment of ADHD. "It's a precursor to Ritalin and doesn't have an addictive quality," he repeats over and over again. I have no idea what he means by "precursor" and don't really care, chalking it up as him parroting some dubious thing he read online or heard from his physician. Eventually a woman replies to his questioning, "yeah I take Vyvanse. The first four days were brutal. I remember trying to come to this group and feeling nervous about being fucked up on new drugs." *That's exactly what's happening to him*, I think to myself, *high and loopy off his first-time dose*. I impatiently look at the time. The weekly Toronto Adult ADD Support Group[12] meeting has not started yet, and people are still trickling in. Those of us who arrived early are either chatting loudly, pacing around aimlessly, or sitting quietly. About thirty chairs are arranged in a circle, facing inwards, group-therapy style. I feel out of place. The people here are much older than me—some even appear to be in their sixties.

Eventually everyone takes their seats and a piece of paper is passed around with a list of common "symptoms" and "traits" of ADHD. Each of us is asked to read aloud one item from the list and then pass the paper on to the next person beside us. (This same ritual takes place at the beginning of every session.) The first few symptoms read aloud are the usual suspects of ADHD: "We are easily distracted and have difficulty paying attention." "We have a tendency to tune out

[12] My description of the Toronto Adult ADD Support Group is purely anecdotal and derived from memory. I attended this group for personal reasons prior to the beginning of my research project on ADHD. These descriptions should not be considered ethnographic data, and are included primarily for the purpose of introducing the reader to the atmosphere of such groups, to help bring them to life, so to speak. The quotations are approximate renderings of the spirit of an utterance but not the exact words.

and drift away." "We are impulsive and make hasty decisions without considering the consequences." As the list goes on, the symptoms start to sound less like conventional ADHD traits and more like personal characteristics: "We can be indifferent and demonstrate an 'I don't care' attitude." "We use rebellion and defiance as a way to disguise the ADD traits that make us feel 'different' from others." "We are poor observers of ourselves and are often unaware of our effect on others." "We have trouble going through established channels or following proper procedure." "We have many projects going simultaneously and have trouble following through with a project or task." And so on.[13] These descriptions, examples of a "second symptomatology" of ADHD (in contrast to the far more restrictive symptomatology found in the DSM), hit me like a brick. Glimpses of past memories flash before me as my mind feverishly works to match each symptom to some past experience I have had. As it turns out, once again, ADHD fits me to a tee. Suddenly those feelings of being out of place dissolve. These people, despite their differences, share much in common with me.

I am experiencing part of what philosopher Ian Hacking calls the "looping effects for human kinds" (1995a: 370), the way in which an identification with a human kind (such as ADHD) "leads people to describe their own past anew," where "constructed knowledge loops in upon young people's moral lives, changes their sense of self-worth, reorganizes and reevaluates 'the soul'" (1995b: 68). This is certainly not the first time I have experienced this phenomenon. A couple years earlier, I attended my first adult ADHD group in Vancouver. At the time, despite having already been diagnosed with ADHD for several years, I knew very little about the

[13] The list of qualities used by this group is borrowed from a book titled, *The Twelve Steps—A Guide for Adults with Attention Deficit Disorder*, authored by an organization called "Friends in Recovery." The Alcoholics Anonymous (AA) influence evident here, while strange, is not generalizable to ADHD communities. It is an idiosyncrasy that I have not seen in any other ADHD self-help book or ADHD support group, and so I do not read too much into it.

disorder outside of what I had been told by my psychiatrist. What struck me more than anything that first time in the Vancouver group was the listing out of *positive* qualities of ADHD that I had never heard of before, qualities like "not holding grudges," "always trying new things," "excelling at constructively criticizing oneself and one's work," and "creating order from chaos." These qualities, which I had always considered unique quirks of my personality, were suddenly laid bare to me for the first time as "positive symptoms" of ADHD.

The general idea behind Hacking's theory of looping effects and my experience of it can be summarized as follows: whereas previously I had not identified with ADHD (I personally felt that my diagnosis was a bit of a joke, but respected the authority of my psychiatrist and took my medication as prescribed), after that initial revelation at the Vancouver ADHD group, I started to reflect on myself in a new way, as someone who is not only diagnosed with ADHD but is now a particular kind of person, the same kind of person as the people in this group. In the words of Hacking, I began to "explain [my] behaviour differently and feel differently about [myself]" (1995b: 68). It is in this way that ADHD, to me, "itself became different." "There was new knowledge to be had about the kind. But that new knowledge in turn becomes part of what is to be known about members of the kind, who change again" (Hacking 1995a: 370). In other words, equipped with this newfound knowledge about myself, I returned to my psychiatrist and started talking to her about my ADHD in new ways. My psychiatrist presumably would have felt vindicated knowing that she was correct in her diagnosis and, further, would continue to learn more about ADHD by keeping me as a patient. She could then use this continually-developing knowledge of ADHD to inform her decisions to diagnose her other patients with ADHD. (Indeed, I remember Googling her name and finding a single "review" of her, stating something

like "good psychiatrist, but she *will* try to diagnose you with ADHD").[14] Those newly diagnosed patients (and I was by no means the first) could then identify with ADHD as well, return to the psychiatrist with their own new ways of describing the disorder, again changing the way she thinks about it, helping her to hone her ADHD-specialized diagnostic and treatment skills. This back-and-forth process continues indefinitely. She might even give a talk at an ADHD conference to share her findings to other experts in the field, helping to change the meaning of the psychological classification on a "universal" level. This is what Hacking calls the "looping effect for human kinds" (1995a: 370).

Looping effects help to explain the "reality" behind such disorders—even if "not biological," human kinds are still "real" because they impart "real effects" on those who identify with them, and on those who study them. On a historical scale, looping effects help to outline the coming into existence of human kinds—in the case of ADHD, from a few, barely perceptible abnormal symptoms in the early twentieth century, such as not being able to sit still in a classroom, to what is now today a full-blown psychiatric disorder entailing frequent references in popular culture, widespread media controversies, marketing campaigns, a self-help industry, and community groups found in every major city (at least in anglophone societies). It is a gradual process spanning decades of slowly reshaping and remoulding observable behavioural or cognitive deficits into a standardized kind of human, an iterative looping process between students and teachers, children and parents, patients and clinicians, research subjects and researchers, and patients and other patients into what is today called "ADHD."

[14] Coincidentally, my psychiatrist was also the psychiatrist of Elisa Lam, the student who drew international attention when she went missing after video surveillance footage showed her acting strange and paranoid in an elevator. Lam later turned up dead in a water tank on the top of an iconic Los Angeles hotel. Some believe the cocktail of medications she was prescribed (including one for treatment of ADHD) contributed to her death.

As such, looping effects can also call into question the veracity of the causal knowledge surrounding human kinds—for instance, does the fact that I and so many others identify with ADHD's symptomatology confirm the existence of a biological etiology that gives rise to such symptoms? A theory of looping effects does not deny such possibilities, but emphasizes that we should consider alternative or additional explanations. For example, is it perhaps possible that the reason many ADHD researchers are so certain of a biological etiology is precisely because of the disorder's plainly observable *phenomenological* reality that looping effects work so hard to construct and uphold? Is it not true that everyone could potentially identify themselves as having ADHD as long as they merely pick and choose the alleged characteristics of ADHD that fit them best while ignoring others that do not, like reading the Sunday paper's astrology section, and call it a "phenomenology of ADHD"? More contentiously, if I had been diagnosed with something else, say, autism, would I have conversely rethought myself and rewritten my past differently, embracing that identity instead, attended those support groups, befriended those "kinds" of people? There is, after all, an overlap of certain symptoms between autism and ADHD (Mayes et al. 2012), and I have been told by clinical psychologists that even specialists sometimes have trouble differentiating the two disorders in children. In thinking through Hacking's theory seriously, these questions, while provocative, are not unreasonable, nor merely hypothetical. On the contrary, these sorts of theories help to shape the way critical thinkers and social scientists comprehend mental health disorders, and can have extensive effects on the way such disorders are perceived and individuals treated in society. For all those of a critical mind who are suspicious of the purported specificities of such disorders, Hacking's theory of looping effects provides a comforting answer. But perhaps such thinkers have become *too eager* to enter this comfort zone.

Of course, one does not need Hacking for comfort. Any variation on Michel Foucault's generalizing theory of "psychiatric power" could do the job. Hacking, unsurprisingly, admits that he is indebted to Foucault (1986: 164).[15] As Foucault describes it, psychiatric power is a form of "disciplinary power," "a particular modality by which political power, power in general, finally reaches the level of bodies and gets a hold on them, taking actions, behaviour, habits, and words into account" (2008: 40). Looping effects are a variation or alternative rendering of this general Foucauldian theme. As such, trying to topple Hacking's theory of looping effects in a thorough manner would be a herculean task, as it would mean simultaneously providing a thorough critique of Foucault's entire system. It is not my intention to attempt such a feat. Instead, my aim is to point out how Hacking's theory is not as *totalizing* as others sometimes make it out to be—or rather, to show how Hacking ends up doing this himself.

In other words, in this chapter, I try to break out of the comfort zone provided by Hacking—and on a more implicit level, Foucault—by challenging the generalizability of looping effects. What might be *specific* about ADHD that Hacking's *generalizing* theory cannot account for? This line of questioning is not as polemical as it might first seem. Despite Hacking's claim that looping effects are a "very general phenomenon" (1995b: 21), he himself construes them differently depending on the specificity of the disorder (or identity-formation) in question. He explicitly does this for at least two distinct illnesses: multiple personality disorder (MPD) in his book, *Rewriting the Soul: Multiple Personality and the Sciences of Memory* (1995b); and autism

[15] Although he is indebted to Foucault, the roots of Hacking's theory can also be traced back to his earlier work in Science and Technology Studies (STS), namely his concept of "dynamic nominalism." In a nutshell it is the idea that a "natural kind" can change as a result of being labeled or classified in a certain way. In his 1986 paper, "Making Up People," Hacking bridges his STS work to human psychology, applying this concept of dynamic nominalism to "human kinds" as well: the way people are classified changes who they are as a person. Regardless of its theoretical origins, at most his theory of looping effects is a simplified but more legible (at least for typical anglophones) version of what Foucault is saying.

in his treatise, “The Looping Effects of Human Kinds” (1995a), and his later book *The Social Construction of What?* (1999). However, to my knowledge, he only addresses the looping effects of ADHD briefly in his 1999 book and does not provide any specific analysis of them.

My argument in this chapter comes down to two premises: first, that in trying to generalize his theory to fit the specificity of autism, Hacking eventually comes to realize that autism requires a much more sophisticated ontology than what looping effects, theory of mind deficits, or recourse to biology can provide. Second, that looping effects are also insufficient for explaining ADHD’s specific ontology—I do not mean its purported biological specificity, but rather its *symptomatic specificity*. My radical thesis is that ADHD (in its symptomatic specificity) is not a disorder primarily concerned with how one understands oneself.

Of course, I do not deny that ADHD community members are vulnerable to discursive power relations immanent to the circulation and application of psychological categories. There are serious ethical questions that need to be addressed in this regard, and I will attempt to do so in this chapter. In terms of methodology, I develop my argument using a mixture of ethnographic data obtained from a university support group for ADHD students, personal anecdotes from my years engaging with ADHD communities, and insightful perspectives from other philosophers and scholars.

Memoro-Politics and Multiple Personality Disorder

Hacking claims that MPD “is an almost too perfect illustration” of looping effects (1995b: 21). In the context of MPD, the “change” that one undergoes through looping effects originates in what he calls “memoro-politics”: “a politics of the secret, of the forgotten event that can be turned, if only by strange flashbacks, into something monumental” (1995b: 214). In this case, he

is explicitly talking about memories of child abuse. There had been an "exponential increase in the rate of [MPD] diagnoses since 1980" and, correspondingly, an exponential increase in MPD-diagnosed adults reporting that they were abused as children (some even claimed that they were abused as part of satanic rituals) (Hacking 1995b: 8-9). Hacking is not so much concerned with the question of whether such abuse actually occurred or not as he is with the question of how such a newly-unearthed memory of being abused can lead individuals to redescribe many different aspects of their past, rewrite the stories they hold about themselves and their life, and "explain their behaviour differently and feel differently about themselves" (1995b: 68).

The basic premise of memoro-politics is that, as a result of the science of memory between 1874 and 1886—namely the works of French psychiatrist Théodule Ribot and his subsequent influence on psychiatry including the works of Sigmund Freud—we moderns have accepted as a matter of fact that "what has been forgotten is what forms our character, our personality, our soul" (Hacking 1995b: 209). Scientific knowledge about the "soul," about what makes a person a person, has been replaced with a scientific focus on what we can remember (Hacking 1995b: 220). Consciousness, personality, and mental illness can all be scientifically studied through a psychoanalytical reconstitution of our forgotten past. In other words, memory became an "object of scientific knowledge."

The 1980s entailed a transitional period for psychiatry: it became standard practice to use the DSM to categorize and diagnose mental pathologies, and yet psychoanalytical influence on therapeutic practice—though on the decline—was still relatively strong. As a result of this dual influence, *failure to reconstitute one's past coherently* increasingly became associated with MPD. The clinical logic behind this association is described by Hacking as follows: "the patient is hazy about the past, and cannot recall what happened when, or is confused about the sequence

of life events. Perhaps that is because unknown [alternative personalities] have taken control from time to time" (1995b: 25). Prior to 1980, there was no standardized system of classification or diagnosis; psychiatrists might have used the older term "double consciousness" to describe these patients, but what they meant by this term or how they treated it could vary greatly on a case-by-case basis. It was not until the DSM-III came into popular usage that a standardized *kind of person* that fit this "pathological forgetting" came about.

The DSM-III brought looping effects into full force. MPD diagnoses rose exponentially. More and more patients appeared to fit the criteria—many with histories of alcoholism and drug addiction, others experiencing "gender confusion" (Hacking 1995b: 26, 29). These characteristics had traditionally been associated in psychoanalytical practice with being sexually abused as a child, among other things, but with the achievements of the women's movements in the 1970s, the public became aware of just how widespread sexual abuse is. "The theory of [MPD] followed in train" (Hacking 1995b: 28). Therapists incorporated a practice of memoro-politics; they encouraged their MPD patients to try to reconstitute a forgotten traumatic event of their past, namely sexual abuse and incest, and this in turn allowed patients to understand their pasts, their pathologies, and themselves in a new light. Those who believed they were abused came to identify with a standardized kind of person: a person who has multiple personalities, and all the characteristics, behaviours, and beliefs about oneself and reinterpretations of one's past that is said to accompany that pathology.

By the 1990s, MPD had become so well known to the public that it became commonplace for people to walk into a physician's office and claim with certainty that they have a number of personalities (Hacking 1995b: 22). The looping effects in play here are evident: one acquires knowledge of MPD, reinterprets any variety of possible psychological fractures or quirks about

oneself as "multiple personalities," seeks diagnosis, and then begins the process of reconstituting one's past to unearth repressed memories of child abuse. Successfully unearthing such memories reaffirms in the minds of clinicians that they are correct in their diagnosis of MPD, and in their association of MPD with child abuse.

Hacking's case study of MPD is the basis to his theory of looping effects. He is able to take his observations about MPD and generalize them to other disorders like ADHD. At face value, this seems to work: people like me are diagnosed with ADHD, learn about what it means to be this kind of person, reinterpret our past and present through this new lens, come to understand ourselves differently, and even behave in ways to better fit the diagnosis. The key difference, of course, is that MPD entails memoro-politics whereas ADHD entails an alternative *bio*-politics. As clinical psychologist Steven Kurtz notes, "we no longer believe that ADHD is an expression of unresolved conflicts, but a frank expression of some hardwiring differences" (in Green 2009).

For example, in a medical school lecture on ADHD I attended, the lecturer (a psychiatrist) described a case of a child who, suspected of having ADHD, was referred to her by the child's teacher:

> The child couldn't concentrate Mondays, Tuesdays, and Wednesdays, but she was fine on Thursdays and Fridays. And I'm like, that is a very weird presentation for ADHD, a neurological-based condition, that it is only present Monday to Wednesday. [The lecture hall erupts in laughter].[16]

[16] The killjoy in me must point out that this joke is only funny for those who subscribe to neuroreductionism. Just because ADHD is a "neurological condition" does not mean its symptomatic presentation should remain consistent from day to day.

As it turns out, the "little girl was being sexually abused by her grandfather on the weekends." In contrast to MPD, this revelation confirmed to the lecturer and her students that the child *does not* have ADHD.[17]

Some professionals would disagree. One clinical psychologist I interviewed claimed that approximately one third of all children diagnosed with ADHD at her clinic "experienced significant adverse childhood experiences," "including child abuse and/or neglect." The official line tends to reject this—as WebMD puts it, "trauma and ADHD can be confused in diagnosis because the symptoms of trauma mimic those of ADHD" (Bhandari 2018). However, some are trying to alter the narrative, as seen in the title of one *Psychology Today* article: "Trauma and ADHD: Think 'And,' Not 'Or'" (Rettew 2014). Regardless, even if there is veracity to this association, it has yet to transform itself into a looping effect. Why not?

One argument would be that the purported association between ADHD and trauma is not well-known enough, not standardized, and not a consensus in the way it was for MPD in the 1980s and 1990s. Individuals who get diagnosed with ADHD do not go digging up their past looking for trauma because that is not entailed in the conventional knowledge surrounding the disorder. They instead associate their ADHD-like behaviours with a biological specificity: a different kind of brain, for instance. This kind of "bio-politics" replaces MPD's memoro-politics

[17] "The really scary thing," the lecturer continues, "is that the child would have responded to stimulant medication." The lecturer then takes a moment to dissuade medical students from illicitly taking stimulant medication: "Pretty much everyone of you is going to improve your attention if you take Ritalin tonight to study. You also will then unfortunately lose your license, not be allowed to be a doctor, or anything, if you take it when you don't have the condition. So I don't recommend it. It has a pharmacological effect, so you can't just say I'm going to prescribe everyone meds." Why are such strong statements made against pharmaceutical "cognitive enhancements," whereas having the financial capability to pay for other forms of cognitive enhancement, such as fast laptops, expensive practice tests for the MCAT (Medical College Admission Test), private tutoring, quiet study spaces, and so on are all perfectly acceptable for medical students?

(Hacking 1995b: 214). Yet, the problem with this argument is that, first, it overlooks the still very-influential psychoanalytical narrative that what we have forgotten is vital for understanding who we are; and second, it ignores all those *critical-minded* ADHDers who are skeptical of the disorder's purported biological specificity, and who *do* look to their past for alternative explanations.

I argue instead that the reason the ADHD-and-trauma link has not transformed into a looping effect is because reconstitution and reinterpretation of one's past has absolutely no impact on ADHD's *symptomatic specificity*. It does on MPD's symptomatic specificity—as a result of their newly reconstituted pasts, their unearthing of unconscious repressions, people start "speaking in two voices," or incorporating new personalities that switch genders or embody different ages (Hacking 1995b: 50-51). My ADHD symptoms, in contrast, remain indifferent to whatever I dig up about my past.

For example, about seven years after I was first diagnosed, I decided to undergo psychoanalysis for a year. Session after session, I attempted to invent narratives about my life that would explain my ADHD symptoms, but they always turned out to be littered with falsehoods. One narrative I came up with was that, when I was about ten, a relative passed away and my cousin had to come live with us, altering the dynamics of my family. This added much change and stress into my life that I had not before experienced, and forced me to come up with new ways of coping. I tried to understand this event as a trauma, and assumed that I had repressed the memories of the surrounding psychological impacts it had on me at that time. In my process of remembering, I realized that to escape the emotional turmoil of my family-turned-upside-down, I began spending all my time playing computer games, which in turn significantly interfered with my performance at school, both by tuning my attention to more stimulating forms

of media, and by preventing me from learning good organizational techniques, study habits, and so on. From that point on, I suffered a "developmental delay" compared to my peers.

The problem with this story, however, is that, later having questioned my family members about it, especially my parents, they reminded me that they set strict two-hour limits on how much time each of us were allowed in front of the computer, that my school performance was always bad even before my cousin showed up, and that my brother of a similar age spent the same amount of time playing video games as I did, but he excelled at school and had no attentional problems whatsoever. That these were *false* memories supports Hacking's argument that my psychoanalyst and I were pathologizing the *idea that I had forgotten something*. In truth there was no repression that *could* be pathologized, only the *idea* that I had repressed something. If this was a dissertation about me having MPD, I could at this point write "case closed, my MPD is made up, I was a victim of looping effects and memoro-politics."

Yet, with ADHD, the opposite occurs. My ADHD symptoms appear to have absolutely nothing to do with repressed memories or looping effects as a result of memoro-politics.[18] As ADHD self-advocate Hallowell writes in *Driven to Distraction*, we don't "have some repressed unconscious conflict" (1994: x). No matter how much I tried to resolve my ADHD symptoms through memoro-politics (e.g., becoming self-aware of the repressed roots that explain my

[18] On a side note, when I told my story to the aforementioned clinical psychologist I interviewed who believes in the link between ADHD and trauma, and asked her if my experiences were an example of trauma, she answered no: "It's not to say that events can't lead to adjustment difficulties and spiral off. You may have ended up playing video games. That might have happened at that point in your life anyway. But with trauma symptoms, what we see in kids is primarily fear based: trouble sleeping, people coming to get them, nightmares, trouble relating to others. Sometimes they are too fearful or scared of others, or there's too much wanting to engage past the point of what's safe, in terms of engaging with strangers for example. They may regress in terms of wetting themselves or soiling themselves. There's a whole raft of trauma symptoms that could appear." To clarify, then, I am not suggesting that my false memories negate the ontology of trauma—whether linked to ADHD or not. My point is that, in my case, I was never traumatized, yet was able to momentarily trick myself into believing I was, because psychoanalysis made me vulnerable to memoro-politics.

impulsive behaviours in order to gain authority over these behaviours), I would still return home after each therapy session and still not be able to clean my room, still act impulsively, still zone out frequently, and so on. No matter how much I tried to "rewrite my soul," my ADHD symptoms stubbornly refused to change. ADHD, in its symptomatic specificity, spits on the very notion of the self. It does not care about my past, my personality, my intentions, or who I am. In contrast, memoro-politics involves the self at its core. It deals with questions of epistemology, of knowing oneself, of knowing one's past, of self-understanding. It is perfectly attuned to a disorder all about the self, or "multiple selves."

This juxtaposition between MPD and ADHD highlights a potential problem with Hacking's theory. The way that looping effects work on pathologies said to be grounded in unconscious repressions is not applicable to disorders that are not grounded in unconscious repressions. While Hacking, of course, alters his theory to account for looping effects that come about via bio-politics or labeling effects, one wonders the extent to which *analogy* plays a role here. It is almost as if the ontology of ADHD is taken for granted as being *analogous* to the generalized ontology of MPD—a disorder entirely constituted by memoro-politics and a very particular historical context. Indeed, this simple observation that looping effects must work differently for different disorders remains unacknowledged by virtually every social scientist I have encountered who uses Hacking's concept. The tendency is rather to view looping effects as a sort of *generalized ontological treatise* that applies equally for every psychiatric disorder (c.f. Choudhury and Slaby 2016: 8; De Vos 2013: 13; Dumit 2004: 9; Elliott 2003: 213; Lock and Nguyen 2010: 383-384; Nadesan 2013: 183-184; Rafalovich 2002: 22; Rose 2007: 108; Silverman 2011: 241; Teo 2015a: 114; Vrecko 2010: 41). Sociologist Jan De Vos, for instance, states that "looping effects are the very fundamental dynamics of psychology" (2013: 13).

Hacking himself, however, is aware of these challenges, at least implicitly. The case of autism, for example, forces him to rework his theory again to account for *its* specificity.

Script-Flipping, Inaccessible Kinds, and Autism

Back in the Toronto ADHD Support Group, during the break, a man sits down beside me and introduces himself. He asks, "what books have you read?" Knowing that he is referring to popular literature on ADHD—self-help books and the like—I reply, "um, well, I don't know if I've read any books, but I've read summaries of books online." I am trying to excuse myself from the horrible fact that I have not read any books on ADHD (except for one titled *ADHD Does Not Exist* by Richard Saul, but thought it best not to mention that to him). He replies, "yeah that makes sense with ADHD that you can just read the short-form of summaries because books are long-form and it's hard for us to stay attentive." "Right," I respond, "and then I end up missing out on all the stuff that the full book offers." "Exactly," he replies, and then recommends that I read Rick Green's book, *ADD Stole My Car Keys*, because it is the kind of book that can be read in short bursts and does not require prolonged attention.

My response in this exchange is an example of what anthropologist Summerson Carr calls "script flipping": "manipulating and mobilizing the pragmatic possibilities of ostensibly presupposing referential forms," or in more simple terms, "telling people what they want to hear" (2010: 191, 194). Carr describes script flipping in the context of state-mandated addiction recovery groups where certain members who are still using drugs will "perfectly reproduce the therapeutic scripts" of a recovered addict, yet what they say does not match their "inner signifieds (i.e., their thoughts, feelings and intentions)" (2010: 191). As Carr notes, this creates "evidentiary crises for social service professionals and ethnographers alike," because it "evinces... the limits of language as a means of detecting or denoting inner states" (2010: 19).

Script flipping can be as simple as recovery group members collectively nodding and responding "yes/hm-hmm/hmm-hmm" in unison to the group leader's lecture about not taking drugs to get up in the morning, when some of those nodding members are still secretly doing just that, or it can be a flat-out lie—a member who still uses drugs telling other members about how much her life has improved now that she is no longer on drugs (Carr 2010: 35, 19). In the ADHD group example, I "flipped the script" when I agreed with the man that the reason I had not read any ADHD books was that I had trouble focusing, even though I knew full well that was not the reason. The truth is that I had been spending all my time reading complex and lengthy social and political theory instead of (or as a replacement for) ADHD self-help literature. Further, I never actually revealed to anyone there that I was a PhD student, as I felt that would not fit the appropriate "script" of a suffering adult with ADHD in *that particular group* (in contrast to student ADHD groups where I did not have to lie about being a graduate student because the scripts were different).

The notion of script flipping raises a question for looping effects in general. If individuals who partake in community groups flip the script in order to fit in, or to strategically push forward a certain discourse, to what extent can such discourse "rewrite the soul" if it does not actually signify the "inner thoughts, feelings, or intentions" of its proponents? Of course, script flipping would not disprove the theory of looping effects—after all, a human kind is still being reshaped and remoulded based on the politics of identification and/or biosocial framings of the disorder; but it raises the question as to whether the theory of looping effects might exaggerate the impact of such politics and framings on an individual's self.

Interestingly, Hacking himself seems to raise this very point in his discussion of autism as an "indifferent kind" (1999: 117) or "inaccessible kind," a "kind in which the people classified

cannot take in how they are classified"; "there cannot be self-conscious feedback" (1995a: 374). He suggests that *if* autistic people are "'self-absorbed' almost from birth," and are "characterized by lack of response to people and actions," then the actions of others (or discourse) to diagnose, label, or rewrite their souls will be unsuccessful, as such external classifications will not—in most cases—interest them (Hacking 1995a: 374-379). Further, if one believes Leo Kanner's characterization of autistic people that "they do not learn to communicate, but echo what other people say" (Hacking 1995a: 376), then of course they will flip the script, as that is all they can do—all communication is detached from "inner signifieds."

Now, such bigoted, infantilizing, and dehumanizing representations[19] of autism are not only highly questionable (and to his credit Hacking does question their clarity (1995a: 379)), but also part and parcel of the broader stigmatization and medicalization surrounding the syndrome that autistic self-advocates fiercely oppose. Even so, such representations concern autism's *symptomatic specificity*. In pointing to the "self-absorption" or script-flipping/masking of autistic individuals, Hacking is admitting to a disorder *whose symptoms, by virtue of themselves, refuse to bow to discursive effects*. This is why he calls autism an "indifferent kind": he sees autistic individuals, at least in terms of their inner world, as *indifferent to how others classify them*.

Hacking changes his tune a few years later in *The Social Construction of What?* (1999). Here he associates autism's indifference not with symptomatic specificity but *biological identity* (1999: 120). This allows him to escape the bigoted representations he drew up in his earlier treatise. Here "we are in the realm of indifferent, 'natural' kinds," Hacking writes (1999: 120). Quoting autism advocates Anne Donnellan and Martha Leary, Hacking writes, "autism is the

[19] By "representations" I mean how such difficulties in communication are perceived and described by others—I am not denying that such difficulties exist, but that the ways in which they are represented are highly questionable.

'way people are' rather than 'a thing people have'" (1999: 115). No amount of classificational influence is going to change who they are, because *that's who they are*. The underlying idea being conveyed is that autism is not a pathology that needs to be cured but an immutable *biological identity* from birth.[20]

Notably, however, Hacking does *not* take autism's biological identity as evidence against looping effects. Instead, he comes up with an alternative mechanism of looping that can still accommodate autism under his generalizing theory. "There can be looping" for inaccessible kinds, writes Hacking, "that involves a larger human unit"—that is, a human kind can be both an inaccessible/indifferent kind and an "interactive kind": "by interaction I do not mean only the self-conscious reaction of a single individual to how she is classified. I mean the consequences of being so classified for the whole class of individuals" (Hacking 1995a: 374; 1999: 115). The idea here is that, even if, by virtue of their biological identity, autistic individuals cannot change who they are, those surrounding them—parents, care-workers, teachers, and more—can still greatly influence and change autistic individuals (through psychotherapeutic and behavioural interventions, strategies, techniques and the like). As a result of these interventions, the

[20] That Hacking can find recourse in biology is admittedly *historical*, a hard-won accomplishment on the part of autistic self-advocacy and parent groups. As sociologist Chloe Silverman notes, no genetic or biological markers have yet been found for autism (2011: 51). Even so, "self-advocacy groups and parents are not merely pawns, expressing the genetic optimism of scientists because that is what they have been told to believe," rather it can be helpful for them to invest both financially and emotionally in such a definition—to fight for greater recognition, improved accommodations, and against stigma (Silverman 2011: 142). Indeed, as Margaret Lock points out, where Paul Rabinow once believed that it was the idea of genetic kinship ("biosociality") that gave rise to group identities based on mental illness, he now concedes that such an idea "makes no sense at all," that "today, in an era when genes have been demoted as the determining forces in by far the majority of illness situations, the idea of biosociality must be modified" (2013: 180). It is not "illnesses themselves [that] cause communities to form"; rather, it is the "political and economic context that makes it necessary to organize around illnesses and biomedical facts in the first place.... Designers of research programs and clinical trials... and organizers of advocacy groups... must all *work hard* to construct illness-based identities" (Silverman 2011: 17, 193, 16; emphasis added).

classification will continue to change in new ways, despite the identity being biological: new forms of intervention are moulded to improve on previous ones, etc.[21]

Looping effects are still very present here, but not in the same direct way as they are purported to be for ADHD or MPD. Changing autistic individuals is not a matter of labeling them with "autism" so they can reimagine and reinterpret their pasts, and change their behaviours accordingly. Nor is it a matter of autistic individuals reconstituting repressed memories of trauma. Instead, the looping effects occur *around* autistic individuals, by parents, teachers, and clinicians, but they do not occur on the part of autistic individuals themselves.

In trying to save his theory's generalizability, Hacking cordons off autism's specificity—that which is not applicable to the generalizing effects of looping, namely its biological identity. But one cannot help but ask, what does it being biological have to do with it being inaccessible to discursive forces? As philosopher Catherine Malabou suggests, "the future of any kind of discourse or of discursive practice... is linked with [neuro]plasticity" (2011: 1). In other words, asserting that autism is a (neuro)biological identity does not, in itself, mean that such an identity is inaccessible to the effects of discourse (or looping). Such a view would be neuroreductionist. In trying to escape bigoted representations of autism by replacing its symptomatic specificity with biological specificity, Hacking muddles his argument more than he clarifies it.

In my view, the *specificity* of a psychiatric disorder—that which refuses to be reduced to an ontological generality—is whatever aspect of it remains *inaccessible to discursive effects*. Hacking would likely agree with me that MPD has no specificity: every aspect of MPD,

[21] For example, Hacking writes, "The autistic family, as we might call it—a family with an autistic child—was severely influenced, and some would say damaged, by the doctrine of the refrigerator mother [lack of maternal warmth]. The subsequent changes in the family contributed to a rethinking of what childhood autism is—not because one found out more about it, but because the behaviour itself changed" (1999: 115).

including its symptoms, are malleable to discourse. In contrast, what appears to be most specific to autism is its resistance to being persuaded by "neurotypical" forms of sociality (I develop this argument in more detail in Chapter Five). One of the interventions I am making here to Hacking's theory is pointing out that inaccessibility is not necessarily restricted to biology.

Hacking does not offer any insight into ADHD's specificity. He only describes the syndrome in two pages in his 1999 book, and there he treats it as the quintessence of looping effects: "I do not necessarily mean that hyperactive children, as individuals, on their own, become aware of how they are classified, and thus react to the classification. Of course they may, but the interaction occurs in the larger matrix of institutions and practices surrounding this classification" (1999: 102-103). But as I argued above, ADHD's symptoms appear to be resistant to discursive effects at least insofar as memoro-politics, or psychoanalytical traditions grounded in memoro-politics[22], is concerned. The question, then, is what is *specific* to ADHD that is not specific to any other syndrome, autism or otherwise? Phenomenologically speaking, how can I assert that I have ADHD but not autism? How can I make this distinction about myself without simply pointing to the fact that I was diagnosed with ADHD, and therefore identified and looped with *that* syndrome versus another syndrome?

ADHD and the Logic of Care: A Case for the Syndrome's Inaccessibility to Discourse

In 2017, I designed and co-facilitated a six-session ADHD support group for students at York University (this is distinct from the aforementioned Toronto Support Group). Although not directly pertinent to my dissertation topic, it is important to contextualize some of the historical problems of the institution in which my research takes place. While approximately 12% of York

[22] In contrast to, say, the Lacanian tradition that situates primary repression in language rather than memory or an event.

University students identify as Black, Black faculty members in the university only make up 2.3% of the faculty complement (Barrett et al. 2020: 2). York University's upper admin, including president Rhonda Lenton, have been accused of anti-black racism and practices (Shahid 2021). Despite an ongoing scandal, which has garnered an open letter from over 100 prominent Black professors and academics in Canada and the USA criticizing the upper admin of the institution, and around which an episode of *The Fifth Estate* titled "Black on campus" aired, York University's Board of Governors voted to re-appoint Lenton for an additional five-year term; of the Board's 28 voting members, only one is Black ("Media Release" 2021).

My support group was hosted and funded by the York University Psychology Clinic (YUPC). The group was purported to have three aims: one, to build community, that is, to provide peer support and mutual recognition of shared struggles in school, life, relationships, and behaviours; two, to provide concrete, take-home strategies each week aimed at resolving or improving particular issues expressed by members related to the weekly topic; and three, to assist in members' recognition of their own capacities to improve and take control over certain aspects of their lives. The group was loosely based on the work of clinical psychologist Mary Solanto (2011) who wrote a guidebook for running adult ADHD support groups. There were six different topics discussed in the group, one for each ninety-minute session: "introduction to ADHD," "planners and task management," "the positives of ADHD," "distractibility," "motivation," and "sleep, medication, and alternative treatments."

At the end of each session, members would receive a "take-home exercise" to complete before the next week's session. For example, the second week's assignment was to obtain a planner and start using it in the way Solanto advises: every hour of the day should be accounted for with activities, including leisure activities; each activity should include a space for "estimated

time to complete" as well as an "actual elapsed time" (Solanto 2011: 107-108). Part of the logic here is that ADHD individuals often have trouble managing their time—putting too much time into one activity at the expense of another, and doing activities based on whatever stimuli hooks and pulls them along rather than following any concrete plan. Solanto's planner activity aims to help individuals become more aware of their time expenditures on activities over the course of the day, and for them to use this raised awareness to encourage themselves to keep using their planner to organize their days so that their "wandering minds" do not have to.

The support group also acted as an ethnographic field site in which I conducted research. The method of data collection was video and audio recording, which I later transcribed and analyzed. Consent forms were distributed and signed. Ethics approval was granted by the York University Ethics Review Board, shockingly within a week after I submitted the proposal (usually I must wait months and then provide several revisions). My assumption is that, because the group was officially tied to YUPC and supervised by a psychology professor, the approval was simple and straightforward. And yet, I could not help but feel that this was the most ethically-questionable research I had ever received approval for.[23] No doubt, this feeling came from me being well-versed in critical theory, Foucauldian anti-psychiatry perspectives, sociological theories of medicalization and labeling, and Hacking's theory of looping effects. Here I was, presenting intensely psychologized frameworks and concepts to eager-to-learn undergraduate students in an *uncritical* way, encouraging them to let themselves become "hooked" to the power relations and looping effects inherent in psychological apparatuses.

[23] The following discussion on ethics is not whether the group was institutionally or legally ethical—clearly it was, as evident by the board's approval—but whether or not I felt it was ethical based on my disciplinary training in sociology, which pertains to different standards than those of the board.

With that said, taking the opposite approach, in my view, would have felt just as ethically questionable: if I were to run a support group on the basis of critical perspectives on ADHD, like stating outright that "ADHD is just a medicalization of normal childhood behaviour," that "ADHD treatment regimens are a form of social control," that "the whole industry surrounding ADHD is based on profit, especially when it comes to the pharmaceutical industry," and so on, I believe that, despite some of these claims having much truth to them, I would have been doing those students a great injustice. This is because the students who attend these sorts of groups are experiencing issues related to ADHD's symptomatology and are in need of support and strategies to help them succeed in university.

An ethical alternative to these two approaches is to utilize what philosopher Annemarie Mol calls a "logic of care" (2008: 66). By "logic," Mol means the "rationality, or rather the rationale, of the practices" that makes "some things more comprehensible than others," that makes certain practices more "appropriate or logical to do in some site or situation" than others (2008: 8-9). For instance, if I had done nothing but flat-out criticize the disorder, it could be said that my rationale for having done this was centered in a "logic of criticism," a logic I learned through my disciplinary training as a sociologist. As Mol notes, sociological "theoretical frameworks seem to be too exclusively adapted to the task of 'criticism'.... If criticism goes on and on it becomes mechanical. Whether it is true or not, it is no longer engaging" (2008: 89-90).

Conversely, Mol claims that in response to widespread sociological criticism of medical professionals in the 60s and 70s, health care rapidly adopted a "logic of choice," emphasizing that it is the autonomous patient who has the choice to accept his or her diagnosis and proposed treatments, and that to make such a choice permits the most efficacious and efficient means to an end, whether that be minimizing the detrimental effects of the disorder or being cured of it

completely (2008: 89-90). Indeed, this language of choice, caked in neoliberal rationality, can be found in discourse on ADHD treatments. For instance, I was instructed by the YUPC supervisor of the group to emphasize to members that they have to "make the choice" to attend each session and complete the take-home strategies otherwise they will not get much out of the group. The problem with the logic of choice is that, more often than not, members genuinely made the choice to try out a new strategy to complete a weekly task, but once at home the strategy failed to accomplish what it was designed to do, or they inadvertently failed to even try the strategy out. If a logic of choice was all that the group consisted of, the group would have been of little help to anyone, instead becoming a series of demoralizing failures and self-blame.

Instead, the group emphasized a logic of care. For example, when it came time to discuss the results of our "task management" strategy assignment, I admitted to everyone that I failed:

AB: I tried to clean my room, that was my task. But I failed. It made me start thinking, how am I supposed to facilitate a group on ADHD when I can't even complete the tasks that I'm supposed to be teaching? [I then explain in detail the strategies I tried and why I think they failed.] Perhaps in the future I will make it more realistic, like give myself more time to do something and spread it across more days. So that was my experience, and maybe now we can move on so one of you can share.

Sharing these sorts of personal stories to other members of the group and hearing their stories too is integral to a logic of care. As Mol puts it, "no actor needs to act alone.... When [something] doesn't work the crucial question is not whose fault it was, but what to try next"—sharing

experiences with each other is thus a "form of public coordination" (2008: 80, 89). Indeed, one member indicated on their feedback form that they liked that "people were willing to share and support strategies"; they only "wish that more people would have attended the group session—to get more information and to see/hear their thoughts." The greater the number, the stronger the coordination, that is, the more support offered in attempting strategies: in sharing what went wrong when trying them, in discussing possible fixes, in encouraging each other to try them again, and in offering alternative strategies. Indeed, in a digital pamphlet distributed to students by YUPC titled "Tips for helping Adults with AD/HD" written by Rose Steele, an ADHD coach and professor in the Faculty of Health at York University, she implies that only through a logic of care will a logic of choice even be viable for ADHD individuals: "Learning through other people vicariously... helps prevent us from repeating the same mistakes over and over again. When we can see various options and make different choices then we're more likely to make better choices" (2012: 30).

The failure of a logic of choice for ADHD individuals provides a glimpse of what might be considered ADHD's symptomatic specificity. Regardless of how much one embraces a diagnosis of ADHD, chooses to join a strategy group, chooses to follow the strategies and treatments provided, there is no guarantee that behavioural change will happen. That is, there is no guarantee of looping effects on the level of behaviour, even when inserting and submitting oneself to what Hacking calls the "matrix of institutions and practices surrounding" ADHD's treatment. This idea was shared to some degree by every member of the group. Consider, for example, a discussion we had about planners:

AB: Put up your hand if you have a planner. [Nobody puts up their hand.] It doesn't mean you have to use it. [Everyone puts up their hand.]

VE: Yeah I think we've all cycled through this, or maybe just myself, but I got a million planners, the problem is keeping it up long term.

ET: Sticking with it. That's a big thing. Sticking with something. You can do good, do good, do good, but something throws me and then it's just like [hits the table], back to the drawing board. [....] It's like I know better, but why is it that I cannot, like, learn from my mistakes? [....] I know you [referring to AB] keep emphasizing breaking it down and doing it over and over but it's like, how do we put those reminders in to do these strategies, to get them into our head, that "I need to get this done," that "I need to set goals and lay out a plan"? It's like, I know I shouldn't do this [e.g. knows they shouldn't skip studying for an exam], but I've done it again, and I've done it again, and I've done it again, and I've done the same thing again. Like I didn't study, and I know if I don't study I won't get a good grade, and yet for the past several days I'm still having an issue with getting myself to study.

VE: It's like, ok this isn't the first time, it's not the thousandth time, it's a pattern.

AT: In your mind it's like "oh I failed again, I failed again, I failed again."

They are well aware of the strategies designed to help ADHD individuals modify their behaviour (like setting goals in a planner, laying out a step-by-step plan, meticulously organizing their time, using techniques to help with short bursts of attention like the pomodoro technique), and yet, even still, the strategies do not seem to work, their ADHD remains *inaccessible* to their efforts.

This is not to deny that looping effects can play an enormous role in the development of an "ADHD self." As with any identity, people can be influenced by discourse, rewrite their past to help explain their present-day issues and personality, and point to biology for an explanation. As one student noted:

BR: I'm the same messed up thing I was five years ago, but now I know why I am messed up, not like five years ago. Now I'm mindful that I'm getting distracted. Before I'd be like, "oh that's natural, I do it all the time, that is me being lazy," but now I know for a fact that that's not me being lazy, that's just how my brain works.

The student describes a transition of thinking about himself as a personal failure (laziness) to thinking about the self in relation to his brain. This is an example of what Foucault calls a "technology of the self" (1982/1988). The concept comes from Foucault's late writings where he offers an emancipatory spin on biopower.[24] One who is embedded in discursive regimes of power relations and domination (such as psychiatric power) can still redirect those forces upon oneself in order to free oneself, in a way that would not have been possible without these regimes. The above student is able to redirect modes of psychiatric harm—what anti-

[24] Philosopher Gilles Deleuze argues that, later in his life, Foucault experienced a "crisis in [his] thought": his worry was that subjects would be locked into "pre-existing determinations" of the self found "ready-made" in discursive configurations (1992: 160-162). Foucault's lecture on the "technologies of the self" (1982/1988) and his posthumously published work on the "care of the self" (1986/1988) can be read as his last-ditch attempts to situate the subject itself as an autonomous agent who can break free from the discursive apparatuses that produced it (Deleuze 1992: 160-162). As sociological theorist Valerie Harwood puts it, "subjectivities can be challenged (and transfigured) by strategically rupturing the very mechanisms that lie at the root of their creation, namely [repressive] technologies of the self, games of truth, and relations of power" (2006: 122). This kind of rupturing is, for some, the *modus operandi* of anti-psychiatry movements.

psychiatrists might call the narrative of being "broken" on the inside, or of having an "internal pathology"—in a way that supposedly emancipates himself from self-condemnation: "that's just how my brain works."

Of course, this example of a "technology of the self" is not fully emancipatory in the way Foucault meant the concept to be—neurobiological framings of ADHD do not *destabilize* psychiatric power. Rather, there is an entire for-profit industry built around the exploitation of this self-brain relationship. For instance, one student in the group asked if anybody had tried "neurofeedback," an expensive treatment for ADHD estimated to cost between $2000 to $5000 (Michaels 2020). Neurofeedback is a treatment in which an individual is plugged into an electroencephalogram (EEG) machine and is able to observe or "interact" with his or her brain waves. The data from the EEG is often translated into a fun medium, such as a video game. The individual attempts to modify his or her brain's activity in simple ways to achieve positive results in the game (like a happy smiley face popping up on the screen). The therapeutic efficacy is still a matter of scientific debate (Brenninkmeijer 2013: 145).

At first glance, neurofeedback appears to bypass questions of looping effects completely: after all, it purportedly targets the brain directly. However, in her ethnographic research on neurofeedback, sociologist Jonna Brenninkmeijer argues that it is still a "technology of the self" whose "overall aim is a change in the human subject (the self)" (2013: 146). Indeed, in their thorough investigation of "the new brain sciences," social theorists Nikolas Rose and Joelle Abi-Rached similarly argue that, while "nonconscious neural processes" are now "considered as the constitutors of moral action," selfhood itself has not changed in any fundamental manner, "personhood has not become 'brainhood'" (2013: 220). In other words, brain treatments still function as discursive forms of power all the same. Despite the "constant slippage of

terminology" regarding whether the brain is the self or separate from the self,[25] either way "the brain has... become a rich register for narratives for self-fashioning" (Rose and Abi-Rached 2013: 220). Neurofeedback is an example of "neurobiological technologies of selfhood, that is to say, practices that seek to mold, shape, reform, or improve aspects of one's person—moods, emotions, cognition, desire—by acting on or through the brain" (Rose and Abi-Rached 2013: 220).

The key difference between my ADHD student support group and neurofeedback treatment is that the latter emphasizes technologies of the self and a logic of choice over a logic of care. As Brenninkmeijer puts it, "neurofeedback practitioners emphasize the message that people are responsible for their own brains and happiness" (2013: 152). They employ technologies of the self—both in how they pose the problem as located in the brain, and how they claim neurofeedback can fix the problem—in order to change the individual. Neurofeedback practitioners *pretend* to assert a logic of care: "practitioners calm down their clients, talk gently to them and make use of several techniques to keep the person motivated" but, behind their clients' backs, practitioners tell a different story: "clients were sometimes described as people with 'broken brains' and successfully treating a client was commonly expressed as 'fixing' someone" (Brenninkmeijer 2013: 153).

This is the opposite to what I tried to project onto the ADHD student support group. To assert a logic of care is not to try to change who people are. Regardless of whatever one thinks, believes, knows, or chooses about one's past, self, or behaviour, a logic of care acknowledges up front what is most inaccessible to its classification, what a change to the self—to how one views

[25] Such as the disagreements in the claims, the "self *is* the brain," versus "it is not that human beings *are* brains, but that we *have* brains" (Rose and Abi-Rached 2013: 22); or in Brenninkmeijer's statement that "the self is *extended* with the brain instead of coinciding with it" (2013: 159).

oneself—will not accomplish. Again, my thesis is that ADHD, at least in its symptomatic specificity, is not a disorder concerned with how one understands oneself. As such, to the extent that a diagnosis of ADHD can itself be called a technology of the self—and regardless of whether this diagnosis helps or harms an individual—ADHD's specificity remains inaccessible to its diagnosis, its label, and its classification.

This is a bold claim, as it rails against critical sensibilities. Take, for example, philosopher and public intellectual Carl Elliott's criticism of ADHD. Following Hacking's theory, he argues that one way in which a classification acts on ADHD individuals is that it re-inscribes behaviour "to make it thinkable in a way it was not thinkable before" (Elliott 2003: 232). Elliott points to an adult recently diagnosed with ADHD as an example:

> Once he became familiar with the signs and symptoms of ADHD, he found it harder and harder to tolerate things that seemed symptomatic of the condition: forgetting to pick up groceries on the way home, taking a long time to leave the house every morning, failing to clean up his office or apartment.... He says it became easier to see his habits as personal failures [as a result of his ADHD], and harder to see them as a natural reaction to his circumstances (i.e., "I took forty-five minutes to get dressed because I was taking care of a baby at the same time; I zoned out at meetings because they were boring and unproductive"). (2003: 256)

In contrast to the familiar trope that a diagnosis often helps individuals feel *absolved* for their behavioural problems or *excuses* them from bad behaviour, Elliott points out that the reverse can

also happen—where blame intensifies—because psychologized discourse so often *erases the context* that would have otherwise helped to explain why an individual did what he or she did.

Elliott's argument, based on his particular reading of Hacking's theory of looping effects, is that, for these sorts of psychiatric disorders to have gained as much traction as they have, they had to "look a lot like ordinary human variation at their edges," e.g., "attention-deficit disorder can look a lot like garden-variety distractibility. The lines between mental dysfunction and ordinary life are not as sharp as some psychiatrists like to pretend" (2003: 233). In other words, a diagnosis of ADHD—as a technology of the self—takes behavioural problems that are actually quite normal given particular contexts (like arriving late to work as a result of taking care of a baby who is having an exceptionally needy morning) and decontextualizes them into symptoms or characteristics of the disorder (like poor time-management). Further, once diagnosed, behaviours that were once under the radar of the individual's awareness now become the objects of intense scrutiny. The individual starts seeing ADHD everywhere, noticing a lapse of attention in a boring meeting and registering it as an ADHD symptom rather than blaming it on the meeting. This reinterpretation and intensified scrutiny of one's behaviour reinforces identification with the classification.

There is no immediate problem with Elliott's analysis *per se*. But it is an analysis of the *self*: how one interprets one's behaviour. It considers how individuals with ADHD-like behaviours are looped into the classification. And there is no denying that this occurs—it is part of the generalizing acuity of Hacking's theory, well-understood and well-studied. Elliott however does not consider what is *specific* about ADHD, namely, that what appears as "garden-variety distraction" or fairly normal human behaviour (forgetting groceries, being late to work, etc.) is

actually something quite *different* for those with ADHD. Consider the following statements from the ADHD student support group:

HD: The difficulties that [ADHD] individuals face, you know, a lot of people can really relate to them and say "oh yeah I have a lot of attention problems," or people joke about it and say "oh I have ADD," but in the back of your head, you're like "oh you so don't have ADD." Like it's just become a bit of a cultural common thing that people say.

VE: If you can bring [a skeptic] to an [ADHD support] group, they'll hear your identical story like thirty or forty times over the course of the night, then they'll be like, "okay wow, it really is something, it's not just a lack of attention."

[....]

ET: [points to VE] You hit home with me the first time you spoke about how you talk to other students and they talk about all these things from past classes. And it's like, I studied ten times more than they did but they can remember things that I am like, "I can't even remember reading that."

These students are adamant that their behavioural (or cognitive) problems are not the same as the problems non-ADHD individuals experience, despite similarities on the surface.

In other words, *what is inaccessible about ADHD is very accessible to those without ADHD*. Forgot to pick up the groceries? Arrived late for work? Failed your test? Here's a solution: use a planner, set your alarm earlier, buckle down and study hard for the next test. But, as members of

the group continuously point out, these solutions do not work for them. The behavioural changes that are easily accessible to others are seemingly inaccessible to those with ADHD. Prominent ADHD researcher Russell Barkley makes a similar point in a lecture to parents of children with ADHD:

> Your brain can be split into two pieces. The back part is where you acquire knowledge. The front part is where you use it. ADHD, like a meat cleaver, just split your brain in half. It doesn't matter what you know, you won't use it. ADHD is a disorder of doing what you know. It is not a disorder of knowing what to do. Your kids have all the information that the other kids their age have. What they can't do is use it. It is the application of what you know that this disorder robs you of. (2014a)[26]

The specificity of ADHD is thus quite different from the other disorders Hacking describes. For the classification of MPD to have any real meaning for those classified, they have to subscribe to its epistemological framework. This is not the case for what is specific about ADHD: regardless of what knowledge the individual obtains—skills and strategies to improve on, new understandings of oneself—what is ultimately inaccessible to such knowledge are the behavioural problems themselves.

[26] The reader may notice that these are all-or-none descriptions of ADHD, as if ADHD children were entirely incapable of applying their knowledge, or as if ADHD university students have no ability to be successful on an exam. I think what is going on here is that the lack of an adequately-described, specific ontology of ADHD—one that can effectively distinguish ADHDers from non-ADHDers—compels these individuals to assert exaggerated characterizations of their ADHD in order to distinguish themselves. I provide a better solution to distinguishing ADHD in Chapter Six, one that does not rely on such all-or-none descriptions.

Conclusion

Of Louis Vivet, the first clinical case of MPD, Hacking writes, "I am not concerned with what Vivet 'really had.' I am concerned with what was said about him, how he was treated, and how the discourse and the symptom language of MPD came into being" (1995b: 174). My concerns are different from Hacking. I want to be able to say that "I really have ADHD" without relying *only* on biological framings (and thereby requiring a "wait and see" onto-epistemology), and without reducing my ADHD to a generalized ontology of looping effects, classification, technologies of the self, and discursive forces of social construction more broadly. I want ontological specificities for ADHD written *by* ADHDers.

Hacking never provides an adequate answer for what ADHD "really is." Unlike autism, he does not call ADHD an inaccessible kind, despite certain aspects of it clearly meeting the criteria. In contrast, I have argued that ADHD is rightfully an inaccessible kind just as much as autism, schizophrenia, or any other number of more "robust" disorders are. Why, then, is ADHD so heavily criticized as emblematic of psychiatric power? Why does it find itself so targeted by skepticism, while these other disorders escape such criticism? Why is ADHD so often perceived to have no specificity, that is, to be, like MPD, nothing more than a historically-construed, heavily malleable syndrome that anyone can identify with? To begin to answer these questions, I turn my focus in the next chapter to the longstanding sociological tradition of criticizing ADHD.

Chapter Two: Against Critical Therapy

This chapter is about the sociological critique (and concept) of *medicalization*. It is not about the veracity of this critique, or about applying this critique to better understand what ADHD is. It is about how this critique became a generalized ontological lens through which so many people now view ADHD. In other words, it is about how this critique left the confines of sociological discourse and made its way into everyday consciousness.

Consider Allen Frances' international bestseller, *Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma and the Medicalization of Ordinary Life*. It is interesting that Frances includes the concept of medicalization in his book's title. Frances is no sociologist. He is a psychiatrist who served as chair of the DSM-IV in 1994, the lead architect of a number of changes to diagnostic criteria that resulted in, as he puts it, "out-of-control" diagnoses. He has since lost faith in the DSM. Of the definitional changes to ADHD in the DSM-IV he writes,

> We changed a few words so that the definition would be more female friendly.... Extensive field testing predicted only a 15 percent increase in rates [of ADHD diagnoses], but we were later blindsided by clever drug marketing which caused rates to triple.... The blaring propaganda message was the usual—ADHD is extremely common, often missed, and accounts for why Johnny is a behavioural problem and isn't learning in school. "Ask your doctor." (2013: Chapter 5, para. 10, 11)

To medicalize something means, at the very least, to put it under the purview of medical professionals. There is not necessarily anything wrong with medicalization. It is good, for instance, that smallpox has become medicalized: accurately diagnosed and treated. This is why some celebrate the sudden increase in ADHD diagnoses over the past two decades. As Frances notes, "diagnostic enthusiasts celebrate the jump as indication of increased awareness of ADHD and better case finding" (2016). They see it *in principio* as a medical disorder that needs to be accurately diagnosed and treated.

The problem with medicalization comes when (a) it starts perpetuating harm—reinforcing pre-existing power relations and social inequalities through the process of labeling or looping, for example. And (b) when it *covers up* said power relations and social inequalities by asserting psychological or biological explanations for what are really *social issues*. For instance, biological framings of ADHD may hide structural oppressions that give rise to its troublesome behaviours—economic inequalities, decrepit public education systems, the overconsumption of lead[27] due to governments not fixing water pipes in poor communities, and so on. It may even hide oppressions rooted in *material relations*—the transformation of precapitalist time into capitalist labour time, the overproduction of overstimulating technologies based on false needs, and more.

There are many variations on the critique of medicalization and I have no intention to cover them all. When it comes to "mental illness," one of the most compelling is Michel Foucault's critique of "psychiatric power." As Foucault describes it, it is a form of "disciplinary power," "a particular modality by which political power, power in general, finally reaches the level of

[27] Several studies have found that ADHD in children can be attributed to excessive exposure to lead (Daneshparvar et al. 2016: 1).

bodies and gets a hold on them, taking actions, behaviour, habits, and words into account" (2008: 40). It is sustained by the scientific production of truth about "madness," a kind of "power-knowledge" developed not by individual patients, but by those in power—doctors, therapists, researchers, and so on (Foucault 2008: 341-346). Patients (whether in psychotherapy, a doctor's office, psychiatric wards, or asylums) internalize this knowledge as truths about themselves and their madness, making them more docile. Foucault sees this as an oppression that can only be overcome through the "systematic destruction" of the asylum "through work inside": "it involves transferring to the patient himself the power to produce his madness and the truth of his madness" (2008: 344). To challenge psychiatric power is to challenge medicalization itself—as Foucault writes, the "demedicalization of madness is correlative with this fundamental questioning of power in antipsychiatric practice" (2008: 346). I do not mean to diminish the worthy accomplishments of antipsychiatry movements; however, when it comes to ADHD, my argument in this chapter is that attempts to *demedicalize* ADHD *are themselves a medicalizing process*.

The concept of medicalization emerged in sociological literature in the 1970s, a time when the discipline of sociology was going through an upheaval against structural functionalism. Structural functionalism was the dominant approach in American sociology from the 1930s through the 1970s. It views society as analogous to an organism, in which different parts work together independently toward the healthy functioning of the whole. In the 1970s, structural functionalism was heavily criticized by critical sociologists ("conflict theorists"). According to them, functionalists assume society is healthy, and that its organization is based on consensus—a collectivist orientation to social order. From the perspective of this critique, a structural functionalist would view medicalization as an agreed-upon method of sustaining social order in

the face of disease and disorder. In contrast, those who oppose structural functionalism view medicalization as a tool of the oppressor, a means to legitimate exploitation under the guise of treating "natural" ailments threatening social order. Nevertheless, there is still a functionalist idea inherent in these critiques. Sociologists such as Robert Merton and Alvin Gouldner attempted to converge functionalism and Marxism by pointing out that society is not healthy, and that modes of rebellion and resistance are sometimes required to restore society to good health. In particular, Gouldner emphasized the role of sociology in seeking out the *etiology* of social dysfunction (Chriss 2000: 205). From this perspective, medicalization, in some cases, contributes to the remarked blindness of "conservative" structural functionalists who make little effort to look beyond "natural causes" for potential social etiologies of dysfunction.

While Foucault, Hacking, and many others are not structural-functionalists, my point is that it is this latter structural-functionalist critique of medicalization, along the lines of Merton's and Gouldner's convergence of functionalism and critical sociology, that continues to persist in public perspectives on ADHD. I hope to persuade the reader that this functionalist critique of medicalization has become a *liability* for critical thought (at least where ADHD is concerned). In this chapter I describe: first, how the sociological tradition of structural-functionalism itself became medicalized; second, the critique of medicalization's foray into everyday consciousness; and third, the exploitation of this critique in the era of neoliberalism. I then, fourth, provide a more personal example of how this foray into everyday consciousness has given rise to a form of "critical therapy" which is "contraindicative" to the symptomatic specificities of mental disorders.

The Medicalization of Structural-Functionalist Discourse

In 1975, Peter Conrad published a paper criticizing ADHD (then called "hyperkinetic disorder") that would end up setting the ground rules for how ADHD is allowed to be thought sociologically. The basic premise is that ADHD is a "medicalization" of normal childhood behaviour (e.g. running around playfully, being free of social constraints, imaginative day-dreaming), and of deviant behaviour (e.g. not sitting still, talking out of turn, not paying attention). Conrad defines medicalization as classifying such "behaviour as a medical problem or illness and mandating or licensing the medical profession to provide some type of treatment for it" (1975: 12).

Conrad would later develop a more comprehensive theory of the concept in his seminal work titled, "Medicalization and Social Control," expanding the former's definition to recognize that medical professionals need not be involved—following Foucault, he claims that a disciplinary society can transpose the medical gaze onto panoptic individuals, diffusing strict medical hierarchies (1992: 216). Arguably, however, Conrad's latter paper could be interpreted as a straightening out of a more radical but lesser-known piece written a few years earlier by social theorist John O'Neill titled, "The Medicalization of Social Control" (1986). Contra Conrad, O'Neill argues that *structural-functionalist discourse itself has been medicalized* (1986: 353).

O'Neill points to the inherently medicalized underpinnings of the structural-functionalist theories of Talcott Parsons (whose student, Jesse Pitts, coined the term "medicalization" in 1968 (Busfield 2017: 759)) and Merton, both of whom are, according to O'Neill, "the major architects of contemporary sociological discourse, whatever its variants and despite all critical responses and alternative discourses (conflict theory, symbolic interactionism, Marxism, phenomenology)" (1986: 355). The general idea is that Parsons and Merton refigure society as a "cross-mapping of

the functions of the social body and its constituent members," that is, as a "holistic system of interchanges whose orderliness is constitutive of its health" (O'Neill 1986: 352).

From their perspective, the health of a society is seen as equivalent to its *orderliness*, the extent to which the *status quo* is upheld. To maintain order, people must be satisfied with the status quo. If any aspect of the "social body and its constituent members" is dysfunctional, or if there is growing discontent in society, then governments—or what O'Neill calls the "therapeutic state"—must employ professional sociologists (and/or their collaborators or progenies—statisticians, government employees trained in sociology, etc.) to restore order. This is done not through overt state oppression (such as using police to crack down on protests), but through the development of reformative policies.[28] From the view of the therapeutic state, it is the role of the sociologist to investigate social disorder, diagnose its etiologies, and apply such research toward the restoration of society to good health. As O'Neill puts it, Parsons and Merton "cast the sociological theorist as a social physician, doctor of society" (1986: 362).[29]

[28] While the reformative aims of the therapeutic state are often "perverse" (Hacking 1995a: 360), sometimes they do genuinely desire an eradication of various forms of oppression in society.

[29] This medicalized understanding of the role of sociology is widespread. For example, Hacking claims that "since their inception," the social sciences have been "inextricably intertwined with prediction and reform"; "the more the status quo is dissatisfied with itself, the more social science studies are in demand" (1995a: 360, 365). O'Neill might consider this a "major analytical reduction of classical sociological discourse," a warped understanding of social science that originated in the influential works of Parsons and Merton beginning in the 1930s (1986: 352).

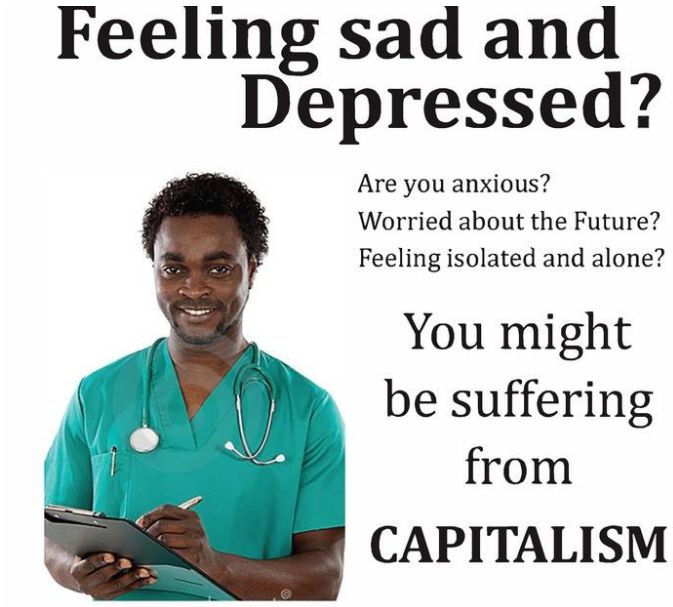

Figure 2.1: An internet meme plays with the idea of a "doctor of society" in its imagery and message.

One of the problems with structural-functionalism is that it tries to absorb alternative sociological discourses into its medicalization. For example, O'Neill argues that Merton, rather than "analyzing the political space that is foreclosed by the American socio-economic order," merely mimics the latter's psychologizing effects (1986: 355). "Rebellion," the rejection of society and its values "in favour of an alternative society" (e.g. "Marxism"), is for Merton simply a "mode of individual adaptation" that allows an individual to feel that he or she is helping to "increase the overall functioning of the social system" rather than enact any fundamental change to it (O'Neill 1986: 354-355). "The result is the foreclosure of revolutionary political space in favour of the *clinicalization of rebellious behaviour*," both in theory and practice (O'Neill 1986: 361).

Conrad, for instance, claims that ADHD behaviour is a "form of social protest" (Whalen and Henker 1977: 590), "symptomatic of some 'disorder' in the school or classroom situation" (Conrad 1975: 20). Here he is *clinicalizing* rebellious behaviour by referring to it as a

"symptom." He is *not* imbuing ADHD individuals with any kind of critical consciousness with which they could, channeling Foucault, "produce their own madness" and "work from the inside" to "systematically destroy" the oppressive institutions of primary and secondary education. No, Conrad is working within the confines of the structural-functionalist approach. In traditional critiques of medicalization, sociologists might point to the school-administration of medications like Ritalin to misbehaving children as a form of social control (Conrad 1975: 19; Rafalovich 2004: 39). Yet, is Conrad not also providing strategies of medicalized social control for the therapeutic state? The driving force behind Conrad's analysis here is to convey the message that ADHD children can be used by school administrations as political leverage for social and educational reform. Structural-functionalism medicalizes ADHD; it "absorbs" and "co-opts" deviancy (O'Neill 1986: 355) as a means to illuminate and criticize social, domestic, or pedagogical ills. ADHD is turned into a diagnostic tool for an ill society.

The diagnosis of ADHD is readily replaced by social diagnoses: underfunded and overcrowded classrooms, lack of physical activities, uninspiring course material, and boring, technologically-out-of-sync lessons—anything that is suspected to cause hyperactive or inattentive behaviour in children. The underlying idea is often that educational reform can *dissipate* ADHD, because ADHD is frequently seen by teachers as nothing more than the expressed "antagonism between students and the institution of education" (Rafalovich 2004: 146). For instance, I recall a professor of mine telling me that his daughter was suspected of having ADHD by her teachers. He took her out of public school and enrolled her in a private art school which she loved. According to him, her ADHD "went away." This is not true of more "robust" disorders like autism. While school administrators certainly call for more funding to

develop and enact specialized educational plans for autistic children, they do not intend this to "cure" autism, to make the autism "go away."

I am not necessarily suggesting that my professor is wrong, and that his daughter still has ADHD, only now, in art school, it is imperceivable through an interpretive lens strictly informed by a deficit model. Maybe that is true, but it is also important to recognize that some, if not many, individuals have been *misdiagnosed* with ADHD through a structural-functionalist worldview (what this looks like is described in the next section). Just because some ADHD-diagnosed individuals are able to overcome their ADHD-like symptoms through reforming or changing their environment or institution does not mean that ADHD is nothing more than a social diagnosis. In the previous chapter, I described how members of my ADHD student support group characterized ADHD's specificity as an inaccessibility to strategies or techniques that normally work for non-ADHD individuals: studying harder, using a planner, and so on. Those individuals would likely scoff at the idea that my professor's daughter "really had" ADHD, because in their minds, the truth of ADHD is in its symptomatic immutability.

In summary, whereas Conrad argues that individuals become depoliticized and docile through the effects of medical labels and medication (1975: 19), O'Neill argues that individuals become *depoliticized and docile through the application of a medicalized structural-functionalist discourse*: whatever discontent, dissociation, confusion, or rebellion stirs within an ADHD individual, it is immediately channeled back into pre-existing formulas of social critique set in place by an orderly society.

The Transfusion of Structural-Functionalist Discourse into Everyday Consciousness

This reduction of ADHD's symptomatic specificity to generalized critiques of social problems is exasperated further when medicalization's *panopticism* is taken into account. To reiterate, Conrad expands the concept of medicalization to recognize that medical professionals need not be involved: a disciplinary society can transpose the medical gaze onto panoptic individuals, diffusing strict medical hierarchies (1992: 216). In other words, one can come to believe one has ADHD not through professional diagnosis but self-diagnosis. With a simple Google search, individuals have immediate access to a wealth of information—online forums, ADHD coaching blogs, digital self-help books, and YouTube channels all geared toward teaching users about identifying ADHD symptoms and learning about its various treatments. Obtaining such knowledge allows individuals to *discipline themselves* into becoming ADHD individuals, and even initiate a therapeutic process through which they learn strategies, techniques, and treatments to try (on) themselves.

There is, however, a flipside to this panopticism of medicalization. It entails a *therapeutic practice of sociology* made available to all. Parsons describes "therapy" as a function of social control: "I should regard deviance and social control as phenomena concerned with the integrative problems of a social system.... Therapy may be interpreted to be predominantly a reintegrative process" (quoted in O'Neill 1986: 359). Under the influence of structural-functionalism in a therapeutic state, therapy no longer has to take place in a clinic, but can be understood more broadly to include any measures taken by the government to reintegrate disordered citizens into society via the recommendations of professional sociologists: ideally, targeting the social and institutional inequalities and oppressions that give rise to the integrative problems of deviancy, disorder, and "mental illness" rather than just passing them off as biological disorders. Indeed, this is Conrad's imperative.

The panoptic flipside of medicalization, however, emerges when sociological professionals like Conrad are no longer needed. Therapy becomes the transfusion of structural-functionalist discourse into a social consciousness of everyday life. The critique of medicalization becomes an *idea*, spontaneously thought by individuals as if it were their own idea: a habit of thought. Everyone becomes a "doctor of society." This can be seen in virtually any online comment section of a news post about ADHD. Comments like: "ADHD doesn't exist! That has already been out of the bag"; "ADD/ADHD is a total made up BS 'disease' as a way to drug and control children and keep people medicated into adulthood"; "Big pharma must come up with more and more medical conditions and mental problems so they can rake in more, more and more money"; "Was no such thing as ADHD when I was a child. It showed up sometimes but that belt on our butts eliminated it quickly"; "Classrooms are overcrowded, teachers can't handle that many kids at once so we have to medicate them to keep them calm"; "ADHD—another term for a child who just wants to be a child. It's an epidemic!" ("People with autism or ADHD" 2019; "ADHD rising among US adults" 2019).[30]

It is important to recognize that these ideas do not come "naturally" to people, "unmedicalized." They have already been medicalized in O'Neill's sense, taught by public academics featured on talk shows and YouTube channels, like when Sir Ken Robinson, a popular critic of education, refers to ADHD as a "fictitious epidemic" in a video viewed seventeen million times (2010); or when a news piece titled, "Canada's adult ADHD epidemic, Study finds growing numbers of healthy people taking 'prescription speed'," is reprinted in twenty-four newspapers across Canada, telling readers that "the diagnostic criteria for adult ADHD are so

[30] I collected this sample of comments (all made by different individuals) by perusing Facebook comment threads on various articles about ADHD by CNN. It took me only fifteen minutes to collect these, indicating just how prevalent these sorts of comments are.

broad they could easily describe anyone who has trouble focusing" and that people "feign ADHD" to get prescriptions for simulant medication (Kirkey 2015). These teachings are then distributed and exchanged through word of mouth and popular forms of media until they appear as intuitive, a "natural" social consensus about what ADHD "really is."

Yet, it is important to acknowledge that these sorts of Conradian critiques of medicalization were never meant to explain how things "really are." The sociological critique of medicalization was not meant to be an ontological theory. From its origins, it aimed to resist the growing power of social control, uncritical biologisms, psychiatric power, and more. But insofar as these critiques are taken as a consensus of how things really are, sociologists with a critical mind will remain trapped in this panoptic prison where, in fear of being lumped in with the uncritical disciplines, none of them dare suggest that a disorder like ADHD might be something more than a medicalization of normal or deviant behaviour. Or among their colleagues they say one thing—asserting an acceptable belief in a general ontology for ADHD—yet behind closed doors act as if they believe another, such as adhering to a medical diagnosis and prescription for their child—a belief in a specific ontology for ADHD.

None of this is to suggest that there is no truth to the claim that ADHD's "epidemic" is, to a large extent, "fictitious." On the contrary, these criticisms still need to be taken seriously. Stimulant medications are one of the top money-makers for the pharmaceutical industry, with annual profits estimated to be $30 billion in 2022 ("ADHD Therapeutics Market Size" 2022). According to Frances, big pharma's increased focus on direct-to-parent-and-teacher advertising of the disorder beginning in the 90s helped to triple the rates of ADHD in the United States (2013: 26). In 2011, the CDC (Centers for Disease Control and Prevention) estimated that 1 in 5 boys and 1 in 11 girls in high school had been diagnosed with ADHD (Piper et al. 2018: 8),

despite an international meta-analysis indicating a global prevalence rate of 7.2% (Thomas et al. 2015).

On the other hand, it is also important to recognize that medical professionals who, strung along by pharmaceutical marketing strategies, overdiagnose ADHD are not always biological reductionists, completely oblivious to the idea that social issues might lead to deviant behaviour or short attention spans. "The system is really the problem," says one pediatrician, but we are "bombarded by this crap (holds up list of DSM criteria)" (in Rafalovich 2002: 198). Many of them have familiarized themselves with the medicalized structural-functionalist discourse that is spread around in the media, one that, for instance, points to the neoliberal intensification of competition in American educational systems as the reason for "overdiagnosis." As *New York Times Magazine* puts it,

> Regardless of ADHD's biological basis,[31] the explosion in rates of diagnosis is caused by sociological factors—especially ones related to education and the changing expectations we have for kids.... Kids now have more homework, less recess and a lot less unstructured free time to relax and play.... High-stakes standardized testing, increased competition for slots in top colleges, a less-and-less accommodating economy for those who don't get into colleges but can no longer depend on the existence of blue-collar jobs—all of these are expressed through policy changes and cultural expectations, but they may also manifest themselves in

[31] Agnosticism over—or easy traversal between—whether ADHD corresponds to a specific or general ontology is more common than outright denial.

> more troubling ways—in the rising number of kids whose behaviour has become pathologized. (Koerth-Baker 2013)

Further, many students are turning to ADHD stimulant medications such as Ritalin, Adderall, and Vyvanse to gain a leg-up in the competition. Prevalence estimates vary, but it is thought that approximately 4-14% of post-secondary students in the United States use stimulant medication, whereas only 2-3% are prescribed such medication, suggesting a large number of students acquire these "study drugs" illicitly through a friend, family member, or dealer (Hartung et al. 2013: 833). In areas with more competitive admission standards, such as the American northeast, rates of stimulant medication use are estimated to be as high as 25% of post-secondary students (Vrecko 2013: 298).

It is not only students who are in on this—parents concerned for their children's future might pressure their doctor to provide a prescription for their children, and doctors themselves might prescribe ADHD medication to make up for what they see as social ills: oversized classrooms, overworked teachers, and, in general, "inadequate schools" (Schwarz 2012). As another pediatrician puts it, "I don't have a whole lot of choice," "we've decided as a society that it's too expensive to modify the kid's environment, so we have to modify the kid" (in Schwarz 2012). In other words, medicalization as a habit of thought inspires not only abstract criticisms of ADHD, but a *sociological practice* of treating society's failures with pharmaceutical supplements which then alter individual (and collective) biology.

From the Therapeutic State to the Therapeutic Market

That individuals—whether medical doctors, parents, or those with ADHD—feel that they themselves must take on the role of the social physician is, without a doubt, an alarming development to O'Neill's original analysis. Structural-functionalist discourse was medicalized with a particular aim in mind: to unearth and give light to the social etiologies of discontent, oppression, and pathological behaviour so that they could be resolved through structural reform. It "rendered the practice of professional sociology itself indispensable" to the therapeutic state (O'Neill 1986: 352). Social discontent and various forms of oppression made work for the sociologist, put bread on the table. But with the dismantling of the welfare state and decades of neoliberal cutbacks since O'Neill published his paper, the playing field has changed considerably. Professional sociology is no longer indispensable to the state, as exemplified in Canadian Prime Minister Stephen Harper's declaration in 2013 that "this is not a time to commit sociology."

As the years go on and calls for social reform continue to be ignored by governments, it is no surprise that people must turn to developing *individuated and market approaches* to work around structural oppressions, such as prescribing stimulant medication, paying for private schools, and everything in between. That is, medicalized structural-functionalist discourse no longer functions as an arm of the therapeutic state. Rather, it is now an integral component to what under neoliberalism might be called the "therapeutic market" where, by design, individuated treatments for social issues turn a profit.

The key problem with the shift to the therapeutic market is that it creates a hierarchy of individuated treatment possibilities based on one's economic, social, and cultural capital. Pharmaceutical workarounds to social malaise are so prevalent because they are the cheapest. For instance, a medical student diagnosed with ADHD feels that medicine is "the most bang for

the buck instead of fixing this and that [about society]" (in Rapp 2011: 18). Home schooling (Rafalovich 2002: 274-275) or changing schools (Rapp 2011: 20) are other options. Anthropologist Rayna Rapp describes a mother who changed her daughter's school three times until they found one where she was not at "grave risk of being labeled and medicated" (2011: 20). Another parent, who is a clinical psychologist, uses his social capital to "have [his] kid's teacher make him run laps when he acted out. He was never medicated" (in Rafalovich 2004: 87). Again, these are all individuated treatments, viable for some but not all. They do not aim to resolve the social problems on a structural level, but work around them using individuated, "social regimens." They are *medicalized sociological practices geared toward the individual's body and biology*.

The Contraindications between Critical Therapy and Symptomatic Specificity

When it comes to mental disorders, critical discourse tends to gloss over symptomatic specificities.[32] Whereas the above section laid out the political limitations to the structural-functionalist critique of medicalization, the following section considers the individual, therapeutic limitations to critical discourse. To begin, political philosopher Raymond Geuss defines critical discourse as a "special kind of knowledge that helps to free agents from socially-induced forms of coercion" but simultaneously helps them to understand "why competing claims to knowledge cannot adopt this same emancipatory role" (in Hartmann 2016: 67-68). In other words, critical discourse surrounding mental disorders is supposed to be *de-medicalizing*, challenging medicalized forms of power, knowledge, and reason in favour of emancipatory ones.

[32] There are exceptions, such as Gilles Deleuze and Felix Guattari's critical analysis of the material specificity of schizophrenia in *Anti-Oedipus*, as well as the field of critical autism studies.

But what is peculiar about the transfusions of medicalized structural-functionalist discourse into the consciousness of everyday life is the extent to which discourse previously incompatible with structural-functionalism, namely critical discourse aimed at de-medicalization, has increasingly been appropriated for therapeutic means. This occurs via a variation of what psychologist Thomas Teo calls "critical therapy" (2015a: 250). Teo uses the term in a different context, describing what might be considered the dream of an applied "critical psychology," an idealized kind of a not-yet-actualized psychotherapy that synthesizes established psychotherapeutic techniques with "analyses of power and social action" in order to improve mental life (2015a: 250). Critical psychotherapy would aim not only to increase the critical reflexivity of the individual undergoing therapy, but contribute to that individual's ability to radically alter the "real-life conditions" that lead to mental strife, a goal that is conceptually similar, as Teo notes, to that of praxis in feminist theory (2015a: 250).

The American Psychiatric Association states that the aim of psychotherapy is to "help eliminate or control troubling symptoms so a person can *function better* and can *increase wellbeing* and healing" (Parekh 2019; emphasis added). For instance, Umesh Jain, a medical doctor well known in Canadian ADHD circles, states of ADHD that "we know for sure that this disorder, when looked after, can make someone very *functional*" (Green 2009; emphasis added). Similarly, clinical professor Margaret Weiss notes that, with proper treatment, ADHD children can "grow into people that [she] admires tremendously, that are kind, that raise families, and *contribute something very significant to society*" (Green 2009; emphasis added).

Some critics, such as sociologist William Davies (2015), argue however that "wellbeing" is a feeling constructed by the American psychological industry, contingent on, at the very least, one's ability to adapt and conform to the status quo. In this view, it might be suggested that

psychotherapy has a symbiotic relationship with structural-functionalism. The health of a society (the degree to which people are satisfied with the status quo) is dependent on the health of its individual members (their ability to function within the status quo) and vice versa; social order becomes sustainable by artificing and attaching a feeling of happiness to this symbiosis.

Regardless of the veracity of this argument, the key intervention that critical psychotherapy would bring to the table is to recognize that "health," "wellbeing," and "functionality" do not have to take on the strict meanings of conformity to the status quo. Instead, illness and dysfunction can also refer to an *inability to think critically* (an inability to discern discourse that has an emancipatory role from discourse that seeks to uphold the status quo). Critical psychotherapy would aim to counter this dysfunction by teaching individuals how to think critically and apply such thinking towards real-world change and, in doing so, to reach a state of wellbeing and functionality that is *not* in service of the status quo.

Alternatively, illness and dysfunction can also refer to an ability to think critically but an *inability to engage in struggles against the status quo,* an inability to participate in radical social change. On the eve of the revolution, will a depressed Marxist get out of bed? This idealized form of critical psychotherapy would recognize that mental disorders can symptomatically, if not physiologically, precede their social or capitalist etiologies. To counter this, critical psychotherapy would integrate psychotherapeutic techniques into its critical teachings, providing patients with practical strategies to alleviate their symptoms whilst still helping them to fight against the status quo and become critical thinkers.

As a result of the gradual transfusion of sociological theory and the transfiguration of the social physician into the governance of oneself, critical therapy has now become a reality, but with a *catch*: it loses its clinical and psychotherapeutic parts. In its *present* form, critical therapy

does not take place in a clinic, but can be understood more broadly to include *any* measures taken by individuals to oppose the status quo via the medicalized application of critical discourse. This includes targeting the social and institutional inequalities that give rise to the integrative problems of deviancy, disorder, and mental illness.

While some might prefer to leave the clinic behind, there is a problem with doing so: critical therapy ends up *lacking* the psychotherapeutic knowledge and techniques to provide specific interventions into ADHD, depression, and other "mental illnesses." It is for this reason that the "burgeoning" field of "Mad Studies," considered by some to be a "continuation" of anti-psychiatry movements[33] (Menzies et al. 2013: 12), despite its myriad approaches and "interdisciplinary and multi-vocal praxis," is a purveyor of an *exclusionary* critical therapy. In their introduction to *Mad Matters: A Critical Reader in Canadian Mad Studies*, Menzies et al. write,

> Following Foucault, the practitioners of Mad Studies are concerned with deploying counter-knowledge and subjugated knowledge as a strategy for contesting regimes of truth... about "mental illness" and the psy "sciences," and about those of us who contend with psychiatric diagnoses and interventions, [who] reject clinical labels that pathologize and degrade. (2013: 14, 10)

[33] Ronald Laing and Thomas Szasz were two particularly prominent figures in the antipsychiatry movements. Laing argued that psychiatric discourse reifies the phenomenological experiences of those labeled mad, preventing us from listening to what they have to say, while comfortably putting us on the side of the "sane" (Noys 2015). Szasz popularized the notion that mental illness is a "myth whose function is to disguise and thus render more palatable the bitter pill of moral conflicts in human relations.... There is no such thing as mental illness" (1973: 98-99).

Mad Studies, to the extent that it operates as a form of critical therapy, reconfigures structural-functionalism's reintegrative process as a reintegration of oneself into the dominant modes of critique and political action, learning to think and act critically, to reject clinical labels and interventions, but at who's expense? As Ann Cvetkovich insightfully writes of her depression, "saying that capitalism... is the problem does not help me get up in the morning" (2012: 15).

In other words, for many, critical therapy works as intended: it transfuses critical and poststructuralist theories into subject-formation and critical consciousness, providing scholars, activists, and others with the intellectual tools needed to fight oppressive systems. Yet, as other sociologists like Cvetkovich have noticed, such a critical therapy is often *contraindicative* to mental illness. In medical terms, a contraindication refers to a treatment that is understood to be unhelpful and potentially harmful to those inflicted with a particular disease or disorder.

For example, in her "auto-ethnography of self-medication," while Elena Trivelli does claim that she "usually finds it more manageable to think of [her] depression as a social construct," and that "losing oneself in analysing discourses... can help to soothe the ache," she also admits that the "security blankets" of sociological critique, like "medicalization," still "get torn and shredded by the aching body": "even when immersed in abstraction, the body makes its call. The body aches, in and beyond any *discourse* on 'depression'" (2014: 152, 157). In another example, Jackie Orr claims that "paranoia 'knows well' the analytic tendencies in social science to turn the complexities of structural dynamics into scary stories of control"; "the contagious paranoia at play in theories of contemporary cyber-ultra-hyper-digital-electro-techno-power-gone-postmodern makes its mark" on her panic disorder (2006: 17). In her analysis of depression, Cvetkovich suggests that, for academics, the depressive "state of being 'stuck,' of not being able to figure out what to do or why to do it," might actually be "produced by forms of critique that

get stuck in... formulaic repetition" (2012: 20-21). What these critical scholars all share is an awareness of how various strands of critical discourse can have 'adverse effects' on their mental health.

Notably, what many of the above examples have in common is that these critical scholars acknowledge the *material effects* of their disorders, effects that are sometimes *exacerbated* when reading critical discourse. It is perhaps for this reason that they are especially attuned to the contraindications wrought by a critical therapy that dismisses such disorders as nothing more than pathologies of their historical materialist conditions, as if changing those conditions will dissipate their disorders once and for all, or as if believing that in itself has inherent therapeutic value. Those hoping to find "respite care" in critical therapy by "checking into" a graduate program will be sorely disappointed in the discourses on offer. More importantly, the transfusions of medicalized discourse into the thought and practice of everyday life will continue to eclipse the specific oppressions that individuals with mental illness face as long as the emancipatory potential of their disorder's symptomatic specificity remains understudied and overlooked.

For example, to bring myself into the mix, I was diagnosed with ADHD back in 2008, and after undergoing years of psychiatric psychotherapy, I eventually decided to move on and try out psychoanalysis for a year. As a different counsellor would later tell me, in her opinion, *ADHD is contraindicative to psychoanalysis*. I can attest to this, at least in regard to psychoanalytical traditions based in memoro-politics: day after day I would sit there in the chair rapidly spewing out random thoughts with little to tie them together, all on the basis that I had to say something to my analyst and could not just remain silent. Indeed, ADHD individuals have been described as "popcorn thinkers" (Surman et al. 2005: 77), "leaping from thought to thought with the grace of

a gazelle" (Hartmann 1993: 80). The problem was that I could not remain focused on any one train of thought long enough to form any sort of "inner understanding" about myself. As a result, my trains of thought were all so superficial—all surface, no depth, no hidden meanings arising from the unconscious or the symbolic.

Sometimes, I would accidentally create falsehoods about myself, my past, and my childhood, not because of unconscious repressions, but simply because of my ADHD-related verbal memory "encoding deficit" due to poor "working memory" (Skodzik et al. 2013). I would mix memories up, forgetting significant events of my life some days and remembering alternative events other days. Then, being under pressure, I would try to spontaneously make up stories about myself with what I could remember in the moment, similar to how ADHD children have trouble with "story recall" tests (Papaeliou et al. 2012).[34] Only hours later, after I had time to reflect without being under pressure, would I retroactively realize my mistakes, but, being that ADHD individuals have trouble learning from their mistakes (Steele 2012: 30), I would then go on to absentmindedly repeat those same mistakes the next day at therapy. Eventually I felt that, because of my cognitive "style," I was not very compatible with psychoanalysis, and any progress made was progress built on false narratives. Not to mention that, after each session, I would return home thinking, "but I still have no idea how to get myself to clean my room!", or whatever ADHD-related symptom was causing problems for me that day. In short, the specificity of the disorder contravened my psychoanalytical treatment.[35]

[34] The practitioner tells a story to a child and then asks the child to either retell the story or answer specific questions about it.

[35] I am unsure what psychoanalytical tradition my analyst was following. Granted, a Lacanian psychoanalyst might have been more appropriate or successful. Jacques Lacan situates repression not in an event or memory, but in the processes of metonym and metaphor in language (Muller and Richardson 1994: 138-139). Hypothetically, Lacan could be useful in developing an explanatory theory of ADHD's "cognitive style," following the differences in use of language for ADHD individuals that I outline in Chapter Six.

The contraindication between ADHD and critical therapy works in a similar way. For example, sociologist Adam Rafalovich, following Foucault, argues that ADHD is best understood as a "field of 'force relations'" in which specific regimes of knowledge (e.g. behavioural psychology, sociology of deviance, psychiatry, psychoanalysis, neuroscience, social constructivism, symbolic interactionism, etc.) "are constantly in flux" as they attempt to gain "temporary dominance over one another," "strategize" for claims over ADHD's truth, try to assert their fields of expertise as the most authoritative, compete for funding, and the like (2002: 87-88). The risk to those with ADHD is the extent to which this field of force relations becomes symptomatically realized in the cognitive style of a popcorn thinker, where one minute I recall and identify with one critical position, say, that ADHD is really just a medicalization of ordinary behaviour and that this whole dissertation is a waste of time; where the next minute, having been influenced by a different train of thought or discourse, I recall and identify with another critical position, say, that maybe my memory problems do stem from my brain being different than others; and then, changing positions again, I decide that maybe my memory problems are really after all the result of some repressed event that happened to me as a child, and that I was wrong to quit psychoanalysis.

Juggling all of these discursive takes on ADHD around in my head makes it difficult for me to function as a critical thinker. It exacerbates certain symptoms that make it harder for me to sustain a singular train of thought or an argument from start to finish. As Gabor Maté, a physician with ADHD, describes it, "never at rest, the mind of the ADD adult flits about like some deranged bird that can light here or there for awhile but is perched nowhere long enough to make a home" (2000: 4). That is, I end up constantly flip-flopping between different discursive positions in my head but never *take a position*. If I cannot take a position, I cannot adopt its

praxis. In turn, I am unable to discern which discourse is the "critical one," which position might grant me *genuine* emancipation. For instance, the theory of medicalization can convince me momentarily that my ADHD label is a façade, that I am actually "normal." If I stick with this position, I could become a political writer and activist who organizes against the oppressive apparatuses of psychiatry and medicine. But I cannot stick with this position because I have this incessant need to constantly move on to the next "perch."

South Korean cultural theorist Byung-Chul Han makes a similar point when he writes,

> [Freudian] psychoanalysis presupposes the negativity of repression and negation. The unconscious and repression, Freud stresses, are "correlative" to the greatest extent. In contrast, the process of repression or negation plays no role in contemporary psychic maladies such as depression, burnout, and ADHD. Instead, they indicate an *excess of positivity*... a being-able-to-do-everything. Therefore, psychoanalysis offers no way of approaching these phenomena. (2015: 41)

The superego—embodying civilization's injunctions, oppressions, regulations, and restrictions on freedom—dominates the unconscious and forces it to repress various aspects of a person's psychological desires. Pathologies that arise from such repression are the objects of study for Freudian psychoanalysis. ADHD, in contrast, does not arise from repression in the Freudian sense. If Han is right, ADHD corresponds rather to an excess of positivity: an impulsive cognitive style that wants to take part in everything, incorporate every possibility into its thought process, and take every discursive position possible: a pathological consequence of an

overwhelming freedom of discursive possibilities. Although I do not agree with Han's take on ADHD as an "excess of positivity," I do agree with his assertion that repression, at least in the Freudian sense, plays no role in ADHD.

In a way, this contraindication between ADHD and critical therapy exemplifies a failure of what O'Neill calls "postmodernism," in which "knowledge is no longer power because power is now knowledge" (2002: 3). In the postmodern tradition, "doing philosophy" becomes less about "loving knowledge" and more about acquiring an awareness of apparatuses of power. Knowledge of oneself is reduced to a sometimes-hateful awareness of one's discursive positionality or disciplined configuration within these apparatuses (Papadopoulos 2008: 140-141). Philosophy is transformed into misosophy. In other words, these various critical discourses can make me aware of my "disciplined configuration" in this "field of force relations," but does not provide me with emancipation from the "discursive flux" that batters me around.

Critical psychologist Dimitris Papadopoulos writes, "common to discursive and social constructionist research... is the claim that identity (personhood) is constituted and reconstituted through discourse and is thus flexible, contextual, relational, situated and inflected by power relations. Davies and Harré argue that who one is is always an open question with a shifting answer depending on the positions made available through talk, in interaction and conversations" (2008: 147). I am not arguing that such discursive flux is unique to ADHD, but that the inability to break free of discursive flux through critical discourse or critical thinking is symptomatic of the disorder.

The above reflections are personal, but can act as a starting point to think about the problem more broadly. ADHD individuals do not need to be scholars engaged in critical discourse to experience discursive flux. As prominent ADHD researcher Russell Barkley puts it,

> Critical thinking is not merely an activity of science or the academic life, but an essential part of daily social life for all of us. It is a means of social self-defence in which we can respond to and defend against the efforts of others to influence us socially for their own self-interests.... Those with ADHD are less capable of such social self-defence; less capable of critically weighing the substantial efforts of social influence by others [read: discourses] to which they are exposed daily; and hence more suggestible, gullible, and socially manipulable. (2006: 324)

It is this never-ending discursive flux of modern societies to which the gullible ADHD individual finds him/herself cognitively "drawn and quartered." Thus emerges a first glimpse of a specific oppression of ADHD: the exclusion of ADHD individuals from critical thought. This renders the ADHD individual *critically disabled*. Notably, it is not Barkley's belief that is oppressive; it is the fact that Barkley is correct.

How can one gain the respect of a friend/colleague if one too easily agrees with everything the friend/colleague says (and then the next day, being seduced by another discourse, betrays such agreement)? How can a "critical" scholar be taken seriously if he or she cannot maintain a steady, coherent argument from start to finish? How can one succeed in a world in which the very basis of critical thought is incompatible with the way one thinks? The medicalized structural functionalist solution might be to provide an alternative form of education or career in which such individuals can thrive, both economically and socially. But in doing so, the individual becomes *depoliticized* and *docile*. Any political imagination that could conceivably *call into*

question the very foundation of critical thought is channeled back into productive activities that maintain the status quo.

I reject the premise that the inability to think critically is a psychological problem. It is rather a philosophical problem institutionalized in powerful structures in society. In summary, acknowledging the contraindications found in medicalized discourse can provide us with a momentary glimpse of a harsh, oppressive existence: by creating a barrier of entry to those who want to become "critical selves" but cannot on account of their disorder; by providing a range of critiques that do not form coherent alternatives to one's diagnosis; by veiling injustices, figuring them as mere "social" problems rather than conceptual, theoretical, and philosophical problems; by creating a detriment to one's capacity to feel coherent about one's way of thinking; and by rendering ADHD's symptomatic specificity *critically* incomprehensible.

Chapter Three: A Case Study of an ADHD Clinic in Japan

The Fieldsite: The ADHD Research Centre

My research study primarily takes place at an ADHD clinic in Okinawa.[36] Okinawa used to be part of the Ryukyu Kingdom before it was annexed by Japan in 1879. Much of the population of Okinawa is indigenous. Racism towards indigenous Okinawans is still very prevalent in mainland Japan, and has carried over to policy decisions at the national level. For instance, Okinawa makes up only 0.6 percent of Japan's land mass, but contains 75% of all USA troops stationed in Japan, what some consider to be a continuation of the USA's "occupation" of Okinawa since the end of WW2 (Tanji and Broudy 2017). According to one indigenous Okinawan I spoke to, when a new USA military base in Okinawa was approved in the late 2000s, the government tried to appease the indigenous population by promising a new state-of-the-art international university which opened in 2011, and in which the ADHD clinic is housed. Unfortunately, not a single Okinawan was hired as a tenured professor, despite the nearby University of the Ryukyus having several potential candidates. When I asked a person who was involved in the hiring process why this was, they stated that indigenous Okinawans were simply "not good enough." Another local told me that indigenous children often go on field trips to this university, but their teachers inform them that they will never have a chance to attend (which, sadly, seems to be the reality, since the university almost strictly aims at recruiting international or Japanese mainland students).

The ADHD clinic is located in an older building that used to be a resort hotel beside the ocean. Giant glass windows look out at the secluded tropical beach, though some of them have

[36] For ethical consistency, I keep the name of the clinic anonymous.

been blurred so that ADHD children will not get distracted by the view. The clinic is comprised of six clinical psychologists (all of whom have a PhD or PsyD (Doctor of Psychology), three technicians (with varying educational backgrounds), and a secretary.[37] All of them are fluent in English; half of them are fluent in Japanese. A few of them are Japanese, and two are native to Okinawa; the others come from varying places including Taiwan, the USA, and New Zealand.

The clinic provides assessments for both Japanese and American children (there is a large population of American families on the island due to the USA military bases). One of the clinicians informs me that, under Japanese law, their unit is not technically a clinic, because only physicians with medical degrees are allowed to diagnose mental health disorders in Japan. In the unit's reports to parents, they do not write "this child has ADHD," but "this child has symptoms/behaviours consistent with ADHD," with which the parents can then visit a physician to get their child officially diagnosed. Regardless, the unit *is* a clinic in every other sense of the word, so I continue to call it the "ADHD clinic," and for simplicity I continue to call the outcome of their practice "diagnosis."

The Biomedical Presence of ADHD in Japan

I chose Japan as a site to carry out my research on ADHD because of the disorder's relative newness to the country. The reported prevalence rate of ADHD in Japan is only 1.7% (Nakamura et al. 2013), far below the estimated (or "average") global prevalence rate of 7.2% (Thomas et al. 2015). Such unfamiliarity with the disorder among the general populace—and possible discomfort with its importation from the Western world—presumably should help to highlight

[37] For simplicity, and to help preserve anonymity, I use the term "clinician" loosely to describe all of them (because technically they all work together at a "clinic"). In cases where their designation, training, or education is important for the context, I will be more specific.

what aspects of ADHD are seen as incompatible with Japanese culture (versus other countries where it has already became fully integrated into the culture and society).

Experts I speak to in Japan[38] suggest that this discrepancy between local and global prevalence rates is due to a lack of awareness in both the general populace *and* medical professionals about what ADHD is. Further, the government provides little resources to schools or parents for children diagnosed with ADHD (in contrast to those diagnosed with autism, who obtain specialized education services funded by the government). Without much government support, parents would arguably be less motivated to seek out a diagnosis for their children. One clinician points to the "underdevelopment" of psychology in Japan as a possible reason:

BH[39]: Psychology doesn't have as strong of a footprint in Japan as it does in Canada, New Zealand, or the UK. Psychology training tends to be at a lower level. I don't mean this to sound condescending, but psychology in Japan in some places is not as well developed.

Another clinician believes that the language barrier is a key factor to why Japan is "lagging behind" Western psychology, but, as someone else points out, neighbouring Taiwan has seen rapid expansion in the training of psychologists using "up-to-date" biomedical literature.

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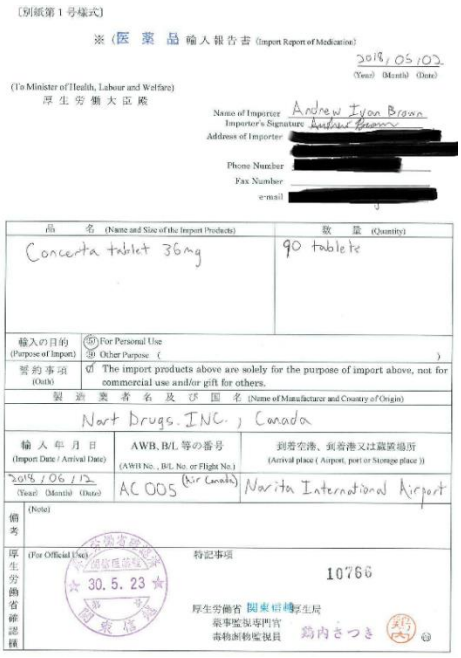
[38] I phrase the question as follows:

AB: Why is the implementation or importation of ADHD into Japan progressing so slowly?
VM: [Sounds offended] The *importation* of ADHD?
AB: I mean, the importation or implementation of an ADHD diagnosis, treatment, awareness, etc., into Japanese psychology systems, mainstream awareness, etc.—why is it taking so long for that to happen?

[39] These are all pseudonyms. In terms of my interview data, there is little reason for me to provide anonymity, as in most cases nothing being said is controversial. Even so, I made the decision to make the interviews anonymous, mostly as a formality.

It could be instead an outcome of Japan's historical legacy of being an isolationist "closed country"—a historical reluctance to integrate foreign culture into its own. Another possible answer is that stigma toward mental illness remains higher in Japan than in other developed countries, leading to an underutilization and underdevelopment of mental health services (Kasahara-Kiritani et al. 2018: 56). When it comes to the implementation of ADHD in particular, Japanese stigma against stimulant medication might be a key factor. For example, prior to arriving in Japan, I first had to acquire a "Medicine Import Certificate" from the Japanese Ministry of Health in order to bring with me 90 tablets of Concerta medication for my ADHD (see Figure 3.1). Stimulant medications are under strict controls and regulations in Japan. Other commonly-prescribed medications for ADHD, such as Vyvanse, Adderall, and Dexedrine are illegal. According to some, this stigma is a long-lasting consequence of the high rates of methamphetamine abuse by Japanese soldiers during World War II, which led to a nation-wide "stimulant phobia" that continues to this day (Takeda et. al 2015). Perhaps the popular association between ADHD and stimulant medication acts as an additional roadblock for the Japanese government to pay more attention to the disorder.



〔別紙第１号様式〕

※（医　薬　品）輸入報告書 (Import Report of Medication)

2018 / 05 / 02
(Year) (Month) (Date)

(To Minister of Health, Labour and Welfare)
厚生労働大臣殿

Name of Importer: Andrew Ivan Brown
Importer's Signature: [redacted]
Address of Importer: [redacted]
Phone Number: [redacted]
Fax Number:
e-mail: [redacted]

品　名 (Name and Size of the Import Products)	数　量 (Quantity)
Concerta tablet 36mg	90 tablets

輸入の目的 (Purpose of Import): (1) For Personal Use; (2) Other Purpose ( )

誓約事項 (Oath): ☑ The import products above are solely for the purpose of import above, not for commercial use and/or gift for others.

製造業者名及び国名 (Name of Manufacturer and Country of Origin)

Nart Drugs. INC. , Canada

輸入年月日 (Import Date / Arrival Date)	AWB, B/L 等の番号 (AWB No. , B/L No. or Flight No.)	到着空港、到着港又は蔵置場所 (Arrival place (Airport, port or Storage place))
2018 / 06 / 12 (Year) (Month) (Date)	AC 005 (Air Canada)	Narita International Airport

備考 (Note)

厚生労働省確認種 (For Official Use)

特記事項

30. 5. 23

10766

厚生労働省 関東信越厚生局
麻薬監視専門官
毒物劇物監視員 鶴内さつき

Figure 3.1: Approval for importing 90 tablets of Concerta to Japan

The ESSENCE of ADHD

Water bottle in hand, backpack strung over my shoulders, I hike through Okinawa's dense tropical jungle in search of the meaning of essence. Eventually I arrive at my destination, the University of the Ryukyus. It is a serene campus; the surrounding jungle provides it with enough cover to keep it hidden and isolated from the nearby bustling city of Naha. I am looking for Professor PL's office, a child psychiatrist who, though not a member of the ADHD Research Centre and Clinic, is affiliated with it. It was recommended that I interview him, as he specializes in ADHD. He is also a student of Christopher Gillberg, a prominent child psychiatrist based in the UK. I take my notebook out of my backpack, and knock on the door to begin the interview. Aside from asking him about ADHD, I also want to ask him about his work relating to Gillberg's concept of ESSENCE, "Early Symptomatic Syndromes Eliciting Neurodevelopmental Clinical Examinations" (2010: 1544).

ESSENCE is a proposed alternative to diagnostic classification for children aged 3-5 years old (Gillberg 2010: 1543). Gillberg claims that problematic children display so much symptomatic overlap between disorders that it is counterproductive to try to "box" them in with a diagnosis (or numerous comorbid diagnoses) at such a young age (2010: 1549). Whatever symptoms a child might have—the nervous tic, rare epileptic seizure, gastrointestinal problems, physical discoordination, mood swings, lack of focus, stuttering of speech—they are not specific to any disorder.

Gillberg's concept of ESSENCE, then, redefines such symptoms as a *generalized ontology* of childhood. He believes that they exist—or can be effectively encountered as though they exist—as a *singular monism of all the possible problems children might experience at a young age*. As Professor PL explains to me, "some people say the concept of ESSENCE is vague, *but I think it is a real thing.* ESSENCE is the essence of child psychiatry."

In practice, "ESSENCE children"[40] do not need to see a specialist trained in this or that specific disorder, but can instead be treated using a "holistic approach" (Gillberg 2010: 1549):

PL: Gillberg and I don't like very fancy, very expensive treatments, and a child shouldn't stay seven hours a day at a specialized clinic undergoing discreet training for several months, where each session will cost big money. Some of them say it works very well but I don't believe it. Maybe it works, but how many children can access this kind of service? So I prefer to build up a system in the community, in the public health services.

[40] "ESSENCE is not a diagnosis," PL claims.

PL recognizes that diagnosing children with specific disorders necessitates higher degrees of specialization, more expensive forms of treatment that not everyone (or every government) can afford, and a proliferation of often-privatized treatment centres such as "Community Pediatrics, GP centres, CAMHS, SLT-services, Special Education Units, Child Neurology, ASD, ADHD, Tourette or Affective disorder centres" (Gillberg 2010: 1549). His answer to these socio-economic problems is to introduce affordable alternatives: holistic treatment centres for all ESSENCE children regardless of their particular set of symptoms or socio-economic background.

There is, however, a catch to this proposed ontological generality. If ESSENCE children are not treated right away, there is a high likelihood that they will suffer major problems in adolescence:

AB: When ESSENCE children get older, do they then start to fit into the boxes of ADHD, ASD, and so on?

PL: Yes. When they get older, yes, some of them will have many diagnoses.

In other words, once the initial window for treating ESSENCE has passed, delineations between disorders begin to become clearer. Essence multiplies. The symptomatic contours of ADHD, ASD, and others can be differentiated by adolescent and adult psychiatrists in ways that now

actually seem to correspond to "reality" (versus at a younger age when such specific diagnoses do not seem to correspond to the "reality of child psychiatry").

Gillberg's is thus a topsy-turvy philosophy. The ontologies of ADHD, ASD, and other psychiatric disorders begin as a singular ESSENCE, that unbridled monism of childhood problems. Then, like the child who flips the toy top on its head by spinning it wrong, the untreated problem-child flips ESSENCE on its head as he or she develops into adolescence, stratifying ESSENCE into many different specificities, becoming definitively diagnosed with this or that disorder, or multiple comorbid disorders. Notably, in his later works on ESSENCE (2021, 2014), Gillberg clarifies that treating ESSENCE children does not aim to cure the neurogenetic underpinnings of what is commonly diagnosed as "ADHD"; rather, ESSENCE treatment helps children with ADHD-like behaviours to get ahead of their symptoms so that they do not fall behind in school or develop social problems; he also believes that a diagnosis of ADHD can be helpful for ESSENCE children as they grow older to improve self-understanding (Sjöberg 2021: 247).

I open with this philosophy of Gillberg's because it is an example of what I call "*ontological traversal*": a traversal between ontological generalities (e.g., accepting the reality of ESSENCE) and ontological specificities (e.g., accepting the reality of distinct, discernable disorders). It is not as if Professor PL and Gillberg believe *only* in generalities and grudgingly diagnose ADHD in children because that is standard psychiatric practice. No, they genuinely believe both in the generality of ESSENCE and the specificity of ADHD.

Contemporary ADHD critics like Mattias Sjöberg perceive such traversals as examples of the "onto-epistemological violence" inherent in all ADHD diagnoses (2021: 243). As Sjöberg writes, "let's get metaphysical.... The classified subject—which at the level of being is a pure

multiple—through the diagnosis [of ADHD] emerges as a 'negative difference,'" an "empty set," "~~ADHD~~" (2021: 244, 252-253). Sjöberg believes that ADHD has no specificity, that it is nothing more than a generality of human diversity, of "pure multiplicity," and so treating ADHD as if it does have specificity is the kind of "onto-epistemological violence [that is] (re)produced by Gillberg" (2021: 248). The problem with these critiques is that they fail to include ADHD-affirmative voices or perspectives, and in turn fail to consider even the possibility that ADHD has a specificity or affirmative dimension to it, that its signification can be more than just a negation of being fully human. On the contrary, when I asked Professor PL about his beliefs surrounding ADHD, he revealed to me that he himself has ADHD, and that he understands it affirmatively:

AB: [my eyes go wide] Really? You have ADHD?

PL: Yes. I know myself very well. You know, Walt Disney, he had ADHD. That's why Mickey Mouse is very impulsive and hyperactive in the first movie. Also, Thomas Edison and Wolfgang Amadeus Mozart had ADHD. And so many other geniuses. It's a different type than the ASD genius. The ADHD genius is kind of very, for example, a joker, very creative, and very active, and they are very interested in many things. So yeah, I don't know. I try to explain that to parents of children with ADHD, because they say so many negative things about their child. I try to explain to the mothers how nice, or how unique, or how interesting ADHD children can be. That is why many children want to come back to me.

AB: Have you been *diagnosed* with ADHD? If you don't mind me asking.

PL: No, no, no. Right now I'm 58 years old. We never have any child psychiatrists who could give a diagnosis of ADHD in that range. [laughs][41]

AB: And you're clearly quite successful so I don't think you need a diagnosis, right?

PL: Well sometimes I start to notice my problems appear again. I try to keep a routine, a daily routine, because as you know, ADHD children, or ADHD people, once you're out of the routine, it can sometimes be big and messy at the end of the day. [....]

AB: When you look back at your life do you feel like your ADHD has helped you get to where you are?

PL: Yes, I think so.

AB: In what ways?

PL: For example, now I'm working as a professor, and also a psychiatrist in two places, a hospital [close to the university], and a shelter house [in another part of the country]. So I get to move between cities several times a month, but I never feel... It's not bothering me. I love to go places. I love to do many different things.[42]

AB: Many things, moving around a lot, trying new things? Still?

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[41] Adult diagnoses of ADHD in Japan, though in rapid incline over the past few years, is still relatively a new phenomenon compared to most countries in the West; there are no treatment guidelines for adults with ADHD in Japan, and virtually no research available on ADHD adults in Japan (Aoki et al. 2020: 1-2).

[42] Because we both have a mutual understanding of the intricacies of ADHD, PL did not explain his answer for me, and conversely I did not ask him to clarify. I understood exactly what he was referring to immediately—namely, that ADHD adults have an "internal restlessness" (Surman et al. 2014: 64) or "organic drivenness" (Barkley 2006: 6) that compels them to "move around a lot" and "try new things," what some call "novelty seeking" (Surman et al. 2014: 9; Hallowell and Ratey 1994: 74). In effect, ADHD adults like PL tend to have "many projects going simultaneously" (Hallowell and Ratey 1994: 73) and frequently jump from one activity to the next at a high pace (Surman et al. 2014: 226; Matlen 2014: 4; Hallowell and Ratey 1994: 97; Hartmann 1997: 56). Some describe this as ADHD individuals being "energetic" (Pinksy 2012: 13; Hallowell and Ratey 1994: xi) and having a "zest for life" (Barkley et al. 2010: 119).

PL: Yeah, still trying new things. I'm now teaching karate. There was a talk here at the university awhile back, and on my panel there was a psychologist, a sociologist, and a philosopher. After our talk, they asked me, "please teach us karate," so I started a class for professors. I teach them twice a month. We've become good friends, and we talk about certain subjects from different viewpoints. This is good for me because I want to criticize my own work from different viewpoints. I am very critical of my own work.[43]

Notably, Professor PL never brought up genetics or neurobiology when discussing his beliefs about ADHD.[44] It might be said that his beliefs hinge not on ADHD's purported biological specificity, but rather its *symptomatic specificity* which flows through him and positively defines his life. His "internal restlessness" due to his ADHD (see footnote 42) compels him to move around and between institutions in an ADHD sort of way, criticizing psychiatric diagnoses in his university office one day, diagnosing ADHD at his clinic in a different city the next, developing an ESSENCE alternative to it in community centres the day after, and all the while teaching other professors the "traditional *Budo* movement," the slow, "concentrated movement" that helps him regulate his ADHD.

* * *

[43] ADHD community discourse describes being overly self-critical (Surman et al. 2014: 45; Sarkis 2011: ix) or cognitive "self-flagellation" (Hallowell and Ratey 1994: 88) as symptoms of adult ADHD. In a couple of talks I have given about ADHD, I have personally advocated for "flipping" these symptoms into a positive: namely, that ADHD individuals do good work because they are constantly criticizing and improving it. This is especially important for academic work. This is how I interpret Professor PL's statement.

[44] Though he does state that ESSENCE is largely biological—i.e., a *biological generality.* Not a singular biological problem or etiology, but biological nonetheless. In this regard at least, it is similar to the concept of neurodiversity.

This chapter is about how clinicians in Japan who specialize in ADHD figure its primary specificity in various ways and simultaneously (explicitly or implicitly) maintain a belief in various ontological generalities of ADHD. In Chapter One, I argued that Ian Hacking's concept of "inaccessibility" helps to home in on what is *primarily* specific about ADHD. The idea I presented was that ADHD is not a disorder about the self. Few would deny that, regardless of what ADHD fundamentally is, at the very least the *label*, "ADHD," is an ontological specificity: that it *exists* as a social construct that can have powerful effects on the self—such as changing how one thinks about oneself and interpreting one's behaviour differently as a result of one's diagnosis. But remember, Hacking's theory originated from his study of MPD: a disorder that, according to him, has no *primary* ontological specificity because whatever specificities it does have—the label "MPD" and the specific effects of being labeled with MPD—are completely accessible to the effects of looping. In contrast, Hacking notices that certain other disorders, such as autism, *do* have primary ontological specificities—specificities that are *inaccessible* to looping effects. I argued that this was true of ADHD as well: regardless of how the label "ADHD" changes the self—and how these changes might loop back to change what it means to have ADHD or identify with ADHD—what is *primarily* specific to ADHD are the aspects of it that are *inaccessible* to looping effects, namely, the symptoms themselves.

The limitation to Chapter One was that my argument rested strictly on the testimonies of ADHD students in my university strategy group. They described their symptoms as inaccessible to discursive techniques and strategies—something that, in their view, was not the case for non-ADHD students who might also struggle from procrastination, inattention, and so on. This is what made their symptoms *specific to* ADHD. No matter how much these ADHD students tried to change themselves and their behaviours, their ADHD symptoms would not budge.

In this chapter, I continue my exploration of ADHD's supposed primary specificity, its inaccessibility. Namely, how do specially-trained ADHD clinicians conceptualize ADHD's inaccessibility? To parse this out further, I consider the question from a cultural perspective. What aspects of ADHD are understood by clinicians in Japan to be inaccessible to *cultural discourse*? By cultural discourse I mean the effects of cultural differences—Japanese belief systems, cultural norms, childrearing practices, and different standards of behavioural conduct and etiquette in both family and classroom contexts. What aspects of ADHD stay the same despite these cultural differences, and what aspects of ADHD *change*?

I break this chapter up into several sections. The organization is a bit messy due to my ethnographic approach—each section demonstrates different approaches to thinking about questions of ADHD and culture, and they do not always link together as a single narrative. I have already discussed ADHD's presence in Japan from a socio-historical perspective, and described my field site—the ADHD clinic in Okinawa. In the next section, I briefly discuss the diagnostic practices that take place at this clinic. From there, through a winding path of analysis, I discuss three distinct—though in practice often overlapping—beliefs about what aspect of ADHD is inaccessible to cultural discourse: its symptomatic, biological, and psychological specificity. In the last section, I critique the notion that psychological specificities are inaccessible. I conclude that, based on my ethnographic observations, the only specificity for ADHD that appears to sustain a quality of inaccessibility is, once again, the symptoms themselves.

How ADHD Is Diagnosed at the Clinic

If there were ever an award given for best diagnostic practices, I think this clinic would take the prize. Their diagnostic process is as follows: the clinic reaches out to all schools within approximately a two-hour drive, so that teachers are aware of the clinic and can refer children to

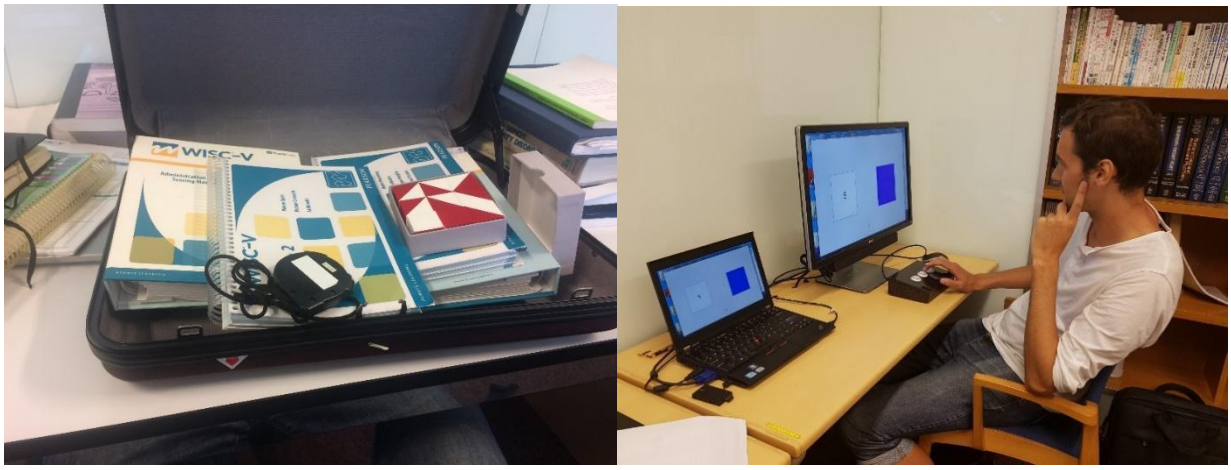
it (via and with the permission of their parents, of course). There is sometimes a lengthy waitlist. Once through the waitlist, the clinic sends an ADHD questionnaire (the *Connors Comprehensive Behaviour Rating Scale* (CBRS)) to the child's teacher and parent(s) to be completed. It includes items referring to different forms of behavioural issues, such as "Often talks excessively." Beside each item, the parent marks off which box best describes the frequency of the behaviour: "Not at all." "Just a little." "Quite a bit." "Very much." It is standard practice in any country (that follows APA guidelines) for clinicians (including general practitioners) to use this questionnaire, or others like it (SNAP-IV, CBCL), to diagnose ADHD and other behavioural disorders.

The child is asked to visit the clinic on three different days, with sessions lasting approximately two hours each day. On the first day, an IQ test (the WISC[45]) is administered to the child, as well as one or two computer tasks[46] (see Figures 3.8 and 3.9). Meanwhile, a different clinician will interview the parent(s) (using the Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS)). It is a semi-structured interview that allows clinicians to phrase questions in ways that are appropriate to the respondent's unique circumstances, socio-economic status, cultural outlook, and belief system. Most importantly, the parent interview helps to provide contextualization. Does the child misbehave in only one environment (e.g. school) or across several different environmental contexts? When did the misbehaviour begin? Can the misbehaviour be explained by (traumatic) events in the child's life? One clinician I talked to

[45] The *Wechsler Intelligence Scale for Children.* The full battery of WISC subtests are administered. A score is obtained for each of the five different areas: verbal, visual-spatial, fluid reasoning, working memory, and processing speed. If the child is found to have a below-average IQ score (lower than 70), a diagnosis of ADHD is *not* permitted (as per DSM guidelines). According to one clinician, a "very low IQ" means that the child's "cognitive ability is not able to sustain longer attention," which is a separate issue from having a "true deficit in attention."

[46] These computer tests are not designed for diagnostic purposes, but for research. They are experiments designed by a third-party researcher who has contracted their work out to the clinic. The clinic administers the test, collects the data (anonymously), and sends it back to the researcher. The data is not included in the child's assessment, though the clinician's observations of the child taking the tests could potentially influence assessment.

referred to the K-SADS as the "gold-standard of making a diagnosis." It is deemed more informative and accurate than conventional rating scale questionnaires (such as the CBRS).



Figures 3.8 and 3.9: (Left) The WISC-V briefcase, including a stopwatch, puzzle, and booklets. (Right) Me taking a computer test.

On the second day, the child is tested (with the WIAT[47]) for certain learning disabilities, and (with the CELF[48]) for language pathologies. If either are found, the child is referred to a different clinic that specializes in such disabilities or pathologies. As one clinician describes, "we just want to get some basic information and ideas. We are not speech and language pathologists, and we are not doing a learning disability evaluation." On the third and final day, a clinician interviews the child (also using the K-SADS) and administers any remaining computer tasks.

A lengthy report about the child is then written by several members of the clinic. The technicians compile and compute the data from the different assessments and display them in the report. The clinicians provide qualitative statements based on various parts of the clinical

[47] The *Wechsler Individual Achievement Test*. Only four (out of twenty) subtests are administered. This can help the clinician determine if the child's performance or behavioural problems might be explained by a learning disability (other than ADHD).

[48] The *Clinical Evaluation of Language Fundamentals*. Like with the WIAT, only a few subtests are administered in order to get a sense of whether the child's performance or behavioural problems might be explained by a language pathology.

evaluation, and include recommendations for the parents. One clinician informed me that in most American clinics that diagnose ADHD, a report that is five pages long is considered a "gift" to parents. In this clinic, however, an average report is ten pages long, and sometimes they reach up to seventeen pages.[49] Importantly, in this clinic, an ADHD diagnosis is not based solely on quantitative scoring. Rather, the clinicians base their diagnosis on the entirety of the clinical assessment, including how the different scores, questionnaire feedback, observed behaviours, interview responses, and insights (e.g. that the child experienced a traumatic event) relate together as a whole.

A diagnostic label or "category" is, by definition, an ontological specificity. As ADHD researcher Russell Barkley states, "an individual either has a disorder or does not. The DSM... uses this categorical approach (all or none) by requiring that a person meet certain thresholds to be diagnosed with ADHD" (2006: 95). ADHD *exists*, at the very least, as a diagnostic category that, when applied to an individual, can have quite a powerful psycho-social effect (e.g., through looping effects). The clinicians at the Okinawa ADHD clinic, however, in their diagnostic practice, envision the specificity of ADHD's ontology beyond just being a "label" or "category" that can be applied to any child experiencing behavioural problems at school. For example, if environmental factors *alone* can explain why the child is exhibiting ADHD-like symptoms, this is indicative, for these clinicians, that the child probably does *not* have ADHD. As one clinician described (of a previous clinic she worked at),

[49] While some of the staff take pride in their thoroughness, others find the lengthy reports to be too time-consuming and a waste of resources that could otherwise be spent on research.

DI: I think that the identification of ADHD does get confused by other factors affecting children's lives. For example, we had a lot of children at that clinic who had witnessed violence in their community, had hard immigration histories, and were living in gang-infested neighbourhoods. So they also had a lot of PTSD, anxiety, and a lot of agitation that they felt. And because of all of that they couldn't pay attention in class. When they hear loud noise they get hyper vigilant, sometimes they get angry easily, because of what's happening in their families. So that gets presented as externalized behaviour and the teachers identify it as ADHD or ODD. So there was a lot of, I think, misreferral or misdiagnosis by the teachers and the parents.

Further, as I indicated in footnotes 45 and 47-48, the primary purpose of the WISC, WIAT, and CELF is to exclude alternative pathologies that could explain why the child is presenting ADHD-like symptoms. In excluding other possible causes or explanations for ADHD-like behaviour, these clinicians are honing ADHD's specificity, giving it more definition.

Although these clinicians use standardized tests, their particular choices of which tests to use, the order in which they administer them, their collective discussions and decision-making about the child, and most of all, their various cultural backgrounds, levels of experience, areas of research interest, and beliefs about ADHD all contribute to a unique, one-of-a-kind "signature" of ADHD diagnosis. I am reminded here of Sharon Traweek's ethnography of particle physics laboratories around the world. Traweek, a science and technologies studies scholar, points out that, in the field of particle physics, each research group develops, constructs, and conceives of its own particle detector device, which in turn establishes the "signature" of the group and their particular variant of the scientific method (2009: 48-49, 72). Similarly, the decision to diagnose a

child with ADHD in this clinic—though following robust, rigorous, and standardized scientific methods—is characteristic of this clinic alone. A clinic elsewhere with different clinicians might have made a different diagnostic decision.[50]

How does ADHD "Travel" to Japan? How Is it "Translated"?

The question of ADHD's "mobility" has been posed in recent bioethical debates. In an article titled, "Why Bao-yu Can't Concentrate: Attention Deficit Disorder in *The Story of the Stone*," comparative literary scholar Dore Levy (1994) argues that the protagonist Bao-yu in a seminal classic of Chinese literature from 1792 has ADHD. Bioethicists Flora Huang and Grant Gillett oppose this interpretation, stating that to medicalize Bao-yu and explain his behaviour through neurobiological dysfunction is to ignore and erase the "crisis in Chinese thought and cultural history" that inspired and drove the author, Cao Xueqin, to write the novel (2014: 186). However, as bioethicists Neil Pickering and Jing-Bao Nie explain, such opposition illustrates a common tendency on the part of social scientists to implement a dichotomy between "East" and "West," implying that Western biomedical disorders do not "belong" in Eastern societies (Pickering and Nie 2016: 249).

Pickering and Nie argue instead for a middle ground, stating that "different cultures have different ways of justifying medicalization of children's behaviours as well as criticizing and resisting it" (2016: 269). For instance, could Bao-yu's concentration problems be understood through the historico-sociocultural context of eighteenth-century China *and* through a biomedical

[50] I am not suggesting this calls into question the veracity of ADHD diagnoses here or in other similarly-robust ADHD clinics, though my findings should emphasize in comparison just how crude diagnostic procedures are when they consist of nothing more than an underqualified physician taking a few minutes to diagnose a child using a simple checklist.

perspective of ADHD that is informed and influenced by such a context?[51] One way of conceptualizing this middle ground is through what anthropologists Margaret Lock and Vinh-Kim Nguyen call "local biologies," "the way in which biological and social processes are inseparably entangled over time, resulting in human biological difference" (2010: 90). In her research on Japanese women, for instance, Lock found that reports of symptoms relating to menopause were far less numerous and less severe than for American women, and that these differences cannot be explained simply by "cultural" or "subjective" differences in reporting; rather, the local biologies of Japanese women are actually different, dependent on historical change and social particularities, such as diet or ambient temperature, leading to physiological differences in the experience of menopause (Lock and Nguyen 2010: 88). One of my approaches to thinking about ADHD on my trip to Japan was to consider whether a local biology of ADHD was possible, a biosocial specificity that is not reducible to just biology or just social or cultural interpretations.

Further, Lock and Nguyen note that biomedical and scientific knowledge, when newly received in a society, does not necessarily erase or "relinquish indigenous theories of disease causation" (Lock and Nguyen 2010: 63). Unfortunately, when it comes to Okinawa, the importation of biomedical knowledge surrounding ADHD *does* appear to continue the imperialist and colonialist legacy of relinquishing indigenous knowledge. Imagine, for a moment, a different world where Okinawa was still part of the Ryukyu Kingdom. What might a locally-developed Okinawan psychology have looked like? In *Uchinaguchi*, one of the two

[51] For example, turning to Japan, prior to the Meiji period, attention was understood primarily in terms of Buddhism or Edo Neo-Confucianism. In 1908, early Japanese psychologist Yuzero Motora developed a treatment for inattentive students that he called "attention training," which was for a short time adopted in public education (Takeda et. al 2015: 102). Motora was trained in Western biomedicine, but combined such training with more traditional Japanese beliefs and conduct (Takeda et. al 2015: 102).

traditional Okinawan languages (of which there are several dialects, but they all share the following words[52]), there is a word, うーまく, which refers to a boy who is "very energetic and childish, but unruly as well. It's not a bad word. It's used in a good way."[53] There is no word similar to this in Japanese or in English. The same goes for とぅるばや, which refers to a girl who sits in one place and just stares into space. This word has a negative connotation, usually implying the girl to be "useless" or "less intelligent." Finally, the word うふそ refers to someone (a kid or adult) who "often makes mistakes and forgets things," someone who is "careless" and a "scatterbrain." "It's like, I made this mistake yesterday—'oh you're so うふそ!'" These are all *character types* embedded into the language of a 700-year-old kingdom that was annexed 150 years ago; and so it is most probable that these words predate all other "first mentions of ADHD" in popular and academic literature.[54] What kind of culturally-specific psychology could have grown from such a language? We will sadly never know.

Returning to the question at hand, how does ADHD "travel" to Japan? I do not mean this historically, but conceptually and perceptually. Social theorist Bruno Latour's concept of "immutable mobiles" is helpful here (1986: 7). An immutable mobile is something that is expected to *stay the same* regardless of where or how it is perceived, discussed, or manifested. In

[52] Though a distinct language from Japanese, *Uchinaguchi* uses a mixture of hiragana and kanji syllabary for writing. Only a small percentage of indigenous Okinawans can still speak in their traditional dialects. Both *Uchinaguchi* and its northern Okinawan counterpart *Kunigami* are considered to be endangered languages.
[53] These quotes are taken from an interview I had with one of the clinicians. I was very fortunate that she could speak *Uchinaguchi*. I am indebted to her for bringing my attention to these words.
[54] Many writers placed the first mention of ADHD to a nineteenth-century poem about a kid named "fidgety Phil," that was until Russell Barkley published an article attributing the first mention to a German nosologist named Melchior Weikard in 1790 (though it is likely that Barkley is indebted to Foucault for digging up Weikard's classifications of mental illness on page 193 in his 1961 book, *History of Madness* (2009)).

order for an immutable object to be mobile, it has to have standardized "inscription procedures" that keeps it "presentable, readable," and most of all "immutable" (Latour 1986: 7). For example, Figures 3.2 and 3.3 are images taken from a Japanese information video created by the clinic. The ontological specificity on display here is a unidirectional biological one, signified by (a) genetic difference (represented by a DNA double helix), which gives rise to (b) differences in neurobiology (represented by brain-scan imagery), which in turn underlie (c) ADHD behaviours in children.

Figures 3.2 and 3.3: (Left) An ADHD brain versus a "normal" brain. (Right) Childhood behavioural problems, genetic differences, and neurobiological differences all represent a single immutable thing: ADHD.

Figure 3.4: Recruiting Attention (Keenan 2017).

This information video is a translated version of a similar information video created in the United Kingdom (both videos are for the New Forest Parenting Program (NFPP), which I discuss

in a later section). Little is changed when these biomedical representations of ADHD travel to Japan—at first, the only translation appears to be literal: from English to Japanese. However, I do notice one other subtle "translation" in the Latourian sense (i.e., an inscription practice used to give an immutable thing mobility). The scenes depicting ADHD children are different—they were re-filmed for the Japanese version of the video. In the English version, the child runs off and the parent must call her back. In contrast, in the Japanese video, the child does not run off, but merely looks away from the clinician when being called. In response, the parent gently puts her hand on the child's head and turns it so that the child is looking at her (see Figure 3.4). This technique is called "recruiting attention." When I asked the Japanese film director why she changed this scene for the Japanese version, she replied,

NM: I just couldn't do it. We spent all day filming that scene, and I told my niece how to behave:

> "you just run away somewhere, and then aunt calls you and you just ignore me the first time." She just couldn't do it. It's all very much artificial in a way. My niece does not have ADHD. So trying to fit her into the role of a child with ADHD, there's a bit of a limitation.

By having her niece look away, the director was still able to demonstrate an attention lapse, and the technique of recruiting attention. This "translation," however, has nothing to do with deliberate cultural transfer, but with difficulties using child actors. The implication of this is that ADHD takes on accidental transcriptions, which may loop back on how ADHD is conceptualized—making it "mutable" after all.

When I asked the director—also a clinician at the clinic—if she felt it was possible to ever authentically capture ADHD on film, she replied:

NM: Maybe in a natural environment. We set a video camera up here [she points to a hidden camera in the ceiling of the room we are sitting in],[55] so we can see the behaviours without letting the child know.

AB: So when you watch children being assessed through the hidden camera, you can actually point to the screen and say "that's ADHD right there"?

NM: Yeah. What do you think? .... There are the observational coding systems. We can observe and code inattention, hyperactive behaviours, and impulsivity and that kind of thing.

In this context, she is referring to a symptomatic specificity of ADHD that can be captured on tape, *behaviours that are specific to ADHD and not general to childhood.*

However, based on other interviews I held, ADHD's cinematographic appearance is also often said to take on a symptomatic *generality*. For instance, a presentation slide the clinic uses at conferences has three photos of children purported to be inattentive, impulsive, or hyperactive (see Figure 3.5). I asked clinicians if these photos depicted ADHD:

AB: Can you show me where the ADHD is in these photos?

[55] Many of my interviews took place in the child assessment room because it was usually unoccupied.

VM: [She laughs]. That's not fair. *You can't focus on one kid and say that's ADHD.* Maybe if you had a photo of an entire class, and you had one kid standing on his or her desk while the rest were sitting, you could say that kid is displaying a symptom of ADHD.

[....]

TR: Look, when I present this slide, I'll say to the audience, in terms of hyperactivity, it's not about the *actual activity*, it's about whether there's a match between the activity level and the situation. I'll say, running, screaming, jumping, yelling outside is perfectly normal, it's not considered okay in the classroom.

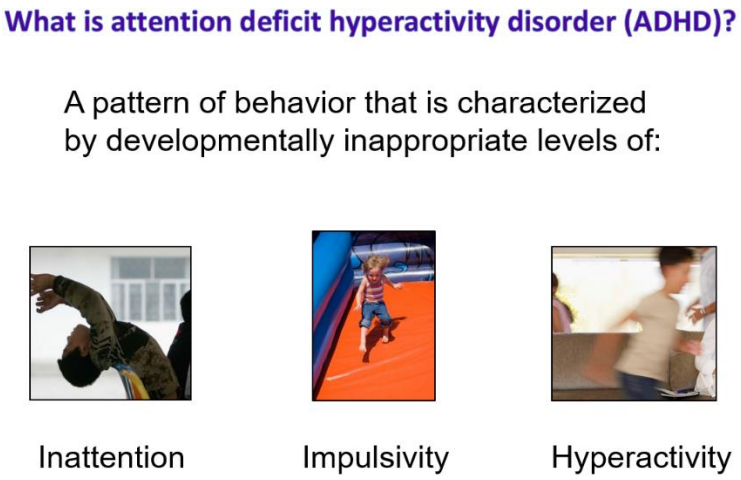


Figure 3.5: Talk slide from the ADHD Clinic

That is, when interrogated with generic, stock photos purported to show ADHD, these clinicians adopted a narrative of ontological generality: the idea that these behaviours are *normal childhood behaviours*, and only become ADHD behaviours when contextualized in settings where those behaviours are no longer appropriate. One cannot "focus on one kid and say that's ADHD" without such context. In contrast, the director above indicates that clinicians *can* focus on one kid and code his or her behaviour as ADHD, despite no other children being in the room, and despite the artificial environment of a clinical assessment room. Interestingly, NM stated that the

clinical assessment room was a "natural environment," at least in comparison to the artificiality of the video she directed. This suggests that, in her view, ADHD behaviours can appear "naturally" as long as the child actually has ADHD, and is not acting.

I do not have access to candid camera footage, but to give an idea of what "natural," specific ADHD behaviour can look like, consider another scene from the English version of the information video (see Figure 3.6). In this scene, a scraggly, unkempt man with a camo sweater sits in a chair, fidgeting nervously, speaking in slow but scattered phrases. The man, while describing his effort to apply for a security guard job, tunes out mid-sentence: "I'm quite nocturnal. I find it really hard to sleep, so it's very easy to stay up at night, and, uh… [pause] [shakes his head as if he is trying to wake himself up], sorry my mind's gone blank." A subtitle appears on the bottom of the screen, "distracted and loses train of thought." The psychologist giving the interview reacts excitedly: "that's, yes, [looks at camera excitedly], that's really good, [laughs], it shows on the tape that it's almost like you're talking about something and half-way through you've forgotten what you were going to say."

Figure 3.6: ADHD "caught on tape." [33] Speaking. [38] Stops mid-sentence. [43] Stares into space. [46] Gives head a shake. [50] Apologizes.

NM suggested that, because this adult does genuinely have ADHD and is not an actor, what is shown on the video is "closer to the natural behaviours of ADHD." Of course, from a sociological perspective, it seems clear that whether an ADHD behaviour is perceived in a classroom against a backdrop of what other children are doing, in an isolated assessment room with no other children, or in a video focused solely on the one adult with ADHD—that in all of these cases a normative presumption is still required to perceive the behaviour (e.g., the presumption that losing one's train of thought is not normal). However, who is to say that a belief in such a sociological "ontology" of social normativity is the "correct" or "true" one? What interests me is the diversity of ontological beliefs at play here—in particular, how these clinicians hold diametrically-opposed ontological beliefs: in the one case, that ADHD behaviours can appear "naturally" without the requirement of context, and in the other case, akin to the sociological perspective, that ADHD behaviours can only appear against a normative context. For NM, it seems that the cultural mobility of ADHD requires little "translation" because its "natural behaviours" remain constant regardless of where it travels to.[56]

What Exactly about ADHD Is "Inaccessible" to Cultural Discourse?

Thus far, I have described how ADHD—as an immutable mobile—travels to Japan and is translated without issue (conceptually speaking, that is). In other words, ADHD appears to be—at least to these clinicians—a specificity that is *inaccessible* to cultural influence. It can be

[56] A sociologist might scoff at NM's belief in "natural behaviours." However her usage reflects the common belief in ADHD self-advocacy communities that ADHD has a primary specificity of some sort. Her use of the word "nature" should be taken with a grain of salt, as English is not her first language—her philosophical vocabulary is limited. I take it to mean spontaneous and without artifice.

diagnosed in Japanese children without issue, for instance. However, what varies between clinicians is their belief as to what exact aspects of ADHD *are* inaccessible. Figure 3.7 is taken from a presentation slide drawn up by the head of the clinic for a conference. It offers a fairly succinct map of how different ontological layers of ADHD can be conceptualized. I deploy it as an interview tool to try to get a sense of where culture fits into this.

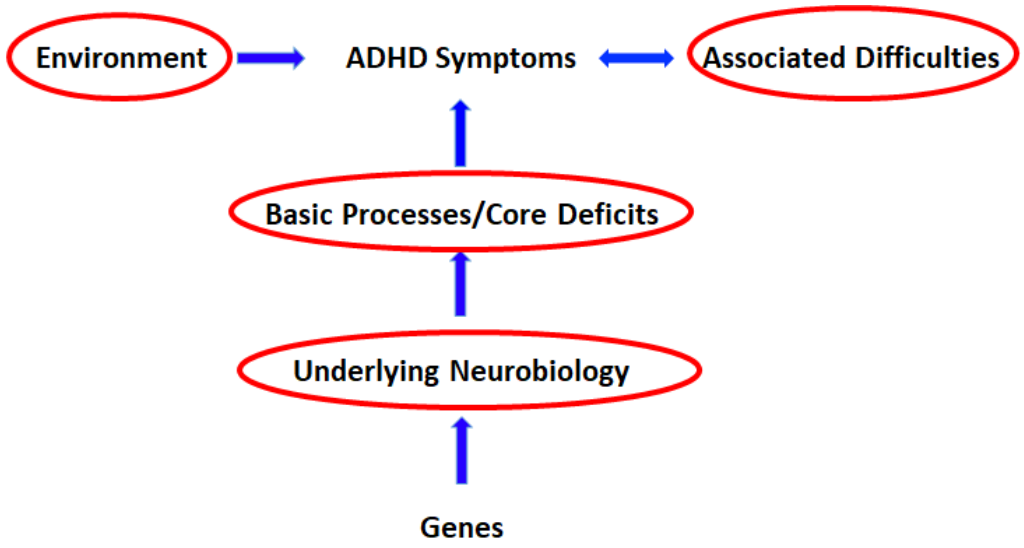


Figure 3.7: ADHD's neuropsycho-ontological mapping (the red circles indicate what the clinic researches)

The diagram indicates that ADHD is fundamentally a genetic difference/deficit that gives rise to neurobiological deficits and corresponding psychological deficits. These psychological deficits, when combined with environmental factors (such as being asked to sit still in a classroom), manifest as ADHD symptoms. ADHD symptoms, in turn, create "associated difficulties" for the child—problems with sociability, school performance, etc.—which can, in turn, exacerbate or further manifest as (in conjunction with already-existing deficits) ADHD symptoms (a kind of feedback loop indicated by the bi-directional arrow).

Importantly, no clinician suggested that environmental factors *alone* could produce ADHD symptoms. If environment was all that was needed to make a given behaviour an ADHD

behaviour (e.g., if a child who stands on his or her desk while the other children remain seated is *ipso facto* ADHD), that would mean, ontologically speaking, that ADHD is nothing more than a label used to characterize behavioural transgressions of social norms. This would be the viewpoint of an ADHD *skeptic*. Taken one step further, if "environment" is taken to include socio-cultural environments and norms, a skeptic might point out that ADHD is *mutable* when traveling to vastly different cultures. It might *become something else*. For instance, a growing number of Japanese youths are suffering from *hikikomori*, a disorder defined by the refusal of youth to leave their rooms, go to school, or go to work, sometimes for years. Indeed, Professor PL states that 80% of his patients (all Japanese children) suffer from *hikikomori*. In his view, it is one of the most common outcomes of an untreated ESSENCE, though he differentiates it from ADHD. Cultural anthropologist Amy Borovoy, on the other hand, argues that *hikikomori* could be interpreted as the Japanese version of ADHD, in that both disorders are, in her view, umbrella terms that describe the reaction of a heterogeneous population of youth unable to cope with social and education norms and expectations (2008: 570-573). From her perspective, *hikikomori* and ADHD are *culturally-differentiated outcomes* of the same underlying socio-environmental problem, a "mutable mobile" insofar as the disorder fundamentally *changes when it travels*.

None of the clinicians believed this to be the case. In their view, there is something *specific* about ADHD that cannot be reduced to an environmental etiology. Clinicians, however, did not all share the same belief about what this specificity is. Three distinct (though often overlapping) beliefs can be observed: a belief in a biological specificity, a symptomatic specificity, or a psychological specificity. Asserting a biological specificity for ADHD was a common tendency amongst most (though not all) clinicians. For example:

VM: If ADHD is a neurological disorder, then cultures shouldn't have an impact because we're all humans. It shouldn't have an impact on our neurobiology. Our brains were built the same way, regardless of culture.

Here, VM assumes that culture is plural and nature is one, and does not consider the possibility of "local biologies."

Asserting an absolute symptomatic specificity was far less common. Most clinicians suggested that it is at least *conceivable* that ADHD symptoms could change due to cultural-environmental influence. As VM put it, "it could be the case that the symptoms presented in the cultures might be different, but the diagnosis will still be ADHD." In this hypothetical scenario, VM is suggesting that what is *specific* to ADHD ultimately is not the symptoms at all, but the underlying neurobiology, genetics, and/or "basic processes/core deficits." This contrasts to the aforementioned assertion made by NM, the director of the information video, that ADHD symptoms *are* specific: that they can "naturally" appear regardless of context or culture.

However, regardless of whether clinicians believed symptoms to be hypothetically inaccessible or not, none of them suggested that ADHD symptoms do actually manifest differently in Japan. To be clear, this is at least in part due to clinicians' perceptual adherence to the DSM-5 criteria for ADHD. The DSM-5 has phrased its descriptions in a "universal" way: each symptom is qualified as needing to transgress *situational* norms. For example, "often leaves seat *in situations when remaining seated is expected*," or "often talks *excessively*" (APA 2013:

60; emphasis added). These situational, normative qualifications for every ADHD symptom allows the criteria to travel cross-culturally without changing.[57]

When it comes to "associated difficulties," however, every clinician I spoke to agreed that they *are* accessible to cultural discourse, both on a theoretical and observational level. In fact, published research has already shown this to be the case: for example, Japanese psychiatrists Wakaho Hayashi et al. point out that the cultural norms and expectations in Japan are that women strive to be a *yamatonadeshiko*, meaning one who is "gentle, polite, modest, reserved, delicate, quiet, attentive, organized, and patient," the "opposite of… ADHD" (2019: 3368). As a result, Japanese women with ADHD "may face greater vulnerability to secondary disorders or impairments due to experience of conflict with social ideals or of being perceived more negatively" (2019: 3368). In their sample of 335 Japanese patients diagnosed with ADHD, Hayashi et al. found that ADHD women were ten times more likely to be unemployed than women without ADHD of a similar age. In contrast, ADHD men were only five times more likely to be unemployed than men without ADHD (2019: 3372). Due to these differences in cultural norms, these "associated difficulties" of having ADHD are exacerbated for Japanese women.

When it comes to ADHD's biological specificity, two clinicians presented alternative perspectives. One of them argued that "environment" *is* an underlying process, insofar as it can influence genes (epigenetics), neurobiology (neuroplasticity), and basic psychological processes. "It's all a big interactive mess," as she put it. When I asked her how culture plays into this interaction, she suggested that any differences between Japanese and American cultural practices

[57] Though one clinician did point out to me that in Brazil this latter symptom has to be taken with a grain of salt, since, according to this clinician, it is a cultural norm in Brazil to talk excessively.

would not be significant enough to alter the neurobiology of ADHD in a way that could be traced through research. In her view, the vast heterogeneity of child-raising practices within and between American families, or within and between Japanese families, is far more significant than cross-cultural comparisons. Socio-economic status, intergenerational trauma, and child abuse, to name a few examples, all have enormous impacts on a child's development, and are not culturally specific. To her, then—and in contrast to most of the other clinicians' beliefs[58]—ADHD's biology *is* accessible to discourse; the biology of ADHD is a *mutable* mobile, it changes from place to place, context to context, person to person. I consider her belief to be an example of a *generalized biological ontology*[59] mixed with a symptomatic specificity. Regardless of ADHD's biological variations and mutability, it is the *symptoms* that ultimately defines ADHD. Importantly, this does not make her an ADHD skeptic, or a sociologist. Like Professor PL, she identifies as having ADHD herself. She does not believe that ADHD symptoms are mere behavioural transgressions of situational norms. Instead, she believes in a rich, phenomenological symptomatology for ADHD that is *not* common to humanhood in general—and for her, this symptomatology is fundamentally what ADHD *is*.

So far, I have discussed two "types" of specificity for ADHD, aspects of it that are inaccessible to cultural discourse—symptomatic and biological specificity. The third and final

[58] When I presented other clinicians with the idea that neurobiology could be changed, many of them became moderately confused. For instance, one replied, "yeah, yeah, she talked about this environment and genes thing, but it's hard to understand." Others argued for a very neuroreductionist version of neuroplasticity (i.e., restricting neuroplasticity to normal brain development that ends around age 30). When I asked one of the non-neuroreductionist clinicians why others seem to have trouble grasping the idea that environment can change neurobiology, she replied, "I think other people in our unit probably haven't had the opportunity to read a lot on the more basic neurobiological principles of brain structures, mostly because they're working on other topics, and you know, their interests may be different. It's not something that you can understand if you read one or two papers, it's something that you really have to dig deeper into it."

[59] In one instance I said to her, "I have a bit of an issue with research regarding brain scanning imagery and mental health, particularly ADHD." She replied, "yeah, I agree, it's not specific to ADHD."

type is what I call "psychological specificity." In this clinic, the dominant phrase used to describe this specificity is "altered reward processing"—the idea that those with ADHD do not respond to positive reinforcement in the same way as non-ADHD individuals do (I discuss this in detail in the next section). Conventionally, psychological theories surrounding ADHD are expected to correspond to neurobiological processes: they become a *neuro*psychological model of ADHD. Indeed, for most clinicians, a belief in ADHD's biological specificity is indistinguishable from a belief in ADHD's psychological specificity—they amount to the same belief.

However, one clinician in particular approaches specificity in the reverse direction. She recognizes that there are no reliable biomarkers for ADHD. She does not take for granted that ADHD has a biological specificity. For her, focusing on ADHD's *psychological* specificity is what helps ground her belief in ADHD. Similar to the previously quoted clinician, she believes that genetics and neurobiology are malleable via epigenetic processes and neuroplasticity which in turn respond to experience. This made her wonder, is there anything about ADHD outside of the symptoms that remains *inaccessible* to socio-cultural-environmental change? To answer this, she conducted cross-cultural research on altered reward processing in children. She found no cultural differences: in her words, "[my research] suggests that the association between ADHD and altered reward processing is not a Western cultural phenomenon." Thus, like most other clinicians, she believes that ADHD has a psychological specificity. But this is not, as other clinicians believe, because psychological processes are neurobiological in nature and therefore cannot be changed. Rather, neurobiology is of course malleable and always changing; what remains consistent are these psychological differences in altered reward processing.

In summary, then, beliefs in ADHD's specificity tend to be grounded in its symptomatology, biology, and/or psychology, while beliefs in ADHD's generality tend to surround those aspects of ADHD that are *not* specific. A primary biological specificity with a secondary symptomatic generality; a primary symptomatic specificity with a secondary biological generality; and so on. Beliefs in what constitutes specificity and what constitutes generality can vary quite drastically from clinician to clinician, but what remains consistent is that they all believe that ADHD has a primary ontological specificity, and that its ontological generality is secondary to this specificity. This onto-epistemological habit of thought is what defines their beliefs in ADHD.

The Dopamine Transfer Deficit (DTD) Theory

Many of the clinicians point to the dopamine transfer deficit (DTD) theory (Tripp and Wickens 2008) as ADHD's purported (neuro)psychological specificity. This theory is primarily concerned with ADHD and "rewards" (or "positive reinforcers"). As one clinician put it, they are drawn to research on rewards because they see "rewards as a potential explanation for ADHD." I am making no claims about the popularity, acceptance, datedness, originality, or degree of reductionism of the DTD theory. I describe the theory here because it is the dominant theory or model of ADHD put forward by *this* clinic.

In layperson (or popular psychology) terms, the DTD theory posits that, first, in "normal" children, a boost of dopamine (a natural chemical in our brain that makes us feel good) will occur when they are given an unexpected reward for doing something, say, the excitement of getting an extra cookie after dinner as a reward for taking away the dirty dishes from the table. As a result, the next time they are asked to take the dishes away, they will receive a decent boost of dopamine *prior* to getting rewarded, as their brain *anticipates* the reward. This *motivates them* to be a helpful child. Eventually, they will regularly get such big boosts of *anticipatory*

dopamine that they do not even need extrinsic rewards anymore to reinforce their helpful behaviour (for example, they will begin to automatically take the dishes away from the table after dinner knowing full well that they will not get an extrinsic reward for doing so). In other words, the children have learned "self-reinforcement"—their brain will continue to reward itself with dopamine on its own accord.

The theory posits second that, in contrast, children with ADHD have an altered sensitivity to positive reinforcement. In particular, ADHD children's self-reinforcing behaviour is "extinguished" much earlier than their non-ADHD peers (Tripp and Wickens 2008: 694). This is because the dopamine boost provided by the extrinsic award has a *deficient transfer* to future anticipatory dopamine boosts (see Figure 3.8). ADHD children have much more difficulty developing self-reinforcing behaviour because the big anticipatory dopamine boost afforded to normal children is *weakened* to such an extent that it does not *motivate them* enough to do the task they are expected to do.[60] Tripp and Wickens, the authors of the DTD theory, conclude that ADHD children are *delay averse*: "even short delays are likely to [negatively] influence the effectiveness of reinforcement" (2008: 695).[61] Another way of putting this is that the ADHD brain is *inaccessible to the material effects of delayed rewards.*

[60] The neurobiological mechanisms underlying this lack of an anticipatory dopamine signal is still "in the process of being defined" (Tripp and Wickens 2008: 699). They think it might have something to do with alterations of neural pathways in the basolateral amygdala and orbitofrontal cortex (2008: 700).

[61] This finding (that children with ADHD are delay averse) is consistent with several other studies dating back to the 70s) (Tripp and Alsop 2001: 696).

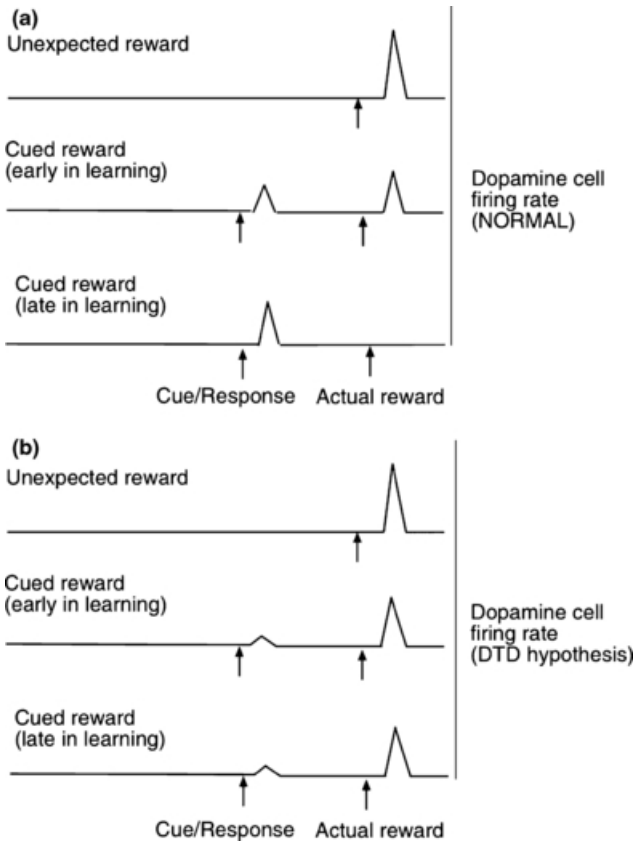


Figure 3.8: The DTD theory expressed as a graph. "Normal" kids are represented by (a), ADHD kids with DTD are represented by (b). (Tripp and Wickens 2008: 693)

For clinicians who subscribe to this theory, this helps clarify why ADHD symptoms do not manifest as a result of environment alone. There needs to be this underlying psychological deficit. The reason one child does not remain seated while all the other children do is because all the other children have been conditioned to remain seated via the promise of a delayed reward. A non-ADHD child might also refuse to remain seated, but this behaviour, in itself, would not be indicative of ADHD because, as the DSM-5 states, ADHD symptoms *cannot* be "solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions" (APA 2013: 59). For an ADHD diagnosis to be valid, there has to be an underlying psychological specificity to explain why the child is behaving as he or she does. Indeed, the DTD theory helps to explain many of the common symptoms of ADHD. For example,

"distractibility": because of the "smaller anticipatory dopamine cell response" in ADHD children, "individual instances of actual [and immediate] reinforcement" (i.e., distracting stimuli in the child's environment) will have "undue influence over behaviour" (Tripp and Wickens 2008: 696). One clinician, FR, provides me with an example of this:

FR: When we talk about these immediate rewards in the environment, we don't necessarily mean prizes and toys and all those kinds of things. It's more, you know, if you poke your classmate and they react, or if there's something more interesting going on outside the window. You could be doing a math problem that is difficult, or you could be watching construction workers outside, and watching the construction workers is much more interesting than the math problem for somebody for whom math is not [immediately] rewarding.

Similarly, this helps to explain why ADHD children are so easily glued to screens:

FR: When I'm interviewing parents, I'll ask them, "what are your children like when they're watching TV or playing on their [Nintendo] DS?" And the parents will say, "silence." And I say, "do you know why they're so focused?" And they'll go, "because they're not motivated." But I tell them, it's actually the opposite: their children are very motivated. If you have a DS in front of you or any kind of computer game, every time you press a button, something happens [the game reacts]. So it's highly reinforcing, you know, it's continuous reinforcement. They want to keep doing it because it's highly engaging. Every reaction has a

positive or negative consequence. So yes of course they'll pay attention if you reinforce them every time they did anything you'd want them to do, and they'd do it a lot more. So I actually try to highlight for the parents how the research explains why children with ADHD can attend to a movie, or why they can attend to playing on their DS, and why they're looking out the window [at distracting stimuli] when they're doing their homework.

AB: You just said with movies, but with movies that's not continuous reinforcement.

FR: No but if it's a highly salient, highly engaging movie, something they really, really enjoy, then it's got a high rate of reinforcement.[62]

In conclusion, Tripp and Wickens state that their DTD theory "could explain the reported lack of self-control of children with ADHD," as well as other DSM criteria such as "often has difficulty sustaining attention in tasks or play activities," "often has difficulty awaiting turn," "often blurts out answers before questions have been completed," and more (2008: 696, 699).

In summary, what is *specific* to ADHD children compared to non-ADHD children is the former's *delay aversion*, or in neurobiological terms, their *dopamine transfer deficit*. Nonetheless, FR makes it clear to me that she still believes in an ontological *generality* of ADHD. As she puts it, ADHD is an "umbrella term" for a whole bunch of behavioural problems observed in children in general: "we don't have any biomarkers yet, and it's probably many different pathways leading to a *fairly common set* of behavioural characteristics." A biological generality ("many different [neurobiological] pathways") *and* symptomatic generality (an

[62] It can be said that movies are an audio-visual form of reinforcement, whereas video games are audio-visual *and* tactile.

"umbrella term for... a fairly common set of behavioural characteristics"). In her view, DTD is "a possible mechanism for why *some* children with ADHD show stronger preference for immediate reward, why they don't like delay, and why they may learn less well under conditions of low rates of reinforcement." This is a peculiar form of ontological traversal: FR reduces ADHD to a generality, but utilizes a theory of a neuropsychological specificity, DTD, to maintain ontological coherency in her beliefs. Whereas Professor PL traverses the generality of ESSENCE to the specificity of ADHD, FR traverses the generality of ADHD to the specificity of DTD. Thus ADHD practitioners can and do move between the general and the specific without perceiving contradiction in their own, or others', thinking and speaking.

No doubt, the DTD theory plays a role in the practical work being done at the clinic. FR tells me that when she speaks to parents when they bring their children in for an assessment, they are sometimes resistant to the strategies recommended to them by the clinic. Neuropsychological explanations like the DTD theory "help them to understand":

FR: We say to them, "we do research on rewards. It's theory, not proven, but we think it helps to explain ADHD. In research on rodents, we see a dopamine spike. If you put a cue before the reward, the response to the cue goes up, while response to the reward goes down [i.e., the dopamine 'transfers']. In humans we think it is similar. With ADHD children [because they are delay adverse] you need to reward them frequently."

However, when I ask FR if it is necessary for the other clinicians working at the clinic to have at least a general understanding of the DTD theory, she answers:

FR: I think that it is helpful but not required. Everyone here already has a background in the basic learning principles of psychology. [She points to her bookshelf.] I have a whole shelf of books on reinforcement.

By "basic learning principles," she is primarily referring to the Skinnerian, behaviourist ideas of operant conditioning: using positive and negative reinforcement to modify behaviour. Her point is that all of her clinicians understand the basic ideas surrounding ADHD and operant conditioning, and so it is not necessary that they learn the DTD theory. As another clinician puts it, "Tripp and Wickens' research ideas on neuroscience and reward systems aren't really new. Those ideas are really old—like they've theorized this stuff for decades." Instead, much of DTD's novelty rests on the idea that a reward response can "transfer" to an anticipatory cue, and that this proposition is theoretically conceivable on the level of neurobiological processes. Its novelty further lies in applying this proposition to explain ADHD in some children.

I was curious as to why some of the clinicians expressed indifference toward the theory of DTD despite it being presented by the clinic as a key theory for explaining ADHD—I mean quite literally presented at conferences and in talks. I received various answers to this question. One clinician suggested it was due to the difficulty of the theory: "not everyone working at the clinic is interested in or understands the neurobiological literature on ADHD.... The literature is quite complex. It took me ages to actually understand what Tripp and Wickens were talking about. Another clinician—the one who believes in a symptomatic specificity of ADHD—stated that "Tripp and Wickens' article is some ground-breaking stuff on neurobiology, but I would

challenge the idea that it's specific to ADHD." In other words, her belief in ADHD's ontology is *incompatible* with the one implied by DTD. A third clinician goes as far as to voice frustration at the very idea that DTD has any bearing on the unit's clinical practice or research: "I've read Tripp and Wickens' article, and its critics', and I still don't have a fucking clue what their model is. Their perspective is based on an assumption, but it needs to be further researched. It's also based on rodents." To be fair, though, influencing clinical practice was never the aim of the DTD theory: as one clinician put it, Tripp and Wickens "wrote this theory to be disproven.... It was never about being right, it was about trying to encourage people to do theory-driven research."

The Implementation of the New Forest Parenting Programme (NFPP) in Japan

These clinicians have had no problems importing and translating ADHD into Japan on a conceptual level *amongst themselves*. That is, in contrast to ADHD skeptics, they do not see any glaring issues with the idea of an immutable ADHD existing in Japan. Still, there remains the question of how translatable ADHD is to *non-clinicians* in Japan. Obviously, this question far exceeds the scope of my research, but I was able to trace a key issue of translation that came up *for parents* in the clinic's implementation of a parental training program. By tracking this key issue, and clinicians' solutions to overcoming it, I made an interesting discovery.

Recall my argument in Chapter One that the problem with ADHD's biological specificities is that they are discursive technologies of the self insofar as they are promissory. There are, as of yet, no reliable biomarkers that can specify ADHD in one person versus another. As such, any purported biological specificity for ADHD is, as of yet, strictly a discursive construct with no verified bio-materiality underlying it. In other words, ADHD's purported biology is *accessible* (to Tripp and Wickens, for example) because it is primarily a construct that heavily partakes in looping effects: people change how they see themselves as a result of the construct, and this

loops back on how the construct is construed (or, in more concrete terms, the more ADHD individuals become invested in neurobiological framings of themselves, the more neuroscientific research on ADHD is spurred forward, so that more and more biological identities for ADHD can be constructed and utilized for improved, though bio-constrained, self-understanding). ADHD's purported biological specificities—as technologies of the self—are thus highly accessible and mutable to discursive effects.

In this final section, I make a similar argument regarding psychological specificity. There appears to be a sort of strategy involved in asserting a psychological specificity for ADHD—one that depends on *effective translation*. A Western psychological specificity for ADHD is lost in translation when imported to Japan, forcing these clinicians to retranslate its psychological specificity into something different. In effect, I argue that ADHD's psychological specificities are—in practice—quite *accessible* to cultural influence.

Initially developed in the UK, the New Forest Parenting Programme (NFPP) is designed to support and teach strategies to parents of children with ADHD (Thompson et. al 2017). The reason it was implemented by this clinic in Japan is circumstantial. A few years back, FR was attending an ADHD conference in Europe, and was introduced to one of the main instigators of the NFPP. She invited him to come give a talk about it in Okinawa, and so he did. Another clinician, NM, observed his talk in Okinawa, and felt it would be helpful to implement the NFPP in Japan. NM had previously tried working with parents of children with ADHD in Okinawa but with limited success. She decided that using a more robust, well-researched, and structured program would be a significant improvement. The head of the clinic approved her request.

The process of implementing such a program to another country/culture is complicated and expensive. The clinic has to pay for and acquire a legal licence to use the program, and clinicians

have to travel to the UK to receive extensive training. According to FR, this is necessary because the terms of the license mandates that the program be "delivered the way it was designed to be delivered and the way we know is effective." The NFPP has undergone rigorous peer-reviewed studies to prove its efficacy, and so it is important that clinicians implement it correctly. This "protects the integrity of the program," FR says.

Notably, the clinic does not provide the NFPP for American families living in Okinawa. It is solely aimed at Japanese families. There are, then, issues of translation—and not just in terms of language. To wrinkle out these problems of translation while still maintaining the integrity of the program, the clinic must continuously work with the UK developers to come up with acceptable middle-ground solutions. For example, NFPP clinicians are supposed to visit individual households to talk to parents one-on-one and watch them practice learnt techniques on their children. However, according to another clinician I spoke to, those involved with the NFPP-J (NFPP-Japan) "decided early on that it wasn't going to work in Japan to run the NFPP in people's homes. The houses are often small, they're sometimes multi-generational, and it's not so common to invite people to your house in Japan." The decision was thus made to deliver the program at community centres in a group-based format to several mothers at once (as of yet, no Japanese fathers have taken part in the NFPP-J). The rationale for this change had to be offered to the UK overseers of the program, and they had to approve it. In turn, the UK overseers ask that peer-reviewed studies of the NFPP-J be completed to retest the efficacy of the program as it is newly implemented in Japanese culture.

The key issue that came up was that Japanese parents partaking in the program were reluctant, or found it difficult, to frequently praise their children—one of the key strategies the NFPP teaches. Yet, in this case, the clinicians were *not* allowed to change this element of the

program. Frequent praise is such a core feature of the NFPP that to alter or remove it due to purported cultural incompatibility would risk the program's integrity. The solution was instead to teach parents *why* frequent praise is so important for ADHD children, even if it flies in the face of cultural customs. In other words, the NFPP-J has to, in order to maintain its integrity, convince Japanese parents that ADHD is an immutable mobile, and that there are "universal," effective strategies for managing it.

In all the conversations I had with clinicians in Japan, this issue of praise was by far the most commonly brought-up topic when I asked about ADHD and cultural differences. There is a general agreement among the clinicians that praise is not frequently given in Japan. One clinician described the issue through the Japanese concept called *ganbaru*, the "virtue of perseverance through adversity," that is, the idea that it is important to struggle through one's work and not expect any "positive feedback." As a Japanese clinician recalled of her childhood, "I was in a play for school, and I remember that after the play my mother said to me, 'you were good, but if you practiced more like the other kids you'd do better.'" She explained that this is a traditional Japanese parenting strategy: frequently using criticism to encourage the child to do better, and using praise only in rare or exceptional circumstances.

She also pointed to differences between Western and Eastern attitudes toward praising children: "VM [a Western clinician] for example has talked about how her kid is so great at math. I would never say that about my kid. Being humble is valued in Japanese culture. And many mothers say that too much praise will make their kid arrogant." Similarly, another Japanese clinician (not a psychologist) explains:

CM: Look, I'm a mother. Age is a big factor here. There are older moms like me, in their 40s, and we don't give that much praise. The issue is it's embarrassing to praise in front of others. You don't want to make it seem like you're bragging. Parenting systems are so much different with young moms though. Younger mothers don't know how to discipline their children. It seems like they've gotten a lot of Western influence.

Further, it is not just Japanese parents who have trouble with praise, but school teachers as well. In contrast to, say, Canadian teachers who might praise a student for doing well on an assignment, NM explains that in Japan, teachers "will refrain from praising a particular student because they want equality." For instance, a parent in the NFPP-J told NM that when she asked her child's teacher to use praise on her child, the teacher responded, "I cannot praise just your one child."

Regardless of how generalizable this cultural difference is to the broader Japanese public, the fact of the matter is that several parents in the NFPP-J brought it up as an issue: the program teaches them to praise their ADHD children frequently, but this conflicts with their cultural norms and practices. How, then, do clinicians solve this issue while maintaining the integrity of the program? I asked NM this question directly:

AB: What do you tell parents [in the NFPP-J] to convince them that frequent praise is good?

NM: I give them a biological explanation. I tell them about how positive reinforcement studies show how dopamine transmitters don't function efficiently in some children. So it's more

important to do external praise instead of internal praise. So it's the result of studies. It relies on Tripp and Wickens' way of thinking.

Similarly, in a second interview I had with her:

NM: Many mothers say that too much praise will make their kid arrogant. So we tell parents not to worry about arrogance. From Tripp and Wickens' theory, ADHD kids cannot accumulate praise, like non-ADHD kids can. So internally they can't praise themselves.

Though her answers are a bit difficult to comprehend (NM is not a native English speaker, and she is trying to translate to me on-the-spot what she remembers telling Japanese mothers in the NFPP-J), she explicitly refers to the DTD theory[63], and draws from it in order to teach Japanese mothers why frequent praise is a good thing.[64]

Yet, NM's adoption of DTD—or even the notion of altered rewards processing in general—is *not* part of the original NFPP's theoretical framework. The NFPP-UK's emphasis on parental positivity or praise has nothing to do with Tripp and Wickens' DTD theory, nor rewards research

[63] It is important that NM provided these answers to me without elicitation. If I had asked her from the get-go, "do you draw from the DTD theory in your clinical work with NFPP-J parents?", I would not have known whether her answers were genuine, or whether she was just trying to be a good interviewee by telling me what I wanted to hear. Instead, she actively evoked the DTD theory in response to my initial question, "what do you tell parents [in the NFPP-J] to convince them that praise is good?", suggesting she finds DTD's explanatory framework particularly useful for dealing with the cultural issue of praise.

[64] When she says "ADHD kids cannot accumulate praise," she is referring to ADHD kids not being able to transfer the potential of dopamine cell firing received from "external praise" to the long-term potentiation of dopamine pathways via anticipatory cues (what she calls "internal praise"). At the same time, she is also "translating" this neurobiological point into a colloquial explanation as to why arrogance is not something to worry about (after all, how can a kid be arrogant if she is incapable of praising herself?).

in general. Instead, it originally derives from a range of child development studies (in Western societies) that show that lack of "maternal warmth" (Thompson et al. 2017: 85), "maternal sensitivity" (Bernier et al. 2010: 328), or of a "mutual positive affective set in the mother-child dyad" (Kochanska and Aksan 1995: 238) compromises the development of self-regulation in children. "Positive parenting practices," or "'positive' or 'gentle' reasoning-based strategies" help to "facilitate self-regulation" (Thompson et al. 2017: 85). For example, positive affects such as positive "facial expressions, tone of voice, and body language" increases the likelihood that a child will accept the "maternal agenda" (Kochanska and Aksan 1995: 242, 241). Such compliance, in turn, contributes to the success of maternal techniques such as "mind-mindedness," where "using mental terms while talking to the child... offers children verbal tools with which to progress from being externally regulated to self-regulated" (Bernier et al. 2010: 328).[65]

When it comes to children with ADHD, not only are they "generally less compliant," but parents of children with ADHD are more likely to react in adversarial ways rather than with positive affect (Thompson et al. 2017: 84). As a result, two of the primary "treatment targets" of the NFPP are to "enhance the emotional relationship between parent and child," and to "create an effective working relationship between parents and child so that the parent can become the child's guide and trainer" (Thompson et al. 2017: 86). This child development literature is what the NFPP's emphasis on praise is based on. It is not based on behaviourism, operant conditioning, or rewards research. Praise is used to enhance the emotional relationship between parent and child, not as a positive reinforcement for learning.

[65] These are all studies cited by Margaret Thompson (2017), the original creator of the NFPP.

I was fortunate to have a chance to interview one of the UK developers of the NFPP, as he happened to be visiting the clinic while I was there. I asked him about the significance of praise:

XI: In the NFPP, the therapist needs to help find ways for parents to use praise even if there's nothing to praise. Instead of them waiting for the child to do something good (because sometimes the parents never see anything good in what their child does), they need to fake praise. They need to engineer praise. [He drops a pencil on the floor.] An ADHD child will impulsively pick that pencil up. It's automatic for them. If a parent asks, can you pick that pencil up, the child will actually try to stop and not pick it up. But the child is already in the motion, and it's extremely difficult for them to stop the motion of picking the pencil up when their motor symptoms are already driving them to do that. So the best thing to do is let the child pick up the pencil, and then say something like "my neck was hurting so I'm happy you picked that up for me. Thank you so much. Good work." And the child then picks up on that and likes the feeling of being told they're doing good work, and will want more of that. So it's a sort of fake praise. What do you want your child to do for you?

AB: Is this related to the concept of "earshotting"?

XI: Yes, "earshotting" is something else the NFPP teaches. So many parents don't like praise for specific reasons. A lot of parents want to strangle their children. They don't like their children. Their children are not the children they were expecting to have years earlier when they decided to have children. So they can't get themselves to look at their children and praise them, even if it's fake. They just can't. Instead you get them to use indirect praise, it's easier. In ear distance of the child, you praise them to another person, like your partner,

> grandfather, whoever, for doing something. This is easier for these parents because you end up being able to recycle something over and over again. You can tell five different people that he did a good job picking up a pencil. Earshotting is easy. And it's powerful for the child—it creates a feedback loop.

There are significant cultural differences observable here in how XI describes why parents are reluctant to use praise and how they can overcome that reluctancy. Whereas Japanese parents are reluctant because it is not custom in their culture to frequently praise their children for completing fairly banal or minute tasks, UK parents are reluctant to use praise because they have a negative, antagonistic relationship with their ADHD children. Regarding how they can overcome that reluctancy, whereas UK parents overcome it by employing the "earshotting" technique, this strategy would not solve the underlying problem for Japanese parents—after all, it is culturally embarrassing to praise their children in front of others. Further, as one clinician pointed out to me, even if a Japanese mother would like to use praise, sometimes she is prevented from doing so by other members of the family: "Japanese families tend to be hierarchical, and it's hard for mothers to disagree with their husbands, or with the grandparents, who tend to like traditional parenting and dislike the notion of praise."

Because DTD is purported to be neurobiological, it accomplishes for NM what her NFPP-UK training could not: a way to bypass the Western bias inherent in this model of ADHD's psychological specificity. For example, would child development studies have come to the same conclusions or constructed the same psychological models if they had originated in Japan? The "Western position" that frequent use of praise is linked to "maternal warmth," or that frequent use of criticism is linked to adversarial parenting, would not really make sense in a society with a

tradition of parenting styles that emphasize the importance of criticism over praise. In Japanese culture, criticism is not perceived as adversarial or as a personal attack. Surely NM cannot use these Western- and Anglo-centric studies to explain to Japanese mothers why praise is so important, as their assumptions and conclusions are inapplicable to Japan's cultural framework. This is where the benefit of a neurobiological theory comes in: neurobiology is often understood to be *universal*. As NM herself puts it, "it's a neurobiological deficit—so even though the cultures are different, the processes of the neurobiology are the same."

The translation of the NFPP from the UK to Japan thus entails a translation of ADHD's purported *psychological specificity*. This is significant because it suggests that, in the process of trying to convince Japanese parents that ADHD is an immutable mobile that requires "universal" strategies for how to approach it, ADHD must become mutable: what ADHD *is* must be strategically altered to fit the cultural discourse.

Conclusion

On the one hand, clinicians have a diversity of beliefs about what ADHD is. On the other hand, these beliefs appear to be subordinate to what is required for effective clinical practice. One clinician, for example, who deeply believes in a genetic and neurobiological specificity to ADHD—far more than she believes in the specificity of altered rewards processing—expressed frustration that the clinic does not take DNA swabs of the children who come in for assessment. She did not suggest that doing so could help with diagnosis, but it *would* assist in global research efforts to identify the specificity of ADHD's genetic makeup. Nevertheless, despite her personal beliefs, she still partakes in a diagnostic procedure that does not conduct genetic or neurobiological assessments of any form.

Similarly, as in the case described above, it appears that NM does not employ the DTD theory in her translation of the NFPP-J because she fundamentally believes in that theory. Rather, she does so because it allows her to effectively convince Japanese parents that they should push past cultural norms and use frequent praise on their ADHD children. If NM believes in DTD as a primary specificity for ADHD, this is likely because clinical efficacy required it of her. That is, ontological beliefs can be subordinated, but *also influenced*, by the requirements of effective clinical practice. This is not surprising, as psychological theory in general—though often covered in ontological gloss—tend to be designed for clinical practicality, not philosophical precision. It makes sense that clinical practice steers ontological beliefs in ADHD.

Another finding of this chapter is that clinicians have little trouble with ontological traversal. I outlined at least four variations of this. First, Professor PL traverses between a generalized ESSENCE of childhood problems and a specificity of ADHD symptoms. Second, clinicians who believe ADHD behaviours can never be perceived or photographed without a normative backdrop—such as showing what "normal" children are doing around the ADHD child—simultaneously assert a strict neurobiological specificity for ADHD. The incoherency here is that, even if a child has an ADHD brain—or however the neurobiological specificity is defined—this specificity will never present any symptoms without a normative backdrop to define them. A double ontological primacy. Third, some clinicians asserted a generalized biology of ADHD—a malleable, ever-changing biology via epigenetic processes and neuroplasticity—while also asserting either a symptomatic or psychological specificity. And fourth, FR characterized DTD as a neuropsychological specificity that can explain ADHD in some children but not others. That is, she reduces ADHD to an ontological generality, while also positing a specificity.

Coming back to my broader dissertation argument, there are, then, three observable pathways that I can take for continuing on my quest to figure an ontology of ADHD. One is to side with ontological generality, as FR does, and think about ADHD primarily as a diagnostic label or umbrella term that, in "reality," represents a diverse range of underlying neurobiological or genetic pathways—DTD being just one of many variations. Two is to "wait and see"—to continue on the path of ontological incoherency and veiled discursive malleability—the inevitable outcome of basing one's belief in biological or psychological specificity. Three is to take seriously the symptomatic specificity of ADHD. Obviously, as my previous chapters have indicated, I am following this third path. The ever-present problem (as a "survivor" of the critical therapy afforded by graduate school) is how to rid myself of the sociological baggage of thinking about everything in terms of normative values and their transgressions.

Apparently, I have now exhausted the limited conceptual vocabulary I presented at the beginning of this dissertation: of generalities and specificities, of ontological beliefs and traversals. The curious case of ADHD requires a more robust, sophisticated—and most of all, critical—conceptual toolbox moving forward. I provide such a toolbox in my next chapter. I aim to reinvigorate my search for what is most specific to ADHD by critically retheorizing what a primary ontological specificity looks like.

Part Two: Philosophical Interventions

Glossary: Philosophical Terms Used in Part Two

In Part One, I made frequent use of the terms "ontological generality," "ontological specificity," "primary ontological specificity," and "ontological traversal." I adopted these terms to help guide my analysis through the variety of beliefs others hold about ADHD's ontology.[66] In Part Two, I move toward developing an initial critical-yet-affirmative ontology for ADHD that not only better corresponds to the rich, phenomenological symptomatology put forward by ADHD self-advocates, but also effectively combats ADHD skepticism and misrecognition. As such, a new conceptual toolbox is required to develop *this* ontology of ADHD (versus the Part One toolbox which was used to describe *others*' beliefs). Notably, however, many of these philosophical terms are used only in Chapter Four. Even so, I include them all here as an easy reference guide for the reader to come back to at any time. These terms will, of course, be defined in the body of Chapter Four as well.

Categorical difference	The kind of difference that distinguishes one identity from another. For example, different types of people, different diagnoses, and so on.
Determination (bottom-up)	Individual differences determine identities (and thus categorical differences). Example: statistical correlations between ADHD symptoms determine the DSM diagnostic criteria for ADHD, and determine the psychological category "ADHD."
Determination (top-down)	An essential identity determines individual differences. Examples: (1) a disease differentiates its symptoms from those of another disease; (2) ADHD, taken as a label, produces a labeling effect, "othering" children with this label by putting them in special ed classes; (3) ADHD, taken as a "brain type," differentiates ADHD individuals from non-ADHD individuals by determining their behaviours.
Dialectic of medicalization	Habits of thought originating from Aristotle that have been institutionalized into modern medicine. Has two "poles" (identity and individual variation) and two ontological "directions" of determination (top-down and bottom up).
Difference in itself	What Deleuze believes is the only true proper concept of difference. A difference that exists in itself, i.e., is not imposed onto the world as a categorical or individual difference. It will be defined and discussed at length in Chapter Five.

[66] The concepts used in Part One do not have exact equivalents in Part Two. "Ontological specificity" is expanded to include "identity," "categorical difference," or, in demedicalized discourse, "difference in itself." "Ontological generality" is expanded to include "individual variation" and "individual differences." "Ontological traversal" corresponds to "the dialectic of medicalization."

Discourse	Anything that is required to produce, organize, configure, and assert knowledge. Use of language, habits of thought, medical techniques, technologies, institutional power, injunctions: these are some examples of discourse.
Epistemology	What counts as knowledge of disease or disorder, with an emphasis on *how* that knowledge was derived.
Equivocity of being	Different, competing, clashing, and contradictory meanings of "existence." Leads to ontological incoherency.
Equivocity of disease	Different, competing, clashing, and contradictory meanings of "disease."
First aspect of indifference	The recognition that imposing differing identities onto individuals does not offer a proper concept of difference.
Generic difference	The difference between the "highest identity" and other identities.
Highest identity	That which everyone and everything can identify with. Also known as the "highest genus" or "generic identity." For Aristotle this is "substance."
Identity	Anything that can grant a disease or disorder an essential identity: diagnostic categories, natural kinds, human kinds, brain "types," disease entities, root biological causes, and Aristotelian genera.
Improper concept of difference	Corresponds to a difference that does not exist *in itself*, but must be artificially imposed on the world. For Deleuze, categorical, generic, and individual differences are all improper concepts.
Indifference	Both a psychological state of indifference and a metaphysical state of indifferentiation.
Individual difference	The kind of difference that distinguishes between unique individuals, or individual behaviours or symptoms. Corresponds to individual variation.
Individual variation	Variation between unique individuals, or variations of individual behaviours or symptoms. Corresponds to individual difference.
Individuals (or "particulars")	Things or people in the world that cannot be divided up any further according to Aristotle's ontology. Aristotle calls them "particulars" or the "lowest species." Includes unique human individuals as well as individual behaviours or symptoms. For Aristotle, these all constitute "substance."
Metaphysical state of indifferentiation	The ontology in question artificially imposes difference onto the world, and does not offer a proper concept of difference.

Onto-epistemology	Emphasizes the notion that ontology and epistemology are mutually dependent and co-constituted (Barad 2007: 185).
Ontology	What it means for a disease or disorder to exist. When I refer to "ontology," I implicitly mean "ontological belief." For example, when I say that the dialectic has two ontological directions, I do not mean that this is how the world actually is; rather, the dialectic provides two ways of *believing* how the world actually is.
Second aspect of indifference	The recognition that individual difference is imposed onto the world, and does not offer a proper concept of difference.
Substance	What Aristotle considers "primary being"—what the world fundamentally *is*. He first conceptualizes substance as the "highest identity," but later conceptualizes it as "the lowest species," "particulars."
Univocity	Opposite of equivocity. "Univocity of being": one coherent meaning of existence. "Univocity of disease or disorder": one coherent meaning of disease or disorder.

Chapter 4: The Dialectic of Medicalization

Initial Foray into the Problem of ADHD Skepticism and Misrecognition

On a recent date with a physician who has ADHD, I was asked if I had read Richard Saul's book, *ADHD Does Not Exist*, and what I thought about it. It is an unfortunate conversation topic for a first date, and not because I hadn't read the book. The full answer requires a deep dive into the history of philosophy and medicine, a critical look at how we understand the nature of existence, and a discussion about the habitualization of thought, none of which I could offer while sitting in a cocktail bar. I hope to accomplish in this chapter what I could not on that date: pointing out why skeptics like Saul are wrong, and why ADHD—as a thing that exists—is worth persevering for.

Why do people continue to question ADHD's existence? Yes, "ADHD does not exist" is a loaded statement. As explored in the Introduction, it can mean several different things. But there is one meaning attached to it that is most prevalent: the idea that ADHD symptoms taken separately are so "normal" that it is wrong to medicalize them as a bonafide psychiatric disorder. The lack of any reliable biomarkers for ADHD (Thome et al. 2012: 379) compounded by the commonality of its symptoms professed right there in its name (Saul 2014: 19) makes it very easy for people to believe that ADHD does not exist. As Saul writes,

> How often do we hear the excuse, "Sorry, I forgot to call. It's my ADD again," or the terms "free-spirited" and "ADD" in the same description of someone? ADHD is an easy catch-all label for children and adults who have trouble with concentration and/or impulsivity. (2014: 19)

Notably, however, disorders like Alzheimer's disease and ASD also do not have any reliable biomarkers, but rarely do people ever question their "existence." What is unique about ADHD skepticism is not the disorder's lack of biomarkers, but, as Saul demonstrates, the belief that its symptoms are common to all humans—"ordinary human variation at their edges," as Elliott puts it (2003: 233).

This sort of skepticism can easily turn into a source of misrecognition. As Thomas Armstrong writes, "the symptoms of ADHD are developmentally normal for infants…. But when they appear in older individuals, these traits are generally seen as abnormal, or as examples of 'developmental immaturity'" (quoted in Cohen 2006: 40). From the skeptic's standpoint, diagnosing adults with ADHD is only giving them an "excuse" for their immaturity. In other words, those who interpret ADHD symptoms *as normal human behaviours* tend to believe that such behaviours can be overcome via normal developmental processes (maturing, developing skills, and "putting in more effort"). The individual who continues, as he or she grows up, to exhibit ADHD symptoms is interpreted more and more as immature, stupid, or lazy.[67]

To give an anecdotal example, recently I was staying at a house with a group of extended friends and family for a couple of weeks. They noticed I frequently forgot small things—like darting back inside the house to grab my water bottle or forgetting to put the lid on the coffee pot while it was running (which ended up breaking the machine). "Thirty-two years old and he doesn't know how to work a coffee machine," one of them angrily muttered. A friend later confronted me and suggested I develop my memory skills. Even though he knew I had been

[67] As an ADHD problem child grows into adolescence, "teachers grow increasingly moralistic in their explanations" (Hallowell and Ratey 1994: 64).

diagnosed with ADHD, to him, forgetfulness was not a disability, but simply a lack of skill, something that I could presumably fix by putting time and effort into skill-building. These examples represent a significant form of ADHD misrecognition. ADHD becomes an *invisible disability* when its symptoms are not recognized as being any different from the problems facing ordinary humans as they develop to maturity.

Such criticisms are common in sociological takes on ADHD. Carey states that "what appears to be going on with most children being diagnosed with ADHD today is normal variations" (quoted in Cohen 2006: 29). In one study, sociologist Ken Jacobson spends three months in a public-school classroom observing students and making note of their behaviours on a 34-item ADHD behavioural checklist. For example, every time a student "was not looking at anything specific" he would mark the behaviour as "daydreaming," indicative of "ADHD" (2006: 158-159). Jacobson noticed that in many cases, the behaviours he checked off could be easily explained by context. For instance, during one lesson, a student threw an eraser at another student, who then threw it back. Other students joined in, and before long, whenever the teacher was not looking, several boys would engage in throwing erasers at each other, representing on the ADHD checklist hyperactive symptoms for all the boys, yet understandable given the context (they were playing a game) (2006: 167). In conclusion, Jacobson suggests that either every student he observed should be diagnosed with ADHD, or, more sensibly, that no student should be diagnosed with ADHD: "I find it reasonable to conclude that, at best, ADHD is grossly over-diagnosed in the United States" (2006: 162). His reasoning is based on the notion that an *ontology of normal individual variation* trumps a *neuroreductive ontology of an essential ADHD identity*. As he puts it, "children (and adults) behave as they do because of the totality of their

individually unique experiences," not because some singular ADHD entity or essence determines them (163).

However, what these critics often fail to realize is that most psychological researchers of ADHD are well aware that ADHD should not be taken as a singular entity or essence.[68] In actuality, many psychological researchers who countenance the existence of ADHD *also* conceptualize ADHD as a *medicalization of individual variation*. As Russell Barkley describes,

> ADHD constitutes the extreme end of dimensions of behaviour that fall along a continuum with the behaviour of typical children…. The dimensional view… does not see ADHD as a disease entity, but as a matter of degree in what is otherwise a characteristic of typical children. (2006: 95)

Similarly, as FR noted to me in an interview,

> FR: I don't think you'd get much argument from psychologists or psychiatrists that ADHD is dimensional. We talk about it being dimensional because the symptoms are on a continuum. It's still about, "is this child's behaviour consistent or inconsistent with their developmental age and stage."

[68] "There is no single lesion of the brain, no single neurotransmitter system, no single gene we have identified that triggers ADD" (Hallowell and Ratey 1994: 269-270).

From these statements, it would seem that sociological critics and psychological researchers who hold the "dimensional view" of ADHD share a belief about the ontology of the disorder (that it is a medicalization of individual variation), but they assign different values to what constitutes "normal" variation. For sociological critics like Jacobson, if some variations are perceived as abnormal, this is a consequence of the implementation of often-oppressive social norms and social control. In contrast, psychologists like FR believe in a natural statistical average: there will always be statistical outliers—children who lag in development—and these represent the natural threshold of psychological norms.

Here lies the problem for people living with ADHD: ADHD's prominent source of misrecognition is rooted in the nature of its supposed ontology. To uproot this source of misrecognition means to uproot this ontology, to push back against not only common sense (that ADHD looks a lot like normal human behaviour) but conventional sociological criticisms *and* these psychological perspectives. How can such a feat be accomplished? Sure, we could confront the skeptics, as many ADHD advocates do, by asserting that ADHD is "neurobiological" or "genetic,"[69] but how long can we keep that up given that (a) no reliable biomarker for ADHD has been found, and (b) psychiatric discourse more broadly is gradually shifting away from neuroreductive thinking?

That is, instead of positing, say, different "types of brains" that can causally determine this or that type of behaviour (neuroreductivism), it is becoming more popular to think of the brain as neuroplastic, as a malleable thing that continuously changes over one's lifetime via one's

[69] For example, ADHD advocates Hallowell and Ratey state that "with every step forward [in neuroscience] we become more sure what the disorder is not: it is not willful misbehaving, it is not a moral failing, it is not a lack of trying nor an inability to take an interest in the world. Neurobiological data now show that the syndrome is rooted in the central nervous system" (1994: 269-270).

interaction with social forms. In effect, it is becoming easier to situate an ontology of individual variation *within* the de-essentializing projects of neuroplasticity and epigenetics—for example, by asserting that an "ADHD brain" is nothing more than "neurobiological diversity." The DSM-5 is already hinting at this: it points out that recent studies in neurobiology and genetics imply a wide range of potential biological pathways from which a single disorder like ADHD can emerge; as a result, the categorical structure of the DSM is "no longer sensible," though it will take time and more editions of the DSM before a new system can be established (APA 2013: 12-13).

These perspectives render the idea of ADHD having a singular identity *obsolete* insofar as they embrace the *medicalization of neurobiological and genetic heterogeneity*. They point to a future where the category of ADHD is decommissioned entirely, replaced by a different classification scheme[70] that lists a heterogeneous ensemble of neurobiological pathways which may underly behaviours that disrupt classroom activity. In turn, the skeptic of the future can argue that there is nothing truly pathological about these neurobiological processes; that they are part of normal neurobiological diversity in humans, and are only deemed "abnormal" due to the imposition of social norms. Further, future skeptics could argue that neuroplasticity and epigenetics allow one to grow out of their childhood "neurodiversity" through normal developmental processes.[71] The framing will have changed, but the skepticism and misrecognition surrounding ADHD will remain unhindered. In short, claiming that ADHD is

[70] Such as the proposed Research Domain Criteria (RDoC) classification system.

[71] For example, in a self-help book tailored to individuals with executive dysfunctions, the authors state that "plasticity... means that in adulthood, when we strengthen a previously weak skill, the underlying brain structures that support that skill undergo change that helps lock in the more proficient skill" (Dawson and Guare 2016: 45). Similarly, another self-help book—oriented toward adults who have ADHD-like symptoms but are skeptical of the disorder—reads, "ADHD is a dynamic neurological condition, meaning it isn't the same all the time. Frontal regions of the brain develop substantially into the early third decade of life, and thus some people may mature out of ADHD" (Surman et al. 2013: 232).

neurobiological or genetic does not actually save it from the belief that ADHD represents nothing more than normal human behaviours and normal individual variation, because everyone *has* neurobiology and genes, not just the diseased or disordered.

Pre-empting this future, I take a different approach to defending ADHD. I do not rely on neurobiology or geneticism to combat ADHD skepticism and misrecognition. Instead, I am interested in how something that has a volatile identity, such as ADHD, can still "exist" in a coherent way, be advocated for, and identified with, while not succumbing to a harmful ontology of garden-variety individual variation and social norms to explain it.

The first step in my approach is to recognize the dichotomous thinking underlying the problem and reject it. For example, why do Barkley and FR dichotomize ADHD as being either "dimensional" or "categorical"? Why do ADHD advocates often hold onto neuroreductionist thinking (e.g., that ADHD is a "type" of brain) in order to oppose criticism that it is normal individual variation? After many years of studying ADHD for this project and living it, I have come to realize that these dichotomies that haunt ADHD are not at all unique to the syndrome, but are part and parcel of the greater project of medicalization. I argue that these dichotomies are sustained through what I call the *dialectic of medicalization*. In a nutshell, the problem is not that "ADHD does not exist"; the problem is the limitations placed on how we are allowed to think about what it means for ADHD to exist. My aim in this chapter is to explore what the dialectic of medicalization is, where it came from, and how it might be overcome. In doing so, I combat ADHD misrecognition *at the root*.

A Preliminary Outline of Key Concepts

ADHD self-advocacy requires sustained conceptual and philosophical engagement. Our habits of thought—the *modes* of arguments and the *kind* of concepts we have available to us—surrounding ADHD and other disorders has hitherto been controlled by the dialectic of medicalization. It prevents us from moving past this existential stalemate, to think of ADHD's ontology *outside of* medicalization, individual variation, and dichotomies of what is normal and pathological. This is why ADHD self-advocacy can find use in philosophy: it can help us to stop recycling the same old arguments over and over again. By embracing philosophy, ADHD self-advocacy can disrupt the status quo by *rehabitualizing thought*: that is, by (1) interrogating the cognitive processes that lead us, the experts, and the greater public to always think dichotomously about the nature of disease and disorder; (2) challenging the supposed universality of these cognitive processes by understanding their emergence *historically*; and (3) forging new visions of ontology for ADHD that run counter to conventional medicalized thinking.

This is not an easy argument for me to make; it requires me to delve into the history of philosophy, and the history of medicine, all while trying to sustain the reader's focus. I ask the reader to be patient with me as I work through these ideas. In this section, I use an analytic style of writing to explain the general principles of the dialectic, and the key concepts to be used. In doing so, I hope to orient the reader so that the following sections are more readable. While this section might come across as merely a product of my overactive imagination, or only indicative of the way *I think*, I stress the importance of reading the whole chapter in order to recognize that this is not the case, that the dialectic of medicalization can be traced historically and institutionally.

As I argue, the dialectic of medicalization sustains particular habits of thought. It informs and puts limits on how we think about the nature of disease and disorder, how we classify (or oppose classification), and how we perceive (or overlook) symptoms and syndromes. If we think about the dialectic in spatial terms, it has two "poles" and two "directions" (from the top pole to the bottom pole (top-down) and vice versa (bottom-up)). The top pole represents *identity*. This includes anything that can grant a disease or disorder an essential identity: diagnostic categories, natural kinds, human kinds, brain "types," disease entities, root biological causes, and Aristotelian *genera* (defined later). The bottom pole represents individual variation. This includes the variation between unique individuals, or variations of individual behaviours or symptoms.

The *direction* of the dialectic represents an ontological belief about the nature of disease or disorder. In this schema, ontology is not simply a matter of sticking to one pole or the other; it always involves both poles. The question is rather one of direction: which pole ontologically *determines* the other? Those who medicalize pathological phenomena as identities *sometimes*—though not always—intend for these identities to correspond to biological "reality." For example, some believe that ADHD is a "real disease entity" that determines individual behaviour (the top pole determines the bottom pole). Others believe ADHD is just a diagnostic category that groups individuals with similar behavioural problems together, and that it does not correspond to a biological entity (the bottom pole determines the top pole). These examples are not meant to be comprehensive, only introductory.

The dialectic of medicalization is also characterized by its *improper concepts of difference*. An improper concept of difference corresponds to a difference that does not exist in itself, but must be artificially imposed on the world. Consequently, another key concept I use in this

chapter is *indifference*. Indifference is what fuels the dialectic, perpetuates it, pushes it through history, and allows thought to swing back and forth between the two poles. I use the concept to describe both a *psychological state of indifference* (in the sense of not caring about something, or dismissing something as unimportant, unhelpful, useless, or unworthy of one's time), and a *metaphysical state of indifferentiation.* A metaphysical state of indifferentiation means that the ontology in question *artificially imposes* difference onto the world, and does not offer a proper concept of difference. I use "indifferentiation" rather than "undifferentiation" to connote how this psychological state of indifference is intertwined with the metaphysical. To put it simply, one feels indifferent to an ontology that is revealed to have no proper concept of difference.

For philosopher Gilles Deleuze, there are two aspects of indifference (1994: 28). Generally construed, the first aspect of psycho-metaphysical indifference is the recognition that imposing identities onto individuals (or symptoms) in order to differentiate them from others, such as the practice of diagnosis or categorization, does not offer a proper concept of difference. For example, a skeptic who is indifferent to ADHD might argue that we are "making up" differences when we diagnose some children with ADHD but not others.

The second aspect of indifference is much more difficult to grasp, and will be discussed in greater detail in the next chapter. It corresponds to an indifference toward an ontology of individual variation. Those who are in this second state of indifference question whether individuals (or individual behaviours or symptoms) actually have ontologically meaningful differences between them at all. As I will argue in the next chapter, this second aspect of indifference plays a central role in critical theories of subjectification—that liberalism *artificially imposes* differences between unique human individuals to make them think they have "individuality," in order to govern them more effectively.

The Historical Emergence of the Dialectic of Medicalization

To recap, so far I have introduced the central problem to be resolved, and provided an analytic description of the structure of the dialectic and associated key concepts. Next, I need to situate the emergence of the dialectic of medicalization in the history of philosophy and medicine. This is important to make a compelling *academic* argument. I have to explain why this dialectic is not just an artifact of my imagination, or simply the way *I think*, but can be traced historically.

I begin this investigation through a reading of Michel Foucault's *Birth of the Clinic* (1975). Foucault, a French philosopher, historian, and social theorist, is interested in the relationship between historical reconfigurations of classification schemes and medical perception as it plays out in eighteenth-century French medicine. His work serves as an excellent illustration of how the meaning of medicalization is by no means static, but changes drastically based on institutional developments (the emergence of hospitals, clinics, morgues, and so on). If, however, the meaning of medicalization changes over time and from institution to institution, how can I claim that it has an "underlying dialectic"? Indeed, Foucault would certainly challenge me on this point, rejecting any notion of a "habit of thought" that is said to continue across varying historical *epistemes* or regimes of medical discourse.

As Foucauldian scholar Derek Hook points out, to analyze "discourse" means to trace it back "to the multiple institutional supports and various social structures and practices underlying the production of truth," thus "sufficiently grasping it in its relation to power" (2007: 106). This is in contrast to philosophical discourse which is (traditionally) thought to be extra-institutional, extra-social, and, in many cases, transhistorical. For Foucault, discourse also includes materiality—the architectural arrangements of institutions, the technologies utilized by different

actors, the material practices of everyone involved—everything required to produce, organize, configure, and assert knowledge.

In contrast, Deleuze, Foucault's contemporary, quite explicitly forges an alternative to Foucault's methodology. Deleuze argues that there is a habit of thought that recurs throughout and *despite* history: what he calls "representational thought." Deleuze explicitly acknowledges his debt to Foucault for first recognizing the discursive structure of representational thought: "as Foucault has shown, the classical[72] world of representation is defined by these four dimensions which co-ordinate and measure it. These are the four roots of the *principle of reason*": "identity," "opposition," "analogy," and "resemblance" (1994: 262; emphasis added). Foucault, however, situates this representational habit of thought as a mode of discourse emerging from the socio-historical context of fifteenth- to eighteenth-century France, whereas Deleuze situates its emergence in the philosophy of Aristotle. This is significant because, if this habit began in Ancient Greece but continued into eighteenth-century French medicine, it would call into question "Foucault's own approach to the history of reason," the belief that thought constantly develops *new* habits via historical discontinuities and new discursive formations (Gutting 1989: 11). In the words of Deleuzian scholar Mathias Schönher, "what Deleuze considers Foucault to have left out of his books is none other than philosophy, which, with its creative thinking, *turns against the historical situation* by setting out the starting points for the transformation of our society and our experience" (2015: 10; emphasis added).

Unlike Foucault, Deleuze understands this representational habit of thought as *transhistorical* (at least until a philosophical alternative can be interjected on history). "The

[72] Not to be confused with the Ancient Greek classical period. "Classical" here refers to the classical period of France, during the reign of King Louis XIV, approximately the mid-seventeenth to mid-eighteenth centuries (Ripley and Dana 1859: 298). Foucault restricts his analysis of representation to this period (Gutting 1989: 139-179).

greatest effort of philosophy," he writes, "was perhaps directed at rendering representation infinite" (1994: 262). In particular, he argues that Aristotle's thought was so influential that it "assigned itself the role of ground" and "traced its doctrine... onto the organs of State power" (Deleuze and Guattari 1988: 376). In other words, representation is an example of a habit of thought that is so grounded in the history of reason and philosophy that it appears unshakeable, universal, and eternal. It narrows the extent to which new institutional arrangements can reconfigure epistemology, and thereby limits what discourses are possible.

I cannot say for sure whether Deleuze is right about representation underlying all thought today; I am only concerned with how representation appears in medicine. By taking seriously Deleuze's critique of representation, an alternative reading of Foucault's *Birth of the Clinic* is possible. In this reading, it becomes clear that eighteenth-century French medicine did indeed incorporate Aristotle's thought into its institutional configurations. I further argue that this Aristotelian habit of thought—now construed by the dialectic of medicalization—continues to underpin the way we think about ADHD. If I am right, this means that ADHD skepticism and misrecognition cannot be solved through institutional change (or public goodwill) alone. What is needed *first* is a direct philosophical intervention—the project at hand. Only by tracing its origins and recognizing its faults can we comprehend that the dialectic of medicalization is not eternal, and that we *can* and *should* shake it. Once we realize this, our minds will be free to think about ADHD's ontology anew.

Aristotle's First Ontological System (Top-Down Determination)

Again, my argument is that ADHD skepticism arises not from a lack of reliable biological markers, but from the dialectic of medicalization. We need to unpack the philosophical history behind this dialectic in order to solve ADHD's "metaphysical mystery." In the following four

short, but *dense*, sections, I discuss the basic tenants of Aristotle's two ontological systems; how these two systems became *institutionalized* in eighteenth-century French medicine across two epistemological configurations; Deleuze's critique of Aristotle's bi-directional ontology; and finally, how this all connects back to ADHD skepticism.

There is no doubt that Aristotle (the son of a physician, no less) played an enormous role in the shaping of medical thought from the Ancient Greek era, through the Middle Ages, Renaissance, French classical period, and into the modern era. As historian Boris Hessen notes, in fifteenth- to seventeenth-century universities, the "main 'natural science' manuals were Aristotle's books.... *Even medicine was taught as a branch of logics*" (1931: 13-14; emphasis added). Further, as Canguilhem states,

> It is not only the history of anatomy and physiology that begins with Aristotle but also the history of what was long called "natural history," including the classification of living things, their orderly arrangement in a table of similarities and differences, study of their kinship through morphological comparison, and, finally, study of the compatibility of different modes of existence. (1988: 133)

The question remains, how did Aristotle's *ontology*, rather than just his classification schemes, transpose itself onto eighteenth-century medical perception in France?

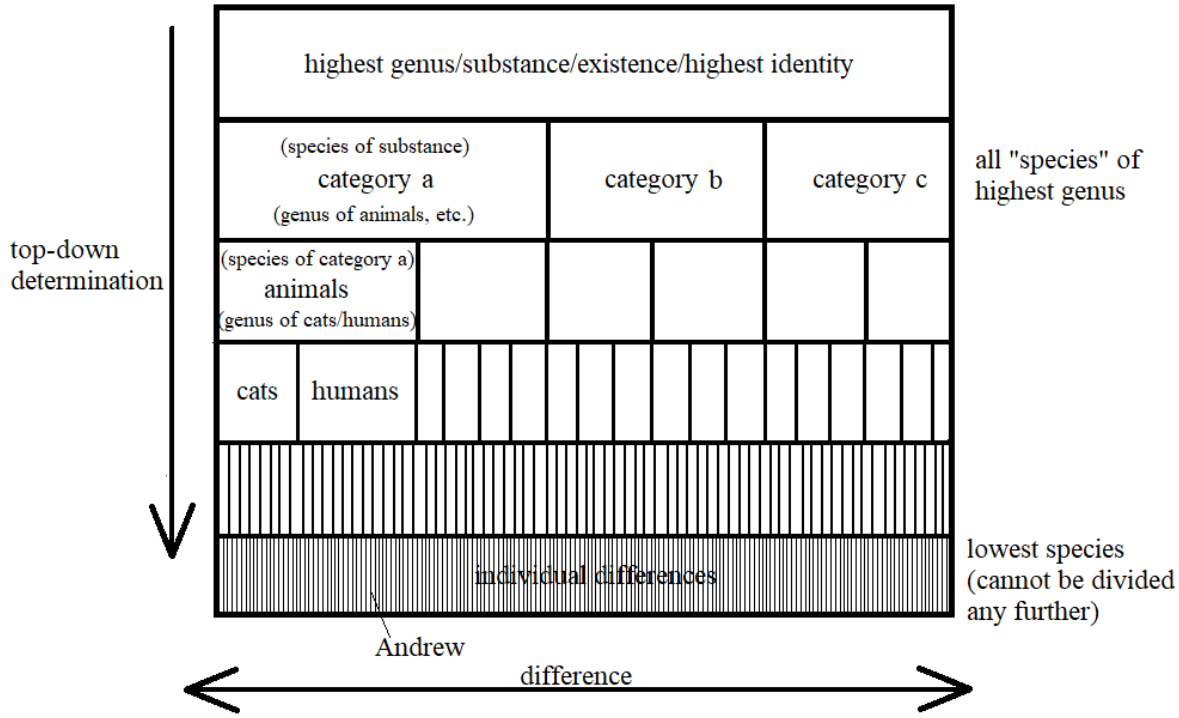


Figure 4.1: Top-down determination according to Aristotle (diagram not comprehensive)

Very briefly, Aristotle's primary concern in *The Categories* (part of the *Organon*, Aristotle's treatise on logic) is with ontology—the study of what it means for things to exist. From Aristotle's perspective on ontology, similar to a shipbuilder who follows a set of blueprints (Feenberg 2004: 8-9), nature *determines* things according to their "essence," the blueprints of their "species."[73] Determination, in this context, does not mean causal or mechanistic determination. In Ancient Greek thought, for something to be determinate means it can be differentiated from other things. Socrates is determinate insofar as he is differentiated from other human beings: a *species* is one of many *specific* determinations of a genus, the genus itself a species of another genus, all the way up to the highest genus, what Aristotle calls "substance"

[73] Modern biological taxonomy uses the terms "species" and "genus" in a different way than Aristotle. Most notably, Aristotle uses these terms dynamically rather than statically—they do not designate a static rank in a hierarchy. For Aristotle (e.g. in his *History of Animals* and *Parts of Animals*), a crow is a species of bird, a bird a species of animal, or alternatively, an animal is the genus of bird, bird the genus of crow, and so on.

(because *everything that exists has substance*). Since "genus" is such an alien term to contemporary readers, I prefer to use the term "identity." If we visualize a hierarchical diagram where the highest identity—that which everyone and everything can identify with—branches out downward into its lower species, differentiation would constitute the x-axis, determination the y-axis (see Figure 4.1). As we move down the diagram, "species of species" become more and more determinate (the differences between species become more and more specific):

> The determination of species links difference with difference across the successive levels of division... until a final difference, that of the *infima species* (lowest species), condenses in the chosen direction the entirety of the essence... thereby becoming itself something unique and indivisible. (Deleuze 1994: 31)

By following the blueprints laid out by the universal essences of substance and its species, nature determines and differentiates the world into smaller and smaller pieces until it can be divided up no longer (the world of particulars). Such division is not to be confused with accidental acts of physical division. If my body is cleaved in half, I do not become two separate Andrews. Rather, me being split in half is what Aristotle calls *accidental* to my essence. Accidents aside, the world of particulars cannot be divided up any further, and this corresponds to the limits of classification. For ease of readability, I use the term "individual" instead of "specific" or "particulars." Instead of Deleuze's phrase "specific difference," I say "individual difference." In line with Aristotle, "individual" can mean human individuals, such as "Socrates" or "Andrew," but it can also mean non-human, individual *things*, such as individual symptoms or behaviours.

For Aristotle, classification and ontology are thus intermingled. His efforts to classify the world according to the differences he perceives between things is simultaneously a mapping out of how the world is determined, the nature of existence.

In early eighteenth-century configurations of disease, Aristotle's ontology in *The Categories* can be found transposed onto medical perception itself. For example, "disease botanists" Thomas Sydenham and François Boissier de Sauvages de Lacroix wrote medical nosologies classifying and categorizing the different types of diseases following Aristotle's classification system. Physicians at the time followed these medical textbooks closely in order to diagnose and treat patients. Importantly, Aristotle's concept of "accidents" (characteristics of a thing that are unessential to it) was transposed onto patient histories: the patient's predisposition, age, and lifestyle were deemed "accidental" to a disease's symptomatic course. As one physician of the era puts it,

> He who describes a disease must take care to distinguish the symptoms that necessarily accompany it, and which are proper to it, from those that are only accidental and fortuitous, such as those that depend on the temperament and age of the patient. (Sydenham quoted in Foucault 1975: 8)

In other words, only the symptoms listed under a disease category in these formal nosological textbooks were to be counted as symptoms. Variegating symptoms from patient to patient relating to their predispositions, age, or lifestyle were not to be counted as symptoms of the disease itself; they were just accidental (Foucault 1975: 8).

This epistemological formation (what constitutes knowledge of a disease) follows a top-down *unidirectional ontology*: essences determine their particulars, or rather, formal categories of diseases in the textbooks determine (differentiate) what symptoms belong to them and what symptoms do not belong to them. The reverse was not true; particulars did not determine their essence. For example, a physician would not have attempted to determine the existence of a new disease based on his patient's accidental symptoms. The medical epistemology of the time prevented physicians from conceiving of diseases in this way. In effect, the *onto-epistemology* of disease did not consider *individual variation* to be relevant for disease ontology.

One problem with this onto-epistemological configuration, according to Foucault, is that accidental symptoms would sometimes be indistinguishable from essential symptoms of other known diseases. This "contradicted and blurred the essence of the disease; it prevented the disease from acceding to its true nature, and, by making it irregular, made it untreatable" (1975: 8). Put simply, in such a confusing conglomeration of accidental symptoms, the physician sometimes would not be able to identify which disease it was. He would be clueless in how to treat the patient, as he was dealing with a monstrosity that did not belong to the world of diseases he was familiar with. There is no room for *hybrid diseases* (blended essences) in nosologies indebted to Aristotle's *Categories*.

The Equivocity of Disease

This rigid, unidirectional form of perception posed an *ontological problem* for French medical practitioners in the early eighteenth century: how to address that *other* world of disease. It was as if there were two distinct, irreconcilable forms of existence: the formal identities of diseases according to their nosological genus classification, and the existence of shadowy, untreatable, unrecognizable diseases whose symptoms could not be untangled from patients'

individual histories or the context of their lifeworlds. Foucault calls this the "double reality... of disease" (1975: 91).

As he argues, this *equivocity of disease*—this schism in what it means to be a disease—was resolved only through significant historical transformations over the course of the eighteenth century: namely, the development of institutions (i.e. the rise of epidemiology, the construction of hospitals, and the birth of the clinic) and their new measurements and tests which forced physicians to consider their patients' unique, symptomatic presentations more carefully:

> The medicine of species becomes engaged in a renewed attention to the individual... [and] ever less able to tolerate the general forms of perception and the hasty inspection of essences.... [Previously] the individual was merely a negative element, the accident of the disease, which... is most alien to its essence. But the individual now reappears as the positive, ineffaceable support of all these qualitative phenomena, which articulate upon the organism the fundamental ordering of the disease. (1975: 15, 14)

Through this historical transformation, the nature of disease is flipped on its head, and determination reverses direction (bottom-up). "There is no longer a pathological essence beyond the [experienced] symptoms," Foucault writes, "their collection forms what is known as the disease" (1975: 90, 91). He is referring to the symptoms as they are actually experienced by the patient—variable, variegated, and contextual. The patient's experience of his or her symptoms, now placed firmly under the medical gaze, defines this new pathological identity.

What is missing from Foucault's analysis, however, is the acknowledgement that this historical transition from one configuration of disease to another is a *necessary outcome* of Aristotle's metaphysics. This new configuration still pertains, as Deleuze would argue, to Aristotle's *transhistorical system of representation*. For Aristotle himself faced the same fundamental problem that confronted eighteenth-century French physicians: he realized that the ontological system he outlined in *The Categories* falls prey to an *equivocity of being*, distinct forms of existence that are irreconcilable with one another (Politis 2004: 117). He became *indifferent* to his own work, and was thus forced to *reconfigure* his ontological system, as I will describe below.

Aristotle's Second Ontological System (Bottom-Up Determination)

In this section, I carefully explicate Aristotle's second ontological system. Remember why it is important to do so: to provide textual, theoretical evidence that the habits of thought underlying medicalization are so *grounded* in the history of philosophy that they became embedded in and across historical and institutional transformations. Following Deleuze's critique, it is not that Aristotle's ontology is still accepted as "true" by modern scientists, clinical researchers, or medical practitioners; instead, it is the structure and dynamic of his ontology that remains *subtly* embedded in medical and clinical thought. What in particular remains of his ontology? Namely, the problem of the *equivocity of being* that Aristotle never fully resolved, and the accompanying lack of a proper concept of difference. As I will show, the problems of skepticism and misrecognition facing ADHD today are themselves examples of these unresolved issues in Aristotle's thought.

Unlike Plato, Aristotle does not believe in an ontology where the question of existence can be answered with recourse to ideal forms. The essence of "being," or substance—the primary

constituent of existence—is not to be found in the Platonic heaven, but in the world around us (Politis 2004: 117). Recall that, according to *The Categories*, things are determined according to their essence, allowing them to be differentiated into smaller species by nature. Yet, substance cannot be a species of something higher than itself because it itself is the "highest identity"—everything that exists has substance. This is why Aristotle rejects the idea that substance could be determined by the essence of an ideal, *other* world (such as the Platonic heaven): the very notion of "existence" would be split in two—a worldly existence (with substance) and an otherworldly, higher identity of existence (without substance) that determines it; in short, an equivocity of being. Even if we were to accept this idea that there are "two worlds," a world of substance and a notion of existence that transcends substance (a Platonic heaven), we would be confronted with the same problem again: what higher identity unifies these two worlds into a single sense of "existence"? And how is that higher identity of what it means to exist then determined? The problem repeats itself, *ad infinitum*.

But why must substance be determined at all? Does its status as the highest identity not by definition exclude it from needing to be determined? The reason Aristotle believes that substance cannot be left undetermined is because doing so would leave us with no starting point to establish a proper concept of difference, a requisite for metaphysics. If substance is left undetermined, it is indifferentiated (i.e., there is nothing that can differentiate itself from substance because everything *is* substance); and if it is indifferentiated, differences themselves cannot be said to *have substance*; they cannot be said *to exist*. As Deleuze puts it, "remember the reason why Being itself is not a genus [or identity]: it is, Aristotle says, because differences *are*" (1994: 32).

For Aristotle, the *differences* between things—both in themselves and how we perceive them—must *exist*; and they must be of *this world*. If not, we are left with the same kind of problem that confronted early eighteenth-century physicians: by *artificially determining* which symptoms counted as essential and which symptoms counted as accidental based on the former's presumed "identity" (what disease they belonged to according to the textbooks), by *artificially imposing these differences onto the world*, the world of disease—in practice, perception, and judgement—became split in two. It became an *ontological problem institutionalized in medicine*.

In his later text, *Metaphysics*, Aristotle offers a "solution" to this problem (one that Deleuze finds inadequate, as I will discuss in the next section). According to philosopher Vasilis Politis, whereas in *The Categories* Aristotle argues that the "essence with regard to each thing is a universal," in *Metaphysics* he argues instead that "essence [is] the ultimate subject of predication," i.e., particulars, the lower species (2004: 116). Particular things in the world (e.g., Socrates, this particular symptom, that particular patient, etc.), whose differences are the most specific, are now considered by Aristotle the "essence" of all being. I call this an *ontology of individual variation*. In this new ontological configuration, nature's determination no longer follows a multitude of formal, universal identities from the highest genus downward, but *moves from individual variation upwards*: the empirically-measurable differences between concrete things determine what kind of things they are. Increasingly larger "genera of genera" can now be differentiated from one another without having such differences imposed on them from above. In effect, *there is no longer a "highest identity" (a universal "substance" or "disease") but a series of identities whose differences are determined by their constituent particulars (the actual "substance" of the world)*. This bottom-up determination is how existence is ultimately construed, argues Aristotle in *Metaphysics*.

One further step is needed to resolve the equivocity of being found in Aristotle's earlier work, *The Categories*. Namely, if particular things in the world are not ultimately determined by a unified, highest identity (that is, if being, or substance, is no longer a highest identity), Aristotle needs to explain how, then, these particular things can all be said to exist in the same way (how "being" can be "said in a single and same sense... *of* all its individuating differences" (Deleuze 1994: 36)). Aristotle answers this with his "focal theory of being": "being is said in several ways" of different particular things in the world, "but ultimately they refer to and depend on a single way and a single kind of being... as it were, their focal point" (Politis 2004: 105). Unsurprisingly, Aristotle uses the concept of "health" to explain what he means. As Politis describes it,

> First, very different things can all truly be said to be healthy: a living organism; a diet [...]; a medical remedy [...]; a certain kind of complexion [...]. Second, health is said in different ways depending on which of these things it is said of. Third, one of these ways is central and focal, and the other ways must be understood by reference to it.... Aristotle refers to this primary case simply as *health*, but what he has in mind is the general condition of a living organism that constitutes its being healthy. (2004: 107)

In Deleuze's interpretation, Aristotle's focal theory of being is none other than the role of *analogy* in judgement (1994: 33-34). A "healthy kind of complexion" is analogous to a "healthy

diet" insofar as they both relate to the healthy functioning of the organism.[74] The same is true of everything's relation to *being*: e.g., we understand what it means for something outside of us to exist by analogically relating it to our own sense of existence.

This ontological transformation in Aristotle's work, institutionalized in the historical transformations of eighteenth-century French medicine, reinvented what it meant to be a disease. No longer were diseases separated from the world of individual patients to avoid "disturbing essential truths" (Foucault 1975: 99). No longer were diseases thought of as ethereal forms 'floating' through individuals: "the clinic is not... that mythical landscape in which diseases appear of their own accord, completely revealed" (Foucault 1975: 110). Instead, diseases now belonged to the *same world* as the patients they afflict, the world of particulars. Patient histories, idiosyncratic symptoms, new spaces of visibility, and new methods of measurement all became essential in determining the classification and existence of different diseases. This transformation had at least three practical implications according to Foucault.

First, the "principle of analogy" now played a central role in progressing knowledge of diseases (Foucault 1975: 100). This principle takes on a simple equation emblematic of Aristotle's focal theory of health. As Foucault states, "analogy... concerns a system of relations and reciprocal actions, a functioning or dysfunctioning" (1975: 100). In other words, an analogous relation to a common focal point (either functioning or dysfunctioning) divides "phenomena" up, as one physician of the era writes, "into those that belong to health and those that designate disease" (Broussonnet quoted in Foucault 1975: 92). In effect, "analogous forms of co-existence" between particular symptomatic patterns of dysfunction make it possible to

[74] In the context of Foucault's work, which Deleuze claims to draw inspiration from, "analogy" is taken as "a matter of resemblance between relations" (Gutting 1989: 141).

identify new diseases that were previously imperceptible (Foucault 1975: 100). For example, *in the previous configuration of disease*, when "gastric fever" was accompanied by "a low and intermittent pulse rate" and "difficulty in swallowing," these symptoms were conceptualized as accidental, a consequence of the weak character of the particular patient—nothing essential to the gastric disease itself (Foucault 1975: 99, 101). In the new configuration of disease, however, gastric and respiratory problems could now be perceptually tied together through their analogous relation to dysfunction, indicating to physicians, *prior to any anatomical understanding of it*, the presence of a novel disease: "bilious pleuro-pneumonia" (Foucault 1975: 101).

Second, what Deleuze calls a "generic difference" (1994: 33) or Foucault an "absolute difference" "that separates health from disease" (1975: 92) was established in order to ensure a *univocity* of disease (the opposite of equivocity). In this new configuration, there is no room or possibility for 'otherworldly' diseases to hide in the shadows of accidents, because the formal distinction between essential and unessential symptoms gives way to a homogeneous "multiplicity of symptoms that signifies [disease's] meaning *without remainder*," regardless of how "unexpected," or "extraordinary" those symptoms are (Foucault 1975: 96, 101; emphasis added). "Without remainder": by process of analogy (to dysfunction), each and every symptom can now be accounted for by "every variety of disease," as another physician writes (Cabanis quoted in Foucault 1975: 99). There was no longer such a thing as unessential, accidental symptoms.

Third, in cases where a specific disease cannot yet be identified (e.g., in the expression of "subclinical" symptoms), a *generic* identity was introduced in order to maintain a univocity of disease. For example, instead of "gastric fever" or "adynamic fever," a physician might only be able to diagnose a generic "fever" in the patient. As Foucault explains, while not a "disease

itself," "fever... makes it possible to designate a pathological state (in contradistinction to health)" (1975: 90). In this sense, fever operates as a sort of pseudo highest identity (as an umbrella diagnosis that designates a pathological state by standing in for "disease" in general). All other remaining symptoms are absorbed into this diagnosis until a more specific disease can be identified.

Importantly, ADHD has taken on, in some quarters, the same generic role that "fever" had in late eighteenth-century medicine. For instance, in a medical-school lecture on ADHD I attended, the lecturer, speaking to her medical students, described this tendency to generalize ADHD as follows:

> The one diagnosis that always comes into people's minds is ADHD. How I think of it is that, a hundred and fifty years ago, if you had fever, that was considered a diagnosis. So maybe I might treat you with cranberry juice. If you had a bladder infection you might get better, but if you had meningitis, your luck was not so good. So ADHD is probably a little bit like that now. It's a grab bag of diagnoses. But I want to get your minds thinking about all the other possible things that can cause disruptive behaviour in children, and to get you realizing that it's not all ADHD.

It is as if ADHD were a "genus above" every other disorder: a "genus of genera," a "highest identity," a "grab bag" that contains within it a collection of other potential, more specific diagnoses, or a "symptom catcher" that lets no unaccounted-for symptom slip by. In this way, ADHD helps to sustain a *univocity of disorder* (so that there are no otherworldly disorders

lurking in the shadows of unaccounted-for symptoms): when the physician is stumped, a diagnosis of ADHD saves the day.

Deleuze's Critique of Aristotle's Proposed Solution

The problem with this supposed univocity of disorder, indeed the problem with Aristotle's proposed solution in *Metaphysics*, is that, as Deleuze argues, it still does not meet the requirements for a *univocity of being*: the requirement that "Being is said in a single and same sense... *of* all its individuating differences" (1994: 36). Because while being is permitted to be "'equal' for all [disorders], they themselves are not equal" (Deleuze 1994: 36). That is, despite them all analogically existing in the same way (as "disorders"), the way that ADHD is different from other disorders is not the same as the way those disorders are different from each other. ADHD's generic difference *stands alone*.

For example, in his book, *ADHD Does Not Exist,* Saul shares the view that ADHD is a grab-bag of diagnoses, and therefore not "real." He provides a number of potential "underlying conditions" contained in the grab bag that the physician should seek to diagnose instead of resorting to an ADHD diagnosis. These include: mood disorders (bipolar and major depressive disorder), hearing problems, learning disabilities, sensory processing disorder, vision problems, sleep disorders, substance abuse, and more (2014: i).[75] But why does Saul believe that ADHD does not exist? In philosophical terms, why does he view ADHD as having a different ontological status than these other disorders/conditions? The answer is that believing ADHD does not exist allows Saul's thought to proceed in a smooth, coherent fashion. *Something* needs

[75] Alternatively, in the school context, sociologist Adam Rafalovich writes, "recalling one clinician's comments calling ADHD a 'garbage can diagnosis,' we can surmise that ADHD is largely a catch-all typology for behaviours that schools deem disruptive and undesirable" (2004: 146).

to fill the generic role, the missing role of the highest identity, and for Saul that something is ADHD.

To elaborate, Deleuze's key argument is that both of Aristotle's unidirectional ontological configurations *enter reciprocally into judgement*; one does not replace the other, both *necessitate* each other. This is Aristotle's "sleight of hand" (Deleuze 1994: 32). In order for Aristotle's *Metaphysics* to maintain its veil of ontological cohesion, determination must actually be *bi-directional*, and "substance" *bi-polar*: a back-and-forth movement by which contraries become complementary possibilities (a dialectic).

In the above case, Saul implies that the diagnosis of ADHD is nothing more than a catch-all phrase. But on the other hand, his belief in the existence of other disorders subtly relies on ADHD's generic identity to maintain a veil of ontological cohesion, a univocity of disorder (i.e., without umbrella diagnoses like "ADHD" or "fever," a range of undiagnosable, "accidental" symptoms would continue to lurk in the shadows, confronting physicians once again with an equivocity of disorder or disease). What Saul fails to realize is that, if ADHD were to become defunct and no longer diagnosed, some other disorder would have to take its place as the highest identity. The problem is not ADHD itself, but the metaphysical role it has been assigned to (I discuss this in more detail, and provide a historical explanation for ADHD's metaphysical assignment, in the next chapter).

To be clear, the *actual* ontological problem here—hiding beneath these habits of thought—is not a question of which disorders exist or not; it is a question of whether the *differences* between them exist in an ontologically coherent way. Saul may believe that the differences between other disorders represent "real" differences while ADHD's generic difference is the "made up" difference, but when the veil is pulled off to reveal their mutual codependence, are they not

equally ontologically fraught? A univocity of *disorder* is sustained only through an equivocity of *being*, where the *ontological* differences between disorders fail to exist in a single sense. As Deleuze puts it,

> When we speak of the univocal, is it not still the equivocal which speaks within us? Must we not recognise here a kind of fracture introduced into thought, one which will not cease to widen in another atmosphere (non-Aristotelian) [i.e., medicalization]? (1994: 33)

My general argument here is that it is precisely this metaphysical "fracture introduced into thought" that leads people like Saul to claim that ADHD does not exist. The problem is not that ADHD has no "reliable biomarkers" (after all, this is true of all DSM-defined disorders—yet few of them[76] face the same level of skepticism that ADHD does). The problem is that ADHD is lent these strange taxonomic powers that other disorders do not have at the expense of itself, and this makes it an easy target for criticism. As ADHD clinician and researcher FR describes,

FR: I've been doing research on ADHD for a very long time and I've often been seriously challenged by people saying "oh it's a made-up disorder," "it's just an excuse," *"everybody's getting diagnosed with ADHD these days."* .... But I don't think you'd get much argument from psychologists or psychiatrists that ADHD is dimensional, that the symptoms are on a continuum. At the end of the day it's about, "is this child's behaviour

[76] Possible exceptions being other generic disorders like chronic fatigue syndrome and circadian rhythm disorder.

> consistent or inconsistent with their developmental age and stage?" Though we treat ADHD as though it's dichotomous. We treat it as present or absent in children, knowing full well they are on a continuum.

"Everybody's getting diagnosed with ADHD these days" *because of* its taxonomic placement as a highest identity, a syndrome that everybody can identify with. Correspondingly, if "everybody has ADHD," or put differently, if ADHD is nothing more than a "continuum of symptoms" that everybody experiences to a greater or lesser degree (relative to behavioural norms), then, similar to Aristotle's concept of substance in *The Categories*, there is nobody that can differentiate themselves from ADHD, and there is no set of symptoms that can differentiate ADHD in itself; it remains ontologically undetermined and indifferentiated.

Deleuze's critique helps to clarify that contemporary debates over ADHD's existence are the consequence of the problems inherent in this particular *habit of thought* passed down through the ages.[77] The solution is not to tirelessly argue back and forth hoping for a resolution. The solution is to get rid of the habit itself, to repair the fracture introduced into thought that gave rise to and perpetuates the dialectic of medicalization. In other words, what is really behind these criticisms is the implicit—but by no means explicit—recognition of an *inadequate concept of difference*. It is above all ADHD's proposed *difference*, rather than its proposed biological "reality," whose existence is continuously being called into question. This habit of calling into question ADHD's

[77] To be clear, I am not denying that, at least in North American societies, ADHD symptoms seem familiar to most people—everyone loses focus from time to time, etc. What I am arguing is that this alone should not call into question ADHD's existence. What was needed was this particular arrangement of onto-epistemology to latch onto ADHD as a scapegoat for medicalization's own failings.

proposed difference corresponds to Deleuze's "first aspect of indifference": acknowledgment that the disorder is ultimately indeterminable.[78]

How the Dialectic of Medicalization became Institutionalized in the Anatamo-Clinic, and Why the Idea of "Biological Reality" Is Historically Insufficient for Foucault (and for ADHD)

Whereas historically one can witness the problem with Aristotle's first ontological configuration "resolve" itself *institutionally* (as in the case of eighteenth-century French medicine), there is as of yet no historico-institutional resolution to the metaphysical problem Deleuze identifies. Instead, we are left with a dialectic of medicalization whose underlying equivocity is masked by ideologies of scientific progress. Consider, for example, Foucault's analysis of the "anatomo-clinic," the name he gives to a new historical formation of the clinic emerging in the late eighteenth century and continuing into the nineteenth, twentieth, and twenty-first centuries. Institutionally, the anatomo-clinic came about when dissection rooms were introduced into clinics, initiating the practice of opening up corpses and looking inside (Foucault 1975: 125, 126). Foucault is clear that there is a stark distinction between this new mode of medical perception and previous ones. Before, symptoms were traced according to the "surface" of the individual's body (having a high temperature, sweating, discolouration,

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[78] Although ADHD's role as a generic identity makes it an easy target, there are other pathways that can be taken to criticize all DSM-defined disorders as indeterminable. For example, Professor PL points out to me that there is no *original* validity to any of the diagnostic categories in the DSM:

> PL: Diagnosis is weird. If you want to build up diagnostic tools [to standardize diagnostic practices], you need validity, but this validity is made up. To determine validity, there should be some group already diagnosed, but this first target group didn't use a [valid] diagnostic tool. There are many, contradictory things in psychiatry.

Ian Hacking makes a similar argument about the diagnostic validity of multiple personality disorder in his book, *Rewriting the Soul* (1995b: 98-103). Similar to the experimenter's regress, this can be called the *diagnoser's regress.*

involuntary movements, disturbed speech, etc.), or in described experiences ("where it hurts," patients' descriptions of their symptoms' chronology, etc.). Now, with the introduction of anatomy, symptoms could be traced, with a much higher degree of certainty than before (aided by new spaces of visibility, new technologies, and new forms of measurement), to the organs within the body.

The rise of anatomy clashed with previous discursive arrangements of medical perception: so what if the symptoms of chronic catarrh (a build up of mucus in the throat) resemble those of phthisis (tuberculosis)? Autopsy reveals "in one case an infection of the mucous membrane and in the other an alteration of the parenchyma" (Foucault 1975: 138). In such cases, the *localization* of the infection or alteration were deemed *more essential* than resemblance or analogy in the role of determining the classification of the disease. *Determination, once again, was flipped on its head, and accidents came back in vogue*: e.g., "there are tubercular patients who do not cough"; physicians know this because they can now see phthisis localized in its "seat" in the body—the variations in symptomatic expression are no longer considered essential to the disease: "there is only one constant phenomenon, the necessary and sufficient condition for the presence of phthisis: lesion of the pulmonary parenchyma" (Foucault 1975: 138).

This new configuration is reminiscent of the essential disease identities defined by formal nosologies. Foucault claims that localization "duplicates the natural or significative space of nosology, and requires, essentially, that it should be brought back" (1975: 139). Only now the *human corpse* is substituted for the Platonic heaven of forms or formal nosologies; the anatomy of the lesion and its theorized determinants become the defined "form" or "identity" of the disease, the anchor point from which medical perception is oriented. What remains otherworldly about the dissection room is that only in dead bodies can diseases be formally defined; their

forms then transcend from the world of the dead—sometimes from a single specific body (a cadaver)—to the world of the living, where visibility is restricted to particular symptomatic determinations on the surfaces of living bodies. The essential identity of disease is once again separated from the world of living patients, becoming formalized and abstract.

As Foucault argues, conventional histories of science (the narrative of unabated empiricism and scientific progress) try to make it out like the anatomical "discovery" of diseases localized in the body were more *real* than previous configurations of disease (1975: 137). Such histories, like those found in science textbooks, assert that anatomy "made it possible for the object to reveal its own secrets with greater clarity... and for the subject to dispense with illusions [e.g., analogical speculations about accidental phenomena] that were an obstacle to truth" (Foucault 1975: 137). But it is a mistake of modern science to always conflate corporeal or biological reality with Aristotle's particulars—as Foucault's discursive history indicates, *eighteenth-century anatomy first presented itself as a space of abstract, formal identities*.[79]

One thing I will add is that this configuration of the anatomo-clinic still plays a role in contemporary clinics, only the meaning of "anatomy" has transcended the dissection room and turned into a plethora of diverse disciplines and fields of study falling under the general category of "biomedicine." For example, instead of the anatomical "seat" of the disease, we now have the concept of a "diagnostic biomarker": a technological representation of a (sometimes) formal, pathological essence inside the biological body (or in bodily effluent). While ADHD in particular does not yet have any "reliable" diagnostic biomarkers, it has several "putative" ones, promising

[79] Similarly, the identification of "pathogenic agents" in the twentieth century once again abstracted and formalized the concept of disease in a new way. The essence of a disease (the "irritating cause") could now transverse from the world of formal identities to that of individual patients by "floating through" them; only this time, such otherworldly abstractions are *organically* (rather than just conceptually or cadaverously) isolatable (e.g., a virus).

candidates that, with more research, might eventually have the capacity to definitively diagnose (and determine) ADHD within an individual (Thome et al. 2012: 379).[80]

To unpack this a bit, in one direction (top-down determination), ADHD is defined as having a formal identity—e.g., a neuroreductive "brain type," a "disease entity," a "chemical imbalance"—that is either "present or absent" in the individual, and, if present, determines its symptomatic expression. In the other direction (bottom-up determination), ADHD is not defined as having a formal identity. Instead, its "substance" is the multiplicity of symptoms whose relations are "analogical." It is the cluster of these symptoms that makes the disease or disorder, and no single behaviour or symptom is necessary or sufficient. Further, as Foucault points out, in medicine the principle of analogy is often supported by a "perception of frequencies" (1975: 101): the more frequently these symptoms (or behaviours) co-occur, the easier it is to posit analogical relations between them. For example, the DSM analogically relates symptoms like "often runs about... in situations where it is inappropriate" and "often talks excessively" to a shared focal point, "hyperactivity," but it only does this because children who display one of these symptoms tend to display the other as well. More broadly, the DSM posits that certain sets of behavioural tendencies can be observed to statistically cluster together, giving rise to determinable constructs such as ADHD, a bottom-up determination.[81]

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[80] ADHD's putative biomarkers include: "neurophysiological markers," visible through electroencephalogram (EEG) readings; differences in the "morphology" of the brain, visible through magnetic resonance imaging (MRI); substantia nigra abnormalities in MRI and transcranial sonography (TCS); "genetic biomarkers"; "biochemical markers," such as deficiencies in monoaminergic systems (serotonin deficiencies) measured in cerebrospinal fluid samples; "proteomic biomarkers"; and more (Thome et al. 2012: 381-392).

[81] As sociologists Elizabeth Cooksey and Phil Brown argue, the DSM can be "understood in two ways: first, each diagnostic category can be seen as a latent class, with still unknown pathophysiological entities.... Second, Mirowsky and Ross continue, 'we can regard the factors as separable attributes of people and the diagnostic categories as subjective constellations of those attributes.' Just as stellar constellations are mythical creations of human perception, so too the diagnostic groupings are 'mental overlays grouping elements that seem to form something distinct, but which may have no real connection with each other.' Another way to look at the problem

Of course, given the fluid dynamic of medicalization's dialectic, not all formal identities are biologically-based, and not all biological markers represent formal identities. As already stated, to the extent that the DSM is taken as a *formal nosology*, the psychological category "ADHD" represents a formal, pathological identity as well, socially-constructed rather than organic, but no less "real." Meanwhile, the search for an essential "ADHD gene" on the top pole, for instance, is replaced by the statistical study of genetic endophenotypes on the bottom pole: a homogeneous multiplicity of statistically-related behaviours transposed onto a homogeneous multiplicity of statistically-related genes.[82] Or to take another example: the assertion that ADHD needs to be understood through a framework of "functional connectivity": a "delineation of functional brain networks defined by *correlated* neuronal activity" (Konrad and Eickhoff 2010: 906; emphasis added). The "default network" is the statistical norm, whereas ADHD represents "deviant connectivity patterns" (Konrad and Eickhoff 2010: 908, 912). In both of these examples, "the visibility of the medical field," Foucault writes, "assumes a statistical structure" (1975: 102).

Clearly, perception still *swings* in contemporary "anatomo-clinics" between identity-as-substance on the one pole, and analogical/statistical substantiality on the other, and neither of these poles holds a monopoly on "biological reality." What Foucault's analysis makes clear is that the discursive history of diseases has always contained within it a dialectic of medicalization: a constant back-and-forth through which physicians struggle to reconcile two

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of latent classes is that psychiatry is merely using current classifications as 'temporary expedients' until real biological markers are found and linked to disorders" (1998: 532).

[82] Prominent ADHD research Stephen Faraone and his colleague Eric Mick write, "several meta-analyses suggest strong association with ADHD [as defined and diagnosed by the DSM criteria] and the dopamine D4 receptor gene (DRD4, 48-bp VNTR), the dopamine D5 receptor gene (DRD5, 148-bp microsatellite marker), the dopamine ß-hydroxylase gene (DBH, 5' taq1 A allele), the synaptosomal-associated protein 25 gene (SNAP-25, T1065G single-nucleotide polymorphism), the serotonin transporter gene (SLC6A4, 44-bp insertion/deletion in the promoter region), and the serotonin 1B receptor gene (HTR1B, G861C SNP)" (2010: 160).

diametrically-opposed configurations, or *natures*, of disease.[83] According to Deleuze, "these two aspects *enter into conflict according* to *whether the large genera or the species are taken to be concepts of Nature*, both constituting the limits of organic representation, and the requisites *equally necessary* for classification" (1994: 34; emphasis added). In Foucault's history of diseases, there is only a continual retreating from one substantial, and *equally necessary*, pole to the other, an endless series of reconfigurations, a bi-directional and bi-polar ontology institutionalized in medicine.

Conclusion

A synthesis of Deleuze's critique of Aristotle with Foucault's *The Birth of the Clinic* suggests that, within the realm of medicine, Deleuze is correct in asserting that the system of representation Foucault first identified transcends historical and institutional *epistemes*. In particular, the dialectic of medicalization represents and sustains habits of thought observable in Aristotle's philosophy that have been perpetuated through the ages as a *transhistorical, extra-institutional* "ground of reason." It sets limits on the kinds of discourse available to us regardless of institutional and historical reconfigurations of knowledge and power.

As a result of the dialectic of medicalization, ADHD continues to find itself in an equivocal state of existence, stretched between two diametric poles of indifference. Perhaps the most harmful materially-specific oppression of ADHD is precisely this metaphysical state of being indifferent to it, a cold expression of indifference taught to soon-to-be physicians by their medical lecturers, crudely theorized by various sociologists or "doctors of society," and the basis

[83] For example, despite physicians who claimed that "if there is an axiom in medicine it is certainly the proposition that there is no disease without a seat," not all physicians of the era agreed with this (Bouillaud quoted in Foucault 1975: 140). Petit, for instance, never ceased to argue that what is most important in the determination of a disease is "the general set of symptoms that distinguish one disease from another" (quoted in Foucault 1975: 175).

of all ADHD skepticism and misrecognition. Indeed, their criticisms of ADHD do not solve the metaphysical problem of indifferentiation inherent to the dialectic; they only smooth it out to make it more tolerable to thought.

ADHD advocates are forced to constantly resist this general state of indifference through recourse to ideologies of scientific progress (i.e., the belief that a reliable biomarker for ADHD will one day be found), but this does not solve the problem of indifferentiation either. As Foucault has argued, the history of disease epistemology—including questions of their ontological status—was never about verifying a biological reality, and I would propose that the same is true of ADHD today. The actual problem confronting ADHD is that it has, historically and institutionally, been forced into the metaphysical role of becoming a generic identity, a highest genus, a grab-bag of diagnoses. Whether ADHD is biological does not change this.

To reiterate, the purpose of this chapter was to work out how this metaphysical stigma surrounding ADHD could be understood through *philosophy* rather than historical analysis alone. In my view, this process of doing philosophy helps to build a framework upon which ontological alternatives to medicalization can be posed. The primary reason for asserting this metaphysical framing of medicalization and calling for an alternative is to *turn against the historical situation* that ADHD finds itself trapped in. Such an alternative—at least more broadly to *representation*—is Deleuze's ultimate project. In the next chapter, I will utilize Deleuze—although sparingly and more in the spirit of this project than his actual project—to begin to work out what it might mean for a syndrome's difference to be supposed *in itself* rather than artificially imposed as an improper concept.

Chapter Five: Difference in Itself

According to sociologist Chloe Silverman, the primary purpose of autistic self-advocacy movements is to establish first, that autism is indeed genetic, and second, that even so, this should *not* justify medical intervention because "autism represents a type of neurological diversity that becomes a disability only due to discrimination and stigma" (Silverman 2011: 143). Autistic self-advocacy groups could be described as what sociologists Vololona Rabeharisoa and Michel Callon call "opposing associations": "fiercely opposing any intervention of established science, which is accused of calling into question the patients' very identity, whose preservation is its chief objective" (2002: 60). While there are varying perspectives within autistic self-advocacy groups, the sense I get is that, generally speaking, autistic self-advocacy does not necessarily oppose scientific research on autism, but rejects the current modes of intervention that occur because of or in the name of such research. They understand autism as an *identity* that medical practitioners or society should not try to "cure"; if there is anything that needs to be cured, it is society itself: its stigmatizing views of autism, its lack of accommodations, and its oppressive practices of assimilation (such as the use of Applied Behavioural Analysis (ABA), discussed in a later section).

To use Hacking's terminology, autistic self-advocacy forged autism into a legitimized "autonomous" or "self-ascriptive kind": "whatever the medico-forensic experts try to do with their categories, the [self-ascriptive kind] becomes autonomous of the labeling" (1995a: 38). Autistic self-advocates "ascribed a chosen kind-term to themselves" that differed substantially from what was prescribed by medicine: people of this new kind "claimed rights to their own knowledges," the known became the knowers, and a "wholly new type of looping effect" emerged (Hacking 1986: 163; 1995a: 381-382). In other words, looping effects on individuals no

longer had to be looped back onto scientific researchers or medical practitioners in order to alter the human kind (to change what it means to be autistic), but could now be legitimately looped on the level of community alone—*self*-advocacy.

In contrast, ADHD self-advocates are all too willing to embrace an intensely medicalized and "interventionist" framing of the disorder without criticism. The primary reason for this is that ADHD self-advocates rely on institutional power for legitimacy. By latching onto the medical and scientific legitimization of psychological categories and neurobiological and genetic knowledge, ADHD self-advocacy hopes to present a strong, united front against the skeptics. In effect, however, their advocacy ends up being reliant on the researchers, psychologists, and neuroscientists who maintain authority over the disorder's legitimacy.[84] This begs the question, are they really advocating for themselves, or is psychiatric power advocating through them in the guise of "self-advocacy"?

For example, when discussed in major ADHD organizations (like CHADD for example), the concept of self-advocacy is framed as a sort of skill-building exercise. In a weekly news post on the CHADD website titled "Self-Advocacy Can Improve Your Life," self-advocacy is described as learning to speak about your specific needs to those around you—your boss, your friends, your professor; even so, they recommend that "you may want to work with an ADHD professional, such as a therapist, counselor, or coach, who can help you explore the areas of your life where you want to practice self-advocacy" (2019). In other words, "practicing self-advocacy" becomes a self-practice of medical intervention. This is in stark contrast to the centrality of the term in the autistic self-advocacy movement, where it is used to express

[84] This reliance may also explain why the term "ADHD" is still used in ADHD advocacy circles despite "deficit" and "disorder" being in the name. Autistic self-advocacy, in contrast, does not use the medicalized label, ASD (Autism Spectrum Disorder).

opposition to the medicalization of the disorder and medical intervention. Indeed, Autism Network International (ANI), one of the major associations of the movement, states on their website that "the best advocates for autistic people are autistic people themselves," and that "ANI is run by and for autistic people" ("Introducing ANI" 2012). Similarly, another major association, the Autistic Self Advocacy Network, uses the tagline "nothing about us without us" ("Autism Research" 2021).

That said, the "neurodiversity movement" (which is basically a continuation of the autistic self-advocacy movement (Nadesan 2013: 205-206) expanded to include other disorders) does try to include ADHD. The "neurodiversity framework" argues that "neurological differences like autism and ADHD are the result of normal, natural variation in the human genome" (Robison 2013: 7). One problem with this inclusion, however, is that, unlike autism, to frame ADHD as neurodiversity, as "normal, natural variations in the human genome" comes awfully close to sounding like critics of ADHD who claim it to be nothing more than, for instance, normal variations in childhood behaviours. As a result, even if there are ADHD groups that adopt the framework of neurodiversity, they are, again, not genuinely advocating for themselves; the autistic self-advocacy movement is speaking for them or through them with a disregard for the specificity of the harm facing ADHD individuals: skepticism and misrecognition. ADHD self-advocates must tread carefully if they choose to adopt the term "neurodiversity."

As the reader may have noticed, I am returning to some of the key topics I brought up in the introduction of this dissertation. Only now I have a robust philosophical framework in place to carry the discussion forward in finer detail. Recall from the previous chapter that ADHD skepticism and misrecognition is held in place by habits of thought that have hitherto remained *transhistorical* and *extra-institutional*. No amount of institutional change or goodwill can free

ADHD from its historical situation *until* a philosophical alternative, a concept of ADHD's difference in itself, is introduced and rehabitualized in thought. That is the ultimate task of the project at hand. We—ADHD *self*-advocates—need to continue our philosophical and conceptual interrogations and deconstruction of medicalization to set the groundwork for this rehabitualization. This includes an analysis of how *autistic* self-advocacy has successfully countered medicalization, but also how the historical situation necessitates an alternative approach for ADHD.

This chapter is split into three parts: (1) the history of the highest identity of disorder; (2) difference in itself and the second aspect of indifference; and (3) the philosophers of white nothingness. The first part explains *why* ADHD found itself in this historical situation (i.e., *why* ADHD was forced into the metaphysical role of the highest identity). I then explain, given their distinct historico-metaphysical placements, how ADHD and autism were faced with different challenges, and how these differences necessitated distinct approaches to self-advocacy. The second part explicates Deleuze's concept of difference in itself, and argues how the dialectic of medicalization gives rise to one rendition of this concept in particular: humanhood-as-difference-in-itself. I point out how this concept corresponds to, or is derived from, the second aspect of indifference toward ADHD. In part three, I explain how the concept of difference in itself evolves in Deleuze and Guattari's later works, and in particular, how it comes to influence and underlie critical theories of subjectification. I then show how the concepts of the autism spectrum and neurodiversity—as concepts of difference in itself—counter these critical theories. Once again, the answer comes down to the notion of *inaccessibility*. What distinguishes neurodiversity is its inaccessibility to neurotypical processes of subjectification. Finally, I indicate why the concept of neurodiversity, now defined in this expanded, critical context, still does not work for

ADHD. The latter's metaphysical role continues to lock it into an ontological generality of humanhood-as-difference-in-itself, not neurodiversity-as-difference-in-itself.

Part One: The History of the Highest Identity of Disorder

In the previous chapter, I discussed ADHD's metaphysical role as the "highest identity" of disorder. If more specific disorders are ruled out, a diagnosis of ADHD is there to save the day. I did not, however, explain why *ADHD* took on this metaphysical role, whereas other psychological categories, such as autism, were spared. The overarching question is, did ADHD take on this position because it is most *ontologically* suited for the role? Or did history *force ADHD into this ontological position*? I argue for the latter. The metaphysical role is what defines ADHD's ontology, not vice versa. An alternative history could very well have forced a different psychological disorder into the role instead.

My argument is that *how* this metaphysical role of the highest identity is historically figured *depends on* whatever "crisis" is facing childhood development in the given time period. I identify five of these crises: the crisis of education in the nineteenth century; the crisis of morality in the late nineteenth and early twentieth centuries; the crisis of intelligence during and after World War II; the crisis of social control beginning in the 1960s; and finally the crisis of attention now facing contemporary schoolchildren. Of course, there are inevitably historical and geographical variations and exceptions to these crises, and the examples I provide are only a rough sketch of the most obvious turns. My goal here is not historical completeness, but socio-philosophical clarity.

The psychological category, "ADHD," is only the latest historical iteration of terms assigned to misbehaving, disobedient, disruptive, or otherwise dysfunctional children throughout the

nineteenth and twentieth centuries. Conventional histories of ADHD trace its scientific study back to the early 1900s, but I am less concerned with tracing its *symptomatic* history than I am in tracing the history of the *highest identity of disorder*. For this, we must look back further, when variations in childhood development first became a *disorder for society*. According to sociologist Nikolas Rose, this occurs with the introduction of universal schooling in England, and a corresponding crisis of education: children who were unable to "reach the standards set by the board of education" became "a source of concern to those who saw the school as a vital moralizing apparatus and an affront to those who considered education to be a right of all citizens" (1990: 140). It is important to recognize the *ontological generality* underlying this identity of disorder: that *all children were expected to be educated, and to be capable of being educated*. When these expectations were undermined, the highest identity of *childhood disorder* came into medical existence as a way to conceptualize the problem: in particular, these children were labeled as "feeble-minded" (Rose 1990: 140). Of course, there were specific exceptions: children who were blind or deaf, despite their own difficulties being educated at the time, were *not* medicalized as feeble-minded because they were grounded in well-understood biological specificities (Rose 1990: 140). They had no need for a generic identity of disorder to determine them.

Throughout the nineteenth century, medicine attempted to break the highest identity down into more specific determinations: "degenerates," "idiots," "imbeciles," and more (Rose 1990: 139-140; Rafalovich 2004: 22-23). Yet, due to the ontological fracture inherent in the dialectic of medicalization, there were always disorderly children who seemed to elude such labels. In particular, these were children who "had a clear understanding of the contents of the law [or classroom rules] and willfully chose to disregard it.... [They] were too intelligent to be

categorized [with] idiocy and too young to be understood as 'criminal minds'" (Rafalovich 2004: 28; Lakoff 2000: 149-150). The perception of these children corresponded to a *new crisis* facing society around the turn of the century: the crisis of morality. As Rose writes, "a [new] class of dangerous children had become visible": "quarrelling, lying, cheating, ... being too outgoing or not outgoing enough... signs of serious trouble to come" (1990: 156). Disorderly conduct was thus reconceptualized by society and medicine as *immoral conduct*, a sign of *moral deficiency*.[85] Once again, medicine tried to break this highest identity down into more specific determinations such as "moral idiocy" or "moral imbecility" (Rafalovich 2004: 25-26). I do not mean to say that previous categories like "idiocy" or "imbecility" (without the "moral" prefix) became outdated or extinct. They were just no longer determined by this highest identity of disorder. They were nominally called "mental disorders," yes, but had their own specific ontologies, and had to first be ruled out before moral deficiency—or one of its more specific determinations—could be diagnosed.

Moral deficiency would continue to characterize the highest identity of disorder until World War II. According to media theorist Kenneth Rogers, WWII created a "crisis of intelligence": the "incapacity of military personnel to appropriately perform tasks of accelerating technical complexity and variation," as well as the problem of how to train soldiers to "respond reflexively to... external disciplinary commands" (2014: 130-131). The solution to this crisis was to standardize (and imbue children with) a concept of intelligence that emphasized individual

[85] The concept of attention—at least in American psychology—first made its appearance from within this moralized framework of disorder. Barkley claims that, in scientific literature, the origins of ADHD began with the work of physician George Still, who in 1902 characterized overactive and inattentive children as displaying a "defect in moral control" (2006: 4). Still cited early American psychologist William James, who believed that a particular kind of willpower—attention—was "the cornerstone of civilized behaviour, a prerequisite to becoming a moral adult" (Lakoff 2000: 149-150). Children who could not maintain focus on the teacher—who could not willfully inhibit their uncivilized impulses—were understood to have a defect in moral control.

consolidation with systems of control (i.e., the more one is able to follow instructions, the more intelligent one is) as well as "wartime vigilance"—maintaining self-control in the sense of not abandoning one's post, and carrying one's assigned task to completion (Rogers 2014: 78-88, 132). In order to standardize a concept of intelligence in this way, wartime vigilance—reconceptualized after the war as *attention*—was made to "appear as a universal human faculty" by American psychology (a universalizing process made easier by the fall of German psychology (phenomenology, etc.) after the war) (Rogers 2014: 132; Teo 2015b: 115-116). As Rogers puts it, attention research "overwrote political morality with psychometrics" (Rogers 2014: 101).

Disorderly children were now understood to entail a new form of cognitive deficiency: a failure to remain vigilant to the teacher and classroom rules; a failure to remain at their "post" (remain seated); and a failure to complete the tasks assigned to them. They were not "mentally retarded" or "morally deficient," they were simply *unintelligent*.[86] Even though the concepts of inattention and hyperactivity obviously constituted this new concept of unintelligence, they remained subordinate to it. This is why, from the 1940s to the 1960s, the dominant medical label attached to disorderly children was "minimal brain damage" (MBD) (Barkley 2006: 6, 8). The name suggests a biological specificity—i.e., soldiers being hit in the head by shrapnel or bullets—but as Barkley notes, this label was applied to children even when there was no indication of brain damage whatsoever (2006: 6). Because of this noticeable absence, MBD would eventually come to stand for "minimal brain *dysfunction*"—an even more generic term for unintelligence.

[86] It is important to recognize that this new concept of intelligence had little to do with the eugenics-based concept of intelligence that had been popular since at least the early nineteenth century. Well-established ontological specificities such as "idiocy" or "mental retardation" that belonged to this "old" notion of intelligence *did not reattach themselves to the highest identity of disorder* after the war; they remained ontologically separated.

Barkley claims that, in the 1960s, "the concept of MBD would die a slow death as it eventually became recognized as vague [and] overinclusive... It would eventually be replaced by more specific labels" (2006: 8). These included dyslexia, autism, language disorders, and learning disabilities. They helped to better explain why some children were not paying attention, not sitting still, and not completing their tasks. Yet, as always, one diagnosis in particular is needed to account for the children whose disorderly conduct cannot be explained by these more specific diagnoses. According to sociologist Peter Conrad, MBD was not "replaced," as Barkley suggests, by several labels, but by one label in particular: "hyperkinetic impulse disorder," a term, popularized in the 1960s, used to describe hyperactive schoolchildren (1975: 12-13). Since there was no standardization for diagnoses back then, MBD would continue to be used by some clinicians until the release of the DSM-III in 1980—but nevertheless, beginning in the 1960s, the term corresponded to a newly figured highest identity for disorder, one now based on the notion of *hyperactivity* (see Figure 5.1).

Figure 5.1: A 1974 Novartis (CIBA) advertisement for Ritalin in the treatment of MBD. One line reads, "an effective agent in the alleviation of the hyper-kinetic disorder."

This historical shift in the meaning of disorder corresponded to a new crisis facing American society beginning in the 1960s: the crisis of social control. The previous crisis of intelligence had been pacified through the establishment of standardized education systems aimed at teaching technical proficiency to children. The ability to use technology for advanced forms of productivity was seen as the "very embodiment of Reason for the benefit of all social groups and interests"; this "good way of life" came under threat by anyone whose behaviour failed to be operationalized toward such technical productivity: thus the rise of behaviourism—and the idea that all disruptive behaviour could be modified (Marcuse 1964: 11, 14). The idea that disorder—*as behaviour*—could be modified helps to explain why pharmaceutical treatment (e.g., Benzedrine, Ritalin, and Dexedrine) for the highest identity of disorder first entered the picture in the 1960s (Conrad 1975: 14-15).[87]

Hyperkinetic disorder was standardized as "Attention-Deficit/Hyperactivity Disorder" (ADHD) in 1980 with the release of the DSM-III. The reason "attention" came to the forefront was due to the work of psychologist Virginia Douglas in the 1970s. Douglas made compelling arguments—reinforced by her studies' findings—that hyperactivity and inattention were theoretically and statistically linked (Barkley 2006: 13; Lakoff 2000: 160). This is unsurprising given that the postwar concept of attention was developed out of wartime vigilance, which

[87] Indeed, stimulant medications had been frequently used by soldiers in WWII not to treat brain damage but to *improve vigilance* (e.g., British and American soldiers taking Benzedrine (essentially Adderall) to stay awake at their posts). Medicated schoolchildren were to become "little soldiers." Notably, a different class of stimulants were used by the Axis powers: methamphetamines and methylamphetamines. These were prescribed to soldiers not only to improve vigilance, but to improve *speed* (e.g., Japanese pilots taking Philopon prior to kamikaze; German soldiers taking Pervitin for use in *Blitzkrieg* tactics (Ohler 2016: 28-29, 67). As one French soldier who survived the German blitzkrieg of France put it, the stimulated Germans were too fast: "our weaknesses were chiefly due to the excessively slow rhythm that our brains had been taught" (in Ohler 2016: 71-72). Today, methamphetamines are popularly known by the street names "speed" or "crystal meth." ADHD medications, in contrast, are amphetamines, methylphenidates, and so on. Nevertheless, the association of stimulant medication with speed would have parents asking, "won't these medications make my child *more* hyperactive?"

emphasized remaining at one's post (i.e., *not* being hyperactive) as well as maintaining focus on one's assigned task and carrying it out to completion. Hyperactivity and inattention, from this American psychological framework, were inextricable. In diagnostic practice, however, hyperactivity continued to hold the highest identity of disorder. In the 1980s, daydreaming children (mostly girls) who were *not* hyperactive but still inattentive were rarely diagnosed with ADHD. As the APA put it, "in a field trial of several hundred children... a clinical diagnosis of Attention Deficit Disorder Without Hyperactivity was hardly ever made"—as a result, the distinction between ADD and ADHD was completely removed in the 1987 publication of the DSM-III-R (revised) (APA 1987: 411). In other words, despite their inattention, these daydreaming children *were not considered disorderly*; as such, they were not diagnosed with anything. Hyperactivity was the bottom line of disorder, not inattention.

This would begin to change in the 1990s, when the crisis of social control was gradually replaced by a crisis of attention. It is difficult to say exactly when the crisis of attention came to the forefront of public imagination. There has been a consistent output of books describing this crisis over the past two or three decades, one example being Maggie Jackson's *Distracted: The Erosion of Attention and the Coming Dark Age* released in 2009. Self-help books—written either for employees or employers—on how to increase attention in the workplace, also became popular (Rogers 2014: 196). The crisis appears to have been manufactured by economists: a whole new economic field came into existence—the attention economy—during the new-media mania of the 1990s—computers, video games, internet, etc.—with the aim of commodifying attention (Rogers 2014: 196). Pharmaceutical companies, for example, began framing ADHD not as a problem of hyperactivity but of attention *scarcity* (see Figure 5.2). As a result of this manufactured crisis, inattention, not hyperactivity, became the bottom line of disorder. In effect,

when everything else is ruled out—*even hyperactivity*—a diagnosis of ADHD-I (the inattentive subtype without hyperactive symptoms, reintroduced by the DSM-IV in 1994) is there to save the day.[88]

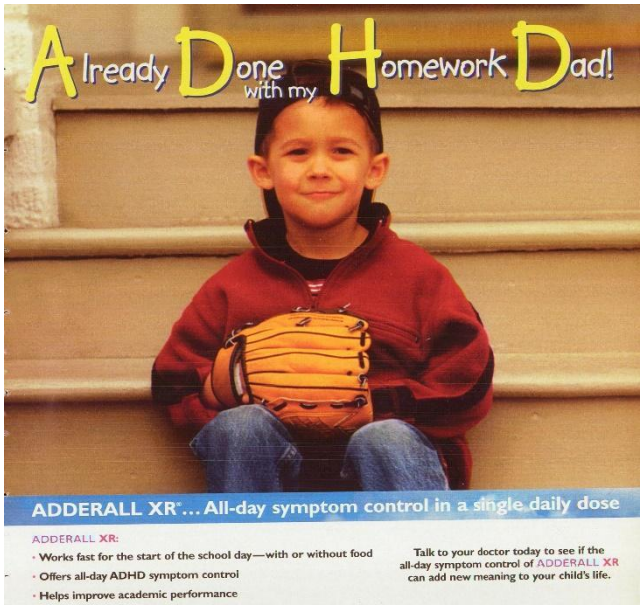


Figure 5.2: An advertisement for Adderall XR: the letters "ADHD" stand for "Already Done with my Homework Dad" (Women's Magazine Archive 2003).

In conclusion, the highest identity of disorder has been gradually whittled down over the past two centuries from a generic inability to be educated to a far more honed—yet still generic—inability to stay focused. This history of childhood crises helps to clarify why ADHD currently holds the metaphysical role of the highest identity. The DSM criteria for ADHD just happens to match the baseline symptoms of what it means to be disordered in general: hyperactive, or more recently, inattentive. This does not mean that ADHD—especially when understood outside of the DSM criteria—is nothing more than a product of these crises.

[88] In a meta-analysis of studies from around the world from 1994 to 2010, ADHD-I, based on both teacher and parent ratings, was estimated to be present in 6.7% of children worldwide, whereas ADHD-H (the hyperactive subtype without inattentive symptoms) was estimated to be present in only 2.9% of children worldwide (Willcutt 2012). This is quite the turnaround from the APA's observation in 1987 that ADHD-I diagnoses "were hardly ever made."

Hypothetically speaking, if history had instead figured childhood disorder as a crisis of, say, *mood* rather than social control in the 1960s and 1970s, perhaps something like bipolar disorder would have taken on this metaphysical role. In this hypothetical alternative, ADHD—or something like it—would surely still have been posited as a disorder by psychologists; only now it would be relatively well-respected by the public and medicine as a legitimate disorder, and not used as a catch-all diagnosis. Bipolar would now be the "made up" disorder, generalizable to all disorderly (moody) children whose behaviours cannot be explained by more specific disorders. If hyperactivity and inattention, having their own specific ontologies, are ruled out, a diagnosis of bipolar disorder is there to save the day. Skeptics would cry, "but mood swings are a normal part of being human!" I do not mean to disparage or misrepresent the symptomatic specificity of bipolar disorder. My point is that no matter how robust a disorder's ontological specificity is, if it is placed in the metaphysical role of the highest identity, its proposed specificity will always be misrepresented, ignored, and reduced to an ontological generality of humanhood.

The Different Ontological Roots of ADHD Harm and Autistic Harm

It is not as if ADHD is lacking in specificities, and *that* is why it had to take on this metaphysical role. There are many theories and beliefs about ADHD's specificities—both psychological and biological—just as there are with other disorders, such as bipolar disorder or autism. But ADHD's metaphysical role always forces it back into generality. For example, as I mentioned in Chapter Three, FR points to the Dopamine Transfer Deficit (DTD) as a specificity for ADHD. Yet, the habits of thought construed by the dialectic of medicalization force her to "divide" ADHD up: DTD becomes a determined "species" of ADHD, while ADHD remains in place as the highest "genus." Similarly, Barkley's theory of ADHD, which specifies it at the level of "behavioural inhibition" (I explicate his theory in Chapter Six), has been criticized by

other psychologists because it only seems to account for *some* people with ADHD but not others (Martella et al. 2020: 3). ADHD's specificities are always subordinate to its generality.

Medicalized *autism* research, on the other hand, appears to move in the opposite direction: it takes autism's proposed ontological specificity as primary, and filters out those who do not fit this specificity as *not autistic*. For example, autism advocates Jacquiline den Houting et al. state that "one highly influential theory of autism describes autistic people as having theory of mind deficits" and that this has become a "deeply ingrained bias within the autism research and practice establishment" (2021: 840). One aspect of this theory is that autistic individuals cannot "infer the mental states of others" because they do not make eye contact (Hagen et al. 2014: 1485). As a result, some clinicians use this theory—or diagnostic guidelines based on it—to specify whether someone is autistic or not (see Figure 5.3).

Figure 5.3: Autistic self-advocacy comic illustrating how the theory of mind deficit can create a barrier for getting diagnosed (Schnumn 2022).

In my view, the influential power of the theory of mind deficit in psychiatry, medicine, and psychology helps to clarify one of the key differences between the development of ADHD and autistic self-advocacy: both were forced to respond to ontological harm, but in the case of autism

that harm is based in its proposed *specificity* whereas for ADHD it is based in its *generality*. Perhaps the most well-cited definition of the theory of mind deficit is the one provided by prominent, though controversial, autism researcher Sir Simon Baron-Cohen: he defines it as a failure to "reflect on the contents of one's own and others' minds" (2001: 169). I already described this theory in Chapter One in the context of Hacking's discussion of autism and "inaccessible kinds": it involves the bigoted ideas that autistic people cannot learn to communicate but can only echo what other people say; that they can only imitate social behaviours but not learn them organically; that they lack empathy; and that they "reflect a profile of a stoic, unfeeling, emotionless automaton" (Vance 2019). In short, it is the belief that autistic individuals cannot "construct a theory of the minds of others in order to attribute beliefs and intentions to their actions" (Rose and Joelle Abi-Rached 2013: 149).

This theory is thought to explain how autistic individuals are *ontologically different* from other humans, in the sense that they correspond to a different "philosophy of mind." This meets Hacking's criteria of a meaningful ontological difference—something which ADHD presumably lacks (1995b: 221, 222). The theory of mind deficit is, no doubt, harmful, as it *dehumanizes* autistic individuals. As Sir Baron-Cohen writes, "a theory of mind remains one of the quintessential abilities that makes us human.... Theory of mind difficulties seem to be universal among [autistic] individuals" (2001: 169). This dehumanizing ontological belief has led to all kinds of harm perpetuated against autistic individuals—mistreatment, stigma, misrecognition, and so on.

Although there are certainly some similarities in the harm experienced by ADHD individuals and the harm experienced by autistic individuals, my point is that the ontological *roots* of these harms are fundamentally different. For ADHD, the predominant form of harm,

misrecognition, is rooted in its ontological placement of the highest identity of disorder, an ontological generality that leads to widespread skepticism. This is not the case for autism, whose "existence" is rarely ever questioned (Béliard, Ortega, and Velpry 2022: 621). Autistic self-advocacy did not need to convince the public that autism represents an ontologically-meaningful difference, because it was not forced into this generic, metaphysical role. Autism's difference was never questioned in the same way ADHD's was.[89]

Nevertheless, autistic individuals have continuously faced great harm, much of it presumably stemming from this theory of mind deficit (assuming one can even trace where many of these harmful attitudes and practices come from). To counter this harm, autistic self-advocacy fights for autism to be recognized as *equally human*—and from this emerges the concept of *neurodiversity*: the idea that autism represents "natural variations of cognition, motivations, and patterns of behaviour within the human species," as one community-based definition puts it ("What is Autism?" 2019). In other words, they fight for autism to be understood as an ontological *generality*, an ontology that accepts them as *fully human*.

One would think that embracing an ontological generality of humanhood would render autism, as an identity, ontologically suspect, just as it does for ADHD. But nothing of the sort happens. Autistic self-advocates can revel in the humanness of neurodiversity and all the while still hold onto autism as an affirmative identity that makes them uniquely different from "neurotypicals." In my view, they accomplished this feat by freeing themselves from the habits

[89] Consider, for example, how in the 1960s, the major form of stigma surrounding autism was that it was caused by bad parenting (Silverman 2011: 143). This did not represent skepticism toward the existence of autism; on the contrary, it was precisely because autism was accepted as a bonafide disorder that parents were shamed for causing it. This form of stigma (including the similar belief that autism is caused by vaccines) has been the key target of much *parent* autism advocacy since the 1960s, and the primary reason for them to insist on a genetic basis to autism (Silverman 2011: 143). In contrast to ADHD, insisting on a genetic basis to autism targets *etiologically*-based harm, not ontologically-based harm.

of thought forced on them by the dialectic of medicalization. They developed their own concept of *difference* for autism. In other words, they developed a primary ontological specificity—a difference that specifies what it means to be autistic—that cannot be classified as a categorical difference, *nor as an individual difference*. Instead, it is what Deleuze calls a "difference in itself" (1994: 28).

Very briefly, a similar approach to autistic self-advocacy can be observed in the "Dingdingdong Collective," the Institute for the Co-production of Knowledge about Huntington's Disease, with chapters currently located in Brussels and Paris. Huntington's Disease is peculiar in that, unlike most genetic-based diseases or disorders, it can be reliably traced to the presence of a *single gene,* which is present in all cases of the disease. It is, in some ways, the exact opposite of the highest identity of disorder. Its biological specificity is absolute. As Alice Rivières puts it in her "Dingdingdong Manifesto," the genetic test used to diagnose Huntington's "transformed medicine into the provider of singular forms of truth, truth-which-cannot-lie, the specificity of which is to crush all others" (2021: 29). Nevertheless, the Dingdingdong Collective rejects the notion that the ontology of Huntington's Disease can be reduced to its genetic specificity. Rivières states that, even though she tested positive for the gene, she cannot say yet whether she is a "Huntingtonian" because the Collective first needs to work out what that means beyond the medical definition (2021: 39-40). She writes, "it's not a collective *against* anything—against the disease, for instance—but rather *for* building something that does not as yet exist, above all, a specifically Huntingtonian way of thinking" (2021: 37). In short, the Collective aims to cultivate *affirmative knowledge* surrounding what it means to be Huntingtonian outside of the dialectic of medicalization; i.e., what makes someone with Huntington's Disease *different* in a way that cannot be reduced to genetic (categorical)

difference, on the one pole, or reduced to an ontological generality of humanhood (variations of individual difference) on the other. Huntington's, like autism, is "*a world* which is theirs and *resolutely not ours*" (Rivières 2021: 40; emphasis added). This ontology of Huntington's—a world that "needs [its] own language, [its] own mythology, [its] own founding texts"—clearly transcends an ontology of individual variation of being human. Is it possible to cultivate a similar sort of affirmative knowledge for ADHD?

Part Two: Difference in Itself and the Second Aspect of Indifference

Intuiting and Feeling ADHD's Difference Despite Having No Concept of It

There are two aspects of indifference toward the highest identity of disorder (ADHD). The first aspect is the recognition that ADHD's primary ontological difference does not correspond to a concept of categorical difference, but *individual difference*. Whereas ADHD self-advocates might believe that the empirically-observable difference between an "ADHD brain" and a "non-ADHD brain" (for instance, as shown in brain-scan imagery) is a "real difference" because it supposedly corresponds to "biological reality,"[90] ADHD skeptics who are indifferent to ADHD reject this idea. From their perspectives, individual difference—the empirically-observable differences between unique children in a classroom—is "real difference" whereas ADHD's proposed specificity is only an "extrinsic difference," or a "socially-constructed difference."

Part of the reason that ADHD skeptics and ADHD self-advocates do not get along is because the latter tend to ground their advocacy in intuition and feelings, not philosophical debate. In the self-advocacy view, ADHD's difference—regardless of how it is conceptualized—

[90] As one ADHD individual describes, "during a course 'ADHD for adults' there was a picture demonstrated with 'these are neurons, this is what they do in normal people and this is what they do in you.' ... This was beautifully explained with clear images and it made a huge impression on everybody" (quoted in Brenninkmeijer 2010: 119).

is *ontologically intuitive and affective*. ADHD can be intuited in others by those who understand the complexity of the disorder on a phenomenological level (such as clinicians specializing in ADHD), or by those who actually have ADHD (even if they do not realize that they have it). For example, "people with ADD tend to find each other—you may see someone across the room is as fidgety as you are and you are drawn to them" (Sarkis 2011: 106). ADHD's difference can also be *felt*. As one ADHD individual describes it, "I have always felt that I think differently from most people" (quoted in Hallowell and Ratey 1994: 97). Similarly, Hallowell writes, "I have developed a 'feel' for ADD not just as a diagnostic entity but as a style of living" (1994: xi).

Left undiagnosed, this "feeling" can become one of "what psychiatrists call 'dysphoria'": "a feeling of unease [that] doesn't have a context or even a name. It's just life.... It is simply a part of you" (Hallowell and Ratey 1994: 173). In other words, this difference, when left undiagnosed, is sometimes felt as an *individual difference*, as just part of one's unique personality. ADHD skepticism would have us believe that this is all that ADHD is: that this difference *is* individual difference. But ADHD self-advocates would disagree. For them, a diagnosis of ADHD can help the individual to recognize that he or she is not alone in this difference, that it is not an individual difference but a *categorical difference*. In other words, ADHD becomes conceptualized as an *identity* that distinguishes one group of humans (ADHD individuals) from others (non-ADHD individuals). As one member of my ADHD student support group put it, "it's like, you're different, you are different. I am not like my husband, he does not have ADHD. I do have ADHD. This [support group] is helpful because it's a comfort to know that it's not just me."

By assuming an identity for this felt difference, the dysphoric feeling described above can be transformed into one of "psychological integrity" (Maté 2000: 4). As ADHD physician Gabor

Maté writes, “it gives *coherence*, for the first time, to [ADHD symptoms]” (2000: 4). Similarly, Hallowell and Ratey write, “finding at last that there is a name for it constitutes a large part of the treatment” (1994: 15). As one ADHD individual put it, “I thought I was just spacey, the ‘dizzy dame’ stereotype.... Then I found out about ADD and everything made sense for the first time” (quoted in Hallowell and Ratey 1994: 78).

Many ADHD self-advocates, however, do not like to conceptualize ADHD’s difference as an identity. As the moderators of the ADHD subreddit put it, “ultimately what we object to is the framing of ADHD as identity” (“Position on Neurodiversity” 2022). ADHD self-advocates would prefer to establish this intuitive and affective difference as a thinkable concept *outside of identity*. Hallowell and Ratey, for example, state that “there is no clear line of demarcation between ADD and normal behaviour. [But] what differentiates pseudo-ADD from true ADD, what differentiates the people who can *only identify with it* from those who *actually have it*, is a matter of duration and [severity] of the symptoms” (1994: 42, 193; emphasis added). Unfortunately, due to the restrictive habits of thought placed on discourse by the dialectic of medicalization, Hallowell and Ratey’s concept of ADHD’s difference only folds back into individual difference. They write, “one must make a judgement based on a comparison of the individual child to his or her peer group” (1994: 42).

Hallowell and Ratey believe this works because, in their eyes, “true” ADHD corresponds to a neurobiological or genetic difference. For them, this is what causes individual differences in terms of frequency and severity of ADHD symptoms. Yet, asserting a biological basis to a disorder does not solve the problem of equivocity (because normal human variation, too, has a biological basis). The concept of “biological reality” is nothing but a crude expression of the habits of thought we so desperately need to detach ourselves from. As always, any attempt to

propose a concept of difference for ADHD immediately folds back into the dialectic of medicalization—either as individual difference or as categorical difference. This is why ADHD self-advocates need to develop a concept of *difference in itself* for ADHD: to establish *conceptual* coherency in what it means for ADHD to exist. *Affectively*, ADHD individuals have already found this coherency, this "psychological integrity," but have no language or discourse to philosophically ground it; ADHD's ontological coherency can be *felt*, but not yet *thought*.

Difference in Itself According to the Second Aspect of Indifference

The second aspect of indifference is the recognition that individual differences are *also* imposed upon the world, and do not correspond to a proper concept of difference either. The second aspect contains within it the first; the solution, then, is not to retreat back to categorical difference. Rather, the natural outcome of the second aspect of indifference is to develop a concept of difference in itself. And this is precisely what Deleuze does after criticizing Aristotle's bidirectional and bipolar ontology. As Deleuze describes this new concept, "instead of something distinguished from something else, imagine something which distinguishes itself—and yet that from which it distinguishes itself does not distinguish itself from it" (1994: 28).

Medieval philosopher Duns Scotus, one of the key influencers of Deleuze's early work, offers a visual example. He uses the concept of white's "intensity" to describe difference in itself. The colour white can be more or less intense without becoming something other than itself: "the intensity expresses an intrinsic grade of whiteness in itself" (Scotus 2016). Differing intensities of whiteness allow whiteness to distinguish itself; it does not need to be placed beside something other than itself, say blackness, in order to for its differing intensities to be perceived by humans. Neither does whiteness become other from itself when it becomes more or less intense: it remains white.

Although Deleuze and other philosophers have employed this concept of "intensive difference" across many fields of study and for various purposes, I am only interested in how it has been employed *by the general public as a result of the second aspect of indifference toward the dialectic of medicalization*. To clarify, most people do not recognize the ontological fracture inherent in medicalization, but there is *one exception*: they recognize that something is not quite right about the highest identity of disorder, ADHD. I have repeated throughout this dissertation that, due to ADHD's generic identity, its ontology is constantly reduced to the generality of individual variation within humanhood. But something I never really explained is why such a reduction would, philosophically speaking, lead to a belief that "everyone has ADHD," or allow physicians to always diagnose ADHD as a "last resort." After all, if it is generally understood by the public that only *some* individuals experience ADHD symptoms frequently or severely enough to meet the criteria, then why would "everyone have ADHD"? The answer is that the *second* aspect of public indifference towards ADHD reduces it not only to individual variation, but to a *concept of humanhood as difference in itself*—a concept of difference in itself that is, at least implicitly, understood by the general public.

Humans differentiate themselves in so many endless ways—varying "intensities" of characteristics, traits, habits, behaviours, pathologies, tastes, and so on. Of course, we like to categorize and classify humans into different "kinds" of people, or as having different "disorders" based on what we—as a society—have deemed normal and abnormal. But do we really need to do that in order to intuit and feel that someone is uniquely different? As Rose puts it, "difference is not pathology, and we have more to learn from recognizing such diversity than we gain from insistence on an ideal of normality" (2018: 188). In a certain sense, one of the underlying ideas behind anti-psychiatry is that we can intuit and feel human differences without

relying on impositions of normativity, categories, types, or kinds to make those differences legible or perceivable to us. When we encounter other human beings in the world, we intuitively and affectively experience their difference in itself. In other words, that person's humanity distinguishes that person as a unique human being, and it does so without needing to compare him or her to other human beings. This is a very intuitive concept of humanhood-as-difference-in-itself. At face value, this concept may sound equal to that of individual difference or individual variation, but in the next section I will explain the distinction more clearly.

Why does reducing ADHD to an ontological generality of humanhood-as-difference-in-itself lead to the idea that "everyone has ADHD"? In contrast to, say, Hallowell and Ratey, who argue that there are "real differences" between individuals in their capacity to stay focused or sit still, ADHD skeptics understand inattention and hyperactivity to be part of humanity's *intensive differences*. That is, according to the second aspect of indifference toward ADHD, inattention and hyperactivity are not understood as permanent qualities of an individual, behaviours that should warrant permanent classification; instead, all humans experience varying intensities in focus and energy from day to day. Inattention and hyperactivity belong to all of humanity. They should not be reified as individual differences set against a norm (i.e., as attention "deficits"), nor pathologized as a categorical difference, "ADHD." This second aspect of indifference towards ADHD—that it is reducible to the generality of humanhood—is where the sentiment that "everyone has ADHD" comes from.

In the case of autism, the theory of mind deficit constitutes a widely-accepted ontological basis for autism's *categorical* difference: a theory that specifies what makes autistic individuals *different from humanity*. In turn, autistic self-advocacy developed a concept of difference in itself—neurodiversity—that argues for their humanity. Yet, there remains a philosophical tension

between the concept of neurodiversity and the concept of humanhood-as-difference-in-itself: namely, the neurodiversity movement embraces identities like autism and ADHD (at least in their supposed demedicalized form), and construes itself largely in opposition to "neurotypicality." In contrast, those who explicitly argue for a concept of humanhood-as-difference-in-itself, such as Rose, would surely view neurodiversity as *philosophically* misguided, insofar as it still asserts, in line with the liberal projects of governmentality, *identities as categorical differences* (e.g., a "neurodivergent identity"). However, as I argue in the next section, what is novel about autistic self-advocacy's concept of neurodiversity is precisely how it escapes the projects of liberalism, and how it retunes the concept of difference in itself in a way that allows for an identity like autism to be affirmatively embraced *without collapsing back into the dialectic of medicalization*. I argue that autistic self-advocates are able to accomplish this precisely because the specificity of autism (its difference in itself) sidesteps the totalizing character of critical theories of subjectification. My further argument is that ADHD self-advocacy must also show how ADHD's difference in itself can sidestep critical theories of subjectification—but due to ADHD's unique symptomatic specificity, this must be argued in an original manner, something I will attempt in the next, and final, chapter.

Part Three: The Philosophers of White Nothingness[91]

Critical theories of subjectification outline the process of becoming a subject, self, or person in advanced liberal societies. They are "critical" insofar as they view subjectification *not* as a process of uncovering and learning internal truths about oneself, but as a process of having one's internal sense of self, personality, individuality, and identity *constructed* and *imposed* by external

[91] I do not mean to generalize the entire canons of these philosophers' works as white nothingness; I am referring to just specific parts of their philosophies—in some cases, found only in a single essay.

discursive structures. Such theories are *totalizing*. They are presumed to offer a *complete understanding* of the nature of subjectivity and, in turn, of psychiatric disorders: namely, that such disorders are a consequence of discursive processes of subjectification, and do not correspond to any internal, non-discursive "truth" about an individual. Put differently, critical theories of subjectification do not suppose the existence of a difference in itself for any *specific* psychiatric disorder.

In other words, it is precisely these processes of subjectification that *give rise to* an intuition or feeling of ADHD's difference in itself even though, from the perspective of these theories, such a difference does not truly exist. In the dialectic of medicalization, ADHD of course does have an identity, but regardless of whether this identity is framed as a socially constructed human kind, a psychological category, a brain type, a disease entity, a singular etiological cause, or whatever, it can never correspond to a difference in itself. In actuality, differences are continuously manufactured by these processes of subjectification—disciplinary societies, psychological apparatuses, neuroscientific technologies, and more.

Such a critique would surely view my project as an extension of liberal politics and a consequence of the widespread subjectification of ADHD in society. That is, I have internalized ADHD as a core identity to my selfhood, believed it to be so fundamental to who I am as a person, that I cannot reconcile that it *has no difference in itself*. I cannot accept that it is nothing more than a normal part of being human—something that everyone experiences—because I have been duped into believing that ADHD is more than that—duped by extraordinarily powerful institutions (psychiatry, pharmacology, psychology, neuroscience, and liberal politics).

Critical theories of subjectification belong to what I call a "philosophy of white nothingness." I use the phrase "white nothingness" to refer to the second aspect of psycho-

metaphysical indifference described in the previous chapter.[92] There I defined this second aspect as an indifference toward an ontology of individual variation. Those who are in this second state of indifference reject the idea that individuals (or individual behaviours or symptoms) actually have ontologically-meaningful differences between them at all.

For philosophers of white nothingness, if differences are said to exist between unique individuals, they must have been artificially constructed and imposed by society (i.e., subjectification). As sociological theorist Georg Simmel observed firsthand in the social changes stemming from the rise of metropolises, city-dwellers increasingly adopted a "blasé" attitude toward "things" and "experiences": "they appear… in a homogeneous, flat and grey colour with no one of them worthy of being preferred to another" (2011: 329-330). As a result of this increasing homogeneity of life, individuals had to develop new ways to stand out from the crowd: "extremities and peculiarities and individualization must be produced and they must be over-exaggerated merely to be brought into the awareness even of the individual himself" (Simmel 2011: 338).

In a similar vein, Rose argues that, through the development of psychological institutions over the course of the twentieth century, individuals became "intensively governed": "thoughts, feelings and actions may appear as the very fabric and constitution of the intimate self, but they are socially organized and managed in minute particulars" (1990: 1). Through these historical processes, the production and over-exaggeration of individual characteristics observed by

[92] The phrase is used by Deleuze in an attempt to offer a visual representation of this field of indifferentiation: a sea of "white nothingness... upon which float *unconnected determinations*" (1994: 28). They are "unconnected" because there are no classificatory differences—categorical or individual—to tie them together. Yet they are "determined" because they have been absorbed into a sort of white monism, a oneness of being from which they can be differentiated intensively without becoming other from the whiteness. Scotus, in a sense, was the first philosopher of white nothingness.

Simmel, once churned through the psychological apparatuses of the twentieth century, now come to appear as *static*, permanent features of the individual, defined through one's personality, biography, upbringing, experiences, tastes, genetic makeup, intellectual capacities, neurological divergences, and so on: individual variation.

Rose draws heavily from the theoretical framework of Foucault, who argues that modernity—or more precisely the emergence of state powers—gave rise to individuality through newly established processes of subjectification. Foucault writes, "the individual is the result of… procedures which pin political power on the body. It is because the body has been 'subjectified,' that is to say… it has been psychologized and normalized… that something like the individual appeared, about which one can speak, hold discourses, and attempt to found sciences" (quoted in Hook 2007: 8). What is interesting about Foucault's theory is that it rejects the notion that the individual—as *being*—ever existed before the introduction of subjectification processes (Hook 2007: 31). For example, according to Rose, only through the introduction of disciplinarity can the unique individuality of each and every child—and the differences or similarities between them—be imposed, "rendered thinkable," and made "scientifically legible, inscribable, and calculable" (1990: 147).

> Universal schooling gathered together large numbers of children in the same physical space, and sought to discipline them according to institutional criteria and objectives. It thus established norms of conduct and performance that organized behavioural space and enabled divergences between children to be charted. (Rose 1990: 136)

As Foucauldian scholar Derek Hook notes, “the psychological individuality produced is both potentially endless… and endlessly distinctive (disciplinary individuals must be unique, always discernible from one another).... Disciplinarity cultivates differences” (2007: 30-31).

This Foucauldian idea that people do not have individuality (excluding “corporeal singularity”) until subjectification processes come into play has been met with skepticism (Hook 2007: 48). As Hook asks, how can there be no individual differences prior to subjectification if subjects, assembled by many of the *same* apparatuses, institutions, techniques, and technologies, are conversely so *different* from one another? Surely, he writes, “some quality, some degree of *differentiability*, is a precondition for disciplinary discursive productions of difference,” “a type of individual difference that disciplinarity *builds upon*, animates and extends, rather than producing from the ground up in a total or originating manner” (2007: 48-51).

One common-sense answer to Hook’s concern is to dialectically turn the concept of individual difference back on its essentialized head, forming social groupings or collective types as ontological explanations for (or “real categories” that explain) individual difference, often grounded in neuroscience or geneticism. For instance, it is supposed by many individuals diagnosed with ADHD that they are the way that they are because they were born with a natural “brain type” called “ADHD.” Hacking’s concept of looping effects is an example of how this dialectical process reinforces itself, where select characteristics of a person are intensely magnified, reinterpreted through a certain diagnostic lens, and then consciously or unconsciously self-exaggerated by the individual in order to fit a certain “kind of person” or diagnosis. In turn, this can reinforce a scientific belief in a bonafide transhistorical “natural psychology” that could theoretically predate or precede subjectification processes. As anthropologist Matthew Wolf-Meyer writes, “this performance of the self is precisely the kind of essentialization of identity

that liberalism requires, and, in so doing, takes what is socially constructed (e.g. a diagnosis like autism) and makes it natural and seemingly self-evident" (2020: 17).

Philosophers of white nothingness, however, take a different approach to answering Hook's inquiry. They develop a concept of difference in itself that accounts for human differences without relying on categories, identities, *or* an ontology of individual variation to explain those differences. In particular, they perceive human differences as a *singular monism*, a oneness that can only distinguish itself from moment to moment but can never become other than itself. For example, Deleuze claims that "very small children all resemble one another and have hardly any individuality, but they have singularities: a smile, a gesture, a funny face—not subjective qualities" (2001: 30). In other words, it is not that children, prior to subjectification, are identical to one another; rather, they are "infused with immanent life": "one is always the index of a multiplicity, an event, a singularity, a life" (2001: 30). These are terms Deleuze uses to try to parse out an alternative to an ontology of individual variation that still respects the "singularities" of children without having to impose static differences between them. All children behave *as children*; their behaviours cannot distinguish them from other children in any classificatory or permanent way, as their behaviours belong to *all* children—the monistic whole of childhood behaviour. As Rose states, "children are ephemeral, shifting, elusive, changing before one's eyes, hard to perceive in any stable fashion" (1990: 146). This monism—where behavioural singularities distinguish themselves from moment to moment, but can never distinguish one child from another child in any permanent fashion—exemplifies Deleuze's generalized application of the concept of difference in itself.

However, as Rose points out, this concept does not only apply to children, but to humans of all ages: "for Deleuze and Guattari, humans… are more multiple, transient, nonsubjectified than

we so often are made to believe…. These nonsubjectified forms they term 'haeccities'—modes of individualization that are not those of a substance, a person, a thing, or a subject"; instead, "you are a longitude and a latitude, a set of speeds and slownesses… a set of nonsubjectified affects" (1998: 170). He calls these nonsubjectified alternatives, following Deleuze and Guattari, "assemblages" of the self, or "folds in the soul" (1998: 171, 36). In other words, underneath our subject-formation lies this *lawlessness* of ever-changing human singularities that continue to define us in non-deterministic and unpredictable ways.

Philosophers of white nothingness Adrian Johnston and Catherine Malabou reach similar conclusions. Johnston claims that, as a condition for the "immanent genesis of subjectivity," "all that exists are heterogeneous ensembles of less-than-fully synthesized material beings, internally conflicted, hodgepodge jumbles of elements-in-tension—and that is it" (2013: 37). Malabou, on the other hand, frames this concept of humanhood-as-difference-in-itself in the context of brain plasticity. Due to an infinite potentiality of plasticity (an infinite number of ways in which environment, experiences, upbringing, and other developmental processes can endlessly shape the brain), "we are no one," that is, no static, unchanging individual: "we may be no one," she writes, "but this impersonality is plastic, which means that this absence of subjectivity is paradoxically malleable, fashionable, so that each of us is no one in his or her own way" (Malabou 2016: 28). "We are no one" insofar as we are not fully-formed subjects and do not have *one* single way to become; but we are "no one in his or her own way" insofar as our neurobiology (always intra-acting with the social) distinguishes us as unique singularities from moment to moment.

Rose also takes a similar approach in his theory of subjectification, but with a twist. He argues that these "haeccities"—these singularities that distinguish themselves in individuals but

do not distinguish individuals from each other—*will* eventually result in fully-formed subjects. In other words, some of these singularities will eventually become *static*, interpreted as subjective qualities to which the individual clings onto as internal truths about what makes him or her a unique individual. According to Rose, this happens because power apparatuses—psychology, the state, corporate capitalism, disciplinary society, and so on—have appropriated the lawlessness of difference in itself by making it *lawful*: manipulating, configuring, and institutionalizing it into a complex network of discursive strategies and techniques to churn out productive citizens and consumers:

> [Deleuze and Guattari's] concept of the fold… suggests a way in which we might think of an internality being brought into existence in the human being without postulating any prior interiority…. Perhaps we might think of the power that modes of subjectification have upon human beings in terms of such an infolding…. That which would be infolded would be anything that can acquire authority: injunctions, advice, techniques, little habits of thought and emotion, an array of routines and norms of being human—the instruments through which being constitutes itself in different practices and relations. These infoldings are partially stabilized to the extent that human beings have come to imagine themselves as the subjects of a biography, to utilize certain "arts of memory" in order to render this biography stable, to employ certain vocabularies and explanations to make this intelligible to themselves. (1998: 37-38)

Subjectification is thus the social, political, and technological control and determination of ever-changing human singularities by these power apparatuses.

Neuroscience is one such example of a contemporary power apparatus that participates in this reining-in of difference in itself to construct a static subject, even if doing so contradicts its own findings. As Johnston writes, "one must ignore the ideological falsifications of the empirical data divulged by the neurosciences…. If anything, the natural sciences undeniably indicate that the body is far from being wholly and completely lawful, and that there is a lawlessness inherent within the very materiality of human bodily existence" (2013: 90-91). Malabou offers what might be called a "strong" theory of neuroplasticity, an endless neuro-infolding of the human brain with its social and environmental surroundings. In contrast, many neuroscientists subscribe to a "weak" theory of neuroplasticity that ends, for instance, after the brain is "fully developed" (around age 30) or is severely limited in scope (e.g., the belief that most of the brain remains unchangeable except for a few malleable areas). As sociologist Martin Hartmann writes, "despite the fact, then, that many brain researchers conceptualize the brain as an open and plastic structure that interacts with its environment and thereby takes on individual characteristics, there is still a strong tendency to downplay this plasticity and emphasize early processes of lifelong determination" (2016: 78). If Rose's theory is correct, neuroscientists tend to hold onto this weak theory of plasticity because it corresponds to the individuating tendencies that advanced liberal societies call for: reification of the individual via the perpetuation of neuroreductive thinking.

In summary, these philosophers of white nothingness provide a concept of difference in itself that provides an alternative understanding of what human singularities look like prior to processes of subjectification, but also how such heterogeneous assembles of singularities, as "citizens *in potentia*" (Rose 1990: 122), can be manipulated and controlled by these processes to

produce and impose static individual differences (unique personalities, biographies of the self, etc.) and categorical differences (diagnoses, kinds of people, etc.).

How the Specificity of Autism Calls into Question the Totalizing Character of Rose's Theory of Subjectification

Autistic self-advocacy has, at least implicitly, called into question the *totalizing* character of critical theories of subjectification. Rose's theory of subjectification at face value seems to explain the origins and social construction of autism. In brief, he argues that standardizations of normality were constructed by psychology to create regularities in individual conduct in order to ease governance of these subjects. A perception of abnormality and mental pathology did not precede or incite psychology's emergence; rather, psychology "scrutinized and studied" human singularities (especially in children) in order to demarcate normativity in a way that would prove most effective for governance. As Rose writes, "normality is not an observation but a valuation. It contains not only a judgement about what is desirable, but an injunction as to a goal to be achieved," i.e., "the projects of the government of children" (1990: 133). Repetitions of human singularities that were deemed abnormal were put under the purview of psychological specialists and experts, given a name (such as "autism"), diagnosed, and treated. Individual and categorical differences relating to socio-psycho measurements of thought and behaviour were imposed and inscribed onto these newly formed subjects. In turn, these processes gave rise to discursive technologies that aimed to reform or cure these subjects and make them into docile and productive citizens (Rose 1998: 70).

According to Rose, psychological apparatuses sought to "produce individuals who *attributed a certain kind of moral subjectivity to themselves* and who evaluated and reformed themselves according to its norms" (1998: 78; emphasis added). "To govern in a liberal way," writes Rose,

is “to govern subjects as responsible but free citizens,” to know their inner psyches, and to pass that knowledge onto them *so that they can govern themselves* (1998: 69). As discussed in Chapter One of this dissertation, the specificity of autism that Hacking identifies is its presumed inaccessibility to certain discursive forces. One description of this inaccessibility is the theory of mind deficit, the belief that autistic individuals cannot “construct a theory of the minds of others in order to attribute beliefs and intentions to their actions” (Rose and Joelle Abi-Rached 2013: 149). When considered in the context of Rose’s theory, this inaccessibility would imply that autistic individuals cannot, or at least have much more difficulty, internalizing a “kind of moral subjectivity” that liberal governments expect of its citizens in order to govern themselves.

As Hacking notes, however, a less-bigoted and more accurate way of thinking about the syndrome’s inaccessibility is to propose that autism represents a “different form of life” (2009: 56). Autism requires a different set of discourses to describe its “inside,” and to explain why it is inaccessible to dominant forms of governmentality. For example, one community-based definition of autism provides an explanatory alternative to the theory of mind deficit:

> All autistic people experience the human social world significantly different from typical individuals. The difference in autistic social cognition is best described in terms of a heightened level of conscious processing of raw information signals from the environment, and an absence or a significantly reduced level of subconscious filtering of social information. Autistic children tend to take longer to learn how to decode non-verbal signals from the social world. (“What is Autism?” 2019)

Another possible way of putting this—in the context of Hacking and Rose—is to suggest that autistic individuals—or rather, "autistic singularities"—are largely inaccessible to *neurotypical* processes of subjectification.[93]

In other words, autistic individuals have an inability or difficulty in taking on faith alone the supposed "truths" of normalized forms of social discourse or structures. So much so that psychologists sometimes resort to severe forms of therapy that try to force neurotypical subjectification onto the autistic individual, such as Applied Behavioural Analysis (ABA).[94] As critical autism scholar Patty Douglas writes,

> ABA, frequently recommended by autism teams to teachers and families, is a normalising tool which works directly on the body as a form of disciplinary power, a programmatic attempt to produce docile, (non)autistic bodies, eventually governable through "freedom" within the project of inclusion. ABA... work[s] directly on autistic bodies in an attempt to *normalise* movements, use of time, occupation of space, pattern of eye gaze, and

[93] It is not my intention here to develop an all-encompassing ontology of autism. I am strictly working within the confines of Hacking's arguments (explicated in Chapter One), Rose's theory of subjectification, the philosophies of white nothingness, and a few instances of autistic self-advocacy or critical autism literature.

[94] In his ethnographic study of an ABA ward for autistic youth, STS scholar Ruud Hendriks describes it as a "simulation model of ordinary life." One of the underlying assumptions in ABA is that autistic individuals are "machine-like," insofar as they do not comprehend "abstract meanings" but respond well to machine-behavioural cues. For example, one autistic individual, Peter, is said to not understand the meaning of "waiting" at the dinner table. He would rather eat his food in a hurry and then leave to do something else. To counter this "inappropriate" behaviour, he is taught to eat a quarter of his meal, and then set an egg timer for ten minutes. Only when the timer goes off, is he allowed to eat another quarter of his meal. He repeats this four times so that he remains at the dinner table for an "acceptable" amount of time. He is said to understand the egg timer, but not understand social symbolic meanings. By using machines such as the egg timer, Peter is able to "simulate" human behaviour (Hendriks 1998: 405-408). Hendriks himself attempts to justify ABA by suggesting that "there is a risk of... *hurting* autistic people, *precisely by treating them as fellow human beings*"—for example, misreading an autistic individual's desire to eat their meal quickly and leave the table as an intentional slight against the chef (1998: 411, 410). While Hendriks correctly identifies such misreadings as a frequent kind of harm perpetuated against autistic individuals, two decades of autism self-advocacy literature since this piece was written makes it clear that ABA is not the solution to such harm.

> engagement with academic work, in this way "readying" such students for the project of inclusion. (2010: 114)

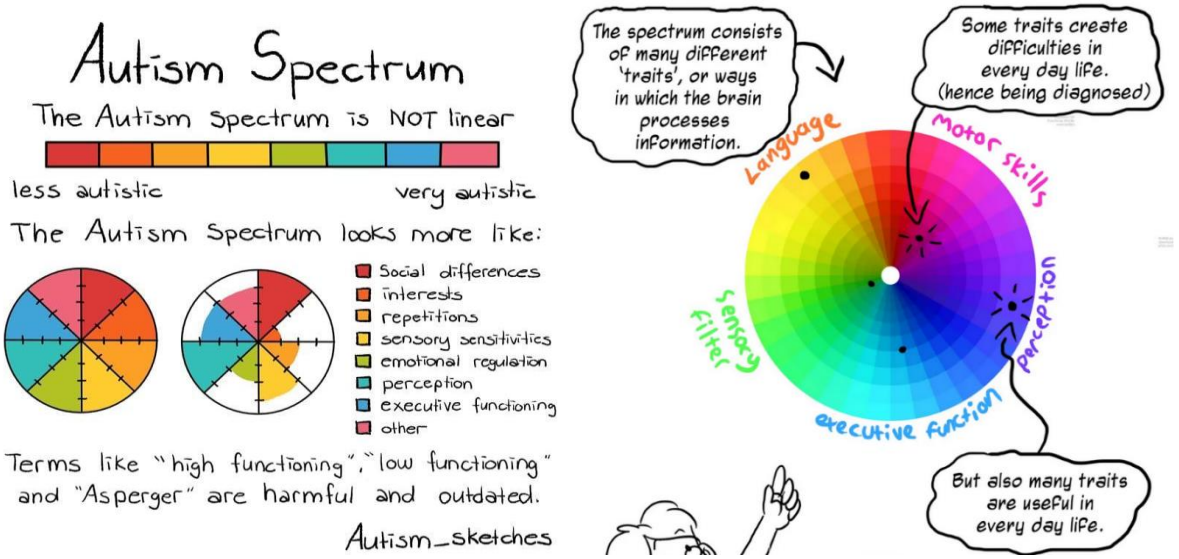
So although ABA is certainly a process of subjectification, Rose provides no explanation as to why a certain subset of human singularities can only be *neurotypically* subjectified through *this* process (ABA) but not through the dominant modes of governmentality (liberal education, early socialization, consumption of goods produced by the culture industry, and so on). This "inaccessibility" suggests that, reiterating Hook, there must be some pre-subjective, pre-discursive difference that distinguishes this set of inaccessible human beings from those who *are* accessible to dominant forms of governmentality. Philosophies of white nothingness do not offer a concept of difference in itself that accounts for this specificity of autism.

In recent years, autistic self-advocacy movements have developed what might be considered their own concepts of difference in itself: neurodiversity and the autism spectrum (see Figure 5.4).[95] They counter medicalized discourse by insisting that the autism spectrum is *not* linear and *not* one of functionality. In other words, whether one is autistic or not, or the degree to which one is "more or less autistic," *does not rely on a backdrop of normative valuations to make such distinctions legible.* Instead, one can have any number of these autistic "traits" *independently* of whether one functions or not in society (implying, against the DSM-5 and much clinical wisdom, that one can identify as autistic even if they experience no dysfunction in their lives). In this

[95] Philosophically speaking, the concept of neurodiversity is an expanded version of the autism spectrum, one that includes intensive singularities beyond just those experienced by autistic individuals.

visual diagram, autistic differences are conceptualized not in relation to norms but as *intensities* of varying colours.

The autism spectrum represents a concept of difference in itself. Differing intensities of autistic traits distinguish autistic individuals. Autism does not need to be related to functionality or norms to be differentiated by human perception. Further, autism distinguishes itself without becoming other than itself—a heterogeneity of individuals, each different from the next, yet nevertheless autistic. However, now that I have explicated difference in itself *as* a theory of subjectification, is it possible to understand the autism spectrum as a theory of subjectification as well? It could be said that the spectrum represents different intensities of autistic *singularities* that predate or precede processes of subjectification and medicalization. In this framing, these singularities distinguish not individual *beings*, but their *becoming*[96] individuals via *neurodiverse* subjectification processes.



[96] As Delanda puts it, "individual beings do exist but only as the outcome of becomings, that is, of irreversible processes of individuation" (2002: 84).

Figure 5.4: The Autism Spectrum (left: Autism Sketches 2021; right: Burgess 2019)

In the words of autistic self-advocate Jim Sinclair, "autism isn't something a person *has*.... Autism is a way of being. It is *pervasive*; it colours every experience, every sensation, perception, thought, emotion, and encounter, every aspect of existence" (quoted in Nadesan 2005: 208). When considered in the context of the philosophers of white nothingness, Sinclair's statement can be read as describing a pre-subjective difference in itself that *neurodiversifies* the "becoming" of individual difference, neurodiversifies the process of becoming a fully-formed subject: "it colours every experience...", etc.

This is a radically distinct concept of difference than what is possible within the limited framework of medicalization.[97] Yes, autistic individuals are all uniquely different from one another, but this does not mean autism is nothing other than a medicalization of normal individual variation. Rather, what they all share in common is not simply a label, or a supposed "brain type," but *an inaccessibility to neurotypical processes of subjectification*. In contrast to the type of "theory of mind deficit" thinking that leads to ABA therapy, neurodiversity argues that autistic individuals are more than capable of becoming fully-formed human subjects, but that this occurs through neurodiverse processes of which society needs to be more accommodating. Finally, to the extent that autism's difference in itself is an *identity*, this is not at all the same restrictive concept of identity as the one found in the dialectic of medicalization. As autistic self-advocate Terra Vance writes, autistic individuals "do not experience identity the same way that

[97] The dialectic of medicalization tries to assert its own incoherent bi-directional ontology of autism. For example, according to Silverman, the changes to the psychological categorization of autism from the DSM-IV to the DSM-5 ("Autistic Disorder" as well as "Asperger's Disorder" were merged into a single category named "Autism Spectrum Disorder") were controversial because some psychologists argue that Asperger's Disorder "has not been studied for long enough to confirm or discount its existence as a separate entity," and some geneticists argue that "a single category incorrectly downplays the biological heterogeneity of the syndrome" (2011: 52).

the world describes identity" (2021). Autistic self-advocacy has no need, for example, to engage in debates over whether autism's identity represents a "disease entity" or a "socially-constructed category" (although due to the dominant habits of thought construed by the dialectic of medicalization, these debates do inevitably occur (Woods et al. 2018: 976-977)). Their identity is rather one of difference in itself: of being on the spectrum, of being neurodiverse, of *experiencing inaccessibility*. Importantly, their identity is not a result of medicalization, memoro-politics, looping effects, disciplinarity, or other neurotypical, liberal subjectification processes.

Why Autism's Concept of Difference in Itself Is Insufficient for ADHD

The alternative that autistic self-advocacy offers to the dialectic of medicalization is, in my view, insufficient for ADHD because of the latter's metaphysical role as the highest identity of disorder. I already argued, in a fairly simplistic way, why the concept of neurodiversity, at face value, does not work for ADHD. I now develop this argument in the context of the philosophies of white nothingness. To put it bluntly, the problem is that, if we define difference in itself in terms of intensive singularities, ADHD too easily slides back into the concept of humanhood-as-difference-in-itself rather than the concept of neurodiversity offered by autistic self-advocacy.

To elaborate, one of the key differences between autism and ADHD is that, where much autistic harm centres around its inaccessibility to neurotypical structures of discourse or processes of subjectification, ADHD misrecognition centres around the assumption that it is almost *too accessible* to such structures and processes. For example, ADHD individuals are often perceived to be easily strung along by the incessant modulations of late-stage capitalist culture: the need for novelty (Hallowell and Ratey 1994: 74), "always jumping to the next 'shiny' thing" (Surman et al. 2014: 9), excessive money spending (Sarkis 2011: 6, Surman et al. 2014: 9, Hallowell and Ratey 1994: 75), an intolerance of boredom (Hallowell and Ratey 1994: 74), etc.

Because ADHD is so accessible to capitalist culture, it becomes easy to perceive as something everyone has. "ADD might as well have been invented in Los Angeles.... Half this city has ADD, you know" (quoted in Hallowell and Ratey 1994: 79).

Indeed, many of ADHD's characteristics appear to be almost indistinguishable from the general state of humanity as described by social and cultural critics. For instance, cultural studies scholar Robert James claims that "the neoliberal subject [has] an insatiable appetite for more and more novel differences" (quoted in Shaviro 2013: 7).[98] Similarly, Brazilian cultural theorist Vilém Flusser, speaking to the experience of living in late-stage capitalism, writes, "we want maximum experience, to accumulate sensations, because in successive sensations we divert the consciousness of our alienation in relation to the world" (2015: 109). Based on my research, and my own personal experiences, these are both very insightful descriptions of the ADHD condition—and yet they are describing neoliberal and capitalist forms of subjectivity in general. My point being, the more ADHD is thought to be accessible to social, political, and economic structures, the more it becomes *indistinguishable from* the human condition in contemporary societies. It is no surprise that, to return to Irving Zola's seminal 1972 paper, ADHD is criticized as a "medicalization of society" (492).

Is it possible to separate this all-too-accessible ADHD subject that everyone *is* to some extent from an ADHD that precedes such processes of subjectification? What might ADHD's "difference in itself" look like? From the perspective of neurodiversity, ADHD could be said to be on the neurodiverse spectrum of intensive singularities; but this solution seems to lack the same quality of specificity that it has for autism—once again, this is because of ADHD's role as

[98] "The point of life is to 'push it to the limit,' to always reach 'the edge of burnout': to pursue a line of intensification, and yet to be able to pull back from this edge, treating it as an investment, and recuperating the intensity as profit" (James quoted in Shaviro 2013: 7).

the highest identity of disorder. How can ADHD be "neurodiverse" if it is so easily molded and characterized by the very neurotypical processes of subjectification that autism finds so inaccessible?

If anything, ADHD's pre-subjective "singularities" or "intensities" sound far more similar to the generalized ones Deleuze and Guattari describe for all humans. For example, Brian Massumi, writing on Deleuze and Guattari's *Capitalism and Schizophrenia*, argues that in order to resist and overcome oppressive forms of governmentality and liberal citizenship, one must abandon one's role as a subjectified individual, turning instead to a nonsubjectified "nomadic distribution": "nomad space is 'smooth' or open-ended. One can rise up at any point and move to any other" (1992: 1-6). It is almost as if Massumi is describing ADHD; in the words of the DSM-5, the ADHD child "often leaves [his/her] seat in situations when remaining seated is expected" (APA 2013: 60). As ADHD researcher Terje Sagvolden notes, ADHD movement "covers a fourfold wider area" (2005: 401). It would not surprise me if Deleuze and Guattari considered ADHD to be a medicalization of nomadic distribution or "immanent life," both in children and adults. This sort of free-flowing, creative, nomadic, nonsubjectified human that Deleuze and Guattari want to recover—they want to take it back from capitalist and neoliberal control—is an example of what difference in itself can look like, but such a philosophy only erases the possibility that there is anything specific about ADHD that is not found in normal, free-flowing children or nomadic, nonsubjectified adults. The problem of ADHD's *indistinctiveness* repeats itself from the standpoint of philosophers of white nothingness.

To clarify, I am not suggesting that ADHD *is* actually all-too-accessible to processes of subjectification, or that it is fundamentally incompatible with the concept of neurodiversity-as-difference-in-itself. My argument is that it *appears* this way because of its role as the highest

identity of disorder. A consequence of this is that it becomes extremely difficult to even conceptualize what an "affirmative knowledge" of ADHD would even look like outside of humanhood-as-difference-in-itself. Any attempt to form a critical ADHD studies, with the critical discourses available to us, would inevitably fold ADHD traits and behaviours—often generalized as inattention, impulsivity, and hyperactivity—back into intensive singularities common to all humans. Unlike critical autism studies or the Dingdingdong Collective for Huntington's Disease, there could be no possibility of asserting ADHD's ontology as its "own way of thinking," or as a "world that is resolutely ours [ADHD individuals'], and not theirs [non-ADHD individuals']." The solution to this problem is to properly establish what makes ADHD *inaccessible* to neurotypical processes after all. To do this, an original theory of ADHD's difference in itself must be developed.

Conclusion

To recapitulate, the first aspect of being indifferent to ADHD implies that its ontology rests on individual differences that have to transgress a certain normative threshold to make ADHD legible. In this sense, ADHD is nothing more than a medicalization of individual variation placed against a normative backdrop. Ultimately, this first aspect of indifference, which designates ADHD in some but not all individuals, does not fully explain the metaphysical role of the highest identity—how it is used as a catch-all diagnosis, or why people tend to believe that "everyone is a bit ADHD at times."

Rather, ADHD's metaphysical role necessitates the second aspect of indifference toward it: the belief that it is nothing more than a medicalization of humanhood-as-difference-in-itself: of the infinite expanse of human singularities, human lawlessness, non-subjectified nomadic distributions, or the primacy of being human found only in childhood but lost in adulthood. Or,

amounting to the same thing, that it is nothing more than a medicalization of contemporary structures of society and economy (fast-paced societies, iPhones, video games, and all the other things that go hand-in-hand with short attention spans and lack of impulse control). This second aspect of indifference is what makes ADHD's metaphysical role in medicalization function smoothly: it allows physicians to always diagnose ADHD as a "last resort" when more specific disorders are ruled out. And it allows the highest identity of disorder to be historically construed to fit whatever crisis is facing subjectification processes in society—e.g., the crisis of how children today are increasingly being "subjectified" by their computer or iPhone screens, leading to short attention spans.

Ultimately, the second aspect of indifference does not grant ADHD any specificity, any difference in itself that is not generalizable to all human beings. However, my analyses of the dialectic of medicalization, the history of the highest identity of disorder, and the specificity of autism indicate that it is possible to establish a difference in itself for a psychiatric "disorder" that does not fall back into the dialectic of medicalization, and that is not confined to the generality of humanhood. Unfortunately, autism's concept of difference in itself does not work for ADHD because, due to the latter's metaphysical role as the highest identity of disorder, its specificity, its distinct mode of inaccessibility, is buried and made almost inconceivable by the concept of humanhood-as-difference-in-itself.

In the next, and final, chapter, I will argue that ADHD *does* have a specificity, but it is buried underneath the syndrome's supposed generality (humanhood-as-difference-in-itself). ADHD's difference in itself can be said—preliminarily—to be a differentiating principle—a sort of "logic"—that explains how each ADHD symptom or behaviour is related to one another *without* relying on analogical, statistical, or essentialist thinking. In other words, how do ADHD

"singularities" distinguish themselves without becoming other (i.e., without becoming "garden-variety distraction" that every human experiences), and without relying on prescribed social or psychological norms to give them existence?

Fundamentally, I am trying to repair a broken metaphysics of mental health and disorder. This *should be* the goal of ADHD self-advocacy, just as it is for autistic self-advocacy. By outlining what is *specific* to autism—its inaccessibility to neurotypical processes of subjectification—I showed how it does not make sense *critically* to wave off autistic self-advocacy as just another political project of liberalism. On the contrary, it is precisely how autism does not easily cave to liberal subjectification processes that makes it such a compelling example of a concept of difference in itself.

The same critical process can be applied for understanding ADHD self-advocacy. The goal of a future critical ADHD studies, a *genuine* ADHD self-advocacy—an advocacy that does not let psychiatric power or autistic self-advocacy speak through it—is to develop concepts of difference in itself that respect the specificity of the disorder, both in terms of its historico-metaphysical role, *and* its unique mode of inaccessibility. I am not trying to reinvent the wheel here. ADHD's difference in itself is precisely what ADHD self-advocates, ADHD coaches, and ADHD-specialized clinicians have already been discussing for years, just not in such philosophical terms, but in intuitive and affective terms. What this movement now needs is a consistent language to give ADHD ontological coherency.

In a way, what I am doing is *philosophizing* ADHD self-advocacy literature to show that it can be read as a *philosophical force*: a force that confronts head-on the destructive habits of thought permeating institutions that hold ADHD in perpetual equivocity. I am providing a language to explain the *ontological* significance of ADHD self-advocacy movements. And I am

providing a conceptual vocabulary that can be used to combat ADHD skepticism and misrecognition *at the root*. By developing a concept of difference in itself for ADHD, I establish—with the momentum and spirit of ADHD and autistic self-advocacy driving me—a possible coherent ontological ground for ADHD to rest on, one that does not collapse back into the dialectic of medicalization.

Chapter Six: Breaking Barkley: The Drive to a Univocity of Attention

My goal in this chapter is to propose a concept of difference in itself for ADHD using a mixture of Barkley's theory of ADHD with additional insights from ADHD self-advocacy literature. Barkley's theory of ADHD, first outlined in 1996, is situated in the crossroads of developmental psychology and Skinnerian psychology. It has been contested within psychological research more broadly, primarily because some of its testable hypotheses have not been successfully verified. Even so, no proposed theory of ADHD has had anywhere near the same kind of traction as Barkley's. Talk of "executive *dys*functions," a hallmark of Barkley's theory, is pervasive throughout ADHD advocacy associations and literature. When it comes to ADHD self-help books, the key tenets of his theory are often found in proposed treatments (targeting the point of performance by externalizing executive functions).

While the popularity of Barkley's theory might have a bit to do with timing (it caught the wave of Hallowell and Ratey's 1994 best-selling book on ADHD in adults), it might also have to do with his success in laying out a *convincing* ontological concept of difference for ADHD. That is, his theory works well as a *conceptual correlate* to the intuitions and affections of those who know ADHD inside and out—namely ADHD self-advocates and clinicians who specialize in ADHD. Even so, Barkley's theory has not been particularly successful in fighting back against ADHD skepticism *at the root*. Obviously, Barkley has done much to combat ADHD skepticism throughout his career, but not at the root. Pharmaceutical companies also combat ADHD skepticism, for example, through advertising. But these ways of fighting skepticism rely on using institutional or economic power to gain control over ADHD's discursive truth. They do not solve the fundamental problem of ADHD's equivocity. Given how widespread ADHD skepticism and misrecognition still is, this is surely an ineffective strategy.

This chapter is split into two parts. In the first part, I explicate Barkley's theory of ADHD and point out why, based on his own descriptions of the role of "theory," it can be read as a difference in itself. I *philosophize* his theory by showing how—when translated out of his scientific language—it formulates a sort of "ADHD logic" that attempts to transcend the dialect of medicalization, to transcend statistical, analogical, and essentializing habits of thought. I then discuss why it does not solve ADHD's equivocity. Namely, it still characterizes ADHD only in the negative: "behavioural *dis*inhibition," "working memory *deficit*," and "executive *dys*function." I unpack this further by showing how Barkley's theory is a "psychologized," non-critical theory of subjectification, or more precisely, a theory of ADHD's specific form of inaccessibility to subjectification. Similar to the "theory of mind deficit" for autism, Barkley's theory does not entertain the possibility that ADHD represents a *neurodiverse* form of subjectification. It only sees ADHD's inaccessibility to neurotypical processes of subjectification as a *deficit*, not an *affirmative difference*. Consequently, Barkley rejects any possibility of ADHD being defined in the positive: of being more than just a deficit, being a "different form of life," or of having positive qualities (creativity, etc.).

In the second part of this chapter, drawing heavily from self-advocacy literature, I develop a new theory of ADHD. It is not meant to refute Barkley's entire theory, but it does replace his negative concept of difference with an affirmative one. I argue that the attention of ADHD individuals is not "goal-directed" *per se*; their comportment to the world is rather a *drive to a univocity of attention*, representing ADHD's *attentive difference*. Such a concept of difference in itself still explains why ADHD individuals experience the executive dysfunctions that Barkley describes, but also offers an *affirmative*, rather than only a *negative*, conception of ADHD's difference to explain these.

Part One: Barkley's Theory of ADHD

Barkley's Implicit Critique of the Dialectic of Medicalization

Barkley is implicitly aware of the dialectic of medicalization, and wants to escape it. He claims that, with few exceptions, all ADHD research up through the mid-1990s was "atheoretical" and "purely descriptive" (2006: 297, 299). By this he means that no convincing explanation is offered for the statistical correlations between specific symptoms, or between childhood ADHD behaviour and adult ADHD behaviour (Barkley 2006: 299). What is the relation between, for example, symptoms of inattention and symptoms of impulsive-hyperactivity? There exists a correlation but that correlation is not, in itself, an explanation. The DSM, for example, lists the criteria for ADHD, and this is helpful for diagnosis, but it does not explain why the criteria is what it is, aside from the fact that the symptoms are correlative; Barkley calls this "grossly inadequate" (2006: 300).

Importantly, Barkley does not consider etiology to be an explanation (2006: 299). In other words, a neurobiological, genetic, or social-environmental[99] cause does not explain what ADHD *is*. It might be said that etiology—taken as an essential identity—determines its symptoms, but these determinations, these relations between symptoms, remain *abstract*, their mechanisms *unspecified*. Barkley is *indifferent* to such a top-down ontology. For example, positing, as some do, that ADHD arises from a "deficient energetic pool of arousal" does not, according to Barkley, "set forth a theory of ADHD"; it "makes no attempt to broaden its explanatory power";

[99] Barkley rejects "social-environmental theories" of ADHD, such as those concerning "the pace of modern life," because they provide no "explanatory or predictive value" as to why some individuals meet the diagnostic criteria of ADHD and others do not (2006: 220, 219). In other words, they are *too generalizing to all humans*. For instance, he states, "TV and videogame playing is not causing short attention spans. If I hear this again I'm going to throw up.… There is no evidence that human attention spans have changed at all. What is changing is the amount of media you can distract yourself with if you so choose" (2014b).

it does not "explain the link that exists between poor behavioural inhibition... and the sister impairment of inattention"; and it fails to "account for the many other cognitive and behavioural deficits" not listed in the DSM that "have received little or no previous research attention" (Barkley 2006: 298, 299, 297). This is Barkley's critique—albeit a limited one—of the dialectic of medicalization. Our habits of thought might convince us that ADHD's etiology can be equated with its ontology, but Barkley rejects this notion. Asserting an essential identity (such as a neurobiological or genetic cause) does not, in his view, explain what ADHD actually *is*.

I propose that Barkley's alternative vision of ADHD's ontology—even though he does not use these terms—can be read as a sort of Hegelian-style, developmental logic. Hegel is a nineteenth-century German philosopher.[100] He argues that ontology—what it means for something to exist—can be ascertained by letting "sheer being" unfold in thought on its own accord, without any presuppositions imposed on it by the philosopher. Hegel calls his method the "science of logic." Similarly, ADHD's development is "logical" insofar as it works itself out *in Barkley's thought* in a coherent, logical manner. *However*, the key aspect of a Hegelian-style logic—versus conventional notions of logic—is that it derives not from some universal rationality, nor from a single philosopher (Barkley), but from its own *being*. For Hegel, this is what makes Hegelian philosophy *onto-logical*. Being "unfolds" itself in thought and, in doing so, proves what it means to exist. As Hegel describes it, "philosophical thinking... simply takes up its object, the Idea, and lets it go its own way; it simply watches the movement and development of it, so to speak" (quoted in Houlgate 2006: 62). Regardless of whether one agrees with Hegel or not, my point is that Barkley, implicitly of course, is trying something similar.

[100] There are two reasons I draw on Hegel in this chapter. First, his unique notion of ontology helps to clarify what Barkley is trying to accomplish. Second, his concept of an "immanent logic" helps to clarify why Barkley's theory is not one of causation.

In Barkley's view, ADHD's *being*—what ADHD *is*—can be logically-ascertained *in thought*—written as theory—by observing the development of ADHD children as they grow older. Do not misunderstand me: Barkley is a full-fledged scientist whose ontological beliefs revolve around positivism and behaviourism. In particular, he seems to believe that only neuroscience has the capability of truly proving his theory (or parts of it). As sociologist Jan De Vos writes, "psychology is supposed to underpin neurological research while the latter is more and more evoked as the final proof of the scientific validity of the psychological theories themselves" (2016: 35). But ontological beliefs can be wishy washy. Barkley continues to espouse his theory of ADHD to parents, teachers, and psychologists as if it were true, despite it not being validated (yet) by neuroscience. It is almost as if his theory's *explanatory value* alone is enough to give it ontological credibility, both in Barkley's eyes and in the eyes of his followers. It provides a compelling, "unifying account" of how various ADHD symptoms and behaviours link together *psycho-logically* (Barkley 2006: 299). This is why I think it is helpful to compare Barkley's theory to Hegel's method: the theory itself is believed to represent ADHD's ontology. It explains what ADHD *is* "regardless of its origin" and, in practice, regardless of its neurobiological correlates (Barkley 2006: 299).

In contrast, the problem with "purely descriptive" views of ADHD is that they rely on what might be called "ana-logic": using analogy to abstractly relate distinct ADHD behaviours. For example, clinician Stephanie Sarkis writes, "when you were a kid, your parents and teachers told you that you jumped around too much from activity to activity. Now that you are an adult, you may find that you lose people when you switch conversation topics quickly, and you may have a bunch of unfinished projects around the house or at work" (2011: 120). Similarly, ADHD advocates Craig Surman et al. write, "people who were hyperactive and impulsive as children

often look somewhat different as adults: instead of bouncing off the walls, they may be fidgety, need to move on to the next thing, talk excessively, and act on impulse" (2013: 23-24). ADHD advocacy literature is full of these sorts of analogical comparisons. But their "explanations" as to why, say, bouncing off walls as a kid relates to talking excessively as an adult relies on, as Foucault would say, a common focal point—a shared identity—to analogically associate these two distinct behaviours together. In this case, they are both analogically related to "hyperactivity," a subcategory of ADHD.

When it comes to ADHD, analogical thinking is a direct consequence of the dialectic of medicalization. It leads to the kind of ontological incoherency that skeptics love to pick apart. For example, it can lead to an *ungrounded* proliferation of ADHD's symptomatology. ADHD self-advocate Thom Hartmann, for instance, posits a generic/genetic[101] difference to explain ADHD: in his view, ADHD individuals are the genetic descendants of hunters, whereas those without ADHD are the descendants of farmers. This generic/genetic difference allows him to analogically expand (determine) ADHD symptomatology in all sorts of weird, questionable ways: ADHD individuals, like hunters, "tend to be lousy chess players, disdaining strategy because they prefer to go straight for the jugular" (1997: 25). In my view, the problem with Hartmann's "purely descriptive account" is not that he is ignoring ADHD people who are good at chess—I am not denying the heterogeneity of the disorder. The problem is the kind of analogic Hartmann uses to explain why being bad at chess *could* be a "symptom" of ADHD at all. Aside from the ludicrousness of his hunter-versus-farmer theory, the core problem with Hartmann's analogical method is that it provides no way of differentiating between ADHD

[101] The dialectic of medicalization construes ADHD as a generic identity, regardless of how its specificity is figured (genetic or otherwise).

symptoms and normal human characteristics. Individuals who believe Hartmann's theory would never know, in practice, if being lousy at chess is a symptom of their ADHD, or just an unrelated personality trait. Imposing analogical, abstract relations between symptoms simply do not offer enough of an explanation to make such a differentiation. Analogy does not provide ADHD with a concept of difference in itself. Relying on analogy is, ultimately, a determinative outcome of generic difference.

How Barkley's Theory Constitutes a Concept of Difference in Itself

In contrast to analogical descriptions, which attempt to relate *distinct* yet similar-sounding behaviours together based on a generic identity, Barkley, at least in my reading of him, theorizes a *monism* of ADHD, a difference in itself. All the symptoms can be unified as *one and the same*; that is, as various "intensities" unfolding from one unified, psycho-logic. To elaborate, Barkley's theory is one of ADHD's *immanence*, its giving-rise-to-itselfness. As Hegel describes his logic of *being*, it is "the process of its own becoming, the circle which presupposes its end as its goal, having its end also as its beginning" (quoted in Houlgate 2006: 58). Similarly, Barkley begins with one basic deficit, and shows how it unfolds into another deficit; in turn, this second deficit unfolds back into the first deficit. Its end is also its beginning. The logic of ADHD, for Barkley, is this *specific immanency*, this specific giving-rise-to-itselfness. And through this immanent process, all sorts of additional deficits arise.

That might all sound confusing but it is actually quite simple. The "first" deficit is behavioural *dis*inhibition. When *neurotypical* children encounter a distraction—whether in the environment or in their mind—they do not immediately react. Instead, they *inhibit their behaviour*. In contrast, ADHD children do not inhibit their behaviour—they immediately react to stimuli, resulting in impulsive-hyperactivity (at least to a greater degree than their neurotypical

peers) (Barkley 2006: 299, 300). Further, when neurotypical children inhibit their behaviour, they succeed at *creating a space of pause and reflection*. In this space they can develop basic "executive functioning skills" such as "working memory" that allows them to look back at past experiences. As Barkley puts it,

> Do you have experiences in this situation previously? If so what would they have told you to do? .... You are visually imagining your history. What does it have to say? This hindsight leads to foresight. You look back to anticipate. What does ADHD lead to? No foresight. You are not thinking ahead because you were not looking back either. You do not use your images of the past to tell you what to do. You will just do. (2014c)

ADHD children do not "stop and think before they act," and so no space of pause and reflection is created in which they can develop or practice working memory skills (Barkley 2006: 308). They will keep making the same mistakes over and over again—no matter the consequences—because they are *temporally nearsighted*. It is in this way that behavioural *dis*inhibition, the "first" deficit, unfolds into the "second," working memory *deficits*.

In return, working memory deficits unfold back into behavioural disinhibition. For context, the *neurotypical* child, as he or she grows into adolescence, will be able to use hindsight to analyze past behaviour, and foresight and forethought to "synthesize" new, productive forms of behaviour to counteract distracting stimuli (Barkley 2006: 314). This synthesis includes the development of other executive functions such as keeping oneself motivated (affective self-regulation by focusing on the goal and its rewards) and planning (arranging in mind temporal

and behavioural sequences required to efficiently and effectively complete the task or achieve the goal). As Barkley writes, "the total process [of executive functioning] creates *goal-directed persistence*—a persistence that is characterized by willpower, self-discipline, determination, single-mindedness of purpose, and a driven or intentional quality" (Barkley 2006: 315). Further, when "interruptions in this chain of goal-driven behaviours occur (e.g., by distraction), the [neurotypical adolescent] is able to *disengage, respond to the interruption, and then reengage the original goal-directed sequence*" (Barkley 2006: 317). In this way, the end unfolds into its beginning, *executive functioning* (e.g., as goal-directed persistence) unfolds back into *behavioral inhibition* (e.g., handling distractions). To clarify, the key to Hegelian logic is that, each time it unfolds back into itself, it proves itself to be more than it initially was (Houlgate 2006: 281). For the neurotypical adolescent, behavioural inhibition is no longer just about pausing before doing; it is about having synthesized new forms of behaviour and executive functions that can effectively handle distracting stimuli from getting in the way of a goal. Behavioural inhibition has proven itself to be something more than it initially was in an earlier state of development.

The same is true of behavioural *dis*inhibition in ADHD's development. As the ADHD child grows older, ADHD "deepens into itself," it "unfolds its own true nature" (Houlgate 2006: 281, 280). Whereas ADHD children, according to Barkley, never stop to think, ADHD adolescents certainly do. They have developed, to some extent, working memory capabilities. They might even have a specific goal in mind, such as cleaning their room, and try to come up with a plan to accomplish this goal. However, due to their "developmental delay," their "lack of practice" in creating a space of pause and reflection, the ADHD adolescent has not yet been able to synthesize the type of behaviour or additional executive functions that would allow him or her to *not be sidetracked by new stimuli*. As ADHD physician Gabor Maté writes,

> You decide to clean your room.... You pick a book off the floor and move to replace it on the shelf. As you do so, you notice that two volumes of poetry... are not stacked side by side. Forgetting the debris on the floor, you lift one of the volumes. [You open the book and] begin to read a poem. The poem has a classical reference in it, which prompts you to consult [Wikipedia] on Greek mythology; now you are lost. (2000: 12)

Behavioural *dis*inhibition has proven itself to be something more than it initially was. In this case, the ADHD adolescent *can* pause and take the time to focus on a goal, but too easily loses sight of that goal when confronted with distractions. He or she *responds* to the interruption but lacks the ability to *reengage* the original goal-directed sequence. This is what behavioural *dis*inhibition now looks like in this later stage of development.

In turn, what working memory proves itself to be, according to Barkley, is nothing other than *attention itself* (2006: 319). To have working memory *deficits* is to be *inattentive*. However, to paraphrase Hegelian scholar Stephen Houlgate, this sort of Hegelian logic does not "presuppose" these concepts as fully-formed or defined from the beginning; rather, its logic shows precisely what these concepts turn out to be *for ADHD* in their unfolding (2006: 179). What inattention is *for ADHD* is one half of this ever-expanding, self-reinforcing cycle of behavioural disinhibition and working memory deficits. Barkley's theory shows, against the skeptics, how garden-variety distraction that every human experiences is *not* ADHD because it does not unfold from this specific, immanent process. What inattention turns out to be for an

ADHD individual is not what it turns out to be for a non-ADHD individual, despite apparent similarities on the surface.

Take another example: Surman et al. describe an ADHD individual who decides to create to-do lists to help him complete all the tasks he needs to do. While he is creating them, "'pop!' a new thought bursts into his head, and then another." Before long, "his to-do lists take on a life of their own," they become so big that he has no idea where to start (2013: 65, 87). In this case, the ADHD individual is able to *accomplish the initial task-at-hand* (creating to-do lists). But he messes this task up by making the lists too big. This is due to the interference of his distracting thoughts about all the things that he could get done, all of which make it into his planning. In Barkley's words, he lacks the ability to *disengage* from the goal-directed sequence to respond to "interruptions," and instead lets those interruptions take part in his planning. Barkley calls this a failure of "interference control," a "special form of sustained attention" (2006: 317). The ADHD individual tries to plan, but ends up with *unrealistic* plans. He is unable to "protect [this executive function] from disruption, distortion, or perversion" (Barkley 2006: 302). This is another example of what behavioural disinhibition and inattention prove themselves to be in ADHD's unfolding.

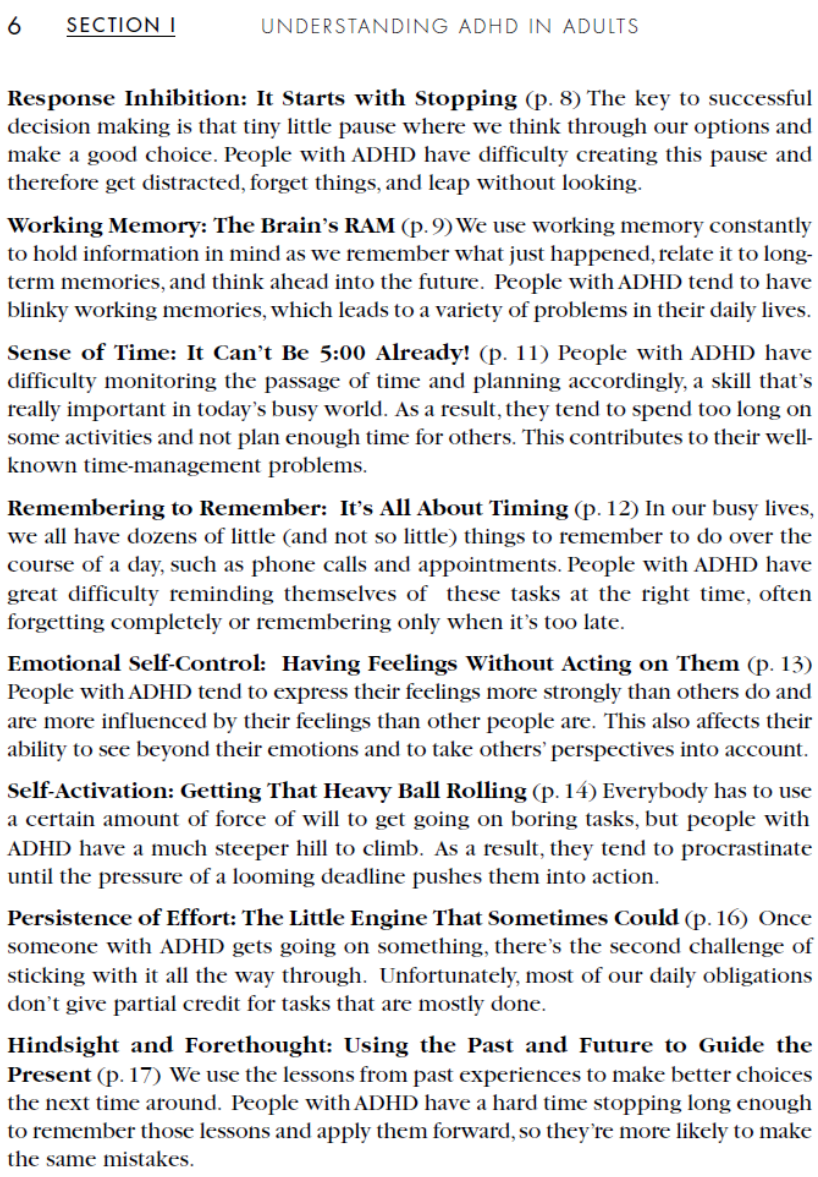
ADHD self-advocate Terry Matlen claims that these sorts of negative experiences—of ADHD individuals trying to organize their lives according to neurotypical standards and failing time and time again—can lead ADHD individuals to be constantly "overwhelmed," creating a "veritable cascade of internal resistance" (2014: 30). As one member of my ADHD student support group put it, "I try to think, 'next time I'll do better.' But then when the same things happen and I fail again I'm like, you know what, what's the point?" One possible outcome of this cascade of internal resistance is *procrastination*. Hallowell and Ratey, in their proposed

revision of "suggested diagnostic criteria" for ADHD, list "chronic procrastination" as a key symptom: "adults with ADD associate so much anxiety with beginning a task, due to their fears that they won't do it right, that they put it off, and off, which, of course, only adds to the anxiety around the task" (1994: 73).

By working through ADHD's immanent logic in this way, it becomes possible to describe procrastination *as a symptom of ADHD*, while simultaneously *differentiating this symptom* from other forms of procrastination. In practice, it might look identical to the kind of procrastination all humans experience from time to time, but it can be *differentiated* insofar as it can be shown to clearly unfold from ADHD's specific logic. More broadly, it becomes possible, on a case-by-case basis, to trace each symptom back to ADHD, or alternatively to determine a particular symptom to be unrelated to ADHD. This is why Barkley calls his theory *explanatory*. In contrast, analogical thinking has no capacity to differentiate symptoms specific to ADHD from similar-looking symptoms generalizable to all humans.

In short, ADHD distinguishes itself. What it means for a symptom to "belong" to ADHD is to be the outcome of this logical, immanent process, this monism of ADHD. Never in this process do ADHD symptoms become *other* than ADHD; they retain this oneness of *being* ADHD. Potentially, there is no exact *limit* to the number of ADHD "symptoms" or "behaviours" out there. In this schema, what makes a behaviour a symptom of ADHD is not a question of whether it belongs to some static classification criteria, or whether it can be analogically related back to "impulsive-hyperactivity" or "inattention," or even whether it has statistical significance to the greatest number of ADHD individuals (e.g., the DSM-5 criteria). Rather, it is a question of whether it can be traced back to this immanent process. Even the most obscure, idiosyncratic symptom can be considered an ADHD symptom if it can be traced back through this logical

unfolding. In contrast, as Barkley notes, the "DSM provides no such utility.... [It cannot] predict new constructs and relationships among constructs or elements" (2006: 300). Symptomatic heterogeneity from one ADHD individual to the next, then, should not raise doubts about this disorder's ontological status. What the disorder *is* cannot be reduced to its most statistically-correlated symptoms, nor to some essential identity, as the dialectic of medicalization would have us believe. In Barkley's words, "ADHD is not an excuse but an explanation" (2006: 325).



6 SECTION I UNDERSTANDING ADHD IN ADULTS

Response Inhibition: It Starts with Stopping (p. 8) The key to successful decision making is that tiny little pause where we think through our options and make a good choice. People with ADHD have difficulty creating this pause and therefore get distracted, forget things, and leap without looking.

Working Memory: The Brain's RAM (p. 9) We use working memory constantly to hold information in mind as we remember what just happened, relate it to long-term memories, and think ahead into the future. People with ADHD tend to have blinky working memories, which leads to a variety of problems in their daily lives.

Sense of Time: It Can't Be 5:00 Already! (p. 11) People with ADHD have difficulty monitoring the passage of time and planning accordingly, a skill that's really important in today's busy world. As a result, they tend to spend too long on some activities and not plan enough time for others. This contributes to their well-known time-management problems.

Remembering to Remember: It's All About Timing (p. 12) In our busy lives, we all have dozens of little (and not so little) things to remember to do over the course of a day, such as phone calls and appointments. People with ADHD have great difficulty reminding themselves of these tasks at the right time, often forgetting completely or remembering only when it's too late.

Emotional Self-Control: Having Feelings Without Acting on Them (p. 13) People with ADHD tend to express their feelings more strongly than others do and are more influenced by their feelings than other people are. This also affects their ability to see beyond their emotions and to take others' perspectives into account.

Self-Activation: Getting That Heavy Ball Rolling (p. 14) Everybody has to use a certain amount of force of will to get going on boring tasks, but people with ADHD have a much steeper hill to climb. As a result, they tend to procrastinate until the pressure of a looming deadline pushes them into action.

Persistence of Effort: The Little Engine That Sometimes Could (p. 16) Once someone with ADHD gets going on something, there's the second challenge of sticking with it all the way through. Unfortunately, most of our daily obligations don't give partial credit for tasks that are mostly done.

Hindsight and Forethought: Using the Past and Future to Guide the Present (p. 17) We use the lessons from past experiences to make better choices the next time around. People with ADHD have a hard time stopping long enough to remember those lessons and apply them forward, so they're more likely to make the same mistakes.

Figure 6.1: An example of Barkley's theory made accessible in an ADHD self-help book (Tuckman 2009: 6)

What I described above are just a few of countless examples I could give to demonstrate Barkley's theory in action. According to Barkley, ADHD, through this immanent process, unfolds into all sorts of additional executive-functioning deficits: emotional dysregulation[102], problems with time management[103], reading, viewing, and listening comprehension, moral reasoning, ideational reconstitution, problems with social communication, and many more. I do not offer a comprehensive overview of his entire theory because, first, much of it can be found in any number of ADHD self-help books (see Figure 6.1 as an example), and second, there are *problems* with Barkley's theory I need to discuss.

Why Barkley's Theory Folds Back into the Dialectic of Medicalization

Barkley tries to distinguish ADHD from the generality of humanhood in order to grant it ontological coherency. He does this by *negating* neurotypical developmental processes. As he puts it, "if it is to be argued that ADHD arises from a deviation from or a disruption in typical developmental processes, then these typical processes must be specified in explaining ADHD" (2006: 300). He draws on developmental psychology to specify these (neuro)typical processes (namely, behavioural inhibition and working memory), and then negates them to establish a theory of ADHD's ontology: an unfolding of "behavioural *dis*inhibition," "working memory

[102] Here, the logic of ADHD takes on an affective dimension. ADHD children cannot regulate their emotions, nor resist emotional outbursts. They lack the working memory—holding in mind the future consequences of acting out—to pause and reconsider their reactions: they cannot "talk to themselves privately, calm themselves down, use images and words that are soothing and positive, [to] thereby quell or greatly reduce the eventual emotional display" (Barkley 2006: 312). They also lack the working memory required for self-motivation—positive self-talk or visualizing the rewards of achieving their goals to "arouse" themselves to do what needs to be done. They lack the "drive, will-power, persistence, determination, 'stick-to-it-tiveness'" to "sustain goal-directed behaviour" (Barkley 2006: 312-313).

[103] For Barkley, the ability to hold in mind the past and the future allows one to obtain "temporal information" about what activities can be done in what amount of time, and thus allows one to synthesize "cross-temporal organizations of behaviour" that "accurately estimate... temporal durations" (2006: 309). Lacking this attention to time, ADHD individuals experience a "lack of punctuality, and a failure to give due regard for the time, timing, and timeliness of their actions" (Barkley 2006: 321).

deficits," and other "executive *dys*functions." Given Barkley's enormous power and influence, one would think that this concept of ADHD's difference in itself—this unfolding—would have persuaded most medical professionals—if not the public at large—with its *explanatory power*.

In my view, the reason it has failed to do so is because it inevitably collapses back into the ontological generality of humanhood. Barkley tries to escape from the dialectic of medicalization, but never fully frees himself, or ADHD, from it. In this section, I argue that the philosophical problem with Barkley's theory is that it never posited ADHD as an *affirmative* difference in itself, only a *negation* of the concept of humanhood-as-difference-in-itself.

According to Barkley, somehow ADHD distinguishes itself and yet never ceases to be distinguished *from* social or developmental norms. Every symptom of ADHD must represent a functional or behavioural problem: a not-living-up-to-normal-standards, a developmental delay, a failure to perform, a lack of attention, and so on. These restrictive parameters granted to what ADHD is allowed to be—a lack of positivity, a lack of "in-itselfness"—are consequences of Barkley's negative theory.

In the previous chapter, I argued that philosophers of white nothingness assert a concept of humanhood-as-difference-in-itself as a process of *becoming*. Moreover, I detailed Nikolas Rose's critical theory of subjectification, which argues that liberal societies inject standards of normality, conduct, and morality into individuals as "inner truths" to allow them to *govern themselves*. Yet, these "inner truths" are "socially organized and managed in minute particulars" (Rose 1990: 1). Psychological institutions play an important role in this project, and the developmental psychology Barkley draws from is no exception. The theory of executive functions is an example of how psychology establishes "inner truths" about what it means to be *naturally human*. As Barkley writes,

> All executive functions represent private, covert forms of behaviour that at one time in early child development and in human evolution were entirely public behaviour and directed at managing others and the environment. They have become turned back on the self (self-directed) as a means to control one's own behaviour, and have become increasingly covert, privatized, or 'internalized' in form over human evolution and over a child's maturation. (Barkley 2006: 305)

In other words, developmental psychology provides a *non-critical* theory of subjectification. In Barkley's view, "early hominids" could not govern themselves privately as individuals; they could only be governed through overt forms of public behaviour—for instance, expressing fear to warn others of danger. Over the course of evolution, humans "internalized" those public behaviours as executive functions, allowing them to manage themselves instead of having to always be managed by each other. Executive functions are not, Barkley writes, "merely a product of cultural training. They are universal and instinctive to humans" (2006: 305).

As Rose would argue, however, executive functions do not represent inner, natural truths about humanhood, but are extensions of the liberal projects of governmentality. Barkley may believe that evolution granted humans a natural ability to be "goal-directed, purposive, and intentional in [their] actions" (2006: 305), but as political theorist Gilbert Germain, paraphrasing Max Weber, writes, "modernity is characterized by the restructuring of action in accordance with the principles of goal-directness and technical efficiency" (quoted in Horowitz and Maley 1994: 250). Two of the key roles of liberal governments are to promote economic progress (under

capitalism), as well as freedom from coercion. To a certain extent, liberalism achieves the former through complex processes of subjectification that create goal-directed, productive citizens (Rose 1990: 110; Foucault 2012: 221). It achieves the latter, in this case, by presenting these liberal forms of subjectivity as natural truths about what it means to be human. One is able to perceive oneself as free from the coercion of others through one's *natural* ability to govern oneself, and yet is nevertheless, knowingly or unknowingly, still "intensely governed" by the projects of liberalism. Developmental psychology assists in these projects by creating a naturalized, *moral impetus* to self-governance—self-control, self-discipline, and self-regulation—through the establishment of so-called "evolutionary," *developmental norms of subjectification*. Schools administer this moral impetus onto young children using measures like "self-regulation" on report cards in early grades. In Barkley's view, liberal self-governance and becoming fully-functioning workers under capitalism is the final step not only of human evolution, but of growing up.

Here lies the problem with Barkley's theory. He assumes executive functions to represent natural, immutable, developmental norms of subjectification; he defines ADHD's difference in itself as a *negation of those developmental norms*; but what happens when, under the sheer weight of capitalism's search for ever-evolving ways to make a profit, these developmental norms are shifted to match ADHD norms? Indeed, as many cultural critics point out, contemporary forms of subjectivity are now characterized by behavioural disinhibition and working memory deficits. Philosopher Jonathan Crary claims that contemporary "24/7 capitalism" is incompatible with any social behaviours that require "action and pause" or "taking turns" (2013: 125). He states that "*billions of dollars* are spent every year researching how to

reduce decision-making time, how *to eliminate the useless time of reflection and contemplation*. This is the form of contemporary progress" (2013: 40; emphasis added).

Crary's argument links back to the crisis I identified in Chapter Five: the crisis of *attention scarcity*. Capitalism manufactures this crisis with the help of new media technologies. As aesthetic theorist Gean Moreno puts it, we are all increasingly confronted by various forms of media that are "jacked into the symptomatology of attention deficit disorders," exemplifying "the incessant modulations that subjectivity suffers through in control societies" (2013: 2). French philosopher Bernard Stiegler argues that due to the rise of "industrial psychotechnologies," "the psychosocial state of the world" has been taken over by a "global attention deficit disorder" (2010: 57). Italian theorist Bifo Berardi claims that advanced semiocapitalism has given rise to an "excess of speed of the signifiers that stimulates a sort of interpretive hyperkinesis," a lack of interference control (2010: 110-111).

These perspectives remind us that liberal processes of subjectification must continuously adapt to the ever-intensifying demands of capitalism. Specifically, *consumers* have to be made. It just so happens that ADHD individuals fit the image of the "ideal consumer" in the attention economy: people who *lack self-governance, and must be governed by the public behaviours of others—i.e. through media and consumer capitalism*. As Barkley describes, instead of being "goal-directed, internally guided," ADHD individuals are "contingency-shaped, externally regulated," "stimulus, response, stimulus, response"; this is why, Barkley claims, "children with ADHD can sustain their attention to video games... for extended periods of time, but cannot pay attention to their homework for more than a few minutes" (2006: 317). They need "externally reinforced persistence" because they lack "self-sustained persistence" (Barkley 2006: 317). Fundamentally, this corresponds to what many in ADHD communities call "the need for

stimulation." We need something stimulating that can regulate our motivation for us, because we lack "self-regulation of affect/motivation/arousal" (Barkley 2006: 300). If not video games, endless hours spent on social media apps; "hypersexuality" and sex with strangers via online dating (Matlen 2014: 115-116; Hartmann 1997: 58; Hallowell and Ratey 1994: 117); party drugs (Surman et al. 2014: 9), or, of course, the most stimulating drug of all: ADHD medication; and other highly-stimulating pursuits or novelty seeking more broadly (Surman et al. 2014: 9; Hallowell and Ratey 1994: 74). Consumer capitalist culture offers countless "externally-regulating" activities for ADHD individuals to partake in. So much so that society itself can now be described as ADHD: "we live in an ADD-ogenic culture…. The fast pace. The sound bite…. The TV remote-control clicker. High stimulation. Restlessness…. Ingenuity. Creativity. Speed…. It may seem that our cultural norms are growing closer and closer to the diagnostic criteria for ADD" (Hallowell and Ratey 1994: 191, 192).

The end result is that Barkley's theory of ADHD loses its ontological credibility in the face of rapid changes to advanced liberal subjectification processes. It *does* represent a concept of difference in itself—it *explains* the relations between symptoms as an immanent process of development. Yet it fails to distinguish this developmental process, this logic of ADHD, from the logic of new media technologies and consumer capitalism under 24/7 capitalism. It thus fails to meaningfully distinguish ADHD subjects from neurotypical subjects-as-consumers. ADHD remains *all-too-accessible* to neurotypical processes of subjectification as they change over time.

The philosophical problem that confronts Barkley occurs precisely because he defines ADHD's difference in itself as a negation of what he believes to be immutable, universal outcomes of human evolution: behavioural inhibition, working memory, and executive functions. ADHD's difference in itself hence collapses back into the generality of humanhood-as-

difference-in-itself when the norms of human development are moved closer to ADHD's own normatively significant features. This is how ADHD's metaphysical role as the highest identity of disorder—historically construed by this manufactured economic crisis of attention—prevents Barkley's concept of difference in itself for ADHD from ever truly escaping the dialectic of medicalization. It never grants ADHD an ontological specificity that *does not collapse back into generality.* Ultimately, the failure of Barkley was that he never entertained the possibility that ADHD might represent a *neurodiverse* form of subjectification rather than merely a delayed or deficient one. That it might represent an *affirmative difference in itself.*

Part Two: A New Theory of ADHD's Difference in Itself

Prelude: Is There Anything Positive about ADHD?

ADHD self-advocacy is divided on the question of whether there is anything positive about ADHD. Much of this divisiveness is a consequence of Barkley's negative theory: he only defines ADHD's difference as a negation, and is unable to grasp even the conceptual possibility that ADHD could confer any benefits to the individual. "Don't ever," Barkley warns, "attribute [your] successful enterprises to your ADHD because it just ain't so. This is no gift" (2014d).

ADHD advocates who believe that there is nothing positive about ADHD tend to point to psychological research to support this idea. For instance, Ari Tuckman writes, "it just isn't true. Research has consistently found that ADHD does not give any kind of advantage.... There are hundreds of studies that document the many and pervasive problems associated with ADHD" (2009: 223). However, this kind of claim is misguided. Absence of evidence should not be taken as evidence of absence. In particular, Tuckman ignores the fact that the scope of most psychological research is limited to pathology. As FR put it to me in an interview, "you have to

remember that people who study ADHD are for the most part clinicians, child psychiatrists, and clinical psychologists, so they're people who are studying psychopathology. We're not studying well-being.... Positive psychology is actually a very small part of psychology anyway."

There are, of course, some studies that do aim at identifying positive qualities of ADHD. For example, Barkley et al. conducted two large-scale, "comprehensive" studies of ADHD in adults; they write, "advocates of adult ADHD have gone so far as to assert that the disorder conveys some positive benefit. To our knowledge, none of these claims have any scientific support at this time. Most, in fact, are refuted [by our studies]" (2010: 2). This is a good example of why ADHD self-advocates should not simply take the word of researchers just because they profess to be using "science." We also must be wary of taking the *conclusions* of research papers to represent "truths" without considering the research methodology. In this case, Barkley et al. conducted surveys asking subjects to indicate on a scale of one-to-five if they associate with the listed symptoms, including several positive ones. When they claim that their studies "refuted" the idea that there is anything positive about ADHD, they simple mean that the positive symptoms associated with ADHD that they listed on the survey did not statistically correlate to people who have ADHD any more than they correlated to people who do not have ADHD. For instance, ADHD subjects did not report being any more "creative" than what was reported by non-ADHD subjects. But to call this scientific "refutation" is ignorant at best, and downright irresponsible coming from someone so influential as Barkley. These so-called "experts" are so mired in their own beliefs about what counts as scientific validation (such as statistical correlation) that they fail to consider alternative ways of conceiving of ADHD's ontology. This is yet another example of the destructive, sterile habits of thought stemming from the dialectic of medicalization.

Over the years, I have given talks to parents of ADHD children on the positives of ADHD. Anecdotal feedback from parents suggests that this can be helpful in making them feel better about their children's prospects in life. For example, I tell them that "lack of follow-through" can translate to "always trying new things, making your child into a well-rounded person." Or that "often daydreams in class" means your child is "imaginative and a creative thinker." Admittedly, this approach relies on the same kind of analogical thinking that is found in many ADHD self-help books. Sarkis, for example, similarly writes, "you come up with ideas that other people don't think of because your brain works quickly" (2011: 119). Some ADHD advocates push back against this approach. Tuckman writes, "[I'm not going to make] a bunch of empty claims about you being able to do anything you put your mind to or a collection of inspirational sayings.... [My book is about] scientific research and clinical experience applied to your daily life" (2009: 3). Tuckman, of course, draws heavily from Barkley (2009: 7). Indeed, there is certainly far more of an economic imperative to pathologize and treat ADHD than to encourage positive renderings of it. The industries of neuropsychology and pharmaceuticals require that these disorders are framed as deficits in need of a fix (Davies 2015).

In the following sections, I take a different approach to considering the "positives" of ADHD, one not based in analogical or statistical determination. I develop a new theory of ADHD's difference in itself that is *affirmative*—not a negation. One benefit to this approach is that symptoms that unfold from this affirmative difference need not be immediately compared to normative values. They do not have to be thought, from the get-go, in terms of functionality or developmental deficits. Don't get me wrong—I do not deny the hardships that ADHD individuals face. Nor do I deny many of the useful explanations (and treatment regimens) that

Barkley's theory provides. But what I, above all, personally take issue with is how Barkley's theory—taken as a whole—characterizes ADHD as an *inaccessibility to self-governance.*

Developing an affirmative concept of difference in itself for ADHD provides at least three *immediate and practical* benefits for ADHD self-advocates. It provides ADHD self-advocates with a conceptual toolbox for (1) distinguishing ADHD subjects from non-ADHD subjects in a lighthearted, inclusionary, affirmative, *yet ontologically coherent way* (similar to autistic self-advocacy's emphasis on self-diagnosis); (2) accounting for some of the less explanatory aspects of Barkley's theory (as I demonstrate below); and (3) understanding how certain symptoms of ADHD can be "positive" *independently* of how liberal societies and discourses of normativity interpret them. That is, they are "positive" insofar as they are conducive to *neurodiverse* forms of self-governance. ADHD may not be a gift, but it is a viable—and I mean that as lively and liveable—alternative.

The Drive to a Univocity of Attention

> Attention is taking possession by the mind... of one out of what seem several simultaneously possible objects or trains of thought.... It implies withdrawal from some things in order to deal effectively with others, and is a condition which has a real opposite in the confused, dazed, scatterbrained state.
>
> -William James, *The Principles of Psychology,* 1890

Neurotypicals like to conceptualize ADHD's attention as equivocal. In the most literal sense of equi-vocity ("equal voices"), *our* attention (the attention of ADHD individuals like myself) is said to be split between a call of many different "voices," each sounding equally significant, important, and pressing as the next. "The compromised executive functioning of the ADHD brain makes all things weigh in as equally important" (Matlen 2014: 11). In turn, we have trouble

attending to one voice at the expense of all the others. This makes us "confused, dazed, and scatterbrained." But what if neurotypicals are mistaken? What if ADHD is grounded in a radically different way of attending to the world? What if our attention is not equivocal at all, but univocal? I do not mean choosing "one voice" over the others. I mean choosing to hear all the voices as one. A univocity of attention.

To be able to focus on one thing by making everything one: is that not the dream? We cannot lose focus when there is only one thing to focus on. We cannot be distracted by one thing at the expense of another thing if both things are essentially the same. "What is my ideal fantasy?" an ADHD stockbroker asks himself. "To live my day in a room with three TVs going, me holding the flipper, my PC running, the fax operating, a CD playing, portable phone held to one ear, the newspaper spread out before me, with three deals about to close" (quoted in Hallowell and Ratey 1994: 178). As another ADHD individual describes,

> I remember this feeling way back in '75 working for a big typesetting company. I'd love being there alone at night because I could get all the machines humming at once.... When I'm 'on,' it is most definitely what you describe as focused, but it's not just one task, it's multi-tasking. All those sounds do blend into a gray shroud, but the bright light illuminates the *mix* of tasks. (quoted in Hartmann 1997: 148, 149)[104]

[104] These are old examples, yes, but for that very reason they illustrate how this drive to the univocity of attention is nothing *new*.

Similarly, another ADHD individual compares his attention to "watching several channels of TV at once": "multiple channels of thought running through [my] head simultaneously" (Surman et al. 2013: 227).

According to neurotypical (liberal) models of subjectification, attention must be *stratified* and *prioritized*. Letting attention wander across "multiple channels of thought simultaneously" is pathologized as equivocal: unfocused, scatterbrained, and in Barkley's view, unproductive and executively dysfunctional. But to conceptualize ADHD's attention as *univocal* calls these neurotypical premises into question.

Attention Surplus and Oversensitivity

Many ADHD self-advocates like to think of ADHD as an "attention-surplus disorder" (Matlen 2014: 10). Almost *too much* attention to *everything*. As Hartmann puts it, "ADD people are constantly monitoring the scene; they notice everything that's going on" (1997: 6). For instance, consider the "invisible gorilla experiment" (Simons and Chabris 1999). Participants are asked to watch a video and count how many times a basketball is passed between players. A man in a gorilla suit walks into the middle of the scene, turns to the camera, and hammers his chest several times, and then walks off the set. Despite the gorilla man being so obtrusive, only 50% of participants notice him. In a repeat of the study comparing ADHD to non-ADHD individuals, 93% of ADHD individuals noticed the gorilla compared to only 22% of non-ADHD individuals (Grossman et al. 2015). The authors conclude that ADHD individuals "demonstrate greater attentional abilities on an inattentional blindness paradigm" (Grossman et al. 2015). The drive to a univocity of attention, in my view, helps to explain this difference more clearly. We are constantly absorbing everything in our sensual peripheries into an *attentional monism*. We

prioritize this monism over the task at hand (such as counting basketball passes) because that is how we sustain our attention—by making everything one.

Unfortunately, this drive to univocity can also lead to physical and affective oversensitivity. In her book *The Queen of Distraction,* ADHD self-advocate Terry Matlen takes a gynocentric approach to describing symptoms of ADHD. She makes little effort to question the gender essentialism underlying many of her ideas, but her book can also be read as a purposeful gendered performance in opposition to the androcentric approach that Barkley takes. She writes,

> Many women with ADHD live with extreme sensitivity to sight, sound, smell, taste, and touch. This high level of sensitivity to stimuli can be overwhelming for them in a number of situations that are humdrum for other people. Their ADHD brains are not able to 'tune out' input, so these women experience it as a painful barrage of stimuli coming at them all at once. (2014: 130)

When I first read Matlen's above description, I was shocked. It had never occurred to me that my habitual *fidgeting* might be related to oversensitivity rather than a generic/analogical description of "hyperactivity." In my view, part of my gendered performance as a cis man is to suppress elements of my perceptual experience that have traditionally been deemed feminine (according to the gender roles I learned growing up), including actively ignoring this sensual dimension in both body and mind. But reading Matlen, I realized that perhaps her theory of oversensitivity and ADHD can be applied to cis men as well. As I wrote in my notes, "this is an eye opener. It's like

I'm suddenly aware of why I'm always shifting around in my seat, scratching, being annoyed at my socks, adjusting my clothing, and moving my hood around my hair."

If we were to take Barkley's theory at face value, it would imply that neurotypicals also experience these sensations, but are able to use behavioural inhibition and executive functions to sustain self-control, to not react to these stimuli, to sit still and not fidget; in short, to ignore their sensual experiences. Based on my own worldviews (which admittedly are quite specific to the cultures I grew up in), Barkley's perspective here represents a masculine-centred, rationalist approach to theorizing hyperactivity as a failure to ignore sensuality. Matlen's theory, if taken to apply to men as well, calls Barkley's theory into question: I fidget not because I am unable to inhibit my behaviour, but because I am overwhelmed by the sensations "coming at me all at once"—a univocity of attention. As ADHD specialist Dr. Jan says, maybe the child is fidgeting because his underwear is too tight; but counter to Dr. Jan's (anti-)medicalized wisdom ("therefore the child does not have ADHD"), *this is in fact all the more reason to think that the child has ADHD*: the child is oversensitive. Attention *surplus*.

It is not that neurotypicals and ADHD individuals experience sensations in the same way, and only the former know how to deal with it, or that dealing with it in a socially acceptable way means suppression. That would imply that ADHD individuals are lost in an equivocity of attention—too many sensations and no ability to filter them out to focus on the task at hand. On the contrary, ADHD individuals are driven to a univocity of attention—they are driven to capture and feel all the sensations at once, often to the point of being overwhelmed. As Matlen notes, oversensitivity can be especially disabling for women: it often leads to anxiety, "mini panic attacks, bronchial spasms (for scents)," migraines, and being "sick to her stomach from smells" (2014: 131, 134). This can also make it difficult to hear what others are saying—not necessarily

because one is distracted, *per se*, but because one is overwhelmed with all the other noises in the environment.

Matlen also believes that ADHD individuals are emotionally oversensitive. Criticisms become "triggers that attack the core of your self-worth, and you then react either by blowing up, running away, or freezing ['shutting down']" (Matlen 2014: 135). I am wary of reducing the emotional difficulties ADHD individuals face to this drive to univocity, as emotions cut through every dimension of human existence, but at least some of ADHD's emotional dysregulation can be explained by it. For example, there is perhaps some overlap here with what ADHD self-advocates call the "wall of awful" (McCabe 2019), a concept I discussed in the introduction of this dissertation. Throughout our life, every time we fail at a task we add a "failure brick" to this wall, or a "rejection brick," "disappointment brick," or "worry brick" (McCabe 2019). The wall eventually becomes so big that it can make accomplishing even a simple task—such as doing the dishes—a herculean task. One common way ADHD individuals break through the wall is to "hulk smash it"—usually driven by a trigger, such as being criticized by a roommate—"fine! I'll do the dishes! Just shut up about it!" (Brendan Mahan quoted McCabe 2019). Such emotional oversensitivity corresponds to us "hulk smashing inwardly.... We start thinking about how much we suck, wondering why can't I just do this, what's wrong with me? That self-flagellation eventually gives us the energy to push through the wall, but that damages our relationship with ourself" (Brendan Mahan quoted in McCabe 2019). In other words, the "wall of awful" becomes the monism of our attention—our "fast minds" rapidly recall all the negative memories and emotions we associate with this task, memories of failure, of disappointing others or ourselves, or of our ADHD being misrecognized. The drive to a univocity of attention turns inward and to the past, and the emotional response tends to be overblown and excessive given the situation.

To give a less trivial example, when I play boardgames with my own friends, we play by unspoken "ADHD-friendly" rules, where if someone makes a stupid or nonsensical move, we correct the person and let them redo the move in a way that makes sense. The underlying idea is that we often get distracted easily when playing, but that should not have punitive consequences on the outcome of who wins or loses at the game. Unfortunately, ADHD-friendly rulesets (not that they would be called that explicitly) are rarely included in board game manuals, meaning ADHD individuals are often at a disadvantage when playing these games. For example, in a scene in the film *Sleeping Giant*, Nate, an individual who I read as having ADHD, is playing the boardgame, *Settlers of Catan*, with his friend's family. It is Nate's turn. The father of his friend explains, "so Nate, you get to put down a road from your house." Nate places a road piece on the board, lets go of the piece, but then immediately picks it up again to put it somewhere else. "No, no," the father replies, "once you take your hand off of it it's done. You can't change your mind." Nate rebuts, "well I didn't know that." "Yeah, well it's part of the rules" (Cividino 2015). Experiences like these generate for ADHD individuals a cascading emotional reminder of all the times in the past we have been disparaged as stupid, incapable, and/or misread as intentionally rebellious for not following the "rules of the game"—of boardgames, of the classroom, of professionalization, of sociality, and so on. This monism of the memorable past, this rapid emotional downward spiral, leads to Nate shutting down and quietly brooding. As a result of his brooding, Nate is temporarily robbed of his capacity to socialize with other players or to focus on playing the game. He falls further and further behind the other players and his frustration only builds. Eventually he snaps, knocks the game off the table, and storms out of the house.

Barkley attributes emotional dysregulation in ADHD individuals to a lack of working memory—an inability to hold in mind the future consequences of acting out, to pause and

reconsider their reactions: they cannot "talk to themselves privately, calm themselves down, use images and words that are soothing and positive, [to] thereby quell or greatly reduce the eventual emotional display" (Barkley 2006: 312). If we take ADHD's attentive difference, however, to be this drive to univocity, it might be said that ADHD individuals *do* take the time to pause and think, but that thinking is hyperkinetically driven to associate similar negative past experiences into a oneness: a singular, extremely-charged, often (socially) destructive *mood*.

Creativity

ADHD self-advocates tend to describe ADHD individuals as creative, as "thinking outside the box" (Matlen 2014: 10). Creativity, of course, is anything but a well-defined concept, and its meaning often changes substantially in different contexts. In this section, I do not attempt to define the concept. Instead, I theorize why the drive to a univocity of attention leads to specific qualities in ADHD individuals that can often be described as "creativity" by an outside observer.

I recall an experience a few years ago where my roommate called out to me excitedly, "*The Happy Prince* is playing in theatres this weekend!" "What's that?" I asked. "It's the film about Oscar Wilde!" To this, I replied, "oh, is that the film about the hotdog?" I was being absolutely serious—no joke was intended. Taken without any context, a psychologist might interpret my response as schizophrenic. Indeed, some studies have compared ADHD to schizophrenia insofar as they both give rise to "thought disorders" (Caplan et al. 2001: 966). Children with thought disorders often show "inappropriate and immature use of causal utterances," such as "I left my hat in her room because her name is Mary," or "I don't like Tim because I call my mom sweetie" (Caplan et al. 1989: 410). Of course, I am not schizophrenic, I just have ADHD. Fortunately, my roommate knew this and asked me to explain what I meant (rather than, say, assuming I was being flippant). Upon her request, I realized I had made a mistake and quickly clarified my

thought process: "oh no, wait, I'm thinking of *The Simpsons*. There's that episode where they sing a song about a hotdog, something about Oscar. I don't really remember." "Oscar Mayer Weiner?", my roommate asked with a grin. "Yes! That's the one."[105]

Russian linguist Roman Jakobson might very well have characterized ADHD as a mild "contiguity disorder," characterized by an "inflation of homonyms" as well as accidental, quasi-metaphoric identification: "[*telescope*] for *microscope*" (1956: 107).[106] In the above case, I inflated the homonyms "Oscar" in "the film about Oscar Wilde" with "Oscar" in "the hotdog brand Oscar Mayer Weiner," leading me to conclude it was "the film about the hotdog." Cognitive psychologists Rochelle Caplan et al. refer to this kind of reasoning as having "lexical cohesion"—connecting ideas together "through word repetition [homonym], a synonym, or an antonym" (2001: 967). Lexical cohesion is normal—everyone makes use of this kind of reasoning, and mixing up words is not exactly indicative of a disorder. *However*, according to Caplan et al., ADHD thought becomes disordered because ADHD individuals tend to *overuse* lexical cohesion and *at the expense of referential cohesion* (2001: 967). Referential cohesion means using "a pronoun, demonstrative, definite article, or comparative to refer back to people or objects in the preceding spoken text" (Caplan et al. 2001: 967). In the hotdog example, it did not occur to me in the moment that I would need to "prime the listener" with additional, referential information (*The Simpsons*, the hotdog brand, and the jingle) for such lexical cohesion to make sense to her. As Caplan et al. write, "increased use of lexical cohesion in ADHD children might... contribute to the clinician's difficulty with following these children's

[105] Oscar Mayer is an American hotdog company. A popular jingle is associated with the brand from the 1960s, which in turn was featured on *The Simpsons*.

[106] I was surprised when I read Jakobson's description, as I have many times accidentally said "telescope" when I meant "microscope" and vice versa.

conversations" (2001: 970). Nevertheless, ADHD self-advocates argue that increased use of lexical cohesion is precisely one of the reasons why ADHD individuals are so creative: "this tendency to get confused or to confuse things—so often regarded as a chief bedevilment of the ADD brain—can enhance creativity most advantageously" (Hallowell and Ratey 1994: 177).

In the introduction to this dissertation, I described a case where an ADHD student received a poor grade on his paper due to "grammatical errors," which the professor attributed to the student's racialized identity rather than his "ADHD way of writing" (Reyes II 2021). It might be said that ADHD has its *own* grammar, its own rules of syntax, its own linguistic operations, (though presumably each individual does not use the same exact operations, having unfolded differently). Barkley himself admits this link between syntax in grammar and syntax in ADHD behaviour, cognitive or otherwise (2006: 315). As he writes of linguist Jacob Bronowski (a close friend to Jakobson), "without [Bronowski's] insights into the unique characteristics of human language, I would still be searching for the clues to a theory of ADHD" (1997: xiv). In contrast to Barkley's negative theory, however, I argue that it is the univocity of attention *in thought, speech, and writing* that clarifies the underlying logic of ADHD's grammar.

In the hotdog example, it is almost as if my default mode of thinking *begins* univocally, where Oscar Wilde and Oscar Mayer Weiner are already one, and then I must work to detangle these ideas—divide my attention up—using referential cohesion (in order to clarify to my roommate or the reader what I am trying to say or argue). This is the opposite of what Barkley assumes—that ADHD's default mode of thinking is neurotypically equivocal, and becomes disordered or incoherent due to a lack of "interference control," a failure to "cleanse and suppress" distracting ideas that "disrupt [thought's] construction and performance" (2006: 302-303).

The default univocality of ADHD's grammar can, no doubt, lead many to frustration. As Matlen notes, "a lot of partners of those with ADHD complain that their partners ramble and/or jump to the next thought without a clear path of connection" (2014: 117). Conversely, however, ADHD individuals also find it annoying to have to do the work of transcribing their univocity of thought into an equivocity of referential links between distinct ideas, concepts, and contexts. As one ADHDer puts it, "I always feel as if describing how I feel and think... is too complicated—its as if I *hear the whole conversation in advance*, and I know all the twists and turns it will take before they happen, so why bother? The effort just isn't worth it" (quoted in Hallowell and Ratey 1994: 90; emphasis added). To paraphrase something my ADHD counsellor recently said to me—and which I have heard uttered in adult ADHD groups in the past—ADHD individuals tend to reach the conclusion of where a conversation (or academic argument) is going long before it gets there. Still, even though they can *think* the conclusion univocally, they have great difficulty *explaining it* to others in equivocal, referential, "causally mature" terms. As Hallowell and Ratey put it, "the tension of constructing an explanation, from A to B to C to D, apparently so simple a task, irritates many people with ADD.... They would like to dump the information in a heap on the floor all at once and have it be comprehended *instantly*" (1994: 90; emphasis added). Having experienced belittlement time and time again for trying to reason univocally in public, eventually ADHDers learn to stop trying, to "just stay silent and feel stupid" (Hallowell and Ratey 1994: 96).

None of this is to suggest that ADHDers should not bother to explain themselves, that their univocal modes of reasoning are somehow "superior" to equivocal modes, that their univocal conclusions are always "correct," or that they should not, in educational settings, have to follow the rules or conventions of university writing according to their chosen discipline. But it does

raise a question about double standards in society. ADHDers are expected to stratify their attention towards *one idea at a time* so that neurotypicals can understand, but neurotypicals are never expected to unify their ideas *all at once* to help ADHDers remain focused on, or stimulated by, the conversation. No doubt, this is an outcome of the pervasive medicalization of ADHD: perceiving it as a *deficit* rather than an *affirmative difference*, believing that ADHD's grammar is *always* in error—a sign of *stupidity* or *weirdness*. Perhaps neurotypicals should, to borrow a phrase from Stiegler, learn "the rules of process by which [a univocity of] attention is constructed... by *paying attention*" (Stiegler 2010: 80).

No doubt, this kind of ADHD misrecognition—this failure to really pay attention to what ADHDers are trying to say—is exacerbated in "repressive semiotic regimes," privileged in most primary or secondary public education, technical disciplines, or natural or medical sciences, where "one, and only one, signified is ascribed to each signifier" (Berardi 2010: 111), and each concept "has no other content than that designated by the word in the publicized and standardized usage" (Marcuse 1964: 87). Asserting even the slightest alteration of a concept's meaning through univocality is deemed *incorrect, inappropriate, or out of context*. It is for this reason that Hallowell warns ADHD individuals not to marry or work for someone who is a "caricature of a bad fifth grade school teacher," someone who says, "this is the way it is, that's the way it has to be"; ADHD individuals often make this mistake "because they got the idea around fifth grade that that's what they needed, that they had to be controlled, had to be demeaned, and put down" (quoted in Green 2009). Fortunately, the rules of grammar tend to be more relaxed with more caring partners and more literary disciplines such as the social sciences and humanities, where signified and signifier are not fixed, where conversations can be playful,

and where texts are "recontextualized with each new reading, necessarily engendering readings that are always different" (Stiegler 2010: 82).

Productivity

Neuroscientists used to call the brain activity of a mind-wandering person "background noise": it represented "low-level awareness of all the sensory stimuli around us at any given time" (Dawson and Guare 2016: 164). More recently, they started referring to it as "the brain's dark energy." A 2010 article published in *Scientific America* claims that "60-80% of all the energy consumed by the brain" is dark energy (Raichle 2010). It occurs in this state of so-called "mind-wandering." Specifically, it is energy that is *not* involved in goal-directed behaviour. As ADHD advocates Dawson and Guare note, "when the brain begins to engage in a purposeful behaviour, the [dark energy] in this network dies down, replaced by focused attention" (2016: 164). Unsurprisingly, research shows that ADHD brain activity spends most of its time as dark energy (Dawson and Guare 2016: 164). But why do neurotypicals assume that only a *stratification of attention* can be "purposeful"? Is it possible that the brain's dark energy represents not mind wandering *per se*, but a type of attentive drivenness that has been largely ignored by neuroscientists due to its supposed incompatibility with neurotypical modes of productivity?

I argue that ADHD individuals *are* purposeful in their attention. They are not driven *by* a goal, they are driven *to* univocity. This *can* result in completing tasks or achieving one's goals *if the drive to univocity aligns with these aims*. This is not always easy to do in a world geared toward *alienated labour*. Productivity under capitalism so often requires that we sever our own desires—including the drive to univocity—from the productive process. Finding subtle ways to insert that desire, that drive to univocity, back into the productive process is sometimes the only

way an ADHD individual can concentrate on the task at hand. For example, as one member of my ADHD student support group put it, "the way that I trick myself into starting essays is that I can always find something that I am interested in and work it in somehow." To be able to connect an unrelated point of interest up with the essay topic—no matter how weird or absurd the connection may be—is a vital step in sustaining self-drivenness.[107] As a result, the method of completion or the final product often look quite different compared to those of neurotypicals—for better or for worse, at least the task is done. As Hallowell and Ratey put it, ADHD individuals have "trouble... following 'proper' procedure" and have to find "novel approaches" (1994: 74).

This is not always a good thing. Having to find awkward ways of aligning the drive to univocity with goal-directedness can—perhaps far more commonly—get in the way of accomplishing the goal, of getting a good grade, of meeting deadlines, of earning a living, and so on. "It's always the same old story: great ideas, but can't get it done" (Hallowell and Ratey 1994: 4). In a world catered toward neurotypical modes of attention, ADHD is still very much a disorder, even if it is not a deficit: Attentive-*Difference*/Hyperactivity Disorder.

Many with ADHD take stimulant medication in an attempt to treat the disorder and be more productive. But stimulant medication is not a "cure": it does not stratify attention, it does not turn an ADHD individual into a neurotypical. As one ADHDer puts it, "the medication helps me focus, but it doesn't tell me what to focus *on*" (quoted in Solanto 2017: 1). If anything, stimulant medications are *univocal enhancements*: they can bring neurotypicals closer to *us*. As Charles Bradley described in 1937 when administering Benzedrine to *neurotypical* children, they

[107] For example, using Hegel to explain Barkley's theory of ADHD.

experienced a "widening of interest in things around them" (quoted in Rafalovich 2004: 71). Caffeine, in contrast, is the drug of goal-directedness. Historian Theodore Roszak states that "it is no mere coincidence that coffee and tea... entered our society simultaneously with the scientific revolution.... Sad victims of a grueling addiction—yet they enjoy high regard for being practical and productive" (1972: 77-78).

My point is, unlike caffeine, ADHD medication reconstitutes purposeful activity as a drive to make everything one: the individual no longer has to split his attention between this or that annoying task because the medication aligns each task seamlessly with the individual's already-established interests—everything and every action blends together as a unified, single comportment toward the world, a sort of "hyperfocusing." In this way, stimulated individuals can be productive without having to make their attention equivocal and goal-oriented. Put simply, when I take medication, I just "do" things without having to focus on them distinctly; my mind is always on the "bigger picture" as I go about my day-to-day tasks and activities.

Of course, not every ADHD individual takes such a high dose of medication (if they take medication at all), and even those who are on a high dose can still run into problems. Life under capitalism necessitates equivocity—a breaking of one's attention between different spheres of life: public versus private, work time versus leisure time, on-the-screen versus off-the-screen, and so on. For instance, I can write this dissertation fine, but, despite being on 54mg of Concerta daily, I still have trouble cleaning my room. For whatever reason, I cannot figure out how to integrate the task of cleaning my room into my hyperfocused, univocal lifeworld, and so it never gets done.

Treatment

In ADHD self-help literature, there are two kinds of proposed solutions to these sorts of problems: (a) exteriorize one's executive functions; or (b) find ways to make one's environment more accessible to a univocity of attention. The first kind of solution stems from Barkley's negative theory. As he puts it, "if ADHD results in an under-control of behaviour by internally represented forms of information, then such information should be 'externalized,' ... that is, it should be made physical and moved outside the individual" (2006: 327-328). For example, a "sense of time... needs to be externalized" (Barkley 2006: 329). This is why many ADHD-specialized clinicians advocate getting a watch. As Solanto puts it, ADHDers "cannot learn to master time without a watch" (2017: 99).[108] Similarly, ideas, plans, goals, and tasks to be completed should be written down and organized temporally in an exteriorized way, such as by using a planner: "if it's not in the planner, it doesn't exist" (Solanto 2017: 19). Alternatively, one's parents, teachers, or even spouse can take the role of one's executive functions: "we like to call these external supports *peripheral brains*.... A wife can become a peripheral brain" (Surman et al. 2013: 106, 108).

Of course, due to Barkley's negative theory collapsing back into the dialectic of medicalization, it becomes difficult to understand how these proposed treatments are any different from the normal sort of "self"-governing techniques every human uses to survive in advanced liberal societies. The underlying bias behind Barkley's theory is the belief that ADHD individuals' brains are never able to fully develop, and so must resort back to less-than-fully-human (e.g., "early hominid") forms of being governed by others or their environment. As I argued in Chapter Five, however, this "brain" that Barkley speaks of, or rather this "cognition," is a discursive construct of the crisis of intelligence following World War II; cognition—

[108] They discourage using a phone to keep track of time because phones are distracting.

including executive function—was reconceptualized *as* technical proficiency (Rogers 2014: 131-132). As anthropologist Edwin Hutchins argues, technological interfaces—from the simplicity of a planner to the complexity of a cockpit—"have cognitive properties in their own right that cannot be reduced to the cognitive properties of individual persons" (1995: 266). For a pilot, "working memory" is not a process of holding in mind the target speed; working memory is the use of "speed bugs"—little indicators on the speedometer—to show what the target speed is (Hutchins 1995: 280-282). Hutchins claims that "speed bugs do not help *pilots* remember speeds; rather, they are part of the process by which the *cockpit system* remembers speeds" (1995: 283).

In advanced liberal societies, we are taught to believe that humans are capable of self-governance through naturally-evolved forms of internal cognition. This makes it easy for ADHD individuals to believe that they have a "natural deficit" when their executive functions fail them. For example, an ADHD individual named Meg recalls frequently breaking down and crying when she forgot to do important things; she believed that "she should just naturally remember [things], as it appeared that other people did. [But] when she actually talked to people, she found that they used systems to help them remember"; for example, she found out that pilots are taught *not* to memorize the predeparture checklists (Dawson and Guare 2016: 132, 134, 136). No doubt, ADHD individuals certainly suffer from executive dysfunctions, but those dysfunctions are not "natural deficits"; rather, they represent an *inaccessibility to neurotypical processes of subjectification*. For example, as I discussed in Chapter One, the members of my ADHD student support group never found planners to be very helpful.

This is where the second kind of proposed solution comes into play: finding ways to make technological interfaces—cognition itself—*more accessible* to a univocity of attention. Hallowell and Ratey state that, when something comes to mind—"an image, a sentence, an idea"—the

ADHD individual "does not immediately put it in its 'proper' place. [He or she] doesn't even know where that place is" (1994: 177). As Barkley points out, this sort of ADHD grammar becomes a grammar of behaviour, or a "grammar of the body" (Barkley 2006: 315; Anthony Easton quoted in Rodas 2018: 11). In the same way that "pieces of cognition [are] strewn about in [their] mind," pieces of clothing, garbage, dishes, and randomly-placed items are often strewn around ADHD individuals' apartments (Hallowell and Ratey 1994: 4). As ADHD self-advocate Erynn Brook describes it, "you [the ADHD individual] come home. You take off your shoes and leave them where they fall, you take off your coat and throw it over the nearest chair. Your keys end up on the first empty surface you see, even if that's the top of the fridge" (Brook 2019). ADHD individuals put things everywhere because in a univocity of attention everywhere is the same—their attention is not equivocally divided in a way that would compel them to put their jacket in the closet or a plate in the sink. Everything can go anywhere.

To solve such chaos or disorganization, one must learn to adjust their technological interfaces in a way that accommodates a univocity of attention yet still meets the standards of adulthood set by liberal forms of neurotypical subjectification. Neurotypical (equivocal) approaches simply do not work. As ADHD organizational coach Susan Pinsky argues, neurotypical methods of organization are "disastrous" for ADHD individuals; instead, "every item should be stored where it is used so it can be stowed in one single motion" (2012: 9, 10). For example, Brook suggests getting a "hook or a coat rack"; she writes, "you're *not* disorganized. You're actually very efficient. *You're finding ways to do what you need to do with the least number of steps possible*.... Are you supposed to take off your coat, open a door, pick out a hanger, hang the coat on the hanger, put it back in the closet, close the door, and remember that you're trying to put away groceries? That's too much" (2019). In their drive to the univocity

of attention, an ADHDer does not have the time or energy to split their attention between distinct tasks in a linear fashion; everything needs to be done "in one single motion." Another way of doing this is to have a transparent, unlabeled, open bin of some sort in every room where an ADHD individual can throw things easily without thinking. The bins do the thinking for them. Indeed, this is precisely what Meg did after learning that neurotypical people use exteriorized systems to organize their lives as well; once she had this system in place, she found that her memory improved (Dawson and Guare 2016: 135-136). Importantly, this kind of strategy is *not*, as Barkley would suggest, behavioural modification. ADHDers like Meg are still univocally throwing items anywhere without having to divide their attention; the difference is that now Meg can easily find things—they are always in the transparent bins, easy to see. In other words, Meg found a way to successfully establish her working memory *through* her univocity of attention. The bins *are* her working memory, in the same sense that complex organizational systems *are* working memory for neurotypicals. Everything ends up "in the correct place"—while not "beautiful or perfect," such an organization system at least lives up to neurotypical standards of executive functioning (Pinsky 2012: 9). In my view, these are the kinds of successful ADHD strategies that actually *stick*.

Conclusion

To clarify, my argument is not that Barkley's theory of ADHD is completely wrong or useless. I am not denying that ADHD individuals experience executive dysfunction. My argument is rather that such dysfunction is not indicative of a natural deficit, but an inaccessibility to neurotypical, liberal forms of subjectification. It can be said that the drive to the univocity of attention gives rise to what Barkley *perceives* as behavioural disinhibition and working memory deficits. I am not saying it precedes them as a "first cause"; I am not using the

language of causality. Instead, the drive to a univocity of attention is a difference in itself, that is, a *differentiating principle* that *logically explains* ADHD's symptomatology. What makes something a symptom of ADHD, I suggest, is whether or not it can be traced back to this univocal attention-drivenness. What makes someone ADHD is whether or not they experience inaccessibility to neurotypical, liberal forms of subjectivity *due to this attention-drivenness.*

Barkley asserts that a theory can be disproven using scientific evidence. While I do not disagree with this, the problem is that, when it comes to ADHD, scientific evidence—indeed all scientific discourse—ends up being construed by the habits of thought inherent to the dialectic of medicalization. Scientific evidence is whittled down to, say, which symptoms are deemed to be most statistically relevant, or which putative biomarker is most promising. In my view, ADHD's ontology—as a concept, disorder, and way of thinking—far exceeds the limited scope of medicalized, scientific discourse. For example, conducting neuroimaging studies to determine whether ADHD individuals have "smaller brains" is itself a brainless activity; it tells us nothing about what it means for ADHD to exist. Similarly, conducting statistical studies to determine if ADHD individuals are "more creative" than non-ADHD individuals is completely unimaginative; one should conceptualize what is meant by ADHD's purported "creativity" before studying it. ADHD's difference in itself—this drive to the univocity of attention—*can* be studied scientifically, but only on the grounds that such studies are not construed by the habits of thought inherent to the dialectic of medicalization.

But why wait for science to break free from the dialectic of medicalization? There is no indication that such a feat will happen anytime soon. It would be wise for ADHD self-advocates to take matters into their own hands. The new theory of ADHD I outlined in the second part of this chapter can be used as a starting point, an ontological ground, from which a renewed self-

advocacy can begin. Figuring ADHD's specificity as an *affirmative difference in itself* allows us to finally follow in the footsteps of autistic self-advocacy and the neurodiversity movement *but without being reduced to those movements*. We can, like autistic self-advocates, encourage self-diagnosis, *but on the grounds that such diagnosis corresponds to ADHD's ontological specificity*, its affirmative, attentive difference, not this crude DSM-5 criteria. A hardliner psychologist like Barkley might think that would lead to diagnostic chaos, but nothing can be more chaotic, or scientifically unsound, than the current state of diagnostic practices surrounding this highest identity of disorder. The status quo, as I have described, presents ADHD individuals with a place in medicine—as deficient—and no place in a critical society, where misrecognition abounds.

Further, and most importantly, establishing an affirmative logic of ADHD's difference that genuinely clarifies how ADHD individuals are different from neurotypical individuals will help to reduce ADHD skepticism and misrecognition. Make no mistake, contemporary forms of media technologies are, fundamentally, technologies of equivocal attention. The basis to any advertisement, Twitter post, suggested "page you may like," algorithmic recommendations, and so on is this notion of attention scarcity, the idea that content producers have only a fleeting moment to capture the attention of, or "hook" readers or viewers before their attention moves on to the next shiny thing. If we take Barkley's theory at face value, of course everyone has ADHD; executive functioning is purposefully short-circuited by these technologies. My theory of ADHD, in contrast, helps to clarify that not everyone who has short-attention spans or is glued to their screens has ADHD. Even if the norms of subjectivity are continuously moved closer to ADHD norms, so much so that ADHD is no longer a "disorder," this does not mean that ADHD will cease to exist, or will no longer be perceivable. Regardless of whatever normative values are

imposed on individuals or institutions in any given society, ADHD remains fundamentally an *affirmative attentive-difference in itself*, a unique, distinct ontology that cannot be reduced to liberal forms of subjectivity or normative valuations.

Conclusion

The case of ADHD is a good example of why neuroscience or genetics is not always the best framework for understanding the "nature" of disorder. Public discourse around ontology—what it means for something to exist—is often whittled down to positivist perspectives begging for discernable sites in the corporeal person. However, when it comes to psychiatric disorders, it appears that ontological beliefs are by no means positivistic. I have argued that what it means for a psychiatric disorder to exist in the public imagination actually has little to do with its purported neurobiological and genetic underpinnings or correlates. Instead, such ontological beliefs appear to be dynamic in nature—a conceptual dance between specificity and generality.

No matter the shape those concepts take, or what discipline or framework they are situated in, what makes someone believe in these disorders' existence is ultimately their compatibility with the dialectic of medicalization. On the pole of specificity, psychiatric disorders are each believed, depending on one's conceptual or disciplinary framework, to be a social construction, disease entity, political identity, brain type, label, nosological category, anatomical "seat," and so on. On the pole of generality, they are each believed to be a constellation of statistically-relatable symptoms, normal variation, human distress, neurobiological diversity, varying genetic makeups, analogically-associable behaviours, and more. Such beliefs are not "stable" in the sense of sticking to one pole or the other; rather, the ontological fracture inherent in the dialectic necessitates a pendular swinging between the two poles. This could occur as a result of a simple conversation with a colleague who points out a flaw with someone's belief in, say, specificity; or it could occur on an institutional level, and shape research trajectories for years to come. No matter the case, what stays the same is the dialectic of medicalization.

I have argued that, at least in the case of ADHD, neuroscientific and genetic research does not help to uncover "truths" about ADHD's ontology: what it is, how it exists, or whether it is social or biological. Rather, neuroscientific and genetic research on ADHD merely continues the operations of the dialectic. For example, a few years ago I attended the annual North American conference on ADHD. I was very much an outsider. Despite personally having ADHD, and despite researching ADHD for my doctorate, all the presentations, posterboards, and people felt so alien to me and my project. They did not seem to me to be studying ADHD at all, but rather helping to keep its ontologically-fraught situation stable enough to keep the research dollars flowing. I wrote down some of the research titles for the posters as I walked around the room: "Anatomical Neuroimaging [biological specificities] of Environmental Risk Factors [associated with a generality of environmental risks] in Children with ADHD"; "Using Behavioural Dynamic Approaches to Test for Gene-by-Gene Interaction [statistical field of genetic association] in Modulating ADHD Behaviours [statistical field of ADHD behaviours and their degree of accessibility]"; "Microstructural Differences in White Matter Pathways [neurobiological individual differences] Associated with Motor and Attention Functioning [statistical field of ADHD symptoms] in Children with ADHD"; "Prenatal Stress [environmental specificity] and DRD-4 Genotype [genetic specificity]: Exploring Gene-Environment Interaction in Children with ADHD."

I am not suggesting that these sorts of studies are necessarily completely useless; but they certainly do nothing to combat widespread ADHD skepticism in society, psychiatry, psychology, medicine, and so on. This is because, unlike other psychiatric disorders, ADHD finds itself in an unfortunate metaphysical position: that of the highest identity of disorder. Being the "catch-all" diagnosis, ADHD allows the smooth-flowing dynamic of medicalization to continue, but only at

the expense of itself: it must open itself up to being ridiculed in a way that no other disorder has to do. Again, putting aside this diagnostic role, it is not as if ADHD is fundamentally different from any other psychiatric disorder: it swings in the dialectic like any other; it has putative but no reliable biomarkers like any other; it has well-established and popular theories of specificity; and it is criticized by critical theories of subjectification like any other. And yet, it comes under fire from the *first* aspect of indifference unlike any other: the constant reminder that it is nothing more than *generic difference*, a medicalization of normal individual variation.

I have argued for the importance of drawing on *philosophy* to help clarify ADHD's ontology both as it has been figured by society, medicine, and the social sciences, but also how it can be alternatively figured in a way that actually transcends the sterile habits of thought that keep it in conceptual purgatory. What is ADHD according to my new theory of attentive difference? It is, above all, a *difference in itself*, a sort of ADHD logic that explains how every symptom or behaviour links up to every other through an unfolding—only one that is defined by this *drive to a univocity of attention*, rather than Barkley's restrictive negative theory of behavioural disinhibition, working memory deficits, and executive dysfunction.

One does not need to postulate whether this drive to univocity is biological, social, technological, learned or born with, and so on. The idea that the ontology of ADHD can be reduced to any of these etiologies is a trick of the dialectic of medicalization. What *specifies* whether a symptom is a symptom of ADHD or not, or whether someone has ADHD or not, *should* have nothing to do with tracing it back to a formal, abstract essential identity—biological or otherwise. This is not to say that ADHD is not biological, social, technologically construed, or whatnot. Rather, what it means for ADHD to exist—when finally freed from the dialectic of medicalization—fundamentally revolves around this attentive difference, one that is clearly not

part-in-parcel with neurotypical, liberal subjectification processes. In all likelihood, this attentive difference can be studied epigenetically, neurobiologically (thinking through neuroplasticity), historical-materially (as preceding and in opposition to capitalist modes of labour, time, and attention), and technologically (not a simulacrum of contemporary forms of media, but possibly enhanced or stimulated by them). These are the sorts of cross-disciplinary and complex analyses that ADHD individuals should advocate for, not the kind of research that only perpetuates the dialectic of medicalization.

At the end of the day, this project is about establishing an ontological ground upon which ADHD self-advocacy can be renewed: one that is not reliant on psychiatric power or control; one that asserts a coherent ontological basis to ADHD; one that is able to be *critical* of the problems surrounding ADHD as a result of its forced role as the highest identity of disorder; one that can *embrace* ADHD as an affirmative difference rather than a deficit or strictly a disorder; and one that can, hopefully, help to combat ADHD skepticism and misrecognition. Autistic self-advocacy is pushing forward fiercely to combat autism misrecognition and diminution; but ADHD self-advocacy remains stifled as long as cries for recognition are ridiculed due to ADHD's supposed "made-upness." I hope that this project has provided a dual role in *explaining* what ADHD is in a way that makes people truly believe in its existence, a difference in itself that is not reducible to the generality of normal human variation, and *therefore* demands that cries for ADHD recognition be taken seriously and empathetically, in the same way such cries are heard and respected for autistic individuals. Of course, autistic self-advocacy still has ways to go to trample out stigma and misrecognition, but I would hope that ADHD self-advocacy can begin the process of working side-by-side with them in their fight—not *working under them, nor against them*, but *with them*.

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