

**The Problem of Power in ADHD: A Scoping Review**

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## **Abstract**

Attention deficit hyperactivity disorder (ADHD) has become the most diagnosed mental health issue for children worldwide. There are substantive critiques of the psychiatric basis for the conceptualization, diagnosis, and treatment that dominate the ADHD context. ADHD discourse and practice are largely influenced by the biomedical framework of mental health and illness. The pervasive, continued acceptance of the dominant biomedical ADHD narrative is problematic in terms of addressing mental health care needs as well as illustrative of the influence and power that psychiatry wields with respect to the ADHD landscape. Further, there is a lack of focus on the concept of power within the ADHD literature. This paper presents a power framework that locates the influence of psychiatric power vis-à-vis instrumental power, structural power, and discursive power. Operationalizing the dimensions of psychiatric power highlights the access points for resistance efforts aiming to counter and disrupt the status quo in ADHD from research to practice.

## Introduction

Attention Deficit Hyperactivity Disorder (ADHD) has become a commonplace mental health diagnosis for children worldwide (Conrad & Bergey, 2014; Faraone et al., 2003). This is especially evident in North American countries where rates of this diagnosis in youth have spiked over the last few decades (Bélanger et al., 2018; Brault & Lacourse, 2012; Conrad & Bergey, 2014; Hinshaw, 2018; Polanczyk et al., 2014). Additionally, the frequency of diagnosis within the adult population has significantly increased in recent years, challenging the basic premise of ADHD championed by psychiatry that the disorder primarily impacts children (Conrad & Potter, 2000; Moncrieff & Timimi, 2010). In actuality, there have been a number of substantive challenges to the validity of ADHD as a diagnosis that date back to its origin (Conrad, 1975b). Critiques have focused on the lack of clarity with respect to etiology (Peter R. Breggin, 2007a; S. Timimi & Taylor, 2004), ambiguity related to the role that heritability plays in the development of symptoms, the lack of evidence for clear causal connections between genetic information and ADHD symptoms (Chaufan & Joseph, 2013; Joseph, 2002) as well as the lack of validity of the behaviourally-based diagnostic criteria (Peter R. Breggin, 2001, 2007a; Pilgrim, 2015, 2017). The continued acceptance of the dominant ADHD narrative despite these critiques is illustrative of the power of psychiatry and its influence with respect to the ADHD diagnosis. *The instrumental, structural, and discursive power that the psychiatric profession has claimed reinforce one another and have helped to perpetuate the primacy of the dominant ADHD biomedical narrative within the mental health care sphere.* This research explores what is

known within the academic literature regarding psychiatry's position of power in relation to the ADHD diagnosis. A discussion follows regarding what was found along with an exploration of the implications for ADHD, the most diagnosed disorder for children worldwide.

### **Background**

Rates of mental illness have increased in an alarming fashion over past decades. Currently, 1 in 5 Canadians is living with addiction or mental illness while half of Canadians are dealing with, or have dealt with, a mental health issue by the time they are 40 years old (S). A staggering 70% of mental illness is diagnosed before age 15 (S), with one Canadian study indicating that 34% of Ontario high-school students have reported moderate to serious levels of psychological distress (S). While depression and anxiety are the most common conditions diagnosed across the general population, the most prevalent mental health diagnosis for youth is Attention Deficit Hyperactivity Disorder (ADHD) (S).

Further, rates of this diagnosis have spiked in North America over recent decades (Manne, 2001). Prevalence estimates have a wide variance ranging from 4-12%, however, research consistently supports that approximately 3.5% of individuals are living with ADHD's disruptive symptoms and the increased rates of adverse outcomes such as issues in educational settings, peer and romantic relationships, accidental injury, motor vehicle accidents, and substance misuse and addiction that have come to be associated with the disorder (Belanger et al. 2018).

There are two main tools that dominate the diagnostic terrain related to identifying the behavioural symptoms associated with ADHD. The Diagnostics and Statistics Manual (DSM) has been championed by organizations like the American Psychiatric Association and American Psychological Association and is now in its 5<sup>th</sup> iteration and has experienced prominence throughout North America with respect to diagnosis and treatment of ADHD. The International Classification on Disease and other Health Related Problems is more frequently referenced in Europe and organizations such as the World Health Organization (WHO). My research is primarily focused on Canada, the United States as well as similar populations such as Australia and the United Kingdom (UK). While historically the ICD has been used in the UK, the use of the DSM as an ADHD diagnostic tool is promoted on the National Health Service website. Accordingly, my analysis will be referencing the diagnostic criteria in the DSM rather than the ICD (although there is minimal difference), given the expanding and widespread use of the DSM.

According to the Diagnostics and Statistics Manual of Mental Disorders, 5<sup>th</sup> edition (DSM-5), ADHD is classified as a neurodevelopmental disorder signified by ‘a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development....and negatively impacts directly on social and academic/occupational activities’ (Bélanger et al., 2018). Three sub-types of ADHD are outlined: predominantly hyperactive-impulsive, predominantly inattentive, and a combined presentation of inattentiveness and hyperactivity. This explanation of ADHD etiology as a neurodevelopmental disorder is widely accepted throughout the literature

and regularly associated with having strong biological basis as well as strong heritability (Boomsma et al., 2010; Brikell et al., 2015; Anita Thapar et al., 2000, 2013).

Historically ADHD has been a disorder that is thought to occur exclusively during childhood, although in more recent years research has indicated that at least half (sometimes up to 80%) of children with ADHD will continue to be dealing with symptoms well into adulthood (Bélanger et al., 2018; Hinshaw, 2018; Weissenberger et al., 2017), making it increasingly clear that mental health professionals and researchers do not have as tight a hold on understanding the etiology of ADHD as often claimed in the literature. This is one among a number of inconsistencies that serve to raise doubts regarding the accuracy and legitimacy of the biogenetic origin story for ADHD.

In fact, extensive research has been aimed at addressing these doubts and developing a clear understanding of the biological basis of ADHD's etiology. One branch of this research has focused on identifying the genetic links to ADHD symptomology. Faraone et al. (2005), Hinshaw (2018), Murphy & Barkley (2014), and Pliszka (2005) all in one way or another argue that ADHD symptomology finds its origin in an individual's genes. Links drawn here implicate deficits in executive brain functioning, motivation, and/or issues related to the dopamine transporter gene (Roskam et al., 2014). Ultimately, this research has played a large role in legitimizing the development of current mental health care apparatus that primarily focuses on consensus-based behavioural diagnostic criteria and pharmaceutical treatment with respect to ADHD care delivery.

Interestingly, despite decades long research aimed at supporting the dominant narrative that ADHD is a disorder that occurs due to a chemical imbalance, which in turn is primarily due to an individual's genetic predisposition, there have not been clear causal connections made (Joseph, 2000; Wallis et al., 2008). There is a consistent absence of research that shows clear biological causal links between genes and ADHD (Sami Timimi, 2017). Further, it should be noted that it is generally accepted that neurocognitive factors do not account for the total variance found with ADHD (Roskam et al., 2014). This begs the question, why is there such a clear push within the research to support the bio-determinant view of ADHD?

Another inconsistency related to the dominant narrative of ADHD is the use of the term 'heritable' throughout the literature. It is somewhat unclear that the use of the term 'heritable' is appropriate with respect to ADHD. Employing this term implies that ADHD can be passed from one generation to the next by way of genetic material. However, as stated earlier, research in this area has not been able to conclusively and clearly link the occurrence of ADHD symptoms with the presence of specific genetic material. This notwithstanding, ADHD is consistently described as a heritable mental diagnosis throughout the literature with researchers often supporting this claim by citing twin studies (which have been shown to have confounding methodological problems) and the high statistical probability that a parent who has been diagnosed with ADHD, will have children that are subsequently diagnosed with ADHD (Joseph, 2000).

A main issue with this line of reasoning is that ADHD is not diagnosed based on an individual's genetic material. Rather, the accepted standard for diagnosis is tied tightly

to observational reports of behaviour which in no way supports the use of ‘heritable’ within the literature. These inconsistencies point to the existence of forces that, operationally, are functioning to direct consensus in opposition to what the facts support. Who would benefit from such a strong push within and beyond the literature to prioritize and legitimate the primacy of genetics as the origin of ADHD?

Alternatively, there has been some literature showing the links between ADHD symptoms with various types of traumatic exposures such as brain injury, birth complications, exposure to environmental toxins and exceptional early life deprivation and adverse childhood experiences (Bélanger et al., 2018; Brown et al., 2017; McLaughlin et al., 2014; Russell et al., 2014). The general pathway here is that a trauma/stress (physical, social, emotional, etc.) or multiple traumas/stressors are experienced, consequently impacting development in such a way that symptoms (coping mechanisms such as inattentiveness, hyperactivity, and impulsiveness) associated with the ADHD diagnosis arise. Connections between traumatic childhood exposure and ADHD are also supported within the literature. Studies focusing on Adverse Childhood Experiences (ACE) have illustrated the links between the lasting impacts of toxic stress on human brain development and the occurrence of negative mental and physical health outcomes over the life course including the presence of ADHD (V. Felitti et al., 1998; V. J. Felitti et al., 2019; Oral et al., 2016).

ACE explanations run counter to the dominant narrative of ADHD and bring important focus to the central impact that environmental forces play in children’s social, emotional and physical development. There is a breadth of work that highlights this

relationship between ACE, ADHD and various learning and behavioural challenges experienced by children, as well as anxiety, depression, and obsessive-compulsive disorders more commonly found with adults (Brown et al., 2017; Jimenez et al., 2017; Oral et al., 2016). Further, environmental factors implicated in impeding secure attachment have been found to be comorbid with the diagnosing of ADHD (Carr et al., 2013; Froehlich et al., 2011; Humphreys et al., 2019; Kissgen & Franke, 2016; Roskam et al., 2014). It is commonly agreed upon that stress is disruptive to development as well as learning and is often the source of social problems. This makes identifying the connection between ADHD symptomology (rooted in socially undesired behaviours) and the emotional/social context within which it occurs a logical one. The findings in this body of research emphasize the neglected but central place of importance that an individual's physical, social, and emotional environment occupy with respect to determining physical, social, and emotional health.

When attempting to address health concerns (such as ADHD or other conditions) and/or improve the health of citizenry through public health policy, the concept of power is not usually central to the discussion. The ADHD discussion is no different. Mental Health policy focuses on constructions of mental health aimed at targeting behaviours, while completely disregarding the central role that societal power structures play in determining individual behaviours (Mikkonen & Raphael, 2010; Raphael, 2009). How do these existing power structures within society impact ADHD policy? What specific power dynamics are at play with regard to ADHD policy?

This is precisely what my research explores; the relationship between ADHD and power. There are two main issues that the literature highlights. The first, is that the dominant approach for treating ADHD is narrow and prioritizes modalities grounded in the biomedical/psychiatric frame. The extreme prioritization of stimulant medications as treatment for ADHD is an embodiment of this issue at play. Why has ADHD treatment leaned so drastically on the biomedical conceptualization of ADHD in the face of numerous inconsistencies? Secondly, the dominant narrative of ADHD etiology seems narrow which is limiting in terms of options at the point of care delivery. Ultimately, what are the implications for supporting those with ADHD given this limiting, nonetheless dominant, conceptualization?

### **Research Goals**

The overarching goal of my Major Research Paper (MRP) is to better understand the way various dimensions of psychiatric power interact with the ADHD diagnosis, ranging from the way it is conceptualized, all the way to how care is delivered and received. The specific research questions are: 1) What is known from the existing literature regarding the position that psychiatry occupies related to the ADHD diagnosis, specifically the various dimensions of power and influence held within and beyond mental health care? 2) What are the potential implications of psychiatry's position and power for the following: a) The mental health care policy context and governance framework as it relates to ADHD? b) Meeting the mental healthcare needs of those diagnosed with ADHD?

In order to explore these questions a scoping review was undertaken applying the framework outlined by Arksey & O'Malley (Arksey & O'Malley, 2005a). The analytic synthesis of the literature was guided by a Critical Realist Exploration of Mental Health, operationalized through the use of immanent critique, as referenced in Pilgrim (Pilgrim, 2015, 2017), along with relevant elements of the “What’s the problem represented to be?”(WPR) approach outlined in Bacchi (Bacchi, 2012). In order to identify and operationalize psychiatric power as it relates to the ADHD experience, I have adapted the framework on power presented by Pulker and Trapp (2018). Immanent critique is a main way by which Critical Realists identify societal contradictions that could hold the key to emancipatory social change (Antonio, 1981). Whereas, the WPR approach finds its origin in a post-structuralist tradition, its fundamentals are steeped in the facilitation of critical interrogation of public policies, which fits well with the overall stated goal of the MRP project, to provide a critical analysis of equity issues in health policy. Underlying the WPR approach is the notion that we can make intelligent deductions regarding what is thought to be problematic in a given situation through the evaluation of the chosen solutions. Further, the WPR approach will be useful in discerning how the ‘ADHD problem’ is represented by psychiatry while providing a jumping off point to develop my discussion. The analysis in this research continues in these traditions through the exploration and critique of systems of psychiatric power where change could have emancipatory impact for those diagnosed with ADHD.

The findings of this MRP have the potential to work towards developing a conceptual map of the various ways psychiatric power functions to shape and influence

the ADHD diagnosis which would serve to inform ADHD research, policy, and practice. This is especially true given the increasingly high number of individuals that are diagnosed with ADHD and the expanding list of inconsistencies that circle the etiological basis of the dominantly accepted diagnostic criteria. The dissemination of this research can identify gaps in knowledge, make recommendations for future research, and start to center in on a much-needed conversation that serves to interrogate, rather than simply accept, the central role that psychiatric power plays with regard to ADHD research, conceptualization, and its implications for delivery of mental health care.

### **Theoretical Frameworks/Methodology**

#### **Research Paradigm**

Critical Realism (CR) has been adopted as the overarching research paradigm applied to the investigation of the research questions and approach. Critical realism as a philosophy recognizes the existence of certain intransitive realities while simultaneously holding space for acknowledging that our realities are made up of diverse experiences across space and time that are mediated by societal and systemic power dynamics. A main benefit of adopting critical realism is that it acknowledges elements of both Positivism and Social Constructivism (Idealism), which allows a degree of flexibility that neither the former nor the latter can deploy in analysis. Both subjective and objective evidence is taken into consideration.

This provides a depth of ontology that views reality as a product of three distinct domains (the empirical, the actual, the real). The empirical represents the experiences and observations, the actual is where events occur, and the real embodies generative

mechanisms, which occur singularly or in number to create events. These domains are of foundational importance for the critical realist mental health researcher. They provide the theoretical grounding for inquiry that can both acknowledge the reality that ‘mental disorders’ as a label are descriptive of something real, while at the same time, the very act of labeling ‘mental disorders’ could be a generative mechanism of the very same ‘mental disorders’ they label.

The critical realist mental health researcher maintains flexibility and specificity in their investigation by deploying methodology that highlights societal power dynamics as central to understanding the nature of mental health and illness (Pilgrim, 2015, 2017)). Immanent critique is one such approach. Broadly speaking the aim of immanent critique is to identify contradictions between epistemological claims that underlie society’s rules and systems and the values that those rules and systems are used to uphold. The ultimate goal is to provide the opportunity or pathway to emancipatory change while maintaining some elements of the theoretical underpinnings of the subject of inquiry (Pilgrim, 2015, 2017). Relevant to ADHD, this type of methodology engages in a discussion of the principles that underlie the psychiatric/biomedical ADHD paradigm with the aim to identify gaps between values (implicit/explicit) and what is being done in real terms with respect to ADHD. Further, there is an aim to show that both psychiatric power and biomedical frame are products of a historical process.

As critical realism can generally be considered a branch of critical social theory, there are no disinterested value-free positions because the critical realist researcher is part of what he/she is studying. This reflexivity has taken a central role throughout my critical

inquiry, referring not only to the necessity to interrogate the values that drive research questions but also the recognition that all research is value-laden and political in some way.

Central to my MRP investigation has been the use of the framework on dimensions of power outlined by Pulker et al. (2018). This framework in its source representation provides a framework for understanding supermarket influence across four domains of power; instrumental, structural, discursive, and political legitimacy. Pulker et al. (2018) use this framework to problematize supermarket influence within and beyond food systems and demonstrate how this has the ability to influence public health. Figure 1 highlights the way this framework can inform understandings of how various forms of supermarket power function and reinforce one another within society.

For the purposes of my MRP I have adapted this framework so that it is relevant to psychiatric forms of power in relation to the ADHD diagnosis. Figure 1 shows the adapted version of this framework that was used to generate themes for the coding of my data collection. Dimensions of power (instrumental, structural, discursive, and political legitimacy) maintained their conceptual meaning in the adapted version of the framework. For each numbered example of supermarket power in the original framework, psychiatric power analogues were produced in order to populate the adapted version. Categories that were not represented within the literature reviewed were not included in final representation of the dimensions of power framework adaptation presented in this paper. Per this framework, instrumental power is represented by the direct influence that psychiatrists have over the decisions of other actors (patients,

patients' caregivers, health care professionals, educators) in the ADHD context. Agenda-setting and rule-making that limits the range of choices of other actors in the ADHD context is an embodiment of structural power. Discursive power is represented by communication of messaging that influences societal norms and values regarding ADHD. Political legitimacy functions to mainly give authority to discursive power, however, can also function to bolster all three forms of psychiatric power.

In order to further contextualize the ADHD experience, my analysis will explore how the neoliberal and individualistic lenses interact with and reinforce psychiatric power. Individualistic ideology prioritizes personal goals over that of the group's (Triandis, 2001). Thinking for oneself, taking individual responsibility for outcomes experienced, are both central to this line of thought (Triandis, 2001). A neoliberal lens proposes that market-based solutions should be prioritized when organizing societal resources. Cutting expenditures for social services, deregulation, privatization and replacing public good with individual responsibility are main components of neoliberalism (Coburn, 2008; Labonté, 2012; Luxton, 2010). While these two lenses have somewhat different points of focus, they do find synergy with one another.

### **Scoping Review Method**

Arksey and O'Malley's (Arksey & O'Malley, 2005a) methodological approach for completing a scoping review was adopted in order to explore the research questions proposed. Scoping studies aim to identify central concepts within a research domain as well as identifying the main source types of information available within the literature (Arksey & O'Malley, 2005b, p. 21). The definition offered here implies a necessity of

breadth in review of the literature. While this is generally true of scoping studies, the degree and depth of coverage can vary from study to study depending on the specific aims of the research (Arksey & O'Malley, 2005b, p. 21). A specific aim of this type of review is to identify gaps within the existing body of literature and ultimately develop an argument based on the overall state of the research (Arksey & O'Malley, 2005b, p. 21). It is anticipated that my MRP will map what is known regarding psychiatric power and ADHD, thus providing important information for policy makers, practitioners, 'patients' and non-patients as well as highlighting access points for engaging positive change in ADHD care.

A central aspect of the scoping study methodology is the detailed documentation of the process as a way to enable study replication, adding a valuable layer of methodological rigor and reliability to any findings. In keeping with the Arksey and O'Malley (2005b, p. 21) methodology, five stages were adopted for this scoping study: 1) identifying the research question 2) identifying relevant studies 3) study selection 4) charting the data 5) collating, summarizing and reporting the results. Expert consultations, the optional sixth stage, was not incorporated in this research. This inquiry has adopted the critical theoretical frame, critical realism, in order to help move the analysis beyond the descriptive nature of the Arksey and O'Malley scoping methodology.

### ***Search Strategy***

A search strategy was created by synthesizing central concepts related to my two main research questions in order to generate relevant search terms. Key concepts included, but were not limited to, psychiatry, policy and governance, power and

influence, mental health care, ADHD, and Canada. The overall process for developing and implementing this strategy was iterative in nature, in-line with the Arksey and O’Malley methodology. Through this iterative process ‘Canada’ was removed from the key search terms due to the lack of relevant scholarship focusing on the Canadian context. Geographical specificity was addressed at the inclusion/exclusion stage. Search terms were populated for each key concept identified from the research questions. The search terms were used with Boolean operators AND, OR, and \*(asterisk). Concepts and their associated search terms are listed in Table 2. Searches were conducted in July of 2019 using the electronic databases Scholars Portal, Medline, PsychINFO, WBOFSCIENCE, ERIC, Ovid, IBIS World and ProQuest. Databases that focus on gray literature were not included in this review. A total of 411 sources were identified from all searches within the strategy deployed.

<b>Concept</b>	<b>Search terms</b>
<i>ADHD</i>	"ADHD" OR "attention deficit-hyperactivity disorder" OR "attention deficit and hyperactivity disorder" OR "attention deficit disorder"
<i>Policy &amp; Governance</i>	"health governance" OR "mental health governance" OR "health polic*" OR "mental health polic*" OR "policy" OR "health regulat*" OR "mental health regulat*" OR "political activit*" OR "Policy context" OR "fee for service" OR "policy development"
<i>Power &amp; Influence</i>	"power" OR "influence" OR "control" OR "domina*" OR "doctor power" OR "doctor influence" OR "influence" OR "policy influence" OR "power dynamics"
<i>Actor</i>	"Psychiatr*" OR "social work*" OR "mental health servic*" OR "social support*" OR "social support network*" OR "Teacher*" OR "Educator*" OR "school counselor*" OR "parent*" OR "Administrator*" OR "Psycholog*" OR "pharma*" OR "big pharma" OR "pharma* industry" OR "big medicine" OR "big money"

**Table 2.** Search terms used for each of the concepts

### ***Inclusion and Exclusion Criteria***

In order to guide the selection of full-text articles, six categories of inclusion and exclusion criteria were applied. Articles were selected if they 1) were published in English, 2) were published after the year 2000 (inclusive), 3) were available in full-text, 4) focused on populations within Canada, United States, Australia, or the United Kingdom, 5) contained an analysis that incorporated power dynamics 6) focused on ADHD conceptualization, diagnosis, or treatment. No exclusionary criteria related to study design. Based on these six parameters for selection, 9 articles were identified that, upon close review were narrowed down to the final 5 eligible articles. (See Appendix A for flow chart)

### ***Data Extraction and Analysis***

A systematic approach was implemented with respect to extraction of information from the 5 articles selected for full review. Organization of searched articles was implemented using Zotero referencing software. The Zotero software provides a digital platform for organizing research references that is customizable through the creation of searchable folders and integration with my word processor for adding citations to writing. Folders were labeled by the date with subfolders indicating the particular database searched. A scoping review charting summary table was created in Microsoft Excel in order to record and track the findings from the selected articles. Charting recorded author(s) names, publication date, setting, research design, population, primary objectives/analytical focus, intervention type, modes of data collection, findings related to the dimensions of psychiatric power, author's conclusions, and study limitations from

the selected articles. Microsoft One Note was used to organize and track the coding of the instances of psychiatric power that were identified within the selected articles. All selected articles were imported into a One Note book for review and annotation. The One Note software allows for the organization of all used references in a viewable form for ease of annotation and access. An interplay of both inductive and deductive approaches was adopted at various points in my analysis in order to both allow for data-driven analysis of findings as well as centering the context within which these findings were produced.

### **Findings and Discussion**

This section will start off by presenting a descriptive summary of the reviewed studies in ‘Nature of Evidence’ and followed by a critical analysis of the dominant themes as they relate to my research questions in ‘Patterns of Power’ and ‘Problems of Power’.

#### **Nature of Evidence**

Out of the 5 full-text articles included in this scoping study, 1 compared the Canadian and United Kingdom (UK) contexts (Malacrida, 2008, p. 147), 2 were focused on Australia (Frances, 2012; Graham, 2008), and 2 on the UK (Bailey, 2010a; Brady, 2014). Three of the 5 articles were argumentative research manuscripts (Bailey, 2010a; Frances, 2012; Graham, 2008) and the other two were studies based on qualitative data gathered through semi-structured interviews (Brady, 2014; Malacrida, 2008). All 5 studies had a broad focus on children and the ADHD diagnosis (Bailey, 2010a; Brady, 2014; Frances, 2012; Graham, 2008; Malacrida, 2008). More specifically, one utilized an

analysis of the DSM in order to level a critique of depoliticized notions of choice, responsibility and individualized deficits in childhood (Bailey, 2010a), one provided commentary on the dangers of instituting a national child mental health policy program that extends the window for ADHD testing to as early as 3 years of age without sufficient prior systematic evaluation of the associated risks (Frances, 2012), one provided a critical review of the ADHD diagnosis and the impact on children given this label (Graham, 2008), one explored the lived experience of children diagnosed with ADHD as they navigate managing their well-being within the context of everyday environmental constraints (Brady, 2014), and one provided insights into the workings of power that influence the everyday experience and choices available to mothers of ADHD children (Malacrida, 2008). Please refer to Appendix B for the full charting of the review results associated with the selected articles.

All of the five documents selected highlighted in some way how various actors (patients, caregivers, professionals) vie for agency within the context of the mental health care systems dominated by psychiatric influence. Further, a recurring theme was that power dynamics put limits on and shaped how this agency can be realized. Narratives around danger and risk reduction in approaches to care were present in three of the articles (Bailey, 2010a; Brady, 2014; Malacrida, 2008). All the articles spoke to the role of neoliberal policy agendas, synergy with individualized discourses and the impact on the ADHD context. Additionally, there was a general consensus that the dominant biomedical psychiatric frame of ADHD plays an influential role in pathologizing children's behaviours. Whether explicitly or implicitly, all five articles highlighted the

necessity for resistance in the context of psychiatric power and influence (Bailey, 2010a; Brady, 2014; Frances, 2012; Graham, 2008; Malacrida, 2008).

### *Places of Psychiatric Power*

All selected documents had reported on at least one aspect of psychiatric power (instrumental, structural, discursive, and political legitimacy) in order to meet the inclusion criteria (Bailey, 2010a; Brady, 2014; Frances, 2012; Graham, 2008; Malacrida, 2008). Figure 1 provides more detail regarding the specific references to power within the selected documents.

**Instrumental Power.** Instrumental power is best represented by situations where direct control or influence is held over the decisions of others. This type of power has been obtained and reinforced through lobbying practices for policy that reinforces the dominant ADHD narrative; funding/sponsorship of research that supports the dominant ADHD narrative; gatekeeping and creation of acceptable ADHD knowledge; the ability to set terms of service for ADHD care delivery; set limits on type of care available to children diagnosed with ADHD. Reporting regarding the limits set on the type of support available and the ability of doctors to set the terms of service were the most frequent across the articles selected.

**Structural Power.** Structural power is best represented by situations where limits have been imposed on the individuals' decision making as a downstream effect that flows from rule and agenda setting. Aspects of psychiatric structural power include private governance; early intervention agendas that normalize pharmacological treatment;

guidelines for care lacking focus on psychosocial support; health care set up in a way that limits children’s participation (agency); ADHD diagnostic tools reinforce deficit-centric ideas of agency and competency; and government funds focus on subsidizing psychiatric care.

### Dimensions of Psychiatric Power

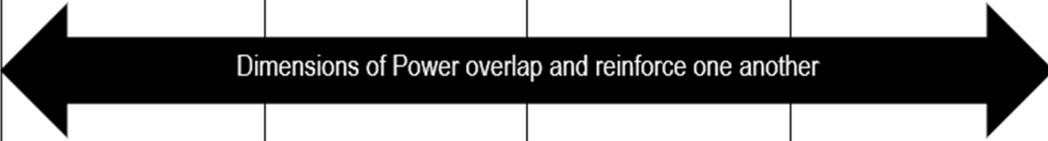
	INSTRUMENTAL POWER	STRUCTURAL POWER	DISCURSIVE POWER	POLITICAL LEGITIMACY
	Direct power held over other actors’ decisions	Rule and agenda-setting that limits decision making	Communication that influences societal norms and values regarding ADHD	Legitimizes dimensions of power (necessary for power to be wielded effectively)
				
Psychiatric channels of influence and strategies	<ol style="list-style-type: none"> <li>1. Lobbying for policy that reinforces the dominant ADHD narrative</li> <li>2. Research funding/sponsorship that prioritizes the biomedical framing of ADHD</li> <li>3. Relationship building</li> <li>4. Legal Action</li> <li>5. Gatekeepers and creation of acceptable knowledge conceptualization of ADHD</li> <li>6. Ability to set terms of service for ADHD care delivery</li> <li>7. Care professionals set limits of type of support available for children experiencing ADHD symptomology</li> </ol>	<ol style="list-style-type: none"> <li>8. Private governance subjectively determined rule sets for assessing ADHD (In continuous flux)</li> <li>9. Highlighting regulatory burden and need for patient access to pharmaceutical treatment</li> <li>10. Early intervention agendas normalize pharmacological treatment</li> <li>11. Institutional guidelines for care lacking focus on psychosocial support</li> <li>12. Health care set up in a way that limits children’s participation</li> <li>13. Deficit-centric ideas of agency and competency flow from dominant ADHD diagnostic tools</li> <li>14. Government limit support for those experiencing ADHD symptomology</li> </ol>	<ol style="list-style-type: none"> <li>15. Framing issues that support the dominant biomedical narrative of ADHD               <ol style="list-style-type: none"> <li>a. Normative child behaviour</li> <li>b. Societal values on risk/safety inclusion/exclusion acceptability thresholds</li> <li>c. Craft actor identities</li> </ol> </li> <li>16. Community involvement</li> <li>17. Celebrity success stories</li> <li>18. Research dissemination</li> <li>19. Devalue alternative mental health/illness narratives</li> </ol>	<ol style="list-style-type: none"> <li>20. Authority (absence of challenge)</li> <li>21. Trust, fairness</li> <li>22. Democratic values               <ol style="list-style-type: none"> <li>a. Participation</li> <li>b. Transparency</li> <li>c. Accountability</li> </ol> </li> <li>23. Neoliberal values and policy formation</li> </ol>

Figure 1 Framework of the dimensions of psychiatric power and influence. Adapted from the work of Pulker and Trapp (2018)

Structural power was most often referenced in relation to ADHD diagnostic tools, such as

the DSM, used in ways that limited the decisions of children diagnosed with ADHD and those responsible for their care.

**Discursive Power.** Discursive power is represented by communication that influences societal norms and values regarding ADHD. This type of psychiatric power functions through framing of issues related to normative child behavior, societal values related to risk, safety, inclusion, exclusion; craft actor identities; community involvement; research dissemination; and marginalization of alternative mental health/illness narratives. This mode of power was most often evidenced through framing of issues relevant to the ADHD diagnosis.

**Political Legitimacy.** Political legitimacy functioned to give authority to the various instances where places and patterns of power were identified. One of the main ways that psychiatric power has gained legitimacy has been through the creation and maintenance of psychiatrists' social status as mental health experts. Social status is garnered and reinforced through authority granted by government and public acceptance as experts, trust based on assumptions of fairness, neoliberal role in policy formation and agenda setting whereby a main role of government is to institute programs focused on medical management, deficit-models of care, individual responsibility in health maintenance, and the prioritization of treatments that are cost-effective. The references to political legitimacy were found to be the least frequent of the power dynamics outlined in the articles reviewed. The most frequently cited examples of political legitimacy were expert status or authority often reinforced by one or more of psychiatric instrumental, structural, and discursive power.

### *Patterns of Psychiatric Power*

I found that there were multiple illustrations of the different dimensions of psychiatric power at play throughout the articles selected. Within this group of articles all the dimensions of power (structural, instrumental, discursive, political legitimacy) were operationalized in a thorough way. This next section describes in more detail some of the specific ways that these different forms of psychiatric power were operationalized within the ADHD literature selected for this review.

Examples of instrumental power were most often exemplified by situations where psychiatric or other ‘helping’ professionals made decisions that had the immediate or latent effect of limiting the choices available to either children diagnosed with ADHD or those children’s caregivers (most often mothers). In the examples of instrumental power represented by both (Brady, 2014; Malacrida, 2008) it was clear that gender dynamics played a significant role. One such example from (Malacrida, 2008) was quite striking as it brings to the fore the issue of forced surveillance in the ADHD context.

I had to go to clinic every week and have them say to me, “we think there’s something wrong with your child. Why don’t you do something?” The surveillance. And the public health nurse would come – unannounced. To me, unannounced visits are, uhm, you know, in Canada if someone comes unannounced, they’re suspecting something. (p. 147)

This particular interviewee was acutely impacted by the scrutiny thrust upon her by health professionals. This type of judgement is an embodiment of instrumental power

in more than one way. The immediate impact of this is the imposition of shame on mothers of children with ADHD. Further, there is an implication here that the caregiver has not lived up to expectations of a 'good mother'. Options for care are inextricably tied to these judgements. Suspicions of issues at home, in this instance, led to the doctor recommending weekly visits to health clinics, bi-weekly family therapy sessions (focused on the role of the family in the child's problems), and a monthly parenting class (Malacrida, 2008, p. 147). In the context of obtaining support for ADHD these recommendations clearly put limits on the mother's choices in a very direct way. The result of the judgmental top-down expert stance of doctors helps to disempower mothers attempting to access systems of support for their children, reinforcing feelings of suspicion and anger (Malacrida, 2008, p. 147). This is an important point since one of the main motivations for seeking support is obtaining a sense of empowerment or agency in an area that has presented as particularly challenging. Mothers are looking to get support and what is being provided seems to work in ways that undermine their development of agency around caring for their children.

Dovetailing from this discussion on surveillance and instrumental power are the notions of compliance/non-compliance.

...particularly as children grew older, they began to question their need for medication ... this was deemed to be problematic...yet the concept of 'compliance' or 'adherence' is problematic, as it implies that patients should dutifully and unquestioningly follow doctor's orders. (Brady, 2014, pp. 8-9)

Children experiencing ADHD symptomology seek out professional support for a number of reasons, one of which is to help them better navigate their lives across domains (social, educational, familial relationship/environment) that are often quite challenging for them. A central aim here is to empower these children so that they are better equipped to be successful in their everyday lives. The tension that arises when an ADHD child explores their 'need' for medication uncovers the coercive nature of dominant top down treatment plans that are common in ADHD care. The irony here is that the very development of agency around personal care and mental health is what elicits the labels of problematic and non-compliant, not to mention the enactment of institutional hyper-surveillance. Surveillance is carried out by the actions of psychiatrists and pediatricians but also other professionals that ADHD children and their parents' interface with, in their daily lives.

Through the review process it was apparent that children diagnosed with ADHD and their caregivers were encountering various sources of instrumental power other than just psychiatric power. Psychologists, school administrators and teachers were identified as having significant direct impact over the decision making of those seeking support for ADHD symptomology. This makes sense, as a main site of difficulty for children diagnosed with ADHD is the classroom. The central role that schooling plays in the development and upbringing of children places teachers in a position to have a great deal of influence in the educational setting. This plays out in a way where teachers are often the first to make recommendations that get the 'ADHD' ball rolling. Graham (2008) explains:

Research in the USA shows that in the majority of cases teachers are the first to suggest a diagnosis of ADHD...The mere mention of hyperactivity, distractible, impulsive behavior is often enough to get the ADHD ball in motion.(p. 95)

There are a number of relevant layers to this conversation. First, when teachers suggest ADHD they are in effect making a choice that de-streams the child from the 'regular' or 'normal' streams of education, into alternative ones, which in most educational contexts, ends up meaning the child is required to attend special education instead of learning with the majority of his/her peers. The focus is often on fixing or controlling 'unacceptable' behavior which is ultimately a subjective determination and will be somewhat different from teacher to teacher. This type of individualized focus at the point of problematization further builds on my discussion of forcing compliance through instrumental power.

Additionally, there are often putative consequences looming for children diagnosed with ADHD ensuring that their behaviours remain within the realm of desirability.

Whether in the form of a classroom teacher who can make or break a child's educational experience, a helping professional who can withhold an appropriate referral, or an administrator who can refuse to approve funding for services, the power wielded by professionals kept most women, at least, temporarily behaved. (Malacrida, 2008, p. 156).

This excerpt speaks to the way care and control are related within the context of seeking support for ADHD symptomology. More importantly, it highlights the way that access to

support is leveraged in order to use preferred treatments (often stimulant-based) on children with ADHD.

Alternatively, structural and discursive power were found to be much less overt or direct than instrumental power, but still very impactful for children diagnosed with ADHD. The most frequent example of structural power identified was the use of the DSM as a basis for assessment and treatment of ADHD. The DSM is currently in its 5<sup>th</sup> release and it should be noted that the diagnoses that are outlined within this manual are determined by “progressive definition refinement” made by the subjective consensus of a select few psychiatrists (Bailey, 2010b, p. 586). Ultimately, the DSM guides how doctors determine what behaviours are acceptable and which ones are not. This type of categorization limits the children diagnosed with ADHD and their caregivers in a number of important ways.

Etiologically speaking, classifying ADHD as a neurological and medical condition has ramifications for what is considered to be an acceptable form of treatment. Second, it naturalizes the diagnosis as something originating from the individual where incompetence, impulsiveness, incapability, and developmental difficulties are genetic in origin. Third, this creates and reinforces a discourse around riskiness and the dangers of ADHD symptomology. Fourth, it prioritizes purification of these risky and dangerous ADHD behaviours over other objectives important for mental health (social inclusion, agency).

Further, due to the widespread acceptance and implementation of the DSM throughout mental health care systems it is unsurprising that this manual provides the ideological basis for much of the mental health care policy in western societies. Mental health programs are integrally tied to the way that the DSM has characterized ADHD and subsequently those that are diagnosed with it. For instance, the medical model of mental health practiced in Australia is highly influenced by the adoption of the DSM and as (Graham, 2008, p. 88) puts it "...professional time is reduced to a DSM symptom checklist...followed by rapid diagnosis...doctors lose their capacity to think about and interpret the meaning of behaviour" (p. 88). An important point is made here that as the DSM becomes more integrated as a guiding influence for mental health practice, there are questions that are raised regarding impact on the quality and rate of ADHD diagnosis.

Additionally, (Bailey, 2010b, p. 586) points out that there has been a rise in diagnostic ADHD that is proportional to the greater acceptance of the DSM. Essentially, as the DSM has gained prominence and authority it has become the go to reference for addressing ADHD symptomology, and simultaneously rates of ADHD have spiked. One study highlighting this compared the third and fourth version of the DSM, finding that the later version produced higher rates of ADHD diagnoses (Bailey, 2010b, p. 586). The sample was of more than 8000 individuals and was replicated at a later date with teachers and clinical screeners (Bailey, 2010b, p. 586). The point re-affirmed here is that as new versions of the DSM are released, rates of ADHD diagnosis have increased dramatically.

The widespread adoption of the DSM and its conceptualization of ADHD has implications for the type of treatments that are made accessible. Stimulants have long

been accepted as an appropriate way to treat ADHD symptomology and some in the psychiatric establishment would say that pharmacological treatment of ADHD is “...crucial in helping to avoid negative outcomes for children, their families and wider society...untreated, they are at risk of long-term social failure” (Brady, 2014, p. 3). The author goes on to explain that a natural extension to this type of thinking is that to not diagnose and treat would be signing on to the continued suffering in the form of social exclusion, educational issues, family issues, and contact with the criminal justice system. It is not a stretch to think that rising rates of ADHD diagnosis, fueled by the widespread acceptance of the DSM would subsequently impact prescribing of stimulants. This is clearly exemplified by the DSM-IV’s redefinition of ADHD criteria so that is now considered a lifelong disorder. As a result the ADHD psychostimulant market has both expanded the type of medication to prescribe and extended the age range that is considered appropriate for receiving a prescription (Graham, 2008, p. 86)

The impact is particularly evident in the Australian context as their system of social security provides financial support for some prescription medications. Following the Australian government’s decision to add Ritalin (a stimulant prescribed for ADHD) to the Pharmaceutical Benefits Scheme there was a tenfold increase in the rate of prescription (Graham, 2008, p. 87). As Brady (2014) highlights that there are often unforeseen impacts of adopting mental health practices that label our children’s undesirable behaviours as neurological disorders – namely the individualization and depoliticization of social problems, not to mention the rapid rise of psychostimulant prescriptions (which have increased by 50% in the UK between 2007-2012).

Interestingly, within the literature selected, the DSM was representative of both structural power as well as discursive power. The DSM serves as a rule set for what constitutes a valid ADHD diagnosis, and as it has become more widely accepted, it has increasingly framed issues related to normative behaviour (for children and adults), shaping societal values on what is acceptable, and playing a central role in how different actor identities are constructed. As laid out in the previous paragraphs the widespread integration of the DSM into mental health care has had clear impacts on the everyday lives of ADHD children and their loved ones by setting limits on the range of decisions available to them. A major pattern identified here was the increase in ADHD diagnosing and prescribing between DSM versions. The adoption of the DSM as the basis for understanding ADHD has functioned in a synergistic way with the patterns of increasing stimulant prescribing. The structural and discursive influence of the DSM have functioned in similarly synergistic ways that build on and reinforce one another. In the development and implementation of the DSM, the psy-sciences (psychiatry and psychology) have effectively shifted public attention to be focused on individual choices, hyper-personalizing societal problems such that ADHD discourse privileges abnormalization of child behaviour and the need to prioritize ‘self-regulating’ treatments (Graham, 2008, p. 92).

The impact of this discursive and structural power interplay is particularly evident within education systems. Graham (2008) argues “...the structural arrangements of traditional schooling encourages teachers to siphon off their problematic students to...guidance officers...behaviour modification programs, alternative-site placement

centres, psychologists, doctors, paediatricians, and psychiatrists” (p. 94-95). These institutionally imposed limits help to reinforce the truth status story of neurobiological dysfunction in ADHD that centers around a within-child deficit-based model of mental illness (Graham, 2008, p. 91). Further, this reinforces medical practitioners as the ADHD experts, ceding primary support status to doctors, and functionally relieving educators and the learning environment from any significant responsibility.

All of the forms of power play a role in the creation and maintenance of psychiatric political legitimacy. As has already been outlined, the DSM has played a central role in helping to legitimize and grant authority status to psychiatry with respect to ADHD care. Absence challenge, authority is maintained over time (Pulker et al., 2018, p. 212). Accordingly, psychiatric authority has been maintained through the use of the medical model to legitimate having a primary role in ADHD treatment.

Relating psychiatric authority and risk, Bailey (2010) highlights the role of the myth/reality debate in the ADHD narrative.

Risk analysis becomes embedded on such a plane, breeding a dependency on those with the ‘right’ knowledge...one effect of which is to further this dependence on authority. (p. 582)

The very set up of the ADHD discourse around dichotomies of right/wrong knowledge, with the backdrop of risky/non-risky child behaviour breeds what Bailey refers to as ‘risk anxiety’. Risk anxiety is representative of the collective desire to avoid the hypothetical undesired future consequences presumed to be associated with ADHD behaviour. Bailey

(2010) continues making the point that when risk becomes a main driver of choice, assessing the danger associated with a given choice is increasingly important. It is within this dynamic where ‘we become anxious slaves to knowledge’ (p. 582). With biomedical discourse constructing itself around naturalistic truth claims regarding the way mental health and illness function, psychiatry has positioned itself well to assume authority over what is understood to be accurate and true with respect to ADHD.

Another way that psychiatric political legitimacy was evidenced within the selected literature was through the development of cross institutional alliances. Both the education and psychology sectors have played a role in helping to reinforce the legitimacy of psychiatry’s position of power with respect to ADHD treatment. As already mentioned, the adoption of the biomedical neurological definition of ADHD within the school setting functions to relieve educational institutions of responsibility for children’s success or lack thereof. This psychiatric narrative of ADHD arms educational institutions with the reasoning that is necessary to empower and reinforce the notion “...that teachers and schools can stick to one-size-fits-all approaches, deviating only slightly when met with ‘deviance’”(Graham, 2008, p. 94). Educational institutions’ acceptance of medical knowledge as the preferred voice in the ADHD arena, not only removes any responsibilities that might be assigned to educators but also reinforces psychiatric supremacy as having priority with all children that are deemed as deviating from the behavioural norm. In effect this incentivizes educators to act in ways that serve to legitimize the dominant psychiatric view of ADHD. This can manifest in a number of ways ranging from teachers denying children classroom entry unless they are medicated

(Malacrida, 2008) to administrative arrangements that remove these ‘troubled’ students from their cohorts’ classroom for alternative-site placement centres (Graham, 2008, p. 94).

Psychology has also come to reinforce psychiatry’s legitimacy. Interestingly, psychiatry’s inability to offer treatments that are successful for more than two thirds of children diagnosed with ADHD, has paved the way for the development of a synergy between the two disciplines (Graham, 2008). Further, Graham (2008) argues, the failure of prescription medications to deliver on psychiatry’s promise of a solution for ADHD diagnosed children, has paved the way for the acceptance of cognitive behavioural techniques (CBT) (p. 92). Moreover, Bailey (2010a) makes the point that psychology is able to translate psychiatry’s neurological and genetic theories into everyday norms of social institutions with new language of self-actualization (p. 585). Psychology’s success here has been in the promotion of multi-model treatment plans which have served to preserve psychiatry’s medical dominance and simultaneously allowed them to acquire expert-type status in the realm of children’s behaviour control (Graham, 2008, p. 92). CBT has been paired up with prescription medication within ADHD treatment plans, with many psychologists continuing to assert stimulant medications as the first line option. An important area of overlapping consensus for these two groups is the focus on locating the problem within the child. There is a clear agreement here for the use of ‘perfecting technologies’ on children diagnosed with ADHD (Graham, 2008, p. 94) in order to address the individualised, personalized, behaviourally differentiated category of ADHD symptomology (Bailey, 2010b, p. 585). Ultimately, psychology and psychiatry

have taken on a similar affinity for the categorization of behaviours as normal and abnormal, where socially undesirable behaviours are increasingly categorized as abnormal.

Another important way that psychiatric political legitimacy has been obtained and reinforced has been through the adoption of neoliberal policy agendas focused on individual responsibility, medical management of care, and deficit-based models of health that preference cost-effective treatments (Graham, 2008, p. 99). We have already spoken about agenda setting in terms of psychiatric structural power and the resulting influence on diagnostic and prescription rates related to ADHD. The relevant neoliberal tenets here are notions of austerity (reducing government spending), and individual responsibility. With respect to austerity, neoliberal-influenced mental health care agendas are often in favour of treatment programs that can reduce costs over time, often leading to policy reductions expenditures on education and health (Graham, 2008, p. 99). Along with this line of thinking, both CBT and prescription medication are presented as promising treatments that are less lengthy than pedagogically or socially focused treatment agendas. In the context of government subsidized care, treatment modalities that offer a simple model for care will often be thought to be more efficient, and therefore fit better with governance that prioritizes economic rationalism. Further, the priority given to medical management of ADHD prioritizes cost-effective treatments and is a perfect embodiment of how the individualization of mental illness is reinforced by neoliberal-led governance and agenda-setting.

Medication and behaviour modification are of particular appeal to institutions...their use has the effect of obscuring the underlying educational, structural and sociopolitical forces affecting the child (and his/her family and community). In effect, they assist in naturalizing the existing order of things. (Graham, 2008, p. 94)

Interestingly, one of the reasons that neoliberal-driven agendas help to reinforce psychiatric power, is due to the fact that ideologically both place primary responsibility of outcome at the feet of the individual. As Graham highlights, this has a reinforcing impact on the status quo. In the context of ADHD, this dynamic ultimately legitimizes psychiatric power which has been shown to dominate mental health settings.

The preceding sections (Places of Power, Patterns of Power) have focused on highlighting what was found within the literature with respect to psychiatric power and ADHD. This addresses the first of my research questions. Moving on to my second question, the following section focuses on some of the implications of the places and patterns of psychiatric power for policy, governance and meeting the mental health care needs of those living with ADHD symptomology.

### ***Problems of Psychiatric Power***

This section will continue my discussion on psychiatric power in ADHD and aim focus at the various issues that have materialized as a result and can be described as flowing from the existing state of mental health care practice. I have implemented the use of Immanent critique used by (Pilgrim, 2017) and ‘What’s the Problem Represented to

be?’(WPR) approach outlined in Bacchi, (2012) to aid in addressing my 2<sup>nd</sup> research question; *What are the potential implications of psychiatry’s position of power for both the mental health care policy context as it relates to ADHD and meeting the mental healthcare needs of those diagnosed with ADHD?*

I will start first with an immanent critique of psychiatry in relation to ADHD highlighting issues of credibility to help problematize psychiatric power. I will then use the WPR approach to continue my analysis of psychiatric power as it relates more specifically to the gap between mental health policy and meeting the needs of those diagnosed with ADHD. While the WPR approach was developed and intended to facilitate critical interrogation of public policies and that is not the goal in this research, the six questions that make up the WPR approach have been slightly modified to specifically address my previously stated research question.

**Immanent Critique of Psychiatry.** Psychiatry’s claim to authority with respect to ADHD (and mental health and illness in general) relies heavily on the notion that psychiatry is a medical science based upon the ideals and concepts foundational to medical disciplines. Further, an immanent critique of ADHD as a psychiatric diagnosis reveals some clear shortcomings as it relates to the foundational concepts in clinical medical practise of measurement/empirical validity, construct validity, predictive validity, inter-rater reliability, test-retest reliability, aetiology, and treatment specificity.

Measurement/empirical validity refers to distinguishable phenotypes expressing a proven disease entity and are necessary in valid medical diagnoses. The ADHD diagnosis

has no measurable signs. Identification of ‘problem’ behaviours is rooted in judgements of what is deemed acceptable or not within the social context. The diagnosis itself adds no scientific explanatory value to our common understandings of socially undesirable behaviours.

Construct validity also adds to the explanatory value of a diagnosis. In order for a diagnosis to have construct validity, it must have clear conceptual boundaries that separate it from other diagnoses. As a psychiatric category, the criteria for ADHD fail to demonstrate this and consistently show significant overlap with multiple psychiatric diagnoses. Further, the lack of clarity associated with the dominant classification system (DSM-V) is highlighted by Bailey (2010b) using an excerpt on the DSM from the American Psychiatry Association:

...although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of mental disorder. (p. 586)

This non-committal stance exemplified here, ascribes a lack of precision to the psychiatric profession and the dominant way that mental health is conceptualized and diagnosed. Despite this and the unreliability of psychometric testing in diagnosing ADHD, normative standards in these types of evaluations continue to be the central way that children come to be labeled with the abnormal tag (Graham, 2008, p. 91).

Predictive validity also aims to add explanatory value in medical diagnosis. Simply stated, there should be a predictive advantage that comes along with any

diagnosis. In terms of ADHD the absence or presence of treatment does little to predict future outcomes. For instance, when a child is diagnosed with type-1 diabetes and receives the associated approved treatment, in this case insulin, there will be a predictable positive response to treatment (Pilgrim, 2015, p. 12). With respect to ADHD the same predictable relationship between diagnosis, treatment and outcome simply isn't applicable.

Alternatively, inter-rater reliability and test-retest reliability both help to confirm the validity of your measurement and construct. Inter-rater reliability is how reliably trained professionals will agree on how to diagnose any particular case. Once a person has received a diagnosis, test-retest reliability refers to the stability of that diagnosis over time. However, ADHD is diagnosed through a combination of self and observational reports that aim to indicate the presence or absence of specific behaviours. Subjectivity does not help with ensuring test-retest or inter-rater reliability. People change their minds and their memories which has negative implications when it comes to diagnosis reliability. Further, inconsistencies in diagnoses has been accompanied by a gradual creep of ADHD diagnostic criteria in each consecutive DSM edition, with the most recent version (DSM-V) expanding criteria to include adults as well. It would follow that if you expand the criteria of the ADHD symptom-based checklist, reliability would conceivably improve. However, the reliability reports from the DSM-V have not borne this out (Pilgrim, 2015, p. 11), serving to further undermine the reliability and ultimately the credibility of ADHD diagnostic criteria.

Aetiology and treatment specificity go hand in hand in that a treatment should be targeted to the conceptualized causes of a specific disease and not any others. Treatment specificity relies heavily on the health professionals' accepted conceptualization of the causes of a given disease. While I have highlighted that biomedical paradigms of mental health dominate the ADHD discourse, there are however legitimate dissenting voices within the scholarship that provide competing aetiological theories ranging from season of birth (Elder, 2010; Krabbe et al., 2014; Morrow et al., 2012), learned attachment styles (Peter R. Breggin, 2007a; Clarke et al., 2002; Erdman, 1998; Maté, 2011; Rutter, 2014; Storebø et al., 2016; Sami Timimi et al., 2004; Zeanah & Sonuga-Barke, 2016), intergenerational family dysfunction (Peter R. Breggin, 2007a; Maté, 2011; Sami Timimi, 2004; Sami Timimi et al., 2004), childhood maltreatment (Brown et al., 2017; Jimenez et al., 2017), social stress related to identity (Peter Roger Breggin, 1998), and exposure to various forms of stress/trauma (Peter R. Breggin, 2007a; Maté, 2011). Medical doctors rely on their professional authority relating to their assumed knowledge regarding the causal elements of disease in order to identify what is 'wrong' with a patient. In relation to ADHD there is clearly a lack of agreement when it comes to causation, and as Pilgrim (2015) puts it "Without this, diagnosis is just labelling or name calling for its own sake" (p. 11).

The above critiques pose a clear challenge to psychiatry's medical legitimacy and their place as the authoritative body when it comes to deciding how individuals experiencing ADHD symptomology are treated. An appropriate question given these critiques is why has psychiatry's medical authority been able to survive the discipline's

clear inability to espouse the basic scientific medical principles of clinical diagnosis? In order to help me explore this, I will engage the WPR approach.

**What's the 'problem' represented to be in psychiatry's approach to ADHD?**

The first line of treatment for ADHD children and adults is often stimulant prescription drugs. However, stimulant treatments have not produced the results promised by psychiatry and the pharmaceutical industry, illustrated by the varying levels of efficacy across those they are prescribed to. As a result, behaviour-modification interventions have grown in popularity and it has become widely accepted within the mental health care establishment (dominated by psychiatric discourses) that multi-model treatment plans combining behaviour therapy with stimulant prescriptions are the gold standard for addressing ADHD symptomology (Graham, 2008, p. 92). Although these two approaches reinforce one another and the dominant medical paradigm in mental health (outlined in the previous section) they have taken somewhat different approaches to ADHD which are illustrative of how each of these schools of thought conceptualize the 'problem' to be solved.

Interestingly, both psychiatry and psychological approaches to ADHD zero in on 'problem' behaviours as the primary issue. Psychiatry's neurobiological framing places the origin of these 'problem behaviours' squarely in the realm of the medical sciences, focusing on the need to address the assumed associated biochemical 'abnormalities' through prescription pharmaceuticals. Alternatively, psychology's behaviour modification approach more specifically focuses on the use of cognition to control 'undesirable' behaviour. While this first question has helped to clarify the implicit

problem representation in the dominant psychiatric approach to ADHD, I will now turn to the second question in the WPR approach to explore the underlying premises foundational to the psychiatric representation of the ADHD ‘problem’.

*What are the presuppositions or assumptions that underpin this representation of the problem?* As pointed out earlier, much of psychiatry’s authority status is garnered from the assumption that psychiatric diagnoses are medical diagnoses. Following this line of thinking we see that for inappropriate behaviours to be under the purview of psychiatry they must be medicalized in some way. The assumption here then, is that the behaviours associated with ADHD are due to an underlying medical condition. This brings me to the next assumption; the cause of these ‘problem’ behaviours is due to a neurobiological abnormality that necessitates a biomedical intervention. Conrad (1975a) points out that defining a problem in medical terms effectively removes it from the public realm where ordinary people can contribute and places the discussion on a plane where only medical professionals can participate. Psychiatry becomes the neutral expert and gatekeeper in determining which behaviours are indications of an underlying illness or biological abnormality and which are not. Further, the widespread acceptance of the stimulant treatments that flow from the medicalization of ‘problem’ behaviours are inextricably linked to the notion that untreated, these ‘problem’ behaviours pose a danger or threat to individual and social well-being. The perceived presence of danger further helps to legitimate the imposition of medical authority over those diagnosed with ADHD by psychiatrists.

The final assumption relating to the psychiatric representation of the ‘problem’ with respect to ADHD I would like to highlight has to do with responsibility. Western medicine is reductionist by nature. The medicalization of ‘problem’ behaviours functions in a similar fashion searching for solutions to complex problems within the individual. Conrad (1975a) speaks to medicalization of behaviour and responsibility:

It diverts our attention from the family or school and from seriously entertaining the idea that the “problem” could be in the structure of the social system...by giving medications we are essentially supporting the existing systems and do not allow this behaviour to be a factor of change in the system. (p. 19)

Acceptance of personal responsibility for ‘problem’ behaviours is a cornerstone assumption within the medical paradigm. Patients that fail to follow doctor’s orders are considered ‘non-compliant’. An interesting dynamic emerges where those diagnosed with ADHD are held responsible for both the ‘problem’ behaviours and their correction (or lack of correction). However, as I’ve previously illustrated, there are multiple ways that psychiatric power operates to limit and control choices of those diagnosed with ADHD in order to target ‘problem’ behaviours. Ultimately ADHD criteria are used to decontextualize children’s behaviours, transforming them into abnormal neurobiological phenomena requiring correction through stimulant treatment. Non-compliance is thought of as a matter of individual responsibility and the implicit assumption is that left untreated there is a danger to self and others.

This brings my analysis to the third question in the WPR approach; *How has this representation of the 'problem' come about?* How have power and influence directed practices and processes involved in shaping this dominant representation of the ADHD 'problem'? In exploring this question, it is important to understand psychiatry's history a little bit more broadly. There has been a long history in psychiatry of expanding its purview through attributing problems in everyday life to physiochemical processes that have yet to be discovered (Ratner, 2014; Szasz, 1960; Zola, 1976). Problems with sleeping, relationships, various addictions, appetite, low energy, high energy, mood, sexuality, and even gender have all been subject to research aiming to discern the genetic and physiological precursors to these socially located problems. As Ratner (2014) points out the increasing tendency to medicalize social-psychological problems has been followed by a lock-step continual diagnostic expansion of the DSM with each new edition.

Psychiatry has been around as a discipline much longer than ADHD has been a diagnosis. The precursor organization to the American Psychiatric Association, The Association of Medical Superintendents of American Institutions for the Insane, was founded in 1844 and then changed to its current name in 1921. The criteria encompassed by the DSM for ADHD only first appeared in 1957, categorized then as 'hyperkinetic impulse disorder' (Conrad, 1975a, p. 13). Since the late 1950's this cluster of 'problem' behaviours has been clinically categorized in several ways including: Minimal Brain Dysfunction (MBD), Hyperkinesis, Hyperkinetic Impulse Disorder, Attention Deficit and

Hyperactivity Disorder (ADHD), and Attention Deficit Disorder (ADD) (Conrad, 1975a; Maté, 2011).

A major effect that has come from defining more and more of our social existence in individual and medicalized ways has been a pharmaceutical revolution focused on creating drugs to address these theorized chemical imbalances. The prescribing of drugs has and continues to be an exclusive right held for medical doctors, and by 1961 the FDA had approved the prescribing of stimulants (Ritalin) for use with children (Conrad, 1975b, p. 14). Following the FDA approval of Ritalin, pharmaceutical firms began mass media messaging campaigns targeting doctors through medical journals, as well as to a lesser extent the educational sector. These elaborate 1-6 page pharmaceutical ads boasted the advantages of treating hyperkinesis, instilling the importance of diagnosing and treating children exhibiting behaviour seen as disruptive, disobedient, rebellious, anti-social, or deviant (Conrad, 1975b, p. 16).

Pharmaceutical companies spent considerable time and money in the promotion of hyperkinesis as a legitimate disorder along with highlighting the merits of stimulant treatments. Large amounts of money flowed from these pharmaceutical firms in order to create and shape the discourse on hyperkinesis. Profits for Ritalin alone topped \$13 million in 1971 and by 1975 hyperkinesis was the most diagnosed childhood disorder in the United States (Conrad, 1975b, p. 17). Over the next three decades ADHD diagnoses have spiked significantly along with the subsequent number of prescriptions for stimulant medication. Breggin (2007a) confirms this pattern, highlighting the more than tripling of ADHD drug sales of \$759 million to more than \$3 billion between 2000 and 2004.

The pharmaceutical sector has clearly played a pivotal role in shaping the professional and public discourse on ADHD. However, there have been other influential factors in maintaining and propping up the biomedical conceptualization of ADHD. The advent of patient advocacy groups like Children and Adults with Attention Deficit Disorders (CHADD) have significantly helped to reinforce the legitimacy of the dominant psychiatric view of the ‘problem’ for those diagnosed with ADHD. Firstly, the framing of ADHD as a problem that finds its origin within the individual, conveniently absolves parents and educators of any responsibility. Breggin (2007a) quotes a CHADD brochure:

Frustrated, upset, and anxious parents do not cause their children to have ADD.

On the contrary, ADD children usually cause their parents to be frustrated, upset, and anxious. (p. 273)

CHADD’s unofficial policy of “we are not to blame” is quite literally on display via the organization’s brochures.

Over the years since it was founded in 1987, CHADD has become quite cozy with the pharmaceutical industry receiving large sums of money from various pharmaceutical companies. Mid-way through 2006 almost 30% of CHADD’s budget had come from pharmaceutical funding sources (Peter R. Breggin, 2007a, p. 274). The fact that a major portion of their funds were received from the pharmaceutical industry doesn’t necessarily confirm they function to forward industry interests. However, Breggin (2007a) argues CHADD is a ‘drug company-funded advocacy group’ that actively and aggressively

lobbies for policies that favor pharmaceutical sales over public safety (p. 274). This is illustrated by a CHADD press release regarding new warnings that the FDA was planning on adding to stimulants concerning cardiac risks in children. The press release called out the FDA warning as premature and highlighted that stimulant treatments were a central and necessary part of ‘comprehensive’ ADHD treatment programs (Peter R. Breggin, 2007a, p. 274). Alarming, stimulants have a wide variety of known adverse effects impacting the body, brain, and mind ranging from things as common as headaches and slight flushing or fever to symptoms that are generally deemed much more serious like vomiting, cardiac arrhythmias, and convulsion (Peter R. Breggin, 2007b, p. 286). Further, some research has even found an increased risk of suicidal ideation with ADHD medications (Peter R. Breggin, 2007b, pp. 294–295). This is particularly troubling given the preference and priority that pharmaceuticals are given when it comes to treatment in ADHD.

An important point here is that patient advocacy groups like CHADD have played important roles in lobbying for policies that prioritize pharmaceutical manufacturers interests regardless of the mounting evidence that illustrates the very real danger associated with giving these drugs to our children. Additionally, the underscoring of the biomedical basis of ADHD is foundational to the organizations’ stance of absolving parents, educators, and broader systemic dynamics of responsibility and thus is a fundamental thread that runs through all their activities. Patient advocacy organizations are positioned as knowing and trust-worthy sources of professional level information, and

thus have helped to solidify the acceptance of this dominant representation of the ADHD ‘problem’ in the public sphere.

Another major force that has helped to entrench the biomedical problematization of ADHD associated behaviour is the education sector. Similar to parents with their children, our educators traditionally bear the responsibility for their students’ successes. The acceptance of the psychiatric framing of ‘problem’ behaviours by our educators relieves teachers and education policy from having to evaluate why there are year over year increases in the number of children that are having attention problems. Graham (2008) points this out, highlighting that focusing on medicinal and behavioural adjustments that the child can be made to adhere to, serves to protect the status quo, which in this case is the classroom environment, pedagogy, and educational practices. This is an attractive offer for the teachers and educational administrators alike as they are often evaluated by their students’ performance. Without the burden of responsibility, it has become common place for teachers to pre-emptively ‘diagnose’ students they deem to be disruptive, often leading to situations where parents are urged to seek a psychiatric assessment and stimulant treatment for their child (Graham, 2008; Malacrida, 2008). For many teachers it is straight forward, these kids have a biochemical imbalance and they are doing their job by referring them to the ‘expert’.

A final point on how this representation of the ADHD ‘problem’ came to be. Government policies in the United States as well as Canada have been driven by neoliberal ideals since the end of the 1970s (Labonté, 2012). Relevant here, are policies focused on cutting back on social spending in the name of balancing the national budget.

This is particularly important in terms of our education sector's capacity to provide quality education. Over the past four decades funding to education has been under constant attack by policy makers touting the importance of balanced budgets and lowering taxes. Class sizes have gotten larger, there are less funds available to the education sector, and teachers are regularly worried about job security. What I am aiming to highlight here is the synergy between economic rationalism that has directed policy cuts to education that has resulted in a downward pressure on educators and supported the medicalization of 'problem' behaviours that can conveniently be treated with a pill. Psychiatry has provided the perfect solution for all to deal with ADHD. Policy makers have bought into this 'solution' because it is cost-effective and easy to implement. Similarly, educational administrators spend less of their time dealing with 'problem' children if they can offload that responsibility to professionals (psychiatrists or psychologists). Teachers can now more regularly just separate disruptive children from their classmates by recommending they be sent to alternative-site placements and parents no longer have to feel like they have failed their children. It has all come together nicely to reinforce the medicalized 'problem' representation of ADHD while simultaneously solidifying psychiatry's place of authority within this mental health care sphere and beyond.

*What is left unproblematic in this 'problem' representation? Where are the silences and can the problem be thought of differently? How has it been questioned?* Firstly, my immanent critique of psychiatry has highlighted important inconsistencies between this discipline and concepts foundational to clinical medical practice. Given that

psychiatry has maintained a position of dominance as the go to ADHD mental health professionals throughout society, it is safe to say that the critiques brought to bear through my immanent critique have been largely left unproblematic by the dominant representation of the ‘problem’. As I have already argued, psychiatric authority has largely been conferred based on the discipline’s ability to be recognized as a medical science.

It is important to unpack why psychiatry has been able to maintain authority while the science that underlies the application of the medical model within the discipline just simply doesn’t add up. Graham (2008) argues that a reason for the continued support of the medical model of neurobiological dysfunction is the maintenance of psycho-pharmaceuticals as the best and most legitimate solution. Ciba-Geigy (the company that manufactures Ritalin) has directed considerable attention to activities centered around ensuring that ADHD is thought of as a medical disorder by both doctors and the general public (Conrad & Potter, 2000, p. 567). Pharmaceutical sponsored research projects have continually failed to identify “...a definitive link between specific biological regions or neurologic components and (1) the so-called ‘symptomology’ of ADHD, or (2) what psycho-pharmaceutical do and how...”(Graham, 2008, p. 86). These findings cast doubt on the legitimacy of psychiatry’s claim to authority in relation to ADHD and the subsequent prescribing of stimulants. However, as stated earlier Ritalin sales are a major source of revenue for Ciba, revenue that is quite literally tied to the notion that ADHD symptomology is caused by a neurochemical imbalance that can be treated with stimulants. Any deviation from this dominant conceptualization of ADHD would

conceivably have a negative impact on the earning potential of Ritalin and other stimulants prescribed for ADHD. However, its not just the stimulant manufacturers that over the years have consistently been fighting to maintain the dominant problematization of ADHD.

The dynamic here is psychiatry has managed to position itself over the years as the dominant mental health authority largely due to its recognition as a medically grounded tradition. Psychiatry has leaned heavily into promoting this narrative of ADHD, which has reinforced the importance of having psychiatrists at the center of diagnosis and treatment of ‘problem’ behaviours. This dominant view on ADHD has long since become the status quo. Moreover, what I have endeavored to illustrate here is that over the years the status quo has become so entrenched within the structures of power that dictate and direct how those experiencing ADHD symptomology are treated that there is what could be described as a institutional resistance to any alternative views. There is an irony here that psychiatry, educators, parent advocacy groups, and the pharmaceutical manufacturers are fighting to maintain the primacy of the biomedical explanations of ADHD, supposedly based in science, while simultaneously ignoring or discounting any science that doesn’t agree.

The large majority of the research on ADHD has not applied a critical eye, accepting the assumptions that underlie the dominant psychiatric conceptualization. There is scholarship that has adopted a rather different focus for the conceptualization of the ‘problem’ in ADHD. Peter Breggin has written extensively regarding the issues that flow from thinking of ADHD as a problem that originates within the child or individual

(Peter R. Breggin, 1999a, 1999c, 1999b, 2000, 2001, 2007a, 2007c). Broadly speaking, Breggin takes the stance that the focus in ADHD treatment necessarily should be directed at creating home and school environments that facilitate caring connections between children and adults. Breggin (2007a) brings into view a different conceptualization of the ‘problem’, one that centers on meeting the basic needs that all humans require throughout their lives, and especially during the early years of social and emotional development. There is emphasis put on adults to take the lead providing caring attention and consistent non-punitive guidance in building skills related to personal responsibility.

Research in the area of Adverse Childhood Experiences (ACE) similarly highlights the impact that environmental trauma and stress can have on the life-course of children (V. J. Felitti et al., 2019; Foege, 1998; Whitfield, 1998). One of the main ideas that has come from this research is the notion that all health and illness are scaffolded in such a way that our early life experiences, and the social conditions within which they occur, are strong determinants of and building blocks toward our future health status (See Appendix B). Interestingly, there has been research that suggests a connection between the diagnosing of children with ADHD and the future occurrence of ACE (Brown et al., 2017; Jimenez et al., 2017). The ACE studies mainly focused on the negative impacts of the environment, however, the message coming out of the studies lines up with Breggin’s (2007a) take on meeting children’s social, emotional, and physical needs.

Breggin (2007a) is particularly sensitive to the demoralizing and deleterious impacts that come about from labeling a child with a brain disorder over which they have no control. This narrative of ADHD has the impact of undermining the self-esteem and

confidence of children that have been diagnosed, which only adds to the emotional burden that these kids have been made to carry. Further, Timimi (2004) argues for the need to “dispense with the notion that ADHD exists as a medical condition” as a necessary step towards meeting the needs of all children, not just those experiencing ADHD symptomology.

In line with this, Måte (2011) outlines a clear pathway connecting attachment and ADHD symptomology. “The ADD child’s difficulty reading social cues likely originates from her relationship cues not being read by the nurturing adult, who was distracted by stress” (p.74). While ADHD isn’t only about missing social cues, Gabor Måte makes an important point here. The origin of ADHD symptomology can be found by assessing the primary caregiver’s emotional state. He proposes that as early as in utero, the child’s emotional state is very much taking its cues from that of the primary caregiver. When a child’s ability to stay connected to their caregiver is disrupted, coping behaviours are developed to deal with the emotional disruption. Following this school of thought, treatment would primarily focus on identifying the areas of emotional disruption between the parent and child and building that into a stable and nurturing connection that the child can count on to be compassionate and responsive to their needs. “Children are not born with emotional disorders; they are born into emotionally disturbing living conditions”(Peter R. Breggin, 2007a, p. 280).

### **Strengths and Limitations**

This MRP provides a critical analysis of various forms of psychiatric power (structural, instrumental, discursive, political legitimacy) and illuminates the way these

modes of power have directed and influenced ADHD conceptualization, diagnosis, and treatment. This review recognizes and operationalizes the various ways that psychiatric power has functioned to maintain dominance within the realm of ADHD mental health care. Through this review's exploration of psychiatric power and ADHD, a framework was synthesized that delineates the direct and indirect ways that psychiatric power functions within and beyond the health care system. Adopting this power framework operationalizes the specific ways that psychiatric power has and continues to influence the lives of individuals diagnosed with ADHD as well as their caregivers. Additionally, this framework provides places where this power can be challenged and resisted. Future studies around ADHD would benefit from centering exploration on how to better disrupt and resist dynamics of psychiatric power, particularly those that reinforce the biomedical narrative of ADHD.

There are some potential limitations of this study. It is possible that the search strategy wasn't able to identify all relevant articles and therefore missed a particular aspect of psychiatric power relating to ADHD. This review was carried out by a single researcher which could have limited the depth and breadth of work evaluated that is relevant to this research. Articles were only accepted if they had been published in English, which means that there is a possibility that some literature was missed regarding psychiatric power and ADHD that was published in another language. Additionally, the analysis presented does not account for the role that different identities (race, gender, class etc.) play with respect to psychiatric power and the ADHD diagnosis. Adopting a frame that would allow for a more nuanced analysis around identity would be fruitful for

future research. In line with the scoping protocol presented in Arksey & O'Malley (2005b), the quality of the included articles was not assessed.

### **Implications and Conclusions**

What this review demonstrates is multifaceted. Firstly, there are clear issues with the dominant psychiatric frame of ADHD and this has implications for research, policy and practise. With respect to research, this review illustrates the immediate need for research that locates psychiatric power and its influence with respect to the ADHD diagnosis. It is important that future researchers in this area use frameworks and analytic techniques that allow for the identification and operationalization of power dynamics as they can play an important role in understanding motives upon which our mental health care system is built. Understanding our mental health care system has implications for how we support individuals experiencing ADHD symptomology. Further, it is centrally important that future researchers in this area adopt a critical mental health frame as it is of the utmost importance that ADHD is detethered from the medicalized frame of thinking that aims to pathologize 'problem' behaviours. A large majority of the research in this area is funded by private enterprise, so changing the medicalized discourse on ADHD will be an uphill battle, but a necessary one.

The implications for policy and practise are somewhat interrelated. The framework on the dimensions of power highlights access points for policy that could go a long way toward better facilitating school and home environments that are more supportive. These policies could address increased funding to education, allowing more flexibility and better application of pedagogical solutions to challenges within the

educational environment; social policies that reduce the material burden like a guaranteed basic income, and universal health care that is truly universal (including dental and psychological supports) to help relieve stress on individuals throughout society. This is related to practise because when good supportive social policies are instituted, practitioners and parents are subsequently less stressed. Teachers have smaller class sizes and are therefore able to spend more time being creative with their lessons and attuning to their students' needs in a more responsive way.

Secondly, there are promising alternatives. The work of Breggin, Timimi, and Mate all highlight the way forward for meeting the needs of those experiencing ADHD symptomology. These authors all emphasize, in one way or another, the central role that the concepts of compassionate caring, patience, affection, emotional support, consistency, and rational discipline play in facilitating supportive family and educational environments of those living with ADHD symptomology. It is imperative for the adults to take responsibility for their relationships with children, prioritizing connection and demonstrating interest in the child's emotional well being.

Finally, psychiatric power dominates the ADHD mental health care landscape. Psychiatric channels of influence dictate who has access to care, what type of care is available, how long the wait will be and how much it will cost. The consistent trend for psychiatry to classify and reframe various human behaviours as pathologies has not been shown to be helpful; in the case of ADHD, it has been quite harmful. It is time to re-think ADHD and this means it is time to re-think psychiatry's position of power and influence.

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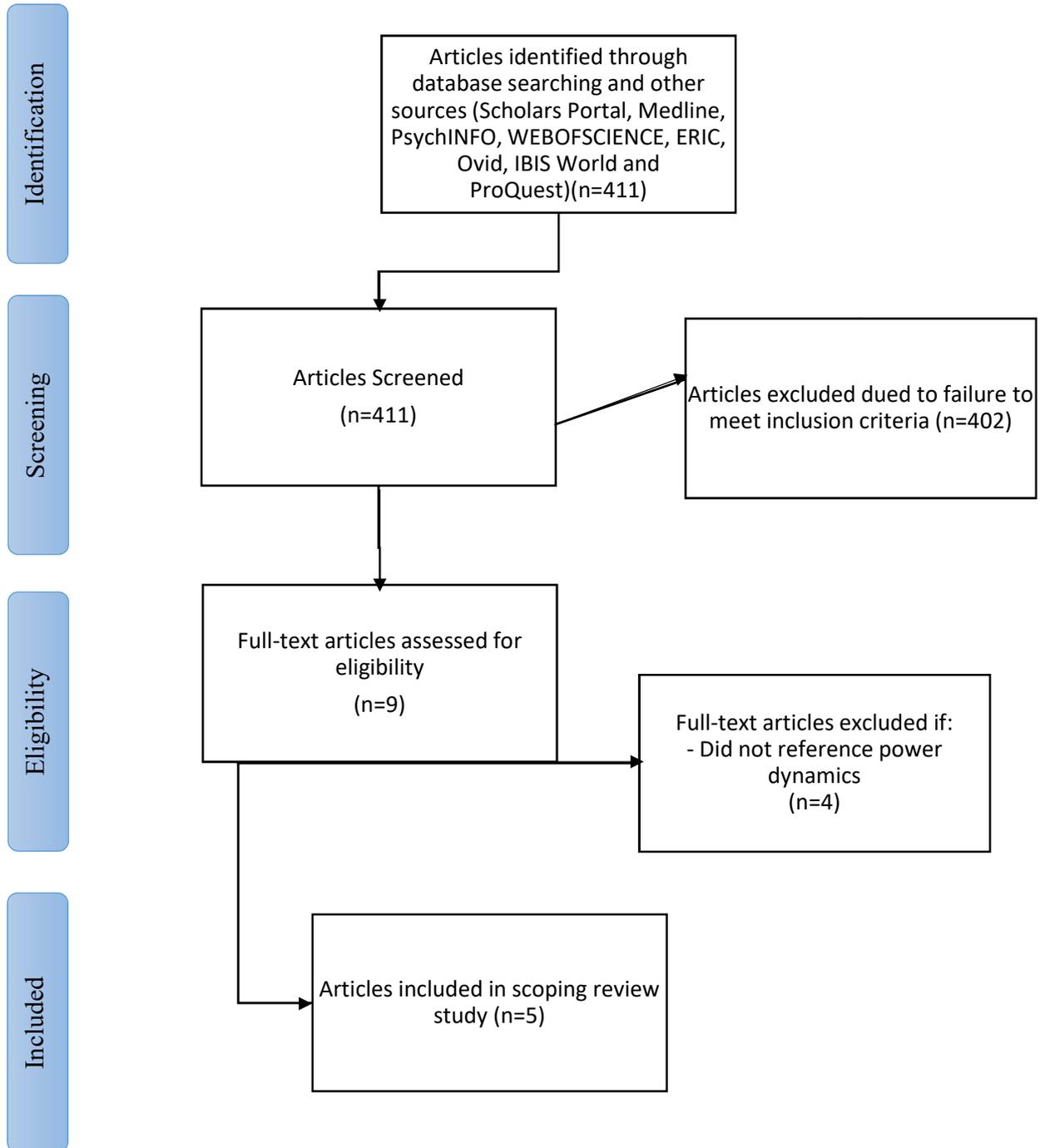
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## Appendix A – Database Search Flow Chart



## Appendix B – Scoping Review Charting Summary

Author, Year, Setting, Design	Population	Primary Objective/Analysis	Intervention	Measurement
<p>Brady, G.M., 2014</p> <p>Setting UK</p> <p>"...research began with non-participant observation of children's assessment appointments at English city Child and Adolescent Mental Health Services (CAMHS)." "Seven families that expressed interest in contributing further...took part in narrative interviews and I worked with seven children...through three indepth data-gathering sessions over a period of 6-12 months."</p> <p>Study Design Qualitative, Cross-sectional descriptive study.</p> <p>Interviews conducted in-person by researchers</p>	<p>Seven children whose parents expressed interest in them participating after they had a ADHD assessment or diagnosis from the CAMHS.</p> <ul style="list-style-type: none"> <li>- Age 6-15years</li> <li>- All were english speaking</li> <li>- Six were boys</li> <li>- One girl</li> <li>- Four were white British</li> <li>- One white North American</li> <li>- One black British</li> <li>- Three families were owners of their housing</li> <li>- Three families rented from the Local Authority</li> <li>- One family rented privately</li> </ul>	<ol style="list-style-type: none"> <li>1. Present the experiences of children seeking and receiving a diagnosis</li> <li>2. a) Highlight the meanings which children gave their actions</li> <li style="padding-left: 20px;">b) Highlight the meanings which parents gave to their health-seeking behaviour</li> <li style="padding-left: 20px;">c) Highlight the meanings which professionals gave to their practice and delivery of services</li> <li style="padding-left: 20px;">d) Highlight the meaning children gave to being diagnosed with ADHD</li> <li>3. Highlight the impact that the dominant biomedical framework has on the agency of children diagnosed with ADHD.</li> <li>4. Highlight issues with defining aspects of children's behaviour as a neurological disorder - often simultaneously individualizing and depoliticizing social problems.</li> <li>5. Highlight the need to question the normalization of the biomedical framework as the primary way to understand children and the implications for how institutions control children's lives.</li> </ol> <p>Open coding &amp; thematic summaries to construct and synthesize larger themes</p> <p>Use Inductive &amp; deductive data coding</p>	<p>Narrative interviews in conjunction with in-depth observations of facilitated communications with the children.</p> <p>Various types of contributions were encouraged in children: oral, written, artistic.</p> <p>Through verbal and visual modalities the participants were given the space to attach meanings to their lives and their health and illness experiences.</p>	<p>Description of children's experiences coded into themes</p>

References to Power					
Instrumental	Structural	Discursive	Political Legitimacy	Author Conclusion	Limitations
<p>i) Gatekeepers and creation of acceptable knowledge conceptualization of ADHD</p> <p>ii) Care professionals set limits of type of support available for children experiencing ADHD symptomology</p> <p>- References to concepts in power framework:</p> <p>pg1 - 1(a)</p> <p>pg3 - 4(a)</p> <p>pg4 - 4(b)</p> <p>pg6 - 2(a)</p> <p>pg7 - 1(a)</p> <p>pg8 - 4(a,b),5(a)</p> <p>pg9 - 2(a,b),3(a),4(a)</p> <p>pg10 - 1(a), 2(c,d,e,f,g)</p>	<p>i) Private governance subjectively determined rule sets for assessing ADHD</p> <p>ii) Deficit-centric ideas of agency and competency flow from dominant ADHD diagnostic tools</p> <p>- References to concepts in power framework:</p> <p>pg1 - 1(a)</p> <p>pg2 - 1(a)</p> <p>pg3 - 4(a)</p> <p>pg4 - 4(a)</p> <p>pg7 - 1(a)</p> <p>pg8 - 4(b)</p> <p>pg10 - 2(a)</p> <p>pg11 - 4(c)</p>	<p>i) Directional framing of issues that support the dominant biomedical narrative of ADHD</p> <p>ii) Devalue alternative mental health/illness narratives</p> <p>- References to concepts in power framework:</p> <p>pg2 - 2(a)</p> <p>pg2 - 4(a)</p> <p>pg3 - 1(a),2(a),2(c)</p> <p>pg6 - 4(a)</p> <p>pg7 - 1(a)</p> <p>pg8 - 6(a)</p> <p>pg9 - 3(a,d)</p>	<p>i) Neoliberal values and policy formation</p> <p>- References to concepts in power framework:</p> <p>pg11 - 2(a)</p>	<p>- Children actively work to create a sense of agency in their lives by actively working to redefine their experiences with ADHD (and without) in order to make them meaningful to them.</p> <p>- It is important to call into question the simplistic perspectives on the taking of medication to regulate the symptoms associated with ADHD.</p> <p>- The biomedical framework contributes to pathologizing children's behaviour and inextricably links care and control.</p> <p>- Children's quality of life and well-being is self-defined rather than defined by adults.</p> <p>- Children's ideas of what behaviours are normal or problematic is rarely considered within the doctor-patient interaction.</p> <p>- There are important implications of the depoliticization and individualization of social problems through the categorization of children's behaviours as a neurological disorder.</p> <p>- Children's lives are controlled by institutions that are greatly influenced by the normalization of biomedical frameworks for understanding children behaviour and thus this frame should be scrutinized.</p>	<p>The analysis didn't increase understandings of class, race, or gender</p>

Author, Year, Setting, Design	Population	Primary Objective/Analysis	Intervention	Measurement
<p>Malacrida, C, 2008</p> <p>Setting Mothers of children diagnosed with ADHD were interviewed in Alberta Canada and Souteast England.</p> <p>Study Design Qualitative, cross-sectional descriptive study</p> <p>Semi-structure interviews were conducted in-person by the researchers.</p>	<p>34 mothers were interviewed total - 17 mothers were interviewed in Calgary, Alberta - 17 mothers were interviewed in the Southeast of England - The sample ranged from single mothers with several children to those who mother a single child within an intact and "supportive" partnership and extended family. - Occupational and educational status ranged from recieving social assistance and less than high school completion to possessing more than one graduate degree and maintaining professional occupatinoal status. - All but six were employed on varying part-time basis. Of those six, three women lived on social assistance, and the remaining three depended on parter incomes.</p>	<p>1.Examine the experiences of women whose children are diagnosed with ADHD.</p> <p>2.Aim to understand what it is like to be a mother confronting multiple 'helping' professionals while supporting their children in dealing with the highly controversial diagnosis (ADHD).</p> <p>3.Provide insights into the workings of power in the handling of children and families that are deemed problematic.</p> <p>4.Highlight how these mothers experienced and countered discourses of inadequate mothering</p>	<p>Semi-structured interviews were conducted aimed at allowing the participants to tell their story regarding their experience related to their child's ADHD diagnosis.</p> <p>The interviews were set in a way to best facilitate a space where they could communicate their stories of conflict, anguish, worry and stigmatization.</p>	<p>Description of mother's stories coded into themes</p>

References to Power					
Instrumental	Structural	Discursive	Political Legitimacy	Author Conclusion	Limitations
<p>i) Care professionals set limits of type of support available for children experiencing ADHD symptomology</p> <p>ii) Ability to set terms of service for ADHD care delivery</p> <p>iii) Gatekeepers and creation of acceptable knowledge on conceptualization of ADHD</p> <p>- References to concepts in power framework:</p> <p>pg142 - 2(b) pg144 - 4(b) pg146 - 4(a) pg147 - 1(a),3(a) pg148 - 1(a),3(a) pg155 - 2(b) pg156 - 2(a),3(a) pg157 - 4(a) pg158 - 1(a),2(c) pg162 - 2(b)</p>	<p>i) Private governance subjectively determined rule sets for assessing ADHD</p> <p>ii) Deficit-centric ideas of agency and competency flow from dominant ADHD diagnostic tools</p> <p>iii) Government limit support for those experiencing ADHD symptomology</p> <p>- References to concepts in power framework:</p> <p>pg143 - 3(a) pg144 - 4(a) pg149 - 2(b) pg150 - 3(a) pg151 - 2(a,b) pg153 - 4(a),5(a) pg154 - 2(b) pg156 - 5(a) pg157 - 1(a)</p>	<p>i) Directional framing of issues that support the dominant biomedical narrative of ADHD</p> <p>ii) Deficit-centric ideas of agency and competency flow from dominant ADHD diagnostic tools</p> <p>iii) Government limit support for those experiencing ADHD symptomology</p> <p>- References to concepts in power framework:</p> <p>pg142 - 2(a,d,e)</p>	<p>i) Authority - educational, gendered capital feeding into power dynamics</p> <p>ii) Trust</p> <p>iii) Neoliberal values and policy formation</p> <p>- References to concepts in power framework:</p> <p>pg150 - 1(a),2(a),4(a) pg151 - 1(a) pg155 - 4(a) pg156 - 1(a) pg158 - 2(a) pg160 - 5(a)</p>	<p>- Maternal strategies are enacted within a context of highly charged discourses of danger and risk that mediate the women's ability and willingness to operate freely.</p> <p>- Mother's were motivated to challenge medical, psychiatric and educational professionals by fear that child would fade away without the appropriate professional support.</p> <p>- Simultaneously mothers are fearful that their advocacy for their children may actual make their children more socially vulnerable.</p> <p>- Present-day risk discourse obsoles institutions and policies of any responsibility, offloading and ascribing risk and danger to the individual and family.</p> <p>- mothers and their children are left with few options of refusal as they will bear the burden of fault attached to the child's problems -- not the doctors, schools, governmental institutions, or psychiatrists.</p> <p>- There is a need for counternarratives to rival the biomedical discourse around ADHD.</p> <p>- Relative success in resistance was related to the varying resources that mothers possessed.</p> <p>- Despite Mothers' industriousness in their adaptation and development of resistance strategies, there are limits to the power they can access as lay mothers.</p> <p>- Success in resistance is significantly constrained due to the amount of material power that resides within institutions and its practices.</p>	<p>Analysis did not include an analysis of class, or race.</p>

Author, Year, Setting, Design	Population	Primary Objective/Analysis	Intervention	Measurement
Frances, A., 2012  Setting Australia Public Policy  Study Design Argumentative Research Manuscript	N/A	1. Highlight issues related to the expansion of children's mental health diagnosis - specifically, a program that aims to institute testing for 3 year olds for ADHD.  2. Experts in child Psychiatry are often blind to the risks will be borne by the patient when imposing new diagnostic testing	N/A	Themes are drawn from the literature in order to produce author's argument.

References to Power					
Instrumental	Structural	Discursive	Political Legitimacy	Author Conclusion	Limitations
i) Preferences in policy that favour expanding ADHD diagnosis to children as early as 3 yrs. ii) Influencing participation through incentive or putative systemic structures of service delivery  - References to concepts in power framework:  pg1 - 3(a), 4(a), 5(a), 6(a) pg2 - 7(a,b), 8(a,b)	i) Early intervention agendas normalize pharmacological treatment   - References to concepts in power framework:  pg1	i) Directional framing of issues that support the dominant biomedical narrative of ADHD -- This type of policy would have the potential to expand what is considered legitimate treatment for children age 3yrs with ADHD symptomology.  - References to concepts in power framework:  pg1 - 5(b,c)	i) Influence of neoliberal ideological influence on policy is illustrated by the exploding growth industry of diagnosing and prescribing stimulants for younger and younger children.  - References to concepts in power framework:  pg1 - 1(a), 2(a,b)	1. Not prudent for psychiatry to 'experiment' on the nation's children prior to evaluating the risk/benefit with a smaller group sample. 2. Testing proposed is 'experimental' and people shouldn't feel they have to participate 3. Instituting this test is a bad idea and can't be justified on psychiatric grounds and therefore should not be put into public policy.	Analysis did not include an analysis of class, or race.

Author, Year, Setting, Design	Population	Primary Objective/Analysis	Intervention	Measurement
Bailey, S, 2010  Setting Nottingham, UK  Study Design Argumentative Research Manuscript	N/A	1. Highlight the importance of applying a socio-cultural frame of 'risk' to understanding the conditions that 'risk anxiety' produces within educators and care professionals that work with children.  2. Analyze the criteria in the DSM-IV for ADHD in order to better understand the techniques and practices that are used to diagnose and treat disorderly subjects.	Analysis of DSM applying socio-cultural lens informed by theories of risk and risk anxiety.	DSM criteria coded through the identification of themes on risk/danger/safety, order/disorder, success/failure

References to Power					
Instrumental	Structural	Discursive	Political Legitimacy	Author Conclusion	Limitations
<p>i) Gatekeepers and creation of acceptable knowledge conceptualization of ADHD</p> <p>ii) Care professionals set limits of type of support available for children experiencing ADHD symptomology</p> <p>- References to concepts in power framework:</p> <p>pg582 - 4(a)</p> <p>pg584 - 4(a)</p>	<p>i) Early intervention agendas normalize pharmacological treatment</p> <p>ii) Private governance subjectively determined rule sets for assessing ADHD</p> <p>- References to concepts in power framework:</p> <p>pg582 - 4(a)</p> <p>pg583 - 1(a)</p> <p>pg584 - 4(b)</p> <p>pg586 - 1(a),3(a,b),4(a)</p> <p>pg588 - 2(a)</p>	<p>i) Directional framing of issues that support the dominant biomedical narrative of ADHD</p> <p>ii) Devalue alternative mental health/illness narratives</p> <p>iii) Research dissemination</p> <p>- References to concepts in power framework:</p> <p>pg582 - 4(b),6(a),7(a)</p> <p>pg583 - 1(b),4(a),5(b),6(a)</p> <p>pg584 - 1(a),3(a),5(a)</p> <p>pg585 - 1(a),2(a),3(a),4(a)</p> <p>pg586 - 4(a)</p>	<p>i) Authority</p> <p>ii) Trust</p> <p>iii) Neoliberal values and policy formation</p> <p>- References to concepts in power framework:</p> <p>pg582 - 3(a),5(a)</p> <p>pg583 - 5(a),6(b)</p> <p>pg584 - 3(b)</p> <p>pg585 - 1(a)</p>	<p>1. Psychiatric/psychologic. Information spreads and is legitimized by the distribution of the DSM, and government rhetoric is driven by risk anxiety, which is influenced by both of the latter, has paved the way to the pathologization of children</p> <p>2. The ADHD diagnosis promote educational disablement - described as the proliferation of practices that individualize and differentiate, limiting the 'valid' notions of inclusion.</p> <p>3. There is a focus on purifying the classroom from certain disruptions/dangers prior to focusing on creating an inclusive educational environment within the school setting.</p> <p>4. Focus on risk in early childhood promotes depoliticized notions of choice and responsibility feeding conclusions of individualised deficit.</p> <p>5. Important to continue to check those with power (psychiatry, psychologists, educators) in order to prevent further conflation of social and individual dysfunction, in pursuit of realizing transformative notions of social inclusivity.</p>	<p>Due to nature of the study personal experience related to dynamics of power absent</p>