Die Renaissance der soziologischen Psychiatriekritik

Springer VS

Michael Dellwing
Martin Harbusch (Hrsg.)

Krankheitskonstruktionen und Krankheitstreiberei

Die Renaissance der soziologischen Psychiatriekritik

Springer VS

Herausgeber
Dr. Michael Dellwing
Martin Harbusch

Universität Kassel, Deutschland

ISBN 978-3-531-18783-9 ISBN 978-3-531-18784-6 (eBook)
DOI 10.1007/978-3-531-18784-6

Die Deutsche Nationalbibliothek verzeichnet diese Publikation in der Deutschen Nationalbibliografie; detaillierte bibliografische Daten sind im Internet über http://dnb.d-nb.de abrufbar.

Springer VS

Lektorat: Dr. Cori Antonia Mackrodt, Katharina Gonsior

Gedruckt auf säurefreiem und chlorfrei gebleichtem Papier

Springer VS ist eine Marke von Springer DE. Springer DE ist Teil der Fachverlagsgruppe Springer Science+Business Media.
www.springer-vs.de

Inhalt

Teil 1
Soziologie und Psychiatrie

Psychiatry as Culture: Transforming childhood through ADHD

Mattan Shachak/Edgar Cabanas Díaz/María Ángeles Cohen/Eva Illouz

Introduction

In the course of the twentieth century, and especially for the last three decades, medical, pharmaceutical and psychological technologies and repertoires have come to play an increasingly central role in providing explanations and ways of addressing deviant child behavior, mainly but not exclusively through the category of Attention Deficit Hyperactivity Disorder and its antecedents (Conrad 1976; Rafalovich 2001). At the turn of the century, ADHD became the most common diagnosis among American children. As of 2007, 5.4 million children aged 3–17 were diagnosed with ADHD (9.5%) in the US, significantly more than in Europe, representing a 22% increase in four years. Rates of ADHD diagnosis increased an average of 3% per year from 1997 to 2006, and an average of 5.5% per year from 2003 to 2007. Boys (12%) are more than twice as likely as girls to be diagnosed with ADHD (5%).

This data shows how vastly ADHD has spread and grown in the last 30 years, after its inclusion in the DSM-III-R in 1987, which provided a simplified and standardized diagnosis and a common language for various actors. Parallel to this increase in ADHD diagnosis the mass marketization of bio-chemical drugs addressing this specific disorder, and the prescriptions of ADHD medications, such as metalphenidates, amphetamines and antidepressants, have risen exponentially. For example, monthly prescriptions of Ritalin increased from just 4,000 in 1994 to 359,000 in 2004, making a $3billion profit in 2006 (Miller, 2008). In 2010, 66.3% of those diagnosed were receiving medication treatment (Bloom et al. 2010).

Instead of being concerned with the ontology of mental disorders, presuming they are natural phenomena to be discovered and intelligible by scientific procedures, a sociological constructionist perspective focuses on those social agents (experts, professionals, teachers and parents), institutions (schools, families, insurance companies), cultural repertoires (psychiatric classifications, psy categories and models), narratives and practices involved in rendering mental disorders vis-

ible, meaningful, measurable, solvable and, in short, existent. From this perspective, the process of medicalization consists of reframing various daily life situations, behaviors, emotions and mental states, in medical categories as pathologies which require medico-therapeutic technologies in order to transform or manage them. This has been the thrust of Berger and Luckman's great insight on the social construction of reality (1966), and of "labeling theory" (Conrad/Schneider 1980, Goffman 1986, Scheff 1984), which has come to be a common ground in contemporary critical sociology.

However, in this article we take this familiar critique one step further, by examining not only how cultural categories become medical (how child deviant behavior is pathologized), but how psychiatric categories and psychological techniques related to ADHD are disseminated, how they are used by different agents, and how they come to reshape cultural repertoires, social relations, models of selfhood and forms of control while being circulated within the family and the school. We offer to view psychiatry and psychology as cultural practices that rely on and institutionalize expert classifications, categories and knowledge in various life spheres. Viewing them as a cultural practices entails addressing it as a process in which these classifications and categories are circulated by various agents in different social arenas, while focusing on the meanings and roles they acquire and lose from their usage by these agents, and their socio-cultural consequences, that is to say, how they affect other cultural categories and come to shape social relations. We argue that the use of ADHD category as a hermeneutic device reshapes the cultural categories of "childhood", "education", "responsibility", "authority" and "parenthood", while establishing a new form of social control which shifts the locus of self-control from moral conduct to emotional management.

This is done by implementing medico-therapeutic practices at school and at home, which problematize emotions, reframe the self and rearrange social relationships. We make two central claims: *First*, the case of ADHD shows how school has become a central site in which medico-therapeutic discourse and practices are circulated and incorporated into its educational apparatus, which implies a new mode of domination which disseminates through making teachers and parents into (lay) experts, and relaying on the mediation of professional authority, ideology and technologies in the construction of their own power. It is indeterminate whether this mode of control corresponds more closely to the Foucauldian concept of discipline through surveillance and professional technologies or to the democratic delegation of authority to the individual. Therefore, we suggest they occur simultaneously and denote a general move from control through moral discipline to control through medical technologies and emotion-management.

Moreover, the success of the category of ADHD results from its ability to establish this new form of seemingly democratic control. *Second*, it reshapes the agency attributed to individuals, the realm in which agency is assumed and promoted and the objects and goals of such agency by dualistic use of contradicting discourses and technologies. While the medicalization of ADHD-related behaviors removes them from the realm of morality, responsibility and individual agency and promotes medical technologies (medication), the emotionalization of ADHD by professionals transforms emotions into the main site and object of individual agency, control and management through therapeutic technologies.

In the *first section*, we examine school as a therapeutic site, in which psy-classification is used to reformulate educational problems and to problematize low school performance as a medical and a psychological issue, while expanding the range of audiences and the authority of psy professionals over the eroded authority of teachers. This transformation highlights a process by which non-experts (parents and teachers) are transformed into (lay) experts, that is, socialized and trained to recognize ADHD symptoms in school by professionals, in order to render diagnoses and interventions more efficient. We examine what psychiatric classification and especially the category of ADHD enables the school as an institution to do and how it is used in this setting to establish a liberal-democratic form of control.

In the *second section* we examine the socio-cultural impact the circulation of the category of ADHD within the family has on the parent-child and family relationships. We show how the category of ADHD is used by family members to label the child's behavior, the practical benefits of the usage of the ADHD category, its influence on other cultural categories such as "responsibility", "authority" and "parenting", and the contradiction which emerges between the bio-medical model used to understand ADHD children and the "normal" autonomous model of self in the context of the changing parental models that have gone from authoritative, hierarchical and imposing to more symmetrical, communicative and negotiable ones.

In the *third section*, we show how emotions have become a central issue in the professional diagnosis and treatment of ADHD in the course of the last decade. Problems related to emotional outbursts, aggressiveness, self-esteem, and problematic relationships with peers, although being well known "side effects" of the medication, are reframed as problems of lack of emotional self-control, and come to be just as important as difficulties associated with scholarly underachievement and discipline in the redefinition of the self by professionals. We argue that this process conveys the infusion of what Eva Illouz (2008) calls the "therapeutic

emotional style" into the telos of childhood as the final move from control through moral discipline to control through emotion-management (Hochschild 1979). Finally, we describe how the different discourses and technologies reshape subjective experiences and result in self-estrangement and social alienation.

We draw on an ethnographic account of a case study in order to examine the structure (family, school counselors, neurologists, psychologists and researchers) in which ADHD appears in a child's life. In this work we focus on the case of a 17 year old boy who was diagnosed with ADHD at the age of 10 and that has just discontinued the medication. We interviewed him (J), his mother (M), a school psychologist (SP), and two clinical psychologists and researchers on ADHD (CP1 and CP2). We analyze the narratives of each of the actors in order to learn how psy-discourse and practices impact the interpretation of both the child's behavior and other cultural categories.

The school as a therapeutic field: education on prevention and early diagnoses

In the course of the last decades, school has become highly therapeutic through the mobilization of psy-professionals, -categories, -classifications and -techniques into the educational arena. Psy-professionals and -categories come to play an increasingly central role in this setting, diagnosing and treating problematic behavior, bullying and exclusion problems, assisting in multicultural diversity concerns, providing academic orientation, dealing with poor school performance or enabling communication between families and teachers. Since school has always been one of the central realms in which socialization for citizenship takes place (Dewey 1998) the advent of a "therapeutic culture" (Lasch 1978; Bellah et. al. 1985; Nolan 1997) has undoubtedly changed the models of citizenship and the ways in which educational problems are understood and dealt with through the increasing professionalization of education (Ferudi 2009). We suggest that therapeutic repertoires and techniques have come to be so powerful in this setting not only because of the central role that the professionals themselves play, but mainly because they succeeded in recruiting ordinary people, i. e. parents and teacher and transforming them into (lay) experts who disseminate these practices in school and family settings. They have become therapeutic agents in detecting, interpreting and monitoring ADHD related behaviors, initiating the chain of diagnosis and treatment or even executing it themselves. By doing this they translate traditional explanations of discipline, authority, morality and education to explain childrens' misbehaviors into the individualized and naturalized psychological and psychiatric language of cognitive dysfunctions, self-regulation problems, emotional management, self-esteem and neuro-chemical imbalances. In what follows, we examine three main features of this process: the expansion of the boundaries of the ADHD category and its meaning to include problems of discipline and poor school performance; the promotion of medical technologies of treatment (Ritalin) that rely on behavioral symptomatology and bio-medical etiology; and the establishment of a new form of social control.

The clinical psychologists we interviewed described the role of teachers in the process of diagnosis and how they are educated to do so:

> *Interviewer: "How could a non-expert detect an ADHD child?"*
>
> *Clinical Psychologist 1: "***If you were a teacher, you could tell that something is going wrong. This is the key question in which we try to educate teachers, family***...so they can sound the alarm as soon as they detect it. A more complex diagnosis needs experts because there might be things that are not visible and that might be affecting them negatively, but it is good that a non-expert sounds the alarm to get an early diagnosis and an efficient treatment".*
>
> *I: "Could you tell me what symptoms you would teach to a teacher to sound the alarm to?"*
>
> *Clinical Psychologist 2: "The most obvious is the child's hyperactivity, which is not the most worrying but it is the easiest thing to detect.* **Right away a teacher is going to complain about a child that does not allow him to teach his class properly. This is a symptom that might sound the alarm**. *Another problem is when that is not that clear, as it is the case among girls, most of whom go unnoticed because they are not fidgety... but maybe that girl is having a lot of academic problems. They need to be helped too, because that might be due to an attentional, intelligence or an affective problem".*

Non-experts are socialized and educated to detect "obvious" and not so obvious ADHD behaviors in children, by monitoring and documenting behavioral aspects of children who interrupt the orderly proceeding of classes and teachers' control over them. Moreover, poor school performance is one of the main aspects that are rendered problematic and aimed to be explained through the psychological category of ADHD: behavior inhibition, self-motivation insufficiency, attention deficit, executive dysfunction. An experienced school psychologist described to us what kinds of conducts are considered characteristic of an ADHD child in class:

I: "What is considered a problematic behavior of an ADHD child at school?"
School Psychologist: "Speaking too much, not doing their homework, not paying attention in class...all of those conducts that are typical of every child. What happens with teachers now? That every school is trained so teachers are able to identify these conducts as problematic and refer children to professional assessment. All these behaviors usually require children to professional assessment. What do teachers see now? teachers to pay more attention than usual. What do teachers see now? **That these behaviors are symptoms of a disease, not a matter of discipline and education**".

What is remarkable here is the profound and quick social transformation of "normality" and the crucial role teachers have in redefining children as disordered. That is, ADHD becomes a cultural category which corresponds with the institutional demands of schools and attempts to redefine a specific mode of attention, by taking as its obvious target any outward behavior that does not conform to norms of bodily and verbal self-control – no fidgeting, no disturbing classmates, self-regulation and monitoring. After learning how to notice and document these specific behaviors teachers learn to interpret them as symptoms of "deeper" biomedical causes. This became clear in the interview with the clinical psychologists:

I: "What is/are the cause/s of ADHD?"

*CP2: "***The origin is neurobiological, not educational***. There are parents worried about the context, but there is a genetic and prenatal cause that is always there; it is not anything that the child has learnt. It is a problem of the prefrontal cortex, cerebellum...there are many affected structures".*

CP1: **"Clearly, we must start by conceiving it as something biological. It is translated into conduct problems, but it has a biological and genetic cause, which is what best explains ADHD**. *Later, of course, we have to take into account the education, but what it is never going to happen is that ADHD could be provoked by a bad education".*

The etiological explanation of behavioral problems of discipline and self-control as biological, although acknowledged as typical childlike behaviors, immediately neutralize any moral responsibility of the teachers, parents and the individual, i.e., the problematic behaviors cease to be seen as a result of the individual's agency (intention, will and responsibility) since they are explained as a result of one's bio-chemical makeup. Moreover, it explicitly removes any responsibility from teachers and parents, since the problematic behaviors explained as bio-medical are *not* the result of bad education. As Rafalovich (2001) shows, while in the 19th century discipline was constructed as a moral problem which resulted from

the child's agency and legitimized control through punishment, from the end of the 19th century physicians worked to construct deviant child behaviors as bio-medical problems. The medicalization of deviancy de-agentizes the individual in relation to his problems while translating it from badness to sickness (Conrad and Schneider 1980). It removes the problem from the realm of morality and submits the individual to the control of psychotherapeutic professionals and medical technologies who redefine the realms, objectives and courses of agency the individual has to foster and cooperate with (Conrad 1992).

We claim that the growing infusion of psy-categories, -repertoires and -technologies, and especially the recruitment of non-experts to exercise expert knowledge and techniques as agents of prevention for detecting ADHD children early, implies more than the medicalization of everyday life (Moyniham et. al. 2002), the cooperation of professionals and pharmaceutical industries in promoting medicalization (Conrad 2010), or the intertwinement of the logics of medicalization and commodification of mental illness which enables it (Illouz 2008). We argue that there are institutional-pragmatic reasons for the infusion of this discourse into schools because of what it enables institutions and actors to do. It enables institutions to redefine authority and forge new practices of discipline in schools by establishing new cultural repertoires for understanding the child, new technologies of monitoring and managing individual conduct, and new modes of evaluation. In this process of the culturization of ADHD, both the category itself and other cultural categories such as responsibility and authority gain new meanings. This implies a new form of control which is mediated through professionals and psy-ideology and -technologies (Conrad 1992), which entails simultaneously discipline through surveillance *and* the democratic delegation of authority and responsibility for self-management to the individual.

The transformation of teachers and parents into (lay) experts enables the use of the psychological and medical language of ADHD as the Lingua Franca of parents, teachers and professionals, providing a common interpretive framework to chart mental and emotional life, and guidelines and technologies to manage and solve the problematic behavior of children and teenagers by submitting them to this new form of control. The a-moralizing effect of the bio-medical discourse enables all actors concerned to shun any specific ascription of responsibility and to avoid blaming one another, while constructing a neutral communicative space which facilitates cooperation in dealing with the problem through the mediation of impersonal professional authority. What facilitates the infusion of psy-discourse into the educational field is the standardization of ADHD, and

the construction of elective affinities in relation to social structures and cultural categories in the field.

The standardization of children's behavioral problems

Since DSM-III was published in the 1980s, a revolution has occurred within the psychiatric profession that has rapidly transformed the theory and practice of mental health, first in the United States, and later abroad. In a very short period of time, mental illnesses were transformed from broad, etiologically defined entities that were continuous with normality to symptom-based, categorical diseases (Mayes and Horwitz 2005). This shift reflects the growing standardization of psychiatric diagnoses, psychological classification systems and therapeutic language. As the case of ADHD demonstrates, this process of standardization enables the expansion of the ADHD category to include various child behaviors and psychological meanings and to radically increase the rates of diagnosis (Conrad 1976). The standardization of ADHD has several important consequences for the culturization of this category, its social usage, and the cultural meanings it acquires when circulated within social arenas such as schools and families. We identify three major results.

First, it over-simplifies the process of redefining a child as ADHD while expanding the category to include problems of discipline, academic difficulties and poor school performance. In this process the psychiatric classification, and the category of ADHD in particular, come to be an explanation of school performance measures, namely the grading system, thus creating an equivalence between mental health and scholastic performance. Poor school performance is the principal concern that sounds the alarm among teachers and parents, whose view of the problem often gains the same weight for the formal diagnosis as the psychological and neurological tests (see, for example, Danforth and Navarro 2001). According to J's mother, the principal reason why she was concerned and turned to redefine her son as ADHD was the low school performance of J: "it was not that the boy was a nuisance or that he moved constantly, which he did, but it was that the kid made no progress in school." J's problems of conduct that are typically associated with ADHD – namely, impulsivity, aggressiveness, egocentrism, depression, heightened reactivity to emotionally charged events – were not problems that he had before; on the contrary, they started only after he took the medication. As many authors have claimed these problems are typical side effects of methylphenidates.

J's mother's account of the process of redefining her son as ADHD following school underperformance shows the convergence between the constant measurement and monitoring of kids by way of school performance measures and grades in the competitive pursuit of individual excellence, with psy-classification systems which are used to explain and deal with them. This interconnection enables teachers and school staff to convert the hierarchy of the grading system to the non-hierarchic or democratic psychological classification system which defines "special needs." Childrens' evaluations are not usually as thorough as they are claimed to be. In-depth clinical interviews with kids, teachers and relatives, or longitudinal reports of the child's behavior are not usually performed. Although professionals say they are crucial to do a proper diagnosis, they come to be redundant in light of the quick, over-efficient and standardized diagnosis.

In fact, one of the school psychologists we interviewed emphasized the premature diagnosis of ADHD in a child who was an academic underachiever and the lack of in-depth analysis of individual and environmental aspects. While the clinical psychologists interviewed claimed that they spent "7 or 8 hours with every child to seriously assess the case" and to "discard other personal and contextual problems" such as divorce episodes for example, the school psychologist commented that "psychologists tend to discard only problems that are quite visible, not the rest of them". Later in the interview he added that "In fact, just when kids don't do what they are supposed to do, both in school, or the homework at home, which will logically create problems between kids and parents, and they carry on this way for six months, they are going to fall straight into the diagnosis". When we asked J what he thought to be the reason why he was being medicated, he responded that "everything started because I did not pay attention in class; I was...I mean, a bit 'itchy feet,' but...I don't know, the thing is that nowadays every child that is a bit as I was is taken to the doctor." It seems that the standardization of the category of ADHD and its diagnosis, as they are constructed by the DSM to allow effective and common labeling, makes in-depth and thorough examination, which is costly and time consuming, redundant and makes it possible to establish and exercise the psycho-medical form of domination in schools and families on a large scale.

Second, standardization of the category of ADHD bestows objectivity and presents a consensus concerning the redefinition of a child as ADHD, although in practice the process is rather ambiguous, ridden with doubts, and lacks consensus about tests and criteria among professionals and academics, as the DSM-IV-TR (2000) itself recognizes. This objectification produces legitimacy and justification for psycho-medical intervention. Since there isn't a consensus on what

tests have to be used, or on what the criteria are to unequivocally interpret the results of those tests as being characteristic of an ADHD case, clinical diagnoses are mainly based on professionals' clinical opinion and on the responses given by parents and teachers to the standardized and generic DSM-IV-TR criteria – despite the fact that several studies "show modest to negligible overlap" between parents', teachers' and children's reports (see, for example, Whalen, et al. 2002; Andrews et al. 1993; Bird et. al. 1992). As the clinical psychologists interviewed recognized, "there is still nothing concrete that can help us decide and diagnose without a doubt. Interviews with parents and seeing the kid for a little while, anyway, is highly informative. Sometimes we see things that clearly point to a clear case of ADHD". In one of J's clinical reports that we had access to, a parent's response to DSM-IV criteria questionnaire was decisive: "following parent's opinion, J meets nine criteria for attention deficit, and six for hyperactivity-impulsivity, so he will be classified as a F90.0 Deficit Attention Disorder with hyperactivity, combined type (314.01)". In the case of J, it seems that his mother's deep concern about school performance drove J straight into the ADHD medical process.

Third, since according to the bio-medical model neurochemical imbalance is assumed to underlie cognitive and behavioral dysfunction, psychiatry states that medication is the best treatment to reduce poor school performance and to increase one's endeavors and compliance with academic and institutional demands. Although many professionals have questioned the necessity of medication to improve school performance in ADHD children while offering other forms of intervention (Lienemann et al. 2007; Resnick and Reitman 2011), medication remains the central technology of control promoted by professionals, teachers and parents. This process represents the convergence of the bio-medical model and the economic approach to disorder management thorough pharmaceutical technologies. Once a certain situation – for instance, school failure – is problematized as individual and isolated issue rather than institutional or holistic, medication becomes the highlight of effective and efficient treatment.

In our opinion, much of the influence of ADHD in reshaping the conception of childhood lies not in its theoretical or discursive background, which has been broadly criticized even by an increasingly critical group of psychiatrists, but in its standardizing and objectifying power displayed by techniques of classification and evaluation. *When a child is redefined as an ADHD, the label of ADHD comes to be prevalent in the construction of self-identity and social relations with peers and parents.* This has been the thrust of Berger and Luckman's great insight on the social construction of reality (1966), and of "labeling theory" (Conrad and Schneider 1980, Goffman 1986, Scheff 1984), a view that has come to be common ground in contemporary sociology.

The circulation of ADHD within the family

Where most studies stop at the 'medicalization thesis' and the 'labeling effect' of psycho-medical diagnoses, we take them a step further and examine how these categories become cultural categories, how they simultaneously shape other categories and are reshaped by them. As we saw earlier, parents have a central role in bringing the therapeutic discourse home and redefining their children as ADHD, and professionals act to socialize them to do so within the school setting. In this section we examine the impacts the circulation of ADHD within the family has on the ways in which the child is framed and familial relations are constructed.

The dialectics of independence and responsibility

J's mother had been terribly worried about J's poor school performance and came to frame his problem as ADHD through the therapeutic discourse the school provided her with.[1] She had done everything in her power to help J with his school duties: she quit her job when J was 10 in order to stay home with him; she would not leave the house when J got home from school just to make sure he was doing what he was supposed to; she would often have him tell her the lesson for next day, something about which they had serious arguments; she made him study with her, and so on. After all these efforts had failed she reached a point where she felt helpless and decided to put him on medication. Understanding J's problem through the terms of the bio-medical model underlying ADHD directed the mother to either support and assist him with his school duties, or to medicate him, claiming that if she had not been there to control him he would have got stuck in his second year of Secondary School because he was not capable of paying attention and fulfilling his duties.

This use of ADHD as an interpretive framework has a bi-directional result in reshaping both the category of ADHD itself and other cultural categories. Once the category has started circulating within the family, the relationship between the child and his parents is then completely imbued by this re-framing of his conduct. The various usages of the ADHD category within the family in daily life transforms not only the meanings of categories such as "responsibility,"

1 Such worries are of course entirely sociological, they are motivated by her fear of unemployment.

and "independence," as we have seen, but also of "authority," "respect," "discipline," "effort," or "commitment," since framing the child as neurologically impaired de-agentizes him and prevents him from assuming those moral categories and carry them out in everyday life. However, ironically, he is still expected to foster those positions by himself. Not only were J's difficulties never blamed on him, but thanks to the bio-medical disease model his problems became a framework for defining "special needs" which accord him privileges and the right to special treatment from his family which, however, still spoke of him as someone who lacked any kind of will and autonomy. Nevertheless, J's mother still expected him to "somehow" be "normal," i. e. responsible and independent, through the use of the drug that diminishes the apparent symptoms of ADHD.

This tension is reflected in J's view of his relationship with his mother as well. J understands his mother's deep involvement and control as limitations that deny him his independence, and actually cripple him:

> *J: "I was in a wheel chair. I was always in a wheelchair, with the pill [Concerta] and my mom. And, of course, when my mom left home I'd do everything I couldn't do when she was there".*
>
> *I: "Even with the pill"*
>
> *J: "Oh, yes, yes, with the pill, with the pill".*
>
> *I: "So don't you think that..."*
>
> *J: "Well, you know, if my mom hadn't been there... I mean, as she's been there since I was little... if she hadn't been there last year I wouldn't be here right now. I'd be a junior or senior in High School again. Because, like, when you get used to being on a leash for such a long time when they take it off you run away and don't want to come back, whereas if you've been with no leash since you were little and they teach you to go anywhere you don't have any problems and it doesn't really matter if you're put on a leash or not. I mean, you know how to run and you know how to come back. Instead, when you're on a leash all day, the second they take it off... what is more, they tell you "we're going to leave you by yourself this weekend. Don't do anything, etc". And I did it anyway".*

While J's mother sees J's underachievement as a symptom of his incapability to control himself, J sees such behaviors as a rebellion against his mother's overprotective involvement regarding his studies. Moreover, the stigma of ADHD keeps him from being "normal" or being granted the freedom to demonstrate independence and responsibility. But on the other hand, being redefined as ADHD grants him privileges, more parental attention and support according to his "special needs," and of course is of great importance in seeking medical or therapeutic help. J admits that when he was a child he really liked all the attention he received, but that has changed since he became a teenager and came to experience more intensively the stigma associated with this label.

J is worried about not being able to get rid of the stigma that has been attributed to him for all these years. He seems to be quite aware of the tautological nature of psy-labeling, that is, once a label frames a certain situation or behavior into bio-medical terms, it becomes almost impossible to get the label off since it refers to deeper bio-physical make-up which exists beneath the "symptoms" and beyond one's control. This is how he expresses the effect of the label on his parents' attitudes towards him:

> *J: "No matter how much I... it's bullshit. Not even with better grades is it possible to take it off. It's a label they put on you and from then on nobody will take it off. Not even family, huh? Not even your parents take it off. They say 'teachers...' no, I don't care for teachers, I see them for two years and then I won't see them again in my life. The point is that it's you [his parents] who put the label on me. The ones who are supposed to want to take it off me actually put it on. So, sure, I leave it on. And although I try to take it off... no... I just know nobody is going to take it off me."*

J thinks that the whole process of being redefined and managed as ADHD involves making him incapable of doing by himself what a mature person is supposed to be able to do without any kind of difficulty. In spite of this, J made up his mind to go on without medication although his mother is reluctant to fully accept his decision until she is sure he is capable of paying attention and putting up with his responsibilities in college.

The interpretive space here exists between two explanatory poles: (1) the bio-medical model, which renders problems as bio-chemical imbalances, hereditary traits, or physical structures in the brain and locates their solution outside the control of the individual; and (2) the autonomous model which defines the healthy and mature individual and demands self-regulation, self-efficacy and responsibility. The play of these two models, according to their usage and results (intended and unintended), comes to structure the dialectics of responsibility and independence of the child and the spheres of agency and de-agency.

Authority without discipline: the outsourcing of parental moral authority to professionals

The involvement of professionals in dealing with parental problems and children's education, functioning, sociability and conduct problems affect the role of parents and the meaning of parental authority. It points to the replacement of parental moral authority with "neutral" professional authority and a shift from a hierarchic and disciplining parenting style to a democratic-therapeutic one. J's mother gives us a glimpse into this process, by comparing her two sons:

> *"I have two sons. They don't have anything to do with each other. One is like hyper-responsible, but, I mean, like 'please, son, go take a walk because you are suffocating me' but both of them have had the same education, the same father, the same mother,* **and the same doses of responsibility and freedom**. *[...] He's always comparing himself with his brother. 'Why is my brother allowed to...?' because your brother is one way and you are another.* **Your brother knows how to use his freedom and he's super responsible because he has proved so to us.** *[...]* **So I don't know if there's a professional that helps you mature. A professional might give you rules of conduct but those rules of conduct... do you think it makes you mature?"**

It seems that J's mother noticed the inability of professional intervention to supply a morally disciplining authority to her ADHD son since their authority and intervention assume an autonomous individual and "freedom management" as an individual capacity. But this understanding did not result in refuting professional explanations and practices or practicing parental authority in the "traditional" way. Although J's mother uses the bio-medical model to understand J's problems and turn to professional solutions, she seems quite aware of other interpretive frameworks and parental models to understand and deal with such problems but avoids their use:

> *"[the doctor] said 'well, this is hereditary' and Juan [J's father]... like... because it's him.* **He's completely hyperactive, and then he tells me 'well, but I managed to get it all done' and I say 'of course, because in the past there was no... I guess there was the whip and the father's slap, no Concerta'** *and of course he managed to get it all done, but it's totally hereditary. Absolutely hereditary. And he is hyperactive. And today he is still hyperactive. And the grandmother who is ninety years old is hyperactive as well"*

Psy-models and -practices are not the only ones available or the most effective, but they seem to be adopted because they correspond with a democratic non-hierarchical parenting style, and although other models exist, they have no practical meaning or influence since they are hierarchical and authoritative. J's mother ignores this sort of explanation, and sticks to the bio-medical model which implicitly enables her to blame the flawed "genes" of her husband's family while avoiding the patriarchal, authoritarian or physical discipline practiced by the previous generation.

It appears each of J's parents use a different model to explain J's behavioral problems and hence point to a different parental course of action. J's father understands J's behavior according to the "traditional" approach to education and discipline, which dismisses the bio-medical explanation for his underperformance or at least the technologies of self-transformation it implies altogether. However, J's mother sees ADHD as a definition of what her son "really is." His father tells him to grow up and take his life into his own hands whereas his mother checks on him daily to make sure he takes his medication and does his homework, which he rarely does. His mother claims that since he started taking the medication he has become "more normal" and responsible, more controllable, less restless, his verbiage has diminished and he has started paying more attention in class. At the same time while his father dismisses medication as a possible solution to his son's lack of "maturity" and "responsibility," although he does not provide an alternative approach to educating his child and avoids disciplining him altogether.

Parental models of normality: the problematization of the average and normalization of success

Parental "thresholds" regarding the child's misbehavior depend on parents' beliefs about the origins of such behavior (Bussing, Gary, Mills and Wilson, 2003) on one hand, and on the referents or "normality" models they are using to compare their child with on the other hand. Those normality models are also socially and politically promoted, and in this case they contribute not only to the reshaping of childhood, but also to reframing the parent-child relationship. In J's case, his brother comes to be the point of reference, the label of ADHD comes to frame the competition with his brother and to explain their differences.

According to the family discourse, J's brother meets all the criteria of what a "good boy" is from their point of view: he is independent, self-sufficient, gets the best grades in his class and "knows how to use his freedom and be responsible," as the mother said. In J's ayes, taking his brother, who appears to be exceptionally successful, as the normality model has far reaching consequences regarding his position in his family compared to his brother's:

J: "I'm not one of the hoodlums among my group of friends, quite the opposite, I'm just average [...] At their homes I would even be considered an angel but not at mine, and that's so annoying. **My mom is always like "your brother..." well no, the point is that what my brother does is not normal, mom. Getting an A plus, an A, a distinction when you are a sophomore in Law is not normal. A boy who never needs anyone to tell him to get down to study is not normal. A boy who has so much autonomy, independence... is not normal.** *When you are nineteen, come on, man, get home drunk one day, bring a girlfriend, crash the car, lose the keys..."*

Being a teenager, as J's eloquently puts it, consists in *not* doing exactly what you are expected, not always being so responsible, and not necessarily achieving top grades in school. The conflicting discourses of normality and J's explicit rejection of the normalizing discourse do not necessarily indicate resistance (since it does not have practical results or effects), but they highlight the new model of normality represented in the ADHD discourse. Confronting his brother as a reference of normality puts J in an awkward position:

"[...] this is serious, it's not fun, it's a very big problem that I have, I'm going to be twenty-four years behind my brother... you know, but then... well, actually when working it'll be the same, because on top of it all he is going to be a lawyer and so am I... it's going to be the same all my life. There I hope... well, I hope nothing bad happens to him but... I hope to be above him one day. But it doesn't look like I will. If it was like he got Cs, man, go get a B. I would get down to study solely and exclusively to get a B, because I'm very competitive, but getting a distinction... you can't overtake that. And even less in my case. It's frustrating. So then, of course, when we do sports... I'm at 100% and I'm very competitive and I step over him."

It appears that the fact that school performance has come be the main measure of self-value and social capital, and not sports for example, leaves J in a poor position when it comes to "winning" this competition or even being recognized as a legitimate competitor. So, first the ADHD redefinition acts as an interpretative tool for what had previously been considered to be abnormal and disturbing for the family. Then, such a label makes J insecure in relation to his capability to do things by himself and also makes him feel helpless at making his family believe he could change and be not like his brother but certainly different to what he had previously been. Thus, the shift from the private experience of a certain problem, with its specific characteristics, to a normalized disorder, that is, a public experience (Conrad 2005) is a process through which other more complex family issues are reinterpreted through the prism of ADHD.

However, the stigma and poor position in relation to his brother is not the whole picture. J's mother's expectations of her children are in turn greatly influenced by her husband's life story: he is a well-known lawyer that reached a high economic position after having been "just like J" as a child, according to her account. J's father was always at work and when he came home, "everything changed," in J's words. J even jokes that if his father were at home more often he would not be an ADHD because when his father is around "the ADHD disappears."

J's mother labels her husband as ADHD as well, but since he is a living model of success, it lacks a medicalizing or stigmatizing meaning and even comes to be a sort of capital in the family context (for an interesting use of ADHD as capital in contemporary culture see Martin 2000). This makes things more complex and the meaning of ADHD more ambiguous. Although for J's mother ADHD is a genetically inherited disorder that makes the child unable to fulfill his duties, the case of J's father, shows he was able to overcome his "difficulties" and lead a successful life. However, at the same time ADHD becomes the unique characteristic and common denominator for J and his successful father. This makes J, from the family's perspective, weak and responsible for his lack of willingness to succeed at school, even though his moral responsibility for his behavior and the practice of parental authority are resolved by the therapeutic discourse. *The ADHD redefinition served the purpose of providing a narrative of pathology in order to put the deviant behavior under the ideal of health and the correcting but non-coercive technologies it implies.* However, the ideal and telos of health are intertwined here with the ideal of economic and social success, which do not entirely overlap, and result in problematizing the average and normalizing success.

1. Summary

It seems that parenting models came to be understood under the discursive structure of therapy: they have moved from authoritative, hierarchical, and coercive, to symmetrical, communicative and negotiable parenting. This symmetric negotiation between adults and children on the latters' behavior through reinforcement and empowerment programs, the emotional and affective nurturing and non-coercive education of the child, the non-authoritarian but "supportive" parenting-style all reflect a more democratic idea of education which has emerged in the last decades. But this democratic idea of education hides another form of authority that is mediated by the authority of professionals – school counselors, psychologists,

psychiatrists, social workers – and the therapeutic discourse, both of which render the problem an individual one while refuting responsibility and replace the need for parents' authority with an abstract and impersonal professional authority.

Within this modern educational framework, the "embracing narrative" of ADHD tends to work as a hotchpotch category embracing all those maladaptive or unwanted behaviors which are excluded from an "adults' threshold." They emerge at the point where parents consider either negotiation, support, reinforcement-punishment techniques or any other educative measure they take as fruitless, and where they feel helpless in controlling the child. Medication here plays an important role. Although, as we mentioned earlier, parents seem to be aware of the medication's side effects, and usually do not consider medication to be the ultimate solution, they still conceive of it as a "magic pill," as J and his mother put it. Even in the worst-case scenario, for instance when suffering from many of the aforementioned side effects, it appears to be a necessary evil that helps put the child in compliance with the standards of what is considered "controllable." The claim is that the medication's sedative and arousal-inhibiting effects make children more prone to self-regulation, more responsive to positive reinforcement and more receptive to deferred gratification, and hence, more susceptible to be controlled by the standards of the therapeutic structure of negotiation, rationalization and cooperation.

The point here is not whether we consider modern educational and parenting styles to be worse than the traditional ones; our point is that a category such as ADHD and its usage is only possible and understandable within this therapeutic educational framework (Ecclestone et al. 2005), within the new patterns of diffusion of responsibility and professional authority, and within the new model of childhood. We argue that in this context, the discourse of ADHD enables to construct a new form of control which consists in surveillance and the encouragement of autonomy simultaneously. The model of childhood which underlies ADHD diagnoses and treatment relies on the ability to manage one's freedom. It requires a self-regulated child who knows how to make plans and comply with deadlines, is capable of independently following instructions, self-managed and self-reliant and who motivates himself to not only do what he is supposed to do but also to like it, a child who is able to be alone and still perform the tasks he is expected to. This model of childhood implies that as the discipline in the workplace grows, so does the discipline in school, and its requirements become similar to those of "late modern" organizations. School children are expected to become adults, but as children are inadapted, their residual behavior becomes normalized and controlled through diagnostic practices and through the mobilization of professionals

and the therapeutic discourse into schools to control childrens' behavior, not their morality. ADHD is a solution to control behavior without using moral categories of good and bad, and without even putting at fault the child who becomes a bundle of psychological, emotional and biological processes, or the school system itself.

Redefining agency and self-control: from behavioral discipline to emotion management

While problems of discipline and poor school performance are de-agentized by the medical discourse which leads to medical technologies of intervention (medication), emotions are constructed as the main locus and objects of individual agency through the cultivation of what Illouz (2008) calls therapeutic emotional style. To complete the picture of the new form of control and its consequences in daily life, we now turn to examine how the professional discourse reinterprets ADHD in emotional terms and re-problematizes the child through his emotional make-up and the subjective consequences of these hybrid discourse and intervention techniques. This process of emotionalization of ADHD becomes central in justifying psychotherapeutic intervention, and in supplying emotional repertoires which are crucial for parents and ADHD children to frame a wide array of misbehaviors and emotional disruptions. We argue that similar to the role the therapeutic discourse played in the transformation of the form of control in organizations, replacing hierarchy and obedience with emotional self-control and communicative ethics, the therapeutic emotional style comes to play an increasingly important role in constructing children's self-management as part of this new form of control.

The emotionalization of ADHD

Even though the DSM-IV-TR (2000) does not include affective, emotional and peer relationship problems as important diagnostic criteria to classify a child as an ADHD, the emotional world of children and adolescents has grown to be a central concern among ADHD professionals in the last decade, especially amongst psychologists. ADHD acquires these new meanings, while being circulated within professional literature and practice, turning emotional disruptions into another core symptom of the disorder, and sets emotional health and social skills as the main objectives of self-transformation through emotional management techniques.

ADHD professionals claim that "the scattered evidence of emotional deregulation highlights the importance of understanding how the mood profiles of indi-

viduals with the characteristics of ADHD differ from those of their peers during the adolescent years, a developmental period characterized by emotional turbulence" (Whalen et al. 2002: 210). Problematic aspects are labeled as "emotional instability" and claimed to establish difficult and dysfunctional peer relationships in ADHD children (Hoza 2007: 655). The clinical psychologists we interviewed also highlighted this aspect:

I: "are there any remarkable and typical affective problems concerning ADHD children?"

RP1: "Many. You can always find 'something' besides ADHD. We are talking about an impulse regulation deficit disorder, which generates dangerous-non-meditated behavior. These children do not predict the consequences their behaviors have for others and for themselves. [...] There are a lot of studies concerning the cognitive or 'cold' part of the disorder, but the problem of affect has usually been left aside, although it is very important in ADHD."

RP2: "It is important to treat self-esteem. We talk about a problem that enormously affects self-esteem, something that can lead to anxiety problems, or make children set themselves above the rest, like intending to be the most extrovert guy in his peer group or like trying to be the leader."

It is remarkable how ADHD-related behaviors are attributed to bio-medical causes, which de-agentize the individual, while the emotional interpretation of ADHD constructs emotions as the main realm of individual agency and self-control, which therapeutic techniques are assumed to completely restore. Despite several difficulties and contradictions between the medical and psychotherapeutic frameworks to consistently develop a theoretical framework to explain this heterogeneity, ADHD professionals claim that all these aspects are nevertheless intimately related to each other, being the reason why combined pharmacological and psychological treatment is needed (Pelham et al. 2005). They claim that this heterogeneity is not problematic. Rather, in the worst case scenario, it is a matter of emphasis or levels of analysis.

Although medication is the main technology for solving cognitive and behavioral problems, psychotherapists state that it is unhelpful in solving emotional problems. For them, psychological therapy is necessary to solve the emotional instability, problems of self-regulation and self-esteem, emphasizing the need to reshape the emotional makeup of children as an indispensable task of ADHD treatment. In both of J's clinical reports, this is submitted as an important recommendation right after the medication prescription: "I also recommend psychological treatment to a) reduce frustration levels, b) foster self-esteem, c) achieve higher self-control, d) eliminate anxiety symptoms, e) raise the mood, and f) change negativistic-defiant behavior to a more positive-adequate one through Barkley's behavior modification program and through training in social abilities." Thus, the emotional reinterpretation of ADHD (focusing on emotions rather than behaviors) introduces the therapeutic emotional style into the telos of childhood and the goal of therapy, it defines emotions as the central locus of individual control, agency and autonomy, and it constructs specific procedures and technologies for emotional self-management. That is to say, it replaces behaviors and cognitions with emotions as the central domain through which social control is exercised.

ADHD as a subjective experience: cultivating the therapeutic emotional style

The therapeutic discourse on emotions has three important influences on the subjective experience of the ADHD child when it meets ADHD medical discourse and technologies: **First**, although emotional problems such as *emotional confusion and disruption*, ranging from aggressiveness to feelings of depression and paranoia are well known "side effects" of the medication, they are de-medicalized and become the main locus of individual agency. Surprisingly, they are not explained as results of bio-medical causes even when the individual is treated with medication, but rather as objects one can monitor, control and manage through "emotion management" techniques. **Second**, it re-problematizes the psychological effects of social stigma and medication as a problem of self-esteem or emotion management. And **third**, it results in a phenomenological contradiction in the subjective experience of the child, and creates deep self-estrangement and social alienation.

Based on empirical evidence, many authors such as Peter Breggin (2001) have asserted that Ritalin has "devastating emotional effects" on children, bringing them into an "emotional roller-coaster" that leads to aggressiveness, anxiety, emotional liability, depression and irritability. Other authors such as Michael Schleifer also corroborate this, emphasizing the problematic effects of the medication on peer relationships: "clinical observations indicated that methylphenidate very often had a negative effect on the child's mood and also on his relationships with peers, causing less social behavior and interaction. These almost always appeared and were reported as unwanted side effects of the drug, including sadness, irritability, excessive hugging and clinging, and increased solitary play, as well as the more usual side effects of poor appetite and difficulty getting to sleep..." (Schleifer 1975: XX). The Vademecum informs about these problems and adds

further warnings and considerations as common effects derived from the medication, such as "abnormal thoughts," "hallucinations," "severe humor changes," "excessive attention focus," and "confusion." When we asked the school psychologist about the common phenomenological experience of a kid treated with psychostimulants, he responded the following:

> *SP: "Strangeness feelings are very common among children under the effects of psychostimulants. A 17 year- old boy has an already elaborated discourse that allows him to explain certain effects of the medication; besides, he can tell them to you. There are studies that show that these children can feel more isolated than the rest of the children. All these feelings and behaviors that derive from the medication, nevertheless, are commonly seen as positive effects of the treatment, as it is working. But imagine now a 6-7 year old kid that experiences those weird feelings but cannot explain them to himself or to others. If they are evident, they are held in check, but if not, we never know how they could be affecting the kid."*

In J's case, the first clinical report at the age of 10 has stated that the only reason for the clinical visit was "failure at school performance," emphasizing aspects such as J's "lack of perseverance," "little motor ability," "lack of attention" or "constant fingers snapping," and the parents' preoccupation with it, but no other emotional or behavioral problems were detected. "A pill of Concerta, 18 mg, everyday at breakfast" was the only treatment prescription at the end of the report. Although J never had social, emotional or affective problems before the treatment, emotional irregularities and other disturbing effects – such as fear, aggressivity, sadness, feeling of "reality disconnection" and paranoid thoughts – they appeared only after months of taking the medication. However, while these changes were an important concern to J, his mother took these emotional disruptions as typical of both adolescence in general and J's personality in particular.

In subsequent clinical reports emotional treatment was recommended to be combined with progressive higher medication doses of Concerta along the years – from 18 mg daily at the age of 10, to 54 mg daily at the age of 17, the maximum recommended dosage according to the Vademecum. This is how J describes how pharmacological treatment affected him:

> *I: "What kind of effects do you think medication has on you?"*
>
> *J: "Mmm, hunger...in a great way, to the extent that I put on a lot of weight after five days without medication".*
>
> *I: "You are not hungry while taking the medication?"*

> *J: I'm not, I'm not at all. The sleeping as well. I do not sleep much.* **Then... I feel different, I change, I do not know how to explain it, it is...I am myself when I do not take the medication, and when I take it...I am even rude, I am quiet...I pay attention, but I am not myself when I take it. And also...well, with people things are also different. That is also an effect of the medication.** *[...]* **I do not act as if it is me who is acting. I mean, everyone has a character and when I take it I have a completely different one. And I feel that it's been three or four years that I am not myself"**...
>
> *I: Do you like yourself when you take the medication?"*
>
> *J: "No, not at all. I don't. Because, maybe, if I had another personality, the change would have not been that severe, but I have a personality...I mean, they are two opposites. I like to talk, to smile, to move... and when I take it I turn into the other extreme, then I do not like it. It is very remarkable. Family, friends...everyone tells me that."*

Academic problems still persist along J's childhood and adolescence. Although J has improved through the years, he is still said to be beneath the average both of his secondary school and high school, and severe emotional problems have started to arise as a serious concern. First, J's experience of not being "himself," but someone else, is repeated in the course of the interview as a severe issue that has really concerned him along the last years. On the one hand, he often had the feeling of not being responsible for his acts or for the decisions he was making, *claiming not to know how to differentiate when they were coming from him and when from the "medicated him."* This is a phenomenological contradictory experience that reflects the contradictions of the two different discourses and technologies, the bio-medical and the autonomous-psychological, about the problem, and the lack of alternative frameworks to explain these feelings which result in deep *self-estrangement.* Moreover, all the attention he got from his mother and, of course, the medication he was taking, even when helpful and productive, could not be considered a product of his autonomous agency, but on the contrary, he could not conceive of them as his own authentic achievements since they originate "outside."

Second, these emotional disruptions had important effects on peer relationships and resulted in *social alienation.* For example, a certain sense of "reality disconnection" and of becoming engrossed in his thoughts keeps J from participating in the common dynamics of his group of friends most of the time. He does not usually feel like talking to anyone, either. As he puts it, "I'm in a bubble where I'm thinking all the time, quietly but thinking about millions of things, not always

about school...that's why I use earphones and listen to music, because nobody disturbs me...for example, when someone says something to me I'm much more sensitive, you know? Everything affects me much more." Aggressive breakouts then often appear as uncontrollable episodes of overreaction that put him into problematic situations with peers and with his family, something he immediately regrets – as he briefly mentioned above. For this and for other reasons mentioned earlier, J has decided to quit the medication, although his last clinical report still recommends it.

Not only are the emotional side effects of the medication re-problematized by professionals, but the social effects of stigma as well:

> *I: "The boy we interviewed a week ago complained about how he was never going to get rid of the label; he also complained about not feeling certain of being able to face problems without the medication in the future. Is this common?"*
>
> *RP2: "I see there a lack of psychological treatment. He needs self-esteem treatment. Though, well,* **sometimes the label of 'ADHD' is better than the label of 'lazy,' for example. The issue is: how can we work with the children to manage that** *(...)* **A feeling of dependence on medication is a problem of self-confidence.** *If things are well explained to him, if he is treated in a proper way..., he will improve for sure".*

This extract shows the tension between the two models – the bio-medical and the psychological-autonomous ones – which points to the shift to emotions as the central locus of agency and control: while the diagnosis and medical treatment rely on the bio-medical model, excluding misbehavior or school underperformance from the child's control and (moral) responsibility, the autonomous model interprets this dependence and lack of autonomy as a self-esteem problem. But what is overwhelming is the turn to the autonomous model to re-problematize emotions (whether as side-effects of medication or not) in order to offer technologies of emotional management and emotional self transformation. The result of these combined technologies of self-management and control is the constant indecisiveness of the child regarding himself or his "real self," which is given to his control and responsibility, which springs from him and which is forced upon him from "outside," and finally, it creates a self-referential loop which constantly translates the psychological to the bio-medical and vice versa.

Conclusion

The culturization of psychiatric classification and psychotherapeutic practices comes to shape what Foucault calls the "ethical substance," i.e. the relations one constitutes with oneself through the available moral and scientific discourses (Dreyfus and Rabinow 1984). However, the process of forging this moral substance involves different and even contradicting discourses and technologies of the self in the case of ADHD, involving the bio-medical discourse and technologies for the problematization and normalization of undisciplined behaviors while at the same time establishing emotions as the principal locus for the expression of agency and morality and managing them through therapeutic technologies. During this process of translation, the psy-category reshapes other cultural categories, modes of evaluation, forms of interpretation and social relations while at the same time being reshaped itself through its use by various agents in different social arenas. This process is carried out and gains scale and scope not only through the direct involvement of experts and professionals, but mainly by transforming "normal people," in our case teachers and parents, into (lay) experts. Ironically, in this form of domination, common childlike undisciplined behaviors come to be pathologized and hence de-agentized, while at the same time the management of one's emotions is assumed to be given to one's control and responsibility. The medicalization of the self thus offers two simultaneous models of the self: one in which the child is not guilty and responsible for being unadapted to the school institution; and one in which a variety of actors mobilize themselves and view themselves responsible to re-empower this deficient self.

Works Cited

Andrews, V. C., C. Z. Garrison, K. L. Jackson, C. L. Addy, and *R. E. McKeown,* 1993: "Mother-adolescent agreement on the symptoms and diagnosis of adolescent depression and conduct disorders". Journal of the American Academy of Child & Adolescent Psychiatry 32: 731–738.

American Psychiatric Association, 1994: Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC.

Bellah, R. N., R. *Madsen, W. Sullivan, A. Swindler, S.M. y Tipton,* 1996: Habits of the Heart. Individualism and Commitment in American Life. London.

Berger, P. and *Luckmann, T.,* 1966: The Social Construction of Reality: A treatise in the sociology of knowledge. New York.

Bird, H., M. *Gould* and B. *Staghezza*, 1992: "Aggregating data from multiple informants in child psychiatry epidemiological research". Journal of the American Academy of Child & Adolescent Psychiatry 31: 78–85.

Bloom. B, R.A. Cohen, and *G. Freeman*, 2010: Summary health statistics for U.S. children: National Health Interview Survey, 2009, National Center for Health Statistics. Vital Health Stat 10 (247).

Breggin, P., 1998: Talking Back to ritalin. What Doctors Aren't Telling you About Stimulants for Children. Monroe.

Bussing R., F. A.*Gary, T. L Mills* and *C. Wilson Garavan*, 2003: "Parental explanatory models of ADHD. Gender and cultural variations. Social Psychiatry and Psychiatric Epidemiology," 38 (10): 563-575.

Callon, M., 1986: "Some Elements of a Sociology of Translation: Domestication of the Scallops and the Fishermen. Power, Action and Belief: A New Sociology of Knowledge", in: *Law, J.* (ed.), Power, Action and Belief A New Sociology of Knowledge? London.

Conrad, P., 1976: Identifying Hyperactive Children: The Medicalization of Deviant Behavior. Lexington.

Conrad, P., 1992: Medicalization and social control. Annual Review of Sociology 18: 209-232.

Conrad, P., 2005: The Shifting Engines of Medication. Journal of Health Social Behavior 46 (1): 3-14.

Conrad, P. and *Schneider, J.*, 1980: Deviance and Medicalization: From badness to sickness. Philadelphia.

Danford, S. and *V. Navarro*, 2001: "Hyper talk: sampling the social construction of ADHD in everyday language". Anthropology and Education Quarterly 32 (2): 167-190

Davis, Joseph, 2010: "Medicalization, Social control and the Relief of Suffering," in: *Cockerham, William C.* (ed.), The New Blackwell Companion to Medical Sociology. London.

Dewey, J., 1944: Democracy and Education: An Introduction to the Philosophy of Education. London.

Dreyfus, H.L., and P. *Rabinow*, 1984: Michel Foucault: Beyond Structuralism and Hermeneutics. New York.

Ecclestone, K., H. Dennis, F. Furedi, 2005: Knowing me, knowing you: The rise of therapeutic professionalism in the education of adults. Studies in the Education of Adults 37 (2): 182-200.

Ferudi, F., 2009: Socialization as Behavior Management and the Ascendancy of Expert Authority. Amsterdam.

Foucault, M., 1977: Discipline and Punish: the Birth of the Prison. New York.

Goffman, E., 1986: Stigma: Notes on the Management of Spoiled Identity. New York.

Hochschild, Arlie R., 1979: "Emotion Work, Feeling Rules and Social Structure," American Journal of Sociology 85 (3): 551-575.

Hoza, B., 2007: Peer Functioning in Children With ADHD. Journal of Pediatric Psychology 32 (6): 655–663.

Illouz, E., 2008: Saving the Modern Soul. Therapy, Emotions, and the Culture of Self-Help. London.

Lasch, C., 1978: The Culture of Narcissism. American Life in an Age of Diminishing Expectations. New York.

Nolan, Jr, J.L., 1998: The Therapeutic State. Justifying Government at Century's End. New York.

Mayes, R. and *A. V. Horwitz*, 2005: DSM-III and the revolution in the classification of mental illness," Journal of the History of the Behavioral Sciences. 41 (3): 249-267.

Martin, Emily, 2000: "Flexible survivors I". Cultural Values 4 (4): 512–517.

Miller, T., 2008: Ritalin. Panic in USA. Cultural Studies Review. 14 (2): 103-112.

Moynihan, R., I. *Heath*, and *D. Henry*, 2002: Selling sickness: the pharmaceutical industry and disease mongering. British Medical Journal 324 (7342): 886–891.

Pelham, W.E., L. *Burrows-MacLean, E.M. Gnagy, G.A. Fabiano, E.K. Coles, K.E. Tresco, A. Chacko, B.T. Wymbs, A.L. Wienke, K.S. Walker* and *M.T. Hoffman*, 2005: Transdermal Methylphenidate, Behavioral, and Combined Treatment for Children With ADHD. Experimental and Clinical Psychopharmacology 13 (2): 111–126.

Rafalovich, A., 2001: The Conceptual History of Attention Deficit Hyperactivity Disorder: Idiocy, Imbecility, Encephalitis and the Child Deviant, 1877?1929. Deviant Behavior 22 (2): 93-115.

Resnick, A., and *D. Reitman*, 2011: The Use of Homework Success for a Child With Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type. Clinical Case Studies 10 (1): 23-36.

Scheff, T., 1984: Being Mentally Ill: a Sociological Theory (3rd edition). New York.

Schleifer, M., G. Weiss, N. Cohen, M. Elman, H. Crejic and *E. Kruger*, 1975: Hyperactivity in Preschoolers and the Effect of Methylphenidate. American Journal of Orthopsychiatry 45: 33-50.

Tait, G., 2003: Free will, moral responsibility and ADHD. International Journal of Inclusive Education 7 (4): 429-449.

Trout, A. L., T.R. Lienemann, R. Reid, and *M.H. Epstein* 2007: A Review of Non-Medication Interventions to Improve the Academic Performance of Children and Youth With ADHD. Remedial and Special Education 28 (4): 207-226.

Whalen, C.K., L.D. Jamner, B. *Henker, R.J. Delfino* and *J.M. Lozano*, 2002: The ADHD Spectrum and Everyday Life: Experience Sampling of Adolescent Moods, Activities, Smoking, and Drinking. Child Development 73 (1): 209–227.