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DISCOURSES OF RISK, BLAME, AND LEGITIMATION:
THE SOCIAL CONSTRUCTION OF
ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD)

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A Marion

“Questi ultimi anni dell'era postmoderna mi sono sembrati un po' come quando sei alle superiori e i tuoi genitori partono e tu organizzi una festa. Chiami tutti i tuoi amici e metti su questo selvaggio, disgustoso, favoloso party, e per un po' va benissimo, è sfrenato e liberatorio, l'autorità parentale se ne è andata, è spodestata, il gatto è via e i topi gozzovigliano nel dionisiaco.

Ma poi il tempo passa e il party si fa sempre più chiassoso (...) e le cose cominciano a rompersi o rovesciarsi, e ci sono bruciature di sigaretta sul sofà, e tu sei il padrone di casa, è anche casa tua, così, pian piano, cominci a desiderare che i tuoi genitori tornino e ristabiliscano un po' di ordine...

Non è una similitudine perfetta, ma è come mi sento, è come sento la mia generazione (...); sento che sono le tre del mattino e il sofà è bruciacchiato e qualcuno ha vomitato nel portaombrelli e noi vorremmo che la baldoria finisse. L'opera di parricidio compiuta dai fondatori del postmoderno è stata importante, ma il parricidio genera orfani (...).

Stiamo sperando che i genitori tornino e chiaramente questa voglia ci mette a disagio, voglio dire: c'è qualcosa che non va in noi? (...) Non sarà che abbiamo bisogno di autorità e paletti?

E poi arriva il disagio più acuto, quando lentamente ci rendiamo conto che, in realtà, i genitori non torneranno più. E che dovremo essere noi, i genitori.”

David Foster Wallace, stralcio di un'intervista rilasciata a Larry McCaffery per la “*Review of Contemporary Fiction*“, estate 1993.

ABSTRACT

Attention Deficit/Hyperactivity Disorder (ADHD), characterized by inattention and hyperactivity/impulsivity (APA, 2000), is currently the most common and debated childhood psychiatric diagnosis. ADHD has mobilized great social attention in the last decade and has primed a profound scientific and public controversy during the last years.

Considering the circulation of competing perspectives, this research aims to analyze the discursive construction of ADHD by the key adults who interact with the child. The study involves relevant social actors who are engaged in the diagnostic/treatment processes of ADHD - mental health professionals, primary school teachers, and parents - that also belong to powerful social institutions for children's education and socialization: the medical field, school and family.

The theoretical framework integrates discourse analysis (Foucault, 1969; Parker, 2005) and positioning theory (Harré & Van Lagenhove, 1999). The general aim concerning the discursive construction of ADHD was articulated in two sub-aims. The first was to map the participants' positioning repertoire, in terms of reflexive positioning, used to position oneself, and interactive positioning, used to position others. The second sub-aim was to analyze the discursive dynamics characterizing the interactions among the members of a self-help group of parents.

The analysis allowed identifying three relevant discursive patterns. First, the discourse of risk, which transversally crosses the narratives of the participants and is related to the positioning of the child diagnosed with ADHD as both "at-risk" for himself and "risky" for others. Second, the blame embedded in the mutual positioning of the key adults surrounding ADHD children. The mutual blame is not merely related to the debate regarding the validity of the ADHD diagnosis. Rather, it is centered on questions of compliance, recognition of authority, and morality. Third, the self-legitimation towards which the narrative produced by the self-help group of parents is oriented. The shared narrative that parents construct functions as a ratified and consensual body of knowledge that constitutes a language to narrate what ADHD and a resource to counter blame and find legitimization for parents' experiences.

Overall, the results shows that ADHD is simultaneously a socially constructed and a "constructive" object, as participants are involved in the process of constructing the child and his/her problem, but they are also negotiating their own and others' subjectivity in relation to the "problematic" child.

Key words: Attention Deficit/Hyperactivity Disorder (ADHD), positioning theory, discourse analysis, risk, blame, legitimation

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INTRODUCTION

This dissertation presents a research focused on the discursive construction of Attention Deficit/Hyperactivity Disorder (ADHD) within the Italian context.

ADHD is currently the most common and debated psychiatric diagnosis released among children; the behavioral spectrum associated to this diagnostic category includes inattention and hyperactivity/impulsivity (APA, 2000).

Given the debated nature of this psychiatric category and the circulation of competing perspectives about the “real” causes of children’s behavior and the “correct” way to treat them, the aim of this research is to analyze the central social actors’ discourses about ADHD and ADHD children.

The study focuses on the polyphonic chorus of voices surrounding the child and adopts a multi-method approach to study the discourses of mental health professionals, primary school teachers, and parents belonging to a self-help group for parents of children diagnosed with ADHD.

Addressing the interplay of professional, scholarly and parental discourses is important to capture the multiple constructions of ADHD in relation to three contexts that are deeply engaged with this topic: medical institutions, schools and families. Indeed, each of these stakeholders - professionals as well as teachers and parents - has a relevant role in the diagnosis and treatment of childhood ADHD, and it is their interaction that determines the presence and the management of the problem.

This contribution aims to extend psychosocial understanding and inform future thinking about the ways in which key adults shape and provide meaning for the phenomenon ADHD. Moreover, ADHD is a fruitful area to explore current assumptions about mental health/illness and childhood that characterize the contemporary socio-cultural Western context.

Before presenting the chapters outline, a premise must be made. Along the dissertation I will use the pronoun “I” to make reference to specific choices that I made during the research process. This form of expression is coherent with the epistemological and theoretical orientation of the study and aims to distance the researcher and the research from the assumption of impartiality that often characterizes traditional research approaches.

Chapters outline

Chapter 1. The first chapter presents the scientific and public controversy centered on ADHD, specifying the main topics of debate and the related different positions. The characteristics of the broader socio-cultural context in which ADHD has emerged and the specificities of the local Italian context are discussed. Finally, the relevant literature on ADHD, and in particular the studies that have analyzed the relational and social factors related to this diagnosis, is reviewed.

Chapter 2. The epistemological and theoretical framework of the dissertation is presented. The theoretical approach that oriented the research and the analysis of the data collected derives from an integration of a plurality of theoretical resources, in particular discourse analysis, as it is conceptualized within the broader umbrella of post-structuralism and critical psychology (Foucault, 1969; Parker, 2005), and positioning theory (Harré & Van Lagenhove, 1999).

Chapter 3. This chapter presents the research that has been conducted. In line with the theoretical perspective, the general aim has been articulated in two sub-aims, which are illustrated in details. The method and the procedures adopted, both in terms of data collection and data analysis, are presented. The study adopts a multi-method approach; the rationale for this choice is discussed. The chapter presents then the results, which are organized in three sections, related respectively to the position attributed to the child, the self and mutual positioning of the participants, and the discursive dynamics enacted within the self-help group of parents and their functions for the group itself. The third analytic section, focused on the parents' self-help group, includes a presentation of the most relevant literature about self-help groups and mutual supports associations. In each analytic section the results are discussed in terms of their relevance and connection with the literature.

Chapter 4. The final chapter discusses the conceptual connections between the results and their potential implications, together with a reflection on their usefulness. The chapter concludes with a meta-level reflection about the whole research project. It includes a discussion of the limitations of the study and an explicitation of my position as researcher together with a clarification of how it may have impacted the study and its results.

CHAPTER 1

ADHD IN CONTEXT

1.1 ADHD CHILDREN IN THE MIDST OF SCIENTIFIC, SOCIAL AND POLITICAL CONFLICTS

The dissertation presents a research that analyzes the discursive construction of Attention Deficit Hyperactivity Disorder (ADHD) within the Italian social context focusing on the interplay of professional, scholarly and parental narratives on ADHD.

Childhood behavioral and mental problems are on the rise in terms of both public attention and the number of diagnoses (Pastor & Reuben, 2008). The most common and debated psychiatric diagnosis currently released among children is Attention Deficit Hyperactivity Disorder (ADHD) (Furman, 2005). ADHD is commonly described as a disorder whose behavioral spectrum includes inattention, hyperactivity, and impulsivity (APA, 2000). Data show that ADHD is 3 times more common among males than females (Barkley, 2006a). The main treatment is methylphenidate (commonly known as Ritalin in the pharmaceutical market), a stimulant medication, whose use in children was approved in the USA in 1961 (Mayes, Bagwell, & Erkulwater, 2008). Stimulant medications were the first drugs specifically targeted to the treatment of a particular diagnosis in childhood (Mayes, Bagwell, & Erkulwater, 2009). ADHD is a relatively new mental disease category, since it was introduced in the Diagnostic and Statistical Manual of Mental Disorders 3th ed. (DSM III) in 1980 (APA, 1980). The first description of ADHD is usually attributed to Still, who in 1902 considered it as a result of a moral defect (Barkley, 2006b; Still, 1902; Still, 2006). Still is frequently cited as the first one who seriously focused medical attention on the behavioral spectrum that approximates what now is called ADHD, despite the fact that, according to Palmer, his account is “seeped in moralism” (Palmer & Finger, 2001, p.70). Later, more than 20 different terms and categories have been used to categorize children who exhibit these problematic behaviors. Between 1940s and 1960s, behaviors currently associated to ADHD were named as “minimal brain damage” (Mayes & Rafalovich, 2007; Strauss & Lehtinen, 1947), a brain malfunctioning ascribed to toxin, infection or head injury. Afterwards, the medical categorization shifted from a poor impulse control with no identified organic damage (Laufer, Denhoff, & Solomons, 1957) to “hyperkinetic syndrome” (Mayes & Rafalovich, 2007), up to the “official” inclusion in the DSM III in 1980 under the name of Attention Deficit Disorder (ADD) (APA, 1980; Kidd, 2000). After 1980, research programs focused not only on management and

treatment but also on the search for genetic evidence and neural correlates (Lakoff, 2000). In DSM-III each subcategory of ADD – inattention, impulsivity and hyperactivity – was associated to a specific list of criteria for diagnosis. For a diagnosis to be released, the evaluator had to identify two or three of the possible symptoms under each subcategory. Evaluation scales of behavior for parents and teachers emerged, such as the Connors Scales, which were first published as a tool for clinical drug research (Connors, 1969). In 1987, in the revised DSM III (APA, 1987), the American Psychological Association added ADHD, attention deficit with hyperactivity, as a possible subtype of the diagnosis. The idea that ADHD can occur in adults was first advanced in 1976 (Wood, Reimherr, Wender, & Johnson, 1976) and then included in DSM-III-R in 1987. In 1994, with the DSM IV (APA, 1994), ADHD was defined as a disorder characterized by persistent hyperactivity, impulsivity and inattention with three main subtypes: primarily inattentive, primarily hyperactive/impulsive or combined (Fone & Nutt, 2005).

The APA criteria for ADHD varies significantly from the European International Classification of Disease 10th edition (ICD-10) (WHO, 2010), which has a stricter definition, according to which all the three characterizing behaviors must be present to cause a diagnosis (Fone & Nutt, 2005). It must be acknowledged that, although the European medical community has in part influenced the psychiatric discussions, “the conceptual history of ADHD (...) reflects the North American psychiatric practice” (Mayes & Rafalovich, 2007, p. 437). More in general, the DSM holds a hegemonic position in psychiatry and clinical psychology (Alarcón, 2009), and, since the first edition (APA, 1952), its classification system has been widely accepted as a standard by mental health professionals (Crowe, 2000).

The current criteria of the DSM IV-R (APA, 2000) include 18 symptoms. Nine reflect impaired attention and nine depict the hyperactive/impulsive dimension of children’s behavior, with 6 symptoms for hyperactivity and 3 for impulsivity. Criteria for diagnosis are shown in Table 1. The DSM identifies three main subtypes of ADHD, the Predominantly Inattentive Type, the Predominantly Hyperactive-Impulsive Type, and the Combined Type, which is diagnosed when at least six symptoms of inattention are combined with at least six symptoms of hyperactivity. Moreover there are five criteria for ADHD to be diagnosed. First, behaviors must occur at a developmentally inappropriate level and must persist for at least six months. Second, the symptoms must have an onset before the age of seven years. Third, symptoms have to cause difficulties for the child in at least two different setting (like home and school). Fourth, the symptoms must cause

significant impairment for the child. Fifth, the symptoms must not be better explained by another cause.

Table 1. DSM-IV Criteria for ADHD

I. Either A or B

A. Six or more of the following symptoms of inattention have been present for at least 6 months to a point that is disruptive and inappropriate for developmental level:

- *Inattentive:*

1. Often does not give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
2. Often has trouble keeping attention on tasks or play activities.
3. Often does not seem to listen when spoken to directly.
4. Often does not follow instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).
5. Often has trouble organizing activities.
6. Often avoids, dislikes, or doesn't want to do things that take a lot of mental effort for a long period of time (such as schoolwork or homework).
7. Often loses things needed for tasks and activities (such as toys, school assignments, pencils, books, or tools).
8. Is often easily distracted.
9. Often forgetful in daily activities.

B. Six or more of the following symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for developmental level:

- *Hyperactivity:*

1. Often fidgets with hands or feet or squirms in seat.
2. Often gets up from seat when remaining in seat is expected.
3. Often runs about or climbs when and where it is not appropriate (adolescents or adults may feel very restless).
4. Often has trouble playing or enjoying leisure activities quietly.
5. Is often "on the go" or often acts as if "driven by a motor".
6. Often talks excessively.

- *Impulsiveness:*

1. Often blurts out answers before questions have been finished.
2. Often has trouble waiting one's turn.
3. Often interrupts or intrudes on others (example: butts into conversations or games).

II. Some symptoms that cause impairment were present before age 7 years.

III. Some impairment from the symptoms is present in two or more settings (e.g., at school/work and at home).

IV. There must be clear evidence of significant impairment in social, school, or work functioning.

V. The signs do not happen only during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder. The signs are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Identity Disorder, or a Personality Disorder).

Based on these criteria, three types of ADHD are identified:

1. ADHD, *Combined Type*: if both criteria 1A and 1B met for the past six months
2. ADHD, *Predominantly Inattentive Type*: if criterion 1A is met but criterion 1B is not met for the past six months
3. ADHD, *Predominantly Hyperactive-Impulsive Type*: if criterion 1B is met but criterion 1A is not met for the past six months

Source: DSM-IV-TR (2000)

In sum, over the last century the spectrum of behaviors now associated with ADHD has been subjected to a number of changes with respect to their conceptualization and classification (Lakoff, 2000). Such changes are not unique to ADHD, but characterize many mental diagnostic categories and reflect socio-cultural variations (Conrad & Potter, 2000, p. 561-562). In particular, Lakoff (2000) relates the emergence and evolution of ADHD to socio-historical changes in expert models of child behavior and the formation of new kinds of identity around disability. The author argues that expert knowledge of

childhood and pathologies of social development allow “insight into the changing norms that are embodied in healthy behavior” (p. 149).

The century old description offered by Still has been used as evidence of the ADHD validity and reality (Barkley, 2006b); in contrast, some authors have highlighted that the “moral defect” proposed by Still to account for children’s behaviors only proves that “the interpretation and classification of behavior is culturally and historically embedded” (Singh, 2008, p. 961), and that changes in psychiatric conceptualization reflect evolving cultural and medical representations (Kidd, 2000; Mayes & Rafalovich, 2007).

ADHD and its pharmacological treatment have primed a profound scientific and public controversy during the last 40 years (McLeod, Fettes, Jensen, Pescosolido, & Martin, 2007), involving a confrontation between competing discourses and schools (Cooper & Shea, 1999; Hughes, 1999) within the psy-complex (Rose, 1985) and supporting different positions (Curtis, Pisecco, Hamilton, & Moore, 2006; Timimi & Taylor, 2004; Williams & Taylor, 2006). In particular, the ADHD debate is characterized by a myth-reality dichotomy (Bailey, 2009) that is constructed around the opposition between two main discourses, the biological and the cultural one.

According to the current bio-psychiatric conceptualization, the conditions associated to ADHD are the specific symptoms of a valid psychiatric disorder, a chronic condition which has well-defined clinical correlates, can be distinguished from other diagnosis, is characterized by a peculiar course and outcome and shows a specific response to medications (Faraone, 2005). ADHD is associated with a disruption of the executive functions linked with abnormalities in the brain (Findling, 2008), specific neurobiological correlate (Faraone, 2005; Rohde et al., 2005) and high heritability (Swanson et al., 2000).

In contrast with the neurobiological view of ADHD, psychodynamic and psychoanalytic (Rafalovich, 2002), critical psychological and psychiatric perspectives (Timimi et al., 2004) argue that the behavioral spectrum characterizing children cannot be ascribed to an identifiable and specific neurobiological disease (Furman, 2008; Parens & Johnston, 2009). Many critics, although not denying the problematic nature of certain behaviors and the difficulties experienced by children (Bailly, 2005), consider ADHD a construct modeled on changes in social and scientific contexts (Comstock, 2011). This position is based on several arguments: the lack of specificity of the behaviors associated to the disorder (Bailly, 2005); the evolving conceptualizations of the disease (Findling, 2008) and its diagnostic criteria (Singh, 2008); the high rate of comorbidity with other

developmental and learning problems (Newcorn et al., 2001), which range from 12% to 60%; the lack of a biological test for the diagnosis, as the diagnosis is based on clinical examination of children behaviors (Nair, Ehimare, Beitman, Nair, & Lavin, 2006) and information from third parties, mainly parents and teachers (Bailly, 2005); finally, the different prevalence rates of ADHD depending on gender, countries and method of diagnosis (Benner-Davis & Heaton, 2007). Indeed, the worldwide prevalence is highly heterogeneous, as it is significantly lower in Europe, Africa, and Middle East than in North America (Bird, 2002). This may be also due to the fact that prevalence rates based on DSM-IV are expected to be 3 or 4 times higher than those based on ICD-10 criteria (Stubbe, 2000), as according to ICD-10 the diagnosis must not be complicated by comorbid conditions.

An important topic of debate regards the genetic and neural evidences of behaviors associated with ADHD. While some authors claim that results from studies using neuroimaging techniques that look for anatomical and physiological differences in the brains of children diagnosed with ADHD show the existence of abnormalities in the brain and support medication use (Faraone & Biederman, 1998), others argue that research has not provided support for a specific biological abnormality linked to the ADHD condition and that “neuroimaging literature provides little support for a neurobiological aetiology of ADHD” (Baumeister & Hawkins, 2001, p.3-4). For example, Leo & Cohen (2003), in a critical review of neuroimaging research, argue that evidences supporting the involvement of specific brain areas with cerebellar modulation in ADHD are confounded because most subjects had prior medication use, and the few studies using unmedicated subjects avoided comparisons with controls. In line with that, Furman (2008) considered the evidences insufficient for a genetic or neuroanatomical cause of ADHD, given that structural and functional neuroimaging studies have not identified a unique etiology and no genetic marker has been identified (Furman, 2005).

Going beyond this debate about whether ADHD is “real” or “unreal”, Mayes et al. (2008) and Singh (2011) suggested that ADHD and its increase should be understood in the light of the interaction between individual vulnerabilities and biological disposition, and environmental features and demands.

The debate has centered also on the potential effects of the use of a label to categorize the child. Supporters of diagnostic labeling state that the label can facilitate the understanding and the communication of the children’s behaviors, help the acknowledgement of the existence of the problematic condition, change the position of the

child from aggressor to victim, and facilitate the access to health and scholarly services (Reid, 1996). In contrast, some researchers suggested that the use of a label could also have a negative impact. Stinnett, Crawford, Gillespie, Cruce, and Langford (2001) found that the presence of the label ADHD can lead one to perceive the child as having a more serious problem than a child without the diagnosis, and thus to alter the interaction with the child. According to other critics, the ADHD label, suggesting the existence of an underlying physical/biological problem, can divert attention away from social, environmental, and psychological factors involved in the child's behavior (Conrad & Schneider, 1999; Ideus, 1998).

The dominant mode of treatment, methylphenidate, is the subject of considerable controversy regarding its actual efficacy and safety (Breggin, 2002) as well as the ethical issues involved (Brock, 1998; McLeod et al., 2007). Skeptics consider medications as simplistic solutions to complex problems that support a "culture of pills" to solve human difficulties (Timimi et al., 2004, p. 61) and may negatively influence a child's autonomy and responsibility (Brock, 1998). Critics also claim that stimulants are overprescribed (Carey & Diller, 2001).

The debate has been exacerbated by the rapid rise of the disorder, in terms of its popularity, number of diagnosis, and the associated expansion in medication use (Sciutto & Eisenberg, 2007; Zito, Safer, Gardner, Boles, & Lynch, 2000). Indeed, ADHD has been mobilizing great social attention over the last few decades. ADHD has received widespread media coverage (Connor, 2011) and has been the focus of an increasing number of scientific articles and conferences. For example, the number of articles submitted on ADHD to PubMed has increased from fewer than 500 in the early '80s to more than 3800 in 2005, and now ADHD is the most common (Furman, 2005) and the most extensively studied (Stern, Garg, & Stern, 2002) behavioral condition of childhood. This attention may influence parental concerns and fears, as well as child-caring professionals' representations and physicians' behavior. The popularity of this diagnosis pairs with the escalation in ADHD prevalence in recent decades (Akinbami, Liu, Pastor, & Reuben, 2011; Schmitz, Filippone, & Edelman, 2003), which in the USA increased 250% from 1990 to 1998 (Robison, Skaer, Sclar, & Galin, 2002), an average of 3% per year from 1997 to 2006, and 5.5% per year from 2003 to 2007 (Pastor & Reuben, 2008).

Although epidemiological studies have produced differing prevalence rates, ranging from 0.5% and 26% of all children (Green, Wong, Atkins, Taylor, & Feinleib, 1999; Taylor & Hemsley, 1995), worldwide approximately 5.2% of children are considered to meet the

current diagnostic criteria for ADHD (Moffitt & Melchior, 2007). In Italy, epidemiological studies have reported differing prevalence rates, ranging from 1.1% to 12% (Bonati, 2009). A 2006 study estimates that ADHD affects 7,1% of children between 6 and 7 years of age (Mugnaini et al., 2006). The incidence rate is expected to be influenced by changes in the diagnostic criteria of the DSM-V. The increase in ADHD prevalence operates in association with an increase in methylphenidate use (commonly known as Ritalin) to treat ADHD (Sciutto & Eisenberg, 2007; Zito et al., 2000).

A number of potential explanations have been proposed to explain the reasons beyond the increased number of diagnoses released and medication used: a legitimate rise in the incidence, a broader awareness of the disorder, a better detection of cases, or improved access to health resources (Goldstein, 2006). According to some critics, instead, these trends reflect a tendency towards medicalization and pathologization (Finn, Nybell, & Shook, 2010; Kindsvatter, 2005; Malacrida, 2004), and an implementation of regulatory devices and forms of social control that shape the lives of children and families (Conrad, 1975; Zola, 1972). Forms of social control enacted within the psy-disciplines have been termed “psychotechnology” (Chorover, 1973). Medicalization is described as the process whereby human problems and difficulties become understood and managed as medical problems (Conrad, 1975). This process is based on the definition of a problem in medical language, the construction of individuals as patients, and the organization of a response to the problem in terms of medical intervention (Malacrida, 2004). According to Conrad (1975), medicalization contributes to remove the problems from the public and political realm, constraining complex problems under the expert control and within the narrow space of individual physical functions. The author, writing on hyperkinesis, which would have become the current diagnosis of ADHD, noted that in general the process of medicalization operates at different levels: the interactional level, between patient and physician; the conceptual level, that is, the use of specific discourses to signify the problem; finally, the institutional level, where medical forms of knowledge encounter the everyday routine work. In particular, Conrad described the role of pharmaceutical research and advertising, and of parental and professional activism, as major factors influencing the timing of the "discovery" of hyperkinesis as a childhood disorder. In a later work, Conrad and Potter (2000) have also analyzed the issue of medicalization in relation to the expansion of the medical boundaries of the ADHD category showed by the emergence of ADHD in adults in the 1990s. According to the authors, psychiatric and medical diagnosis definitions are intimately bound with the claims-making of particular interest groups, such

as self-help and advocacy groups, social movements, and health-related organizations.

The impact of various competing interest groups, like parental associations and governmental organizations, on the popularization of ADHD and the ADHD debate has been traced also by Mayes et al. (2008, 2009). The authors, although viewing ADHD as a legitimated disorder with neurobiological correlates and stimulants as effective and safe, showed that “ADHD and stimulants do not exist in a clinical vacuum” (Mayes et al., 2008, p. 152) and like any other mental issues they are social, psychological and cultural to the core (Good, 1997). Overall, these studies underline that ADHD is not simply a private medical finding, but carries a lot of policy ramification (Mayes et al., 2008). Within this critical perspective, Timimi and colleagues (Timimi & Taylor, 2004; Timimi et al., 2004) argue that the medical model of ADHD is a simplistic reading of the phenomenon that disengages parents, teachers, and doctors from personal and social responsibility, and states that some social factors have contributed to the production of cultural conditions for the propagation of the ADHD construct in the Western Culture. Drawing on a cultural perspective, the author underlines the role of diverse socio-cultural elements in the “epidemic” diffusion of ADHD: loss of extended family support, pressure on schools, collapse on the parental authority, and “a market economy value system that emphasizes individuality, competitiveness and independence” (Timimi & Taylor, 2004, p. 8; Prout and James, 1997).

1.2 THE SOCIAL CONTEXT OF ADHD EMERGENCE AND POPULARITY

ADHD has emerged within a dominant perspective on children's mental health that, according to Liegghio and colleagues (Liegghio, Nelson, & Evans, 2010), nowadays is ruled by some embedded values: an individualistic conceptualization of children's mental health; pathologization and medicalization of mental differences; the tendency to maintain social order by exerting control on children and students with mental health problems; finally, an emphasis on biomedical models and an underestimation of relational and social influence that leads to focus the intervention on the child and his/her family, ignoring the societal and community conditions. This pairs with the fact that worldwide, at the economic and political level, recent policies have been characterized by budget cutbacks for social welfare and educational systems, which reduce the human and economic resources necessary for communities and schools to run their educational mission and deal with problematic situations, and contribute to the individualization of the child's problems. As Prosser (2008) argued, the current practice around ADHD is more focused on integrating students rather than inclusive education.

Because the debate and the related narratives must be understood in their context of emergence and with reference to the cultural patterns giving them meaning (Kirmayer, 2006), I draw below some features of the current Italian social context as related to the ADHD topic. In Italy, ADHD is a relatively recent issue for debate compared to the USA, Australia and other European countries. In a 2007 article, Frazzetto and colleagues (Frazzetto, Keenan, & Singh, 2007) emphasized that ADHD was not recognized as a valid disorder by many Italian child-psychiatrists, and methylphenidate was not available in the market. A small group of parents fought to educate the public and teachers about ADHD. Things have rapidly changed, and ADHD is now a popular disorder among professionals and lay people. It is mostly diagnosed by child psychiatrists and, in some cases, by psychologists who work in public services or as private practitioners. DSM-IV (APA, 1994) criteria are used to carry out a diagnosis, and national guidelines were published in 2007 to homogenize assessment procedures.

The number of people diagnosed has increased significantly in conjunction with the introduction of methylphenidate to the Italian pharmaceutical market, which was authorized by the Italian Drug Regulatory Agency in 2007. Moreover, the Italian government created a National ADHD Registry, including all children who receive a

diagnosis of ADHD, in order to estimate its prevalence and drugs' effects. These changes are also linked to the activity of associations and advocacy groups attempting to influence social policies and legislation regarding ADHD and the use of medications for its treatment, which show that the scientific controversy has come to be reflected in the growing public interest for the problems linked to the diagnosis of ADHD (Hansen & Hansen, 2006). On the one hand, there are some committees and national information and awareness campaigns that have focused on the potential abuse of medication during childhood, such as "Giù le mani dai bambini" ("Hands off children"), and the psychiatrization of human behavior, like the campaign "Perché non accada anche in Italia" ("Preventing in Italy what has happened in other countries"). On the other hand, the "Italian Association of ADHD families" (AIFA) and the professionals' association "Italian association of Attention and Hyperactivity Disorder" (AIDAI) aim to promote the social acceptability of ADHD, creating supporting networks for parents, organized trainings for teachers, and countering critical information. This shows that ADHD has entered the public sphere and also the arena of politics (Buitelaar & Rothenberger, 2004). The presence of these social movements also exemplifies that in the contemporary society people are not passive subjects dependent upon experts' judgments and advice, but are increasingly active in the search for answers to their questions (Beck, 1992).

Given the debated nature of ADHD, its popularity and spread, and the relevant implications it has outside the medical realm, in particular for families and schools, a significant amount of studies have dealt with ADHD. The literature that has dealt with the analysis of the interactional and social factors related to ADHD will be considered. Many studies have been conducted in clinical, educational and familiar settings, as well as through media analysis, highlighting diverse social implications and aspects of the ADHD phenomenon. Regarding media analysis, Horton-Salway (2011) used a discursive approach to analyze the way ADHD was represented in UK newspapers and identified two main discursive repertoires, the biological and the psychosocial, both embedding different subject positions for children and parents. A broad amount of literature concerns the social actors engaged with ADHD-related issues. Some authors addressed the level of acceptance of the medical model among general practitioners (Rafalovich, 2005), showing that "clinicians do not practice within a vacuum" (p. 318) and that they show ambivalence about the diagnostic validity of ADHD paradoxically within a context that displays a stable medication use. This apparent contradictory attests for the uncertain status of clinical practices related to ADHD (Kildea, Wright, & Davies, 2011).

Many researches have examined the parents' experiences and understanding of ADHD, their relation with the broader social context, and the dilemma they have to face (Harborne, Wolpert, & Clare, 2004; Hansen & Hansen, 2006; Klasen & Goodman, 2000). The literature suggests that social rejection can instill in parents feelings of incompetence, isolation, and low self-esteem (Harrison & Sofronoff, 2002; Podolski & Nigg, 2001). Parents of hyperactive and inattentive children have been reported to experience guilt and feeling blamed for their child's behaviors by professionals, family members and society and a profound sense of alienation, as their family and social roles, as well as their self-perception, are affected (Harborne et al., 2004; Klasen & Goodman, 2000). In general, ADHD is associated with high levels of stigma (Bell, Long, Garvan, & Bussing, 2011), whose effects are not confined to children, but also impact their families (Goffman, 1963). Within this stigmatizing context, the ADHD diagnosis is often perceived as relief by parents, as it locates the problem within the child's brain (Harborne et al., 2004; Singh, 2004). Thus, medicalization may function to legitimate parents' experiences and validate their parental abilities. This dynamic is related to the fact that parents often describe conflicts with others, including professionals, who do not see the child's difficulties as a biological problem (Hughes, 2007; Kendall & Shelton, 2003; Neophytou & Webber, 2005).

Thus, literature has emphasized themes of blame and responsibility, underlining that ADHD is socially framed in relation to the dimension of morality (Schubert, Hansen, Dyer, & Rapley, 2009; Singh, 2011). In this regard, the role of the masculinity stereotypes and mothering ideology in influencing the rates of the disorder has been addressed (Singh, 2002, 2003, 2005). The notion of "mother-blame" (Berman & Wilson, 2009; Singh, 2004) refers to the feeling of inadequacy and guilt experienced particularly by mothers in relation to the behavior of their children and see these feelings as promoted by the cultural value of maternal self-sacrifice. Singh (2004) argued that the ADHD diagnosis and the embedded brain-narrative constitute a promise of absolution for parents, and especially mothers, who see the biomedical model of ADHD as a tool for identity self-preservation in a culture that valorizes self-sacrifice. According to the author, medicalization and the use of drugs are a way to enhance the success of both mother and son. This paradoxically reinforces cultural prescriptive formulations about what it means being a mother and a boy, and shows the role of culture in constructing a social need for medicalization. In line with this research route on mothering, Bennett (2007) employed a Foucauldian approach in order to discuss how mothers negotiate their experience of blame and affirmed that "although the data

suggest the diagnosis can free women from blame, mothers appear unable to easily resist the blame associated with having to know everything, having to get it right, and the taking on of the child as their absolute responsibility” (p. 108).

Regarding the specific Italian contest, Frazzetto et al. (2007) identified four main narratives about ADHD circulating in the public debate: the right to health, the right to childhood, the feelings of guilt of parents, and the public stigma. The authors stated that the different positions on ADHD in Italy “are embedded in valued civil and cultural ideas as well and socio-political and governmental practices” (p. 409). Other authors have focused on children’s experience, highlighting that children labeled as ADHD believed that a core dimension of their “real” selves was persistently “bad” (Singh, 2007).

Despite the vast literature that has analyzed the construction of ADHD and has highlighted a range of implications of the ADHD phenomenon (Bennett, 2007; Horton-Salway, 2011; McHoul & Rapley, 2005; Schmitz et al., 2003; Schubert, Hansen, & Rapley, 2005; Schubert et al., 2009), to my knowledge no research has dealt with the interplay of professional, scholarly, and parental discourses. In this sense, the literature has paid insufficient attention to the relationships between the adults proximal to the ADHD child, and this topic requires further examination and understanding. Indeed, ADHD children and their social environment undergo a process of mutual shaping (Singh, 2011). Furthermore, the socio-contextual implications of ADHD constitute an under-researched topic of study in Italy. As Frazzetto et al. (2007) noted, it is important to deepen the understanding of the national characterization of ADHD to appreciate how the phenomenon is shaped by specific institutional, social, and cultural factors, which may constitute a “surface of emergence” in the ADHD phenomenon (Singh, 2006, p. 451).

ADHD is an important area to explore current assumptions about mental illness/health and childhood that characterize the contemporary socio-ideological context. First of all, developments in the mental health field are associated to the increasing salience of health within the contemporary western culture, which is linked to a tendency to define problems in terms of health and illness, mainly in the form of treatable bodily conditions (Rose, 2003). Diagnosis is a matter of the “politics of definitions” (Conrad & Schneider, 1992, p. 22) rather than a matter of discoveries. A diagnosis is a social act of attributing meaning to experience and behaviors rather than an “act of recognising a pre-existing and autonomous object” (Berrios, 2006, p. 470). This is also showed by the periodic redefinition of mental disorders by part of psychiatry. Psychiatry is not a value-free activity that provides an exact picture of the world, but depends on the historical,

social, and moral criteria on which the object of inquiry is defined (Berrios, 2006). In this regard, Rose (2003) considers ADHD an “example of a culture bound syndrome” (p. 52), a psychiatric category that codifies and reproduces social norms and standards, whose role is neutralized through a brain-based discourse (Singh, 2002) which defines and understands people’s identities in terms of brain functioning.

Concerning the issue of childhood, the child is a subject on whom different semantic attributions converge, a symbolic field of construction of meanings, which are articulated in relation to historical criteria of legitimacy and socio-cultural concerns and prescriptions about nature, technology, and family relationships (Burman, 2011). Indeed, the construction of childhood as well as its “modes of expressions” mirror socio-political modifications (Burman, 2011). Nowadays, children’s wellbeing constitutes a central social concern and evokes a wide array of collective hopes and fears. As the concept of childhood is a cultural product, researching about children can reveal something about adults; indeed, “socialization calls into being an adult-in-the-making” (Kehily, 2009, p. 8). Specifically, developmental psychology has contributed to construct childhood as a process of social adaptation, structured on a staged progression towards adulthood (Walkerdine, 2009).

Moreover, in the specific case of ADHD, children are at the center of a scientific and social controversy about the “real” causes of their behavior and the “best” way to treat them. Because there is no organic marker for the disorder, ADHD is a socio-cultural process as its presence is established by stakeholders - professionals as well as teachers and parents - whose interactions determine the diagnosis and management of the problem. The presence of conflicting discourses regarding ADHD children and the role of key adults in the diagnostic and treatment process lead to interesting analyses of how different groups of social actors discursively frame and understand the nebulous problems linked to ADHD. These discourses shape and provide meaning for this phenomenon, and show how ADHD relates to the larger social, political and economic contexts of children’s lives (Singh, 2011).

In this sense, this research project aim at re-contextualizing the children’s troubles in their setting of emergence and rising, addressing the relational and discursive landscape inhabited by the child, and resisting the oversimplification tied to narrow the focus of the analysis on the single “problematic” child and his/her brain or genetic condition (Berrios, 2006; Singh, 2002). In line with that, the research design includes diverse figures - professionals, teachers and parents - who populate the social circuit of the child labeled as ADHD.

Finally, the recent and ongoing rise of ADHD diagnosis is a reason to analyze how psychiatric classifications, and the related discourses, influence the way people perceive and understand behaviors. Indeed, when classifications are put to work in society and institutions, they change the ways in which individuals experience themselves and may even “lead people to evolve their feelings and behavior” (Hacking, 1999, pp. 103-104) in response to the expectations associated with the classification itself. Experience, behavior and interpretation are not only influenced by the way in which people are classified, but more in general they intertwine with social discourses circulating within a specific cultural and political context. Because of this, it is important to consider the influence of socio-cultural patterns and assumptions that manifest themselves in health and illness practices. To address these questions, the theoretical framework on which this study is based integrates discourse analysis and positioning theory, as explained in the next chapter.

CHAPTER 2

THEORETICAL AND METHODOLOGICAL FRAMEWORK

2.1 “THE WORLD OF WORDS CREATES THE WORLD OF THINGS”

This research project draws on a social constructionist epistemological perspective. Epistemology can be defined as “the study of the nature of knowledge and the methods of obtaining it” (Burr, 2003, p. 202) and it is concerned with the way we come to know what we know. Social constructionism assumes that human experience, knowledge, and practice are constituted through social interactions within specific cultural and historical contexts (Burr, 1995). Phenomena are seen as produced and constructed through historically-based interpersonal, social, and institutional processes; in this sense, social constructionism argues that what is considered true and real is always an historical and social outcome, as it is located within and constrained by specific cultural contexts. Thus, knowledge is not culture-free; in particular, the term *social* refers to the fact the individual experience is always shaped by culturally shared categories of meanings (Harper, 2006; 2011).

Gergen (1985) has identified five basic assumptions of social constructionist research, which Harper (2006) resumes as follow: a doubting approach to the taken-for-granted world; the view of knowledge as historically and culturally located; the conceptualization of knowledge as dependent on social processes; the idea that descriptions and explanations of phenomena cannot be neutral, rather they constitute a social action. Thus, social constructionist research is interested in how knowledge is generated (Gergen, 1985) and why some forms of knowledge are seen as more valid than others (Harper, 2011).

In line with these assumptions, scientific productions are not considered objective; rather, scientific inquiry is seen as a social act and science as a powerful social institution that produces and circulates specific versions of reality and truth (Burr, 1995; Nightingale & Cromby, 1999). Therefore, research informed by a social constructionist epistemology focuses on the processes through which social reality is “constructed, negotiated and perpetuated in everyday interactions and through institutional and scientific practices” (Bilić & Georgaca, 2007, p. 169). In line with the sociology of science, scientific ideas should be understood as social products dependent on the particular context in which they are produced. As Fleck (1981) showed in relation to a physical condition like syphilis, the

changing conception of symptoms and treatments of a disease can be understood by reference to the styles of thought involved in their production.

Social constructionism is often accused of denying the reality of human experiences, like psychological distress, by invoking that they are just constructed (Harper, 2011). Actually, bringing attention to the fact that the way we conceive and experience distress is historically and contextually informed does not correspond to say that the distress that people experience is not true or real. To avoid sliding into a relativistic position, according to which it is impossible to claim something about reality as we cannot have a direct access to it, this work takes a critical realism stance (Burr, 2003; Harper, 2006; Parker, 1998). Critical realism is a version of social constructionism that does not deny the existence of specific realities and the value of scientific findings, but emphasizes the social character of human interpretations (Mallon, 2007). Burr defined critical realism as “the view that, although we cannot be directly aware of the material objects in the world, nevertheless our perceptions do give us some kind of knowledge of them” (Burr, 2003, p. 204). Critical realism acknowledges that the complexity of human experience cannot be captured by analyzing small fragments of behaviors, cognition, or emotions (Parker, 1997), but should be approached considering the broader historical, cultural, and social context (Harper, 2011). For instance, in the case of psychosocial phenomena, the recognition of the social nature of individuals is not incompatible with the idea that there may be relevant biological and innate influences on human life (Mallon, 2007). Thus, a socio-constructionist account is not necessarily in opposition to the attribution of a significant role to biology, but claims that biological accounts cannot offer a complete explanation of complex processes that also involve social factors.

Within the psychological field, social constructionism has contributed to shift from a view of psychological processes as intrapersonal and individual phenomena to a vision of psychology as a science that is structurally social and deals with interpersonal categories (Bilić & Georgaca, 2007). Because of this, the analytic focus is on the socially constructed nature of the scientific notions of psychological processes and on the implications of these constructions for personal experience.

The social constructionist approach emphasizes the role of language in both producing and constraining meanings. Because claims about knowledge are made through language (Avdi, Griffin, & Brough, 2000), language not only has a descriptive function but “is united inextricably to whatever is known” (Pardeck & Murphy, 1993, p. 1192). Usher (1997) argues that every kind of knowledge is textually-mediated, that is, produced and

mediated by language, as it involves “writing the world, not uncovering it” (Chamberlain, Cain, Sheridan, & Dupuis, 2011, p. 166). In this sense, “the world of words creates the world of things” (Lacan, 1977, p. 65).

According to structuralist theories of meaning deriving from the linguist Ferdinand de Saussure (1974), the meaning of a term depends on its relations with other terms (Hawkes, 1977). Language, on the one hand, is the marking of difference and, on the other hand, is the repetition of a language that precedes the individual (Derrida, 1976). This tension between difference and repetition is a key element in a discourse-oriented view of language, and has important implications for how the signifiers that people use to talk about their experience are interpreted. Experience, indeed, is seen as constituted by the language within which it is constructed (Allen & Hardin, 2001); at the same time, language is continuously reproduced and modified through its use (Young, 1990).

Meaning also depends on its relationship with the social and interactional context in which it is produced. Wittgenstein (1953) argued that an understanding of behavior and phenomena can be approached by looking at meaning, that is, what people do with word patterns and other sign systems. The use of signs is governed by rules depending on the specific context inhabited. In this sense, truth is the product of “language game”. Thus, individuals position themselves within the complex structure of rules and practices within which they moves (Winch, 1958).

Within the postmodern tradition, Austin (1962), with his theory of speech acts, emphasized the action orientation of language, as it performs actions and acts of various kinds. Following this traditions, Harré and Gillett (1994) and Davies and Harré (1990) argue the central role of discourse in psychological phenomena and in the ways in which people produce social and psychological realities. In particular, Harré and Gillett (1994) affirm that “the delineation of the subject matter of psychology has to take account of discourses, significations, subjectivities and positionings” (p. 23). People inhabit many different social discourses, each of which is associated to a particular cluster of signification. Meaning arises from, as well as constitutes, the subjectivity of an individual in relation to what is signified. Coherently with this view, discursive phenomena are not manifestations of hidden psychological phenomena; rather, they are the psychological phenomena, which, in their public form, take the shape of behavior and, in their private form, represent thought (Harré & Gillett, 1994). Within this perspective, other authors have contributed to a further articulation of the issues of meaning and language. Billig (Billig, 1996; Billig et al., 1988) proposed a rhetorical approach that assumes the intrinsic

argumentative nature of thought, and focused on the relevance of contradictions and dilemmas in the discursive production of meaning.

Overall, this postmodern view of language has three important effects (Allen & Hardin, 2001): it helps in linking language to other significant practices, by asking what kinds of difference a person is marking through his/her speech and highlighting the performative aspects of language; it facilitates the recognition of social and historical influences, emphasizing that our experience is always embedded in already established “social conversation” (Allen & Hardin, 2001, p. 167); it permits to understand subjectivity outside the traditional macro-micro binary. I will return to the issue of subjectivity later in this chapter.

Within the broad framework outlined above, in the present research two approaches are integrated and used as theoretical, methodological, and analytical tools to deepen how the child diagnosed as ADHD is constructed and how the main people involved in this process – mental-health professionals, teachers, and parents - shape their own and others’ subjectivities. Because ADHD is at the center of a collision of different and competing statements constructing distinct versions of reality, some of which more dominant than others, I integrated tools derived from discourse analysis (Foucault, 1969; Parker, 1994; Parker, 2005) and positioning theory (Davies & Harré, 1990; Harré & Van Lagenhove, 1999). In the following paragraphs, I will detail these two different but overlapping approaches.

2.2 DISCOURSE AS SOCIAL ACTION

Discourse analysis is a term used to name different approaches to language (Edwards, 2005). In the present work, I will rely on discourse analysis as it is conceptualized within the broader umbrella of post-structuralism and critical psychology (Hodge & Kress, 1993).

Critical psychology (Fox & Prilleltensky, 1997; Hepburn & Potter, 2003) is a field of research that adopts a critical stance towards some basic elements of social institutions, organizations or practices. Within the wide field of critical psychology, critical health psychology “attends to the socio-historical context within which health and illness are created (...) and connects the illness experience to that context” (Marks, 2002, p. 15; see also Murray & Poland, 2006). In other words, critical orientations within health psychology have tried to counterbalance the individualistic focus of traditional approaches

reintroducing a concern about social, cultural and political processes, and establishing “the subject as historically developed” (Motzkau & Jefferson, 2009, p. 3). Health and illness are related to the material conditions of everyday life and the character of our symbolic worlds, in the sense that health conditions are meaningful only as mediated by collective and subjective symbolic signification (Ogden, 1997, 2003).

Within this perspective, there is a large body of work about psychiatric and psychological knowledge addressing the ways in which psychiatry, psychology, and their products are culturally and historically constructed (Radley, 1994; Samson, 1995). Cognition is not rejected but is conceptualized as a social and language-based activity (Parker, 2007), and as mental phenomena always involving the symbolic or imaginary presence of an Other (Parker, 1997). Cognition is considered as symbols-based, and thinking is seen as an interpersonal process based on language. This view of language as the prime instrument of thought and social action recalls Vygotsky’s (1978) ideas about the fact that mental processes depend significantly on interpersonal relations as well as culture and history.

In contrast with the de-contextualizing tendency of traditional psychological approaches, critical psychology addresses the psychological phenomena of everyday life focusing on cultural patterns of social relationships and structures (Parker, 1997). In particular, an expanding amount of literature drawing on post-structuralism has significantly contributed to a critical analysis of psychiatric diagnosis and classification, focusing on the construction of mental illness and its representation (Bilić & Georgaca, 2007). Within this frame, diagnosis is not understood as an act of discovering pre-existing individual categories, but as a process of construction of meaning and naming. According to Bilić & Georgaca (2007), diagnosis is a “sets of concepts and practices that are constructed and maintained by the scientific disciplines that deal with human distress” (p. 169), which, in turn, permeates lay knowledge influencing how people perceive and name their experiences (Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995). This literature has focused on a number of topics. Some authors have investigated the historical development of psychopathological categories, with a specific focus on the construction of mental disorder definitions in the Diagnostic Statistical Manual (DSM) of the American Psychological Association (APA), to highlight the underlining assumptions and criteria used to establish the boundaries between the normal and the pathological. For example, Crowe (2000) stated that the DMS-IV’s definition of mental disorder is constructed as related to socio-cultural norms and valued dimensions like “productivity, unity, moderation

and rationality” (p. 69). Other authors have addressed the diagnostic processes. They criticize the biomedical model of mental illnesses, questioning in particular the reification of the body as an asocial machine (McSwite, 2001) and suggesting that “the body is located in discourse” (Lester & Paulus, 2012, p. 261).

Willig (2000) has shown that discourse analysis has been variably and usefully applied in critical studies of health and illness, as it can help relate to subjectivity, lived experience, discourse, and psychological practice. Similarly, Harper (1999) noted that the field of mental health has been the focus of much recent discursive-oriented research.

A critical discourse approach addresses the way in which various forms of language work and discursive practices serve social, ideological, and political interests (Fox & Prilleltensky, 1997). Discourses are conceptualized not only as patterns of meaning that people use to talk and describe their world, but as forms of social action (Austin, 1962; Edwards, 1996) contributing to the organization of the symbolic system we draw on (Parker, 1999) and to the constitution and transformation of our world and subjectivity (McHoul & Rapley, 2005). Indeed, people continuously construct themselves by enacting particular discursive practices that, once internalized, guide our actions and shape our identities (Allen & Hardin, 2001). The discourse analysis stance marks a shift from the notion of representation as a direct picture of reality to the concept of signification which “itself gives shape to the reality it implicates” (Henriques, Hoolway, Urwin, Venn, & Walkerdine, 1984, p. 99). The social world, as well as the knowledge we produce about it, are seen as texts, and talk is seen as social in its nature, because it is shaped by culturally shared resources and situated within specific broader contexts.

Therefore, the analysis of discourses is important to understand the complexity of our social world and the implications of certain meanings. Meanings are not only transmitted from one person to another, but are produced in discourse, shaping the way people relate to one another (Parker, 1997) and constituting what we can see and cannot see and what can be seen only at certain points (Parker, 2005). Thus, the objective of discourse analysis is to interrogate the discourses taken for granted as true or false and their effects in terms of constraining our understanding of ourselves and the social reality (Graham, 2005). Language constitutes specific kind of objects and subjects, whose construction realizes particular relations of power and reflect particular ideologies (Billig, 1996). Language does things in terms of legitimatizing or challenging what it describes, within the wider social structures that frame the ways in which we make sense of our world.

A critical discursive approach always involves a form of deconstruction of dominant systems of knowledge (Derrida, 1981) to question and unpack a text in order to make clear what might be its implicit assumptions, values, effects, and cost. Harper (1996) has argued that deconstruction in the mental health field is about challenging binary oppositions and dichotomies within medical and psychiatric categories, such as individual/social, pathology/normality, objective/subjective (Parker et al., 1995).

From a theoretical point of view, a vast amount of literature in this area (Henriques et al., 1984; Hollway, 1989) relies on the work of the French philosopher Michel Foucault (1971; 1977), who defined a disease as a “discursive formation” (Foucault, 1972). Foucault drew a history of madness that showed the “dividing practices” used to talk about mental problems and focused on the relationships between discourses, mental health construction, regimes of knowledge, power dynamics, and governing-practices of normalization (Foucault, 1988; Parker, 2008). On the one side, his “archaeology” work described how specific structures of knowledge penetrate our understanding of the world and showed that the psychological and psychiatric concepts usually taken for granted are the product of historical processes of construction and reconstruction of knowledge (Foucault, 1970). Indeed, changes in epistemological and ontological boundaries within a culture determine changes in what is thinkable. On the other side, the genealogical approach is interested in the analysis of what Shapiro (1992) calls “proto-conversations”, that is, the social discourses that makes particular conversation possible.

Foucault also stated that our time is an “era of governmentality” (2001a, p. 220). According to Foucault, modern societies are organized around discourses of the “self” (Allen & Hardin, 2001), that valorize self-analysis and self-monitoring as ways of adjusting to normative ways of beings. The author refers to the cultural importance accorded to practices of self-governance and the disposal of technologies for self-regulation and normalization, which can be seen as enactments of power. In Foucault’s (1972) words, discourses regulate the body, “exercising upon it a subtle coercion” (p. 137). As the forms of government do not depend on authoritarianism but on normalization, the production of knowledge is bound up with the concept of norm, and normal individuals, and the related techniques of population management (Walkerdine, 1986). In this sense, psychiatric categories and practices codify, reproduce, and reify social norms and standards, removing them from the social body and the historical space (Foucault, 1971). Foucault (1972) has identified three points of departure for the analysis of particular objects of discourse: first, the surfaces of their emergence, referring to the historical

movements of specific ways of knowing; second, delimitation, which allows for mapping the boundaries of an object of knowledge; third, specification, describing the functions performed by the object.

The Foucauldian approach has been criticized for its strict structural stance that seems to reduce every personal experience to the influence of social and institutional power on the consciousness. Actually, Foucault in his later work focused more on the concept of subjectivity and individual possibility of acceptance and resistance (Panas, 2006). Although our selves are constitutively shaped by the Other, people are not victims of dominant ideas, but active agents who can produce counter-discourses and arguments challenging the taken-for-granted discourses that produce and reproduce power relationships (Parker, 2007). In Foucault's words, "there is no relationship of power without the means of escape or possible flight" (Foucault, 2001b, p. 346). As Allen and Hardin (2001) pointed out, social organization is not the product of external structures forcing people to behave in certain ways; rather, it is "an *effect* of taking up [discursive] practices and reproducing and modifying them" (p. 163).

Some authors have extended the work of Foucault into psychology. In particular, Nicholas Rose (1985; 1998) has articulated the notion of *psycomplex*, which refers to the pattern of theories and practices that proliferate within the academic, professional and popular contemporary western *psy* disciplines (psychiatric and psychological) and influence how people understand, categorize, talk, and regulate their mental and social experience. The *psy-complex* is part of a "regime of truth" (Parker, 1997) that we use to make sense of our experiences; in this sense, it is related to specific forms of subjectivity's construction and ways of governance.

According to Rose (2003), the *psycomplex* has been contributing to an understanding of mind and selves in terms of brains and bodily malfunctions, also via new tools like brain imaging technologies and genomics. Indeed, in the mental health field, patterns of brain activity and sequences on chromosomal regions are now used to distinguish between normality and abnormality. According to the author, we are developing a sense of ourselves as somatic individuality, that is, "the tendency to define key aspects of one's individuality in bodily terms (...) and to understand that body in the language of contemporary biomedicine" (Rose, 2003, p. 54). Indeed, biomedicine gives us instruments to understand our mood and desires in terms of the organic functioning of the body/brain and to improve ourselves by acting on the brain. Thus, our fears and anxieties are shaped in a clinical form and "through an account at the level of molecular

neuroscience” (Rose, 2003, p. 57). In this sense, that view presupposes that our psychological life is ascribable to specific configuration of neurotransmitter systems or cognitive scripts, and that human subjective capacities can be routinely reshaped by psychiatric drugs. Thinking about our psychological life mainly in terms of chemical imbalance in the brain, that can be corrected with the use of drugs, make us “neurochemical selves” living in a “psychopharmacological society” (Rose, 2003, p. 46), where health care practices are more and more dependent on pharmaceuticals.

As psychoanalysis shaped new ways of understanding human experience in terms of constructs like the unconscious, repression, neurosis and the Oedipus complex, contemporary psy-disciplines recode psychic life relying on biomedical models (Rose, 2003). Therefore, corporality is currently an important social site for ethical judgment. This “neurochemical reshaping of personhood” (Rose, 2003, p. 59), which is based on brain anatomy, brain chemicals and brain functioning (Rose, 2000) has important ethical implications. First, as many authors have argued, exclusive biological accounts of human capacities and difficulties generate a mental health politics that individualize and essentialize experiences, and constrain those found biologically defective (Rose, 2001). Second, Novas and Rose (2000), referring to Hacking (1999), argue that biological psychiatry is producing not only new ways of conceptualizing mental illness and mental health, but is also producing a new “human kind”, the somatic individual potentially at risk. Third, there are relevant links between these new ways in which we understand and shape ourselves and the emergence of pathological conditions and the development of new drugs (Rose, 2003).

Rose, developing Foucault’s thought, points out that the *psycomplex*’s theories and practices in the Western world are linked to the contemporary neoliberal emphasis on values such as freedom and individual responsibility. The author notes that “modern individuals are not merely free to choose, but obliged to be free” (Rose, 1999, p. 87); in this sense, many mental pathologies are pathologies of the active, responsible, and choosing individual, and the main task of psychiatry is to teach people how to act responsibly for their own health condition. Intervention becomes what the author calls a technology of “responsibilisation” (Rose, 1999, p. 74), from which a specific kind of subject emerges: an individual free from others and able to govern himself through acts of choice (Terkelsen, 2009). Thus, individuals constantly monitor, govern, and modulate themselves and others under the social incitements to, and demands of, self-realization and improvement.

2.3 POSITIONING THE SELF AND OTHERS: MAPPING RIGHTS, DUTIES, OBLIGATIONS AND POWER DISTRIBUTION

The notion of subject positions is a concept through which subjectivity has been formulated and studied in discourse-based works (Avdi & Georgaca, 2009). Thus, a critical discourse approach is integrated with positioning theory in order to consider how subjects' positions - enacted, recognized or delegitimized through discursive practices - simultaneously situate the self and the others in relation to the field under discussion, and the negotiation of power relations (Ling, 1998).

Positioning is a discursive construction used to locate and define both the self and the others who are participating in the narratives (Van Langenhove & Harré, 1999). Subjective positions are defined as the speakers' set of "rights, duties and obligations of speaking" (Harré & Van Lagenhove, 1999, p. 404), where rights and duties refer to the normative clusters of beliefs within which people live and are bound (Harré, Moghaddam, Cairnie, Rothbart, & Sabat, 2009). Positioning can be reflexive, when a person positions oneself, or interactive, when the speaker positions another person (Davies & Harré, 1990).

The concept of positioning has been first used by Hollway (1984) and refers to positions as relational processes that constitute interaction among individuals and explain the dynamic of their interplay. Discursive positioning conceptually refers to the Bakhtinian notions of multivocality and dialogism (Bakhtin, 1981). Michael Bakhtin argued the dialogical nature of the relationship between the self and the social world and the multivocal character of the individual narratives (Skinner, Valsiner, & Holland, 2001). Every act of positioning is situated within the context of multiple social discourses, a condition that Bakhtin calls "heteroglossia" (1981, p. 263, 428). Within this "corridor of voices" (Bakhtin, 1986, p. 121), which may be in agreement or in opposition one another, the construction of meaning is structurally relational and dialogical. Indeed, firstly, meaning emerges from the combination of different social languages, and, secondly, every utterance is formulated for an audience, is involved in a social conversation and depends on the particular stance taken by the speaker.

Each position is associated to specific obligations and expectations about what one can say or the way one could behave. These patterns of rights and duties of speaking and acting define a particular local moral order within one or more story lines that are usually taken for granted (Harré et al., 2009). Thus, positioning theory proposes a triadic model

based on the articulation of position, speech-act, and storyline (Van Langenhove & Harré, 1999): positions are produced through specific speech-acts and distributed within the broader context defined by one or more storylines. Indeed, at a first level, presumptions about rights and duties are produced by, and determine, the illocutionary force of speech acts (Austin, 1962). At a second level, both positions and speech acts are influenced by and influence the taken-for-granted storylines.

The positioning repertoire, that is, the range of subject positions available to individuals that determine what positions are taken up and accepted by social actors, produce the local moral space in which people operate and negotiate their social relationships through positioning and repositioning (Harré & Van Lagenhove, 1999). This local moral order defines how individuals may view themselves and others, how they should interact, and establishes what is admissible in terms of speaking and acting and for whom. Thus, the significance of positioning analysis stays in what they can illuminate about the relations between language, categorization, thought, and action (Harré, 2005).

It is important to underline that positioning, and the associated discursive practices, are not understood as necessarily intentional (Harper, 1996). In line with post-structuralism, Davies and Harré (1990) note that any narrative draws on wider social structures that limit the possibilities for a person to be recognized and accepted. This means that cultural, social and political meanings are always attached to a position and that a position must be acknowledged by others to function as a position (Davies & Harré, 1990). In this sense, positions always demand negotiation.

Positions not only provide social recognition; they also shape people's subjectivity and perception of their world in line with the storylines and the concepts that are made available and relevant within the discursive practices through which individuals are positioned (Davies & Harré, 1990). As positions embody specific ways of ordering and understanding social experience and ourselves, it is important to take into account the emotional meanings associated to positions and their connections with personal experience (Harré & Van Lagenhove, 1999).

As noted above, positions' meanings are relative to the position taken by or attributed to others (Hermans, 2001) and are associated to a whole set of rights, duties and obligations that speakers have. For this reason, positioning theory is useful to address the way in which power is constructed, distributed, and localized through discursive practices (Boxer, 2003; Parker, 1997). Discursive practices are implicated in the construction and negotiation of power via the recognition or the delegitimation of specific subjective

positions (Ling, 1998). Positions are characterized by different levels of privilege concerning the possibilities for action and the right to be viewed as legitimate social agents (Winslade, 2003). Thus, subjective positions, and their related power differentials, are connected to specific regimes of knowledge and to the broader historical, socio-political, and discursive context in which the power is embedded (Foucault, 1969).

Positioning theory, with reference to the post-structural research paradigm, emphasizes both the constitutive force of discursive practices, that provide specific subject positions incorporating a conceptual repertoire, and the possibility for the subject to exert a personal choice in relation to those discursive practices (Davies & Harré, 1990). Individual agencies may always re-negotiate the positions and the related power relationships. In this regards, the core of positioning theory is the study of how specific subjective positions, and the related rights and duties, are ascribed or appropriate, defended or refused, accepted or denied, through interpersonal activity (Harré & Van Lagenhove, 1999). These processes contribute to the creation, reproduction, and deconstruction of the social order (Tirado & Gálvez, 2007).

2.4 “PERSONAL IS POLITICAL, POLITICAL IS PERSONAL”: DISCOURSE, POSITIONING AND SUBJECTIVITY

The concept of a subject's position is in line with a conceptualization of subjectivity as fragmented, dynamic, and shaped in the processes of social interaction, depending on who is perceived to be the other. Consistently with that, positions are not considered static, stable, unified, and ritualistic (Gough & McFadden, 2001), as implied by the notion of role, but dynamic, flexible, negotiable, changeable, polyphonous, and transforming with the interaction (Hermans, 2006; Blackman, Cromby, Hook, Papadopoulos, & Walkerdine, 2008). Within the polyphony of social voices, corresponding to a plurality of perspectives, the individual can occupy a number of positions that allow mutual dialogical relations (Hermans, 2001). In this sense, positions acquire meanings only in relation to the position taken by, or attributed to, others and people may position themselves in many different, and potentially contradictory and discontinuous, ways. Although we can take up various positions and these positions may be contradictory, we tend, and are expected, “to reconcile them within a consistent narrative to produce a unitary story of ourselves” (Davies & Harré, 1990, p. 49).

In contrast to the notion of role, which appears to be a strongly determined and

determining factor, “subject position” accounts for the fluid nature of social action and experience (Harré & Van Lagenhove, 1999). In role-theory, roles dictate the words that are spoken, while positioning theory focuses on the way in which discursive practices constitute the speakers and the hearers through negotiation processes (Davies & Harré, 1990). Whereas roles imply a scripted existence, positions permit to focus on the development of social exchanges considering the dynamism of subjective experience and action. The spatial metaphor embedded in the term “position” suggests its flexibility and fluidity in relation to context and time. Indeed, positions are realized within a local context, and thus can be momentary and challenged, and may lead, within a circular process, to modify the meaning of the actions performed and the story-lines in which they are embedded (Harré et al., 2009). The relevance of the concept of positioning for social psychology resides in its capacity to offer a tool for the understanding of the psychological processes that underlie complex social dynamics.

The theoretical framework deployed provides the conceptual space to theorize the notion of subjectivity on which this research relies. Subjectivity is understood as the sense of selfhood deriving from the dialectic between the “inside” and the “outside” (Parker, 1997) or, in other words, between social structures and individual agency. The central role attributed to culturally available discourses, institutional complexes of power and knowledge in defining the experience, producing certain types of subjectivity, and defining the boundaries of the interaction, has not to be confused with mere determinism. Individuals are considered active agents who always have space for change and resistance with respect to the discursive practices they use. A person is not seen as “either the autonomous origin of his or her experience or the ideological pawn of social determination” (Allen & Hardin, 2001, p. 163), as suggested by the “individual *versus* society” model (Allen & Hardin, 2001, p. 169). Thus, subjects are not passively produced by psychiatric and medical discourses or governmental apparatuses, as implied by a pure dialectic of ideology, as well as they are not the direct effect of their consciousness (Hook, 2005).

Rather, subjectivity emerges from a personal and sometimes paradoxical use of the multiple resources available in social discourses and from the variegated field of everyday experience (Terkelsen, 2009). Identities are constituted by the language that people speak, and, at the same time, language is co-created through individual discursive practices: subjects can re-authorize their own positions but the “re-authorization is dependent on the subject positions available” (Allen & Hardin, 2001, p. 174). Thus, subjectivity is both a

dynamic product and an evolving process. In this sense, the slogan “personal is political” and *viceversa* (Tobach, 1994) guides this approach, showing the dialectical relationship between the personal/individual and the social/structural (Murray & Poland, 2006).

Thus, the socioconstructionist epistemology, critical psychology, discourse analysis, and the concept of subject positions set the stage for the analysis of the data collected.

CHAPTER 3

THE RESEARCH

3.1 RESEARCH AIMS

The general aim of this research project is to analyze the discursive construction of ADHD by the key adults who interact with the child. As shown in the previous pages, ADHD is a debated issue, constructed “at the intersection of multiple vectors of action and control” within a circuit of practices (Hook, 2005, p. 17). Thus, ADHD constitutes a fruitful site for the analysis of how rising and unfixed troubles get framed, signified and contained by people involved with them. Because the field where ADHD finds its existence cannot be reduced to the influence of one single actor, the goal is to analyze the interaction of diverse bodies of knowledge, in order to capture the multiple constructions of ADHD reality and to address how this poly-phonic “chorus” of voices constitutes the object ADHD in relation to specific interests and power dynamics.

When an ADHD diagnosis arises, it involves three main partners who represent powerful social institutions involved in children’s education and socialization: the medical field, school and family. For this reason, the research was designed to include stakeholders belonging to these three contexts deeply engaged in the topic of ADHD: mental health professionals, primary school teachers, and parents who belong to a self-help group for parents with children diagnosed with ADHD. Indeed, the diagnostic and treatment process for ADHD bounds together these various actors (Lakoff, 2000).

The analysis of the “expert discourse” allows for the exploration of the accounts that the *psy-complex* (Rose, 1985, 2007), that is, the theories and practices characterizing contemporary psychiatric and psychological disciplines, builds around ADHD. Medical and psychological discourses are discursive formations that serve to explain the causes of certain behaviors, feelings and conditions and direct towards their resolution (Griffith, Griffith, & Slovik, 1990). Thus, professionals’ accounts influence the way people understand, perceive and front their own and others’ mental conditions.

Analyzing the teachers’ way to construct ADHD is of particular importance because they are a mediating agent to diagnosis and treatment: they are often the first to suggest the diagnosis of ADHD (Kidd, 2000; Sax, 2003), are included in evaluation and diagnosis processes for childhood conditions (Havey, Olson, McCormick, & Cates, 2005), and their conceptualization of ADHD may be at the origin of classroom educational

practices (Ohan, Cormier, Hepp, Visser, & Strain, 2008; West, Taylor, Houghton, & Hudyma, 2005). More in general, since schools are institutional arenas where children are educated and socialized under the influence of socio-political values and expectations (Singh, 2006), it may be fruitful to analyze how teachers manage the encounter between the medical discourse on ADHD and the scholarly discourses they are familiar with.

Parents were asked to participate in the study because they have a concrete personal experience with ADHD and the ADHD child and because they are the most important people of reference for the children. Moreover, their experiences are frequently characterized by social blame and isolation; this makes interesting an analysis of the way they conceptualize their children and their children's problems. In addition, parents are given an important role in both diagnostic and treatment processes of ADHD. The parents who participated in the study were members of a self-help group. The following is one comprehensive definition of a self-help group: "A self-help group is made of people who have personal experience of the same problem or life situation, either directly or through their family or friends. Sharing experiences enables them to give each other a unique quality of mutual support and to pool practical information and ways of coping. Groups are run by and for their members" (Self Help Nottingham, 2000). This definition is in line with the statute of the Italian Association of ADHD Families (AIFA), which stated that "the goals [of the association], which aims to support and help the families who represent the core of the Association, are expressed in a project called the 'ADHD Project Parents for Parents'" (Art. 3.1, AIFA Statute). Furthermore, the association defines itself as "mainly a mutual-aid group constituted by parents of children affected by ADHD" (Art. 11.1, AIFA Statute).

Addressing self-help groups (and more generally, the mutual support associations in which they operate) is of particular importance because in relatively recent years, they have become a prominent component of the healthcare system and a common form of help within the mental health field (Borkman, 1999; Davison, Pennebaker, & Dickerson, 2000; Elsdon, Reynolds, & Stewart, 2000; Munn Giddings & McVicar, 2007). The choice to study self-help groups is based on the recognition that people increasingly mobilize to collectively promote and shape certain medical diagnoses (Conrad & Potter, 2000). In fact, there is evidence that patients and their relatives have a general need to associate with one another (Mundell, Visser, Makin, Forsyth, & Sikkema, 2012), indicating new ways through which people collectively try to attribute meaning to their experiences and cope with similar challenges. In addition, the self-help group is part of a national advocacy

association that is one of the most prominent voices in the actual Italian debate on ADHD. Indeed, these parents, through their activism, are contributing to the construction of specific discourses and the circulation of a peculiar system of knowledge related to ADHD within the social arena. In this sense, the discourse of the self-help groups can be considered a form of institutional discourse (Barton, 1999) because the discourse is produced within the broader framework of a national non-profit organization. Furthermore, in the specific case addressed in this study, the discourse has been constructed to achieve the organization's goals, which are disseminating information and sensitizing public opinion about ADHD (Drew & Heritage, 1993). As mentioned in the introduction, the role of parental advocacy groups in producing and spreading specific knowledge on ADHD and influencing public policies has already been discussed in the literature (Conrad & Potter, 2000; Mayes et al., 2008). In particular, Lakoff (2000) argued that the expert model of ADHD, which is based on the role of executive dysfunction, was pushed by these advocacy groups, and Castellanos (1997) proposed that parents of children with ADHD have been the most vocal proponents of stimulant treatment for ADHD. Therefore, the observation of the self-help group can offer insights about the type of ideological work the members want to achieve.

The general aim concerning the discursive construction of ADHD is articulated in two sub-aims. The first regards the positioning repertoire of the participants. The analysis focused on how the stakeholders position the child, as well as their self-positioning and mutual positioning, because discourses about ADHD construct different subjectivities for children and the people around them. Specifically, the interest was to understand how the subjectivity of the child is shaped into the identity construction of the adults, and how participants define a specific local moral order, establishing coherence within an ambiguous semantic field. Thus, the focus was on the attribution of rights, duties, responsibilities and power issues. The analysis paid also attention to the interplay of the discourses of the central social actors to appreciate the interaction dynamics ongoing within this "theatre of voices". These dynamics are important because they not only shape people's subjectivities (Willig, 2001) but also affect their perceptions and actions (Winslade, 2003). As Singh (2006) claims, to understand the relation between the adults and the child we should also understand the relation between the adults themselves and the institutions in which they live and work. The analysis conducted on the basis of this specific sub-aim is presented in the analytical paragraphs 3.3.1 and 3.3.2.

The second sub-aim concerns the way that parents, through their interactions within the self-help group, collaboratively articulate a specific narrative about ADHD and the functions that this particular construction serves. The analysis related to this specific sub-aim is illustrated in the analytical paragraph 3.3.3.

In the first two sections of the analysis, parental accounts have been analyzed focusing on the construction of the subjectivity of the child, the self-positioning of parents and the way they position the others circulating within the concrete and symbolic field they and their children inhabit. In the third section, instead, the focus is on the role the group plays in creating specific ways to articulate parents' experiences with ADHD that are accepted and adopted within the group. The analysis concentrates on uncovering patterns of mutual influence and the discursive dynamics that characterize the interactional processes in the self-help group. In particular, the goal was to capture how parents collectively construct a common and shared story about ADHD, to examine the way in which the group influences the individual narratives, and to determine the functions that the group tries to perform by producing and promoting a specific "version" of the reality of ADHD and its related phenomena.

The parents' self-help group is the target of a specific analysis because compared to mental-health professionals and teachers, parents lack a reference discourse to articulate their experiences with ADHD. The other two groups of participants can rely on their expert discourses, medical discourse and professional education discourse, both of which are socially recognized, although at different levels. In contrast, parents do not have a legitimized discourse to lean on, although they have a double burden associated with their child's condition: the daily management of difficult situations and social stigma. Thus, a specific analysis of the parents' self-help group is particularly important because parents not only counterbalance feelings of isolation but also find a space for legitimacy within the mutual aid group. Moreover, although I do not aim to generalize the results, observing this self-help group offers a window for understanding the dynamics and processes that may occur in similar mutual-aid groups.

To summarize, addressing mutual support groups related to ADHD is important for two reasons. First, it can illuminate certain aspects of the experiences of parents with children diagnosed with ADHD, given that, as discussed in the introduction, a substantial body of literature documents their difficulties. Second, it is important to understand the group dynamics implicated in the construction of specific narratives because this

understanding can illuminate, and foster an appreciation of, the benefits, the critical elements, and the socio-political influence of this type of psychosocial support.

Before specifying the methodological approach and presenting the results, an important point must be made. I do not aim to enter the debate about the reality of ADHD or to establish the truth. In accordance with my theoretical framework, I suggest that phenomena are constructed through discourse, “in the web of meanings created by those persons who engage in dialogue about the problem” (Griffith et al., 1990, p. 23). Therefore, rather than focusing on etiological factors or the efficacy of treatment, my analysis will address the interactional strategies and the cultural resources used by people to talk about ADHD, the participants’ positioning, the discourses to which these positions are associated and the implications that these discourses have for the subjectivity of the people involved. In sum, I will focus on the process of conceptualizing a scientific object like ADHD and the effect of the process on the reality. Following Singh’s approach (2002, 2008), my questions are not centered on the reality of ADHD; they have to do with the functions that this diagnosis performs in the social arena and the implications of the diagnosis.

Moreover, it is important to specify that I am not contesting the experiences of children with ADHD and their families, and I am not interested in establishing the “validity” of participants’ discourses about ADHD. A discursive approach is not meant to downplay the phenomenological and experiential realities of everyday life. My objective is to investigate how people construct the problem and the potential effects of the discourses they employ in shaping and constraining their experiences and practices. Texts are conceptualized as tools to explore how participants are influenced and how they influence their social, cultural, historical and political context (Allen & Hardin, 2001). Thus, I consider the participants as social actors to emphasize their active role in the construction of the topic under examination, even though the use of specific discourses by individual speakers is not necessarily intentional (Harper, 2006).

Like most qualitative research studies, especially those that use discourse analysis, this study does not refer to hypothetico-deductive logic. It does not aim to verify or dispute specific and clearly structured hypotheses, and it does not frame questions in terms of comparisons (Barker, Pistrang, & Elliot, 2002). To avoid an *a priori* definition of the analytic focus, the research is driven by several open-ended questions, some of which developed as a result of the interaction between the analyst, the participants and the texts (Harper, 2006).

The first part of the analytic section has addressed questions regarding the position attributed to the child, such as, who is the hyperactive and inattentive child? In what ways is ADHD characterized? The second section of the analysis has been oriented by questions regarding the participants positioning, such as, how do social actors organize their reflexive and interactive positioning? How are moral dimensions and power articulated within this positioning dynamic? The third part of the analysis has focused on questions about the main functions performed by the group, the interactional patterns and discursive practices that are established within the group to advance a specific version of the children's problems, and the effects these practices may have on the participants.

3.2 METHOD

3.2.1 Data collection, participants and procedure

Data were collected using multiple qualitative methods, including interviews, focus groups and non-participant observations of natural group meetings, to engage respectively professionals, teachers, and parents. A theoretical form of sampling has been used to include participants who, because of their particular social position, could have a different perspectives or draw on different discursive resources (Harper, 2006). Research methods are important; indeed, methodological practice informs what we can see and what we cannot see (Mason, 2006). As Chamberlain, Cain, Sheridan, & Dupuis (2011) argue "how we seek knowledge determines what knowledge we find" (p. 164).

Traditional approaches argue that qualitative methods alone are not enough to validate data and that they need quantitative methods to ground the research more scientifically (Shank, 2006). It must be clarified that the aim of this research was not to validate the results nor generalize the findings; instead, the aim was to examine how ADHD is locally constructed, gaining insights about how different social actors frame ADHD and the subjectivities of the people involved with this topic, identifying patterns of understanding, coherence, and contradiction. As it is concerned with the "situatedness of social experience" (Mason, 2006, p. 17), qualitative research's strengths lie in its ability to provide access to the social context and the dynamics of social processes and change. This kind of contextualized knowledge can be transferred to similar contexts and situations.

In addition, the goal was not to compare one group with the others via collecting "equivalent data", but to make links and connections among the participants' discourses

(Shank, 2006), developing “multi-nodal” dialogical explanations (Mason, 2006, p. 9). Thus, the study addresses three possible ways of understanding ADHD to get insights about their interplay and to see how one might inform the others.

As already anticipated, multiple qualitative methods have been used to collect data with the different groups involved in the project. Pluralism in recent years has led to an increase in the combined use of empirical and theoretical applications (Frost & Nolas, 2011). The value of a qualitatively driven approach to combining methods in a research project has been underlined by diverse authors (Chamberlain et al., 2011; Maclachlan, 2000). Mason (2006) argues that multiple methods offer potential for understanding the contexts of the social experience. Again, Maclachlan (2000) stated that “incorporating different approaches to collecting data can enhance our understanding of cultural factors in relation to health” (p. 374) and that health psychology can benefit from a pluralistic approach that incorporate “a diverse array of practical techniques and theoretical perspectives” (p. 374).

Within the traditional research epistemology and approaches there appears to be “an unspoken demand to have a specific, identified, and defined methodology (...) instead of allowing method to diversify in the service of answering the research objectives” (Chamberlain et al., 2011, p. 152). In contrast with this perspective, pluralism is believed to constitute a fruitful way to approach complex social problems and can result in an integrated research process; clearly, the multiple methods should be aligned to the theoretical and epistemological assumptions underlining the research (Chamberlain et al., 2011). Harper (2011) recognized that there are a number of different ways to combine methods. In this respect, there is a wide and well established tradition on the combination of qualitative and quantitative methods; although some authors have pointed out that the different methods should be used within a coherent epistemology (Bryman, 2007; Giddings, 2006).

Methodological pluralism can be a way to bring flexibility into the research and overcome a rigid adherence to only one method (Bevan, 1991; Slife & Gantt, 1999; Wertz, 1999). Thus, a pluralistic position values a question-driven approach, adapting methods to the specific research questions (Yanchar, 2005). The use of different methods in relation to specific contexts and questions permits to take advantage of their peculiarities as tools to look at the social reality, given that all methods have peculiar strengths and weaknesses and are based on specific assumptions that delimit their range of applicability (Gadamer, 1989). Indeed, every method is theoretically developed to be sensitive to certain aspects

and angles of a phenomenon. Therefore, the methods selection is structurally both a theoretical and a practice-oriented process (Yanchar, 2005), as the choices should be based on the theoretical orientation, the different contexts in which data are collected, and the researcher's assumptions about the fact that specific ways of collecting data are more likely to be appropriate for certain groups (Harper, 2011).

In line with a logic according to which methods of collecting data can be diversified depending on specific aims, contexts, and conditions, I decided to work with different participants in different ways to understand their perspectives and practices, as related to the local and peculiar processes and situations on the basis of which they construct particular accounts on ADHD (Chamberlain et al., 2011). In order to do so, I used different kinds of qualitative data analyzing them with the same qualitative method of analysis (Harper, 2011).

Using a pluralistic set of data does not mean invoking triangulation as a strategy to achieve the truth or the essential nature of phenomena (Moran-Ellis et al., 2006). In line with Katsiaficas, Futch, Fine, and Sirin (2011), I did not mean to triangulate methods "in service of confirmation" (p. 135) or validation of the analysis. Instead, the value of using multiple methods is that it offers the possibilities to focus on processes, relationships, and interconnections among phenomena related to complex social objects (Kincheloe, 2001, 2005). Thus, this choice was meant as a way to engage multiple meanings and connecting perspectives, looking at the participants' accounts to open different angles of inquiry. Moreover, as Hook (2005) argues, a Foucauldian approach can benefit from polymorphism of data sources, which can show the articulation of different forces in shaping the phenomena under study. I used goal-oriented, practice-informed, and contextually sensitive methods (Yanchar, 2005) to address specific questions within the research project program and let new questions emerge. In particular, I collected:

❖ 13 in-depth one-hour interviews with mental-health professionals

Composition of the sample: 5 child psychiatrists, 5 psychologists, 3 social workers.

Gender: 10 women, 3 men.

Average age: 41.30 years \pm 10.49.

Age range: 30-65.

Average number of years of experience with ADHD: 9.4 \pm 9.55.

Range of years of experience with ADHD: 2-37.

❖ 7 focus groups with primary school teachers

Composition of the sample: 54 teachers, among whom 12 special aid teachers.

Gender: 54 women.

Average age: 44.7 ± 8.6 .

Age range: 28-60.

Average number of teaching years: 20.57 ± 10.78 .

Study degree: 13 teachers with a university degree; 41 teachers with an high school diploma.

❖ Data from a six-month observation of the meetings of a self-help and support group for parents with children diagnosed as ADHD

35 parents, 20 women and 15 men, have participated in at least one of the self-help and support group meetings, which have been followed for six months.

Other data regarding parents could not be collected because permission to participate at self-help group's meetings was given by the representatives of the association, subject to not asking members any personal information.

Some theoretical assumptions have oriented the sampling strategy and the choice of the methods employed. Personal interview was adopted as the method with mental health specialists. The type of interview that was used has been given different names within the literature, such as qualitative, open-ended, in depth, and semi-structured (Potter & Hepburn, 2005). According to Potter and Hepburn (2005) "an interview of this kind will typically be guided by a schedule of topics or questions, although their order in the interview may vary and interviewers are likely to depart from the schedule and use a variety of follow-up questions" (p. 283).

Recently there has been a debate about the use of qualitative open-ended interviews in psychological research. Potter and Hepburn (2005) have challenged the taken-for-granted position according to which open-ended interviews are "the method of choice in modern qualitative psychology" (p. 282) and suggest that there are more advantages in working with naturalistic materials. In contrast, Smith, Hollway, and Mishler (2005) argue that it is not possible to have access to raw data, as they are always involved with intervention and interpretation. In particular, Smith (2005), though agreeing with the fact that "interview has become unnecessarily dominant as a research tool in qualitative psychology" (p. 309), underlines that the choice of the method should depend on the

research's interests. Thus, though recognizing that interviews create particular kinds of interaction (Gilbert, 1980) and they should not be seen as natural kinds of conversations, I considered interviews the best way to collect data with professionals in relation to my research issues. Indeed, I was interested in exploring how professionals constructed accounts on ADHD starting from their concrete experience, and how they provided reasons to support and legitimize their professional practice connected to such a debated topic. Interviews allow for addressing a standard range of themes with different participants, while naturalistic materials can make it difficult to achieve. Moreover, putting professionals in a group situation could result in a polarization of the discussion centered on the ADHD controversy, which was not the focus of this study.

Focus groups were found to be an appropriate source of data with teachers because the group discussions allowed one to witness the social interaction processes implied in the construction of a contested topic like ADHD (Kitzinger, 1994). Although focus groups should not be considered as equivalent to natural occurring data, they constitute a research setting where participants enact conversations that could approximate everyday situations of interaction and debate (Kitzinger, 1994). Indeed, focus groups draw on people's normal and everyday experiences of talking and arguing (Wilkinson, 1999). Particularly, I chose to collect data with pre-existing groups of teachers who already knew each other through working together, to explore how teachers might talk about ADHD within the group in which they actually operate and may discuss the topic sharing their experiences and opinions in the everyday professional life. Group data permit one to contextualize people's talks, and work with pre-existing groups provides the opportunity to observe "the social contexts within which ideas are formed and decisions made" (Kitzinger, 1994, p. 105), as these groups represent a natural social network which provides the scripting for the understanding of, and the response to, the illness and the related events (Khan & Manderson, 1992). Thus, focus groups have some advantages (Kitzinger, 1994): people can relate to each other's comments by referring to common experiences and shared anecdotes; show the resources that members of the group use to articulate the problem; facilitate the analysis of group norms; permit to appreciate differences of opinions and the ways these differences are argued and managed.

The observation of the parents' self-help group was selected as an appropriate setting for data collection because entering the self-help group's space allowed for the observation of how parents, through the interaction with other parents, are socialized to the "ADHD world" and the "appropriate" ways of talking about ADHD. It is true that only a

minority of parents are involved in this kind of groups. However, as particular groups facilitate the articulation of specific perspectives, it is useful employing methods that allow for the consideration of the collegiate networks where people operate and the examination of the social processes in action (Kitzinger, 1994). In the case of parents, the observation of the self-help group allowed for the understanding of what stories operate within this setting and how these stories are mobilized in social interaction. Examining how discourses develop within this particular and socially relevant context provides insights into the operation of group processes in the articulation of broader forms of knowledge.

Intensive observation is a typical method of the ethnographic approach (Howitt, 2010), and open to the possibility of deep description of specific groups, appreciating their complexity and respecting their uniqueness and peculiarities. The goal of an ethnographic approach is to understand from the inside the development of social processes (Flick, 2002). Thus, I adopted an ethnographic-discursive approach (Zuccheromaglio, 2003) to discursively analyze the social construction of ADHD within the self-help groups, focusing on the specific forms of interaction and collaboration enacted by parents. This approach allows for the analysis of discourse in interaction, illuminating the way people construct their social world while taking into account the broader historical and cultural contexts in which the discursive productions are enacted. A combination of ethnography and discourse analysis is especially useful in evolving and dynamic group context, and also allows for the observation of the evolving nature of participants' interactions over time and for the elucidation of processes of change. The ethnographic approach, as a method to access the perspective(s) of people participating in the research, together with a discursive frame, allowed me to have access to the "world of meaning" through which people signify their words, actions, and behaviors. An ethnographic discursive methodology allows for the analysis of "groups in action" (Zuccheromaglio, 2002), describing their social practices through the description of their interactional activities.

In particular, the research's interest was in the ways through which parents discursively interact to produce a collective narrative on ADHD. In this sense, I assumed that the way parents come to understand their children and themselves is shaped by the social interaction processes that run within the group. Thus, the focus was not the individual, but the local system in which, and through which, s/he constructs the meanings associated to the parental experience of ADHD. Indeed, the parents' group constitutes a place for negotiation and production of narratives that encapsulates shared meanings and offers resources to interpret the everyday experience (Zuccheromaglio, 2003).

The observation of the self-help group meetings were supplemented by materials coming from field notes, informal conversations with members of the group, books and brochures published by the parents' association, and my involvement in the group's mailing-list, which was used both to circulate information about meetings, events, seminars, and to share experiences and provide practical advices. All these materials have been used to contextualize the parents' narratives and facilitate the interpretation of data collected through the observation of the self-help group.

Sample size is one of the aspects that mostly distinguish discourse analysis from traditional research perspectives (Potter & Wetherell, 1987). According to discourse analysis, sampling criteria should consider the potential for data to express significant features and elucidate specific patterns relevant for the phenomena under study. As Harper (2006) pointed out, rather than focusing on the representativeness of a person's accounts, the focus is on the reason why people adopt certain discursive resources. Potter and Wetherell (1987) highlighted that discourse analysis is a very laborious approach and, because of that, collecting too much data might lead to the inability to analyze linguistic details. Further, the authors stated that "a large number of linguistic patterns are likely to emerge from a few people, small samples or a few interviews are generally quite adequate for investigating an interesting and practically important range of phenomena" (p. 161).

In line with these assumptions, I considered that about fifteen interviews with mental-health professionals would represent a proper number. Indeed, a larger number of interviews would have prevented an in-depth analysis of data, and a fewer number of interviews would have not allowed to include different kinds of disciplinary sectors (psychiatry, psychology, and social work). Therefore, a purposive sampling strategy has been used to have a cross-professional representation of ADHD diagnostic and treatment processes. Sixteen specialists were contacted and three among them declined the invitation because of time constraints. This resulted in a sample of thirteen professionals. This sample size is in line with previous research based on discourse analysis (Avdi et al., 2000; Benford & Gough, 2006; Stevens & Harper, 2007). Regarding the data collection with teachers, a number of about eight focus groups could offer a wide and diversified, but still manageable, amount of data. Nine schools have been contacted; given that two schools' principals did not accept the invitation to participate in the research because of concerns about the difficulties in organizing the groups, the final sample includes seven focus groups. Concerning parents, a six-month observation of their meetings was considered a

reasonable time to develop some level of intimacy and trust with parents in order to observe the spontaneous intergroup dynamics.

For professionals and teachers, two different semi-structured interview schedules were used to conduct interviews and focus groups. The schedules tried to “elicit experience-near accounts” (Smith et al., 2005, p. 313) using narrative kinds of questions; the interviews and the focus groups were conducted in an open way, with a non-interventionist style and permitting participants to set the priorities. The schedules covered participants’ opinions and concrete experience with ADHD, ADHD children, and their contexts. In particular, the interview schedule for mental health professionals addressed: the professional history related to ADHD; issues, implications and problems associated with the diagnostic and treatment processes of ADHD; the relationships with the family and the school contexts; the relationships with children. The interviews lasted on average one hour. The focus groups schedule for teachers covered the following area: opinions and experiences related to symptoms of hyperactivity and inattention and the diagnosis of ADHD; opinions and experiences associated to the pharmacological treatment for ADHD; the relationships with families and mental health professionals. The focus groups lasted on average 2 hours. The schedules used for interviews and focus groups are included in the Appendix.

Regarding the self-help group of parents, I adopted the position of a silent observer, trying to avoid an active involvement, in order to respect the intimate space of talk that parents have constructed to share their experiences and feelings and to appreciate the spontaneous dynamics taking place within the group. Parents met monthly, and the encounters were moderated by a woman and a man who were active members of the Italian Association of ADHD Families (AIFA). The meetings were attended by varying numbers of parents, ranging from 5 to 16, and each meeting lasted about three hours.

Participants were recruited through a number of channels. Some schools, public child-psychiatric services, and private practitioners/therapists in a northern Italian area were identified and contacted to introduce the research and ask for their participation. Participants were also approached via personal contacts. The self-support group of parents was contacted through the Italian Association of ADHD Families (AIFA). E-mail and telephone invitation were adopted to contact prospective participants who, before being involved in the study, had been told about the aims of the investigation and asked for their consent to audiotaping. Participants were informed that the research’s objectives regarded the social aspects and implications of the ADHD diagnosis, and that members of other

social groups involved with the ADHD issues had been asked to participate. Their anonymity was guaranteed. Interviews, focus groups, and observation of parents' self-help groups were conducted in 2011. All data have been digitally audiotaped and then transcribed.

For what concern the transcription conventions, an orthographic representation of the talks has been used. Potter and Hepburn (2005) suggested the use of the Jeffersonian style of transcription, which reports in details specific aspects of the conversations, to capture relevant elements related to interaction processes. However, other authors (Smith et al., 2005) stated that the little details associated to interactional features do not have to be the primary focus of every discourse analysis study. Rather, transcription should be consistent with the purposes and orientations of the research. Moreover, the type of transcription adopted orients towards a specific reading, emphasizing some features of the talk at the expenses of others. It has been highlighted that it may be difficult to appreciate at the same time the "interactional features" and the "substantive topic" of an extracts from data (Smith et al., 2005, p. 310). Thus, the research approach and questions should determine the most appropriate type of transcription, especially when different levels of analysis are combined. Because in the present study the analytic purposes were directed not only to discursive strategies but also to patterns of discourse, positioning, subjectivity, and broader ideological contexts of talks and discussions, the representation of fine-grained details of interactional speeches have not been included, to avoid the risk of reducing participants' narratives to the current interactions and distracting the reader from broader discursive organizations and patterns (Smith et al., 2005).

On the whole, Jeffersonian transcription conventions were not used, but some devices have been applied (Potter & Wetherell, 1987): extracts have been punctuated to facilitate reading of the transcript; the symbol (...) has been used to indicate the omission of a part of the transcript; within square brackets clarifying information is included; pauses are indicated by a full stop in brackets (.), even if the pause lengths were not considered in the analysis.

3.2.2 Data analysis

Discourse analysis (DA) was applied to analyze data in order to identify the different discursive practices that are associated with the positions participants occupy and attribute to others and that characterize the interaction within the self-help groups of

parents. Discourse analysis is a methodological approach widely used for the social constructionist analysis on psycho-social phenomena (Bilić & Georgaca, 2007) and, as Harper (2006) noted, DA is a valuable tool for the analysis of contested issues like ADHD.

Discourse analysis is an umbrella term used to refer to a range of approaches to the study of language (Harper, 2006). The approach of this study integrates two different but overlapping traditions in the field (Parker, 1997; Wetherell, 1998), as it draws on both discursive psychology and Foucauldian discourse analysis (Willig, 2001). Diverse authors have integrated ideas deriving from, and have moved between, these two theoretical frameworks (Stevens & Harper, 2007) to develop a more synthetic approach to discourse analysis. Wetherell (1998), for example, has argued for a more integrative approach, noting that both orientations address equally important research questions.

The first one can be defined as a micro-discursive approach and corresponds to the interpretative repertoires paradigm (Edwards & Potter, 1992; Potter, 1996), which is influenced by works in ethnomethodology and conversation analysis (Heritage, 1984). This paradigm implies a close analysis of the text to describe the discursive strategies and resources (Stanton-Rogers, 2011) used by speakers to reach certain goals, like constructing specific versions of reality, making them appear factual (Edwards & Potter, 1992), countering possible alternatives, managing issues of agency and accountability, and presenting themselves as credible. Discursive psychology focuses on the rhetorical and pragmatic aspects of the text (Edwards, 2005), as well as the discursive sequence and the use of language, to describe “how people use discourse in order to achieve interpersonal objectives in social interaction” (Willig, 2001, p. 91). Interpretative repertoires are defined as contrasting ways of explaining phenomena or as culturally familiar and habitual lines of argument (Wetherell, 1998), or, again, as systematic ways of talking about a topic that speakers use to manage their positions in actual interaction and intersubjectively build a local social order (Harper, 2006). Discursive analysts are particularly interested in the variability in the use of language, which is seen as a consequence of the way texts are organized to perform certain actions (Harper, 2006). In sum, the focus is on action-orientation and situated-ness of talk (Hepburn & Potter, 2003; Potter, 2003).

This description of discursive strategies is useful to understand what people are doing when speaking and how language is used differently depending on the functions it performs. Given that accounts are always intertwined with the major contexts in which they are elicited (Wooffitt, 2005), and since I wanted to identify the links between the stories told by participants and socially available discourses and processes of power, this

approach has been integrated with a Foucauldian inspired discourse analysis to contextualize the use of language (Parker, 2008) and link personal narratives to the social discourses from which these narratives come from (Allen & Hardin, 2001). This macro-discursive approach is informed by critical realism (Willig, 1998), psychoanalysis, and post-structural theories, in particular those by Michel Foucault and Jacques Derrida (Burman & Parker, 1993). Macro-discursive approaches take a deconstructive stance to elucidate the taken-for-granted meanings in texts and focus on the connection between discourse, power, ideology and subjectivity (Stainton-Rogers, 2011). In particular, the historical context of emergency of phenomena is considered (Harper, 2011), in order to locate the text within wider discursive resources. In line with Foucault's definition of discourse as social "practices that systematically form the objects of which they speak" (Foucault, 1969, p. 49), the goal is to examine how discourses constitute particular phenomena and encourage us to take these particular constructions of phenomena for granted. In Rose's (1990) words, the aim is to analyze how language makes "new sectors of reality thinkable and practicable" (pp. 105-106).

The Foucauldian influence on discourse analysis has not been formulated in a precise technique for the analysis of talk and texts (Edwards, 2005). Overall, the analytic focus is on patterns of discourse; that is, systems of meanings and practices linked to wider social discourses, ideologies, and structures on which people draw upon when talking about their experiences and opinions and which form their subjectivity (Parker, 1997). In this sense, the analysis goes behind the text, considering how the individual narratives embody patterns and resources available in the specific socio-historical context, which are linked to power dynamics and institutional constraints. The objective is not to understand the "true nature" of phenomena, but the social and historical conditions that support certain discourses at certain times and that affect the psychological, social, and material reality of phenomena (Willig, 2001). Because discourses construct objects and subject positions, Foucauldian discourse analysts also examine which positions are made available to the subjects.

In sum, micro interactions and macro discourses are closely connected, as "the macro cannot be fully explained without speaking through (...) the micro" (Mason, 2006, p. 15) and people's everyday experiences and lives are the basis for the production of macro social structures and processes (Chamberlayne, Bornat, & Wengraf, 2000; Lawler, 2002). This means that the discrete aspects of language, such as words and their meaning, turns of phrase, arguments, etc., are seen as deeply linked to wider meanings and practices.

Broadly speaking, the analytic attitude concerns the functions, effects, and consequences of accounts (Harper, 2006). Within this framework, personal experience is not reduced to an internal state of the mind, but is seen as both an account, a rhetorical and action-oriented move, and a way of understanding ourselves linked to particular discursive resources that sent up specific subjective positions for the speakers and others (Harper, 2006).

The original transcripts in the Italian language were first read several times to produce a list of recurring and interesting categories and features of the texts and associate them with the relevant extracts. This list constituted the basis for the analysis and was directly elaborated in the English language. The extracts from the transcripts were first translated from Italian to English, and then reviewed by a bilingual interpreter to ensure equivalence of meaning. The list on the basis of which the analysis was performed was elaborate in English language to allow a pluralistic approach. In fact, the analysis involved two other researchers, an English mother tongue researcher and an Italian mother tongue researcher. The goal was not to simply reach points of consensus or search for inter-rater reliability, but to engage in a dialogical process in which diverse perspectives can be a source of new insights and understandings (Smythe & McKenzie, 2010). Thus, in the research project pluralism has been enacted at different levels (Frost & Nolas, 2011): a pluralism of theoretical approaches, a pluralism of methods, and a pluralism of researchers engaged in the analytic process. Then, following a recursive process of coding, discursive strategies and patterns emerged progressively through several discussions with the researchers who collaborated with me in the analysis.

Following Parker (1992, 1994), attention has been paid to the “objects” appearing in the text and their multiple significations, as well as the “subjects” populating the participants’ accounts, and the right, duties, and responsibilities associated to each of them. I then mapped diverse discursive strategies and linguistic features on the basis of which accounts and stories are constructed as factual, as well as systems of meaning and practices that make sense of, and are produced by, the strategies used by speakers. I considered in detail the actions performed by these strategies and patterns; the positions they make available for speakers and others; the relationships between different discourses; patterns of variation, inconsistency, and apparent contradiction within the accounts; the role these discourses play in reproducing or subverting power relationships; the effects of different strategies and patterns for the people involved and the broader environment. The analysis within each group of participants was followed by an analysis of the dynamics and the

interplay between the three sets of accounts, to identify elements of concordance, contradiction, and contrast within and across the different voices of the participants.

Quantitative approach to reliability and validity are not applicable in discourse analysis studies (Sherrard, 1997). Criteria for validity and reliability, which are not so clearly separated in discourse work, should be based on different criteria (Morse, Barrett, Mayan, Olson, & Spiers, 2002; Potter, 1996): the methodological coherence between research's questions and methods, the internal coherence of the analysis, the presentation of extended materials, the ability to offer theoretical insights and generate fruitful further questions, the reader evaluation, and the significant of the analysis for participants.

Coherently with the epistemological, theoretical and methodological orientation of this study, I reflected on the impact of me as a researcher on the narratives constructed by the participants (Allen & Hardin, 2001). For instance, it must be acknowledged that, despite the researcher's position as a silent observer during the parents' meetings, the presence of a psychologist and the use of recording technology may have influenced the parents' conversations. For example, the presence of a psychologist may have led the parents to enact justifying and legitimating strategies, or to exhibit their knowledge. To minimize these effects, a period of acclimatization has preceded the observation (Potter, 1996).

3.3 RESULTS

The following two analytical sections (3.3.1 and 3.3.2) present the results derived from the analysis of the participants' positioning repertoire. Section 3.3.3 illustrates the results of the analysis of the interactional dynamics of the parents' self-help group.

In relation to the first sub-aim, that is, the analysis of the participants' positioning, Table 2 offers a brief overview of the broader discursive landscape in which the ADHD child emerges and is constructed. Multiple discourses about ADHD characterize professional, scholarly and parental narratives. In particular, three types of discourse shape ADHD as it relates to the positioning of social actors, which is articulated around the position(s) taken by the speaker and the position s/he attributes to the child and the relevant others. The first type of discourse is linked to the positioning of the ADHD child and is permeated for all groups by a risk rhetoric. The second type relates to the reflexive positioning, that is, the construction of ones' own subjectivity in relation to the ADHD experience. Finally, there are discourses related to the positions attributed to a plurality of

others who inhabit storylines that are characterized by a ‘blame loop’. What distinguishes the social actors is a peculiar interplay of the socially available discourses regarding children hyperactivity and inattention.

The presentation of the results start with the discourse that is characterized by the greater level of agreement between the different voices, centered on the child’s positioning and the embedded circulation of risk. The second part will present discourses related to the self and others’ positioning, which show the dialogical relation between the construction of one’s own subjectivity and the symbolic locations attributed to others involved in the narratives.

Table 2. Participants’ positioning repertoire

	Positioning the child: the risk discourses	Reflexive Positioning: the personal engagement discourses	Interactive Positioning: the blame loop
	<i>Who is the ADHD child? What is ADHD?</i>	<i>What personal engagement with ADHD?</i>	<i>Who is guilty? Who is responsible?</i>
Mental health professionals	ADHD as a deficit and children as at-risk, risky and malleable objects	Exclusion of subjectivity and the responsibility-taking circle	The dangerous implications of the medical discourse and the incompetent specialists
Teachers	The pathological childhood of today: uncontrollable bodies not fitting the group	The fall of the scholarly discourse: between the need for experts’ knowledge and reclaiming an educative role	The old-fashioned scholarly discourse and the ignorant teacher
Parents	Potentially futureless children	Parents as self-sacrificing heroes and lonely fighters	Noncompliant parents and the new generation of parents

3.3.1 The ADHD subject dangling between risk and control

3.3.1.1 *Mental-health professionals' discourses. ADHD as a deficit and children as at-risk and risky subjects*

Mental-health professionals construct their accounts of ADHD by positioning themselves as stable and confident in relation to their specialist body of knowledge, and by discursively excluding any trace of ambivalence and any reference to their own subjectivity. This may also be related to the fact that they have been interviewed in individual situations, and not within group settings like teachers and parents; in this sense, they did not have to confront with different voices or counter-arguments and this might have contributed to the fact that their presence as subjects in the narratives is always related to their self-position as evaluators of children's, parents' and teachers' behavior.

ADHD is often defined as damage, a functioning defect not due to ill will, in order to remove the blame from the child. A pathological skills deficit makes children's actions unintentional, associating their physical impairment to their "moral hygiene" (Burman, 2011):

These difficulties are due to a lack of (.) I explain to them [the children] that we are all born (.) in general, I draw a wall with many bricks, and explain that they are all sort of building blocks of intelligence, the bricks of knowing how to read, how to write; and then there is the one that self-regulates when to do and when not to do something (...) [I tell them] "It is not that you do not have this brick; it is a more transparent than the other ones, which means that it is hard for you to behave in a certain way, and it is something that you may not like, but you were born this way, you were born this way, and coming to me helps you color in this brick a bit".
(Psychologist 2)

Being able to write and read, self-regulate, and follow social rules are conceived as innate and naturalized capabilities, linked to an idea of child development as a goal-oriented progression. Therefore, the ADHD child is constructed as an incomplete human being, an individual characterized by "lack", in the words of a social worker, implicitly evoking the idea of humans as naturally free from deficit and supporting the use of medication as a way to "compensate" for this lack and to fill a "hole" within the individual:

Evidently there is something you [the child] lack, a small piece you lack, and for this there is medicine that helps you to compensate for it. (Social worker 3)

This contributes to a reified and essentialist view of the child who is positioned as structurally deficient, and so deviant with respect to a normative classification of development:

An ADHD child is a different child. If not he would simply not have ADHD. (Psychologist 2)

This kind of discourse seems to give the child a predetermined destiny:

An ADHD child (.) one knows that this is how he is and will remain so. Therefore one can learn how to manage oneself but it is this way, the problems remain. I think that the objective is that the child grows and learns to live with this difficulty that he will have forever, which will remain for all his life. (Social worker 1)

The skills deficit makes children innocent and not responsible for their own actions; at the same time, the reified vision of the child supports the idea of ADHD children as structurally unable to exert control on themselves, needing someone else to discipline and shape them.

The first of the next quotes shows how the comparison with physical disabilities is used to construct ADHD children as needy of support, help and fulfillment, whereas the second highlights that children are considered as passive objects of external influence, in line with the discourse of “tabula rasa” that characterizes the modern understanding of childhood (Kehily, 2009):

It is not their fault, they are this way, and because of this the children need to be helped to manage themselves. As with children who cannot walk, we give them wheelchairs, these children, who cannot do specific things, we must give them the help they need, tools to make them make it. (Psychologist 2)

The child is still clay in your hands, that is, if you are a conscientious professional and you do your job well (.) deep down the child is still to be shaped and guided. (Psychologist 5)

The treatment is conceived as a path toward children's better knowledge and understanding of themselves, as a child-psychiatrist claimed: "*You give the child instruments to understand himself*" (Child psychiatrist 2). As this quote suggests, children diagnosed with ADHD are located in the position of unaware subjects who do not know themselves enough to be able to exert control over their bodies and minds. Therefore, the first therapeutic aim is to produce a subject identified with his/her pathological label and aware of being in need of experts' help and knowledge. This process of raising awareness is conceived as a propaedeutic activity in order to educate children to the self-management of their diversity:

A lot of work has been done on the consciousness, and the fact that she went through certain situations (...) she didn't experience them due to her own fault, but because unfortunately she had a disease and this thing needed a lot of work and help from other people. (Psychologist 4)

On the one hand, the child is presumed to lack competences and skills to the point of not having the right to choose an educational carrier according to his/her desires and aspirations:

Very often one chooses beforehand the kind of school best suited to them, thus one would not advise parents to enroll them in high-level high schools. (Psychologist 2)

On the other hand, the ADHD child should become able to self-regulate himself/herself. This is in line with a neo-liberal idea of choice, which is structured along an individualistic notion of responsibility and morality and entails that individuals must behave for their own and others' wellbeing (Rose, 2005, 2010). The person is not responsible for his/her mental disease, but s/he is accountable for being aware of and managing it:

At the present time one tends to teach children to take care (.) meaning "look, after eating, you must do this [taking medication]" and so you must enter into a personal

automatism in which you feel big, you feel autonomous, in which you feel (.) that “It’s mine, I’ll take care of it, I’ll see to it”, though clearly the child is always supervised, always (.) but I think that this makes them feel big, autonomous, makes them feel like “I am in charge of myself and therefore I’ll do it”. (Social worker 2)

Overall, the position attributed to ADHD children as deficient, needy and unaware subjects converge toward the deployment of a risk discourse. The child is viewed as both an at-risk person, who have to be protected, and a “risky” subject, who should be disciplined for s/he not to be dangerous for the others (Finn & Nybell, 2001, p. 141; Lupton, 1999, p. 8). Mental-health professionals stress the necessity of an early “*treatment during pre-school age*” to avoid a potential future when the child, if not treated, is vulnerable to become “chronically ill”, or antisocial and marginalized, as expected from a person with a borderline disorder:

When they are 16 years old, at that point you have a very structured disorder and the possibilities for intervention (.) yes, of course there is always the option to intervene with pharmaceuticals (.) the sadder aspect is that when the disorder is already installed, let’s say, on the organization of one’s personality, it has an evolution (.) there are limited ways it can evolve. At best a behavioral disorder consolidates which then evolves in some borderline patterns. (Psychologist 4)

The embodied riskiness of the child serves to construct professionals’ intervention as fundamental to optimize children’s lives via an early transmission of appropriate information. Even though drugs are not always assumed to be needed, the specialist’s work and his/her scientific knowledge are constructed as the only way to interrupt a risky path and prevent the danger of children becoming what they are designed to be:

The sooner the child is diagnosed, the less his behaviors are rooted and structured, and the easier it is to unhinge them; the smaller the child is, the more he is likely to realize that there is something that must be controlled and adapted, and the easier it is to make him notice that, and give him suggestions for behaviors that are more adequate. (Child-psychiatrist 3)

The rhetoric based on the idea of an innate risk may also operate to discipline fathers, constructing them as ill subjects. Indeed, fathers are considered as both carrying

and conveying the genetic root of ADHD, which in the majority of cases is diagnosed to boy children. Therefore, they are frequently guided to the correct interpretation of their past, in the light of their child's genetic condition, and helped to trace back past indicators of their ADHD condition which was never diagnosed. In this regard, when fathers use their life-stories to exemplify the possibility of personal change over time, as well as the dynamic nature of the individual identity, they are corrected by professionals who, instead, employ a lens of risk to counter these childhood-adulthood accounts. Fathers disagreement and skepticism about their supposed pathological condition are located by medical professionals as a lack of awareness and self-consciousness, which must be corrected showing fathers the reality of their childhood experiences in opposition to their "false" memories. In particular, professionals use a rhetoric according to which it must be avoided that boy children experience the same distressing and painful childhood of their fathers. This also contributes to position professionals as those defending the children's right to a happy childhood:

[Parents tend to] understate the symptomatology of their children, so: "I was always like that as a child and I improved" (.) This implies to pass on the idea to the parent that maybe he was a hyperactive child too, so I may say "Ok, that's fine, you were also this way, but what difficulties did you have? How were your school years?" and they are like "Ah terrible! The teachers always turned me out of the classroom" (...) You realize that deep down it has not been so good and I say "Ok, the objective is to not let the same thing happen to your child." (...) However (.) It may be true, but it does not mean that your child must go through the same thing. (Psychologist 2)

Children's voices are recalled mainly to legitimize and support the procedures and interventions to which they are subjected. The child's words and perspective show up in the accounts to demonstrate that the child recognizes being "different", like in the first of the following quotes, and that they see the medication as an ally, as in the second of the following excerpt:

[Within the child] there is the precise understanding that there is something wrong (.) there is the wish to fix the problem and there is gratitude when they feel they perfectly work. (Child psychiatrist 4)

Children see it [Ritalin] always as an ally. It is very interesting; last year we had a child brought to first aid because confronted with an assignment he was not able to do, he thought that, given that the medication makes him feel so good, if he had had more medicine he would have been fine. He was alone at home and he took 5 or 6 pills thinking it would have made him feel very good. It was odd. Thank goodness the drug does not give big problems. Anyway the mother came home from shopping and found him all stunned, and he said “It’s just that (.) I thought that if I had taken more medicine, I would have been fine”. (Child psychiatrist 5)

3.3.1.2 Teachers’ discourses. The pathological childhood of today: uncontrollable bodies not fitting the group

When teachers are invited to comment upon the symptoms associated to ADHD, that is, hyperactivity/impulsivity and inattention, they do not automatically activate a medical conceptualization. Instead, they frame these children’s expressions within a socio-educative paradigm that allows them to speak about these symptoms. In this sense, the teachers’ voice is ambivalent: they converge with the mental health professionals on some topics, but problematize the psychiatric narrative with respect to other aspects. Teachers’ accounts are also much tied to their own subjectivity: they are particularly worried about the risk, the threat and the danger that the problematic child constitutes to the classmates, and feel responsible and concerned to protect them from potential harm.

Teachers’ discourses hardly stay in the boundaries defined by the ADHD diagnostic label, and children’s hyperactivity and inattention are understood as a new type of social tendency. In this sense, children’s behavior represents to teachers a “social emergency”, which makes the childhood of today more pathological than in the past and that is problematic irrespective of whether the child has an ADHD diagnosis:

They are not necessarily diagnosed, many children will never be diagnosed. Above all in the last few years, kids who are agitated and have difficulties in controlling their bodies, hands, legs, sitting down (.) there are more and more of them. (Focus group 5)

T1: The lack of attention is increasing

T2: On the rise

T1: In escalation

T3: But not for the diagnosis. (Focus group 2)

The ADHD child is positioned as a tormentor, a risk to others and to the order of the class, as s/he “*creates problems for the management of the whole class*” and “*penalizes the other children in the class*” (Focus group 6). The child is considered “*dangerous to himself and to others*” (Focus group 3) via the narration of diverse episodes regarding the risk, the peril and the threat that the child represents for himself/herself and for the others:

He is unpredictable, what he does to you he does to his companions too; he attacks the ears and necks of his classmates, and there have been moments in which the students felt terrorized and have cried, and felt afraid of coming to school. (Focus group 3)

The scholarly context seems to be not able to include children who, being problematic and dangerous, pose a problem regarding the appropriateness of letting them be an integral part of the class-group:

I think you must, yes, let them enter [the class context], but not (.) not make it so that the others become dominated, that is you must find moments in which the others can breathe for a minute! (Focus group 4)

Hyperactivity is in general conceptualized as expression of a generational problem of children in managing their bodies. Children seem to lack a body-mind relationship and their bodies are compared to a “*machine needing to expel energy*” or to a “*motor that need to discharge and cannot be stopped*” (Focus group 5) via the use of an energetic-mechanistic metaphor. Being out of control, children’s bodies need to be controlled, limited, and disciplined:

He is the kind of child that must always be kept under control (.) you must limit this aggression because he harmed the schoolmates. (Focus group 1)

You always have to say “stay still, stay still, stay still.” You have to physically touch him for him to do so. (Focus group 5)

The construction of the child as a subject who needs to be controlled is linked to the issue of drugs to medicate hyperactive and inattentive children. Some teachers, though frequently using a disclaimer to affirm their general negative view of medications, make use of a “quality of life” rhetoric to claim that drugs might be useful in order to help the child having a better life. Helping the child to improve his/her life is constructed as a moral imperative:

Let me first say that I have always been against pharmaceuticals, but seeing a situation like this one, in which someone, who has a pathology, has become aggressive, I say why should we keep harming him [the child] and making him, and the others who are close to him, live badly? Therefore we need to help them.
(Focus group 3)

Many teachers appeal also to the idea of necessity, aiming at constructing medications use as an inescapable procedure, a direct consequence of a specific situation that does not depend on personal choices or opinions:

I don't (.) I don't agree with the use of drugs (.) but if this is the only remedy...(Focus group 7)

Some other teachers show an ambivalent construction of the drug issues: indeed, despite the recognition of the possibility of personal change over time, drugs are represented as a personhood-enhancement device, a way to ensure that individuals have the possibility to be part of the large society. This shows the deep connection between ADHD and the duo social acceptance/social exclusion:

Maybe when they get older a small dosage may be useful to find a better job or integrate oneself better into society. (Focus group 6)

As it was for mental-health professionals, some teachers claim that drugs should be used to avoid potential negative outcomes in future, legitimatizing their administration via the anchorage to the children's embedded risk and uncertainty: you never know what ADHD might become.

If this kind of difficulty is not managed, controlled and so on, it is destined to become worse, especially in social terms (.) in the long run the social implications are very serious, like not being able to be with the others, not having a decent affective life, destroying one's family life, not having friends, and therefore falling victim to other pathologies. Because it rises as hyperactivity but then who knows... (Focus group 1)

Some teachers totally refuse the use of medication, raising issues about the need for education in opposition to pharmacological intervention. Even within this critical narrative, it is implicitly argued that hyperactive and inattentive children need to be taught about the correct way to behave:

Calming a child with drugs doesn't seem to me (.) I would prefer for the child to be educated. (Focus group 4)

The drug could be a form of relief for the moment, but it doesn't teach you anything. (Focus group 7)

Another parallelism between mental health professionals and teachers in terms of discursive patterns is "calling the child into the conversation" mainly to support adults' decisions, as the next quote shows:

I see a student of mine who searches something, I mean drugs, he says "How come they cannot find a drug to make me sleep? To make me sleep during the night, to make me rest?" When he is lucid he tells you things that (.) like "I am not going to get better if they don't help me with a drug for a few years until it passes, I cannot get better without it" (.) he says, "I'm tired". (Focus group 7)

3.3.1.3 Parents' discourses. Potentially futureless children

Many parents point out that they realized since the beginning that something was "not normal" or "deviant" with their children if compared to other people of the same age. This is something to which they can attribute an "acceptable" meaning relying on the biomedical discourse about ADHD. The psychiatric categorization pairs with anxiety about the child's future and the possibility for him/her to not achieve the essential features of the

good and socially integrated citizen. To avoid this potential risk, parents rely upon the regulatory devices indicated by experts, that prescribe for parents the need to control the child and for children the awareness of their condition.

Parents come to construct their children's problem through making comparisons with other children of the same age. This comparison process has already been described in other studies on parents' construction of their children disabilities (Avdi et al., 2000). ADHD children are considered different in relation to a normative and progressive idea of development. In this regards, also being too clever and too precocious can be considered as a form of deviance and abnormality:

Let's say that since the very beginning we realizes that this child (.) he was precocious even in language, which made him outside of the norm, as much as it is true that according to diverse tests he has a superior IQ, which is not always a great thing, because the child has always had problems socializing with others. Even this is not normal, I mean, because, there is a time for everything (.) so we have always realized that there was something deviant, something that was not normal. (Mother 13)

In order to attribute an "acceptable" meaning to their children's non-normative way of being and behaving, parents rely on the psychiatric discourse about ADHD. In the next quote, the supposed organic nature of ADHD takes the shape of the presence of a "little devil" inside the child. This constitutes an adaptation of the traditional and romantic images of the child as either innocent angel or evil devil (Scraton, 1997). As a result, ADHD is defined as a sort of malign, de-contextualized and itself alive entity, which is separated from the innocent child who embodies it:

They know that they are capable of doing certain things, but they cannot make them because within them there is a sort of "little devil". (Mother 6)

This kind of conceptualization pairs with the tendency to "divide" children (Conrad & Schneider, 1992; Conrad, 1975) in a series of different pathological categories in order to understand the complex variability of their behaviors. As a result, the child ends up to be fragmented in a set of multiple diagnostic labels. The following extracts exemplify this pattern of compartmentalization:

Well ADHD is ADHD, and that's it. ADHD is often correlated with other pathologies, which are other pathologies (.) dysortography, dyslexia (.) they are all correlated but they have nothing to do one another (Mother 1).

Due to their supposed different and deviant nature, children's future seems to be already given by their psychiatric condition(s). The psychiatric categorization establishes a pathological self-realization, characterized by many limits regarding who these children might be, and pairs with anxiety about the child's future, as one parent affirmed: "*When they are very small one always thinks that these children will never have any future*" (Father 1). The parental concerns are linked to a representation of the good socially integrated citizen, as a father claims:

What do we want for our children? Social relationships (.) and that they can go to work... (Father 2)

Parents are particularly worried about their child's possibility of having a family, highlighting the fundamental and indispensable role that the notion of family has in the construction of the image of the normal adult. Having a family and being part of the society is not only a right, but also a duty:

Father 1: Many times the family's reaction is "Will these boys and girls ever be able to have their own families?" I would say so, but (.) I think that this is our biggest concern, to think of the future they will have, their tomorrow and their future on the question "Will they be able to have a family?"

Mother 2: The possibilities are really many. It's not that one has to graduate from school or...

Father 1: Well, no, the concept of education and degree is one thing, while family is another.

This involves a gendered discourse that attributes to boys the role of breadwinners and according to which "*It is the male who one day will have to have a family, while the female have to take on another role instead*" (Father 1).

This "futureless children" construction covers the idea of change over a lifetime, but it is foreboded in a negative direction and linked to the circulation of risk around

children's development. In particular, parents share their worries about the possibility of their children becoming part of socially marginalized minorities, such as delinquents:

The child with ADHD and strong hyperactivity (.) the older he gets, the greater the chance is for him of becoming violent, of being rejected by others, and this is exactly the kind of combination that may lead one to do something wrong. (Father 3)

The risk discourse leads parents to consider medical and psychological interventions as the only way to escape an inauspicious future. This has many implications for both parents and children.

First, the moral obligation for parents to control their children for them to not become "antisocial" people. In this sense, parents feel responsible for re-writing the child's destiny. In the above quote, a parent makes a direct link between not following, controlling or supporting the children, and the possibility they will become homeless. The image of homelessness functions as a paradigmatic representation of the out-of-society individual:

Before, if not followed properly, these kids had the potential to end up living out on the streets. So let's keep in mind that now they are indeed controlled and supported by us. I believe that it is important to track them during this period (.) It matters what kind of support they had previously, while the others have had absolutely no support at all. (Father 8)

Within this logic of support, parents have to intervene to prevent the potential enactment of the child's self. This kind of discursive pattern structures a significant part of the parental narratives and works in order not only to establish the parents' responsibilities and duties, but also to underline the importance that kids themselves come to accept all the medical procedures (analysis, tests, controls) they have to undergone. In the following extract, this is conveyed by a comparison between the "easy to manage" kid, who accepts being screened, examined, and evaluated, and a risky scenario, linked to antisociality, drawn in the case the child refuses to be submitted to all these procedures:

We have to go doing this blood exam and he comes, we have to go doing this visit and he comes (.) but there are kids that refuse, and what happens then? In between the lines, they become autistic, or they shut themselves at home and never go out,

thus they do not have relationships with others anymore or, because of their hyperactivity, they go out and they want to smash the world, they are violent and lack social relationships, are not capable of maintaining good relationships at all.
(Mother 3)

The members of the parents' self-help group position themselves as responsible subjects who treat their children coherently with the medical prescriptions. In this sense they are not blameworthy, in opposition to other parents who do not align themselves with the medical and psychological establishments indications. These parents seem to deserve to be blamed, as their children deserve to be considered delinquents, because of their irresponsible decision to not make the right choice:

Mother 4: There is a child in the class who is really dangerous, and at noon he leaves or else he starts throwing punches.

Father 1: This is another child with full-blown ADHD who has never been treated.

Mother 4: He is a delinquent thug, that boy is really a thug who rolls joints, fist fights, and does whatever he wants (.) and he had full-blown ADHD with an oppositional-defiant disorder, aggression, impulsivity...

Father 1: He has never been checked on by his parents.

Mother 8: This scares me a little, I think about the adolescence...

Mother 4: My son had all these traits too but I have followed him.

The risk that is made circulating around the child supports two main pillars of the medical practice, which for parents represent a commitment. In this sense, the construction of the child is closely connected to parents' self-construction and position: as the child is at risk, parents have specific tasks and duties that the medical discourse about ADHD attributes to them. Parents subjectively assume particular responsibilities and obligations. The first parental commitment is the need to act in favor of an early intervention; treatment is seen as a race against time and prevention as the main road to manage threat:

Mother 17: The more time passes the worse it gets.

Mother 1: The fact of taking them in while they are very young is so that they get used to behaving in a certain way (.) the sooner you take him, the sooner you manage to intervene on this thing.

The second parental commitment is drug use. In this regards, Hansen and Hansen (2006) have already shown the influence of parental expectations and goals for their child's future in solving the dilemma of giving medication to children. In the next extract, medication is presented as necessary to prevent the risk of being socially excluded and marginalized. In this sense, drugs are the key to open the doors of the social realm and permit to have a life:

My son unfortunately had to resort to pharmaceutical treatment because he was impossible (.) whether to keep him at school, or make him attending studies along with other students, or have a life. (Mother 14)

The idea of risk operates also in relation to children's inattention, which is represented as a potential threat for life, both for the child and for the people interacting with him:

Father 5: She said that it [Ritalin] was proposed only in extreme situations, but in their case one is actually talking about not being able to pay attention.

Mother 9: Inattention can also be serious though.

Mother 6: For example, he might cross the street without realizing that there is a street, or he might not realize that a window is there and that he can fall, because of his inability to pay attention.

Mother 1: If he were not being given Ritalin, we probably both would not be here (.) this was really killing me.

The concept of risk crosses both parental and professional discourses, which, through their interaction, come to define and determine the good choices that must be taken about children's lives. As a mother says in the following extract, her child's doctor makes an explicit reference to the fact that there is no obligation regarding the use of medication. However, as reported by the mother, the physician formulated the point as a free choice between a sure help for the child and a risky future. This anecdote shows the interplay between the discursive construction of risk and the contemporary neoliberal idea of rational subjects who have the individual responsibility to behave in certain ways if they do not want to be considered liable to their life's difficulties or challenges (Rose, 2007). The mother has the autonomy to make the right choice assuring a responsible position to herself and a socially acceptable status to her son:

Doctor X had told me that my child needed medicine, but that it was my choice to go ahead with it; the decision was not pushed upon me. But he told me I had to decide whether help A. [the child] or let things take their own course, with the pros and cons. I decided to give him the drug and with it the situation improved a lot. (Mother 11)

In line with professionals and teachers, even for parents the children's legitimacy to speak about themselves emerges when their words are functional to give direct evidence of the validity of the ADHD diagnosis or proofs that children are happy with the medication, to the point of asking for it:

“He recognized himself in the text, and said “Mom, this is me”, conscious of the fact that all those qualities corresponded to him” (Father 6)

He is well when he takes (.) sometimes he asks, sometimes he asks (.) when he has to do an assignment, etc., it is him that asks me for it [Ritalin], because he feels well, he is well in sum, and he knows that this makes him feel well. (Mother 12)

Overall, despite the fact that children are generally positioned as structurally lacking self-consciousness and awareness, when their claims, demands and requests are consistent with the decisions adults have made for them, their connotation undergoes a switch toward a “mouth of truth” position. This construction of the child as both lacking functional abilities and as being a sort of “mouth of truth” concurs in preserving a romantic representation of the child as an innocent angel (Kehily, 2009), whose behavior, in this case, is assignable to a physical devil that does not pervert his/her moral nature.

3.3.1.4 Discussion

The first part of the analysis has been focused on the discursive positioning of the child by part of mental health professionals, primary school teachers and parents of children diagnosed with ADHD. The categorization of the child as having a mental disease is used to cohere the past with the present - making legible the child's behavior - manage the present - in the light of risk - and stabilize the future - informing the decision to be taken. The classification orients the vision of the possible future and impacts on the

practices enacted around the child, exerting a powerful influence not only on children's activities (Bowker & Star, 1999) but also on the possibilities for the kinds of people that these children can be (Tsou, 2007).

There are some overlapping discursive patterns between professionals, teachers and parental narratives, as well as differences. All the social actors converge towards a characterization of the ADHD child essentially as an "anti-social" subject, threatening the social field and people inhabiting it. ADHD associated expressions are seen as a pathological inability to "stay with the others" that implies, for the child, the actual and potential experience of social exclusion and, for the others, being in danger. ADHD children challenge the assumptions about what the children should be and how they should behave (Nybell, 2001). This dynamic makes these children "uncatchable", both physically, because of their bodily expressions and the related difficulty to make them stay still, and discursively, as the traditional pedagogical and educational discourses on which teachers and parents used to rely upon seem to be non useful for attributing meaning to the children's behavior. The difficulties in understanding and signifying the children's behavior together with the frame of risk are part of the conditions of possibilities for medicine and psychiatry to enter schools and families. Indeed, children are constructed as both risky and at-risk (Rose, 2010) on the basis of the claimed genetic etiology of the child's behavior. Genes seem to represent an indelible truth written into the heart of the corporeal existence (Kenen, 1984).

The three groups of participants articulate the notion of risk in partially different, though overlapping, ways. For professionals, children are likely to develop serious psychiatric conditions; for teachers, children represent mainly a potential threat and a danger to other children and the schools' social order; for parents, the child in the present is susceptible to be marginalized from society and school and, in the future, to become an "out-of-society" individual, an adult at risk of being a criminal, or not having a family and a job. This shows that the notion of risk is articulated in a multiplicity of ways and that participants characterize the definition of ADHD including a variety of risky behaviors and conditions, not necessarily associated to the diagnosis's specific symptoms, and whose spectrum goes from antisocial behavior and marginalization to oppositional conduct, violence, criminality, personality disorder and low learning performance.

The construction of the ADHD child as interwoven with risk resonates with the contemporary pervasive public discourse about childhood that, according to some authors, is focused on risk and fear (Burman, 1994; Jackson & Scott, 1999; Massumi, 2010; Nybell,

2001; Pica-Smith & Veloria, 2012). As Finn & Nybell (2001) claim, “young people are variably constructed as problems and victims in powerful if vague discourses of risk” (p. 139). The language of individual risk pervades also educational practices and policy making (Fine, 1995). Within the mental-health field, the risk discourse is not unique to the ADHD case. Indeed, the notion of risk constitutes one of the central concepts and trends of the contemporary psychiatric practice (Hegarty, 2007; Rose, 2007). Some authors have pointed out that the rise in many psychiatric labels prevalence can be also associated to the circulation of notions of risk and fear linked to the spread of scientific and psy-discourses (Liebert, 2011; Massumi, 2010).

With regards to the analysis presented in this chapter, the risk to others and to himself/herself that the child embodies defines the nature of ADHD: risk operates as a central regulatory device (Clough, 2007; Grewal, 2003) leading from warning (picturing a possible future) to action (preventing this future). As Rose (2010) claims, “biology (...) is not destiny” (p. 96) because psychiatry and medicine provide new practices to prevent unfavorable pathways. Indeed, the risky character of the child and the construction of ADHD as a lifetime and life-defining condition imply the necessity and the moral obligation to intervene and mobilize to protect children. This justifies the intervention on the child’s behalf that can legitimize the experts’ authority, preserve the schools’ social order, and live up to parental expectations for their children.

In this sense, children become subjected to a disciplinary inscription and must be governed in the name of risk and insecurity (Rose, 2005), through a number of practices that go from surveillance - the fact that they must be constantly under the controlling gaze of adults - to a morbid form of segregation - according to which s/he must be allowed to participate in the social realm in a way that does not trouble the social order - to self-regulation - prescribing for the child the awareness of his/her pathological condition, the identification with his/her label, and the responsibility to take care of himself/herself as s/he grows up, through self-medication and self-controlling practices. The emphasis on the importance of self-regulation shows that, as Novas and Rose (Novas & Rose, 2000; Rose, 1998) claim, risk is also associated to new forms of subjectivity, as it implies for the person at risk new personal responsibilities in terms of identification with his/her condition and self-management. In this respect, the categories of health and illness are contemporary vehicles for the production of subjectivities endowed with the faculties of choice, will, rationality and self-control (Greco, 1993). Overall, the medical ways of managing ADHD children imply tasks assigned to families, schools and health services that are implemented

on the basis of the idea of the child's "best interest", critically addressed by Stainton-Rogers and Stainton-Rogers (1992).

There are also some differences among the groups of participants. In particular teachers, differing from professionals and parents, rely less on the psychiatric discourse of ADHD and conceptualize its expression as a sort of social emergency, characterizing more contemporary childhood than specific children. The child is at the center of an ambivalence, according to which s/he manifests the symptoms of a disease and represents the symptom of a changed childhood at the same time. This might be a way through which teachers integrate two different and opposing orders of discourse, the medical and the pedagogical, without renouncing either of them. In this sense, teachers seem to distinguish between the behavioral, the diagnostic and the treatment levels: hyperactivity and inattention as behaviors are increasing irrespective of the diagnosis, and for some of the teachers the presence of problematic behaviors or an ADHD diagnosis (whose general validity is almost never directly contested) does not necessarily justify the use of medications to treat children.

Another common pattern among the participants is that the children's words are recruited into the conversation mainly to demonstrate the appropriateness of adults' actions. This discursive strategy portrays children in general as innocent subjects who say the truth; thus, ADHD children appear to have no effective agency but when their romantic representation as authentic and non-corrupted subjects (Kehily, 2009), preserved by the brain's deficit narrative, might serve the proliferation of psychiatric and psychological practices around them.

3.3.2 The ADHD Blame Game

3.3.2.1 *Reflexive positioning: personal engagement with ADHD*

In this section, I address how participants position themselves in the process of constructing ADHD. It will be shown that professionals construct their accounts in order to give evidence of the objective character of their activities and to exclude their subjectivity from the decisional processes implied by their practices. On the other hand, teachers and parents are clearly personally engaged with children expressions, which constitute for them a challenge and a subjective treat.

Many professionals exclude the subjective nature of their own perspectives from the ADHD-associated activities. They do so by referring to “*precise guidelines and procedures*” (Child psychiatrist 2), “*well established treatments*” (Child psychiatrist 4), and “*check lists*” (Child psychiatrist 5). This construction functions to avoid any reference to the specialist’s personal perspective and subjective involvement in the diagnostic and treatment processes and to conquer a self-position as a mere executor of protocols that provide “*an objective feedback of what happens*” (Child psychiatrist 5).

As one psychologist claims “*there is a wide range of tools that provide the clinician with clinical indexes that then he has to (.) to group*” (Psychologist 5), pointing out that clinical data have just to be grouped and avoiding any recall to the interpretative process involved in the diagnosis. Regarding the use of medications, which is one of the most frequently debated issues related to ADHD, professionals use two main strategies. The first strategy is the use of the rhetoric of scientific proof and objectivity:

My approach is so scientific and rigorous that drugs are given in an absolutely objective way. (child psychiatrist 4)

The second strategy is articulated around the need for a pharmacological intervention. Evoking the idea of necessity works to construct experts’ choices as “non-real choices”, that is, decisions that depend on the external situation and are not related to personal responsibility:

I have used the pharmacologic treatment a lot with kids when (.) we just had to use

it. We are not a drug-oriented unit, but in some cases, another approach was not thinkable. (Child psychiatrist 5)

This emphasis on the objective and neutral nature of their professional work contrasts with the fact that professionals, when confronted with the diagnostic process and the evaluation of treatment outcomes, use subjective criteria to assess the child. As the first of the following quote shows, not having friends is considered a criterion to differentiate between a lively child and an ADHD child; thus, the subjectively determined level of social acceptance is used to establish the presence of a psychiatric disorder. The second quote exemplifies that many professionals rely on subjective assessment criteria also for the evaluation of treatment/intervention:

Distinguishing the normal liveliness of a kid from a hyperactivity problem or an attention deficit is not so easy (.) it might seem a silly test but it actually works very well (.) to know his popularity among classmates! An ADHD child is never or hardly ever popular among his classmates, he is considered very unpleasant. So this is generally a criterion, the fact that the kid has no friends. (Psychologist 3)

It is not a strictly clinical evaluation, it is also a very subjective one (.) when the kid goes to school without getting 27 reprimands in a month and passes in all subjects (.) then the treatment was effective. (Psychologist 1)

A minority among the psychologists has a critical perspective on what they consider an oversimplification tendency of psychiatry. In opposition to the universalistic discourse of psychiatry, their counter-narrative refuses the idea of a necessary uniformity of treatment processes for children diagnosed with ADHD:

I always think that even if you choose a privileged treatment for that moment, there is really never an elective one. I mean (.) I believe you always have to tailor it to the patient, seriously (.) I don't believe this stuff, that there's just one cure for a pathology (.) the token, you have this so I give you this. And if you don't get better it's your problem, it's you not fitting in the statistic because this treatment works. This scares me. (Child psychologist 2)

Another discursive resource that mental health professionals use to exclude any form of responsibility is to engage in a “cross-reference circle” to resolve dilemmas related to drug administration. In particular, psychologists and social workers tend to refer to the authority of child psychiatrists, claiming that doctors are in charge of understanding medications issues and affirming their own incompetence and inability to take a stance on the use of drugs:

The drug-related damages can be well understood only by those who deal with [them] (.) say, the neurologist, the psychiatrist, the child-psychiatrist. I really can't enter that field because I lack specific knowledge (.) how can I tell it? (Psychologist 5)

This statement shows that the “rhetoric of expertise” operates even within the community of experts by defining ADHD as a medical affair and by developing a hierarchy that positions the majority of professionals as mere executors of predetermined (medical) procedures. Child psychiatrists in turn refer to the Italian ministerial protocol, delegating their responsibility to the abstract and reified level of default procedures and guidelines. As one psychiatrist affirmed when asked what he does in case of treatment failure, “*It depends on what the protocol says*” (Child psychiatrist 4).

Unlike the majority of professionals, teachers' accounts show that they are professionally and personally engaged with issues related to ADHD because children's behavior constitutes a challenge to teachers' professional role and social position. Teachers' subjectivity seems to be at risk because of the challenge that children represent to adults. As one teacher says, “*It's a challenge with the adult, they challenge you in every possible way (.) as a grown-up, it's destabilizing*” (Focus group 6). In particular, ADHD children do not respect the boundaries established by the traditional inter-generational discourse that requires children to respect adult status and teachers' authority:

They contest you, you feel questioned by a kid (.) at times if I say that something “is so” it is so, then you gotta step back and say, “Now I'm the teacher here and you must listen, period”. (Focus group 1)

Hyperactive and inattentive children “*speak to much, decide by themselves what to do and what not to do, interrupt the teachers speaking, do not listen to them, and disturb*” (Focus group 2), indicating an inversion of the traditional roles of children and adults,

mainly regarding the dimension of listening and speaking. Children are not anymore docile or passive recipients of knowledge and teachers have to relate with them by negotiating what they were used to take for granted:

I enter the class and I look him in the eyes and I see (.) if in that moment he'll allow me to (...) to get what I want, I try. Or else I let go. (Focus group 5)

Because of this disrupted image of the “innocent child” (Beah, 2007), teachers’ educational practices cannot longer be directed by the traditional scholarly discourse. This “fall” leads teachers to feel anxious and uncertain (Nybell, 2001) and to question their ability to manage situations associated with hyperactive and inattentive children.

TB: There’s fear in managing these situations (.) I never know if I’m adequate, if I’m capable, if I can tackle it.

TE: If you’re doing it right or not.

TA: I’m afraid of that too (.) of failing!

(Focus group 4)

Teachers’ frailty and lack of self-confidence seems to provide an opportunity for medicine, psychiatry and psychology to enter the school system and contributes to a transfer of responsibility to mental health professionals, who are considered in charge for managing children’s behavioral problems:

It’s fundamental to have also medical support in the education of the child (...) The educator will sustain the development (...) but we need a scientific reading in school. (Focus group 7)

Educative practices cannot be anymore independent from psychology and psychiatry:

T: It [ADHD] makes me think that teaching is becoming harder and harder. You have to have an always wider preparation to face problems that (.) weren’t so striking before.

T: We should be psychologists.

(Focus group 4)

Teachers' reliance on medical knowledge and experts' authority also implies new professional goals, which should now include the duty to detect potentially disturbed children. In this sense, psychiatry must enter the schools and teachers must join the medical enterprise to screen e rehabilitate children:

In the end the question is who you should worry about (.) to send the family to a specialist evaluation. (Focus group 1)

On the one hand, teachers position themselves as in need of doctors' knowledge and support. On the other hand, teachers reclaim the value of their social mission and their right to exert a recognized educational role. For example, during a focus group a teacher commented on an encounter with a child-psychiatrist who, in response to a request for suggestions and indications, "*told us 'this is the pathology' so it's this way because he's sick, period*" (focus group 2). This quote highlights the gap between what teachers feel they should do and what they think is suggested by some specialists. Furthermore, the next extract by the same teacher shows the conflicting character of the relationship between professional and scholarly discourses and teachers' struggle to find a non-subordinate space for action:

The frustration of thinking, "What the hell, we're here to teach something, we have an educational role here" (.) the rules, it's true that he [the child] can't internalize them, but what are you gonna do? Let him be? (Focus group 2)

Likewise, ADHD is a challenge to parents' identity as they question their parenting abilities and feel stigmatized by the school and by professionals who do not reference the ADHD diagnosis for their children's problems. Parents make use of many types of narratives to manage blame and to construct themselves as prototypes of good parenting.

Parents as self-sacrificers. This narrative especially characterizes mothers, who construct themselves as able and ready "to do everything" for their children. In this sense, mothers internalize the value of sacrifice associated to the maternal role (Singh, 2004) and construct themselves as the subjects responsible for their children's state of being:

I gave up working, I resigned and I immediately started being at home (.) I started

going around, doing, bringing (.) now people say to me, “You’ve been great, you’ve done this, you’ve done that”. I haven’t been great, I simply love my son (.) it’s normal, I believe this is the normal thing that every parent should do. (Mother 1)

Parents as real experts. The majority of parents place their accounts within a chronological frame according to which they realized that “something was wrong” since the very first years of the child’s life. The purpose of this construction is to underline the non-educational character of the problem and to demonstrate parents’ ability to understand their children:

In the first grade, I said, “There’s something wrong here”. I was sure of myself and of the things I was doing (.) but luckily I had the confidence to say “it’s not (.)”, I mean, there’s something wrong and it’s not our fault. He [the child] was lucky, I believe, to have two parents that were over-confident, because I was very self-confident and I immediately understood there was something wrong. It was not an education issue, but I could get the [ADHD] certification after two years even if I had immediately understood. (Mother 12)

Parents as lonely fighters. In line with the position of real experts, parents shape their subjectivity as victims of others’ ignorance who must fight against schools, psychologists and doctors to have their children’s pathology recognized:

I’ve worked for 12 years on my own when there were no resources on this (.) without doctors, without psychologists, I was alone and I fought against everybody, psychotherapists, psychometricians (.) I found such teachers and I had to move him to another school because they haven’t understood the problem, I brought all sorts of certifications and he wasn’t accepted. (Mother 15)

Self-diagnosed fathers. A special discursive pattern pertains to some fathers who, given the supposed hereditary character of ADHD, categorize themselves as having ADHD in response to their children’s diagnosis. Whereas mothers internalize the discourse that identifies them as the primary subjects responsible for ‘fixing’ their children’s behavior, fathers assume biological responsibility for their children’s condition, constructing their

selves in conformity with medical knowledge and with ideas of self-formation and self-improvement (Comstock, 2011).

While being at the association, I discovered that I have ADHD myself. Considering all of the things we were told during meetings, I'm actually like that (...) I can't focus while reading, I can read a page and forget about it right after that, I'm never finishing what I start (...) so putting two and two together, I found out that I actually have ADHD. I'd like to try this famous Ritalin drug. I can manage to do things pretty well even now, so we'll see after I take it. (Father 6)

3.3.2.2 Interactive positioning: the blame loop

In this section, the dynamics of the mutual positioning between social actors “at work” in the context of the child are discussed. As it will be shown, people who are personally and professionally engaged with ADHD negotiate the reality of the child's condition, the necessary interventions, and their subjectivities within a circle of mutual blame. This blame loop is related to the subjective positions taken by the social actors as they have been discussed in the previous session: professionals as having an objective, standardized and neutral knowledge; teachers as persons who, on the one hand, are challenged by the ADHD phenomenon and in need of experts' knowledge and, on the other hand, reclaim the importance of their social mission and their role as educators; parents as innocent victims of others' ignorance.

Both teachers and parents view medical knowledge on ADHD as authoritative and unquestionable from a theoretical point of view. For some teachers, especially the youngest ones, the presence of a psychiatric diagnosis certifies per se the existence of a physical condition:

If someone is diagnosed with something, it's because he has (.) an organic, structural problem. (Focus group 4)

Similarly, parents frame the medical understanding of their children's behavior as the scientific proven “truth” of the illness, which clears them of responsibility:

- Father 2: ADHD doesn't come from psychological distress, so you don't have to think to be responsible for that.
- Mother 1: This is very important (.) you don't have to blame yourself (...) they are born this way (.) it's a genetic thing.

Although teachers and parents construct hyperactivity and inattention as topics under medical authority, many professionals are blamed for diverse reasons.

For teachers, this blame relates to the potentially negative implications of the medical discourse and the struggle of resisting them. By positioning themselves as active social agents in children's education, teachers reclaim the right to "try to do something". The following extract compares two different psychiatric centers to offer a concrete example of the legitimacy of teachers' practices. The attempt to reclaim a specific space for action paradoxically reinforces the position of specialists as those who are in charge of judging the teachers' work.

The child-psychiatrist [told us] (.) because we were looking for answers (.) the answer was, "When he grows up, he'll either be a suicide or a criminal". When we didn't accept this and said, "We're not ok with this", they looked at us (.) these two idiots! Now he attends another center and the answer has been, "No, it's not like that, the work you did was actually very good" (.) Maybe he'll be a delinquent, but he might also become (.) at least we've tried! (Focus group 2)

Parents signify their experience of being stigmatized blaming the majority of the *psy-community* for not recognizing ADHD and addressing it in a standardized way:

- Mother 4: [You have] to go to a psychologist, but one that knows what we're talking about.
- Mother 7: Right, because in the vast majority of cases they don't.
- Mother 4: They don't! They don't know, and many times they refuse it! They have to know what you're talking about to help you in the right way! Because if you end up in the hands of a child psychiatrist or psychologist who doesn't understand this thing, they're gonna ruin your kid!

As the above quote shows, the supposed incompetence of some professionals is linked to the idea of risk for the future of children.

Parents use the medical knowledge they have acquired on ADHD as a device to reverse the traditional relationship between passive patients and authoritative specialists, positioning themselves as the real experts and many professionals as in need of training:

We can't sit in front of someone that knows less than us (.) I told the psychologist, "Doctor, how come that I know more than you? (.) If it's so, let's switch roles, and let's have you paying me the hour and I'll teach you what an ADHD kid is" (.) I respect professionals who know more than me, if I know more than you...(Father 3)

Teachers are positioned by mental health professionals as anchored to an old-fashioned educational outlook and are criticized for their "*scarce knowledge and awareness of this pathology*" (Psychologist 4). This position is tied to what professionals see as teachers' intentional unwillingness to recognize experts' authority and related negligence towards the child. Teachers are discursively positioned as subjects who refuse to help the child:

Some teachers want to diagnose kids themselves. I hear a lot of "but, in my opinion...". There are some parameters and standards, and we put them to use. Questioning the diagnosis means to not give the child the necessary support. (Psychologist 2)

The lack of compliance by teachers is attributed to their inability to accept that their "legitimate place" is under the authority of psychiatrists and psychologists:

There is ignorance and overconfidence on the part of teachers (...) They are also overconfident in the sense that they don't want to acknowledge the phenomenon, they complain (.) So everyone should do their own job and know their place. (Child psychiatrist 4)

Parents also blame teachers. In light of the ADHD diagnosis, teachers are accountable for the child's performance deficit, and they are often considered culpable for not updating their "obsolete" knowledge or adapting their practice to scientific prescriptions:

When he was diagnosed, I brought the papers, and they [the teachers] didn't even know what it was. Not only didn't they take any classes, but they didn't even treat him with the compensatory and dispensatory measures. (Mother 15)

These divergences lead parents and teachers to frequent debates and conflicts about who is capable, authoritative, and understanding of the problem:

The main teacher didn't know anything at all (.). She thought she was so clever and good at managing him, and she blamed us parents for being incompetent (...). She attacked me because I'm incapable of giving him rules and all, whereas actually she is the incapable one. (Mother 13)

Although parents are positioned by professionals as '*victims of the pathology*' (Psychologist 5), they are intensely blamed for a vast array of reasons.

In particular, parents are under scrutiny with respect to their own mental condition and the family's configuration. Even if these aspects are never directly linked to the child's difficulties, professionals assess parents to determine whether they will be willing to follow the experts' instructions. In the next quote, a psychologist re-conceptualizes the concept of normality, a socially unacceptable term, translating it into the ability "to make the specialist's work easier":

Many ADHD children have families that are not so well structured (.). single parents, strange domestic partnerships, them being taken care of by the grandparents (.). or with personality disorders (.). Let's consider a normal family (.). I don't like the word normal, I used it without thinking (.). Let's say a family that makes this task easier. (Psychologist 5)

When parents do not apply professionals' instructions, they are pushed into an infantilized position that depicts them as victims of their own psychological defensive mechanisms or as incapable of accepting the idea that they are affected by the same pathology as their child. This dynamic supports Berman and Wilson's (2009) results, which stated that mothers' resistance to medical statements is frequently constructed as pathological:

Parents always have a defensive attitude towards new rules suggested by the therapist for them to apply as parents (...) They sometimes disobey. (Child psychiatrist 1)

Parents' struggle to accept that their son has a problem represents also their struggle with accepting that they have a problem themselves. The mother of an ADHD kid was a clear case of undiagnosed ADHD, and she didn't want to accept it. (Psychologist 1)

When parents refuse to accept medications, they are instrumentally positioned as guilty via a rhetoric that distinguishes between observable medical evidence and parents' "anchorage to prejudice", mistaken perceptions, irrational feelings, fears, personal problems, and selfishness:

The pharmacological treatment was interrupted due to the fact that (...) as for the other failing treatments (...) family's disorders, they were failing because, I mean, they made it easier for the treatments to fail (...) so say the drug had side effects that actually weren't given. (Child-psychiatrist 2)

In many cases, they are skeptical [about drug use] (...) There's this fear, but the fear is only theirs. I mean, it might have to do with them, their problems, their past (...) Well, all these parents don't put themselves in their sons' shoes, they don't feel the struggle and the pain of the child. It's some sort of selfishness (...) I mean, I don't know, I'd call it selfishness. (Child psychiatrist 2)

The teachers also draw upon a discursive blame pattern when they position parents. Throughout the focus groups, most teachers came to articulate their discourses on the causes of hyperactivity and inattention around the interaction between genes and environment. Without explicitly denying the role of genetics and biology, teachers highlight the powerful influence of social factors to signify the increase in children's level of hyperactivity. The social environment is seen as the problematic root of many contemporary childhood difficulties. In line with the theme of "lost or stolen childhood" characterizing the contemporary discourses of childhood (Kehily, 2009), lots of teachers argue that the contemporary society denies children the right to move and use their body, preventing them to express their real and authentic nature. The original healthy and free

child is made sick and corrupted by the “toxic society” (Burman, 2010; Palmer, 2006), which imprisons him/her in artificial and excessively regulated social structures:

The management of their body is so complicated because there’s an organization of time and space in which the kids are not free, because this kind of society is not suitable for these children. (Focus group 6)

The family is viewed as the place where negative social tendencies exert an influence on children, and parents are positioned as perpetrators of negative educational practices. Society affects families, which, in turn, affect children:

TC: They don’t have any rules at home, so they come to school and they can’t even accept a minimum of regulation.

TB: They are at the computer or they watch TV.

TE: So there’s this inadequacy of the educative role [of parents].

(Focus group 1)

Adopting a nostalgic rhetoric, teachers position parents as incorporating a new form of parenthood that makes them unrecognizable with respect to the past. As one teacher argued: “*After 15 years I went back to work in classes and over these 15 years parents have changed*” (Focus group 3). In this sense, families embody negative social tendencies and are constructed as the harmful and misleading Other, whereas teachers position themselves as suffering the consequences of the contemporary inability of parents to grow up children:

If you have some principles in class and at home kids have opposite behavioral models, well, you are building something and they are demolishing it. (Focus group 6)

Within this logic of contraposition between antithetic agencies of socialization, “the sick family” and “the resilient school”, teachers find an identity foundation in positioning themselves as those in charge to supply parents’ failure, offering children good models to counterbalance bad parenting and bad societal influence:

You always try to propose an idea of what an adult is (.) I mean, I am the adult, the adult behaves like this (.) you give them a helm. (Focus group 5)

3.3.2.3 The positioning game: knowledge, compliance, authority and morality

The results presented in the previous sections suggest that participants shape their own and others' positions around four main interrelated issues: knowledge, compliance, authority and morality. In this section these dynamics will be explored in depth.

Mental health professionals construct their activities and practices with reference to the concept of objective knowledge, and they claim that teachers and parents must be trained to become "more effective educators". In this sense, professionals locate parents and teachers in a "childlike position", and their educational relationship to the child is considered an outcome of possessing the proper knowledge:

Both schools and families need to learn how to manage these children, following a training path to be better educators themselves because these children need a specific approach, at school and in the family. (Social worker 2)

The relationship between health specialists and schools is limited to passing on the standardized "*instructions to follow*" or "*recipe*" (Psychologist 1) necessary to manage the child. Between professionals and parents, a powerful discursive pattern regarding the "parental function" of science dominates the relationship: parents should be trained to become "*skilled problem solvers*" (Child psychiatrist 2), they should be "*educated on how to interact with their son*" (Social worker 1) and they should focus on applying "*instructions for use for the ADHD child*" (Psychologist 4).

Teachers and parents are placed in a powerless position and are accused of lacking understanding of ADHD children; professionals put themselves in the authoritative position of fulfilling the social mandate to educate children when parents and schools are unable. Overall, this dynamic explains why specialists blame teachers and parents despite the fact that the children's conditions are considered to have a biological origin. Refusing to accept experts' authority and demonstrating non-compliant behavior lead to guilt because failing to follow experts' instructions is construed as an irresponsible action that works against the child's future. Within this local moral order, teachers and parents show a mix of acceptance and resistance to medical discourse. On the one hand, teachers

problematize some of the medical discourse statements and implications and struggle with professionals to have their role recognized and their right to agency legitimized; on the other hand, parents manage the identity-threatening situation linked to the intense scrutiny and pervasive blame directed towards them by “returning the blame to the sender”. In both cases, they struggle against the position of “passive executors” and reclaiming their right to speak and act.

Legitimacy and authority issues characterize also the conflicted relationship between teachers and parents:

TA: The changed role that we have as teachers also has an influence (...) We lost that importance we had in the society and in the parents’ eyes, and kids feel that (.) what about the stuff the teacher says? You listen to it if you want to.

TG: Today everybody is an expert in education, isn’t it?

TD: As teachers, we’re not authoritative anymore.

(Focus group 3).

There are teachers who are sure to know everything. My son’s teacher is insane, I told her, “Please, if you wanna come to one of our [parents’] meetings, so you can understand lot of things” (.) nothing. They think they know everything just because they are teachers. (Father 4)

The above excerpts show that schools and families often depict themselves as antithetic agencies of socialization that do not recognize their authority to one another and blame each other for not behaving in a “responsible” way. ADHD children are inscribed within this conflicting context and constitute a channel for the expression of oppositions between home and school.

Overall, the underlying problem facing key adults shifts from the causes of the child’s behavior to questions of true knowledge, compliance with instructions, and recognition of authority. The network of adults does not distribute blame for the child’s behavior; rather, social actors distribute blame for the lack of respect towards medical, educational or parental authority. The actors struggle to have their voice recognized and create a space of action that others restrict or limit. These topics are linked to the issue of morality. Compliance and recognition of others’ authority are framed as assumptions of

moral responsibility for the child's best interest and a sign of normal psychological functioning.

By contrast, the lack of recognition of others' role and authority, either shaped as lack of compliance with professionals, underplaying the social role of teachers or scrutinizing parents, is constructed as an immoral act of refusing to behave in the child's interest. These dynamics attest to the relevance of moral dimensions related to ADHD (Singh, 2011) and show that morality pervades the relationships between the adults involved.

3.3.2.4 Discussion

The results presented in this second analytic section show that blame and mutual accusations are constitutive elements of the social relationships among the adults who play a significant role in the lives of children with ADHD. The conflicting relationships between social agents who are supposed to work together for the child are not merely a matter of believing that ADHD is biologically based or related to psychosocial factors. Rather, these relationships are concerned with questions of compliance, authority and morality.

As discussed in the paragraph 1.2, the literature has highlighted that ADHD is discursively placed within a culture of blame (Hansen & Hansen, 2006; Harborne et al., 2004; Singh, 2004). Consistent with this literature, our results show that even though hyperactivity and inattention are ascribed to biological and genetic conditions, this conceptualization does not prevent conflicts among medical, scholarly and familial institutions. This contribution shows that blame not only affects parents but circulates in the triangle of adults who interact with the child. This blame discourse is the storyline by which all participants inscribe others and themselves and frames their construction of subjectivity.

The circulation of blame is articulated differently for the three groups. Experts' construction of their knowledge as objective leads them to devalue teachers' and parents' knowledge and expertise. In particular, experts blame schools and families when they do not conform to their indications. Teachers may not question the medical understanding of ADHD, but a substantial number of them direct blame towards parents and society to account for the child's behavior. This pattern is coherent with the "toxic childhood" rhetoric (Horton-Salway, 2011, p. 12) that characterizes some discourses about ADHD, but

shows that ADHD's biological and psychosocial discursive repertoires, as identified by Horton-Salway (2011), are not markedly distinct in the case of teachers, who construct mixed discourses. This process might be indicative of the tension between the tendency to conform to the psychiatric body of knowledge and the effort to maintain a distinct perspective. Therefore, the tendency to integrate the academic and medical agendas, which suggests that medical and psychological knowledge is needed for proper child development (Singh, 2006), is supported primarily by professionals and is partially resisted by teachers. Finally, parents, particularly mothers, counter the blame by both professionals and teachers by shaping their subjectivity in terms of narratives of sacrifice. Mothers' arguments attempt challenge blame but simultaneously contribute to reproducing the social order that positions them as objects of oppressive social expectations related to the maternal role (Singh, 2004).

Regardless of the way the positioning is articulated, the transfer of responsibility from the self to others represents a common discursive pattern among participants. It is interesting to note the primacy of individual responsibility as opposed to collective responsibility (Fine, 2012). Indeed, we can witness an individualization of guilt via a common rhetoric strategy that opposes a homogeneous chorus of voices relying on a well-recognized knowledge to a single isolated voice that 'willfully' refuses to accept the truth.

The *blame game* is a way for adults to negotiate not only what must be done but also by whom, allocating rights, duties and obligations in ways that (re)produce power relationships and efforts to resistance. Indeed, social actors are embedded in a politics of knowledge (Baert & Rubio, 2011; Foucault, 1980) that defines medical and psychological statements as legitimate and establishes a priori whose knowledge counts and who has the authority to dictate instructions to others (Fine, 2012). These conflicting dynamics outline a constellation of different levels of legitimacy; blame emerges as a way to resist these power inequalities. In this sense, the ADHD phenomenon constitutes a channel for the expression of opposition between three major social institutions: the family, school, and medicine.

Although some discourses are normative and others are marginalized, everyone is constrained by certain social bonds established in discourses (Parker, 2005). The discourses presented in this section prescribe specific positions that are limiting for teachers, parents and professionals. For the two former social actors, the legitimacy of their views, the relevance of their "evidence", and the value of their expertise are frequently limited and constrained. As professionals scrutinize teachers and parents, they also monitor

each other within a general dynamic of mutual devaluation and surveillance in the name of the child's wellness. Teachers and parents are not the only targets of criticism and prescription. Professionals are also pushed to embrace the medical "hegemony" (Gramsci, 1975, p. 1249), and every act of resistance is constructed as intentional ignorance, a refusal to know, or irresponsibility.

Overall, these results are in line with studies that suggested a deep relationship between moral issues, such as blame, guilt, and responsibility, and contemporary concepts of health and illness. In fact, the relevance of blame in the mutual positioning of the social actors exemplifies that health issues are intrinsically linked to ideas of "good" and "correct" (Crossley, 2003) and, in this sense, constitute a "key organizing symbol for the good, moral, responsible self" (Crawford, 1994, p. 1347).

3.3.3 The interactional dynamics characterizing the self-help group of parents

The third part of the analysis concentrates on the interactional dynamics of the parents' self-help group. To theoretically contextualize the analysis, the most relevant literature related to self-help groups and mutual aid associations is discussed.

3.3.3.1 Self-help groups and mutual support associations: benefits and dynamics of functioning

Self-help groups are defined as voluntary associations formed by people who share similar difficulties to try to address these difficulties (Humphreys & Rappaport, 1994). They are based on mutual peer assistance, and they are characterized by the fact that the meetings are free and open to anyone (Wituk, Ealey, Brown, Shepherd, & Meissen, 2005). As Riessman and Banks (2001) underlined, one of the main principles regulating self-help groups is that “the consumer is the producer”, or the “prosumers” (p. 174), in the sense that people produce their own help.

Extensive research shows that more and more people, especially in the USA, are involved in self-help groups (Kessler, Mickelson, & Zhao, 1997). This phenomenon is also taking place in Europe and Italy, as demonstrated by the presence of many patients' and relatives' associations in Italy (Burti et al., 2005). The proliferation of these types of groups makes a critical analysis of the self-help movement relevant for the health field (Kessler et al., 1997). Within the “self-help arena” there is broad variety (Davison et al., 2000), as the processes and dynamics of every specific group are tailored to the participants' problem and their needs, goals, and interaction. Whereas associations like Alcoholics Anonymous have a widely recognized model, the majority of self-help groups are diversified in their structure, mission, and focus. In addition, self-help groups exist for people with many diverse types of physical and medical disorders, from people with chronic illnesses or physical disabilities to people with mental distress and families of people with similar problems (Kessler et al., 1997).

One major difference between groups is that some groups are focused on the illness experience and some groups include mutual aid and peer supports as part of a broader activism frame. In the former type, the group is seen as a potential tool for recovery, as exemplified by Alcoholics Anonymous and groups for patients sponsored by institutions

such as hospitals (Williams, 1996). The basic assumption is that people facing similar challenges and difficulties can help each other by sharing their experiences and beliefs. These groups may be organized with or without professionals' intervention and facilitation (Davison et al., 2000). Generally speaking, these groups substantiate the fact that the illness experience is social in nature, that the "social fabric" (Davison et al., 2000, p. 205) that surrounds people experiencing physical problems or mental distress impacts the way they understand and signify their feelings and behaviors. Regarding the latter category, groups do not constitute a direct resource for recovery, but forms of associations based mainly on peer exchange (Barton, 1999) and not ruled by professionals; often they aim to penetrate the society. Indeed, despite the fact that the majority of these groups are composed of a few people, they are part of a larger movement that involves patients collectively entering the social realm and targeting the political agenda to advocate for their rights. Self-help groups are frequently part of associations that organize disease awareness campaigns to draw the attention of lay people and medical practitioners to the existence of a disease and the availability of treatment, shaping people's fears and anxieties into a clinically recognizable form (Rose, 2003). Thus, self-help groups are now recognized as an emerging social movement (Borkman, 1990), because groups are frequently formalized into nationally recognized self-help organizations (Wituk et al., 2005) that also engage in political action through their social activism (Humphreys & Rappaport, 1994).

With respect to the social action of these groups, Oliffe et al. (2011) suggested that the self-help movement is a constitutive element and an indicator of the broader phenomenon of health consumerism. Health consumerism is a social and political movement that has been reshaping the medical field (Irvine, 2002) as patients and their families state their needs, reclaim their rights and resist to the subordinate positions invoked by some health providers (Lupton, 1995, 1997). In this respect, self-help groups have also been criticized on the assumption that they are primarily organizations that work to influence services, rather than to serve as a source of mutual support (Elsdon et al., 2000).

Overall, the elements discussed above highlight the importance of understanding the processes involved in the formation and functioning of self-help groups (Mundell et al., 2012). The literature has mostly focused on quantitative measurements of the efficacy of self-help groups and their benefits for people with physical (Bradley et al., 1987) and psychiatric diagnoses (Burti et al., 2005; Pistrang, Barker, & Humphreys, 2010). Some

studies have focused on comparing between different disease categories and the amount of support sought from the groups (Davison et al., 2000). In general, certain valuable aspects of self-help groups have been highlighted: the capacity to provide feelings of connectedness and a related decrease in feelings of loneliness; the dimension of support, linked to the sharing of experiences with other members; the opportunities to learn by obtaining information and answers; the raising of community awareness; and the enhancement of the effects of professional, especially psychiatric, interventions (Burti et al., 2005; Dadich, 2010; Wituk et al., 2005).

In particular, Harwood and L'Abate (2010) affirm that support groups are spaces where people can find resources to counter the stigma associated with specific mental health conditions. Indeed, as Davison et al. (2000) suggested, during the course of particular illnesses, relationships may be broken, and people may suffer from social stigma. The author found that the social embarrassment and stigmatization associated with a health condition were associated with an increasing need to seek of support in self-help groups. Thus, having a socially stigmatized condition and experiencing the related social anxiety may increase affiliative behaviors (Davison et al., 2000). In this respect, Borkman, (1999), in response to the criticism directed at support groups because they frequently do not provide professional help (see Harwood & L'Abate, 2010), argued that self-help groups create more positive and less stigmatizing "meaning perspectives" than professional interventions. In addition, participation in these groups may enhance psychiatric treatment outcomes (Burti et al., 2005). Kessler et al. (1997) has also found that those who participate in self-help groups are more likely to seek professional help than those who do not.

Mutual support groups for caregivers are also increasing (Barnes, 1997). A qualitative study from Munn Giddings and McVicar (2007) explored the reasons why caregivers attend self-help groups and the benefits they gain from their membership. The main reasons identified were similar to the reasons why patients attend groups: social support and relief from feelings of isolation in the usual social network and access to information, emotional coping mechanisms, and experiential knowledge. A study on support groups for families of adults with mental illnesses (Heller, Roccoforte, Hsieh, Cook, & Pickett, 1997) found that members perceived two major types of benefits: more information and improved relationships with the ill relative. On a macro level, Chapman (1997) has reported growing socio-political awareness among families of people diagnosed

as mentally ill and a parallel increase in their social influence through self-help groups and collective activism.

In this respect, mutual support groups of parents with children experiencing some sort of disabilities or distress are an increasing phenomenon in the self-help arena. Diverse authors (Kerr & McIntosh, 2000; Law, King, Stewart, & King, 2001; Munn Giddings & McVicar, 2007) have suggested that parents who participate in a support group experience a range of benefits similar to those experienced by patients, such as emotional support, more information, and a sense of empowerment derived from sharing goals and advocacy. According to Borkman (1999), these benefits come from the production of collective knowledge build over time, which affects the members' ways of (re)conceptualizing the issues they face.

Enlarging the perspective, Solomon, Pistrang, and Barker (2001) conducted a study on mutual support groups for parents of children with disabilities and identified three main domains of support: the socio-political, related to an increased sense of control and agency; the interpersonal, involving a sense of belonging to a community; and the intra-individual, linked to self-change. According to the author, identity changes related to empowerment, social identity, and self-esteem represented the core categories around which the support groups were organized.

The literature has provided an important contribution to our understanding of the processes that characterize the dynamics of the self-help groups. Dibb and Yardley (2006) have shown that social comparison processes (Festinger, 1954), or the tendency to compare ourselves with others in a similar situation to gain information to evaluate our own situation, occur among the members of parents' self-help groups. A recent study by Hodges and Dibb (2010) examined the experiences of parents participating in a support group for parents of children with Duchenne muscular dystrophy; the results uncovered a broad range of social comparisons on illness and dimensions of coping. The findings suggest that social comparisons do not always have positive effects (Dibb & Yardley, 2006); for example, parents may feel anxious about interacting with parents who have very different experiences with their children (Pain, 1999).

Focusing on a support group for parents with children with disabilities, Barton (1999) showed the relevance of repeating of slogans and sayings, which serve both informational and interactional functions; they aim to disseminate information and to establish solidarity among the participants. Slogans and sayings are common features of

the discourses in self-help groups (Gubrium, 1986) and are used to manage the complexity of a group meeting.

Mundell et al. (2012) identified 4 processes characterizing support group dynamics: identification, based on the feelings that others have similar experiences and are in the same situation; modeling, referring to the fact that participants see others as role models and learn from one another; acceptance, when participants feel supported by the group; and empowerment, related to the feeling of strength that derives from being part of a group. Previous studies have already underlined the relevance of identifying with other patients in similar situations drawing a parallel with the experience of commonality often featured in group therapy (Roth & Nelson, 1997).

Overall, one of the major theoretical contributions to the understanding of mutual help organizations (MHOs) was made by Rappaport (1993), who described MHOs and related self-help groups as “normative narrative communities where identity transformation takes place” (p. 239). According to the author, people decide to participate in these groups mainly “to answer identity questions” (p. 247). In fact, mutual support groups allow for the emergence of an alternative culture that permits the members to redefine their identities (Shotter & Gergen, 1989). As discussed above, support groups are especially valued by people whose social identities have been put at risk (Davison et al., 2000). The stories that people share contribute to a group narrative that shapes their subjectivity (Gergen & Gergen, 1997) and, in turn, impacts on people’s social context. This conceptualization contributes to an understanding of the way personal life-stories are linked to community processes and promotes the exploration of the social processes enacted within self-help groups.

Despite the important results of the studies about mutual help organizations, the majority of them have collected data using quantitative surveys (Dibb & Yardley, 2006; Wituk et al., 2005), interviews (Hodges & Dibb, 2010; Munn Giddings & McVicar, 2007) or focus groups (Solomon et al., 2001), rather than capturing the observable dynamics occurring within mutual aid groups. Thus, although membership in peer support groups can have a powerful effect on the people involved and their environment, and despite their growing diffusion in the mental health field, little is known about the patterns and the interactional processes characterizing support group participation (Davison et al., 2000).

3.3.3.2 The format of the self-help group for parents of children with ADHD

To contextualize the analysis of the parents' interactions within the group, the setting where the parents' meetings occurred is described below. These self-help groups are distinct from Parent Training courses, courses where mental health professionals educate parents on the techniques to be used to manage their children who have been diagnosed with ADHD. The group had no a professional mediator, although two authoritative persons (two parents, a woman and a man) were reference figures within the mutual support association and played the role of facilitators and moderators of the conversations.

The meetings were held on a regular basis, and their format was very open, without a specific set of goals. Usually, after a brief introduction to the group by part of one of the two moderators, the parents attending the group for the first time presented their stories, and the parents who were already members of the group introduced themselves briefly. The themes of the discussions were not pre-established, as they emerged from the participants' presentations of themselves and their experiences. Each parent had the freedom to enter the discussion at any moment. The two moderators typically concluded the meetings by summarizing the crucial points addressed, focusing particularly on the issues relevant to the group. The group meeting room was set up in a conversational format, with chairs arranged in circle and no tables.

3.3.3.4 The dynamics of the self-help group of parents: the functions performed by the group and the related discursive devices

The results are organized in two subsections that address the main functions performed by the self-help group. The first part presents the first function performed by the group - establishing the group as a homogeneous space - and the discursive devices used to accomplish this function. There are two primary discursive devices: favoring homogeneity within the group by mirroring and encouraging mutual identification and promoting the heterogeneity of the parents' group with respect to the outside world by establishing differences between the group itself, construed as a safe shelter, and the society, constructed as an unsafe place.

The establishment of the group as a homogeneous space sets the scene for the performance of the second function: producing a shared and meaningful narrative to

signify the parents' experiences. The second part of the analysis addresses the discursive strategies enacted to establish a specific narrative that is adopted and accepted by the group and the characteristics of this narrative that are related to the causes of ADHD and the management of children with ADHD. Both the production of a homogeneous space and the shared narrative aim to absolve parents of guilt, offering them resources to signify their experience and enabling them to escape social blame.

The presentation of the results retraces the analytic process, which focused on how parents construct ADHD as a shared experience and come to deploy the accepted ways of talking about ADHD by establishing a particular language; for example facilitating and supporting the expression of certain aspects of the experience at the expense of others, inhibiting participants from expressing certain things, and censoring deviations from the group's standards and rules (Kitzinger, 1994). Therefore, the analysis is articulated around the mobilization of group consensus as well as the "crashes". Indeed, as Parker (2012) wrote, Foucauldian discourse analysis searches for points of conflict. I use the term "crashes" to refer to the conversational situations where parents disagree or misunderstand one another. These "breaking points" within the group can be identified in some phases of the parents' interaction, and considering these points helps the understanding of what is really important for the group and thus relevant for the parents' subjectivity. The agreements and conflicts between the participants will be used to clarify what the group values and why, what is considered evidence within the group, the underlying assumptions of the parents' arguments, the factors that influence opinion changes, and, more generally, how facts and stories operate in practice within the group to support a particular ideology (Kitzinger, 1994). The units of analysis are the repeated and recurring discursive practices, the crashes, and the moments of contestation and negotiation within the group because these events appeared to be meaningful markers of the semantic and symbolic field shared by the parents.

It is important to remember that there are two facilitators who, because of their longer membership in the parents' association and their experience with ADHD, moderate the group meetings and rule the conversations. As the following sections will show, the moderators represent the authoritative voice within the group and work to establish a "hierarchy of credibility" to acquire and defend their position as "experts" within the group.

Table 3. Functions performed by the self-help group and the related discursive strategies

Functions of the self-help group	Discursive strategies enacted to perform the functions		
<p>Setting the scene: The production of a homogenous space</p>	Homogenizing the “inside space” of the group: mirroring and mutual identification		
	Marking the difference from the “outside space”: the group as a safe shelter in an unsafe society		
<p>The actors in the scene: The production of the perfect narrative for the imperfect child</p>	Strategies of normalization		
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3.3.3.4.1 Setting the scene: the production of a homogenous space

As shown in the previous analytic sections as well as in the literature (Harborne et al., 2004; Klasen & Goodman, 2000; Singh, 2004), parents of children diagnosed with ADHD often perceive blame by their social context, which results in feelings of guilt about their children behavior. The group works to fashion a story that can give parents tools to signify their experience without blaming themselves and to preserve their identities as “good parents”. As Gergen and Gergen (1997) wrote, “stories bring selves into being” (p. 266). In this sense, the group’s discursive activity is centered on subjectivity issues, and

the group appears to have one main function: absolving parents from guilt. This function is performed through a double-vector dynamic: the group homogenizes the “inside space” on one hand, and on the other hand, it marks the extreme differences with the “outside space”. These two dynamics are discussed below.

Homogenizing the “inside space” of the group: mirroring and mutual identification

The group shows the tendency to construct itself as a homogeneous space where the experiences of parents and the children are “the same”. This pattern, on the one hand, favors the integration and cohesion of the group, promoting mutual identification; on the other hand, it de-individualizes and normalizes the experience, by invoking the commonality of the situations to demonstrate that the parents have not done anything wrong.

The first strategy relates to the fact that the parents, when talking about their kids, tend to reconnect the particular experience of their child to a broader collective. In particular, they frequently shift from using the third-person singular form to the third-person plural form:

My husband and I smiled, and then I told him “He is the only one who can do that.” (.) Only our [children] can do that (Mother 12)

This generalizing strategy promotes the grouping of children into a homogeneous category, a category to which the children belong, which makes it possible to explain the unexplainable behavior of the individual child:

Therefore, he was always very stigmatized due to his personality, which is very exuberant on the one hand and on the other hand (...) very sensitive, hypersensitive (.) like all of them [the children] are. (Mother 14)

The group’s facilitators encourage this shift in the use of pronouns, from “s/he” to “they”, to generalize the personal experience of one child to virtually every child with a diagnosis of ADHD, de-singularizing personal characteristics:

Father 7: Our son reasons in terms of (.) of protection. He is protective. If there's someone there that (.) you'll see him protect him, defend him...

Mother 1: Do you wanna know why? (...) Wanna know why he does such things? 'Cause he feels uncomfortable, he feels very uncomfortable, so he understands (...) so they are always the ones to understand when someone is in a difficult situation. It's because they go through difficult situations on a daily basis (...) so when they feel stronger, they need to (...) they do these things.

Another way through which parents build a sense of belonging to a broader community and favor mutual identification is by excluding differences, adopting the rhetoric "It's the same for all of us". As the next excerpts show, one group leader frequently affirms the reproducibility of parents' and children's experiences. This type of statement is repeated at almost every meeting and thus functions like a slogan or a saying, which are common features of the discourse in self-help groups (Barton, 1999). These slogans may be understood as "key signifiers" or "nodal discursive points" (Laclau & Mouffe, 1985, p. 112) in the formative experiences of the parents, and they serve to suggest that the patterns of the children's development are identical and predictable.

These are all the same paths, reproducible paths. One could just say "My [child] is 7 years old, how old is yours?" "14." "Tell me how it went so I know how it will end." Because sometimes that's the answer (...) our children are typical, their behaviors are typical. You might think of them as photocopies (.) (...) Then, if you like, we can tell you the sports we would have had them do, 'cause sooner or later you'll go through that, too. (Father 1)

Emphasizing the identical experiences of parenting a child with a diagnosis of ADHD constitutes a powerful discursive resource to normalize the experience and to resist blame from oneself and others. Indeed, if all the stories are the same, to the point that they are predictable, a child's behavior is not likely to depend on the specific family context and parenting practices, permitting the parents to be absolved from guilt:

Father 9: We started seeing things differently (.) in the beginning, we saw everything in black, we were very pessimistic, then we started seeing things (.) maybe not in white but in grey when we started attending these kinds of meetings. The first thing we worried about before wasn't understanding what his [the child's]

problem was, what his difficulties were, but what we had done, if it was our fault that he became like that.

Father 1: Sure.

Father 9: Then we heard all of the other people's experiences. Sharing experiences, we saw that in the end the result was (.) You heard one, two, three, four people, and you started wondering, what's the story here?

Father 1: The reproducibility, there is a reproducibility.

Father 9: Ultimately, we started thinking that maybe it wasn't all our fault.

The following excerpt also shows that the group speaks in one voice to demonstrate the collective and shared nature of the parenting experience. When asked by a parent attending the group for the first time how they felt at the discovery of their child's condition, many participants affirmed that they experienced relief when the child's problem was given a name and thus codified. As Avdi et al. (2000) stated, for parents the diagnosis is "a relief, in terms of having a question answered" (p. 248).

In this sense, a medical understanding of children's hyperactivity and inattention makes it possible to name incomprehensible manifestations (Lester & Paulus, 2012), and the diagnosis has the power to eliminate feelings of guilt from parents. The diagnosis is a way for parents to symbolically regain some order in their lives, and the group works as a united front to sustain the value of the diagnosis:

Mother 18: I listened to all of your (.) let's say, your stories. Can I ask you something? As parents, when you knew that your son, let's say, was sick (.) how did you feel?

Father 10: Good.

Mother 7: Indeed, good.

Mother 12: It was a relief because we finally knew what it was.

Father 7: At that point, at least you know an illness was diagnosed, 'cause previously you thought it was...

Mother 13: Or that you were...

Mother 3: Maybe it's because we had been through hell before.

Mother 13: Yes indeed.

Mother 1: We spent so many years without knowing what it was, whether it was our fault or not and so on, so once you finally know something (.) I mean, obviously it's not an easy thing to accept, but at least you know what it is. (April 12)

However, the collaborative interactions between the parents, aiming to make the group a homogeneous space where participants can identify one another, do not proceed without any incidents. The following excerpt exemplifies a moment of conflict. This constitutes an example of a “crash”, showing the tension activated by a mother who was new to the group and at her first meeting, attributed the “successful” development of her son to the fact that “we [the parents] have worked a lot”. This assertion individualizes the parenting capabilities of the mother and her husband, rather than constructing them as a given feature of the whole group of parents. In fact, the use of the personal pronoun “we” particularizes the object of discussion, potentially implying a difference between the speaker and the audience. Moreover, the speaker’s assertion seems to imply a causal relationship: work and sacrifice on the part of the parents lead to successful results for the child. This implication is potentially threatening to the identity of the other parents listening, as they may feel devalued and responsible for the difficulties they are still experiencing in relation to their child’s behavior. Indeed, another mother reads this claim as an implicit accusation that she has “not worked enough for her child” because the statement that other parents have worked a lot makes her feel like a mother who deserves to be blamed for her son’s “unsuccessful” path. She intervenes by distancing herself from the idea that some parents have worked more than others for their children, and she explicitly affirms that she has worked “more than a lot”:

Mother 9: The problem arose when we took him [the child] to another school (...) There, I needed help. There was a psychologist there, I informed him; I gave him the diagnosis, and he told the teachers, and they helped a little, with the parent-teacher meetings...

Mother 15: You were lucky, very, very lucky.

Mother 9: But we worked so hard.

Mother 15: I’m sorry, but I have to disagree on this, because I helped my son more than a lot. I too realized it when he was 2 and a half years old, I worked hard.

Taking a broader perspective, it can be said that the new mother in the group challenged an established assumption that was taken for granted: that every parent within the group is disposed to sacrifice for their child. Consequently, she was discursively “sanctioned” by the reaction of another mother. In that sense, this particular interaction is

situated within the broader values of the group, which include the fact that parents, by definition, make sacrifices for their children.

This dynamic shows that some things are not allowed to be said within the group because they can threaten its members and that the group works to re-orient some storylines (and the related moral order) by making different and contrasting statements. In this case, the group constructs and accepts a rhetoric that externalizes problems (Avdi et al., 2000), stating that problems mainly come from an ostracizing external context, rather than from parents and their practices. Overall, echoing, resonance and mirroring (Burman, 2004) are the patterns characterizing the group's dynamics, and they reverberate across the discourse of the self-help group, favoring integration at the cost of differences, which do not seem to be welcome in the parents' mutual aid group.

Marking the difference from the “outside space”: the group as a safe shelter in an unsafe society

The homogenization of the “internal space” of the group is combined with a second pattern that represents a tendency to mark the difference between the parents' group and the external world. This pattern of distinction has already been discussed in relation to the “blame game”. Here, the focus is not on the blame from mental-health professionals and teachers that parents perceive in relation to their personal experiences with ADHD but on the process of marking the difference between the parents' group, on the one hand, and those who underestimate the problem, including other associations and movements, on the other hand.

Parents establish a clear difference between themselves, who represent a secure space for their children, and the outside society that is unable to understand and correctly address their children's problems. Within this dichotomized view of the opposition between families and society, with the latter represented as a risky and potentially dangerous jungle, parents position themselves as enterprising subjects who should work to educate the public on ADHD:

When they go out (.) it's the jungle, no one can understand. Even now though, even in school, they are not being understood, people don't use the same strategies as we do (.) and this is the thing that I believe we should be working on as parents, to make people understand how such a thing works. (Father 19)

In the next excerpt, one of the group's facilitators differentiates the parents' mutual-aid association from the members of some movements critical towards ADHD by positioning the latter as a mainly powerful and rich group ("Here in Italy, there are movements that are financed by the wealthy.") whose members have never experienced parenthood ("I think they probably don't have children at all."). This type of discursive positioning performs two actions. First, it suggests that critical associations have an interest in opposing the biomedical conceptualization of ADHD, implying, by contrast, the independence of the parents' mutual-aid association from powerful institutions. Second, it emphasizes that the members of the self-help group have full access to the experience of parenthood, unlike those questioning the validity of ADHD and the use of medications for its treatment. Therefore, the concept of parenthood is used by parents to delegitimize the perspective of others and to defend themselves and their choices.

Here in Italy unfortunately there are movements that are financed by the wealthy (.) they organize all sorts of smear campaigns against us. I think none of them has a child with ADHD, and I think they probably don't have children at all. (Mother 1)

As shown above, attributing negative qualities to other social actors creates "two sides of the story": the speakers and their audience represent the "us-group" and the others, negatively depicted, are positioned as the "them-group" (Reyes, 2011, p. 785). This opposition has the function of valorizing the mission of the parental self-help group and association. Because the outside world is a space of ignorance, parents have to communicate their experience and spread information about ADHD. The following quote shows this pattern of emphasizing activism; in particular, one of the fathers does not talk as an individual but from the starting point of his "institutional identity" as a member of a broader collective:

We have a lot of representatives that are raising hell all over Italy (.) thanks to them, we have information circulating in schools (.) a small part of this is also thanks to our association. When they started 10 or 11 years ago in Italy, there was no information available. (Father 4)

Belonging to the group implies faith in its advocacy mission and in a better future.

Mayes et al. (2008) argued that the debate about ADHD seems to be “religious in nature” (p.11) In line with that argument, being a member of the parents’ association has a “religious” connotation, as a father metaphorically claimed:

That’s why I started to get in touch with the AIFA representatives and the AIFA parents, because I have faith (.) I am optimistic. If I didn’t believe, then why would I bother...? (Father 6)

Altruism is another pattern used to legitimize the advocacy activities of the mutual support association (Reyes, 2011). In the excerpt below, a father positions the group as having no personal interests in fighting for the medical and social recognition of ADHD; rather, he states that the group has been working for the future benefit of other parents:

We probably won’t see the results, others will. Thinking that someone will be able to benefit from the results of what we’re doing and that some parents will not go through what we’ve been through...(Father 1)

Overall, one of the central rhetorical features of the self-help group is the use of contrast and binary schemes that juxtapose opposites. According to Edwards and Potter (1992), this discursive device constructs a factual version of reality in opposition to an unconvincing and problematic alternative.

3.3.3.4.2 The actors in the scene: the production of the perfect narrative for the imperfect child

The group’s interactions aim to construct specific ways of talking about ADHD that encapsulate and disseminate a particular perspective about the experience of parenting a child with ADHD. This part of the analysis addresses the discursive strategies enacted by the group to establish what is appropriate to say, what is unspeakable, and what the effects of such discourses may be. The focus of this section is on how parents learn from each other, share, create and collaborate in constructing the perfect narrative for the child with ADHD (Mason-Schrock, 1996), that is, a narrative that protects the parents’ identities and can be accepted by the group. Indeed, the self-help group works to define a specific

common language to talk about ADHD that should be adopted by parents who enter the group if they want to be accepted.

A useful theoretical concept in this respect is the concept of “performance” (Jaworski & Coupland, 1999). Performances are defined as ritualized processes that people use to “construct and project desirable versions of identity” (Jaworski & Coupland, 1999, p. 407). Similar to what Lester and Paulus (2012) stated in their study on parents of children with autism, conversations about ADHD can be conceptualized as discursive performances enacted through a variety of interactional activities.

In the following pages, it will be argued that specific versions of ADHD causes and management are constructed and transmitted to novices through the processes of initiation and negotiation about the correct way to understand and talk about ADHD. These processes capture a number of patterns that may create cohesive or disjointed relationships (Barton, 1999).

Strategies of normalization

A pattern characterizing the dynamics of the self-help group is the trend towards normalization. For example, although the group and its moderators often emphasize that the children’s condition should be certified as pathologic to assure them their rights, parents refuse the explicit use of words like “pathology” and “illness”. For instance, in the next excerpt, parents reject the signifier “pathology” to avoid an association with the stigmatized fields of disability and mental illness, which are linked to frightening cultural representations:

Father 1: I never call it a pathology; I call it a hardship. Let’s call it that.

Father 18: Let’s not call it an illness.

Mother 2: Because it’s not an illness.

Mother 16: A hardship is something different; the word sounds less harsh (...)

Father 13: When you speak about an illness, the child is sick, I don’t like the word.

Father 1: No, the child has a hardship.

Mother 19: There is nothing pathological; it’s not a pathology.

Mother 1: It’s not a pathology, it is a hardship with which they coexist and we coexist.

Thus, discourses about disability are employed in certain situations when they serve to promote the need and right to access mental health services and refused in other situations when the aim of the group is to normalize the children's condition. This movement shows that there may be discursive shifts depending on the group's contingent interests.

Normalization practices are often activated when the controversial and critical topic of using medication to treat ADHD arises. One strategy involves the normalization of the side effects of drugs. In the first of the next excerpts, methylphenidate is equated with any other medication, whereas in the second, it is compared to a common and popular drug, such as aspirin. This comparison aims to counteract the image of methylphenidate as a peculiar and especially dangerous drug:

We also gotta stop demonizing it 'cause it's a drug like any other drug, with its side effects and its positive effects.(Mother 3)

Father 5: It [the medication] scares me.

Father 3: It scares everybody, if that helps.

Mother 1: Sure, it scares everybody, like any other drug. Go read the aspirin label...

Father 5: Of course, the drug information leaflets are...

Father 1: Read the labels of any other drugs, and you will see...

Another example of normalizing in the self-help group comes from the following quote, where ADHD is constructed as a physical condition and methylphenidate is compared to a vital drug, such as insulin:

Father 3: The ADHD guy doesn't produce enough dopamine to (.) there's a neurotransmitter called GAVA (.) what people don't understand when they say "he [the child] takes the drug" is that the drug acts chemically through a neurotransmitter that our children lack. It's like insulin. You don't have it? The diabetic person takes insulin shots and no one says anything about it.

Father 15: But insulin is vital!

Father 3: The idea is the same.

Strategies based on concrete evidence

The tendency to rely on different types of evidence to demonstrate the validity of ADHD and the utility and safety of drugs is a foundational aspect of the group dynamics. The evidence produced by the group and within the group belongs to two main categories: evidence from personal experience, related to individuals' stories, and evidence from objective data, associated with the apparently objective nature of facts and numbers.

❖ *Evidence from personal experience*

"I have already passed through that". One of the strategies used by the parents' group to bring incarnate evidence about the reality of ADHD and the usefulness of drugs is adopting the rhetoric "I have already passed through that", which has already been identified as a general cliché occurring in support groups (Barton, 1999).

I've been living with this drug thing for many years. It's obvious that no one is ever happy to give it...(Mother 1)

This rhetoric is most often used to confront skepticism and to offer the credibility of a first-hand experience. The next quote is taken from an interaction between a couple participating in their first meeting and another father who is a regular member of the group. The experienced member legitimizes the couple's fears and ambivalence towards the use of medication by telling about his own initial skepticism, his subsequent change of heart and the positive results of his final choice to use drugs. This discursive strategy is used to show that others' fears are accepted, to demonstrate their legitimacy, and to lead the listener to treat the conclusions as factual rather than as representations of personal interests (Potter, 2004). Thus, the father's account does not represent only a simple report of personal experience, but aims to change someone's mind.

Father 14: As parents, we are not totally cool with the drug, but we also don't know where this thing will go. I mean, the kid is 7, so he is still (.) but we don't know if he is going to need it [the drug] in the future, and we'll have to...

Father 7: I went to the hospital begging them to give me the drug after I had been against it all the time (.) we were exasperated.

Mother 12: ‘Cause they [the doctors] told us it was necessary. He didn’t agree with that, I did. They let us think about it, but at some point he just went.

Father 7: I went there to ask them, “Give me the drug“. Otherwise we’ll need treatment too (...) Now he has super high marks, he’s very attentive, when he is taking the drug, he causes no problems.

Claiming parents’ choices as responsible. Another discursive strategy used to confront skepticism towards medications is characterizing the choice as a responsible and informed choice (Reyes, 2011). As the following excerpt shows, decisions are presented as the result of thoughtful and deep reflection, including the exploration of different options and consideration of the consequences (Childs & Murray, 2010), rather than a naive acceptance of the easiest way. Constructing choices as the outcome of a long and hard process of thinking works in two ways: on the one hand, it justifies specific courses of action and constructs choices as fact-based (Reyes, 2011); on the other hand, it refuses the negative implications of being parents who drug their children (Childs and Murray, 2010). Furthermore, this excerpt ends with the suggestion of an implicit association between the responsible choice and successful results:

Father 3: We thought about it, we thought about it and thought about it, then we said to ourselves, let’s try it, and G. didn’t just do fine, he did great! He took Ritalin, now he has almost stopped taking it.

Mother 18: We tend to be against it.

Father 3: We were against it until I said (...) because we searched for a lot of information on this thing (.) we said, let’s try, and for us, for our diagnosis, it had good results.

❖ *Evidence from objective data*

The authority of expertise. The group also works to produce factual types of evidences that are more related to facts and numbers than to personal experience.

Calling expertise into question is a discursive device that is often enacted to deploy factual evidences, especially to manage interactions that are potentially threatening to the group and its discourses. In particular, the facilitators of the group often confront the ambivalence, doubts, and insecurities of other parents by bringing information, in the format of facts and numbers, to answer parents’ questions. This information is constructed

as a form of sophisticated knowledge resulting from their longtime experience with ADHD. In this sense, they position themselves as the voice of expertise, exerting a sort of “authoritative speech” (Philips, 2004). In the quote presented below, the facilitator deploys her knowledge about drug dosage in her reply to another mother who implicitly questions the efficacy of medication while describing her experience. This exchange positions the facilitator as an authoritative figure. At the same time, the moderator balances the expert position by emphasizing that her assertions are the product of experience (“*it’s always good experience*”). This discursive strategy helps to maintain the facilitator’s status relative to the status of the other parents, preserving her credibility as a peer and keeping the possibility of mutual identification:

Mother 20: As far as school is concerned, we thought that Ritalin was magic (.) she had a wonderful trimester ‘til Christmas, everybody was happy with her [the daughter] (...). February and March were awful, they told us it was like she wasn’t even in class (...) That happened over two months, whereas before they told me she was being more attentive, so I don’t know.

Mother 1: I’m sorry (.) it’s always good experience (.) did anyone suggest a dosage for the drug or...?

Mother 20: She takes one a day.

Mother 1: The 10 kind?

Mother 20: Yes.

Mother 1: That won’t be sufficient for a girl.

Mother 20: Yeah I don’t know, I’ll tell them...

Mother 1: Yeah I mean (.) I’m sorry, but that’s not effective at all.

Emphasis of the results of treatment. Emphasis is another discursive practice used to present evidence of the positive results of medication and the absence of negative side effects. Emphasis instills certainty in the listeners and leaves no space for doubt. At the same time, reality is constructed as the product of facts, rather as the product of the speakers’ expectations (Potter, 1996). Moreover, in the following quote, the use of a list (“(...) *Lack of appetite (.) and trouble sleeping (.) and growth problems (.) it’s 4 things*”) creates a sense of completeness and representativeness (Bowker & Tuffin, 2007).

Father 14: I’m giving the child a lot of omega 3 (.) that’s what I’m working on, more natural stuff that doesn’t (.) the drug scares me a lot.

Father 3: We are still scared of using it, still scared, but he has been taking it for years and we have him checked because it has (.) but no side effects, thank God...

Mother 2: Yeah, no side effects in our case either.

Father 3: So the only side effects it can have, as the list says, are tachycardia...

Mother 1: Lack of appetite

Father 3: Lack of appetite (.) and trouble sleeping (.) and growth problems (.) it's 4 things. Does he sleep? Yes, he sleeps a lot. Does he grow? He is growing perfectly.

He is not 6'1". He's 15 years old, and he is 5'6". Tachycardia? He works out, so we always have him checked.

Mother 1: Every six months he has to...

Father 3: He runs and everything, he's as perfect as it gets.

Mother 8: Does he lack appetite?

Father3: He eats like an animal.

Mother 16: Is this a case in a million or is it the norm?

Father 3: It's the norm.

Father 14: You say that that's the norm, though.

Father 3: I'm sorry, it isn't the norm.

Father 14: No, that's your case.

Father 3: It's my case and the case of many others. The truth is you won't know until you do it.

In the last part of the above quote, the speaker has to manage a moment of interpersonal tension. Indeed, the listener does not uncritically accept the emphatic generalization that the experienced father makes to present his personal experience as a praxis ("*You say that that's the norm, though*"). In this sense, a first-order act of self-positioning as a person who knows how things go is contested by a second-order act that downsizes the absolute assertion by the first speaker (Harré et al., 2009). The experienced member of the group manages this interaction by suggesting the necessity of trying the medication to know its consequences. Thus, new parents are invited to verify the facts and the proof he is offering by trying the drugs, making their own assessments and reaching their own conclusions (Holt, 2000).

Reversal of critical aspects. Another way of providing evidence within the group is the reversal of criticism directed at ADHD. In the following quote, this discursive strategy is used to counter one of the main criticisms of medications, that is, the fact that they are not

a real treatment but an “on-demand expedient” to calm children down. Parents do not directly oppose this criticism; they accept and overturn it with a positive spin, stating that once the medication’s effect disappears, it is like the child had never taken it. This strategic reversal implies that the drugs have no long-term effects:

Mother 1: Once the effect vanishes, it’s like he never took it.

Mother 3: Yeah, that’s it, exactly.

Father 1: When the effect is gone, it’s all over.

Mother 10: What do you mean?

Mother 1: That if he takes it today, tomorrow it’s like he never took it.

Strategies to counter “derailment” from the shared narrative of the mutual-aid group

The self-help group adopts discourses that construe ADHD as an innate and stable condition. Therefore, the group’s interactions encourage parents, especially those new to the group and to ADHD, to adopt specific perspectives when describing and accounting for their experiences. In this sense, the group educates new parents in the correct interpretation and management of their children’s behaviors. This process is particularly clear when negotiation occurs between competing views in the course of the meetings. There are three main discursive strategies that the group employs to confront and manage accounts of ADHD that contain different and contrasting views from the one shared and promoted by the group: circumscribing, correction, and contestation.

❖ *Circumscribing*

The first strategy used to protect the language that the group has constructed about ADHD is containing derailing narratives and their potential impact within the group. An example of this pattern can be found in interactions in which the participants refer to subjective elements to downsize problems, mainly related to the side effects of medications.

The quote displayed below shows this dynamic. In contrast to the homogenizing trend, whereby the self-help group tends to construct the experiences of parents as identical and reproducible, when parents bring the negative side effects of drugs into the conversation, the experienced members of the group react by claiming the subjective and

unique nature of these effects and by referring to examples of different cases and reactions:

Mother 5: Anyway, my daughter got chubbier [because of Ritalin].

Mother 1: My son didn't, that's subjective!

D6: No, I don't know, I feel like she got fatter in the 6 months she's been taking Ritalin than...

Mother 1: My son is (.) I mean, skinnier, he always looked like a stick (...) my nephew though, my sister's son (.) you have to take the plate away from him. I mean, it's subjective (...)

Mother 5: Well, okay. We'll bring it up on Wednesday during the check-up.

Mother 1: I always find that when someone takes the drug and something is wrong, it's always a matter of dose.

In this sense, parents appear to adopt two different accounts, the empiricist accounts and the contingent accounts, whose characteristics have been discussed by diverse authors in relation to scientists' narratives (Burchell, 2007; Gilbert & Mulkay, 1984).

The empiricist account constructs beliefs and actions as objective elements deriving from the conditions in the natural world. By contrast, the contingent account describes beliefs and actions as elements that flow from personal inclinations, prejudices and interests (Gilbert & Mulkay, 1984).

Indeed, the parents' group tends to use an empiricist account in some circumstances, when presenting the medical understanding of their children's condition as an objective form of knowledge that makes sense of common experiences, but they adopt a contingent account, individualizing experiences and invoking personal and subjective factors, to explain the differences among the group members and to contain the potential negative effects of certain discourses on group cohesion.

❖ *Correction*

In some cases, accounts that do not fit the group's interpretative framework of ADHD and its related issues are reformulated via a collaborative act of correction.

In the following quote, the group, especially its facilitators, intervenes to prevent an account that suggests some manifestations associated with ADHD may be temperamental

aspects, re-orienting the parent toward a biological view of the problem and thus re-establishing the innatist discourse they promote:

Mother 8: That's what I wanted to understand (.) what about growth and adolescence?

Mother 1: The hyperactivity fades, what remains is the attention deficit and the impulsiveness.

Father 13: That depends on personality, though.

Mother 1: No.

Father 1: No, nooo.

Father 13: I think it depends on personality.

Father 3: There is a base, now it stays. It's written.

The corrective action of the group is directed to promote a neurobiological understanding of children's behaviors and, thus, to amend accounts that may evoke the role of educational practices in the management of children. In the excerpt below, the parents collectively oppose the account of a new member who implies the potential usefulness of physical punishment for controlling children by invoking the neurological nature of the problem. The utility of physical punishment is not disowned at a general level, but its efficacy is denied for children diagnosed with ADHD; because the behavior is biologically determined, deterrents have no effect on the body. In Pardeck and Murphy's (1993) words, "punishment serves little purpose if individuals cannot control their actions" (p. 1190):

Father 6: Well back in the day (.) it was normal to spank kids, a spank was admissible. Actually, it was more like, "His father is right to spank him". Today it's more like, "Why does he beat his kid?". And we get bewildered. Back in the day, that was the remedy, that was the remedy for exuberant kids (.) and I remember that my dad's slaps were useful to me, they helped me modify my behavior, and that's good.

Father 1: But it's not about the whipping, it's about you changing.

Father 6: Yes, but...

Mother 12: 'Cause with these kids, there's little you can do (.) you can slap them as much as you want, but eventually you just get the opposite.

Father 7: You can rock them, but they don't get it.

Father 1: Absolutely, it's useless because...

Father 3: It's useless because it's a neurological thing.

Mother 1: Yes, that's true, it has nothing to do with it, it's about neurotransmission.

Father 6: ok, that's why today we need neuroimaging.

Another example of correcting “unacceptable” accounts, related to the management practices of ADHD, is shown in the next quote. A father attending the group for the first time is corrected twice. First, a regular member of the group explicitly contradicts the conceptualization of the child's difficulties as unrelated to a structural lack of ability but instead related to a lack of will (“*It's not a matter of being unable*”). Second, parents counter the comparison made between blackmail and the management strategies they have been taught at in Parent Training courses (“*it is not a trick*”). In particular, because the problem is constructed as the same for everyone, as previously shown, the strategies to confront it should also be shared and standardized:

Mother 1: You should work on negative things one at a time (...) in short time spans, with immediate responses. Like, “Look, if today and tomorrow you pack your own bag, or you put forks on the table, or...” find...

Father 13: He is able to do everything, that's not the point.

Mother 1: It's not a matter of being unable.

Father 13: He always says no! That's his favorite word, no!

Mother 1: I get it, I get it. But if there's something you'd like him to do, you can try to say “If for two days you do this thing we'll go, I don't know, to McDonalds to eat, I'll buy you a sticker album”.

Mother 6: I don't know, I saw that this works when it comes to the PlayStation, which is quite...

Father 13: Yes, but we also tried that, like, “D. if you are a good boy, if you sit properly, tonight I'll tell your mom you can play videogames”. Then he would sit (.) but that's a trick, a blackmail!

Mother 1: No, it's not because...

Father 13: Yes, it is, it's like I'll give something to you if you give something to me, it makes no sense.

Mother 4: If there's a diagnosis...

Mother 1: It's not a trick, you have to reward him with something anyway, it's a reward for having done something.

❖ *Contestation*

The third way to educate parents about the narrative shared within the self-help group is to explicitly contest claims that oppose issues of crucial importance for the group. This type of disjunction is shown in the following quote that reports an interpersonal crash between the two facilitators and a new but experienced participant.

Mother 9: Ritalin, but always, always with the parents working, 'cause we did all sorts of parent training to manage our kid because the drug alone does nothing.

Mother 1: Well, that's not true.

Mother 9: Anyway, the drug alone doesn't work.

Mother 1: I don't agree. It's been 6 years that my son has taken Ritalin. So this is the story (.) no, I'm sorry, you are such an expert and all, so you are saying what you are saying as an expert (...) I'd just like to specify one thing (...) Here in Italy, first of all, the drug is a suggested solution only in very serious cases, first off...

Father 1: No, when she said "No, the drug alone"...

Mother 1: I got what she was saying.

Father 1: ... in a multimodal approach, 'cause it's not enough by itself.

Mother 1: I got what she was saying, I know, I understood. Since it's been years that I've been living this, I understood what she was saying, but that could have been unclear for those who (.) I mean, it's not true that the drug (.) I mean (.) a multimodal therapy is proposed, the drug is proposed, not prescribed, in the worst cases, here in Italy, wherever there are problems in managing these kids and therapies don't work (.) I'm talking about psychotherapy, psychomotor therapy and so on. Those are therapies that don't work by themselves because they [the children] don't stay still, so they propose the drug (...) The drug works, 'cause Ritalin immediately (.) it works immediately, when you give it to them, after 30 minutes (.) perfect!

In the above quote, a novice mother who had considerable experience with ADHD outside of Italy challenges an implicit norm of the group, that is, supporting the value of medication use, by suggesting that drugs alone are not effective. One of the group's leaders explicitly contests this type of narrative and deflects criticisms by locating the use of medication within the specific Italian context, thus mitigating the implications of what has

just been said by a new attendee for the other attendees (Harper, 1994, 1995). The facilitator's discourse aims to neutralize an unaccepted way of talking about ADHD, as well as to regain the position as the expert within the group and the related authoritative status. In this sense, the group's leader discursively performed for an audience (i.e., the rest of the group) to defend and reproduce the collective narrative that holds the association and the self-help group together.

Overall, challenges and lack of conformity to the distinctive dialect of the group are sometimes discouraged and sometimes muted (Barton, 1999), fostering specific (biomedical) accounts on the causes, characteristics and management of ADHD. In this sense, the work of the group in managing the interactions around ADHD is related to potential (mis)interpretations.

3.3.3.5 Discussion

The third part of the analysis was focused on the interactional dynamics of the self-help group and their functions for the group itself. The analysis showed how the parents' group interacts with ADHD in a way that contributes to the mutual identification of the members and to the related production of a shared narrative. Thus, the group discursively manufactures consent and legitimizes certain types of discourse around ADHD using the allocation of different positions, prescriptions and prohibitions, in a "trans-individual operation of discourse" (Hook, 2012). In particular, the group enacts a series of strategies that range from the homogenization of the internal space of the group and differentiation from the outside world to normalization, the use of various forms of evidence, the support of certain beliefs and the correction of accounts that are "not allowed".

The interpersonal dynamics enacted by parents within the confined context of the self-help group are oriented toward the production of a uniform and safe space, which in turn can allow for the construction of a common narrative. This shared narrative seems to function as a ratified and consensual body of knowledge that constitutes for parents not only a language to narrate what ADHD is and means (within and outside the group) but also a resource for legitimization. Indeed, the group, in contrast to the stigmatizing social context that blames them for a large range of reasons, appears to be a setting where parents can find recognition for their experiences, voices, and parental authority.

The narrative of the group, which acquires its legitimacy from its consensual character, represents a means by which parents acquire a position that authorizes them to

actively enter the social space they inhabit without feeling less legitimate than other social actors, such as mental health professionals and teachers. In this sense, self-disclosure and sharing experiences are tools to produce an empowering story that changes parents' positioning and gives them access to certain practices, such as contesting the authority of medical professionals and teachers, reclaiming specific rights, and asserting their competence.

The local form of knowledge that parents produce constitutes a form of "lay expertise" (Novas & Rose, 2000, p. 488). Lay experts are experts by experience, as they generate and authorize their own knowledge. Indeed, parents build and claim their own authority position not through training or membership in a professional group but in relation to their experience, which acquires legitimate status because of its shared and consensual character. In fact, manufacturing consent around the accepted accounts of ADHD is particularly important for the self-help group and its facilitators because it helps to specify and maintain the social order (Filmer, 2012). Thus, parents construct a form of "experiential authority" by associating with one another (Novas & Rose, 2000, p. 503). The practices of mutual disclosure in settings that facilitate identification are significant because they produce a "novel form of authority" based not on training or status but on experience. In this sense, parents act as a sort of "proto-professionals" (Hilton & Slotnick, 2005), who may position themselves as more experts than a lot of mental-health professionals.

Overall, the search for legitimacy and the creation of experiential authority show that the parents' narratives are infused with social and political conflicts about ADHD, and they are linked to the institutional orientation of the parents' association toward these conflicts. In this respect, a significant dimension is the fact that the self-positioning of parents as lay experts who educate one another implies a reconfiguration of their relationships with experts and the related power dynamics (Novas & Rose 2000). Professionals, in the mental health field as well as in education, are not regarded as authorities holding the truth, and parents see themselves as active subjects engaged in political action to support the biomedical understanding of ADHD.

In this respect, by mobilizing notions of hereditariness, parents reproduce a medicalized version of their children's problem (LaFrance, 2007) while they contest and deconstruct medical expertise. This phenomenon recalls the concept of the parental entrepreneur, proposed by Darling (1988). The author, focusing on the development of activism among parents of disabled children, argued that parental activism can be viewed

as a response to the failure of society to provide resources for children and their families; in this sense, these types of advocacy groups represent a challenge to the authority of professional experts. Overall, the small interactions between people and the forms of talk around which they are organized, can be used to understand the wider organization of power (Whelan, 2012).

The discursive practices and strategies taking place within the local context of the parents' meetings not only have implications for the positioning of the self-help group as a collective and active body, but can also be seen as "techniques of the self" (Novas & Rose, 2000, p. 502). The development of a collective narrative (Rappaport, 1993) and a local culture (Gubrium, 1989) are processes mutually created with personal experiences and subjectivity. As Parker (2012) writes, "knowledge and being are woven together". Indeed, the forms of interaction and the ongoing processes within the sub-culture of the group shape the participants' subjectivity in relation to others they recognize as similar to themselves. Thus, there are processes of self-construction taking place within the dialogical and interactive setting of the self-help group (Mason-Schrock, 1996). First, the homogeneous setting and the common language of the group represent a resource to sustain the subjectivity of parents as subjects not responsible for their children's behavior. Second, through a series of strategies aiming to reabsorb conflicts to produce a coherent and consistent narrative, the members are educated within the group about the correct ways to treat ADHD. These discourses, which the parents may accept or not, influence not only their experiences but also their conceptions of themselves, as they do not blame parents for giving medications to their children. In this sense, the group's work initiates new members and renders certain discourses meaningful to them so that they can take responsibility for maintaining these discourses within and outside the group.

The social interactions that take place within the "small place" of the parents' group are not only significant because they produce certain subjectivities but also because they sustain a larger value system (Augoustinos, 2012). Indeed, the local narrative of parents is established in relation to broader discourses that frame the way people make sense of particular issues and assign meaning to them. For instance, the self-help group's discourses are embedded in, and reproduce, normative patterns and dominant themes in contemporary society and the mental health field, such as the value of parental self-sacrifice for children, the innatist discourse, the determinist view of genetic susceptibility, the legitimacy of using drugs to enhance performance, and the frightening character of disability.

Overall, the analysis showed that it is important to understand the “minutia” of everyday discursive exchanges for two reasons: first, parents’ interactions affect their subjective positions; second, the dynamics that take place in small interactions may reveal many things about social activity in general (Hook, 2012).

CHAPTER 4

CONCLUSIONS

The aim of this research was to analyze the discursive construction of ADHD by mental health professionals, primary school teachers and members of a self-help group of parents of children diagnosed with ADHD.

The study has been conducted in the light of two theoretical and methodological approaches that have been integrated: positioning theory (Harré & Van Lagenhove, 1999) and a Foucauldian orientation to discourse analysis (Parker, 2005). In line with these theoretical perspectives, the general aim has been articulated in two sub-aims. The first was to map the content and the organization of participants' positioning repertoire, including both the reflexive positioning, which is used to position oneself, and the interactive positioning, which is used to position others. The second aim was to analyze the discursive strategies and patterns characterizing the interactions among the members of the parents' self-help group.

The results have been presented in the previous chapter and they were organized in three sections, related respectively to the position attributed to the child, the self and mutual positioning of the participants, and the discursive strategies enacted within the self-help group of parents. To summarize, three relevant discursive patterns have been identified: the rhetoric of risk, which transversally crosses the narratives of the three groups of participants and is related to the positioning of the child diagnosed with ADHD; the blame embedded in the mutual positioning of the relevant social actors; and the legitimation towards which the narrative collectively produced by the self-help group of parents is oriented. The specificities of these three discourses have been discussed in details in the analytical chapter, in particular in the paragraphs 3.3.1.4, 3.3.2.4, and 3.3.3.5.

The three discourses of which I have discussed some potential implications are deeply interconnected each other. The connection between these three discourses provides the frame for the social construction of ADHD. The construction of children as potentially at-risk and risky interplays with the mutual attribution of blame among the adults significant to the child. The rhetoric of risk allows adults simultaneously to not consider the problematic behavior of children as their fault and to blame each other for not being aware of the risk and not behave properly to manage it. In this sense, the adult is morally blamable if s/he does not take responsibility for preventing the risks that the child and

his/her environment can encounter. These dynamics have a concrete correlate: all the participants are engaged in the moral enterprise of discouraging the others from choices or behaviors that may turn out to be risky for the at-risk child (Crossley, 2002).

In this sense, the risk discourse creates the conditions for the conflict between social agencies, the medical, the scholarly and the familiar ones. This conflict is primarily based on attribution of individual responsibility: doctors feel legitimized to blame teachers and parents that do not behave in a compliant way, actually exposing the child to the risk s/he embeds; teachers blame parents, because they represent a potential connection between a “toxic society” and the child, and doctors, because their practices are considered potentially dangerous; parents, worried about the risks they see for their children, blame others for not being able to recognize and manage the problem. This deep connection between risk and blame partially distant the results of this study from the idea proposed by other authors, such as Lakoff (2000), according to which the construction of ADHD as a neurobiological disorder implies relief from guilt and blame for all the social actors involved. Differently from this hypothesis, the results presented in the previous chapter show that risk is a locus of blame, even though the biological model of ADHD ignores questions of personal and social responsibility (Pardeck & Murphy, 1993). This is in line with what Kildea et al. (2011) wrote: “the label ADHD appears to offer an explanation, but this begins to dissolve when the reality of everyday experience starts to attach new (and often negative) meanings and connotations” (p. 615) to the same problem that multiple actors have to front.

Enlarging the perspective, this articulation of risk, blame and morality can be read in the light of broader theories on risk, such as those on the contemporary ‘risk society’ (Beck, 1995; Lupton, 1999). As Beck (1992) argued in his theorization, the production and management of risk are considered human responsibility, within a logic that sees human being as choosing subjects in control of themselves, and thus potentially blamable if they do not take into consideration the information they received regarding the intrinsic risks of diverse behaviors.

Mutual blame is also interwoven with issues of authority and different levels of legitimacy, as shown in the section 3.3.2, and therefore with legitimation discourses. This connection is exemplified by the analysis of the dynamics that take place within the self-help group of parents. The group fronts the blame that parents have experienced on a daily basis producing a common narrative, which is based on the biomedical model of ADHD. This common narrative represents a form of knowledge that both re-establishes parents’

moral status, reducing their feelings of guilt, and, due to its shared character, gives legitimacy to parents' experiences, evidences and rights. The effort by part of parents in promoting the medical discourse on ADHD and finding a legitimated space for social and political actions resonates with the contributes of other authors (Conrad & Potter, 2000; Mayes et al., 2008).

The discursive patterns discussed in the chapter dedicated to the analysis and their interconnection have a number of potential implications. In this regard, Foucault's notions of governmentality and normalization have proven to be relevant in the context of this study. This research has shown that these notions are articulated in relation to ADHD in terms of discourses of risk and medical intervention on children, schools and families. These discourses and practices can be conceptualized as programs aiming at teaching people how to monitor, regulate, and govern themselves (Terkelsen, 2009).

The risk discourse and the related practices of prevention and containment establish an essentialist view of children, whose development seems to be framed as a series of steps marking a path to rational and regulated subjectivity (Walkerdine, 2009). Thus, children are framed through pathological discourses (Finn & Nybell, 2001) and subjected to new forms of calculation and disciplining practices (Walkerdine, 1986), which are often branded as supportive care (Stephens, 1995) or legitimized by a "right to health" rhetoric (Frazzetto et al., 2007). In addition, the risk associated to genetic susceptibility, as argued by the biomedical model of children hyperactivity and inattention, may result in neglecting psychological and relational factors and, therefore, in the restriction of the options for managing children's behavior (Hughes, 2007). The notion of individual risk may also lead to an underestimation of the role of socio-political and economic realities, relieving experts, school, and families from the responsibility to interrogate themselves about the major socio-cultural context in which children express themselves (Finn et al., 2010) and about their practices of education, training, and social inclusion (Lubeck & Garrett, 1990). This can prevent the consideration and reform of schools' and social conditions (Weis & Fine, 1993), reinforcing in turn medical institutions.

Foucault's theorization has been also useful in conceptualizing assignation of authority as an effect of social processes that build and reflect unequal power relationships. In the case of ADHD, these processes are represented by the blame game, discussed in the section 3.3.2. Concerning discourses of blame, because the relationships between adults and their respective institutions influence the relationships between adults themselves and

the child, this mutual refusal to recognize the rights and agencies of others may have concrete negative implications for children. It may prevent effective collaboration within the network of parents, teachers, and clinicians, negatively influencing the quality of care given to the child. These dynamics may also influence the practices of child welfare and educational system. For example, blame on professionals and the related pressure to provide a standardized answer may lead to a marginalization of alternative ways of understanding children's difficulties, which may result in a greater tendency towards medicalization and an increased prevalence of the ADHD diagnosis. Moreover, blame exerted on teachers may interact with structural conditions, such as a lack of resources in public schools, large classroom sizes, and rigid programs. This interaction may lead educators to conform to the dominant mode of treating children with medications, with the adverse effect of reinforcing the "psychologisation and therapisation of teaching" (Miller & Leger, 2003, p. 26). Finally, blaming parents may encourage them to adjust to simple and quick solutions to complex problems instead of adopting more holistic and inclusive approaches. This systemic mutual blame may also lead to a further search for biological evidence of ADHD in hopes of resolving this controversy. This approach may reinforce a reductionist view by linking problems to the brain, restricting therapeutic options, and increasing the tendency to provide partial solutions to a multifaceted phenomenon.

The dynamics discussed in relation to the interactions of the self-help group have a range of potential implications, too. They can have beneficial effects, such as cohesion for the group and a relieving sense of belonging for its members. Moreover, the group provides participants with a language and a vocabulary to articulate their experiences and to positively sustain their subjectivity within a stigmatizing social context.

However, as the results show, experiences must be shared in accordance with particular rules, norms, values and forms of authority that govern the setting in which the disclosure takes place. In the specific case of the ADHD group, and potentially in other similar contexts, this dynamic based on the tendency to maintain and repair the orderliness of the group's interactions, might have problematic implications. For example, given that the group constructs a narrative that tends to ignore or counteract information that is incongruous to it, different perspectives may not be valued or may be excluded from the group. In this sense, behind the apparent dialogic nature of the group, there might be a monologic mode of organization.

The results focused on the self-help group of parents offer also insights to conceptualize more extensively the social role and the political action of patients' and their

relatives' organizations, as well as at the contemporary articulation of the relationship between "experts by expertise" and "experts by experience".

Overall, results show that the practices activated around a psychiatric diagnosis, especially in the case of childhood diagnosis, are not the effect of "medical imperialism"; rather they result from the "interaction of lay and professionals claims-makers" (Conrad & Potter, 2000, p. 575), and in this sense, derive from a collective and polyphonic action whereby diverse social actors actively contribute to shape a common problem. As Bourdieu (1984) wrote, "the power to impose recognition depends on the capacity to mobilize around a name" (p. 481); this research has shown the different ways in which diverse groups mobilize around the name ADHD and try to both obtain recognition for themselves and exercise influence on the way the problem should be conceptualize. In this sense, the child and the adults relevant to him/her are located in a network of relatedness, commitments and obligations, where multiple forms of expertise are developed in multiple settings: the clinics or the hospital, the school, and associations of lay people who feel to be similar.

Therefore, the results indicate that ADHD is socially constructed in relation to specific interests and power dynamics characterizing the relationship between the social actors that are relevant to the child and his/her contexts. This conclusion does not implies that genes do not play a role in children's behaviors; rather, it indicates that genetic dispositions express themselves always in interaction with other factors, which are relational, social and political and which significantly impact on the way we understand, represent and front specific problems. Thus, subjects cannot be reduced to a mere expression of their genetic complement (Cooper Dreyfuss & Nelkin, 1992) as illnesses are socially constructed by the bodies of knowledge that aim to explain and describe them (Macey, 2000).

It is important to highlight that ADHD is simultaneously a constructed and a "constructive" object. Participants are involved not only in the process of constructing the child with ADHD, but they are also constructing themselves and others within a theatre of voices struggling for their identity in relation to the "disturbed" child. This has been clearly shown, for example, in relation to the self-positioning of parents as not guilt subjects, the fathers' self-definition as ADHD subject, the subjective frailty and professional uncertainty of teachers, the self-construction of mental-health professionals as possessing an objective knowledge, and the interplay between the notion of a susceptible child with the idea of

responsible parents and teachers. Thus, what is at stake is not only the construction of ADHD and the ADHD child, but also the self-concepts of all the people involved.

In this regard, the use of positioning theory has permitted to address the issues of subjectivity and practices of subjectification without reducing them to the mere result of dominant discourses, which however constitute the frame into which people is embedded, but considering people as active in constructing their world and themselves. In the case of the present study, it has been shown that ADHD, like other psychiatric and medical categories, is not just a diagnosis, but an act of positioning, as every social actor plays an active role in the game of diagnosis and treatment, constituting at the same time the child, him/herself and others, through complex processes of appropriation, reformulation or rejection of different discourses.

The social construction of ADHD is also linked with wider social discourses that are relevant in the contemporary Western society and are related to the social power of medicine and psychiatry, the contemporary context's anxieties about threat and prevention (Liebert, 2010), the relevance of normative and prescriptive conceptualization of development, the delegitimation of public education, and the underestimation of the influence of relational and social factors on children's mental health. These discourses can be located within what Michelle Fine (2010) names neoliberal "shrinkage", that is, the psy-technologies' tendency to strictly focus on individuals, which may lead to shrink people into classified spaces and to downplay the role of contexts in mental distress enactment.

A final reflection on the research process

I conclude the dissertation with a meta-level reflection about the whole research project; it includes an explicitation of my self-position as researcher, with a clarification of how it may have impacted on the study, and a discussion of the limitations and value of the research.

Coherently with my theoretical and methodological perspective, I do not want to propose the findings of this study as a new "correct" standpoint (Parker, 1999). According to the assumptions of discursive approaches, the researcher is considered an active agent of interpretations and the analysis is not presented as the only reading of texts, but as one possible reading of many (Harper, 2006). The goal, instead, was to present a different view of ADHD, showing a further angle for the understanding of usually unproblematized and taken for granted phenomena concerning the relationships between the children's behavior

and their contexts (Mallon, 2007). Therefore, the analysis was informed by the attempt to relocate the child within his/her social context, and to show the effects of discourses - those attaining the status of science and those that do not - and the assumptions of what we take for granted or natural, questioning qualities of “givenness” or “naturalness” (Dean, 1994).

In particular, I aimed at “enlarging the space of the possible” thoughts (Sumara & Davis, 1997) about what the behaviors of hyperactive and inattentive children mean to the adults involved and around what it means to educate and be educated in the contemporary mental health files, especially for children. Starting from the assumption that “knowledge is not made for understanding; it is made for cutting” (Foucault, 1984, p. 88), I did not want to produce new authoritative certainties about ADHD, but introduce some points of disruption in the progressive and incremental build-up of knowledge about childhood hyperactive and inattention. This discontinuity may represent a “cut” with the continuity of past research in the field of mental health and illness, “rather than an intensification [...] of what was already ‘there’” (Osberg, 2010, p. V); this cut may open a new space of thinking about children’s behavior and expressions.

The form of knowledge deriving from this disruption can be used to do something different. For instance, the results of this study have been discussed with some of the participants, in particular the coordinators of the parents’ association, and will be discussed with teachers, to engage them in a process of re-authoring their narratives that may contribute to new and flexible forms of positioning for the child, themselves and others. Broadly speaking, insights coming from this research could be used to develop social network interventions that may help parents, clinicians and teachers to gain access to diverse and different forms of viewing the phenomenon ADHD and managing children’s educational and health trajectories. Working with the diverse social actors relevant to children may create a reflexive space to make sense of complexity (Kildea et al., 2011), promote respect for diverse forms of knowledge, and prevent the minimization and marginalization of others’ voices. Moreover, I wish to circulate my research and have an impact on the medical and professionals’ community through my scientific publications.

The present work has some limitations. First, I argued that the children’s voice has not been offered space within this collage of adults’ narratives - apart from when their words attest to the identification with the label attributed to them and the satisfaction with their treatment – but I have excluded the children too from this study. As I recognize the importance to include children’s perspectives in projects on ADHD (Singh, 2011), I tried to have children participate in the research, but consent was denied by their parents, who

were concerned about the potential stress that might be caused by participation to a research project that was not associated with any skills training or therapy. Exploring the perspective of children diagnosed with ADHD could be a possible line for future research, in order to understand how they construct their own and others' subjectivity and to appreciate their interpretation, experience and responses to their own feelings. Another interesting future research area could be the analysis of the narratives of older adults who were labeled as ADHD in their past, to explore how they (re)construct their experience of having being categorized and medicated.

Second, the group of parents is unique because it is involved in an association that works specifically to promote the social acceptability of ADHD. In this sense, the group represents a minority of parents. Yet, the choice to involve this group of parents has proven to clarify important dimensions concerning new social movements organized around biomedical psychiatry and their relation with experts. Future research might involve parents who are not members of associations or social movements as well as mental health professionals who have an alternative vision of children's expressions.

Third, the methodological approach employed, both in terms of data collection and analysis, makes the analysis a necessarily partial interpretation of the material (Burman & Parker, 1993). However, as already suggested, the research did not aim at collecting representative samples, nor to produce generalizable findings. Overall, discourse analysis provided a useful approach to examining the complex meanings that the diverse multiple actors construct around the diagnosis of ADHD.

I acknowledge that the analysis I have presented, as any other, derives from the interaction between me, and the researchers who collaborated with me, and the material. In the entire process of research I have reflected on my own position and how I might have influenced the study and I recognize that my interests and aims may have impacted on the field of observation and analysis, with particular reference to my orientation to unfold power dynamics between the "gatekeepers" of the ADHD symbolic field and challenge taken for granted hierarchies of knowledge.

In addition to my subjective position, another factor of influence might have been my orientation towards the history of the discipline of which I am a representative (Hook, 2005). I consider social psychology in particular, and psychology more in general, as particular formations of knowledge, whose developments are socially and culturally based and that are contributing to the constitution of "ahistorical, internal and universalizing trends of explanation" (Hook, 2005, p. 28).

To conclude, although this study focused on the specific case of ADHD, the findings could inform thinking around the complex ways in which medical and psychiatric diagnosis, especially in childhood, are constructed by the range of actors involved. Results also extend psychosocial understanding of some phenomena and processes to which literature has already dedicated space: the established tendency towards the somatization of mental distress; the implications of medical discourses and “brain narratives”; the potential role of specific policies, such as budget cutbacks for social welfare and educational systems, in contributing to the individualization of children’s problems; the consumerist trend within the health field and the demanding orientation of patients and their relatives; the power relationships between plural forms of knowledge; the connection between moral issues and concepts of health and illness. Hopefully, this research, despite its limits and its structural interpretative character, will inform future reflection on these important aspects of contemporary health care practice.

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Appendix

Schedule of the focus groups with teachers (original version in Italian language)

Presentazione della ricerca

(Obiettivi e finalità della ricerca, motivazioni per il coinvolgimento dei partecipanti, introduzione al tema del focus, regole generali/tempi, registrazione audio, confidenzialità dei dati)

Come vi è già stato accennato, stiamo conducendo una ricerca sui problemi psicologici e sociali legati ad alcuni possibili disturbi dell'età evolutiva, in particolare l'iperattività, l'impulsività e la disattenzione infantili. Stiamo quindi coinvolgendo diverse figure che, sia a livello personale che professionale, si trovano ad avere a che fare con questo genere di problemi, in particolare insegnanti, genitori, medici, neuropsichiatri, educatori.

In particolare, la vostra partecipazione alla ricerca è importante poiché, per la professione che svolgete, con ogni probabilità avete avuto occasione di incontrare e dover gestire situazioni di questo tipo e perché in ogni caso siete delle figure di riferimento di riferimento sia per i bambini che per le loro famiglie.

Il gruppo di discussione di oggi ha quindi l'obiettivo di approfondire le vostre opinioni e le vostre esperienze concrete riguardo ad alcuni sintomi e disturbi che possono presentarsi nell'età dello sviluppo, in particolare l'iperattività e la disattenzione, e sulle loro implicazioni per le figure coinvolte, quindi per i bambini, per le loro famiglie, per la scuola e per la società più in generale.

Questo incontro durerà non più di due ore. Il mio ruolo è quello di stimolare la discussione tra di voi su questi temi attraverso alcune domande che non prevedono in alcun modo una risposta giusta o una sbagliata. Quello che ci interessa è la vostra opinione e la vostra esperienza. Non ci interessa quanto siete esperte, ma quali sono le vostre idee su determinate questioni, anche se sono questioni di cui vi trovate a discutere qui per la prima volta.

Questa è una discussione tra di voi, per cui l'importante è che vi sentiate sempre libere di intervenire per aggiungere, spiegare, ma anche esprimere un'opinione diversa rispetto a quella delle vostre colleghe. L'importante è che di ogni questione che affronterete pensiate sempre che sia stata trattata in maniera completa e che il vostro punto di vista sia stato

rappresentato. Non c'è un ordine di discussione, siete liberi di intervenire quando e quante volte volete. Il mio compito sarà di dirigere il traffico della discussione per garantire a tutti la possibilità di esprimersi. Vi chiederei ora gentilmente di controllare se avete spento i cellulari per non rischiare di essere disturbate durante la discussione.

Questo incontro verrà audio-registrato per avere una traccia fedele delle vostre opinioni. Per questa ragione di chiederei di parlare a voce alta e uno alla volta. Per il trattamento dei dati verranno rispettate le norme sulla privacy e i dati che otterremo saranno analizzati esclusivamente a livello di gruppo e non a livello individuale. Questo significa che nell'analisi dei dati non sarà possibile risalire a chi ha detto cosa e in questo senso il vostro anonimato sarà assolutamente rispettato.

Presentazione dei partecipanti (Nome, disciplina di insegnamento, anni di esperienza)

Esplorazione di opinioni ed esperienze sui problemi psicologici e comportamentali dell'infanzia

- a. In relazione alla vostra esperienza, vorrei che discuteste tra di voi di quali sono a vostro avviso le principali difficoltà psicologiche e comportamentali diffuse tra i bambini e le bambine con cui voi avete a che fare.
- b. Quali problemi pongono questi disturbi?
- c. Come li avete affrontati nella vostra esperienza di insegnanti? Potete fare degli esempi?

Esplorazione di opinioni ed esperienze su iperattività e disattenzione

- a. Tra i sintomi che possono presentarsi tra i bambini e le bambine, vi sono l'iperattività/impulsività e la disattenzione. Dal vostro punto di vista di insegnanti, quali problemi specifici sono connessi a queste caratteristiche? Perché?
- b. Come avete vissuto e affrontato queste situazioni nella vostra esperienza di insegnamento? Potete fare degli esempi?

Esplorazione di opinioni ed esperienze su ADHD

- a. Vi è mai capitato di sentir parlare di ADHD, che sta per Disturbo da Deficit di Attenzione e Iperattività? Se sì, in che occasioni?

- b. Cosa ne pensate, sia per ciò che ne avete sentito dire sia per ciò che avete vissuto nella vostra esperienza di insegnanti?
- c. Avete avuto occasione di insegnare a bambini con una diagnosi di ADHD? Che tipo di esperienza avete avuto?
- d. Che difficoltà avete vissuto? Come le avete affrontate? Potete fare degli esempi?
- e. Che tipo di rapporto si instaura tra scuola e famiglia quando ci sono bambini che presentano questo tipo di sindrome?
- f. Che tipo di relazione si instaura tra scuola e medici/psicologi quando ci sono bambini che presentano questo tipo di sindrome?

Esplorazione di opinioni ed esperienze sui trattamenti farmacologici

- a. I bambini a cui viene diagnosticata l'ADHD possono essere curati anche con dei farmaci specifici, il Metilfenidato, più noto come Ritalin. Ne avete sentito parlare? Se sì, in quali circostanze?
- b. Cosa ne pensate della somministrazione dei farmaci ai bambini con una diagnosi di ADHD?
- c. Avete avuto occasioni di contatto con bambini che assumevano questo farmaco? Provate a discutere tra di voi delle vostre esperienze anche portando degli esempi concreti.
- d. Ora vi mostrerò due brevi testi che espongono posizioni differenti sul tema della somministrazione dei farmaci ai bambini *. Vi chiedo di commentarli discutendone tra di voi.
- e. Qual è secondo voi il modo migliore per aiutare questi bambini?

Conclusione

- a. Riassunto dei punti principali
- b. Ultimi commenti dei partecipanti (Avete qualcosa da aggiungere?)
- c. Ringraziamenti e saluti

* Testi sulla somministrazione dei farmaci per l'ADHD

Testo 1 (tratto dal sito www.giulemaniidaibambini.org il 17 Gennaio 2011)

La cura è un procedimento terapeutico che, rimuovendo le cause che hanno generato la patologia, porta alla guarigione. Il sollievo e la remissione dei sintomi, per quanto siano eventi importanti, non qualificano un intervento terapeutico come cura. Sia la cura che il trattamento sintomatico devono comunque garantire il rispetto della dignità umana e l'integrità psicofisica, condizione che gli psicofarmaci per l'ADHD attualmente in commercio non sono in grado di rispettare. Non ci sono dubbi che tali prodotti farmaceutici hanno effetti collaterali anche gravi, inclusa la morte del paziente.

I loro effetti si manifestano con la soppressione dei sintomi in presenza di assunzione regolare del farmaco, in quanto l'interruzione del trattamento farmacologico fa riemergere la situazione antecedente al periodo di regolare assunzione. Questo è il motivo per cui si rende necessaria la somministrazione a lungo termine, anche quando essa è sconsigliata dagli stessi specialisti ed a volte dalle stesse industrie produttrici. In un documento del 1999 il National Institute of Mental Health dichiara che: «Gli stimolanti sopprimono i sintomi dell'ADHD ma non curano il disordine, e come risultato i bambini etichettati ADHD sono spesso trattati con stimolanti per molti anni...»

La terapia con questi prodotti farmaceutici di per se non migliora il rendimento scolastico dei bambini, in quanto i procedimenti legati all'apprendimento sono qualcosa di molto più complesso del semplice “prestare attenzione”.

Afferma il Professore Cesare Cornoldi in merito alla prescrizione di Metilfenidato (Ritalin):« E' bene allora ricordare che si possono registrare effetti positivi nel controllo dell'impulsività, dell'iperattività e dell'attenzione, per la durata della somministrazione del farmaco; i disturbi invece dell'apprendimento, della condotta e la difficoltà di interazione sociale richiedono interventi di natura diversa. Generalmente comunque la terapia farmacologica è cronica, perché se viene sospesa la somministrazione del farmaco – in assenza di interventi di tipo psicologico e pedagogico-didattico - il bambino in breve tempo tende a ripresentare la stessa sintomatologia. » (Cesare Cornoldi, Iperattività e autoregolazione cognitiva, Erickson, 2001, pag. 188.)

I benefici a lungo termine dei farmaci non sono stati verificati sperimentalmente e quelli a breve termine non devono essere considerati una soluzione permanente sui sintomi cronici dell'ADHD. Gli stimolanti possono migliorare l'apprendimento in alcuni casi ma danneggiarlo in altri e la durata del loro effetto è troppo breve per agire sul risultato scolastico. Inoltre, non ci sono miglioramenti negli aggiustamenti a lungo termine (Tratto da “*Talking Back To Ritalin*”, 2001, Peter R. Breggin)

Si può pertanto concludere che gli psicofarmaci non migliorano l'apprendimento scolastico, che non curano la presunta patologia ADHD, piuttosto agiscono sui sintomi permettendo una migliore accettazione sociale dei bambini da parte degli adulti. Poca attenzione è stata dedicata a studiare le ripercussioni psicopatologiche a lungo termine che i trattamenti farmacologici hanno sui bambini, ed anche nuove molecole commercializzate come “novità”, apparentemente prive degli effetti collaterali lamentati per gli stimolanti, sono in realtà banali “rivisitazioni” di psicofarmaci tristemente conosciuti in passato per i

potenziali effetti collaterali dannosi nel medio-lungo periodo. I casi meritevoli di attenzione sotto il profilo clinico – sono una esigua minoranza – dovrebbero essere prioritariamente trattati con strumenti di carattere pedagogico (pedagogia tradizionale e clinica), strumenti per i quali è in corso anche in Italia una vera e propria codificazione sotto forma di protocolli standard di intervento specificatamente mirati.

Testo 2 (tratto dal sito www.aifa.it il 17 Gennaio 2011)

Gli psicostimolanti, nei casi sintomatologicamente più gravi, sono necessari e rappresentano un'importante e decisiva risorsa terapeutica, come viene rimarcato da tutta la letteratura scientifica mondiale di questi ultimi quarant'anni e lapidariamente affermato da Barkley in un articolo su *Psychiatric Times* del 1996: "I farmaci stimolanti hanno dimostrato la loro efficacia in svariate centinaia di studi scientifici in doppio cieco, rendendoli non solo uno dei pochi successi nella storia della psichiatria infantile di questo secolo ma i farmaci meglio studiati di qualunque altro farmaco prescritto per i bambini".

Le Linee Guida per la diagnosi e la terapia farmacologica del Disturbo da Deficit attentivo con Iperattività in età evolutiva affermano che "la terapia farmacologica, quando accurata e rigorosa, costituisce la risorsa più efficace e potente per aiutare i bambini con ADHD. Ne consegue che tale terapia dovrebbe essere disponibile per tutti i bambini con ADHD, nei quali l'intervento psicoeducativo risulti solo parzialmente efficace".

Non possiamo permettere che questo importante strumento non possa essere utilizzato solamente per il paventato timore di possibili abusi. Il pericolo dell'abuso è scongiurato dalle direttive previste dal Registro Nazionale per l'ADHD che consentono la prescrizione del farmaco esclusivamente nei Centri di Riferimento. Il farmaco è un "mezzo". Il problema sta nel corretto, saggio e responsabile uso del "mezzo", non nel "mezzo".

L'uso degli stimolanti non differisce molto dall'uso dell'insulina per il trattamento del diabete. Si tratta, cioè, di una terapia sostitutiva - anche se il termine per l'ADHD non è proprio corretto – ma sfortunatamente, come accade per l'insulina, anche gli psicostimolanti hanno un effetto solamente temporaneo. È questo effetto temporaneo che porta a ritenere erroneamente che lo psicostimolante mascheri il problema senza risolverlo. Allo stato attuale essi rappresentano il solo trattamento che normalizzi il comportamento disattento, iperattivo e impulsivo dei bambini ADHD.

Le campagne mediatiche riportano ancora una serie di effetti letali che sarebbero causati dagli psicostimolanti (es. suicidi, infarti) che non hanno alcun fondamento scientifico e che invece creano soltanto panico tra i genitori con figli che, per la gravità del disturbo, stanno assumendo questi farmaci. Gli studi che hanno valutato questi casi hanno dimostrato da tempo che nell'utilizzo del metilfenidato i casi di decessi sono ricollegabili o ad assunzione dello stesso con particolari antidepressivi oppure a malformazioni cardiache congenite e quindi non direttamente ascrivibili al farmaco. I casi di suicidi sono ricollegabili invece alla comorbidità dell'ADHD con altri disturbi (depressione maggiore, disturbi antisociali della personalità, etc.) e/o alla contemporanea assunzione di droghe e alcool.

I media denunciano la presunta dipendenza dal farmaco, mentre tutti gli studi fatti nei decenni scorsi sconfessano totalmente tale possibilità. In un recente studio pubblicato su

Pediatrics di gennaio 2003, si è giunti nuovamente alla conclusione che “non sussiste evidenza consistente o convincente che il trattamento con stimolanti nella fanciullezza o durante l’adolescenza sia associato al rischio di abuso di sostanze nell’adolescenza ed in età adulta...”.

Nei ragazzi con ADHD il trattamento multimodale (costituito da terapia farmacologica insieme alle migliori terapie cognitivo-comportamentali) non si è rivelato migliore del trattamento farmacologico da solo e la terapia cognitivo-comportamentale si è rivelata molto meno efficace del solo trattamento farmacologico. La conclusione è che insegnanti e terapisti devono continuare a fare ogni sforzo con le più avanzate tecniche di terapia cognitivo-comportamentale per aiutare i soggetti con ADHD ma parimenti devono anche comprendere che se non si interviene sui fattori biologici che sono alla base dell'ADHD, non si può sperare in grandi miglioramenti.

Schedule of the interview with mental health professionals (original version in Italian language)

Presentazione della ricerca

(Obiettivi e finalità della ricerca, motivazioni per il coinvolgimento dei partecipanti, introduzione al tema dell'intervista, tempi, registrazione audio, confidenzialità dei dati)

Come le ho già stato accennato, stiamo conducendo una ricerca che indaga le implicazioni di carattere psico-sociale legate ai sintomi dell'iperattività e della disattenzione infantili, in particolare alla diagnosi di Sindrome da Deficit di Attenzione e Iperattività.

Il progetto prevede la partecipazione di diverse figure che, a livello personale e professionale, si interfacciano con le problematiche inerenti il tema dell'ADHD: genitori, insegnanti, psicologi, neuropsichiatri infantili, pedagogisti, educatori, medici. In particolare, ci interessano le principali implicazioni e le eventuali problematiche legate ai sintomi dell'iperattività e della disattenzione infantili e alla diagnosi di ADHD, al suo trattamento e alla relazione con i bambini e con il loro contesto.

La durata di questa intervista non sarà superiore ad un'ora circa. Le chiedo il suo consenso alla audio-registrazione dell'intervista. Questo serve solo per avere una traccia fedele delle sue opinioni. La ricerca verrà condotta nel rispetto delle norme sulla tutela della privacy, e il suo anonimato verrà assolutamente garantito.

Storia professionale relativa all'ADHD

- a. Come le ho già anticipato, mi interessa la sua esperienza professionale con bambini iperattivi, disattenti e con ADHD. Per cominciare le chiederei di raccontarmi la sua storia professionale relativa a questi specifici problemi *(Rilanci: da quando si occupa di ADHD? Di cosa si occupa in particolare? Secondo quale approccio?)*

Processo diagnostico

- a. Vorrei adesso approfondire con lei gli aspetti relativi alla fase diagnostica. Mi può raccontare come funziona solitamente questo processo nella sua equipe/struttura? *(Rilanci: come inizia il processo diagnostico? chi lo suggerisce di solito? quali figure coinvolge? come si sviluppa?)*

- b. Ci sono delle problematiche o difficoltà specifiche che si è trovato/a ad affrontare nella fase diagnostica? Se sì, può raccontarmi degli episodi significativi da questo punto di vista? Come affronta queste situazioni?
- c. Ci sono delle criticità specifiche che caratterizzano la diagnosi di ADHD rispetto a quella di altri disturbi di cui lei si occupa? (*Rilanci: in che senso queste criticità sono specifiche? come le affronta?*)
- d. Qual è il ruolo del bambino nella fase diagnostica?
- e. Qual è il ruolo dei genitori nella fase diagnostica?
- f. Qual è il ruolo degli insegnanti nella fase diagnostica?

Trattamenti

- a. Vorrei adesso approfondire con lei gli aspetti relativi alla scelta del trattamento per l'ADHD. In particolare mi può raccontare che tipi di trattamento si è trovato/a a utilizzare? Cosa ha orientato la sua scelta tra le diverse alternative possibili?
- b. Ci sono delle problematiche o difficoltà specifiche che si è trovato/a ad affrontare nella fase del trattamento? Se sì, può raccontarmi degli episodi significativi da questo punto di vista? Come affronta queste situazioni?
- c. Che ruolo ha la famiglia nel trattamento? Può farmi degli esempi concreti?
- d. Che ruolo ha la scuola nel trattamento? Può farmi degli esempi concreti?
- e. Quando è opportuno secondo lei dare un farmaco e quando non lo è?
- f. Può darmi una sua valutazione circa l'efficacia delle terapie attualmente utilizzate? (*Rilanci: quando un intervento può dirsi riuscito? Può farmi degli esempi? Quando invece l'intervento viene considerato non riuscito? Può farmi un esempio che mi chiarisca come si procede in questi casi?*)

Contesto familiare

- a. Nella sua esperienza, che domanda le portano i genitori che incontra? (*Rilanci: cosa è saliente e prioritario per i genitori? Cosa le chiedono?*)
- b. I genitori come vivono il processo diagnostico? Come si pongono quando lei restituisce loro la diagnosi?
- c. Per quanto riguarda il trattamento farmacologico, quali sono i vissuti dei genitori?
- d. Nella sua esperienza, che tipo di relazione si struttura con i genitori? (*Rilanci: ci sono delle problematiche o difficoltà specifiche che si trovato/a ad affrontare nella*

relazione con i genitori? Può farmi degli esempi? Si tratta di problematiche specifiche? Se sì, in che senso? Come le affronta?).

Contesto scolastico

- a. Che tipo di occasioni di contatto ha avuto con le istituzioni scolastiche, e con gli insegnanti in particolare, relativamente ai casi bambini con una diagnosi di ADHD?
- b. Nella sua esperienza, che tipo di relazione si struttura con la scuola e gli insegnanti?
(Rilanci: ci sono delle problematiche o difficoltà specifiche che si è trovato/a ad affrontare rispetto alla relazione con il contesto scolastico? Può farmi degli esempi? Si tratta di problematiche specifiche? Se sì, in che senso? Come le affronta?)
- c. Nella sua esperienza, come sono i rapporti scuola-famiglia?

Relazione con i/le bambini/e

- a. Ci sono aspetti caratterizzanti della relazione che lei instaura con il bambino che vede per la diagnosi/per il trattamento dell'ADHD?
- b. Quali vissuti e quali emozioni portano questi bambini in relazione al loro comportamento?
- c. Quali sono i vissuti dei bambini rispetto al trattamento farmacologico?
- d. Le è capitato di relazionarsi con bambine con ADHD? Ci sono delle differenze rispetto al lavoro con i bambini? Se sì, quali?

Conclusione

- a. Riassunto dei punti principali
- b. Ultimi commenti dell'intervistato (Ha qualcosa da aggiungere?)
- c. Ringraziamenti e saluti