the language of mental health

The Discourse of ADHD

Perspectives on Attention Deficit Hyperactivity Disorder

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The Language of Mental Health

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Preface

This volume is the third book in The Language of Mental Health book series (Eds. Michelle O'Reilly and Jessica N. Lester). We trace the discourse of Attention Deficit Hyperactivity Disorder (ADHD) across a range of perspectives to critically examine how its meaning has been constructed through the discourse of various standpoints, science, media, parents and personal experience. This will contribute to a growing area of studies that consider how mental health categories are constructed through discourse and will appeal to a wide readership, from health professionals, therapists and academics to social support organisations that have an interest in ADHD, and educationalists who work with children and adults who have special needs. We anticipate that this book will be a resource for postgraduate students with an interest in discourse analysis and also for those working on mental health projects. Although the book is primarily aimed at an academic and professional readership, the lay public have an interest in ADHD because of the debate about its meaning and legitimacy and the history of struggle for medical recognition.

The discursive approach used in this book is a distinctive and different approach to language, focusing on how the meanings and

definitions of both the social and the natural worlds are defined and constructed through discourse and social practices. To this end, we aim to explore how science and medicine has defined ADHD in a variety of ways, how the media have taken up different ideas and represented them to the public as a controversy, and how families and individuals are affected by negative and stigmatising representations and definitions of ADHD and how they resist them. We conclude by analysing accounts of personal experience that help us to understand more about the consequences of ADHD, the difficulties arising from the unmet needs of children and adults, and the potential for more empowering, transformative and enabling narratives of lives and selves.

The themes arising from the ADHD debate are identified early in the book and are thereafter picked up as threads that run through all of the chapters. These are, the constructive power of discourse and culture, the social identities that support different representations of ADHD, the significance of gender in the meaning of ADHD, and the power of discourse as a form of social resistance. The processes we will describe in this book have an application to a wider context than ADHD discourse. We have taken the view that contested mental health conditions share common threads and an analysis of discourse can help us to understand how they have emerged, how they rely on cultural definition for their meaning, and how this has social consequences. We explore the following:

- How medical and mental health categories are defined in both science and lay discourse, and how this draws on cultural representations.
- How social identities that are all too often negative or stigmatic are constructed alongside mental health categories in discourse.
- How the meanings of categories such as ADHD can be defined through gendering.
- How the discourse of mental health is constructed through negative stereotypes of impairment that are both taken up and resisted in discourse.

ADHD as a mental health category has been shaped by a long history of controversy that allows us to explore more closely the 'battles over truth' that have produced its meaning in variable ways. This book aims to map out some of the cultural issues arising from the discourse of ADHD, and we put the case that people who are affected by mental health categories require greater public and professional understanding of how those categories have come about and how they have social consequences.

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Contents

Abbreviations

ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
APA	American Psychiatric Association
BA	British Academy
BPS	British Psychological Society
CDP	Critical Discursive Psychology
DP	Discursive Psychology
DSM	Diagnostic and Statistical Manual of Mental Disorders
EBM	Evidence-Based Medicine
ECF	Extreme Case Formulations
GP	General Practitioner
ICD	International Classification of Diseases
MBD	Minimal Brain Dysfunction/Damage
ME	Myalgic Encephalomyelitis
MRC	Medical Research Council
MRI	Magnetic Resonance Imaging
NHS	The National Health Service
NICE	The National Institute for Health and Care Excellence (formerly The National Institute for Clinical Excellence)

NSPCC	The National Society for the Protection of Cruelty to Children
PET	Positron-Emission Tomography
SSK	Sociology of Scientific Knowledge

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Introduction

Mary Horton-Salway and Alison Davies

Attention Deficit Hyperactivity Disorder (ADHD) has been one of the most debated medical categories affecting children in different parts of the globe. Increasingly this is recognised as a lifelong disorder that can continue into adulthood, a diagnosis that has been reflected by the incorporation of adult criteria into the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, DSM 5 (APA 2013). The diagnosis and medical treatment of ADHD for both children and adults is rising and this is based on the view that ADHD has a biological, neurodevelopmental, genetic basis and, in the UK, it is typically identified by educational and health practitioners who refer to guidelines from the *National Institute of Clinical Excellence* on three areas of behavioural functioning: impulsivity, hyperactivity and inattention (NICE 2009).

Despite the classification of ADHD as a mental health category, there has been no absolute consensus historically and even currently about its status as a health condition, its meaning and causes which continue to be discussed, researched and debated by scientists and health practitioners, educationalists, multi-media and by members of the public. There have been claims, counterclaims and contributions to knowledge

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that have spanned over a century, ranging across perspectives of genetics and the biological sciences, to the psychological, social, educational and health sciences. Perspectives on ADHD and its previous labels have been followed up, summarised and debated in the media and further discussed by the public, families and individuals who are personally affected. This has given rise to a range of discourses about ADHD, constructed and contested through a long and chequered history that informs current understanding.

Science, Fact Construction and 'Ships in Bottles'

To give this a wider context, allow us to unpack one of the theoretical principles informing the analysis in this book. The meaning of any medical category is as much a product of social activity and culture as it is a scientific discovery. According to sociologists who study the production of scientific knowledge, any scientific fact (even an apparently uncontroversial one) can be understood as the product of social constructive practices. This process of fact construction has been demonstrated in studies of the discourse and practices of scientists. For example, Woolgar (1988) described how science came to be regarded as a superior form of knowledge that is set apart from other forms of knowledge and distinguished as a means of discovering objective truths. In the natural sciences essentialists assumed that 'scientific knowledge is determined by the actual nature of the physical world' which is out there waiting to be identified (Woolgar 1988: 27). The scientific method of discovery was developed to define science as a neutral and objective process and a superior and reliable form of positivist enquiry. This, they argued, resulted in scientists being able to describe and represent the nature of the real world of objects, events and phenomena. However, a new wave of relativist philosophers and sociologists of scientific knowledge (SSK) challenged these realist and essentialist views of the world and argued that representations of reality are underpinned by culture and produced through social practices. The task that SSK set for itself was to study and describe how scientific facts were constructed in the discourse and practices of scientists. This approach has queried

positivist views of science that treat scientific discovery as a process of describing a reality that exists prior to scientists' representations.

In his seminal work, *Science the Very Idea*, Woolgar (1988: 32) pointed out that for any phenomenon it is 'always possible to nominate an alternative to any specific proposed meaning'. Elaborations of meaning will always refer back to some other meaning that cannot be fully explained without resorting to a further representation and so on. Woolgar contended that where science is concerned, we accept the status of its facts and representations because science has itself convinced us that its models and practices are reliable. As he put this; 'the perception of reliability is a consequence of its claimed superiority, not a cause' (Woolgar 1988: 32). Phenomenologist Merleau-Ponty also regarded classical science as 'a form of perception which loses sight of its origins and believes itself complete' (Merleau-Ponty 1945/1962). In a circular manner, the idea of science as an objective activity is itself dependent on perceptions that are derived from an ideological framework that supports the idea of positivist science and objective facts (Woolgar 1988). Where error or anomalies might arise in scientific activity and findings, these can be put down to 'technical difficulties' or to problems in the work of individual scientists so that these contingencies do not threaten the robustness of science as a whole (Gilbert and Mulkay 1984).

Woolgar's argument rests on the relativist philosophy criticising the underlying idea that *any* form of representation could be a reflection of a prior existing reality or an objective truth. Social constructionism is a way to explain the social processes that are involved in the construction of science facts and also the process of scientific change, such as the paradigm changes described by Thomas Kuhn (1962/1970). For example, Woolgar described the process of scientific change in the representation of 'unusual rapidly pulsating radio sources' that later became known as 'pulsars'. He describes how this 'discovery' was published in 1968 in *Nature* by Bell and colleagues at Cambridge University in the UK and, at the time of writing his thesis, Woolgar (1988: 64–65) traced the development of this discovery through its 'five separate incarnations', including 'unusual trace', 'interference' extra-terrestrial activity 'little green men', and a 'pulsating radio source'. Since naming the discovery as a 'pulsar', this was then defined as a 'white dwarf star', and became

re-defined as a 'a rotating neutra star', a 'neutron star with a satellite', and 'the plasmic interaction between binary neutron stars' and so on. Woolgar went on to describe how the existence and character of the discovery had depended, not only on a social network of scientists, but also the culture of science for its meaning. The term 'discovery' implied that something was there and had now been found and named, but Woolgar contends that it was not possible to demonstrate this without representations that depend on other representations, and so on, for their meaning. In other words, to be represented in the first place, an object or phenomenon relies on a range of prior 'discoveries' and the current state of scientific knowledge that is treated as fact. Collins (1985) had earlier described such facts as appearing 'like a ship in a bottle'. It is difficult to unpack the processes of construction that built such a ship because it looks as if it has always been there. The existence of pulsars as a named phenomenon (a 'ship in a bottle') came into being through processes of construction that included observation, theorising, representation, re-presentation and fact construction within the framework and assumptions of positivist science. Woolgar's approach to understanding this process was to turn to the discourse and rhetoric of science to describe in detail how scientific discourse 'constitutes the nature of the object it claims to be merely reporting' (Woolgar 1988: 81).

The Context of Health and Illness

In a health context, a social constructionist analysis can help us to deconstruct the 'ships in bottles' of medically recognised categories. For example, coronary heart disease did not appear in official statistics as a cause of death until the 1920s and, as Alan Radley (1994) has observed, the discovery of degeneration in coronary arteries did not by itself make for a medical explanation. Degeneration was attributed to causes that were partly cumulative dietary, physical and lifestyle risk factors and these were theorised as factors having a specific link to congestion of the coronary arteries. Such theories about the part played by lifestyle risks have been further backed up by statistical epidemiological research and the significance of those findings for heart disease are continually being

amended, updated, contested and argued about to this day. However, Radley pointed out how the discovery of degeneration in the coronary arteries had to be combined with explanatory theories about lifestyle risk factors to provide the specific diagnosis of coronary heart disease and a warrant for medical interventions. These interventions were pharmaceutical and increasingly social and psychological as discoveries were made about the relationship of lifestyles, diet and environment. How people experience and manage heart disease is dependent on these ideas and facts for its meaning. Congestive heart disease has now become like a 'ship in a bottle' that depends on a history of theory and positivist science 'discoveries' and validates medical intervention in lifestyles. We mostly take the causes of congestive heart disease for granted as objective truth. Lifestyle choices, diet and the details of public health policy are themselves an ongoing issue of contention, but congestive heart disease remains a medical fact.

Despite the solid appearance of medical facts as having an independent existence, prior to scientist's theories and representations, many phenomena that we know as health conditions only make sense within certain social and cultural contexts (see also Foucault 1973). The boundaries between definitions of disease and normal or social phenomena are far from clear or fixed. Many categories that have been afforded the label of disease might also have been interpreted as ageing. For example, the treatment of the menopause as a 'deficiency disease', rather than a natural stage of a woman's life, made sense not simply because a reduction of oestrogen in women after the menopause had been identified as a physiological fact. As Woolgar argued, there are always alternatives to any specific proposed meaning. The fact of a reduction in oestrogen was therefore not, by itself, 'enough to make this variation into a disease' (Radley 1994: 29). Radley argued that the case for oestrogen as a 'therapy' to correct a deficiency was based on a number of things. Oestrogen was considered effective in helping prevent deterioration of bones and congestion of arteries in older women, but the advantages of the 'therapy' were also grounded in currently held cultural ideas about the maintenance of youthful attractiveness, social worth and women's psychological well-being. The 'treatment' of menopause as a 'deficiency disease' was introduced despite some significant

concerns about long term health risks of the 'therapy'. The clinical risks might easily have been represented as at least as great as the advantages for bone and artery health and for some women they were even greater. Making a case for oestrogen therapy was not the only clinical conclusion that could have been made and the deciding factor in the choice to medicate or not to medicate was, at the very least, a balancing act that was influenced by the social and psychological 'benefits' of the treatment as well as the relative risks to health.

The Social and Psychological Worlds as Medical Business

In addition to the power of natural science to provide representations of reality as fact, these examples of oestrogen 'therapy' and coronary heart disease indicate something of the potential power of the 'clinical-gaze' to define ever wider aspects of the social and psychological world as medical business (Foucault 1973). The origins of medical interest in the social and psychological world has evolved partly with the development of the social, psychological and health sciences that now inform the application of the biopsychosocial model in medicine.

The term biopsychosocial has been attributed to Grinker who introduced it in 1954 to psychiatry 'to emphasize the biologic against psychoanalytic orthodoxy' (in Alvarez et al. 2012: 173). George Engel (1977, 1980) later identified a crisis in medicine which he attributed to medicine's 'adherence to a model of disease no longer adequate for the scientific tasks and social responsibilities of either medicine or psychiatry' (Engel 1977: 589). This so called outmoded model was a traditional 'biomedical model' with its emphasis on the biological and natural sciences and the idea of measurable physical causal variables. This model of reductionist science was used 'by medical scientists for the study of disease' (ibid.: 589). When applied to the study of disease in human beings it implied a philosophy of mind-body dualism in which the body was separate from the mind (ibid.: 591). Not only does this assume that physiological variables can be explained by biology but also that behavioural ones can. Engel also described a simultaneous crisis in psychiatry as a 'question of whether the categories of human distress with

which it is concerned are properly considered "disease"… and whether exercise of the traditional authority of the physician [applying the biomedical model] is appropriate for their help functions.' Paradoxically, the issue for physicians was the extent to which they needed to 'be concerned with psychosocial issues which lie outside medicine's responsibility and authority.' (1977: 589–590). Engel's original contention was that psychiatry had struggled to 'clarify its status within the mainstream of medicine… if indeed it belongs in medicine at all', meaning that they were not really applying the scientific biomedical model (ibid.: 591). Engel quoted one 'critical psychiatrist' (Ludwig 1975, cited in Engel 1977) as saying "psychiatry has become a hodgepodge of unscientific opinions, assorted philosophies and 'schools of thought', mixed metaphors, role diffusion, propaganda, and politicking for 'mental health' and other esoteric goals" (cited in Engel 1977: 589) and it appears that factions were taking up oppositional positions about the proper place of psychiatry in relation to medicine. One solution was to 'exclude psychiatry from the field of medicine, while the other would adhere strictly to the "medical model"…' (1977: 590). The medical model, Ludwig argued, was based on the premise that "sufficient deviation from normal represents *disease*, that disease is due to known or unknown natural causes, and that elimination of these causes will result in cure or improvement…" (cited in Engel 1977: 590, with Ludwig's italics). An article in *Psychiatric News* (19 August cited in Read 2005: 596–597) expressing concern at 'the over-medicalization of mental disorders and the over-use of medications' by psychiatrists, suggests that since then there had been an increased dependence on a 'quick fix' of medication treatment along with a reduction in psychotherapy. So it seems that the second solution described by Engel, that psychiatrists adhering to the biomedical model appears to have overcome dissenting voices that might have otherwise taken a different route. Writing in *The Psychologist*, John Read (2005) applauded the 'dissident viewpoint' expressed by the, then, president of the *American Psychiatric Association* who had the courage to challenge a model that made his profession appear to be 'mere pill pushers and employees of the pharmaceutical industry' (*APA*, cited in Read 2005: 596).

Meanwhile, mainstream medicine struggled to introduce and apply a more complex and inclusive model that was less reductionist and included psychological and social aspects of health. Ogden (2000: 4–5) describes how developments in health psychology based on Engel's biopsychosocial model inform health practice today. Decades prior to that, this model was officially adopted as a model to guide general practice by the Royal College of General Practitioners in the UK (1972). Its holistic systemic perspective focuses on understanding the biological causes of disease, but also considering the cognitive, emotional and behavioural aspects of health, and the social norms, values, expectations and demographics of health that influence outcomes. In practice this translates as practitioners listening to their patients and trying to understand the social and psychological context of illness. This also translates as a more intrusive 'medical gaze' than ever before and, although it can be interpreted as benign, it warrants greater authority to intervene in people's lives. In practice though, if you are a time pressed health practitioner, who needs to provide treatment based on reductionist 'evidence-based' physiological medicine as well as weighing up the relevance of psychosocial concerns and contributory factors, the biopsychosocial model is far from easy to apply or compatible with workloads. In one example of cardiac care in the US, Herman (cited in Soltile 2005: 401) observed the 'physician's lament about feeling either inadequately prepared or time-deprived to provide competent psychosocial care'. He noted that physicians admitted not applying the biopsychosocial model to all of the patients who consulted them at a clinic and observed that referrals to multidisciplinary rehabilitation teams was only between 10 and 20% across the US, with girls, women and older people less likely to be referred (Soltile 2005: 400). These matters prompted Soltile to ask the question; how far had medicine been successful in integrating the psychosocial into the biomedical model? This question was echoed in an article by Biderman et al. (2005) in the same year. Simultaneously, according to Read (2005: 596–567) psychiatrists have embraced a 'bio-bio-bio model' retreating into the arms of the pharmaceutical industry. He wondered 'what happened to the 'psycho' and the 'social' in explanations of mental illness.' Perhaps, he pointed out, 'the supposed integration of perspectives implied by the term 'bio-psycho-social'

model since the 1970s is more illusion than reality'. Not integration at all, he claims, but 'a colonisation of the psychological and the social by the biological' in a way that reduces social and environmental influences to mere triggers 'of an underlying genetic time bomb'. This, he contends, fails to deal with the wider contextual impacts on health.

Shaping the Meaning of Medical Conditions

The two models of medicine described above, the biomedical and the biopsychosocial, are both theoretical frameworks for explaining phenomena and they shape the meanings of medical conditions; both facts and treatments are derived from within these theoretical frameworks. Even at the level of laboratory science, we note Woolgar's and Gilbert and Mulkay's contentions that the representations of natural scientists are not as objective as some might think. Scientists in laboratories construct their discoveries using the language, discourse and current understandings of their time and place and in the specific ideological discourse of an objective positivist science (Gilbert and Mulkay 1984). Atkinson (1995: 61), for example, demonstrated that 'there is no agreement as to a stable world of phenomena' but medical students are taught to 'see' and interpret what is under the microscope in laboratory training. Even the apparently solid entities seen under microscopes have no independent meaning outside the interpretative frameworks used to define them.

As studies arising from SSK have demonstrated, science is as much a socio-political activity as anything else. A wide range of knowledge disciplines, including the social and health sciences have now adopted a broadly social constructionist approach that is based on the philosophical ideas of Berger and Luckmann (1966/1971). Should these be seen as mere philosophical wrangles and esoteric concerns or do they have a relevance to the everyday lives of health professionals, and people who are affected by conditions such as ADHD? We contend that mental health categories such as ADHD are constructed and understood through the lens of shared culture and through the state of current taken for granted forms of knowledge about science, medicine and what

it is to be human. This knowledge can be seen as true, for all intents and purposes, for the present, but constantly in a process of construction, contestation and flux. Since the dynamic forces of construction and process are less visible to us than the finished product of the 'ship in the bottle', we have set our investigation of perspectives on ADHD within that fluid and ever changing context of socially constructed ideas, theories, facts, explanatory discourses and assumptions about human beings, in order to make these more visible.

The aim of this book is to examine how ADHD was, and continues to be, constructed as a category and how discourse about it circulates in knowledge networks in the form of 'translations' (Latour 1989). This does not imply that we are sceptical about the existence and significance of ADHD as a category, or that we are sceptical about the existence of science knowledge or reality for that matter. Current knowledge, what is true for now, is the reality that impacts upon our lives after all. The fact that ADHD is a recognised mental health category within our current systems of classification is *precisely* the phenomenon of interest and we want to see how this 'ship in a bottle' was built and how it is now a fact (albeit a dynamic and controversial one) that affects the lives of many.

Our Approach

To unpick the threads of discourse from a variety of contexts, we will examine both historical and current perspectives on ADHD. We begin by looking at how science, medicine and psychiatry have defined ADHD as a mental health category (in Chapter 2) and then move on to describe how alternative ideas have been taken up by the media, how they are represented and debated (in Chapter 3). We will unpack the matters arising from ADHD discourse produced in the media and how that positions parents, children and adults with ADHD. The parents' perspective is an important aspect of this, so we describe their experiences of having children with ADHD and see how they take up different meanings and resist stereotypes (in Chapters 4 and 5). Finally, but not least important, we consider the personal experience of ADHD through studies of childhood, adolescence and transitions to adulthood,

including the voices of women as a more 'invisible' group in relation to ADHD (in Chapter 6). Our chapters draw on a range of original research that we have undertaken and we discuss a range of literature that represents the history, the media debate, parents' viewpoints and personal experience.

Our approach is language based and informed by social constructionist philosophy about the constructed nature of knowledge and the sociology of scientific knowledge (as discussed above), the genealogical approach of Michel Foucault and topics in social psychology such as categorisation, social identities and gendering. Using an analytic approach that focuses on both the detail of interaction and the wider context of discourse, we apply a critical discursive psychology rationale to examine the role that discourse has played and continues to play in constructing our everyday knowledge of ADHD, how individuals are identified and positioned within that discourse and how they respond to that. In this way, we aim to unpack issues and concerns of participants in the discourse of ADHD and map some of the matters arising and social consequences.

We will argue that the category of ADHD, as with all mental health categories, is not a neutral or independent label which has been consistently applied to a pre-existing disorder (see also Rafalovich 2004/2008). Mental health categories have been produced alongside 'cultural and historical practices that shaped the very meaning of mental health' (O'Reilly and Lester 2016: 5). Although our focus is on ADHD, this social constructionist perspective is also applicable to a wider range of general and mental health conditions, although the process of construction might appear more obvious for those with a history of controversy, such as ME or ADHD (Horton-Salway 1998, 2011, 2012). Controversial histories provide a window on the discourse of medical categories especially where the status of both expert and experiential knowledge is much debated (Horton-Salway 2001, 2002, 2004). These discourses have a bearing on social identities, perspectives on normality and pathology, definitions of mental and physical illness, disease and cultural understandings of mind, body and disability. An analysis of such discourses is a way to unpack the constructive processes that have produced ADHD and how this has impacted upon the lives and selves

of people who are the subjects of this discourse. We focus on how the facts of ADHD are constructed in theory, media and lay discourse and how a mental health category such as ADHD can rely on various forms of cultural representation for its meaning, such as the construction of social identities and forms of gendering that can be both obvious and subtle.

Social Constructionism and Mental Health Categories

This book contributes to a growing body of work which adopts a broadly social constructionist approach to mental health (see O'Reilly and Lester 2015, 2016; Harper 1995, 2013). ADHD is recognised as a mental health category by the *Diagnostic and Statistical Manual of Mental Disorders* (APA 2013). However, the social constructionist approach takes the view that mental health categories do not have an objective, independent, prior existence. As discussed above, this is a relativist perspective on reality that takes the view that facts are embedded in the historical contexts and discursive practices within which they are produced (Berger and Luckmann 1966/1971). Four assumptions of this perspective were identified by Kenneth Gergen (cited in O'Reilly and Lester 2015: xiv) and are summarised here:

1. That we should take up a position of scepticism in relation to forms of knowledge.
2. That knowledge is situated in cultural, social and historical contexts.
3. That knowledge is produced and sustained by social processes.
4. Descriptions of phenomena are never neutral, but are examples of social action which constitute certain ways of being.

Why Discourse Analysis?

The turn to the study of language and discourse in social science is underpinned by changes in philosophical thought, including a turn to pragmatics in linguistics and social constructionism. In linguistics this was a move towards language as a form of social action rather than

treating language as simply reflecting reality (Austin 1962). All forms of discourse analysis share the assumption that discourse is a form of social action and assume that when we describe the world, we also constitute and construct its meaning. Some focus on identifying the broadly defined 'discourses' or explanatory 'repertoires' that are used to make meaning whilst others focus on normative features of conversation and social interactions to see how meanings are negotiated in those contexts (Burr 2003; Edwards and Potter 1992; Potter and Wetherell 1987; Willig 2013). Foucault used the term 'discourse' to refer to all forms of signification, representation, meaning-making, cultural ideas and social practices. Social practices, such as day-to-day interactions, the processes of scientific classification, institutional activities, all social phenomena, theoretical ideas and (medical) categories, are seen as constructed. Knowledge systems in current or historical time and place are regarded as 'regimes of truth' (Foucault 2006). Those who live within their meaning systems are captured by them because dominant forms of truth are largely taken for granted and embedded in the institutional forms of governance that are in place at the time and also because they recognise themselves as the subjects of discourse. This is largely consensual, as are the forms of 'self-governance' that induce the take up of cultural and moral imperatives or self-improvement technologies. These ideas about how discourse functions are some of the influences that underpin the turn to language and discourse in the social sciences and they inform our analytic approach in this book. However they have been relatively 'underexplored' within mental health contexts (O'Reilly and Lester 2015: xiii) although they are especially suitable for the study of lay discourse about mental health (Smith 1978) and also for the study of discourse in mental health contexts (Harper 1995).

A discursive form of psychology is also highly relevant to understanding how social identities are constructed alongside the discourse of ADHD. Rather than taking psychological and social processes as causal factors that contribute to ADHD, discursive psychology is concerned with how the meaning of 'psychological' and 'social' categories are constructed in discourse about ADHD and how they are drawn on to build explanatory accounts. The reasons for this will be apparent in the later chapters of this book as we analyse how biological, psychological

and social forms of reasoning contribute to producing the category of ADHD as an epiphenomenon.

Background on Discursive Psychology

Discursive psychology emerged in the mid-to-late 1980s as a critique of cognitivism (Edwards 1997; Edwards and Potter 1992; Wetherell 2007). Cognitivism is a mainstream version of psychology that has its focus on the psychology of internal mental processes, treating language as representing inner thoughts, ideas, attributions and emotions, or reflecting an external reality that pre-exists our description of it. Discursive psychology has an alternative focus on the actions performed by discourse about such categories such as memory, personality, perception or emotion (Edwards 1997). Key figures in discursive psychology's challenge to the cognitivist perspective included Potter and Wetherell (1987), who applied discourse analysis to social psychology topics such as social identities and Edwards and Potter (1992, 1993), who applied discourse methods to a variety of topics in cognitive psychology such as memory, causal attribution and fact constructing. Antaki and Widdicombe (1998) and Billig (1996) also analysed how people reason and argue and Billig et al. (1988) examined the kinds of ideological dilemmas that people encounter when they are using discourse and how they work to resolve them, maintaining their version as credible.

Rather than studying internal cognitions or mental states discursive psychology is concerned with *how* constructions of mental states are produced in talk. We are interested in *how* people describe themselves, others and events, how they attribute cause or blame, how they account for their actions and how they defend themselves or argue points of view. It is in the context of using language and discourse that individuals negotiate and formulate social and psychological concerns like mental states, beliefs, social identities, social categorisation and attribution of causes (Widdicombe and Wooffitt 1995). The construction of social identity is taken to be discursive and language use is thoroughly implicated in the construction of moral psychological selves. Speakers, for example, are concerned to present a 'credible and creditable moral

position' (Burr 2003: 135) so as a consequence their management of personal accountability and identity is embedded in their descriptions of actions and events (Potter 1996; Hepburn and Wiggins 2007; Burr 2003; Horton-Salway 2001; Widdicombe and Wooffitt 1995; Edwards and Potter 1992). This is why discursive psychology is a relevant and useful approach to explore the way individuals negotiate their understanding of ADHD. As discussed above, ADHD is a somewhat controversial category that has historically been subject to a range of critical attention. Therefore there is much at stake for science, medical practice, the media and the people who are personally affected by ADHD.

Discursive psychology is influenced by theories located within disciplines including sociology (Berger and Luckmann 1966; Garfinkel 1967; Goffman 1959, 1961, 1963), semiology (Barthes 1964), anthropology (Geertz 1973), linguistics (Austin 1962) and philosophy (Wittgenstein 1980). This multi-various background accounts for a range of different perspectives within discursive psychology that have their emphasis on micro or macro contexts or a blend of the two. Micro approaches to discourse, which include ethnomethodology and conversation analysis originate in the work of Garfinkel (1967) and Harvey Sacks (1995) and they both focus on the 'nuts and bolts' of social interactions, how people make sense of one another's talk in such contexts. This has its focus on the organisation of talk (Heritage 1984; Widdicombe and Wooffitt 1995; Potter and Wetherell 1987) and studies how meaning is accomplished through the sequence of conversational turns, as, for example, in 'troubles-talk' (Jefferson 1988). This is a data driven method focusing on what participants make of their turn by turn interactions and it has been used to explore (among others) the process of mental health encounters between professionals and patients to examine how diagnoses are done and how mental health problems are constructed in the process (see Parker and O'Reilly 2012; Kiyimba 2015; Thompson and McCabe 2016).

Taking a wider focus, the 'macro approach' in discursive psychology, focuses on the discourse of wider cultural and historical contexts. This is influenced by the post-structuralist perspective with its focus on culture, social practices, social relations and institutionalised practices. According to relativist philosophy, discourses and practices within any