ADHD and the mass medication of young children is an area of some considerable contestation within professional, academic and popular media, which makes up ‘an intellectual territoriality characterised by struggles over whose knowledge is of most worth’ (Graham, 2007, p. 12). Within this struggle, one of the most hotly debated topics is the question of aetiology – who or what is to blame for this disorder? This contestation is well illustrated by the following statement from the National Institute of Health in the U.S., who after weighing various different perspectives acknowledged that; ‘after years of clinical research and experience with ADHD, our knowledge about the cause or causes of ADHD remains largely speculative’ (NIH, 1998). Yet leading neuropsychiatrists in both the UK and the US repeatedly point to the mass of evidence favouring a neuro-genetic aetiology for ADHD, which, they claim, is much more robust and precise than for most mental disorders (Barkley, 2006, Taylor, 2006). Many critics contest this body of research for, among other things, methodological weakness (Breggin, 2000, Cohen, 2001, DeGrandpre, 2000, Leo & Cohen, 2003) and the influence of corporate pharmaceuticals (Baughman & Hovey, 2006, Southall, 2007, Timimi, 2005).

Social critique is often seen as unsupportive for those in families, schools and health services grappling with the ‘reality’ of ADHD in their everyday work, in comparison to which medicine is able to project a ‘value-neutral’ self-image. Recent responses in the critical literature have focussed on ways to inhabit this dichotomy of critique and support. This has often been pursued through empirical work with the everyday reality of ADHD both in schools (Graham, 2006, Graham, 2007, Hjorne, 2006, Muthukrishna, 2006, Prosser, 2006) and families (Bennett, 2007, Carpenter & Austin, 2008, Ongel, 2006, Singh, 2003, 2004, 2005). The contestability of the ADHD phenomena is important as it has bred a politically charged discourse, and this has repercussions for the everyday experience of the disorder. However, in this paper it is less the ‘condition of ADHD but the condition of motherhood of these children’ (Carpenter & Austin, 2008, p. 40) that is to be explored.

It has been suggested that women are more vulnerable to discourses of responsibility and blame and to the belief that any problem with their children is their fault (Carpenter & Austin, 1999), and mothers have told stories of the feelings of guilt, shame, responsibility and blame which attend the responsibilities of parenting a child with ADHD (Bennett, 2004, Singh, 2002). Within some of the more prevalent medical opinion on ADHD, the parental role in the production of behavioural problems in their children should be played down, in favour of neuropsychiatric and genetic discourse. As a recent ‘international consensus statement’ puts it;

’To publish stories that ADHD is a fictitious disorder or merely a conflict between today’s Huckleberry Finns and their caregivers is tantamount to
declaring the earth flat, the laws of gravity debatable, and the periodic table in chemistry a fraud’ (Barkley, 2002, p. 90)

Things are not always quite as black and white as this suggests, however, as can be read on the same page of this same statement;

‘This is not to say that the home environment, parental management abilities, stressful life events, or deviant peer relationships are unimportant or have no influence on individuals having this disorder, as they certainly do’ (Barkley, 2002, p. 90)

National health guidance for effective treatment of ADHD involve not only stimulant medication, but also various psychosocial interventions such as family therapy and parent training (NICE, 2006, NIMH, 2006). As such parents hold a somewhat ambivalent place within this field, with the desire to defame those who lay blame in the immediate society of the family tempered by the admission that this environment must mean something.

Further complicating this picture is what has been called the ‘awkward alliance’ (Graham, 2007, p. 13) between several different medical and mental health discourses within prevalent understandings of ADHD. The definition is one made by the American Psychiatric Association, yet this definition is widely recognised not just by psychiatrists but paediatricians, general practitioners and clinical and educational psychologists also. While professional boundaries are blurred and many individuals will not fit a neat discursive position, it could be claimed that psychiatric and paediatric responses to behaviour disorder reflect more of a biological developmental approach while the discourse of psychology, while still developmental, may emphasise alternative, ‘cognitive’, ‘psychosocial’ or ‘environmental’ factors in their approach. This does not mean that attention to variables associated with the family are the sole province of one or the other discourse, merely that the family will be differently implicated in both the aetiology and projected response to the child’s problems.

In terms of response this difference could be read in a doctor’s recommendation that the child should be put on medication, while a psychological response may recommend a more behavioural therapeutic approach. The psychological response carries the most obvious responsibilities for parents in terms of behaviour modification techniques, which in turn carries a fairly obvious indictment of their current and past behaviour in relation to their children. However, one should not ignore the somewhat more invisible work of parenthood with regards medication (Singh, 2004, 2005). I will return to this work of parenthood below, however first I would like to take a look at some of the psycho-medical perspectives on ADHD.

From a more biological developmental perspective, various aspects of pre- and post-natal physical development implicate the actions of the mother in the presentation of behaviour. Frequently cited, though inconclusively evidenced, is the effect of gestational exposure to cigarettes or alcohol (Bhatara et al., 2006, Rodriguez & Bohlin, 2005).

Within the psycho-social developmental perspective the importance of mother-child ‘attachment’ (Halasz et al., 2002), maternal ‘attributions’ (Collett & Gimpel, 2004) and maternal psychopathology (Banks et al., 2008, Harvey et al., 2003) are all implicated in the production of the child’s behavioural anomalies. These approaches are epitomized in the desire of one group of psychologists to re-brand ADHD as ‘attachment-deficit-hyper-reactivity disorder’ (Halasz et al., 2002). This
alternative translation of ADHD is offered most forcefully through the hypothesized impact of post-natal depression on children’s behaviour:

“In those earliest interactions, the infant of a depressed mother will mirror the mother’s difficulties both with facial expressions as well as with measurable changes in brain activity” (p. 4)

This leads to the ‘conceptually creative hypothesis’ (p. 4) that:

“the traumatic experience for the infant who is not held in his mother’s mind due to his mother’s depression displays symptoms of early trauma characterized by hyper-vigilance and difficulty focusing on anything other than the threatening situation. Over time, the picture that emerges resembles ADHD” (p. 4)

This theory takes what could be judged a ‘natural’ response to the accumulation of work and emotion associated with the post-natal lifeworld and labels it ‘depression’. It then assumes that this ‘depression’ will not only represent the child as having no place in ‘his’ mother’s mind, but that this fact will be read consistently by the child and reacted to in a consistent manner. The formula is complete with the convenient ‘resemblance’ to ADHD.

Additionally these excerpts illustrate a somewhat more complex picture of professional perspectives on ADHD than is evidenced in Barkley’s claim that the indictment of the family in the account of ADHD is solely the province of ‘the wholly unscientific views of some social critics in periodic media accounts’ (Barkley, 2002). For here is an account, in the ‘scientific’ language that neuropsychiatrist Barkley may recognise as allied with his own, which places mother and son at the very centre of a judgemental and reductive hypothesis.

A culture of mother-blame

Finally, far from being ‘conceptually creative’ the attachment hypothesis of Halasz et al. appears practically unchanged from past psychoanalytic theories of psychopathologies such as schizophrenia lying in the ‘frigid’ mother. Singh traces the ‘schizophrenogenic mother’ to the immediate post-war period and the German psychoanalyst, Freida Fromm-Reichmann:

‘The schizophrenic is painfully distrustful and resentful of other people due to the severe early warp and rejection he encountered in important people in his infancy and childhood, as a rule mainly the schizophrenogenic mother’ (Fromm-Reichmann in Singh, 2002, p. 583)

Almost every element of this argument, right up to the two-way gender indictment of mother and son, is reproduced in the attachment hypothesis on ADHD over 50 years later. Singh argues that texts such as these, along with more populist writing such as Dr Spock’s Baby and childcare created the detachment of which they spoke in the relation between mothers and sons. For Singh, the shared assumptions over ‘a child’s “adjustment” or “pre-delinquent” states’...combining psychoanalytic premises with biomedical understandings of disease prevention’ could be read from the mental hygiene movement, through Spock’s manual, down to the articles in popular women’s magazines of the same period.

Where Singh cited Dr Spock, today we have hundreds of books and publications aimed at parental guidance regarding ADHD which invoke the same detachment and vulnerability. As one such book opens:
'Do you feel that you can no longer cope with your child’s behaviour, that you and his school have done everything possible for him and that he is beyond redemption?' (Train, 2005, p. 11)

Concerning images once again abound; the gendering of his, him and he: the aberrant child in need of ‘redemption’ for his sin; and, the manipulative condescension of the personalised style of address: this is an account about ‘you and your ADD child’, to borrow the title of another such text (Wallace, 1999) The account continues:

‘You may deeply resent him because his behaviour has turned you into a physical and nervous wreck, destroyed your career or your marriage, caused friends to desert you and neighbours to shun you. In your eyes he may have become the embodiment of everything you hate in yourself and others. In essence, you may feel that he has made your life a misery and that you have had enough.’ (p. 11)

Having opened up this essence of exclusion, helplessness and loathing, the account moves in for the reassuring kill; ‘you should not feel guilty about this’ (p. 11), before launching into whatever miracle cure it has for the helpless mother and demonic child. The deployment of this personalised and emotive language, marks passages such as these in using ‘words that perform in that they evoke images that increase the effect of the statement’ (Graham, 2007, p. 11). This ‘performance’ only serves to bring attention to the attempt which this genre represents, to manipulate ‘the active engagement of individuals in the promotion of their own bodily efficiency’ (Rose, 1999). The representations of parents, children and families that can be found in these texts can be read as what Donzelot referred to as ‘the regulation of images’ in which he describes the diffusion of the methods of psychoanalysis throughout the social body (Donzelot, 1979). For Donzelot, fragments of this ‘medico-psycho-pedagogical center’ are to be found throughout social institutions and discursive plains; ‘in a discrete room of the divorce courts, in the services for the protection of mothers and children, in the birth-planning centers, and in the sex-education organizations’ (Donzelot, 1979, p. 169) and, here, in the ‘support’ literature for parents of children with ADHD.

Through her analysis of the mental-hygiene movement, cited above, as well as through empirical work with parents and children, Ilina Singh coined what she calls a ‘culture of mother blame’ within ADHD discourse. Predicated on the proliferation of images of inadequacy, itself based on some conception of ‘naturalness’ in maternal relations, within which ‘mothering with ritalin’ (Singh, 2004) becomes a similarly ‘natural’ response to the work of parenting the behaviourally disordered child. Parents of disorderly children, due to their position of mediation between the public worlds of medical and educational discourse and the private space of the family, ‘occupy space in most positions within the web of blame’ leading to the claim that ‘parent blame is both specific and scattered, both highly visible and diffuse’ (Singh, 2004, p. 1194).

For Singh, parents seek absolution from their self-images of blame and inadequacy, through psycho-medical discourse, in which neuro-genetics and Ritalin become panaceas; currencies by which to make the exchange; ‘mother-blame-brain-blame’ (Singh, 2004, p. 1194). As Donzelot’s triad reminds us, however, this is also a pedagogical discourse, one by which parents are expected to regulate themselves, ‘learn’ about themselves and conceptualise parenting as a ‘project’ or, to borrow Foucault’s term, a ‘technology’ (Foucault, 1988). In this instance the technology lies in techniques of self-exploration and codification
epitomized by the therapeutic confession; ‘the means of access to and transformation of the alienation, repression, and fragmentation of the self in modern times’ (Rose, 1999, p. 217). Looking back at the passage cited above from Train's support text, these metaphors – alienation, repression, fragmentation – all seem relevant to the production of the need for therapeutics, by such means these texts 'systematically form the objects of which they speak’ (Graham, 2007, p. 1).

One of the ways this formation may take place is through what Hacking calls 'the looping effect of human kinds’ (Hacking, 1995), which starts with a subject becoming conscious of a description about them and by which they must then modify their action; whether or not they see the description as fitting consciousness of the description demands them to place themselves in relation to it. However the description is not as dynamic, as open to change, as experience, so 'what was known about people of a kind may become false because people of that kind have changed in virtue of what they believe about themselves’ (Hacking, 1999, p. 34).

The story told here begins with parents becoming conscious of their position in a discourse, making themselves active in relation to that discourse and in relation to what they believe about themselves. An attempt is made to falsify that discourse about them, encouraging the means by which their action may loop 'back to force changes in the classifications and knowledge about them’ (Hacking, 1999, p. 105). However, what this story also tells is that this is a dangerous position to adopt, and that 'the current mode of being’ (Hacking, 1999, p. 121) a parent of a child with ADHD is one of considerable discomfort. Having established the social relations of blame and absolution through the above analysis of the attachment theory and the popular representations contained in parent 'support' texts, this paper will make further use of Singh's concept of mother blame and analysis of my data will take the form of an investigation into the 'loop' in which, through a medicalised advocacy 'mother-blame is reconstituted rather than abolished’ (Singh, 2004, p. 1194).

**Connecting the individual to the social**

Methodology is informed by Dorothy Smith’s institutional ethnography (Smith, 1987, 2005). This method makes the everyday worlds of participants the point of departure and proceeds by exploring ‘the social relations individuals bring into being in and through their actual practices’ (Smith, 1987, p. 160). The method was first advanced by Smith to bring attention to the many forms of women’s and mother’s work which dominant sociological paradigms tended to conceal; 'in this literature mothers appear in a peculiar way as necessary links in a causal process, but without agency (Smith, 1987, pp. 163-164). As such the objective is to pursue this 'invisible work' through the action, intention and rationale of the individual within the context of the social relations which connect the individual world to institutional ideologies. In such a way research of this kind aims to cut through the forms of social knowledge in which mother’s work, ‘their thinking, the effort and time they have put in, and the varying material conditions under which their work is done do not appear’ (Smith, 1987, p. 164)

This critique of 'social knowledge’ and ‘institutional ideologies’ proceeds according to a conception of discourse derived from Foucault, which at its most general denotes a ‘group of signs’ or ‘verbal performances’ (Foucault, 1972, p. 120). Smith operationalises this conception as follows:

we want to address discourse as a conversation mediated by texts that is not a matter of statements alone but of actual ongoing practices and sites of
practices, the material forms of texts...the methods of producing texts, the reputational status structures, the organization of powers intersecting with other relations of ruling’ (Smith, 1987, p. 214)

In this conception the ‘social knowledge’ to be excavated can be seen as an example of what Foucault called a ‘discursive formation’, which he used to refer to statements which share a rationale both in the objects they approach and the way they approach them, thus Foucault spoke of ‘clinical discourse, economic discourse, the discourse of natural history, psychiatric discourse’ (Foucault, 1972, p. 121)

While institutional ethnography was originally conceived as a ‘sociology for women’ (Smith, 1987, p. 49), its aim ‘to find the objective correlates of what had seemed a private experience of oppression’ (Smith, 1987, p. 154) does not limit it only to this group. Smith conceived institutional ethnography as a way of connecting individuals to the relations and systems by which individual action is conceived and from this she states ‘it has to work for both women and men. It has to be a sociology for people’ (Smith, 2005, p. 1)

This last point is important for this study where though the mother’s voice is often the dominant one, and where it is the mother who is perhaps more tightly regulated by the image of naturalness, it is also a story of fathers, sons, schools and professionals.

**A social critique of biological nature**

The data used in this paper is drawn from a doctoral project investigating the social production of psychiatric discourse through the school and family. The study combines an ethnography of the early years classroom with interviews conducted with the families of two children with a diagnosis of ADHD. As well as the interview data, documentary data in the form of letters between home, school and doctor and personal diaries were analysed. Parents recruited for the study by responding to a message sent from the administrator of a support group for parents of children with ADHD. Upon contact parents were sent full information on participation, and, if they wished to proceed, were asked for some brief background information, and were informed of their right to withdraw. As such recruitment was confidential, voluntary and with no binding obligation. All names of people and places have either been altered or removed to protect anonymity.

The data here is drawn from two interviews, the first was conducted with both mother and father present (family 1) the second was conducted with just the mother (family 2). In each case semi-structured interviews of between 1-1½ hours were conducted, recorded digitally and later transcribed according to accepted conventions. Prior to interview participants were told of some general areas that were of interest. These included details of the events which had led to the diagnosis; details of the everyday work associated with the disorder; and, details of the social relations – school, authorities and medical professionals – which connected the family to the institutional organisation of diagnosis and management. These areas were pursued through open questions with the individual stories of each participant guiding discussion as far as possible. This is in keeping with the aim of institutional ethnography, which is to learn “how things work” through open-ended inquiry into “everyday life work”; ‘the point of interest is the informants activity, as it reveals and points toward the interconnected activities of others’ (DeVault & McCoy, 2006, p. 25).

As such this was partly a strategy to hand back some of the ownership of the means of knowledge production to informants and one way in which I tried to
minimise the privilege of the researcher position, exploring rather than controlling the co-construction of the interview. This meant not only being led by each parent’s story, but also encouraging the reverse exchange, inviting parents to question me, both about my own relevant experiences and the rationales which I may be pursuing through my questions, both within the interview and later in reflecting together on transcripts. The attempt with such tactics is to acknowledge and explore the ‘active’ nature of knowledge production through the interview context (Holstein & Gubrium, 1995).

**Participating families**

Family 1 is made up of mother and father, Louise & Mike and their three sons. Middle son, Liam, was 7 years old at date of interview (30th November 2006) and had been diagnosed with ADHD aged 5. At this time Liam was in a special class at school and his parents were waiting upon a decision about his statementing allowance. The family live in a predominantly working class area of an ex-mining town in the South West of England, when I met them neither parent was working in order to make time for the children, particularly Liam.

Family 2 is made up of mother and father, Sian & Neil and two sons. Eldest son Charlie had been diagnosed with ADHD at the age of 7, but had subsequently progressed to secondary school and by the date of interview (14th March 2007) was approaching his GCSE exams. The family live near a small town in a rural part of South East England. Sian had not worked since prior to Charlie’s diagnosis, though Neil was in full-time employment.

That both families were contacted through parental support networks has some significance for the argument. Membership of such networks implies an active role in the everyday work of parenting a child with ADHD. The experiences detailed below explore what this advocacy role meant for each parent in the implications it had for the way they were viewed and viewed themselves as parents. In terms of self-image, I offer ‘active mother’ as a distancing from the images of the inadequate mother, ‘characterized by her lack of sufficient care, positive emotion, knowledge, insight and action’ (Singh, 2004, p. 1196).

**Active parenting**

For each family, this active work of parenting starts with the attention to and identification of behaviours in their children which they deemed problematic or abnormal. For Louise (L) and Mike (M) the initial basis for abnormality was in Liam’s divergence from both his brother’s behaviour and an external standard of expected young-child behaviour;

L About three years ago I started looking into it because I knew my child was different to my older child then. From three months old we knew that he was completely different; even just sitting in the bouncer. He was sat in the bouncer but he was just constantly on the go...He wouldn't sit and watch the telly. He has never ever played with a toy. I'm not saying that if there was a baby sat here now with a car he would get the car and push it up the room but then that's it. You know, he's never done something and it's lasted for an hour.

M And the concentration level has been no more than seconds
From this basis of over-activity Louise recalls typing ‘hyperactivity’ into an internet search engine, which is where she first learned about ADHD. Once this conclusion over the nature of Liam’s problems had been reached the work of parenting became one of actively seeking support;

L from about eighteen months I was taking him down the Health Clinic asking the health visitors, doctors, to sort him out and they just said that he was coming up to the ‘terrible two’s’ and when he was two it was the same and when he was past two it was - no he’s still got the ‘terrible two’s’. Well he had the ‘terrible two’s’ for about two or three years. So, like we said, two years ago we went down to the doctors and said that we were not happy with this - this child is different to other children and we pushed and pushed and pushed to see a paediatrician first

What a medical label such as ‘ADHD’ offered to Louise was the chance to think of her son’s problems as something “other”, something which was separable from ‘him’ an internal ‘evil agent’ (Hacking, 1999, p. 113) which acts upon ‘him’ and which could be ‘treated’ as such. In the above comment, the institutional response that she received, which was one of ‘ordinary’ boyhood encapsulated in the ‘terrible two’s’ image, was unhelpful for Louise as it offered no means to re-normalize the family environment according to an external abnormality over which they had no control. What this frustration leads to is the active role of ‘pushing’ in order to try and essentialise and encapsulate Liam’s difference as outside ‘ordinary boyness’.

A similar story was also told by Sian (S) in relation to Charlie, who at 3 years old was;

S Very physically aggressive; he would attack me and thump, kick, bite; trash the house; pull curtains off the walls; broke toys; ripped clothes. We’d have huge tantrums that would last for two or three hours at a time where he would be inconsolable. You couldn’t reason with him at all.

As Sian did not have other children of her own to compare Charlie to, it was not until he reached school that she was able to start thinking of his behaviour as something ‘other’;

S being the oldest child you always think that it is you being a bad parent who can’t cope with the way they are and that sort of thing. It’s only when you start talking to other parents and all the things you’ve tried have worked on other children but they don’t on your own. Like taking toys away and stopping them watching telly and that sort of thing. Whatever you’ve tried to control his behaviour has not worked whereas on their children it worked

From this perception of abnormality, Sian encountered various media through which she came to the conclusion of ADHD;

S I’d actually seen a programme on telly about a young girl and I thought: ‘That’s what he does!’ So I rang up the NHS help line
and they sent an inset pack out that came from MIND and they suggested a book in there to read and I went and bought this book and virtually every page I turned over was about him.

R1 What book was that?

S Dr Green: ‘Understanding ADHD’. And I could highlight virtually on every page and it was him.

Like Louise and Mike, Sian also received what she perceived to be unhelpful responses from outside agencies;

S I was referred to [local mental health services] and they came back and they said that they couldn’t see him because he wasn’t suicidal. So I was referred to another clinic and they said that perhaps I should go on a behaviour management course and that it was a parent issue and not a child issue.

With the same frustration for this as an explanation, Sian took on a more ‘active’ role in gaining the responses she sought;

S So I spoke to [a parental support agent] and she suggested that there was a [specialist clinic] and perhaps we could go down there. So I spoke to the GP and he said that he would refer us and that the local authority would fund him to go down and he said that it would take about a week to get through and six weeks later we still hadn’t heard so I rang him up and asked him what was going on and he said that he hadn’t heard but he’d ring again and I said: ‘No, I’ll ring. Give me the number’. So I rang up the Health Authority and they agreed to fund him to go down for an initial assessment and they’ve been paying ever since.

Though details differ, both accounts so far have followed a similar pattern whereby a perception of abnormality will lead parents into contact with professional discourses who will not always provide the responses they require in order to initiate the blame exchange that they seek. What this means is that in order to help their children, parenting has to become active ‘self-help’ (Giddens, 1991) through which parents attempt to re-appropriate specialist information according to their own knowledge and experience of their children. The next section will go on to discuss what some of the consequences of making oneself such an active agent may be.

‘It’s about us as parents’: Struggling for agency

This analysis starts with the everyday work of ADHD for each of these parents, firstly, in the active role taken in terms of gaining some recognition and support for their children, in the face of institutional knowledge beneath which their agency was frequently undermined and their knowledge subjugated. This relation was frequently enacted through dealings with the school, as Louise says in relation to trying to get Liam assessed for learning difficulties:

1 Researcher
Yes, he's going for a test for dyslexia now. Again I've been telling the school that he's dyslexic. Alright I'm no professional but I am a mother and I know when he is struggling. So I've talked to the SENCO for over a year to try and get an assessment for dyslexia but they said: 'No, no, no, there's nothing wrong with him'.

This assertion of the legitimacy of her knowledge as a mother is testament to the agency that Louise feels she needs in regard to decisions being made about Liam, which she is currently being denied, she continues:

with a statement we wrote the letter ourselves and sent it off to them ourselves. The school was going to do it but we got in there first so I wanted to refer Liam myself but she said that I couldn't do it.

For Louise, the institutional ideology of the school has denied her the agency to influence decisions both regarding the specialist assessments Liam receives in school and his statement. The frustration both Louise and Mike feel in terms of the unresponsiveness of the school is well illustrated in Mike's comment that;

Up to now we've had two years of education where nothing has happened at all. Basically we've had enough, haven't we? Come August we said that we can't cope with this anymore. We've had two years of going back and forth between the school trying to solve this: trying to solve that; going to the psychiatrist once a month and nothing was getting done. So really we took it in our own hands and said that we weren't having it anymore. We're not going to allow it to happen.

Mike's statement makes clear reference to the difficult position of mediation that these parents find themselves in 'at the junction between the private world of the family and the public world outside' (Vincent, 2000, p. 27). The 'public worlds' that they encounter are those of education and psychiatry, yet what they perceive as their duty; what they will not 'allow' to happen in terms of Liam's future, has been introduced to them through discursive means which, to some extent, undermine the public/private dualism.

Where once it may have been useful to consider the 'particularistic' family feeding into the 'universal' values of school (Parsons, 1961), what can be read through these accounts is that new universalisms proliferated through 'psy-medi-ped' discourse have re-formed the social body according to much more diffuse distinctions. Ready-formed norms of behavioural development, which are conceived as acting 'regardless of culture' (Barkley, 2002, p. 89), and complete with a set of 'outcomes' by which the future can be known and subverted, are one example of this invasion, this 'technologising' of families in which 'parenting' has shifted imperceptibly away from something that is 'natural' towards something that has to be learnt and that can be perfected, or at least improved' (Vincent, 2000, pp. 22-23).

What the parents in this account deem 'natural' parenting, is an active role whereby they encourage others to become literate in the same social behavioural discourses as them. That biological inference is deemed 'genuine causality' (Hacking, 1999, p. 123), even by such knowledge skeptics as Hacking, gives
biology some claim to this term ‘natural’ and sustains the image of the self-improving ‘good parent’. Yet what can be seen through this analysis is that ‘natural’ should be re-termed ‘normal’ according to whichever social knowledge is most desired. ‘Normal’ draws greater attention to the social and political production of scientific knowledge, to the socially produced environment of the family, and to the socially produced regulation of parental imagery.

In the following excerpt, Sian experiences a similar regulation, firstly through the loss of personal agency in an exchange with her GP:

S  
So I had to go back to the GP and explain it to him that we needed the pure Ritalin but he said that he wasn’t prepared to give me that prescription and he asked why I needed the pure Ritalin. You almost feel like… I actually said to them: ‘Well I’ll tell you what I’ll do. I’ll bring my son in when he’s off medication and you can keep him here for a week if you like’.

Through further investigation Sian found out that this refusal by the GP was the product of a correspondence between the school and the GP about Charlie’s medication, which had been conducted without Sian ever being contacted:

S  
But I thought: hang on a minute! You have nothing to do with him. You’ve never seen him and you can’t judge from the outside. And it was only because I went to the GP that I found out about this letter and it had been openly discussed at a teachers meeting with outside teaching advisors there and everything and nobody had asked permission. So I sent a copy of the letter to [Charlie’s specialist] and he got very stroppy and wrote straight back saying that this child has been under our care since he was eight and that the school weren’t qualified to comment on medical conditions.

In both these excerpts from Sian’s interview a similar mechanism can be seen at work, in which her knowledge and agency regarding Charlie is undermined and each time she responds with a reinforcement of Charlie’s problems. In the first excerpt this comes in the form of asserting her own everyday work in managing these problems, in the second it is to the greater expertise of Charlie’s specialist that she turns. In each case Sian experiences a threat to her legitimacy as a claimant in her son’s affairs, and to each threat she responds by reinforcing his deficits.

This raises the question of why it might be that either Sian or Louise may feel the need to assert the legitimacy of their own claim to a stake in decisions regarding their children. Each parent’s perception of their responsibility for their child is reinforced through the subversion of their identity beneath the ideology of the school. This introduces a ‘mechanism of obligation’ (Dermott, 2005, p. 93) whereby they must advocate for their children in order to gain the ‘correct’ support and escape images of inadequacy. As detailed above, this responsibility is firstly felt in relation to the initial presentation of disorder. Insinuated by professional and popular discourses of guilt and blame, this then feeds into a responsibility to fight for whatever support and recognition that may be available.

The spectres of the ‘aberrant child’ and ‘bad parent’ were sufficiently influential for both parents to be motivated to find an alternative set of descriptions for their children’s behaviour, however they did not always find comfort in these
enclosures of expertise’ (Rose & Miller, 1992, p. 188), and as such were forced to take on progressively more active roles, each time resulting in a reinforcement of the child’s deficit and the family’s dependence on specialist information.

This dependence can firstly be read in each parents attempted self-improvement, through the acquisition of specialist discourses of behavioural development. This can be read in Sian’s obvious frustration at the ‘common sense’ explanations she received from early referrals, grounded in the threat she perceives in these of her claims to her child’s forms of difference;

S  We tried everything: star charts; money in a jar; taking toys away; stop him watching the telly. But none of it worked. He just shrugged his shoulders I mean you’d send him up to his room and, you know...well we found it wasn’t a good idea to send him up to his room because he would trash it. So we sat him down on the bottom step of the front door because that was the only place where he couldn’t do any damage but then he went through a period of banging his head on the wall

This comment echoed similar experiences in Louise’s discourse:

L  you know, we’ve done all the positive parenting classes even before we had the diagnosis...even those really you can push out of the window - the positive parenting classes - because with ADHD, you know, a lot of it doesn’t really work.

R  Where did you do that?

L  I did one in the crèche and I did one up in the nursery when he was in state nursery.

R  And they were telling you the fairly generic //

L  Yeah, pick a chart...praise the good when they are being good and ignore the bad. You just can’t do it, you know. Like I said when Liam is being bad he can be bad for five hours if we don’t stop him. You tell me where he gets the strength to pick up things and throw it and I’ve got to ignore that and say: ‘Don’t do that Liam’. You know...when he is off on one, as we call it, he don’t care who he hits. Whoever is in his path will get it.

Again, what can be seen in both mother’s responses is a battle for legitimacy which is reinforced with every perceived lack of support, again this reinforcement happens through a re-assertion of the child’s difference.

Sian, unhappy with the ‘problem parent’ explanation sought advice from a support group through which she was able to contact the specialist who would become both the means to Charlie’s treatment and to Sian’s ability to reject the culture of mother blame. Louise went a stage further and after consulting a parent support group, set one up herself. For Sian it was the medical discourse that offered her the opportunity to reject this culture, but it is not always so clear cut, as Mike
states in response to a question about his and Louise’s use of the term ‘anxiety’ to describe Liam’s state of mind:

M  it probably comes through the way we’ve looked at it and the way that we’ve been taught ourselves because with this [specialist] assessment it’s as much about parents as it is about children, you know. The whole assessment about Liam is also about us as parents and it’s for us to be able to understand each stage that Liam is going through

So for Mike and Louise, part of receiving specialist intervention has been to take on board certain responsibilities in relation to their own assumptions and practices as parents. Modifying one’s behaviour in terms of a professional discourse has implications for thinking about one’s position in relation to that discourse:

M  But, again, it’s about us being positive as parents. Because we are now positive and we know what’s happening with the hospital and so on and that has an impact on how we deal with Liam. Ultimately if you are feeling negative about it then that negativity will come through you into Liam

The job of parenting a child with ADHD is understood here by Mike as a project of self-improvement, whereby, it is them as parents who have to acquire specialist discourses not only to describe their children’s abnormality, but also to interrogate themselves, as such providing an example of what Giddens calls ‘reflexive modernisation’ (Giddens, 1991) in which individuals react to feelings of powerlessness through an attempted appropriation of specialist discourses. Yet actors become engulfed within these discourses; their search for certainty takes them into choices whereby they must either abandon the search for support or submit entirely to the authority of specialism and relinquish the agency they desired in the first place.

As Mike states in relation to the decision whether or not to medicate Liam;

M  Because [the specialist assessment] have said that he needs medication but, of course, it’s us as parents who have to ultimately make that decision and it’s a difficult one to make. He’s a child of six coming on seven and to commit him to long term stimulants is a big ask of parents.

What Mike strikes with this comment, is the central paradox that operates through each parent’s attempt at empowerment through specialist discourse; in which it is this specialism that will require parents to constantly check their own agency, their own actions and behaviour – ‘it’s us being positive as parents’, ‘it’s us as parents who ultimately have to make that decision’, it’s as much about us as parents as it is about children – what each parent’s experience repeatedly tells us is that one cannot appropriate a specialist discourse without becoming an object of it.

Natural roles and social obligations

From the image of the bad parent in relation to their child’s behaviour, the parent seeks an active and supportive role – a ‘good parenting’ role – in establishing support for these problems. Within this role what the experiences above tells us is that they are likely to be regulated according to further derogatory imagery –
the pushy parent, the excuse maker, the 'continual and relentless thorn in the side of anyone of influence' (Garlington in Fine, 1997, p. 464). As such in this struggle for recognition parents face a double bind, which is encapsulated in the phrase taking responsibility for their children. Either they must accept a discourse which holds them responsible for the production of the disorder in the first place or, in rejecting this discourse, they must take responsibility for the 'correct' recognition of their child, which will involve the submission of the subjectivity they sought and the implicit acceptance of the illegitimacy of their own knowledge and experience. Either way, the deficit resides in the child and the responsibility lies with the parents.

The image of naturalness is held against parents of children with ADHD, defining their responsibility for their children's aberrance, however, once parents make themselves vulnerable to the social knowledge of therapeutics, they sacrifice personal agency and autonomy and face threats to their knowledge as parents. As Louise stated, 'I'm no expert, but I am a mother and I know when he is struggling' and it is this image of the mother by which they were tied to the discourse in the first place. As Carpenter & Austin note, 'the mothers of children with ADHD have crossed an imaginary line of what is unacceptable and acceptable in motherhood by having a child whose behaviour does not conform to what is arbitrarily and subjectively decided on as being normal' (Carpenter & Austin, 2008, p. 38). As such therapeutic discourse fashions the image of the 'natural' ‘caring’ and ‘good’ parent and then makes that image unattainable. The parent who takes up these images faces the permanent frustration of the very 'naturalness’ they strove for in the first place. What this story tells us is that it is not the repressive therapeutic state forcing its labels through institutions such as the school upon the powerless parent. Therapeutics supplies the descriptions and makes the insinuations, but it is each parent that must take up these descriptions and then fight to have them accepted. Rather than make a re-appropriation of expertise through this advocacy, each parent was complicit in constructing the means by which they themselves faced appropriation.

This is the central paradox to this account; that in order to seek empowerment and support parents are forced to wed a discourse which will require them to sacrifice agency in favour of biological descriptions of reality. This returns us to the point made at the beginning of this paper concerning the perception of an advanced state of genetic and neurochemical research for ADHD. The genetic account of ADHD epitomizes this paradox in offering an account of human behaviour which, though susceptible to differential environments, is perceived to be ‘natural’ and inescapable. A recent textual analysis of the writings of leading ADHD neuropsychiatrist Russell Barkley revealed two dominant metaphors – the brain as ‘cybernetic system’ and people with ADHD as 'slaves' (Danforth & Kim, 2008). Parents in this account sought the genetic explanation in order for them to consider their child’s problems as separable from ‘him’ and ‘his’ immediate surroundings, and in order to re-empower their own agency in the face of self-images of inadequacy. However, adoption of the ‘cybernetic slave’ account requires the total submission of agency. Elizabeth Ettorre offers the term 'genetic reproduction’ to describe the way in which women’s bodies are moulded to make the reproductive process susceptible to the genetic gaze and the production of ‘normal’ foetuses and children (Ettorre, 2002). What this account suggests is that the ‘reproduction’ does not stop with birth, and, that this is a metaphor that can be used to describe the genetic account in general – which through the subjugation of agency promises an ideal and the means by which to reproduce that ideal, creating normalising projects in the reproductive and developmental aspirations of parents.
References


Education: Culture, economy, society (pp. 460-475). Oxford: Oxford University Press.


*This document was added to the Education-line database on 10 September 2008*