UNIVERSITY OF EAST LONDON

ADHD:
‘Because You’re Worth It’

The Marketisation of ADHD to Adult Women

Helen Winter

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ABSTRACT

Drawing on the traditions of discursive psychology and critical discourse analysis this study examined the marketisation of 'Attention-deficit/hyperactivity disorder' (ADHD) to women in a small sample of online *YouTube* videos. Of specific interest was the constructed and constructive nature of discourse at a 'micro' level, with a particular focus on the reification and commodification of the 'ADHD-product'; and the discursive strategies used to persuade women of the potential benefits of 'ADHD' diagnosis and 'treatment'. The video material analysed represented a combination of first person testimonies from the 'sufferer', and the sharing of 'expertise' by 'professionals', and comprised of both verbal and visual aspects. The analytic categories generated told a 'story' of the construction and commodification of the 'ADHD-product', unproblematically positioned within the biomedical discourse; followed by the active promotion of 'ADHD' to women, with strong endorsements for the use of stimulant medication to 'enhance performance' and 'increase one's potential'. Attention was also paid to the possibility that this diagnosis might threaten women's selfhood and undermine personal authenticity. Implications for research and professional practice are discussed in light of the analysis.

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This Thesis is Dedicated to Professor Mark Rapley

1962-2012

If I told you what it takes
to reach the highest high
You'd laugh and say 'nothing's that simple'
But you've been told many times before
Messiahs pointed to the door
And no one had the guts to leave the temple

The Who - "I'm Free"

Thank you, Mark.

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Your desk is a mess, and you can forget about completing your to-do list—you don't even have one. Your mind darts from one thought to the next. And that handbag you've been madly searching for on your way out the door? Yes, it's already on your shoulder.

ADHD affects women differently: What to look for, how to fix it.

Health Magazine (2009)

1.0 INTRODUCTION

1.1 Introduction to the Study

'Attention-deficit/hyperactivity disorder' (ADHD) is a diagnosis which divides opinion and ignites debate. Some have fought for its recognition as a legitimate medical disorder (e.g. Asherson, 2013); others have contested its existence and refer to it as a cultural construction (e.g. Timimi &Leo, 2009). Regardless, reported prevalence rates continue to increase amongst the child and adolescent population (Getahun et al., 2013); whilst the incorporation of more adult-inclusive criteria into the DSM-V 'sets the stage' for the adult diagnosis to follow suit (Whitely, 2011).

In contrast to the predominantly *male* child population, research indicates higher diagnosis and prescription rates amongst adult *women* (Castle et al., 2007). Some authors have related this discrepancy to the under-recognition of 'ADHD' in girls (Simon et al., 2009); others have related it to pharmaceutical promotion and the frameworks available to women through which they may express their unhappiness and suffering (Moncrieff et al., 2011).

This study draws on the traditions of discursive psychology and critical discourse analysis to examine the marketisation of ADHD to women in a small sample of online videos.

1.2 Issues of Definition

I will now briefly deconstruct the title of this thesis; "ADHD: Because You're Worth It: The Marketisation of ADHD to Adult Women". Adding the suffix '-isation' to a noun denotes an *act* or a *process* of *doing* or *making* something. The notion advanced here is that ADHD is being turned into a commodity that can be 'bought' and 'sold'. The use of the *L'Oréal* advertising slogan - "Because You're Worth It" (L'Oréal, 2013) – is to draw attention to a hypothetical parallel between the way both 'ADHD', and beauty products are marketed to women (Moncrieff et al., 2011). That is, in the same way as *L'Oréal* advertising implies a claim to make women look younger and prettier; 'ADHD' (and stimulant medication) offers to improve women's quality of life and productivity; thus, women are buying the concept, not the product.

'Marketisation' is a fairly broad area, so to allow a systematic approach to the data; I have selected a more specific analytic focus. In particular, I will be focusing on the construction and commodification of the 'ADHD-product'; and the discursive strategies used to persuade women of the potential benefits of receiving a diagnosis of 'ADHD' (and the assumed stimulant 'treatment').

The validity of the construct of 'ADHD' has been heavily contested (Timimi & Leo, 2009a); hence, I use the term with 'critical' intentions. However, for ease of reading, inverted commas have not been used past this point in the text[1].

1.3 Researcher's Position

Qualitative researchers have argued:

> *(...) it is impossible for a researcher to position themselves outside of the subject matter because the researcher will inevitably have a relationship with, or be implicated in, the phenomenon he or she is studying.*
>
> Willig (2001, p.7)

[1] ADHD is used interchangeably with 'ADD' throughout.

The alternative to what may be considered a naive attempt at objectivity; a *God's eye view* (Haraway, 1988), is for the researcher to employ a degree of personal reflexivity in considering the values and assumptions they may be bringing to their study (Burr, 2003; Willig, 2001).

My enthusiasm to study this area developed out of a convergence of interests and experiences. Pre-clinical training I worked in a number of posts within the context of 'child and adolescent mental health' and 'learning disabilities'; including in a specialist 'ADHD-Team'. A high proportion of this team's referrals originated from one inner-city postcode; an area known for its relatively high levels of social deprivation and teenage pregnancy. The particularly 'challenging' referrals were passed to psychology for 'family-therapy'. However, families often declined to be seen; stating it was their *child* who had the 'problem'. In a piece of service-evaluation ("ADHD: it's not just about the drugs"), interviews with service-users indicated that, above all else, they valued space to talk; raising issues of bullying, chaotic home-lives, separation and abuse. The drugs were described as "mental-pills" which the young people felt compelled to take to stop them "going crazy" or becoming violent.

Taking these, and similar experiences into training I became keenly interested in the work of Foucault, Wittgenstein, Ussher, Boyle, Rapley, Moncrieff, Timimi; to name but a few. Encouraged to reflect on our epistemological stance, I found a connection to more social constructionist ideas; at a philosophical level, but also considering both clinical and academic applications.

I position myself as a feminist and a critical practitioner; questioning of the dominant medical model of mental illness and the simplistic focus on pharmaceutical interventions to 'rectify' the *neurochemical self* (Rose, 2004). According to Ussher (1991), women can be labelled as 'mad' for not conforming to the "stereotypes of femininity" (p. 139) As a twenty-something female, engaged in my career, I feel very aware of the tensions and contradictions of my own multiple roles (Gill, 2007).

In this study I intend to join previous authors (e.g. Butler, 2006) in challenging the notion that *biology is destiny*. I also hope to contribute to a widening of the lens; focussing less on the individual (specifically the 'ADHD-woman') and more on the wider social context; a context which is now heavily influenced by a complex array of multimedia networks and increasing methods of communication and information sharing.

1.4 Literature Review

My literature review began with one key paper which inspired the conception of this study; 'The construction of psychiatric diagnoses: The case of adult ADHD' (Moncrieff et al., 2011). I also looked through the reference list to identify other relevant articles and took recommendations from the authors for further reading.

Following this I began a more extensive literature review, Appendix 1 details the search strategy employed.

1.5 Diagnosing ADHD

In his study of the history of madness, Foucault (1972) describes the way diagnoses emerge from psychiatric discourse. Specifically, he discusses how a label is given to the status of an object "making it manifest, nameable, and describable" (p.46). Below the object of ADHD is described, using the language of the American Psychiatric Association (APA)

1.5.1 DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition)

According to the current version of the DSM-IV (APA, 1994, p.85), the essential feature of ADHD is a "persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and is more severe than is typically observed in individuals at comparable level of development". The individual must display six or more symptoms of inattention (e.g. 'is often forgetful in daily activities') and six or more symptoms of hyperactivity-impulsivity (e.g. 'often fidgets with hands or feet or squirms in seat') "for at least six months to a degree that is maladaptive and inconsistent with developmental level" (APA, 1994, p.92). These 'symptoms' must cause impairment in at least two settings and "some

hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7 years" (p.85).

According to the DSM-IV, in the majority of cases 'symptoms' reduce during late adolescence and adulthood. However, there are a few individuals who will retain some, or all of their 'symptoms' through to mid-adulthood.

1.5.2 DSM-V (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition)

Within the DSM-V (released May 2013), a number of changes have been made to the ADHD criteria; these include moving the age of onset forward by 5 years (symptoms present by 12 years); reducing the amount of symptoms needed for a diagnosis of 'adult-ADHD'; adding new age-related symptom examples (APA, 2012).

The APA elected to add examples "that make it easier for clinicians to see the applicability of the criteria across the lifespan" (APA, 2012, p.1). For instance, 'inattention' now includes the example of *failing to finish household chores*. In considering potentially negative consequences, the APA suggest "it is conceivable that changing the examples available would result in changes in how the items are rated or applied, leading to changes in prevalence or correlates of ADHD" or that "possible changes in examples would lead to changes in how published rating scales need to be written" (p.1). However, these were not considered to outweigh the benefits of more age-applicable examples.

1.5.3 Prevalence

Uncertainty surrounding the definition of ADHD has resulted in varied prevalence rates in epidemiological studies of between 0.5% and 26% (Timimi & Taylor, 2004). Researchers have also shared concerns that the proposed changes in the DSM-V are likely to further increase its prevalence in both child and adult populations (Batstra & Frances, 2012).

1.6 ADHD: The Story So Far

The first recorded medical conceptualisation of over-activity, impulsivity and poor concentration dates back to the early 20th century (Barkley, 2006; Conners, 2000;

Rafalovich, 2001). British paediatrician, Sir George Still (1902) presented a series of lectures to the Royal College of Physicians on 'Some Abnormal Psychical Conditions in Children'. The lectures included an examination of a group of young people who presented with an "abnormal defect of moral control" (p.1008). Morality was deemed to possess a cognitive component, and thus immorality was assumed to originate in the mind.

Still (1902) was particularly interested in studying those children who he believed displayed this defect, but not as a result of physical disease or "impairment of intellect" (p.1079). As later described by Rafalovich (2001), these were not children who "due to being too stupid to understand the moral codes of society, acted out against those codes" rather, they possessed personal agency and, as such, *chose* to break the rules of society (Rafalovich, 2004, p.105). Such an account of volition is in contrast to contemporary descriptions of ADHD, which portray the 'ADHD-sufferer' as completely lacking self-control (e.g. Barkley, 1997).

Still concluded that these children required more focused medical investigation to come to a fuller understanding of the cause of their presentation (Rafalovich, 2001). In the interim he recommended no treatment other than *good discipline* (Timimi & Leo, 2009). Whilst many authors see this as the beginning of a biomedical account of ADHD (e.g. Barkley, 2003), others (e.g. Rafalovich, 2004) emphasise the importance of locating Still's theory within the dominant medical discourse of the early 20th century, including the emphasis and popularity of biological accounts of 'moral imbecility'.

During 1917-18 the United States (US) suffered a series of encephalitis epidemics. Children who survived the disease often presented with learning difficulties, restlessness and personality changes. This constellation of 'symptoms' was later termed 'minimal brain damage' (MBD) and also became associated with hyperactivity and inattention in children (Timimi & Leo, 2009). In 1937, a chance discovery by an American child psychiatrist, Charles Bradley associated the administration of psycho-stimulant medication with a reduction in the problematic behaviours observed in MBD (Bradley, 1937). However, Bradley

also noted that the calming effects of taking a low-dose of stimulants would likely be observed in any individual, not just those presenting with hyperactivity (Timimi & Leo, 2009).

In the 1960s the 'MBD' hypothesis was abandoned due to both a lack of evidence for underlying brain lesions; and a mounting interest in behaviourally defined syndromes (Timimi & Leo, 2009). Nevertheless, the assumption that the 'disorder' was caused by a precise and discoverable brain abnormality remained strong. This assumption is still present to this day; regardless of research suggesting that brain damage is neither linked to, nor tends to cause over-activity (Rutter, 1982).

'Hyperkinetic-reaction-of-childhood' was presented in the DSM-II in 1966, replacing the diagnosis of MBD (APA, 1966). Gradually this behaviourally defined 'syndrome' transitioned from a topic of marginal interest to a position of central prominence in psychiatry (Whitely, 2011). The renaming continued into the 1980's with the introduction of 'Attention Deficit Disorder' (ADD) in the DSM-III (APA, 1980) and then 'Attention-Deficit/Hyperactivity Disorder' (ADHD) in DSM-III-R (APA, 1987).

'ADD' offered a three dimensional approach to the diagnosis, meaning the individual could be diagnosed with or without 'hyperactivity'. However, 'ADHD' later assumed that 'hyperactivity', 'attention-deficit' and 'impulsivity' were in fact all part of one disorder (APA, 1987). The diagnosis further evolved with the introduction of the DSM-IV (APA, 1994) and the two-dimensional model. Thus, 'attention-deficit' and 'hyperactivity-impulsivity' were now presented as two separate sub-categories. The DSM-IV also offered a new diagnosis of 'ADHD not otherwise specified' for occasions when the young person presents with 'symptoms', but not to the extent that they may receive the full ADHD diagnosis.

As described earlier in this chapter, the construction of ADHD will continue to evolve with the release of the DSM-V.

1.6.1 A Critical Historical Perspective

Historical depictions of ADHD vary according to the position of the author in relation to *ADHD-as-a-disorder*. Brief histories have been written by advocates of the ADHD diagnosis (e.g. Barkley, 1990, 1991, 1997; Kessler 1980) and also by those who argue against its validity (e.g. Breggin, 1988; Conrad 1976; Timimi & Leo, 2009; Walker, 1998).

Barkley (Psychiatrist, US) has been described as the "modern champion of the ADHD diagnosis" and one of the most prominent supporters of "a brain dysfunction model" and the use of drugs to correct this dysfunction (Timimi & Leo, 2009, p.3). His depiction of the past 110 years is one of *development*. For Barkley, the recognition of ADHD came about as a result of progress and modernisation of clinical practice; "slowly honing its nomenclature to greater levels of scientific validity and practical effectiveness" (Rafalovich, 2001, p.95).

In contrast to Barkley, Breggin (Psychiatrist, US), described as "the conscience of psychiatry" (Pert et al., 2009, p.3), perceives the concept of 'ADHD-as-a-medical-disorder' to be completely "fabricated" (Breggin, 1998, p.186). As such, his interpretation of the history of ADHD is one of control and the *medicalisation of childhood* (cf. Breggin, 2002)

Smith (2008), has written about the history of 'hyperactivity' in the context of the "evolution of psychiatry from a field dominated by Freudian psychoanalysis to one rooted in the neurosciences" (p.541). He suggests that, contrary to conventional beliefs, the neurological explanation of hyperactivity is relatively new. This explanation materialises from the debate between three dominant fields of psychiatry in the 1960s: psychoanalysis, social psychiatry and biological psychiatry. The biological account prevailed; not due to its superior scientific validity, but owing to its rationale and approach being perceived as most suited for the current social context.

Conrad (1976) also attributed the discovery of 'hyperkinesis' to a changing trend in the medical profession, whereby behavioural problems were increasingly interpreted as organic or biochemical in origin. In his study, Conrad also

discussed the impact of the 1960s ‘pharmaceutical revolution’ and the comprehensive advertising campaigns promoting the stimulant drug, Ritalin to the health and education sectors.

ADHD and prescriptions of stimulant medication have continued to rise over the past decade or so (Kendall et al., 2008); and scepticism has also persisted. More recently, Whitely (2010), an Australian politician and campaigner, has related the rise in ADHD to its lucrative marketing potential; with each DSM ‘rebranding’ triggering significant increases in diagnosis and prescribing as the criteria becomes ever more inclusive.

According to Whitely, (2010), under the DSM-III-R, ADHD was often viewed as a “boys disorder” (p.16) due to the requirement to present with both ‘hyperactivity’ *and* ‘inattentiveness’. Girls were perceived to present with more *internalising behaviours* and were hence seen to be overlooked by the current criteria. In order to foster increasing public recognition and diagnosis of girls, the DSM-IV emerged with its two-dimensional model allowing diagnosis of a predominantly inattentive type, without the presence of hyperactivity.

Whitely (2011) has described this process in relation to the influences of the pharmaceutical market; by making the diagnosis more inclusive, there is an increased *demand* to *supply*. He also argued that the transition to the DSM-V will not only work to further augment the child market, but will also promote a smooth transitioning of prescribing into adulthood. Similarly, according to Conrad and Potter (2000); “by redefining ADHD as a lifetime disorder, the potential exists for keeping children and adults on medication indefinitely” (p.568).

Miller (2008) has related the emergence of ADHD to the phenomenon of ‘moral panics’; whereby parts of society are used to embody wider societal problems (cf. Cohen, 1973).

> *Particular kinds of individuals are labelled as dangerous to social well-being because of their deviance from agreed-upon norms of the general good. Once identified, their life practices are then interpreted from membership of the group and vice versa.*
>
> Miller, (2008, p.105).

Indeed, referral patterns have been related to specific neighbourhoods and areas of social deprivation (Newnes, 2009). National data also shows social deprivation to be a primary factor in childhood physical and mental illness, including rates of ADHD (Hart & Benassaya, 2009). Miller suggests that ADHD may be considered a more appropriate case for 'panic' alongside emotive issues of poverty and social inequalities. Consequently, ADHD could be conceptualised as the 'scapegoat' for wider societal issues.

1.7 Explanations of ADHD

Conventional accounts of ADHD relate its cause to an interaction between biological, psychological and social factors; a *biopsychosocial* model (Tannock, 1998). However, often the *psychosocial* aspects of understanding are lost; thus the dominant explanation of ADHD aetiology used in Western society is one of biomedical disease (Visser & Jehan, 2009). Representative of such an account, Barkley (2003) proposes a range of biomedical influences including; neurochemical imbalances, genetic abnormalities, brain dysfunction and complications in birth or pregnancy. As such medication is seen to be the logical treatment option to help *correct* or *reverse* the biological abnormalities.

In the ongoing debate, some authors (e.g. Murray et al., 2006), have argued for ADHD to be recognised as a legitimate medical diagnosis. Others (e.g. Moncrieff et al., 2011), hold the position that we should avoid reifying ADHD and, instead, place this discourse within its cultural and historical perspective.

Two prominent child psychiatrists debated this topic in 2004 (Timimi & Taylor, 2004). Taylor argues that to understand ADHD we need to focus on the way both genetic and social factors interact to produce the 'disorder'. Furthermore, he

suggests that there is currently an ‘under-treatment’ of children with ADHD and that social influences “work against recognition of a treatable risk” (p.9).

The alternate view, presented by Timimi, contests claims of any biological origin of ADHD on the grounds that research has failed to provide any “specific cognitive, metabolic or neurological markers and no medical tests” (p.8). Timimi describes the potentially damaging influence of offering a one-dimensional (medical) explanation of behaviour; disengaged from any historical or cultural context. He goes on to explain that there has, as yet, been no success in standardising the criteria for ADHD within cross cultural studies. Furthermore, there is no specific treatment for ADHD; with medication having similar effects on children regardless of whether they have a diagnosis or not.

According to Boyle (2011), the biomedical model of mental distress functions to defend those in influential positions in society from being considered responsible for the suffering of the less powerful. As such, the biomedical construction of ADHD absolves the dominant institutions and individuals from being held accountable for people’s emotional distress or ‘troublesome’ behaviour. What is more, the assumption of pathology leaves little room for reflection on the social, political or environmental causes of distress (Lloyd et al., 2006).

1.8 Adult ADHD

Thus far, adult-ADHD has been diagnosed using criteria originally intended for children (Kieling et al., 2010). However, the DSM-V now differentiates the presentation of ADHD in adults on several ‘symptoms’ (APA, 2012). This transition punctuates a period of ‘category-expansion’[2] for the ADHD diagnosis (Conrad & Potter, 2000).

Earlier versions of the DSM advanced the possibility of the persistence of ADHD into adulthood. The DSM-III (APA, 1980) began with the expansion of symptoms away from school based activities to incorporate interpersonal behaviours; the revised version offering examples of symptoms which may occur in the work

environment (APA, 1987). By 1994, the DSM-IV (APA, 1994) reflected the mounting consensus that adults may be diagnosed with ADHD, as long as symptoms had been present before the age of 7 years. However, 'ADHD-advocates' insisted adults should not *necessarily* need to reconstruct a historical account of their childhood (Barkley & Bierdman, 1997).

In addition to the above, over the past four decades, professional studies (e.g. Weiss et al.,1979) and popular media (e.g. Wolkenberger, 1987) have increased the 'awareness' of adult-ADHD amongst academics, clinicians and the general public (Conrad & Potter, 2000).

According to Conrad and Potter (2000), the expansion of the diagnosis was not due to new scientific discoveries about the "biomedical nature of the disorder" (p.573). The authors instead situate the expansion within certain historical developments such as the "Prozac Era"; in which taking medication for life-long problems was deemed as "acceptable" (p.571); and the rising paradigm of genetics in medicine, supporting the notion of ADHD as a lifelong disorder.

In considering some of the consequences of this 'category expansion', Conrad and Potter (2000) introduce the concept of "The Medicalisation of Underperformance" (p.573) and discuss the emergence of "A New Disability" (p.574). Specifically, the authors suggest; "For adults, the issue surrounding ADHD is performance, not behaviour" (p.573); and within this medicalised definition there are numerous *social* advantages such as "mitigation of personal blame, medical excuse, health insurance, or disability" (p.576).

Attending to the *beneficiaries* of ADHD 'category expansion', Conrad and Potter (2000) note an alignment between the claims of "sufferers and professionals" (p.575), as well as an active seeking out of the diagnosis. This is contrasted to other less desirable diagnoses (e.g. 'schizophrenia') which, through the lens of *Labelling Theory* (Scheff, 1984), represent "a fundamental conflict between social control agents and putative deviants" (Conrad & Potter, 2000, p.575).

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[2] "Adult ADHD offers a clear example of how a medicalized category can expand to include a wider range of troubles within its definition" (Conrad and Potter, 2000, p.575).

This study will attend to the roles of 'professionals' and 'sufferers' in the expansion of the ADHD category. However, the additional context informing my analytic foci is the change in gender demographic, as explored in more detail below.

1.8.1 The Changing Gender Trend: From 'Naughty Boys' to 'Desperate Housewives'

On the basis of the diagnosis' reputation and most data in children, it may be assumed that the adult ADHD demographic will be predominately male. However, many studies have not supported this prediction.

Simon et al. (2009) conducted a meta-analysis of studies looking at the prevalence of ADHD amongst adult populations. Their general conclusions suggest that, diagnosis and prescription rates are more equally distributed in adulthood, with some countries diagnosing more women than men. For example, in Italy and New Zealand the ADHD population is made up of 86% and 83% women, respectively.

In an earlier study, Castle et al. (2007) analysed a large sample of American pharmaceutical data. The results indicated that between 2000 and 2005, women between the ages of 20 and 44 showed the highest annual prescription growth rate of any demographic group (21.4%). Moreover, the intensity of the treatment provided was shown to be higher for boys than for girls but higher for women than for men.

Some authors have attributed this change in demographics to previously undiagnosed cases in childhood and the presentation of "pseudo-new" cases in adulthood (Simon et al., 2009, p. 209). This theory is informed by the assumption that males display 'their' ADHD through externalising behaviour whereas girls present with internalising behaviour. As such, girls are not referred for treatment in childhood, but once they reach adulthood they refer themselves to services due to "emerging co-morbid psychiatric disease" (p.209). Thus females only become 'symptomatic' with the introduction of adult stressors such as family, work and study (Bren, 2004).

An alternative viewpoint examines societal discourses in relation to mental health and women. Moncrieff et al. (2011, p.18), citing Ussher (1991), suggest that ADHD may be the "latest framework offered to women through which to express their distress and dissatisfaction". The authors support this by highlighting the increase in promotional material aimed at women.

Moncrieff et al. (2011) also discuss the construction of adult ADHD in relation to the market drive of pharmaceutical industries and the medicalisation of behaviour. Specifically they refer to Rose's (1998) concept of the 'neurochemical self' and the tendency for psychopharmacology research to provide only biological explanations for variations from the norm; thus encouraging people to adopt purely biological descriptions of themselves and ways to act upon themselves. If this is so it may be that women are less inclined to consider external societal/relational/familial pressures and instead look for biological and medical problems within themselves.

Relating the concept of *moral panics* to the increase in women being diagnosed, it may be hypothesised that these women are "manifesting distress only as a result of deeper or wider injustices" (Ussher, 1991, p.121).

1.9 A Focus on Women

1.9.1 Mental Health and Women

> *(…) to talk of 'mad' came to mean to talk of 'women'.*
>
> Ussher (1991, p.70)

In 1979 the UN Assembly adopted "The Convention on the Elimination of All Forms of Discrimination against Women" (UN, 2003, p.3) into the International Bill of Human Rights. The bill sets an agenda for action against the discrimination of women, including issues around "Sex Role Stereotyping and Prejudice" (p.13). However, despite efforts to eliminate discrimination as well as women's evolving role within society, discourses available to females have remained limited and perceptions remain stereotyped; "the discursive practices have merely become more entrenched" *(*Ussher, 1991, p.93).

Discourses of femininity have been described as:

> *(...) sets of shared cultural beliefs and practices that construct the meaning of "woman", what it is to be a woman, and experiences of subjectivity in women.*
>
> Stoppard, (2000, p. 23)

So described, these discourses define and constrain femininity; laying down invisible barriers in the guise of 'normality' and 'social acceptability'. As these discourses are hidden they are unquestionable and often so limiting that some have suggested they provide the explanation for many of the 'female disorders', such as postpartum depression (Knudson-Martin & Silverstein, 2009) and the over representation of women within the prevalence data of many mental health diagnoses (Ussher, 2010).

Within the discourse of 'madness', Ussher (1991) argues that awareness is being diverted "away from the problems within society, focussing attention instead onto the individual, who is suffering only as a direct result of societal pressures" (p.148). She also highlights the need for attention to be paid to the gender differences in psychiatric diagnoses; without which, conventional explanations will continue to be used automatically to "categorise, to compartmentalise, to control" (p.104).

1.9.2 Women and the Media

It has been argued that media representations of gender are significant because they pierce the collective social conscience and strengthen culturally dominant hegemonic theories concerning gender, which characterise men as dominant and women as subordinate (Almy et al., 1984). Stereotypical representations are thus seen to both limit behaviours and create gender role models to aspire to (Devereaux, 2002).

Women have been portrayed within many gender stereotyped roles by the media. Often privileged are domestic, sexual and consumer portrayals of women to the

exclusion of all other potential roles (Tunstall, 1983). However, some authors have noted a shift in the representation of women in the media over the last 25 years. Westwood (1999), for example, proposes that British television is now depicting more *transgressive* female roles. In advertising, Gill (2008) has also noted that women are less likely to be portrayed as passive objects of the male gaze, and are instead represented as emotionally and financially independent. However, some authors argue that this only creates a shift in advertising strategy with marketing campaigns now offering false guarantees of rebellion, connection and control, if you buy their product (Kilbourne, 2000).

1.10 ADHD: A Current Affair

In recent years there have been numerous representations of ADHD in the popular media, with a particular focus on the unprescribed use of medication (Kennedy, 2008)[3].

According to Krinsky (2003), the recreational appropriation of Ritalin has gained significant media coverage as part of an emerging moral panic. Although the action of taking unprescribed drugs is framed as *socially unacceptable;* each representation also appears to highlight what might be *achieved*. What is more, although guilt or concern does develop eventually, initially lives appear to be managed better and more is accomplished.

1.11 Selling Sickness: Marketing a Medical Understanding

> *There's a lot of money to be made in telling healthy people they're sick.*
>
> Moynihan et al. (2002, p.886)

According to Moynihan (2005); "the first step in promoting a blockbuster drug is to build the market by raising public awareness about the condition the drug is designed to target" (p.192). One way to do this is to provide the media with fear inducing stories about such a condition (Moynihan et al., 2002). Indeed, the

[3] See Appendix 2 for examples.

media has been described as an influential source of reference on mental health problems, with the ability to shape public belief (Hansen et al., 2003).

In the US, the profitability of the pharmaceutical industry is second only to the arms industry (Public Citizen, 2002). Timimi (2009) has suggested that it is no longer scientific concerns that provide the driving force behind pharmaceutical advancement. Instead, the industry may be located within its capitalist framework with the commercial drive to expand markets and increase custom.

Healy (2004) has discussed the way "marketing can both transform the perceptions of physicians and shape the experiences of those seeking treatment and the self-understanding of those not in treatment" (p.219). Within a consumerist society there is a constant drive to find a 'quick fix'. The ADHD diagnosis offers women a simple and detached explanation for their struggles as well as a discreet and instant 'solution'.

1.11.1 Going Online

Between 2000 and 2011, worldwide internet access increased by 481.7% with an estimate of 2,099,926,965 users across the globe (Internet World Statistics, 2011). This provides a highly accessible international stage for "selling sickness" (Moynihan et al., 2002, p.886). Indeed, according to Fox (2001), 80% of internet users look for health information online in preference to other sources. With respect to ADHD, 'ADHD medication' is positioned in the top ten most searched for treatments on WebMD (a popular health and medicine search engine).

Conrad and Potter, (2000) have related the expansion of the ADHD category to "new markets" (p.575), popularised via the rapid transmission of information through television, internet, and popular literature. On entering 'ADHD' into the Google search engine, 60,500,000 results were offered within 0.16 seconds [accessed January 5th, 2013]. The authorship of these 'hits' may vary from claimed 'medical professionals' to 'anonymous' internet users; with little clarity on how information is regulated. Indeed, in 2006 *Time magazine* presented 'the general public' with their 'Person of the Year' award in recognition of the millions

of people who anonymously contribute to user-generated content (such as Wikipedia, YouTube, Facebook and so on).

The ability to create and share material online has resulted in an immense increase in content; indeed many marketing strategies now seek to exploit the use of consumers as potential publishers and promoters (Odden, 2012). With the growth and diversification of internet usage the platform for 'disease mongering' seems ever-increasing (Moynihan & Henry, 2006).

1.11.2 Direct to Consumer Advertising Campaigns (DTCA)

DTCA brings pharmaceutical product details directly to patients as opposed to via medical professionals; resulting in an increase in diagnosis and prescribing (WHO, 2009). Regardless of the controversy surrounding ADHD diagnosis and treatment, drugs such as Ritalin have received much promotion via the mechanisms of DTCA (Leo & Lacasse, 2009).

DTCA is currently only legal in the US and New Zealand (WHO, 2009). However, due to the 'borderless' nature of the internet, it has become more of a challenge to regulate these boundaries. Leo and Lacasse (2009) have described the interactions between DTCA and the press as "unknown and unquantifiable" (p. 301), and that "Googling 'ADHD', now inevitably links users to DTCA websites that promote psychostimulants" (p.288). Recent Google developments may further expand this to include YouTube searches for DTCA linked video material, as discussed later in this chapter.

1.12 Previous Research on the Marketisation of ADHD to Women

Holding in mind sections 1.8-1.10 as a background, the construction of the 'ADHD woman' is relatively new, as is critical research into the area.

Moncrieff et al. (2011) note the changing trend in the adult diagnosis; with significantly more women now being diagnosed than men. In analysing online magazine articles they describe the ways in which ADHD appears to be specifically marketed to women; including via the use of symptom "checklists"

(p.21). Ebeling (2011) has suggested that the use of *self-diagnosis* tools has received very little analytic attention.

Although the notion of the 'marketisation-of-ADHD-to-women' is relatively new, some research has focused on the general promotion of 'ADHD-as-a-medical-disorder'. For example, Leo and Lacasse (2009) conducted a study of consumer advertisements for ADHD medications (DTCA). They suggested claims made were empirically unsubstantiated, and "oversimplified, one-sided presentations of complex medical and social issues" (p.308). Moreover, the ambiguity presented in medical literature was not mirrored in these adverts, with claims instead presented as unproblematic and straight-forward. The authors highlight the need for future research to focus on the full impact these adverts have on the diagnosis and treatment of ADHD; emphasising the increase in internet usage by 'consumers'. They also note that thus far there has been a severe lack of critical literature available in high-profile, mainstream journal publications or popular media outlets.

Although not written from a 'marketing-ADHD' perspective, three further studies are worthy of note. Norris and Lloyd's (2000) analysis of the representation of ADHD in newspaper articles found a clear preference for a biological account. In this study, the UK press sample presented parents and self-help groups as the strongest voices and advocates of the biological construction of ADHD. These groups were depicted as actively seeking diagnosis and medication; questioning medical professionals if they felt they were being denied such interventions. The authors describe these individuals as a "more challenging client group, with an increased emphasis on a right to diagnosis" (p.133).

Clarke (2011) examined popular portrayals of ADHD in magazine articles. Using content analysis she found numerous contradictory messages. Initially the articles appeared to cast doubt over the existence of the biomedical construct of ADHD; framing the medication as problematic. However, the aetiology of ADHD was consistently named as genetic or biological.

Finally, in Horton-Salway's (2010) discourse analysis of ADHD in UK newspapers, she also identified competing repertoires at work; the biological and the psychosocial. However, both appeared to still construct ADHD as individual pathology in need of professional intervention, and families in need of regulation.

1.13 Development and Environment of the Current Study

The development of this study has been influenced by the diverse literature available on ADHD as represented in this chapter. It has also been guided by discursive works on the construction of factual accounts; attending to the visual and the verbal (Potter, 1996; Woofitt, 2005; Emmison & Smith, 2007). In addition, inspiration has been taken from feminist critiques of mental illness (e.g. Ussher, 1991), philosophical accounts of the construction of knowledge (e.g. Foucault, 1972) and numerous authors who have studied the construction of 'psychiatric disorder' (e.g. Boyle, 2002; Rapley et al., 2012).

I am interested in language and the way it may be used to represent 'reality' and to promote action (Potter, 1996). Hence, discursive approaches are particularly appealing. I am also interested in attending to the 'visual', and considering the ways in which images cement the rhetorical claims that are made; offering a "literal visual-transcription of the real world" (Hall, 1973, p. 241).

Recently authors have been arguing for the visual to be taken more seriously in research. Emmison and Smith (2007) noted a tendency to use visual materials "in a purely illustrative, archival or documentary way rather than giving them more analytic treatment" (p. ix). However, they suggest that we are entering a new historical era; where the visual is positioned as a fundamental aspect of social life.

As discussed further in chapter 2, 80% of UK households now have an internet connection, increasing the accessibility of online material to the general public (Office of National Statistics, 2012). As such I elected to maintain a focus on electronic resources; choosing to select my corpus of data from the online video search engine YouTube.

1.13.1 YouTube

Founded in 2005, with a slogan of 'Broadcast yourself', YouTube has become a significant platform for people to share their thoughts and for companies to promote their products (Biagi, 2012). Operating as a subsidiary of Google (Woog, 2009), YouTube currently gains over 800 million new users each month, with over 1 trillion views in 2011 (YouTube, 2012). 72 hours of video footage is uploaded every minute, allowing registered users to comment, share, or vote whether they 'like' or 'dislike' a video (usage of this function has doubled since its inception in 2011) (YouTube, 2012). One hundred million people take such 'social action' on YouTube every week, and 700 YouTube videos are shared on Twitter (a linked on-line social networking facility) each minute. As stated on the website "people like to tell other people about the stuff they love" (YouTube, 2012).

1.14 Justification of the Current Study

The market for ADHD is growing and the sale of stimulant medication is rapidly increasing (Kendall et al., 2008). With the introduction of the DSM-V and more adult-inclusive diagnostic criteria, this trend looks likely to continue.

Moynihan & Henry (2006) have described 'disease mongering' as "the selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments" (p.425). The internet is now seen as *fundamental* in helping to deliver messages, sell products and promote action; hence it would make a valuable, if novel avenue of analysis (Conrad & Potter, 2000; Norris & Lloyd, 2000).

In the adult population research indicates 'treatment' rates to be highest amongst *females* (Castle et al., 2007). It would appear that promotional material is both exploiting and encouraging this trend (Moncrieff et al., 2011). However, thus far there has been minimal research into the construction of the 'ADHD-woman' or the ways in which the 'disorder' has been 'sold' to women (Moncrieff et al., 2011). Given the changes outlined above, it feels important to explore further the multi-media mechanisms through which 'disease mongering' and marketing may work

in relation to the promotion of ADHD to women, as well as the potential implications of this.

Clinical Psychology has come under heavy criticism in the past for failing to confront the medical perception of human distress. For example, Newnes (2011) has described the way clinical psychology strives to protect its privileged position by alternating between compliance and eclecticism in relation to psychiatric discourse. As a consequence clinical psychology has been seen to inadvertently strengthen the divide between 'normal' and 'abnormal' (Harper, 2010; Smail, 2001). Some authors have argued for clinical psychology research to take more of a political position (e.g. Patel, 2003). However, previous studies focusing on representations of ADHD in the media have either not stated a clear epistemological position (e.g. Horton-Salway, 2010) or have aimed to maintain a 'neutral' stance (e.g. Rafalovich, 2001). In taking an explicitly social constructionist approach to this study I hope to instead follow the lead of authors such as McHoul and Rapley (2005) in my critical, discursive approach.

Finally, I hope to contribute to the growing body of literature which challenges the construction of ADHD as a legitimate medical diagnosis; as well as reveal further mechanisms through which it maintains its status.

1.15 Research Aims

According to Harper (2006), some discourse analysts may choose not to formulate research questions in advance. Specific questions may excessively restrict focus, thus potentially missing interesting avenues of enquiry. Although this is an area of debate (Wooffitt, 2005); discursive psychologists tend not to include pre-determined research questions, instead providing a description of the intentions of the study (cf. McHoul & Rapley, 2005).

The aim of this study is to examine on a *local level* (cf. McHoul & Rapley, 2005) how ADHD is being turned into a commodity and marketed to women via publically accessible online videos. In the course of making transparent these processes I hope to encourage further questions (Foucault, 1977); thus contributing to "social change through critical analysis" (Wooffitt 2005, p.139).

2.0 METHODOLOGY

I will begin this chapter by discussing my epistemological position. I will then go on to describe the methodological approach of this study, before turning to a discussion of sample size and my approach to the analysis of the data.

2.1 Epistemology: A Social Constructionist Approach

Social constructionism should not be thought of as a "single and unified position" (Gergen & Gergen, 2003, p.2). Rather, it is best understood as a developing dialogue with many origins and interpretations. However, each account of social constructionism is thought to be connected through a "family resemblance" to one another (Burr, 2003, p.2). That is, the positions are brought together via their subscription to one or more key assumptions; there is no such thing as an objective reality waiting to be discovered; knowledge is maintained through social processes and is located within a historical and cultural context; it is vitally important to uphold a critical stance toward all taken-for-granted assumptions (Burr, 2003).

A specific distinction in social constructionist positions emerges in relation to the author's position on 'truth' and the status of 'reality' (Burr, 2003). A critical realist stance would hold that there is a reality which exists outside of discourse (e.g. Willig, 1999). In contrast, a relativist position would maintain a view in line with Derrida's claim that "there is nothing outside of the text" (Derrida, 1976, p.158). The latter, therefore takes more of a bottom-up approach (Burr, 2003) and pays close attention to the performative and context dependent nature of language (Foucault, 1972; Wittgenstein, 1953).

I have elected to take a *micro* social constructionist stance to this study; a relativist position. Such an approach "sees social construction taking place within everyday discourse between people in interaction" (Burr, 2003, p.21). This is in comparison to a macro approach which recognises the constructive power of language as derived from social structures and relations.

2.2 Methodology: Discourse Analysis and Discursive Psychology

To remain congruent with the values of such a micro approach, I have chosen to follow the principles of discourse analysis (DA) (Potter & Wetherell, 1987) and discursive psychology (DP) (Edwards & Potter, 1992). As such, I will aim to attend to the ways in which social construction occurs through the use of language in everyday discourse (Potter, 1996). Furthermore, I will be following the assumption that multiple versions of the world are potentially available, with no one version being any more 'real' than another, as the only reality we have access to is the text of this discourse (Burr, 2003).

2.3 Method: A Hybrid Discursive Psychology Approach

In this study I follow the lead of previous researchers (cf. McHoul & Rapley, 2005; Schubert et al., 2009) in employing a hybrid version of discursive psychology. The framework of my study will follow the traditions of DA and DP (Edwards & Potter, 1992; Potter & Wetherell, 1987). In addition, my epistemological stance will feature aspects of critical discourse analysis (CDA) (Fairclough, 1995) in that I am taking a 'problem-orientated' (Wodak & Meyer, 2009) approach to the examination of the marketing of ADHD to adult woman.

CDA and DP possess broad similarities such as a critical stance toward traditional psychological research methods (Wooffitt, 2005). However, they also possess subtle yet significant differences which may be seen as complementary of one another. Specifically, DP is primarily concerned with "*how* people *use* discursive resources in order to achieve interpersonal objectives in social interaction" (Willig, 2001, p.91, italics in original). In contrast, CDA aims to make transparent the relationships between discourse practices, social practices and social structures; relationships that might be opaque to the layperson (Fairclough, 1992). As such CDA "adopts an *overt political stance*, in terms of both the kinds of topic it studies and the role it sees for the results of the research" (Wooffitt, 2005, p.139). Thus CDA complements this study as it adds to the 'how' by asking *whose* interests are being served. In this way it has been said to function as an intervention "on the side of dominated and oppressed groups and against dominating groups" (Fairclough & Wodak, 2004, p.358). It also differs from other

forms of DA in that it begins with a declaration of the "emancipatory interests that motivate it" (Fairclough & Wodak, 2004, p.358).

I will now go on to discuss each aspect of my methodology in greater detail.

2.3.1 Discourse Analysis

DA emerged out of the sociological study of scientific knowledge and the observations of ethnomethodology, sociolinguistics, structuralism, speech act theory and rhetorical psychology (Wooffitt, 2005).

Typically the term 'discourse' has been understood as a concept belonging to linguistics (Potter & Wetherell, 1987). However, Foucault (1972) expanded the use of 'discourse' to include an analysis of the ways knowledge is produced through language and the rules that have governed discourse throughout history (Hall, 2003). Following this broader and more socially focussed understanding of 'discourse', Potter and Wetherall (1987) defined DA as the analysis of any form of "spoken interaction, formal and informal, and written texts of all kinds" (p.7).

2.3.2 Discursive Psychology

DP draws on research methods derived from an amalgamation of ethnomethodology and conversation analysis (Edwards & Potter, 1992). It may be seen as a descendant of DA, within a hierarchal relationship. However, the terms are also often used interchangeably (Burr, 2003). Edwards and Potter (1992) have suggested that DA helpfully draws attention to the connection with linguistics and social psychology. However, the title 'discourse analysis' is also often seen rather simplistically as a technique or method of analysis, similar to a questionnaire or experiment. Billig (1997) suggests DP is more than a methodology as it "involves a theoretical way of understanding the nature of discourse and the nature of psychological phenomena" (p.43). The title 'discursive psychology' was introduced to "indicate that there is more than a methodological shift at work; there is some fairly radical theoretical rethinking" (Edwards & Potter, 1992 p.11); away from a cognitivist approach.

Conventional psychological approaches to research generally employ more realist assumptions and interpretations of language and social action. Such approaches might focus on internal systems of mental representations and the rules that govern the cognitive mediation of external stimuli (Willig, 2008a). These mainstream approaches would treat language as a "window upon stable underlying representations of the world" (Edwards & Potter, 1992, p.8) and therefore a true reflection of a person's cognitive processes and underlying mental states.

DP makes a significant departure from this sort of cognitivism and instead seeks to examine the mechanisms through which knowledge is produced. As such, DP begins with discourse (talk and text) both theoretically and empirically. Discourse is not seen as the product of cognition and mental states, but as a domain of action in its own right (Edwards & Potter, 1992). By employing a micro-level analysis and examining naturally occurring talk and text, DP aims to uncover the way descriptions become 'fact' and how they are assembled in a way that allows such factual descriptions to perform particular actions (Potter, 1996). Rapley (2011) suggests five key questions that should be asked of talk:

1. Why *this*, now?
2. What other *than this* might have been said here?
3. What is *denied* by this utterance?
4. In what/whose *interest* does this utterance work?
5. What *position* does it serve to promote?

I hope to bring aspects of these questions to my analysis and discussion.

In summary, DP may be seen as offering a method of analysis that can help to inform us "about the discursive construction of social reality" (Willig, 2008a, p95); but *also* as a critique of mainstream psychology and conventional understandings of language.

2.3.3 Critical Discourse Analysis: 'Social change through critical analysis'[4]

In their analysis of an ADHD diagnostic session, McHoul and Rapley (2005) draw on CDA and conversation analysis within a discursive psychological framework. By implementing a hybrid approach, I will also be incorporating features of CDA.

CDA combines both macro and micro levels of analysis to examine and display the ideological workings of language. As discussed by Benwell and Stokoe (2006), CDA is "an explicitly political approach, which is dedicated to uncovering societal power asymmetries, hierarchies, and the oppression of particular groups" (p.9). Its aim is thus to identify the ways in which *discourses* function to maintain these hierarchies. Therefore, the inclusion of CDA somewhat alters the premise of this study as it does not commit to the typical obligation of "value neutrality" seen in other forms of discourse analysis (Burr, 2003, p.158). Rather, it selects the topic for study according to what is perceived to be a significant social problem (Fairclough, 1995). However, as Wodak and Meyer (2009) point out; the topic under examination does not need to be "related to negative or exceptionally 'serious' social or political experiences or events" (p.2), as might be taken from the lay understanding of the word 'critical'. Rather, critical investigation may be applied to any social problem; but this still inevitably "raises the question: A problem for whom?" (Fairclough, 2001, p.30).

Conventional psy-complex (Rose, 1985) and mainstream perspectives view ADHD as the problem to be examined. In contrast, I have chosen to perceive the construction and preservation of 'ADHD-as-a-disorder' as the social problem to be studied (cf. McHoul & Rapley, 2005). A principle assumption of CDA is that language and power are linked (Fairclough, 2001); I am also interested in analysing the ways in which ADHD is not only sustained within the biomedical discourse, but also powerfully promoted to women as a desirable diagnosis to attain.

CDA "is not a method, but rather a critical *perspective*, *position* or *attitude* within the discipline of multidisciplinary discourse studies" (van Dijk, 2009, p.62, italics in original). As such, it draws on a range of methods from discourse studies,

[4] Wooffitt (2005, p. 139).

social studies, psychology and the humanities. Accordingly, and following on from previous 'hybrid' research (cf. McHoul & Rapley, 2005), I will not be presenting CDA as a separate section of analysis. Rather, I plan to draw on CDA throughout my analysis and discussion in deconstructing the themes, concepts and power relations that are embedded within the text (Fairclough, 1992).

2.4 Researching the Visual[5]

There is an increasing interest in the analysis of visual images in research (Emmison & Smith 2007; Floch, 2000).

Potter and Wetherell (1987) describe the aim of social psychologists as "expecting to gain a better understanding of social life and social interaction from our study of social texts" (p.7). However, the interpretation of what counts as 'text' has been somewhat debated (Burr, 2003).

In discussing Foucault's approach to discourse Hall (1992) explains: "since all social practices entail meaning, and meanings shape and influence what we do – our conduct – all practices have a discursive aspect" (p.291). Following the suggestion that all social practices carry meaning, Burr (2003) proposes the metaphor of seeing "life as a text" (p.66). She suggests that texts are not limited to spoken utterances or the written form, but may be understood to be "any printed, visual, oral or auditory production that is available for reading, viewing or hearing" (p.18).

Within a CDA approach 'text' is also interpreted as referring to "a speech or spoken discourse, written documents, visual images, or some combination of these three" (Wooffitt, 2005, p.139). As described by Wooffitt (2005), texts are regarded as "multi-semiotic because many forms of representation may be combined in their construction" (p.139). Taking the example of a television advertisement, Wooffitt describes the multiple layers of meaning (music, spoken words, written words, visual images) which strengthen the compelling nature of the message about the product on sale. To attain a balanced understanding of

[5] Emmison and Smith (2000).

the way meaning is produced it is thus essential to extend the analysis beyond purely linguistic representations. These additional properties of the text are seen as "extraordinarily sensitive indicators of sociocultural processes, relations and change" (Fairclough, 1995, p.2).

As I am aiming to examine the marketisation of ADHD to women, my analysis will attend to both the spoken utterances and the visual images presented in the videos. The term *visual rhetoric* has been used to describe the "relationship of visual images to persuasion" (Hill & Helmers, 2004, p.1). I am interested in examining the ways in which the pictures do the rhetorical work of cementing the claims that are made; as well as how these additional 'textural' properties 'reflect broader cultural and social influences' (Wooffitt, 2005).

2.5 Description of the Sample

I will be analysing data collected via 'YouTube' (www.youtube.com), using the simple search term 'ADHD Women' to ensure the videos are easily accessible to the general public. My sample will incorporate information shared by both 'sufferers' and 'professionals' on the emerging social phenomenon of 'adult-ADHD-in-women'.

The videos selected for analysis are those which appeared most consistently within the top seven results during the census period of September 2011 and July 2012[6] (see Appendix 3). They represent a combination of clips recorded in the US and the UK. I am aware that this study is part of my NHS-funded, UK doctoral thesis, and as such, it may be argued that British videos would hold more relevance. However, I used the inclusion criteria of 'top-seven results' instead of 'UK only', as these are the videos that people will find in the *UK* when 'ADHD Women' is searched for. YouTube is a global phenomenon and I feel that restricting analysis to British videos would be a misrepresentation of the information that is being accessed by the UK population.

[6] 8 repeated searches every 6 weeks

2.5.1 Sample Size

> *Nature uses only the longest threads to weave her patterns, so each small piece of her fabric reveals the organisation of the entire tapestry.*
>
> Feynman (1965, p.34)[7]

According to Potter and Wetherell (1987), the successful outcome of a study is not dependent on the sample size. This is in contrast to conventional positivist approaches to psychological research with an emphasis on attaining a large sample size to maximise the reliability and generalisability of results (Clark-Carter, 2010). Rather, the main determinant of sample size of a discursive piece rests primarily on the research question. Indeed, a number of studies have been based on the analysis of a single text (e.g. Coulter & Rapley, 2011; McHoul & Rapley, 2005; O'Byrne et al., 2006; Smith, 1978).

The aim of my study is to examine the discursive strategies used by 'sufferers' and 'professionals' in the marketisation of ADHD to women. My sample size therefore needs to be of a sufficient size to identify a range of strategies and their use within different discursive contexts. However, I also want to avoid "getting bogged down in too much data and not being able to let the linguistic detail emerge from the mountains of text" (Potter & Wetherall, 1987, p.161). This is made even more prominent by the pragmatic context of the time limitations placed on a doctoral thesis.

By drawing on the traditions of discourse analysis and discursive psychology my aim is to complete a very detailed analysis of a small sample of videos (N=7). Consequently, I am not intending to claim generalisabilty of my analysis. However, as with discursive studies before this, I am relying on Sack's (1992) assumption that cultures display 'order at all points'. That is:

[7] Nobel-Prize Winning Quantum Physicist

> *Cultures are such that their features can't simply be aggregated or counted. Instead, even very small fragments of them (particular 'cultural objects'), according to Sacks, must (as with holograms) display the order inherent in the whole.*
>
> McCarthy and Rapley (2001)

I am therefore working from the premise that, if by taking only a few small fragments of video footage I find examples of specific discursive practices in play; then I can logically anticipate the discovery of similar practices elsewhere. Henceforth, in my analysis of these videos I am hoping to expose something about wider discursive practices related to women and ADHD.

2.5.2 Using Naturalistic Data

"The discursive approach is itself strongly orientated towards naturally occurring texts and talk" (Edwards & Potter, 1992, p.95). One of the many advantages highlighted in using naturalistic data is the absence of researcher influence on the material collated (Potter & Wetherell, 1987). This is in comparison to, for example, researcher-generated interview data. In keeping with such traditions, I have elected to use naturalistic data gathered from publically accessible online videos.

2.5.3 Using Online Data

I will now briefly turn to an anticipated critique of this study: the use of online information for analysis. It could be argued that the use of YouTube videos is likely to produce unreliable data from potentially dubious sources. Furthermore, if such information was followed up by a psy-professional or medical doctor it may be easily invalidated and disregarded as misinformation.

In a survey of individuals who sought health related information online, 90% believed the information they received was reliable (Harris Interactive, 2011). We are now very much in a 'digital-age', a transition tracked by Hansen et al. (2003). The authors described the rise in psychological software in the 1980s, accompanied by the availability of more affordable computers for both public and

domestic use. Subsequently, the internet was introduced; connecting households and offering everything from psychological self-assessments, to cyber-therapy, to self-help and support groups. Recent data from the Office of National Statistics (2012a) has revealed that internet access has continued to increase with new technology expanding the horizons of accessibility and convenience. In Great Britain, 80% of households now have access to the internet and 45% of internet users browse online using a mobile phone.

Moncrieff et al. (2011) have noted the rapidly increasing amounts of ADHD educational and promotional material aimed at women, including an abundance of online material. Websites often refer to the 'risk' of women being overlooked and therefore missing out on both their diagnosis and potential treatment. Moncrieff et al. (2011) also make reference to the ADDitude magazine's website with articles that offer help to recognise 'symptoms' and access help (Connolly, 2010). A number of these 'self-help', charity and commercially sponsored websites now also have their own channels on YouTube (ADDitude being one such example).

'Sufferers', 'doctors', 'family members', 'life coaches', 'psychotherapists' and 'news reporters', all claiming authority and expertise, are ready to offer their advice and encouragement via the highly convenient and compelling medium of YouTube; they are just 'a click away'. Coupled with the credibility people seemingly ascribe these internet sources (Harris Interactive, 2011), and the message from many of the videos promoting the need to 'fight for your diagnosis', I feel this is a new social phenomenon well worth exploring.

2.5.4 Using Edited Media Texts

The videos presented for analysis in this study are edited, constructed media texts. As an important feature of fact construction in broadcast media, interviews can be edited in a way that strengthens or weakens particular perspectives (Potter, 1996). With each of these videos, it is likely that the material presented was consciously chosen by the producers to tell a story and accomplish particular aims. Hence, in the videos with an 'interview' component, it is likely that the interviewees were not chosen at 'random', but rather they were chosen to ensure

a specific message was communicated. The interviewees may have been briefed or provided with scripts and I am aware that at least one of these videos possesses a clandestine connection to a pharmaceutical company (see 3.7.1).

The aim of this thesis is not to ascertain the credibility of the YouTube footage. Rather, I am interested in what the various pieces of 'ADHD talk' are achieving, and how they are doing this.

2.6 Process

> *There is no method to discourse analysis in the way we traditionally think of an experimental method or content analysis method. What we have is a broad theoretical framework concerning the nature of discourse and its role in social life, along with a set of suggestions about how discourse can be studied and how others can be convinced findings are genuine.*
>
> Potter and Wetherell (1987, p.175)

2.6.1 Analytic Steps

1. Having decided on YouTube as my sampling source, I searched for 'ADHD Women' and noted the top seven results. I repeated this process a further seven times over the census period of September 2011 - July 2012[8] (each search approximately six weeks apart, see Appendix 3).

2. I collated the seven most commonly featured videos and ordered them according to frequency of appearance (see Appendix 4).

3. Using freely available software I downloaded the videos and audio in mp4 and mp3 format (for compatibility with the transcribing software).

[8] New videos have been added since July 2012, however, due to the time and size restrictions of my thesis; I used July 2012 and 'seven videos' as my cut-off.

4. After watching the videos a number of times, I transcribed them using the Jefferson Lite protocol (Parker, 2005)[9] and began the process of preliminary coding[10]. As noted by Potter and Wetherall, (1987), the aim of coding "is not to find results, but to squeeze an unwieldy body of discourse into manageable chunks" (p.167). This is unlike the characteristic techniques of content analysis; with an emphasis on frequency of occurrence equalling the analysis. Thus, coding aims to be *as inclusive as possible* rather than the "analytic goal of collecting together instances for examination" (p.167).

5. I closely examined the text and accompanying screenshots a number of times over different days during a period of around four months. Throughout this time I continued to highlight words and phrases and make notes. Potter and Wetherall (1987) suggest that analysis involves two phases: phase one centring on the identification of "systemic patterns in the data" and phase two focusing on a search for "functional effects and consequences" (Tuffin & Howard, 2001, p.203). In line with these phases I began by grouping the text based on patterns of similarity and difference (e.g. in relation to common sense understandings used) before moving onto phase 2[11].

6. Tuffin and Howard (2001) have emphasised the importance of resisting any urge to impose groupings upon the text. Rather, categories should be allowed to materialise from the numerous readings and re-readings. Once the categories had been decided, I carried out a closer reading of each grouping whilst referring back to the accompanying screen shots. My aim was to identify the particular micro-level rhetorical devices that had been used whist also attending to the themes, concepts and power relations embedded within the text (Fairclough, 1992).

[9] See Appendix 5: Transcription-Key.

[10] See Appendix 6: Glossary of Rhetorical Devices.

[11] See Appendix 7: Worked Example of Transcript.

2.6.2 Reflexivity

Qualitative analysis is highly subjective and my analysis of the material may yield different results to that of another researcher. Reflexivity played a vital role here; I endeavoured to remain aware of my assumptions and aspects of language I might 'take for granted'. I regularly asked myself "why am I reading this passage in this way? What features produce this reading?" (Potter & Wetherall, 1987, p.168). Maintaining a reflexive diary (Appendix 9) and engaging in ongoing conversations with my colleagues and supervisors helped me to remain flexible and interested in new ideas and hold in mind the "concepts of construction, variability and function" (Tuffin & Howard, 2001, p.203).

In addition to research supervision, I was also in contact with the Loughborough Discourse and Rhetoric Group (DARG). I was fortunate enough to present a section of Video 2 to DARG (see Appendix 8) and engage in a number of supervisory consultation sessions with the group's members.

2.7 Ethics

The data used for analysis in this study is comprised of publically accessible online material; no participants were involved. As such, ethical approval was not sought from NHS or clinical ethics committees. Furthermore, no special measures were required with regards anonymity and confidentiality.

This study was registered and approved by the University of East London, in line with doctoral clinical psychology research guidelines.

3.0 ANALYSIS AND INITIAL DISCUSSION

In this chapter I present my analysis of YouTube videos following the search criteria of 'ADHD women'.

3.1 The Corpus of Data

3.1.1 The Videos

The extracts analysed in this chapter represent a combination of first person testimony from the 'sufferer', and the sharing of 'expertise' by 'professionals'. The videos are either presented as a 'blog'[12] (Videos 3-7), a brief-documentary (Video 1) or a news item (Video 2). As such, a common rhetorical device employed is that of *category entitlement*[13] (Potter, 1996), either as a 'professional expert', a 'sufferer', or both. This device will be explored in greater detail later in this chapter.

Further information about each of the videos may be found in Appendix 9.

3.1.2 The Categories

Following the process described in chapter 2, the presentation of my analysis will be organised by the following categories:

- The ADHD Checklist.
- 'ADD is real': Biomedical Discourse
- The 'Light-Bulb' Moment.
- If you get this Label, your Life will be Better.
- The Invisible Disability: Prejudice and the Battle to be Diagnosed
- ADHD ~~Performance Enhancers~~ Medication
- Who am I? A Note on Identity.

I will now go on to discuss each of the above categories in turn by providing example extracts from the videos.

[12] Written, audio or video internet postings in which opinions, information and experiences are shared.

[13] Italics are used to signify the use of a rhetorical device.

3.2 The ADHD Checklist

In each of the videos the audience is offered a number of 'symptoms' which relate to a diagnosis of ADHD. When presented by 'professionals', these 'symptoms' take a somewhat structured 'checklist' form; allowing the female audience to identify aspects of the 'disorder' which may relate to them. Potter (1996) has described how the use of *lists* is very effective in achieving credibility in oratory. *Lists* in this context may also be experienced as reminiscent of those presented in 'professional' diagnostic manuals.

In this section I will explore the work 'professionals' do to provide a precise presentation of 'ADHD-in-women', as well as offering numerous *cues to action*.

3.2.1 DIY Diagnosis

According to Visser and Jehan (2010) the biomedical discourse of ADHD gains ascendancy to the position of 'truth' by channelling its content to the public through individuals in a position of power, such as doctors and psychiatrists. These people are "perceived to create, sustain and convey the knowledge which crystallises what is deemed to be 'right' and 'wrong', what is deemed to be 'normal' and what is 'deviant'" (p.135).

The credibility of the 'professional' accounts is enhanced by the assumed 'expert' status of the presenter. That is, it is generally accepted that certain categories of people are entitled to make specific knowledge claims, thus giving special credence to their accounts. Potter (1996) described this rhetorical device as *category entitlement*. For example, within the context of Western society it is accepted that doctors possess authority on the topic of illness and are therefore especially knowledgeable in that area. Likewise, a title of 'clinical psychologist' or 'psychotherapist' suggests that this is an 'expert' who is permitted to convey specialist knowledge about *mental health*. Any statement from this expert is accorded a taken-for-granted level of unquestioned credibility. The plausibility of said expert is further exaggerated by the addition of 'Specialist' or 'Consultant' to their title, increasing their apparent level of expertise.

Below are extracts of professional testimony from: Dr Mary Solanto (“psychologist who specialises in ADHD”, Video 2 Line 34), Dr Stephanie Sarkis (“author and psychotherapist”, line 1-2, video 5; diagnosed with ADHD) and Dr Carolyn Long (“therapist, minister, author and consultant”, Line 19, video 7).

The symptoms listed in some of the videos are too long to include in their entirety here. For example, Dr Long speaks for just under 7 minutes on the different indications to look out for. Often the symptoms are very general, for example “Do you struggle with inattention, that is, day dreaming or being easily distracted?” (video 7, lines 2-3). Other examples are more specific to adulthood as exemplified in extracts 1 and 2.

Extract: 1

58 You know those adults who struggle
59 with parenting. They struggle with taking care of their work
60 place. They struggle with maintaining their life, err, activities,
61 such as keeping their house, buying the groceries, err,
62 balancing the cheque book. Or they may be people who are
63 crisis prone; there’s just one crisis after another. And many
64 of these crises maybe related to the fact that they are very
65 poorly organised.

Video 7, Dr Long

As Dr Long works through her list of symptoms she stands, smartly dressed, wearing glasses, in front of a well stocked book shelf (Figure 1). This image succinctly shows us evidence of Dr Long’s academic, educated and knowledgeable status. Her furrowed brow and clenched teeth create a look of intensity and help to communicate her message as ‘serious’. A banner across the bottom of the screen reads ‘Education - Counselling - Consulting Services’, followed by ‘Christian Psychotherapy Service’ and finally ‘Invite Dr Long to your next event!’ The inclusion of ‘Christianity’ implies morality and honesty. All of the above adds to her ‘doctor’ credibility.

Figure 1

Dr Long was the only black professional represented in this corpus of data. Amongst black children in the US, the gender gap in diagnosis appears to be decreasing (Getahun et al., 2013). However, ADHD is still predominantly seen as a disorder for 'white boys' (Timimi & Taylor, 2004). Dr Long may help to raise the 'visibility' of ADHD to women of black and minority ethnic backgrounds.

Similarly to Dr Long, Dr Solanto's expert status is emphasised by her environment as can be seen in Figure 2.

Figure 2

Dr Solanto is filmed in what appears to be her office. She is sat in front of a computer which displays pictures of brains scans. Her positioning suggests she has just turned from her work to talk to the camera. Also within view is a shelf holding what appear to be academic books, and a notice board full of papers.

In considering the visual imagery it is important to reflect on the historical and cultural lens of the audience (Hill & Helmers, 2004). A variant of the layout in Figure 2 may be seen in most doctors' surgeries in the UK and other western countries. Thus, this layout becomes synonymous with receiving specialist medical advice and treatment. In addition, this arrangement may be witnessed on news items in which experts share their professional opinion on issues of public interest. Hence, the audience's familiarity with this setting and the corresponding scripts enhance the visual rhetoric of extract 2, and work to cement Dr Solanto's position as an expert worthy of national news coverage.

Extract: 2

Dr Solanto: Paying bills, doing taxes, house cleaning, maintaining order and organisation. Those are the kinds of tasks that people with ADHD find particularly (.) aversive.

Reporter: To an extreme though, I mean you're describing everybody out there <Dr Solanto: yeh>. Everyone forgets to complete tasks <Dr Solanto: yeh>, everybody walks into a room <Dr Solanto: yeh> and forgets why they went there <Dr Solanto: yeh>.

Dr Solanto: Everybody does (.) now and then, but, err, for people with ADHD this might go so far as forgetting, or not paying the bill, even though one has the money, so often or for such a long time that the lights get turned off.

Video 2: CBS News

In lines 39-40, the reporter points out “Everyone forgets to complete tasks”. Indeed, critics of ADHD would argue that the behaviours described in both extracts 1 and 2 are relatively ‘normal’ behaviours as opposed to symptoms of an underlying illness. Smith (1978) suggests that what is thought of as normal or abnormal is indexical. Hence, what helps Dr Solanto construct such behaviours as abnormal and pathological is both her use of the word ‘*even’* in the sentence “even though one has the money” (line 45) and her description of the extent to which the behaviour is occurring as “so often and for such a long time” (lines45-46). Furthermore, this response has been set up by the reporter who has already opened the suggestion that the behaviours must be “extreme” (line 38) to be considered a problem. These sentences provide examples of *extreme case formulations* and as such, construct the behaviour as significantly different from the norm (Pomerantz, 1986).

The rhetorical device of *concession* (Potter, 1996) is used by Dr Solanto in the beginning of her response to the reporter. In using a *concession* the speaker explicitly acknowledges a potential counter-claim; in line 43 Dr Solanto accepts the suggestion that “everyone forgets to complete tasks” (lines 39-40). Hence the “but” (line 43), symbolic of the position Dr Solonto eventually advocates for, seems more reasonable and robust as she appears to have considered both sides of the argument before reaching her conclusion. Consequently, Dr Solanto is portrayed as balanced and informed, and her conclusion thus seems to reflect an evaluation of the available evidence rather than her own personal agenda.

In lines 44-45 of extract 2, the relatively benign example of “not paying the bill” is offered as an illustration of an ADHD symptom. This ‘symptom’, as well as others presented by Dr Long and Dr Solanto, works to efficiently *democratise* access to the ADHD diagnosis. That is, these are common, ‘every-day’ experiences, but have been conceptualised as symptomatic of a disabling brain disorder for which help must be sought. Thus ADHD becomes a remarkably *inclusive disorder*.

According to the health belief model (Becker, 1974), it is hypothesised that a person’s beliefs will influence their health related actions or behaviours; and an important influence on peoples beliefs are the *cues to action*. These can include

external events, such as news reports and health awareness campaigns. At the end of Dr Long's video she draws attention to the cue to action by asking: "have you heard anything that maybe pertains to you? Or maybe to someone very close to you" (video 7, lines 78-79). In the following extracts, Dr Long and Dr Sarkis provide encouragement to seek further treatment and support.

Extract: 3

82 If you perhaps are diagnosed with
83 ADHD as an adult women then I want you to know that there
84 is hope, there is help and there is healing. There ar-, there
85 are resources to help you live the abundant life, even if you
86 do have this diagnosable disorder.

Video 7: Dr Long

Extract 4:

51 erm, even though you were diagnosed later, that's ok, erm,
52 the important thing is that you do know now, that ADHD is an
53 issue and now you can seek treatment.

Video 5: Dr Sarkis

The word "even" is again used in both extract 3 and 4. This time it functions as an alert to women who may think they have the disorder to take action. It suggests that *even* though they have the "diagnosable disorder" (extract 3, lines 85-86) or *even* though they were "diagnosed later" (extract 4, line 51) there is still time to get help. This is reminiscent of physical health campaigns aiming to engender optimism in treatment. For example: "So, *even* if you have recently been diagnosed with prostate cancer (...) there is a good chance your cancer will be cured or controlled" (Cancer Research Institute, 2009, p.1, emphasis added).

By using an easily recognisable health promotion model there is encouragement to trust the advice on the assumption that it is backed up by *good scientific*

research. Whereas previously in the extracts the audience have been offered 'do-it-yourself' lists via which *they* may select 'symptoms' relating to their own experiences (*internal locus of control*), there is a switch to a more infantilising attitude in this excerpt. This implies an *external locus of control* and the need to 'purchase' the doctors expertise, which is coupled with encouragement to "seek treatment" in a passive, patient-type role (extract 4, line 53).

As discussed in chapter 1, the goal of DTCA is to encourage potential patients to visit their doctor (Loden & Schooler, 1998). It is hypothesised that people will be more likely to visit their doctor with concerns, if they have witnessed an advertisement for a 'disease'. Supporters of DTCA suggest this is essential in promoting health awareness and ensuring people get treated. However, implicit in this logic is the assumption that the information being provided to the 'consumers' is both rigorous and valid (Leo & Lacasse, 2009); an assumption which has been met with a great deal of criticism (Timimi & Leo, 2009).

3.3 'ADD is real'[14]: Biomedical Discourse

As discussed in section 1.6, the validity of the ADHD diagnosis has been heavily contested. However, each of these videos unquestioningly promote a biomedical account; constructing ADHD as a legitimate medical disorder.

Extract: 5

27	ADD is real. And some people treat it like it's some magic
28	thing that's never been studied or proven before. It's pretty
29	simple to run a test to see if there's physical proof of the
30	malfunctioning of chemicals in your brain. And it's also pretty
31	simple to take a pill that corrects those imbalances.

Video 4: Ashley

As proposed by Boyle (2002) in her analysis of the construction of 'schizophrenia'; one of the most successful ways to transform a social construct

[14] Extract 5, line27

into a medical disorder is merely to state that it exists. Statements such as this can be observed throughout the videos as exemplified here by Ashley when she declares: “ADD is real” (extract 5, line 27). This process of fact construction is assisted by the rhetorical device of *reification* (Potter, 1996) which works to “turn something abstract into a material thing” (p.107). There are examples of reification throughout all of the extracts, as ADHD is offered to the audience as a factual ‘thing’ that exists in the world. Hence, claims such as “I have ADD” (video 4, line 5) may be made without question. Such claims also work to undermine any alternative accounts of the phenomenon; a device Potter (1996) has termed *offensive rhetoric*.

The mini-documentary ‘ADHD Myth or Reality’ (video 1) begins with an image of a waterfall before the presenter steps into shot (Figures 3 and 4). She then speaks of her own positive experience of being diagnosed with ADHD and outlines her aim to disprove the “common myth in society, and even in parts of the professional world that ADHD grows out of teenagers once they reach the age of 16 to 18” (video 1, lines 14-16). Use of the natural environment is often used in advertising to signify purity and the ‘natural’ qualities of a product (Hill & Helmers, 2004). Considering the question of ‘Why *this*, now?’ (Rapley, 2011), it may be hypothesised that these are some of the qualities the documentary makers are hoping to entwine with the concept of ADHD; a normal, natural and accepted disorder. This construction is explored in more detail below.

Figure 3

Figure 4

3.3.1 'ADHD' Brains are Different to 'Normal' Brains

3.3.1.1 Neuroimaging

> *Brain imaging is a persuasive visual rhetoric by which neuroscience is articulated as relevant to the construction and maintenance of desirable selves.*
>
> Johnson (2008, p.147)

Brain scans are often called upon as concrete and undisputable evidence of the existence of ADHD. Indeed, as Leo and Cohen (2009) point out, for those "who wonder whether or not the ADHD diagnosis points to an underlying disease, and whether its treatment requires drugs, the neuroimaging research and its accompanying images can be deciding factors" (p.92). Unquestioned in such claims is the assumption that 'the brain' is *dormant* unless some measurement display is brightly activated; showing the brain is now *alive*.

Extract: 6

Reporter: But what causes ADHD? Dr Solonto showed us these scans that point to a problem in the brain's executive centre.

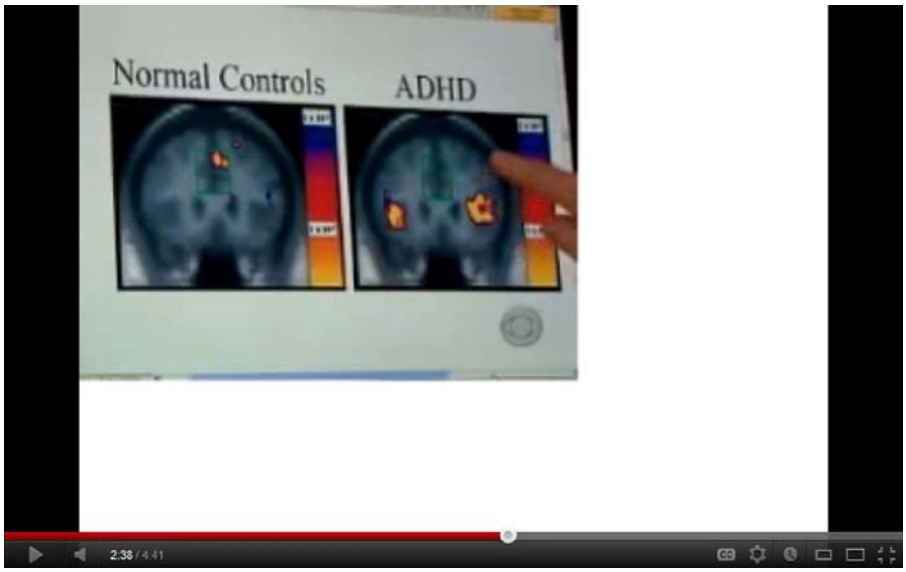
Dr Solanto: The 'Normals' have a lot more activation in this executive centre. The ADHD people have virtually none. They activate a different area, in a larger, more diffuse way.

Reporter: Any idea of a cause?

Dr Solanto: All the evidence indicates it's genetic, in origin.

Video 2: CBS News

Figure 5



Extract: 7

Reporter: All 3 women got help from medication, which works by stimulating the area of the brain that <u>isn't</u> active. Doctors say this is the <u>best</u> form of treatment.

Video 2: CBS News

Images of brain scans (Figure 5) hold significant rhetorical appeal, yet they do not represent the “controversies and uncertainties” (Stepnisky, 2007, p.191) surrounding neurological hypotheses of ‘mental illness’. Regardless, research utilising modern neuroimaging techniques is amongst the most cited in support of the use of stimulants to treat “abnormal brains” (Leo & Cohen, 2009, p.92). Indeed, such images of the brain “have become a powerful aid in the marketing of ADHD medications, as the images are believed to document the existence of a definable and visible neuropathological abnormality” (Leo & Lacasse, 2009, p.289). Analysis of these studies, however, reveals inconsistencies and incoherence (Baumeister & Hawkins, 2001). Similarly, the notion of genetic aetiology (e.g. extract 6, line 53) has been contested. Nonetheless, through the funding and publication of research into bio-genetic causes of ADHD, a relationship has been constructed between the disorder and organic causes, regardless of what results are reached (Timimi & Radcliffe, 2005).

As described by Potter (1996), “in situations of conflict in both scientific and everyday settings people will provide increasingly technical support for positions and be increasingly concerned with giving a basis to their claims” (p.158). The validity of ‘brain scans’ in evidencing the existence of ADHD is highly contested (Leo & Cohen, 2009a). However, extracts 6 and 7 demonstrate numerous rhetorical devices, which work to make such accounts appear more credible.

In declaring ADHD is a ‘brain disorder’, requiring medication, the presenters employ what Edwards and Potter (1992) have titled *systemic vagueness*. This device functions to provide a vague global formulation, with sufficient information to establish a statement, whilst averting the straightforward challenges that a lot of detail might permit. Here, this device works to convince the audience of the neurological aetiology of ADHD, whilst making it difficult to establish any counter claims. To take video 2 as an example; in extract 6 Dr Solanto explains that the brains of individuals with ADHD are active in different areas to “normal” brains as they lack activity in the “executive centre” (line 49-50) and are instead active “in a larger, more diffuse way” (line 51). This leads smoothly into the closing account of the reporter, (extract 7, line 65) who states that the drugs work “by stimulating the area of the brain that isn’t active”. However, there is no explanation of: the

mechanisms via which the drugs take action; exactly what area of the brain *is* activated; how the drugs stimulate only specific parts of the brain.

The convincing nature of these extracts is also aided by the use of *empiricist discourse* (Gilbert & Mulkay, 1984). This describes the language 'scientists' utilise when presenting such impersonal grammatical constructions as "All the evidence indicates it's genetic in origin" (extract 6, line 53). Such a rhetorical device functions to construct what Potter (1996) has labelled *out-there-ness*. This produces a description as independent of the presenter whilst the evidence is also seen to *speak for itself.* Hence, when Dr Solanto presents this *extreme case formulation*, her contribution to the collecting or interpreting the evidence is minimised. She personifies the claim as though it is the evidence itself that makes the case, not her subjective interpretation of it. Thus, the data is constructed as having its own agency; with Dr Solanto as a passive messenger of the empirical findings. This process has been described by Gilbert and Mulkay (1984) as *grammatical impersonality*; the focus is taken away from Dr Solanto and her potential *stake* in the account she is providing, as well as any responsibility for it. Moreover, through the primacy given to the role of empirical findings and the omission of reference to Dr Solanto's beliefs or actions "the speaker's scientific conclusions appear entirely unproblematic and in need of no further support" (Gilbert & McKay, 1982, p.400).

The device of *out-there-ness* is mirrored in the reporter's summary of the effectiveness of medication: "Doctors say this is the best form of treatment" (extract 7, lines 65-66); a misleading and unsupported assertion. However, through the rhetoric of *category entitlement* the source of information is credited to 'doctors'; the plural form implying *all* doctors would make this recommendation.

3.3.1.2 Chemical imbalances

The notion of the 'chemical imbalance' encapsulates popular "lay and professional conceptions of the mechanism of mental illness" (Cohen & Hughs, 2008, p.176). Indeed, the discourse of 'neurotransmitter imbalance' is often used as supporting 'evidence' for the biological origins of ADHD. Ashley (Figure 6) provides such an explanation in extracts 8-9, with the aid of a 'graph' (Figure 7).

Figure 6

Extract: 8

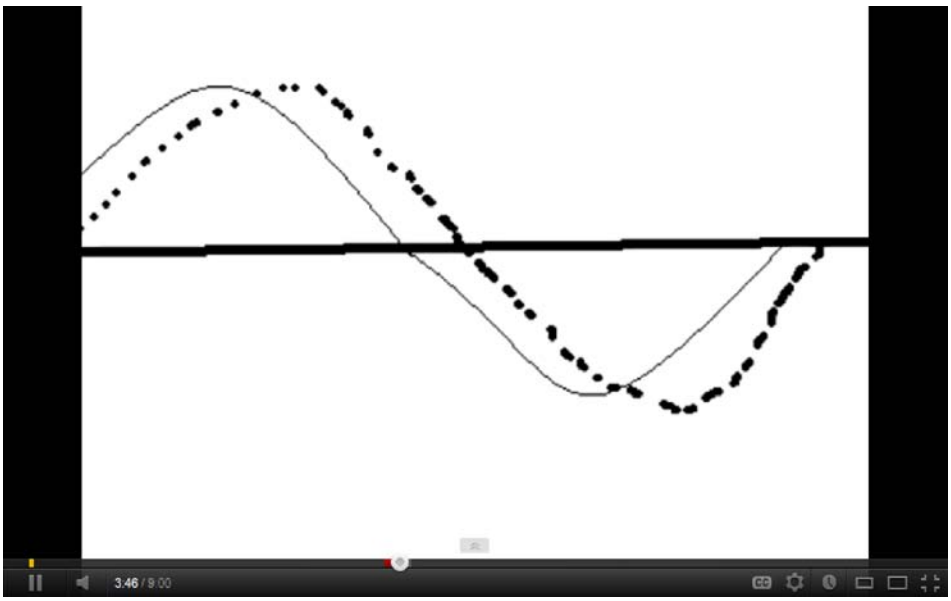
Ok, my doctor explained it like this: it's like the chemical that makes us satisfied with whatever we're doing is produced w::ay less in my brain and that causes me to want to move on to something different every 2 minutes coz I'm never satisfied with what I'm doing.

Extract: 9

Now this is important; if you take ADD medication; Adderrall, Ritalin, Concerta and you don't have ADD, your brain tries to correct an imbalance that isn't there. Effectively giving you ADD. Ok a friend of mine explained it this way: Alright, now the solid line is a normal brain wave, the dotted line is a particular brain wave that is known as 'out of phase'. It's a rebellious, delinquent brain wave. It doesn't sit with the other brainwaves correctly and that's the problem. ADD medication shifts those particular waves back into phase. Now if someone's brainwaves are perfectly in phase, and they take ADD medication, it pushes them out of phase. This is why it has an opposite effect in people without ADD.

Video 4: Ashley

Figure 7



Self-help literature has been seen to disseminate “neuroscientific vocabularies” to the general public (Johnson, 2008, p. 147). Indeed, the above extracts would appear to reflect the consumer information which is often provided within pharmaceutical leaflets and websites, supporting the theory of a *chemical imbalance*, for example:

> *The behavioral manifestations of ADHD are believed to involve an interactive imbalance between dopaminergic and other neurotransmitter systems.*
>
> Shire (2009)

> *Stimulants are believed to enhance the availability of the brain's chemical messengers dopamine and norepinephrine.*
>
> Concerta (2012)

Leo and Lacasse (2009) have outlined four potential challenges to the atypical neurotransmitter model of ADHD. Firstly, the chemical imbalance theory represents a metaphorical illustration as opposed to *scientific fact.* Secondly, a

valid test of neurotransmitter levels does not exist. Thirdly, no scientific study has evidenced altered neurotransmitter levels in individuals with a diagnosis of *ADHD*. Fourthly, these types of statements made by pharmaceutical companies are grounded solely in indirect evidence.

Ashley's testimony helps to establish this theory as fact by providing a first person account of the impact of such 'abnormality' on everyday life (e.g. extract 8). Here, the 'biological' account is made to appear more plausible by presenting agreement between 'scientific fact' and 'sufferer testimony'. Potter (1996) has referred to this as *consensus and corroboration*. What is more, as a 'witness' Ashley could be considered an appealing messenger to other young women of her presumed cultural setting. Her stereotypic attractiveness and apparent qualities of assertiveness and intelligence may be seen as aspirational within the western culture (Figure 6). This is reminiscent of advertising campaigns for beauty products and enhancers which are often personified and promoted by beautiful women (Hill, 2002). Ashley's physical presentation thus further adds to the already powerful devices of *category entitlement* and *direct reported* speech (Wooffitt, 2005).

Stimulants improve attention regardless of whether the individual has been diagnosed with ADHD or not (Rapoport et al., 1978). However, Ashley endorses a warning that medication will induce ADD in someone who has not been diagnosed with the disorder (extract 9). As discussed by Leo and Lacasse, (2009), consumers will have no inkling of the contentious nature of the biochemistry claims if relying solely on information supplied by pharmaceutical companies. For Ashley this appears to have led to a somewhat 'naïve faith' in claims based on a highly controversial and selective evidence base.

Regardless of the validity of Ashley's claims; her argument could be experienced as persuasive. This is in part aided by the use of the graph (Figure 7) as visual reinforcement (Campbell & Huxman, 2009). She also enhances the level of persuasion by using the *rhetoric of argument.* For example, in extract 9 she uses *hypothetical syllogism* (McKay,1999) to construct an account of ADHD brains as

different to normal brains. This is described in the study of 'Formal Logic' as a *valid argument form* (McKay,1999).

> *If you don't have ADHD and you take drugs, then your brain tries to correct an imbalance that isn't there.*
>
> *If your brain tries to correct an imbalance that isn't there, then you have given yourself ADD.*
>
> *So if you don't have ADD and you take ADD meds, then you have given yourself ADD.*

In theory, even an *invalid* argument structure could be persuasive; "the truth or validity of this argument in some abstract realm is beside the point - our concern is not at that level" (Edwards & Potter, 1992, p.135). Rather, it is by virtue of the *argumentative form in itself* that such a construction has rhetorical recompense. That is, the conclusion appears justified as it seems to have developed from a detached operation of logic, and not from Ashley's own motivated inferences. Hence her explanation that medication will have a differing effect depending on whether "brain waves" are "normal" or "rebellious" (extract 9, lines 56-58) may be accepted as rational and robust.

3.3.1.3 Models of drug action

The model of drug action exemplified in these extracts and presented in all of the videos is one of a 'disease centred' model; the drugs work by "reversing an underlying biological abnormality or disease" (Moncrieff, 2009, p.12).

Models of drug action have been analysed by Dr Joanna Moncrieff (2009), a psychiatrist at University College London. Pre-1950s, it was believed that drugs influence the expression of symptoms by *inducing* an abnormal biological state such as 'stimulation'; a *drug centred model*. Following the pharmaceutical revolution, a new range of drugs were introduced, and with them came a transformation in the conceptualisation of how they operate. Specifically, they were seen to *reverse* the underlying psychiatric disease; a *disease centred*

model. This new model was accepted by psychiatry without scrutiny or examination. There is little supporting evidence to say a *disease centred model* is superior to the *drug centred model*, yet this is assumed by the majority to be the case.

Many people have been persuaded that their 'psychiatric problem' stems from a chemical imbalance and thus they need to take psychiatric drugs to be 'normal'. As Moncrieff (2009) explains, "the pressure to prescribe psychiatric drugs now comes not just from professionals but also from patients, and potential patients, who have become convinced that they have a brain disorder and that drugs offer a solution to their difficulties" (p.2). Consequently, drugs company profits have been significantly bolstered by their 'pharmaceutical bestsellers' (Moncrieff, 2009, p 2). This active seeking out of a diagnosis will be further explored later in this chapter.

3.4 The 'Light-Bulb' Moment

In videos 1 and 2, women talk about the first time they heard about ADHD and their subsequent realisation that they too could be diagnosed.

Extract: 10

54 **Reporter:** Evelyn learned she had ADHD when her eldest son was
55 diagnosed. It was as if the therapist was talking about her:

56 **Evelyn:** It was a light-bulb and it was a sense of relief. Erm, y'know,
57 I'm not crazy, lazy, stupid. There was a reason all that stuff
58 was going on.

Video 2: CBS News

Extract: 11

Teresa: Yes, I have ADHD, erm, when me son was diagnosed, when he was 5, and err I read up more about ADHD I realised, that there was a link, like, erm, the missing jigsaw, erm, and I just fitted into the ADHD criteria, erm.

Extract: 12

Teresa: me life has been in turmoil, because of me ADHD and I didn't know it was ADHD, until I was 40 when Danny was diagnosed. And then I realised, you know (.) it's not me, I have a condition.

Extract: 13

Constanze: So, finally I had an explanation why I seemed to be different than all the other kids, teenagers and even adults.

Video 1: ADHD Myth or Reality P1

Extract: 14

John: Erm, I guess since she was diagnosed, there are certain things that now make sense, like when she didn't tax the car, and, erm, for a few months and it was late, you know, those things that were frustrating, now seem to have a reason behind them, err, why, why those things were skipped, yeh.

Video 1: ADHD Myth or Reality? P2

In extracts 10-12 the women describe not realising they had ADHD until their sons were diagnosed (a scenario described previously by Conrad & Potter, 2000). The women are thus positioned as *morally* good mothers who have taken their 'troubled children' for a diagnostic assessment (Antaki et al., 2012) and

experienced a coincidental “light-bulb” (extract 10, line 56) or “missing jigsaw” (extract 11, line 57) moment; it was “as if the therapist was talking about her” (extract 10, line 55). Moreover, John (husband of Mags) offers the male confirmation which makes this line of argument even stronger.

Each of the above extracts depicts the women’s realisation that they too have ADHD as a *revelatory* in nature (Antaki et al., 2012); “finally I had an explanation” (extract 13, line 11). This *revealing* or *discovery of truth* is such that it will not be superseded or weakened over time; their lives have been permanently altered. An example of the *revelation* is depicted in extract 10. Here, Evelyn uses the ‘light bulb’ metaphor to imply a switch between the binary of *not understanding oneself* and *completely understanding oneself* in relation to the ADHD diagnosis. The light bulb metaphor is characterised by an immediate and intense recognition of light, causing any darkness or uncertainty to disappear. It has often been used in religious literature, for example when describing *discovering faith* (Swinburne, 2002). However, light bulbs do not switch *themselves* on and therefore the power and hence the control as to whether the light is on or off remains with someone else (Tobin, 1993), such as in this case, a medical professional.

Following the diagnostic *epiphany*, there is a *step-change* to the content and mood of the extracts (Antaki et al., 2012). That is, there is a sudden and discontinuous shift from a life of “turmoil” (extract 12, line 83) to a life of clarity and understanding. ADHD has offered these women an explanatory framework for their past, present and future actions. For example, in extract 14, John uses the diagnosis to guide his understanding of why his wife previously forgot to do things like “tax the car” (line 32). Such a *script formulation* (Edwards, 1994) allocates a group of actions to the ADHD pathology; hence John’s wife is no longer responsible for her actions as these things would happen to anyone diagnosed with the disorder. This demonstrates the appeal of the *sick role* (Conrad & Potter, 2000).

Extract 13 also offers an example of the tautological reasoning underlying diagnosis (Pilgrim, 2005); behaviours are observed which are labelled as ‘ADHD’, but ADHD is defined by a collection of characteristic behaviours.

Powerful rhetorical work is also seen in extract 10, when Evelyn uses her ADHD diagnosis to redeem herself from being labelled as “crazy, lazy, stupid” (line 57). Jefferson (1990) has hypothesised that a *three-part list* can indicate completeness, or the normative status of a class of objects. Indeed, the notion of the ‘power-of-three’ has a long history in religions and belief systems around the world (Jones & Flaxman, 2011). By employing this *three-part list*, as well as an easy-on-the-ear alliterative device, Evelyn persuasively presents ADHD as a far more attractive branding than the potent collection of alternative labels one would otherwise receive. Thus, Evelyn offers the viewer the lens of ADHD through which her actions should be judged.

The construction of the *life altering* qualities of ADHD is explored in more detail below.

3.5 If You Get this Label Your Life Will be Better

Extract: 15

26	**Beverly:**	I, I, I really really feel that if I got a diagnosis and coaching,
27		like, to manage me ADHD, that I’d be so much better.

Video 1: ADHD Myth or Reality Pt1

A dominant construction across the videos is that of the *aspirational* and *life-improving* qualities of ADHD. Women in these videos are either ‘happily diagnosed’ or ‘seeking diagnosis’ (extract 15). To support this construction the rhetorical device of *contrast* (Boyett, 2008) is frequently used (verbally and visually) to favourably compare a life with diagnosis to a life without. For example, in video 1, viewers are offered contrasting images of Beverly, ‘seeking a diagnosis’ (Figure 10), and Mags ‘diagnosed with ADHD’ (Figure 11).

Figure 10

Figure 11

Beverly appears restless as she speaks about her experience of trying to get a diagnosis. In 150 seconds of filming the audience is offered numerous close-up shots of Beverly's 'twitching' feet and hands. The zoom is used in filmmaking to focus attention and lend significance to what the interviewee is doing or saying (Barbash & Taylor, 1997). It appears the filmmakers wish to ensure the audience is aware of Beverley's fidgeting. Thus, as well as what is said verbally (e.g. extract 15), Beverly is also *showing* us she has ADHD; she is *doing being ADHD*[15], constructing herself as someone in need of diagnosis and treatment.

In comparison, Mags appears calm as she speaks with ease about being diagnosed and 'treated'. The images show her in a comparatively 'homely' environment; painting, sitting relaxed in her arm-chair, and petting her dog; a significant contrast to the close-up images of Beverly's twitching limbs.

The use of contrast is explored in more detail below by looking at the constructions of life pre- and post-diagnosis.

[15] Adapted from Sacks (1984) 'doing being ordinary'

3.5.1 Life Pre-Diagnosis: 'Chaos'

Extract: 16

36 **Mags:** Err, before the diagnosis I lived in complete chaos and
37 disorganisation. Err, and I was stressed as well and anxious,
38 because of that, things would get on top of me. Err,
39 deadlines would arrive before I could, err, realise they were
40 on their way.

Video 1: ADHD Myth or Reality Pt2

In extract 16, Mags retrospectively narrates her emotions and actions (or inactions) as a consequence of being initially undiagnosed. She begins with the word "before" (line 36), immediately setting up a *contrast* by implying a preferable 'after' (Boyett, 2008). This contrast is used discursively to construct the nature and cause of Mags' experiences as well as to manage her accountability.

Mags' account draws power from *extreme case formulations* (Pomerantz, 1986), such as, "before the diagnosis I lived in complete chaos and disorganisation" (lines 36-40). This works to make her account more effective as it illustrates an *extreme* impact on her life, emphasised by the precursor of "complete". The affective repercussions of living without diagnosis are also provided in Mags' description of becoming "stressed" and "anxious" (line 37). Here Mags employs the *emotional thesaurus* (Edwards, 1999, p.272); a comprehensive vocabulary of psychological concepts which have become a fundamental part of everyday discourse.

Examples of the *emotional thesaurus* can also be found in extracts 17 and 18.

Extract: 17

Reporter: Evelyn Pope Green went to College on a scholarship but once there she couldn't keep up, and she dropped out.

Evelyn: I can remember sitting in my apartment for days at a time in the dark, because once I fell behind, I didn't know how to catch back up. I didn't know what to do, erm, to fix it.

Reporter: Kirsten Boncher found daily life overwhelming:

Kirsten: It's every little task that you have to do in a day; making breakfast, making lunch, making dinner and you see something else that you have to do so then you do that to.

Reporter: Does the stuff somehow not get done, or does it get done?

Kirsten: Erm, it gets done but it's, it's such agony.

Reporter: And with the agony, comes a feeling of failure. Lisa Wright couldn't seem, to finish anything:

Lisa: It's like having 99% done and I can't get the last step.

Reporter: Did it leave you with a lot of self esteem issues?

Lisa: Yeh, mhmm, absolutely. Because I wanted to live up to be (.) what, what I thought I could be or what other people are, y'know.

Video 2: CBS News

Hepburn and Potter (2007) have described the use of *empathic receipts* in response to crying. According to the authors, this type of *epistemic management* is composed of two elements; a formulation of mental or emotional state and an indication of the consequence or origin of that formulation. Although the interviewees do not cry in the CBS news item, the interviewer uses an *empathic receipt* in connecting, for example, a "feeling of failure" (the *origin*, line 27) with her question about "self esteem" (the *emotional state*, line 30); all within the milieu of life-before-diagnosis.

Dropping out of college, falling behind with household chores, struggling to "finish anything", all serve as indexes of the *extremity* of the problems these women suffered as a result of not having been diagnosed and 'treated'. Through the *corroboration and consensus* (Edwards & Potter, 1992) between the women, it appears plausible that life without diagnosis was both *dysfunctional* and *bad*; undiagnosed and untreated these women were all *underperforming* (Conrad, 2000).

In considering the impact of ADHD pre-diagnosis the reporter weaves together the women's stories to create a depiction of something wrong with the internal workings of their bodies (Edwards, 1999). Hence, despite all their efforts these women could not achieve in the ways they wanted, and in trying it has been "such agony" (line 26). The *action packaged within the descriptions* (Edwards & Potter, 1992) is therefore a drive to "fix it" (line 20) which opens the metaphorical door to what ADHD is later presented as offering these women. This search for a 'fix' is also touched upon by Dr Long in extract 18.

Extract: 18

Many women will ha-, with an undiagnosed ADHD disorder, have grown up thinking that there was something terribly wrong with them. But they never really knew what to call it. They never really knew that they had a diagnosable mental health disorder, that was also very treatable.

These women may have suffered unnecessarily under functioning and underachieving both at home and at school. These women may have struggle in their daily lives believing that they were lazy and unmotivated. And maybe even that was told them. And certainly that would have affected their self esteem.

Video 7: Dr Long

In extract 18, Dr Long begins with a *self-repair* (Schegloff et al., 1977) in clarifying that the "Many women" (line 25) who have "grown up thinking that there was something terribly wrong with them" (lines 26-27) are actually those "with an undiagnosed ADHD disorder" (line 25). The organisation of this repair works to ensure the audience clearly hear and understand the link between being *undiagnosed* and something being *terribly wrong*. Dr Long then connects the 'not-knowing', with a *list* of difficulties (lines 30-33) which could have been easily rectified *if only* the women knew they had a "diagnosable mental health disorder that was also very treatable" (lines 28-29). The 'if-only-they-knew' *lamentation* (De Montigny, 1995, p.80) works to also create the possibility of cognitive dissonance in the audience (Festinger, 1957).

Cognitive dissonance theory has numerous applications, including in the promotion of 'healthy' and 'pro-social' behaviours (e.g. Stone et al., 1994) and within the field of marketing (e.g. Gbadamosi, 2009). To offer extract 18 as an example; a woman watching this video might relate a number of Dr Long's examples to herself. She would then hear Dr Long's *vivid descriptions* of a life without diagnosis in which a person has "suffered unnecessarily" (line 30). The

uncomfortable feeling she may be left with, could encourage her to visit her doctor and request assessment for diagnosis and treatment.

According to Potter (1996), *vivid descriptions* present an account as informed, reliable and accurate. Hence, Dr Long's description of a life without diagnosis becomes increasingly compelling. However, in her description she frequently uses the precursors of "may" or "maybe" (lines 30, 32 & 33) which function as a defence in her account (Harper, 1999).

The second half of this section reinforces the benefits of being diagnosed by offering attractive descriptions of 'life-with-ADHD'.

3.5.2 Life Post-Diagnosis: 'Doing Well'

Extract: 19

77 **Reporter:** Today, with the right diagnosis and treatment all three
78 women are doing well; Kirsten can now enjoy her family
79 more, Lisa started her own business and Evelyn is a school
80 administrator in Chicago. It's not always easy, but that's ok.

Video 2: CBS News

The majority of the videos explicitly relate an improvement in quality of life with receiving a diagnosis of ADHD. This is exemplified in the *three-part-list* of extract 19; demonstrating the ways these women's lives have changed for the better "with the right diagnosis and treatment" (line 77). Furthermore, the presentation of *three* stories is, in itself is a three-part device. The rhetorical work of this section is complemented by the accompanying images as presented below.

Figure 12

Figure 13

Figure 14

The images and narration above reflect western values in relation to both family (Figure 12) and career 'success' (Figures 13 and 14). Offices and laptops hold strong connotations of business, academia and work, whilst reading with children promotes ideas of a happy, settled family life. Each of these women's stories is suggestive of the drive to reach the *American Dream*; "It's not always easy, but that's ok" (line 80). Diagnosed and medicated, these women are now capable of working hard to achieve the possibility of prosperity and upward social mobility; "all three women are doing well" (lines 77-78). Their stories are constructed in a way that communicates that only *with* diagnosis and treatment is it possible to gain access to the trope of the *American Dream*. This is captured in extract 20 which is also reminiscent of powerful and evocative political speeches invoking *hope* (e.g. Obama, 2012).

Extract: 20

81 **Evelyn:** Most days, I feel really good about myself; not every day but
82 most days I do feel really good about myself. And those
83 days that I don't I always feel like there's hope.

Video 2, CBS News

In extracts 21 and 22 two younger females provide separate *corroboration and consensus* statements on the positive qualities possessed by people with a diagnosis of ADHD.

Extract: 21

42 people that I know, that have
43 ADD, are generally very intelligent. Now that could be
44 because we're well rounded, or, it could be because our
45 brains are very fast.

Video 4, Ashley

Extract: 22

I think that there have been a lot of successful people with ADD and erm, if you have ADD, it's no big deal, just definitely, if you erm, can see a doctor about it.

Video 3: Arie

Thus what emerges from these videos is the creation of an aspirational quality to the ADHD diagnosis; that is, with the correct 'treatment' it appears to *enable* as opposed to *disable*. However, for some, (extracts 21-23) this enablement is ascribed to 'the ADHD' alone rather than 'the ADHD plus treatment'. Indeed, Mags in Video 1 states:

Extract: 23

Mags: I would describe my personal ADHD as a gift. I would say, I wouldn't be without it, err, it's me, it's who I am, err, I'm an artist, I do paintings. I don't think I would be an artist without my ADHD.

Video 1: ADHD Myth or Reality P2

The extracts presented in this section appear to encourage women to seek treatment, as well as stressing the positive qualities of the 'label'. In contrast to 'less desirable' diagnoses (e.g. 'schizophrenia' or 'personality disorder'), ADHD is not depicted as morally tainted or hopeless. Rather, it is somewhat glamorised; a "personal gift" (extract 23, line 20). Consequently, these women appear to be left with a binary choice; get diagnosed (and treated) and live 'happily-ever-after' or, remain undiagnosed and live a life of hardship and judgement; a typical device used to *persuade* throughout time.

In observing such binaries it may be helpful to consider how certain discourses become prioritised; shaping and creating our *meaning systems* (Foucault, 1988). For example, how is it that the ADHD discourse gained its status as the 'truth'?

Taking a Foucauldian perspective, some may argue that certain behaviours, such as those represented in these videos, have been deemed to break, or fail to reach, certain western norms, values or social rules (e.g. a mother struggling to complete household chores, extract 17). Seen through the invisible lens of the *discourses of femininity* (Stoppard, 2000); these behaviours are categorised and pathologised; subsumed under the label of ADHD. In the process, ADHD comes to dominate the options available to women seeking to understand and organise their lives. Simultaneously, alternative explanatory discourses are marginalised and subjugated in a way that prevents resistance or potential challenges to hegemonic practices (Foucault,1988).

Szasz (1961) argues that it is the classification and diagnosis of behaviours that result in the individual being 'scapegoated' by an oppressive society. With 'treatment', potentially stigmatised women are promised a means via which they may be brought back into the fold. Issues of social inequalities and power are notably absent in these videos, with only the 'neurochemical self' (Rose, 1998) left available for manipulation and modification.

3.6 The Invisible Disability[16]: Prejudice and the Battle to be Diagnosed

Extract 24

65 **Constanze:** I can say one thing for sure now, and that is: adult ADHD is
66 not a myth, it is a reality.

Video 1: ADHD Myth or Reality P2

The challenges faced by women wanting to be diagnosed are frequently addressed in the videos. Such discussion tends to be framed in disbelief, as the women perceive ADHD to possess the status of an *unquestionable* "reality" (extract 24, line 66).

[16] cf. Conrad & Potter, 2000

3.6.1 Use of Analogy: Physical Medicine and Disability

Extract: 25

24 **Teresa:** If I was in a wheelchair you could see, I had a disability, but,
25 because it's hidden (.) no one understands.

Video 1: ADHD Myth or Reality P1

Extract: 26

61 **Kirsten:** It is painful when people say to you: "oh you don't have
62 anything wrong with you". They wouldn't judge whether I
63 had a heart condition or not. It's an invisible disorder.

Video 2, CBS News

Extracts 25 and 26 offer examples of *argument by analogy* (McKinlay & McVittie, 2008). Both interviewees draw similarities between physical disability or health problems and ADHD. The use of rhetorical analogy has been described as a way of *indirectly persuading* the audience of a particular position; developing or defending a point (McKinlay & McVittie, 2008). The content of these statements again stresses by implication the presumed physical nature of ADHD, and the way that the presence of a physical condition affects responsibility, in accordance with the 'sick role' (Conrad &Potter, 2000).

These extracts present an extreme version of non-argumentative persuasion as they are *rhetorically self-sufficient* (Wetherall & Potter, 1992). That is, they draw on principles that are taken to be beyond doubt; you would not question a person's disability or diagnosis if it was visual and/or physical. The analogous argument here is that ADHD should also be granted this status; thus, commonsense understandings of what it means to be physically ill or disabled become intertwined with what it means to 'have ADHD'. Such statements work in the same manner as *proverbs*; impossible to challenge and thus useful tools in persuasive arguments (Gandara, 2004).

Diagnosis within the physical realm is seen to result from 'objective' medical research; identifying patterns and relationships between phenomena known as *signs* and *symptoms*. However, within the field of psychiatry, the steps taken to identify a new *disorder* are in complete contrast to such a process (cf. Boyle, 2002; Coulter,1979). Regardless, the power of the rhetorical analogy helps to shift ADHD into the physical health domain, bringing with it many taken-for-granted assumptions. ADHD thus becomes *ethically* uncomfortable to question, as anyone querying the diagnosis could be seen as inflicting *pain*, being *judgemental* (extract 26, lines 61 & 62) and *not understanding* (extract 25, line 25). Thus one would run the risk of being positioned as morally *bad*.

Reluctance to question the women's statements is also aided by the visual rhetoric of images such as Figure 15, in which Kirsten is filmed with her child; thus reinforcing her category of 'mother'.

Figure 15

3.6.2 Demand your Diagnosis

Most women in the videos sampled describe the process of getting an ADHD diagnosis as a *struggle* with "many who are still fighting for it" (Constanze,

Video1, part 2, line 64). In considering the difficulty in gaining a diagnosis, the explanations most commonly drawn on relate either to a lack of understanding or knowledge on the doctors' behalf; or a discrepancy between the way 'problems' are formulated and understood. This is discussed explicitly in Video 1, as exemplified in extracts 27 and 28.

Extract: 27

Teresa: So I've, I've wanted to try and get a diagnosis but I've found it really really hard. I think in, erm, Liverpool there's not much, understanding and I don't think Doctors know enough about it. And I tried to get a referral and they wouldn't refer me, because I was in care as a child. The only way for me to get diagnosed is either to go private, which, I will do; I'll be going to the Priory in Manchester. But at the moment I can't do that because me life is so busy with me own son, but eventually I will, try and get that diagnosis and I know I will, if I go private I will get it.

Extract: 28

Beverly: o-or, when I went, the, to a psychologist. Err, I was going every week, and, he was asking me all questions about, like, right from like from when I was a child, erm, and he said like that: I'm "just lazy". And that, it it it is because I was abused and on drugs as a child. That's why I am like I am [sniffs]. But, erm, I don't, I don't agree that, erm, I am like how I am because of the past.

Video 1, ADHD Myth or Reality P1

In the above extracts the women discuss their own experiences of the 'battle to be diagnosed. Teresa begins by stating it has been "really really hard" (extract 27, line 59). The use of sequential word repetition employed here is known as

epizeuxis; a rhetorical device used to appeal to the audiences emotions; an *appeal to pathos* (Howard, 2010).

Once the emotional context has been set, Teresa begins to account for the diagnostic struggle by identifying the obstacles to diagnosis as: a general lack of understanding in Liverpool, and a specific lack of 'professional' knowledge. This scepticism in relation to the doctors' knowledge is in contrast to the credence previously allocated to *authoritative discourse* (McKinlay & McVittie, 2008).

As the extract develops, Teresa suggests she would need to "go private" to get diagnosed (lines 63-64); inferring that only *private* doctors hold the expertise and knowledge to diagnose. This is reinforced when Teresa mentions the Priory as her diagnostic destination of choice. The Priory Group offers private mental health care and rehabilitation (The Priory Group, 2012) and holds an 'elite' status due to its 'celebrity' clientele, (e.g. Kate Moss and Amy Winehouse) (Moya, 2010).

As well as now belonging to a realm of *specialist knowledge*; ADHD also appears to be entering the unabated domain of consumerism amidst burgeoning expectations for women to fit "uniform and unrealistic standards", in body *and* mind (O'Grady, 2005, p.33). Private cosmetic surgery is on the rise, for example the number of breast augmentations rose by 275% between 2002 and 2007 (The British Association of Aesthetic and Plastic Surgeons, 2008). Similarly, with the increasing availability of private clinics offering ADHD diagnosis and treatment; the "modification of thought, mood and conduct by pharmaceutical means becomes more or less routine" (Rose, 2003, p.46). Thus, as with cosmetic surgery, if you are unable to get the desired intervention through the NHS, then you can buy it from a private institution: "eventually I will, try and get that diagnosis and <u>I know I will</u>, if I go private I will get it" (extract 27, lines 66-68). ADHD diagnosis and 'treatment' thus becomes something to save up for and invest in.

Despite Teresa's passionate drive to be diagnosed she describes currently feeling unable to visit the Priory as she is already very busy with her own son's

needs[17] (line 66). This description functions as a rhetorical device as it appeals to the character of the speaker as a *good mother*, prioritising her son; an *appeal to ethos* (the honesty and authority of Teresa) and *pathos* (Teresa's emotional appeal) (Howard, 2010).

Another barrier to diagnosis discussed by Teresa appears in lines 62-63; "they wouldn't refer me, because I was in care as a child". A similar account is also provided in extract 28 when Beverly speaks of her experience of meeting with a psychologist who related her current problems to a history of abuse and drugs. She explicitly states in lines 103-104: "I don't agree that, erm, I am like how I am because of the past". Thus, both interviewees construct their problems as the result of something *internal* or *physical*. They hold firm to the construct of ADHD as a biomedical disorder; which to them is incongruent with any theories incorporating environmental or developmental influences. This is consistent with previous sections in this chapter, as again, only the 'neurochemical self' (Rose, 2003) is left available for *treatment*.

3.7 ~~Performance Enhancers~~ ADHD Medication

> *All the talk of genetics, biology, and medicine simply provides a false air of legitimacy to what is nothing more than the disbursement of a performance-enhancing drug.*
>
> Leo and Lacasse (2009, p.307)

By using the medical discourse of *disorder* and *diagnosis* there is an implied need to see a doctor to 'get better' and that *medication is the answer* (Johnstone, 2000). Such language is used across all the videos analysed and is indicative of the taken-for-granted nature of ADHD as a disease to be medically treated.

3.7.1 Increase your Potential

As discussed in previous sections, the use of *direct reported speech* is a powerful medium through which to convey a message that is both credible and convincing

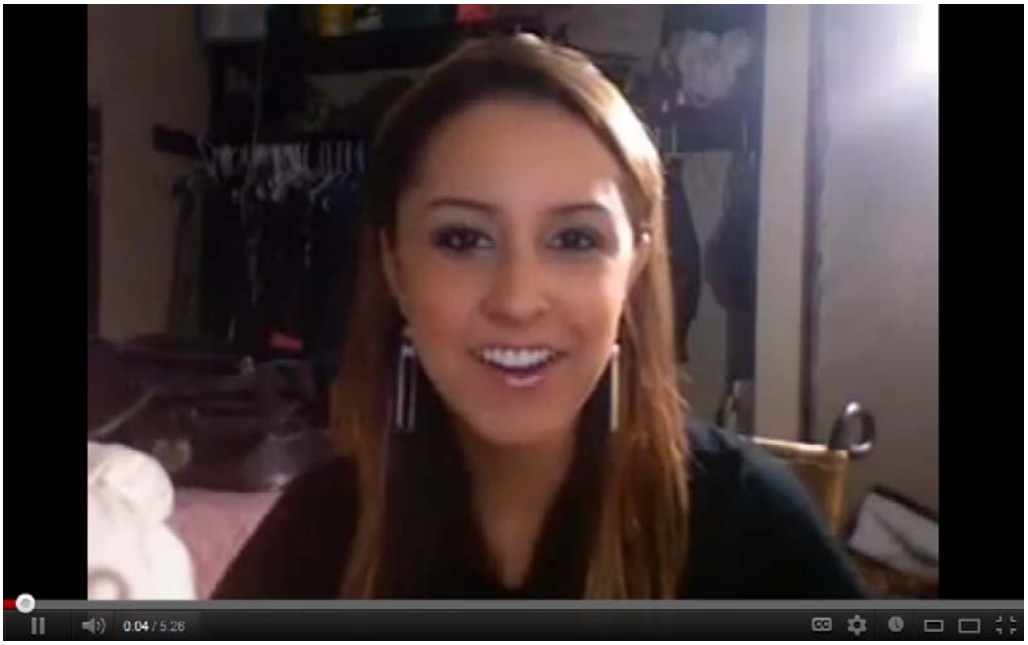
[17] Diagnosed with ADHD.

(Wooffitt, 2005). The testimonies of the women in these extracts support the dominant biomedical discourse surrounding ADHD; as well as the need for medical intervention to alleviate the symptoms. As 'ADHD-sufferers', their witnessing of the benefits of ADHD drugs is aided by the rhetorical device of *category entitlement* (Potter, 1996) which works to enhance the apparent *reality* and *truth* of their claims.

In video 3, the narrator introduces herself as "Arie with prettyceo.com" (line 1). In contrast to what the title of the site implies, on entering the address into internet explorer, one is redirected to "ADDTabz: The Adderall Alternative for Everyone" (see Appendix 10). This is suggestive of a covert DTCA agenda and raises questions over Arie's position as a 'neutral consumer'.

Similarly to Ashley, the visual presentation of Arie conforms to the beauty norms of her presumed social background. In Figure 16 Arie appears to be in her bedroom; a common location for 'blog' films. By setting the video up as a 'blog' entry, the context implies this is a *personal* opinion piece; not part of a pharmaceutical campaign. Here, Arie speaks with energy and enthusiasm about the positive impact Adderall has had on her life and career as illustrated below.

Figure 16



Extract: 29

2 And, today I'm gonna talk about Attention Deficit Disorder,
3 because I definitely have it. And, I finally got medicated,
4 which is something that has really changed my life. And has,
5 erm, been very positive for my business.

Video 3: Arie

Arie begins her video by succinctly and unproblematically presenting ADHD in its *reified* form; "I definitely have it" (line 3). Her description of *having* ADD is synonymous with the way one may describe *having* the flu; it possesses a *disease* status. However, psychiatric critics have challenged the application of such a simple disease model to problems that are defined by mental processes and behaviours. For example, according to Szasz (1971, p.94):

> *Gould's Medical Dictionary defines disease as a disturbance of the function or structure of an organ or part of the body. The mind (whatever that is) is not an organ or part of the body. Hence it cannot be diseased in the same sense as the body can.*

Regardless, through this process of self *categorisation*, Arie constructs herself in a way that leads logically to the action of getting "medicated" (line 3) (Potter & Wetherell, 1987). In describing the outcome of the medication as *life-changing* and *positive for business*, Arie employs *extreme-case-formulations* (Pomerantz, 1986) which are designed to be dramatic and persuasive.

In the following section, Arie uses the rhetorical device of *active voicing* (Wooffitt, 2005; Hepburn, 2003) to present the views and impressions of her colleagues as corroborating her depiction of the difficulties she faced pre-medication. This also creates a *shift in footing* (Dickerson, 1997; Potter, 1996), as Arie becomes merely a reporter of her employee's opinions.

Extract: 30

"hey, you know, Arie, you need to get some ADD medicine, because you can't focus on what you want us to do, and, y-you have a hundred things going at the same time, and erm, you can't, err, channel all your energy so..."

Video 3: Arie

Arie also explicitly connects her increased 'potential' with taking the drug:

Extract: 31

I feel like my potential has sky-rocketed now that, erm, I'm on medication.

Video 3: Arie

Arie constructs her difficulties within the dominant biomedical discourse providing a narrative of *abnormality*. The rhetorical device of a *narrative form of accounting* (Potter, 1996) can also be seen to be at work here. This involves the linking together of events into a sequence, in a way that implies causality and increases the plausibility of an account (Harper, 2004). Arie's argument runs thus:

> *I have ADD > I had difficulty focussing and channelling energy > employees noticed and commented on this > employees provided encouragement to get ADD medication > I finally got medicated > medication changed my life > medication has been positive for my business > my potential has sky-rocketed.*

The taken-for-granted assumption inherent in this narrative is that ADD exists as a legitimate medical disorder. Proof of this construction is taken from the reported improvements in Arie's symptoms after taking Adderall. However, *correlation does not imply causation* (Utts, 2004) and it would therefore be circumstantial to make such a claim (McKay, 2000). As discussed by Leo and Lacasse (2009), it is well documented that ADHD stimulants improve attention

span, along with other stimulant drugs like caffeine; but there is little evidence that they have beneficial effects in the long-term, or effects on any presumed underlying pathology that is independent of these established psychoactive effects (Moncrieff, 2009a).

Similarly to caffeine, however, there is a discourse surrounding ADHD medication that would imply one could use the drugs in a similar way. For example:

Extract: 32

125 And I only take it on days that are very
126 academically demanding. Because there are side-effects
127 and they're not fun.

Video 4, Ashley

In comparison to a 'typical' *relationship* to prescription drugs for a 'biomedical condition'; Ashley suggests here that the drugs are a 'means to an end'. They help her with her academic work; enhancing performance on "days that are very academically demanding" (lines 125-126). However, because she does not like the side effects, she *chooses* when to take the drugs; in a similar manner as one might *choose* to drink coffee to facilitate concentration, but avoid caffeine at other times due to migraines. There are also parallels here with recreational drug use, whereby the user is not 'addicted' but rather they are pursuing a "temporary but potent altered state of consciousness" (Page & Singer, 2010, p.9).

Krinsky (2008) has discussed the "moral apoplexy" (p.151) caused by Ritalin, due to its similarity to cocaine. Fifty years ago in Sweden a link was established between the medical applications of Ritalin and recreational drug use; with its subsequent removal from distribution (Krinsky, 2008). In the US, the Drug Enforcement Agency (DEA) categorised the drug as a Schedule-II substance which implies it may lead to 'abuse'. This was appealed in 1995 by CHADD[18] and the American Academy of Paediatrics who argued that Ritalin had minimal

[18] Children and Adults with Attention Deficit/Hyperactivity Disorder; a 'non-profit' organisation.

recreational potential. However, the DEA refused to lower the regulatory controls, stating the drug's capacity to 'suppress appetite, induce wakefulness, and make people happy' (Krinsky, 2008, p 151).

Although Ashley does not explicitly state the brand of drug she uses, her descriptions fit with the 'increase-your-potential' discourse; suggestive of the drugs recreational value and likelihood of occupational improvement (Krinsky, 2008).

In video 6, Dr Sarkis speaks about her own experience of ADHD and the positive impact the medication has had on her home life.

Extract: 33

Erm, I also noticed that, if I cook, coz I love to cook, I can actually clean the kitchen afterwards, which has been, like monumental, because I cook and I just like leave it because, y'know I don't like to do all the detailed work. Erm, also I can read through something all the way through the first time and know what it says. And before I would read a paragraph, have to go back and read it again, because by the time I got to the end of the page I was like what did I just read? So medication's really helped in those aspects of life.

Video 6: Dr Sarkis

One question discursive psychologists have in mind as they read an account is, "to what problem is this account a solution?" (Harper, 2004, p.381). Dr Sarkis, within her professional remit as a 'psychotherapist', writes and broadcasts for Additude, a magazine aimed at children and adults with a diagnosis of ADHD (Video 5). This connection is made available for the audience by her YouTube profile page under the name of 'DocADHD'. Hence the rhetorical device of *category entitlement* (Potter, 1996) is called into play, not only due to her presumed knowledge in the area as an 'ADHD-patient'; but also as a 'doctor' specialising in ADHD. Thus, it may be presumed that a key concern for Dr Sarkis

would be to establish the legitimacy of ADHD and the positive effects of the medication, in order to protect her 'identity' as well as her career and her credibility as a known 'ADHD-expert'. This is achieved in extract 33 via the use of the rhetorical device of *contrast* (Boyett, 2008) whereby Dr Sarkis favourably compares her medicated life with her life pre-diagnosis and treatment.

As seen elsewhere in this chapter (e.g. 'The ADHD Checklist'), Dr Sarkis chooses examples which, by their ubiquity, effectively democratise access to the ADHD label; needing to re-read paragraphs as one's mind has wandered (line 31); feeling reluctant to clean up the kitchen after cooking (line 27); each example, demonstrating how ADHD medication can provide a 'quick-fix' "in those aspects of life" (line 32). Indeed, in the 'comments' section of this video one user writes: 'the dishes! OH MY GOD! it's always the dishes!' [*sic*] to which Dr Sarkis responds:

> *I have to unload and load the dishwasher today, and I have done everything else on my "to do" list except that. lol Maybe "dishwasher dysfunction" should be added to the DSM diagnostic criteria for ADHD. :) [sic].*

The visual presentation of Mags (Video 1) appears older than the other females presented in this section (Figure 17). In extract 34, she uses the analogy of "a pair of glasses" to describe how the ADHD medication provides her with "mental focus" and helps her to "concentrate" (lines 52-54). Simultaneously, images of ADHD medication packets (Figure 18) ensure a link is made between the drug and its 'positive' effects.

Figure 17

Figure 18

Extract: 34

52 **Mags:** It gives me focus, like a pair of glasses gives you
53 visual focus; it gives me, mental focus. And it helps me to
54 concentrate.

Video 1: ADHD Myth or Reality P2

The use of *rhetorical analogy* (McKinlay & McVittie, 2008) here helps to persuade the audience of the performance enhancing properties of ADHD drugs. This analogy may be seen as consistent with Mags' age, which helps to broaden the appeal to an older generation whilst bolstering a message of 'it is never too late to get help'. Indeed, often people only require glasses later in life (Schwartz, 2009).

Mags' husband John provides *consensus and corroboration* (Potter, 1996) for Mags' glasses analogy in the extract below.

Extract: 35

57 **John:** Erm, I think what it, what it probably does is is
58 enable you to, erm (.) to have a more of a focus to get
59 through the things that you need to get done.

Video 1: ADHD Myth or Reality P2

People in particular categories are afforded specific kinds of knowledge. The category of 'husband' is sufficient to indicate that John possesses special knowledge of his wife, which does not require further explanation; *category membership entitlement* (Potter, 1996).

Demonstrated in this section and elsewhere, women are constructed as advocates for psychopharmacological intervention; not psychiatrists or pharmaceutical companies. The women speak passionately about improvements in their performance and capacity, all *thanks to the drugs*. Hence these women

appear to *want* to be medicated; or at least to benefit from the increased potential the medication is perceived to provide.

The drive to increase ones potential is not limited to the 'ADHD-woman'; it is endemic within a 'democratic', 'capitalist' and 'psychologised' (cf. Maslow,1962) society. An important property of such a society is the concept of *consumer choice*; with increased choice being "as sacrosanct a *desideratum* in the canon of contemporary capitalism as increased growth" (Porritt, 2007, p.302, italics in original). In the following extract consumerism is extended to women who have received a diagnosis of ADHD; which brand of stimulant would suit you best?

3.7.2 Choose Your Brand: What is Your Desired Effect?

Gill (2007) conducted an analysis of gender in the media in contemporary western societies. In doing so she addressed the extent to which the evolving discourses of "feistiness and independence and girl power" (p.187) are synonymous with ideas of consumption. Thus, feminist independence becomes constructed around consumerist ideals and women's agency is presented first and foremost in terms of buying things.

Extracts 36 and 37 are taken from video 3, with 'Arie'. Arie may be considered by some as an example of the *feisty female consumerist* described by Gill. The title of the video is 'Ritalin vs. Adderall by a Women Entrepreneur with ADD'.

Figure 19

In igure 19 Arie is seen bringing a medication bottle into shot in the same manner as presenters endorse beauty products in online *makeup-tutorial- blogs*[19]. The visual image of the *product* helps to add credibility to Arie's claims; she must know what she is talking about as she has tried the pills herself.

In extract 36, Arie begins by describing her experience of taking Ritalin. She then speaks about a visit to her doctor during which she asks to "try something else" (line 75). At this point Arie is prescribed Adderall. In extract 37 Arie goes into some detail about her experience on Adderall before providing her personal endorsement for the product.

Extract: 36

68 Erm, so I noticed in my personality I felt kind of 'zombieish',
69 kind of like, urrrgghh, out of it, u(h)hum, and not really
70 focused, like just kinda like: "erm ok, should be doing
71 something, what's wrong me, I feel funny". Y'know? So,
72 a::nd I, I kinda felt my personality, kinda like, just dull, dulled
73 out. Erm, so I didn't like the Ritalin.

74 So I go back and I talk to my doctor and I'm kinda like: "hey,
75 can I try something else? Y'know, this isn't really working".
76 So, erm, she prescribed me with Adderall and I got 20mg,
77 erm, tablets, time-release, err capsule, and I just have to take
78 one in the morning and, err, it lasts the whole day long. So,
79 what I feel like on Adderall is I feel completely, erm, able to
80 fulfil the tasks that I erm, tell myself I have to do in the
81 morning.

[19] E.g. 'Everyday Makeup Routine' https://www.youtube.com/watch?v=jh2Ods1mvvs

Extract: 37

And Adderall, it lasts 12 hours, so it didn't feel like you know, it's cracked out, or didn't feel like, y'know, much, like, er, big rush of, of, 'concentratedness', if you wanna say. But, it was a very even, even feeling all throughout the day of being productive, and, err, I, I didn't lose my personality.

So, I mean, go to your doctor, see what they say, obviously. But for me, erm, the Adderall worked better, for my condition. So, anyway just wanted to share that experience, and err, check back for more, women entrepreneur tips, or y'know, my 2 cents on 'what have you'. Err, next time on prettyceo.com. See ya.

Video 3: Arie

It may be argued that Arie's visit to the doctor mirrors the process of returning an unwanted item to a shop, with the hope of exchange. Indeed, this is what Arie receives; a tablet that she only needs to take once in the morning, helps her to fulfil all her tasks for the day, lasts for 12 hours, provides an even feeling of "being productive" (extract 37, line 94), and allows her to *keep her personality*. This is a *five-part-list* (Jefferson, 1990); a comprehensive account of the benefits which can be expected if one takes this drug, and possibly *cumulatively* more persuasive than a *three-part-list.*

Across these two extracts, Arie acts as a *witness* to her own experiences with medication. In doing so she provides a *vivid description* of the drug effects of each brand. By offering this first person testimony, as opposed to a second-hand report or interpretation, Arie allows the recipient to make their own inferences (Potter, 1996). Thus, in the final paragraph of extract 37, the audience may have already reached the conclusion that Adderall is the better drug of the two, only for this hypothesis to be confirmed by Arie in her final statement of "for me, erm, Adderall worked better" (line 97). In this endorsement, Arie manages her level of

responsibility by referring the viewer to “go to your doctor, see what they say” (line 96); thus also working toward the advertising goal of achieving the move from cognitive to behavioural outcomes. However, much of the promotional work to convince the audience of Adderall’s benefits has already been completed earlier in the extract.

3.7.3 Me vs. My Chemical Self

Extract 38 offers another example of ADHD medication being used to increase productivity and efficiency; suggestive of the performance enhancing qualities of the drug. Similarly to Ashley, Lisa uses the ADHD drugs selectively to “help her finish her work” (lines 72-73); however, she provides a different rationale for this pattern of usage. Here she implies a contrast between *being herself* and *being her medicated self*.

Extract: 38

68 **Lisa:** Then I went through a phase where I was very, err, unhappy:
69 I have a problem that requires that I take medication for the
70 rest of my life. Erm, and that, that wasn’t a good phase at
71 all.

72 **Reporter:** So Lisa compromised; taking medication to help her finish
73 her work through the week, but not using it on the weekends.

74 **Lisa:** I like to be myself on the weekends. I’m creative, I’m fun and
75 outgoing. My impulsivity happens to be a thing that most
76 people, who I know, like about me.

Video 2, CBS News

An important piece of work in this extract is achieved in lines 75-76: “My impulsivity happens to be a thing that most people, who I know, like about me”. ‘People who I know’ implies reciprocity in the ‘peoples’’ knowledge of Lisa, and works rhetorically to add *consensus and corroboration* to her statement (Potter, 1996). The term ‘happens to be’ possesses a strong element of *defensiveness*; it

claims something (Antaki et al., 2012). Here, it appears Lisa is revealing something about her central identity, that she is *fun* and *impulsive* and that these qualities are valued by herself and others. Again this shows the ambivalence in attitudes to ADHD, and is at odds with other statements.

Complex moral work appears to take place in this extract, specifically in relation to identity (Antaki et al., 2012). Lisa presents ADHD, like a heart condition, as inseparable from herself. She also works hard to present herself as a 'nice' person, liked by others. This is aided by her *three-part list* (Potter, 1996) "I'm creative, I'm fun and outgoing" (lines 74-75). According to Lisa, these are enduring "deep-rooted personality dispositions" (Edwards, 1999, p.274), that is, she is not just 'fun', she is a 'fun *person'*; but how can these be authentic descriptions of Lisa? If she *has* ADHD, then this is not *Lisa,* it is the *disease*; her friends do not like *her* they like the *ADHD*. To illustrate this complexity further, a comparison may be made between Lisa's list and Evelyn's *three-part list* presented earlier in this chapter (page 53, extract 10, line 57). Evelyn works hard in her interview to convince the viewers that the negative labels: "crazy, lazy, stupid", were never part of *her*, they were the *ADHD*. For Evelyn the medication worked to help her avoid negative assumptions about her character. So which is it? Is it the 'medicated self' or the 'real self' that is preferred? Or can the 'real self' only be accessed via medication? The complexities of identity in relation to ADHD will be explored further in section 3.8.

Possibly the message from 'CBS-News', is that there are a range of ways to be 'disordered', and they are merely presenting the audience with a 'menu' (Antaki et al., 2012). What appears to be important, is that you accept you have a disease, you take your pills, and then everything will be ok; then you can *enjoy your family* (extract 19, line 78), *socialise* (extract 38, lines 74-76) and *hold down a job* (extract 19, line 79-80). Thus the 'news item' becomes a marketing tool; much is promised if you buy this story, in the same way as much is promised to you if you buy the new L'Oréal anti-wrinkle face cream (Antaki et al., 2012).

Unlike Lisa, Mags does not think her personality is affected by the medication. This is again corroborated by her husband:

Extract: 39

54 **Mags:** It doesn't change my personality, in any way;
55 I'm still me.

56 **John:** I don't think, erm, the drug necessarily changes your
57 character.

Video 1, ADHD Myth or Reality P2

As highlighted by Wiggins and Potter (2008), characteristics of talk, such as *emphasis* are fundamental in making sense of a communication. To accentuate her point that she is still herself, Mags adds emphasis to a number of words in her sentence including, "in any way" (line 54); this is in itself an *extreme case formulation.*

Although John corroborates Mags' statement, he speaks more generally about "the drug"; thus, he includes the less forceful word "necessarily" (line 56). This would suggest that although he does not think a character change is inevitable, he does not completely rule out the possibility of it happening either.

John also adds emphasis to the final word in his sentence "character" (line 57). Adding emphasis can be heard as wanting to ensure a particular point has been conveyed (Potter & Hepburn, 2010). A priority for both John and Mags appears to be for the audience to know the drugs have not changed Mags' personality or character; *she is still Mags*.

As touched upon in this chapter, there are ongoing debates as to whether ADHD drugs mask, alter or improve one's character. However, there also appears to be more general uncertainty as to what aspects of the self actually need to be altered (e.g. extract 38). This raises questions such as 'is it me or is it the ADHD?'; as addressed in the concluding part of this chapter.

3.8 Who Am I? A Note on Identity

Examples of the 'ADHD-or me' tension may be observed throughout this chapter; from the checklists at the beginning, offering explicit examples of what should be categorised as ADHD; to consideration in the previous section, of what aspects of the self need to be medicated. The rhetorical work conducted in these extracts has been essential in *abnormalising* behaviour and channelling pathology within the *disordered individual*; into the disease and away from the self (Stepnisky, 2007).

However, the question of: 'what is me and what is ADHD?' is not clearly resolved and thus the issue of: '...and how am I to be judged?' remains (e.g. extracts 10 & 26). This quandary is articulated in this final extract.

Extract: 40

135 **Beverly:** If, if there's no ADHD, wha-what's wrong with me then?

Video 1, ADHD Myth or Reality P1

In her interview, Beverly expresses frustration at the perceived barriers to receiving an ADHD diagnosis. In particular she mentions the psychologist, who related her current difficulties to being "abused and on drugs as a child" (extract 28, line 102). One might hypothesise that ADHD could offer Beverly a quick and detached explanation for her struggles as well as a discreet and instant solution. Possibly, this would be more appealing than engaging with the traumas and injustices she appears to have suffered in her life; events which could not be reversed by a *chemical cure*.

Stepnisky (2007) has written critically about the relationship between selfhood and developments in biomedicine. His essay mainly focuses on the use of antidepressants; however the observations made are equally pertinent to this study. Extracts presented in this chapter appear to portray ADHD as a "splitting narrative" (Stepnisky, 2007, p.202). That is:

> *(...) parts of the self that seem strange, incomprehensible and oftentimes deeply painful are held apart from the self. They are seen as illnesses, rather than as aspects of one's self or one's personal history.*
>
> Stepnisky (2007, p.202)

Within this narrative, medication becomes a tool, enabling women to "hold back, contain or split-off" parts of themselves into the 'illness'; something which they otherwise cannot control (Stepnisky, 2007, p.203). If this narrative is challenged (as experienced by Beverley), then the *container of biological dysfunction* also comes under threat; and the need to *fight for the diagnosis* becomes a reality (section 3.6.2).

It has been reported in bioethics literature that the use of psychotropic drugs can threaten autonomy and free will and undermine personal authenticity (Singh, 2005). Individuals seeking a diagnosis or treatment appear to be weighing these considerations against the advantages of being entitled to enter the *sick role*. It would appear that a diagnosis of ADHD in itself may be enough to induce numerous existential dilemmas for the women presented in these videos.

4.0 FURTHER DISCUSSION AND CONCLUSIONS

I commence this final chapter with a summary of my analysis and discussion, and a comparison of my findings to some of the literature discussed in chapter one. I then offer an evaluation of this study, including a quality-review. Implications for clinical and research practice are considered, before I conclude with final reflections.

4.1 Summary of Analysis

4.1.1 Summary

In this analysis I have examined how, through a range of devices and techniques, ADHD has been constructed, reified and marketed to women via publically accessible online videos.

The rhetorical precision with which language was used, as well as the oratorical prowess of the majority of the speakers, appears to have been fundamental in establishing a factual account of the 'ADHD-woman'. Such a perspective is discordant with conventional psychological conceptualisations of language as a 'true' reflection of a person's cognitive processes and underlying mental states (Edwards & Potter, 1992).

Using a combination of empiricist and biomedical discourse, and drawing on the rhetorical device of *category entitlement* (as 'professional' or 'sufferer'), ADHD emerged as a 'real disease', with direct implications for women. Any suggestion of alternative 'explanatory' frameworks (e.g. in relation to childhood experiences) were quickly discarded in favour of the medical account (cf. Beverley and Teresa, 3.6.2). The dominant explanation, in every video was one of biomedical disease (Visser & Jehan, 2009).

ADHD behaviour and 'identity' were constructed using numerous rhetorical devices in the women's testimonies. These devices helped to define ADHD as a 'disabling disorder', with a significant impact on 'performance', outside of the women's control. Simultaneously, with the offer of medical 'treatment', the women were promised a means via which they may reorder their lives and

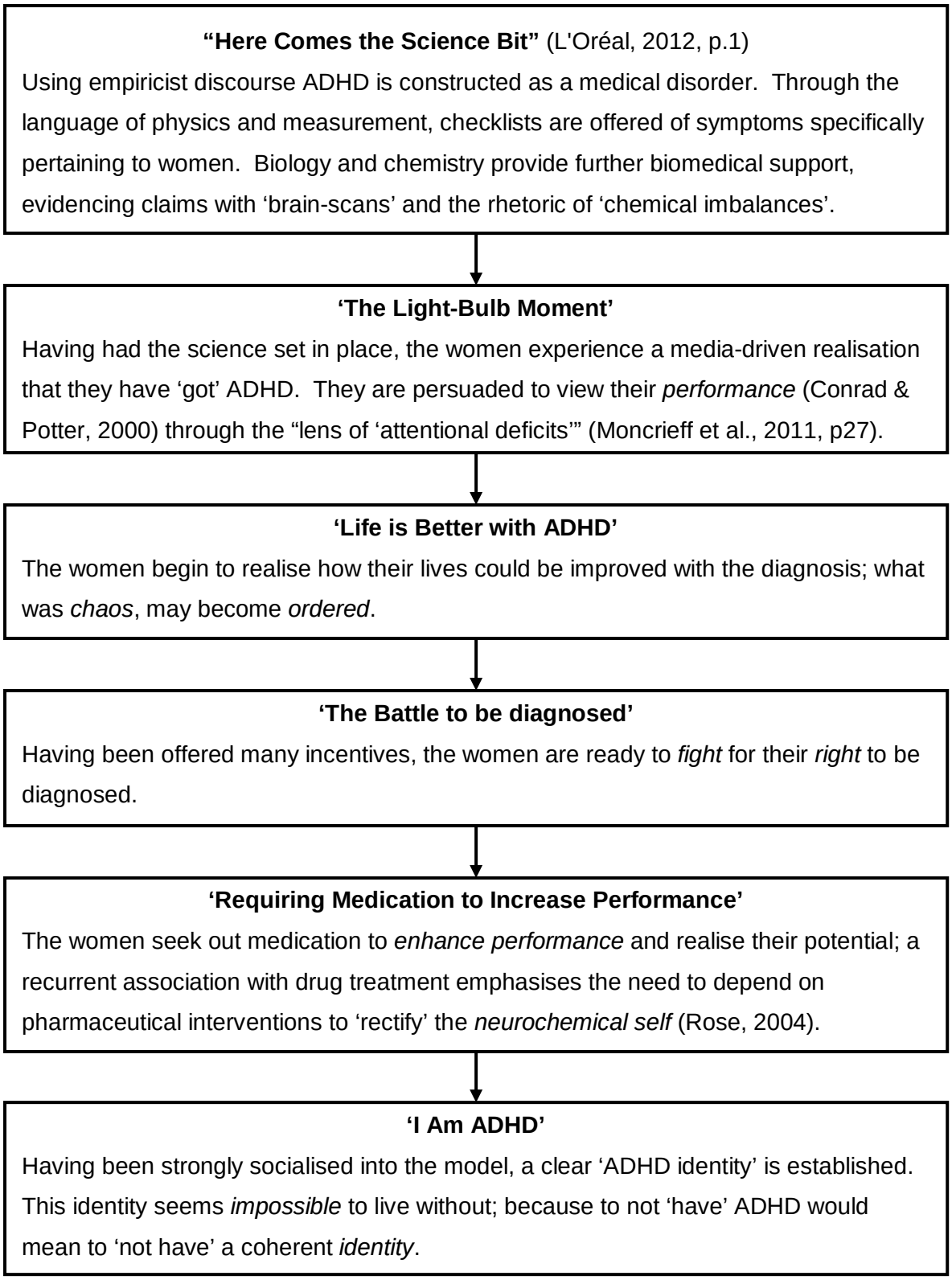
enhance their performance (see 4.1.2 for further discussion). The rhetorical device of *contrast* was frequently used to persuasively bolster this narrative; in numerous forms it favourably compared a life with diagnosis and treatment, to a life without (see 3.5).

Stimulant medication was constructed as "the best form of treatment" (extract 7), with very little attention paid to alternatives. The exceptions being a few references to 'psychologists' who appeared to encourage a more multi-dimensional formulation; yet were perceived by the women as simply adding a barrier to their deserved diagnosis and 'treatment' (see 3.6.2). Beverley, in extract 15, also briefly mentioned *life coaching*, but this was not explored further.

Extending my analysis beyond purely linguistic representations, allowed the development of a more balanced understanding of the way 'meaning' was produced in relation to the 'ADHD-woman'. The visual rhetoric of the images helped to strengthen the compelling nature of the narrated message of marketisation. For example, allowing the women to 'show' they have ADHD (cf. Beverley, Figure 10) or 'professionals' to evidence the underlying pathology (cf. brain-scan imagery, Figure 5).

As well as attending to the micro-level analysis, it was particularly striking to note an overall 'story' of inferred *marketisation* (see 1.2), which appeared to emerge from the data (Figure 20).

Figure 20


"Here Comes the Science Bit" (L'Oréal, 2012, p.1)
Using empiricist discourse ADHD is constructed as a medical disorder. Through the language of physics and measurement, checklists are offered of symptoms specifically pertaining to women. Biology and chemistry provide further biomedical support, evidencing claims with 'brain-scans' and the rhetoric of 'chemical imbalances'.
'The Light-Bulb Moment'
Having had the science set in place, the women experience a media-driven realisation that they have 'got' ADHD. They are persuaded to view their *performance* (Conrad & Potter, 2000) through the "lens of 'attentional deficits'" (Moncrieff et al., 2011, p27).
'Life is Better with ADHD'
The women begin to realise how their lives could be improved with the diagnosis; what was *chaos*, may become *ordered*.
'The Battle to be diagnosed'
Having been offered many incentives, the women are ready to *fight* for their *right* to be diagnosed.
'Requiring Medication to Increase Performance'
The women seek out medication to *enhance performance* and realise their potential; a recurrent association with drug treatment emphasises the need to depend on pharmaceutical interventions to 'rectify' the *neurochemical self* (Rose, 2004).
'I Am ADHD'
Having been strongly socialised into the model, a clear 'ADHD identity' is established. This identity seems *impossible* to live without; because to not 'have' ADHD would mean to 'not have' a coherent *identity*.

In this study, the ADHD 'product' appears to have been marketed to women via personal endorsements and testimonials of both 'professionals' and 'sufferers'. Contrary to what may typically be thought of as *science*; "the world of facts" (Potter, 2006, p.17) with a reliance on *evidence based practice*; this analysis suggests ADHD may be more appropriately defined by the context of its emergence, as a commercial 'product' with an identified female 'market'.

In the course of making transparent the above processes this study also aimed to encourage further questions (Foucault, 1977); thus contributing to "social change through critical analysis" (Wooffitt, 2005, p.139). This will be addressed in sections 4.4-4.5 as I explore the implications of this study for clinical practice and research.

4.1.2 'Desperate Housewives' vs. 'Superwomen'

As outlined in chapter one, a new symptom-example incorporated into DSM-V is *failing to finish household chores* (APA, 2012, p.1); versions of which appeared repeatedly throughout this analysis (e.g. extracts 1, 2, 17 and 33).

As the research progressed I developed a curiosity with regards to the ways in which ADHD drugs appeared to be marketed to women in line with the patriarchal ideology of 'the-woman-in-the-home'; whilst at the same time as emphasising the construction of the 'career woman'. Despite the fact that 69 per-cent of women in the UK are in paid employment (Office for National Statistics, 2012), 92 per-cent are still carrying out all the household tasks; spending on average 180 minutes per day on housework (Office of National Statistics, 2006).

As well as *falling behind with chores* some women in this study also spoke about struggling in their place of work (e.g. extracts 1 and 38). In her critical analysis of gender in the media, Gill (2007) suggests that, for women, "carrying out a double-day is rendered invisible by the superwoman imagery" (p.97) of 'having it all'[20]. I propose that the women represented in this study have 'failed' to reach this culturally-determined *superwoman* status. Hence, in the same way as ADHD in

[20] Managing a family, having a successful career, continuing to look young and attractive.

the child population has been critically conceptualised as “Requires medication to progress academically” (Rogers & Mancini, 2010, p.87); it could be argued these women ‘require medication to reach ‘superwoman status’.

Medication has been used to ensure children who are doing ‘ok’ in school, increase their performance to *exceptional* levels (Leo & Lacasse, 2009). Similarly, with women, it now seems unacceptable to be a *good enough* mother, housewife and employee; optimum performance is necessitated in all areas of their lives.

Feminist authors have written about the relationship between a patriarchal society and women’s use of substances (Ettorre, 1994*).* If women fail to reach *superwoman* standards then they are encouraged to look for a solution; the material used in this study would suggest the clandestine marketing of stimulant medication has offered an appealing resolution to such ‘deficiency’ in performance.

4.2 How My Analysis Compares to Other Studies

In line with the literature reviewed in chapter one, my analysis indicated a strong preference for a biomedical account of ADHD (Clark, 2001; Horton-Salway, 2010; Leo & Lecasse, 2009; Norris & Lloyd, 2000). Moreover, the findings also reflected both Leo and Lacasse (2009) and Horton-Salaway’s (2010) studies in that ADHD was constructed as necessarily requiring biological intervention. However, there was notably less consideration of other forms of intervention (i.e. ‘psychosocial’), as seen in previous studies (e.g. Horton-Salway, 2010).

With regards to gender, this study supported claims made by Moncrieff et al. (2011) that ADHD is being specifically marketed to women.

4.2.1 The Medicalisation of Underperformance

In addition to the above, this study offers an illustration of Conrad and Potter’s (2000) thesis (see 1.8); with an additional focus on women.

Extending the concept of the *medicalisation of underperformance*; these women "feel that they could/should be doing better and seek help in improving their performance" (Conrad & Potter, 2000, p.573). Thus "the medical explanation for their underperformance, allows for the re-evaluation of past behaviour, and by shifting responsibility for problems reduces self-blame" (p.573). Beyond an explanation, the medication also "provides a strategy for improving the underperformance" and has been credited with "saving marriages, rebuilding faltering careers, and transforming what had been problematic personalities" (p.574).

Examples of the above may be seen throughout the analysis. Moreover, as ADHD is assimilated into the "disability" discourse, recipients of the diagnosis become the "potential beneficiaries of a 'medical excuse' for their life problems" (Conrad & Potter, 2000, p.574), whilst new benefits and accommodations are made available.

Finally, in accordance with the observations of Conrad and Potter (2000, p.575), the results of this analysis show numerous examples of the "lay-professional alliance", with a clear union between the claims of 'sufferers' and 'professionals'; as previously observed in media presentations and 'charitable groups' such as CHADD.

4.3. Critical Review

4.3.1 A Hybrid Method

As discussed in section 2.3, in this study I have employed a hybrid version of discursive psychology (e.g. McHoul & Rapley, 2005; Schubert et al., 2009). Thus, in analysing my corpus of data, I have tried to conform to some of the main principles of *discursive psychology* (DP) (Edwards & Potter, 1992); whilst orienting to features of what is generally described as *critical discourse analysis* (CDA) (Fairclough, 1995).

Billig (2009) used the analogy of flavours of ice-cream in discussing the combination of different 'discursive' approaches. Although this analogy might suggest different flavours may be easily combined according to taste; some of

the proponents of the various forms do not see their approaches as being easily compatible (Billig, 2009).

Using CDA within the DP framework allowed me to adopt an overt political stance; as opposed to starting from the text as would be expected in a purely DP approach (Fairclough, 2001; McHoul & Rapley, 2005; Wooffitt, 2005). As such, I began by asking how ADHD was being presented to women, therefore raising the possibility that there might be alternative ways of doing so. Thus, from the DP/CDA union I hoped to [1] see the extent to which a small sample of online videos, analysed in some degree of detail, may shed light on the processes of ADHD-marketisation-to-women; and [2] that these findings may stand as a hypothesis for further investigation (cf. McHoul & Rapley, 2005).

4.3.1.1 Visual

In chapter two I outlined my intentions to include YouTube screenshots in my analysis. The inclusion of the images was not intended purely for 'illustration' purposes (Emmison & Smith, 2007); rather I was interested in examining the *visual rhetoric* of the images, and how they functioned to cement the verbal claims that were made (Hill & Helmers, 2004). Such an approach was also in line with the traditions of CDA and its concern with how "language and/or semiosis" relate (Fairclough, 2001, p.25).

Reflecting back on chapter three, I found myself less able to be as systematic with the visual material as I was with the verbal. This may, in part, be because I approached the written text with suggestions of "how discourse can be studied" (Potter and Wetherell, 1987, p.175); as well as an abundance of literature on taking a discursive approach to the analysis of verbal rhetoric (e.g. Edwards & Potter, 1992; Hepburn & Potter, 2007; Potter, 1996). In contrast, there has been relatively little written on the analysis of visual rhetoric. Certainly, there is a great deal of literature on conducting a *semiotic analysis* (e.g. Barthes, 1972; Chandler, 2009; Reavey, 2011); but such a detailed analysis was beyond the scope of this study.

Taking the above into consideration, where possible, I aimed to uphold the quality criteria for discourse analysis as described by Antaki et al., (2003) and presented in 4.3.4. There remains, however, scope for future research to take a more systematic approach to the visual data.

4.3.2 Generalisability

In contrast to the aims of quantitative research, by drawing on the traditions of discourse analysis, I did not intend to claim generalisability of my results. However, as discussed in section 2.8.1, this study followed Sack's (1992) theory that cultures display *order at all points*. Henceforth, as with other discursive studies focussing on a *local level* analysis, (cf. McHoul & Rapley, 2005), the content presented in this study – extracts from seven easily accessible YouTube videos – may be assumed to be found elsewhere on a broader scale. Indeed, examination of other related YouTube videos, online magazines, self-help literature and pharmaceutical and charitable websites would imply the material I have presented is neither extraordinary nor uncommon in the online data pool (cf. the quotation at the beginning of my study, from www.health.com).

4.3.3 Reflexivity and Language

Reflexivity is an essential component of discourse analytic research (Willig, 2008; Wooffitt, 2005). It necessitates an "awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining 'outside of' one's subject matter whilst conducting research" (Wooffitt, 2001, p.10). Completing a reflexive diary and engaging in regular supervision sessions helped with this process (Appendix 11).

According to Wooffitt (1992), "arguments about the constructive nature of language use apply also to [the researcher's] own writings, including the discourse through which such observations are made" (p.58). Curt (1994) also suggests; "We cannot get iffy over other people's power-games with language, and then pretend we are not players in the game too" (p.19).

Reflecting on my own use of language I am aware I have used numerous rhetorical devices to analyse the rhetoric of others. Indeed the presentation of the analysis section – organised into seven categories – may be seen to resemble a rhetorical *list* in itself (Potter, 1996). However, this does not necessarily weaken or invalidate my analysis:

> *It is possible to acknowledge that one's own language is constructing a version of the world, while proceeding with analysing texts and their implications for people's social and political lives. In this respect, discourse analysts are simply more honest than other researchers, recognising their own work is not immune from the social psychological processes being studied.*
>
> Potter and Wetherall (1987, p.182)

Another influence on my writing was the requirement to develop a coherent, consistent and linear argument, in order to tell a particular story (Harper, 2009). Again, this called upon rhetorical strategies (e.g. persuasiveness); resulting in a narrative that I purposely constructed, "in a particular way, for particular reasons" (Stainton-Rogers, 1991, p.10). However, I am not claiming to be "telling it 'like it is', but rather saying 'look at it this way'" (Stainton-Rogers, 1991, p.10).

4.3.4 Quality

In this section I offer an evaluation of the quality of my research, guided by the potential shortcomings of discourse analysis as proposed by Antaki et al. (2003).

4.3.4.1 Under-analysis through summary

I aimed to avoid presenting text purely in summary-form; devoid of examples or explanations of the function of language (or specific use of imagery). Taking a micro-level discursive approach required me to attend to specific words and phrases; holding in mind the questions proposed by Rapley (2011) also helped with this process (see 2.3.2).

4.3.4.2 Under-analysis through taking sides

Throughout this thesis I have aimed to remain transparent with regards my non-commitment to the typical obligations of "value neutrality" seen in other forms of discourse analysis (Burr, 2003, p.158). However, I am also aware that discourse analysis is not simply the process of offering evidence of one's own personal, moral or political attitudes alongside a piece of text (Antaki et al., 2003). As such, whilst this study may contain numerous examples of my position in relation to ADHD; I have not let this 'stand alone' as evidence; rather I have endeavoured to support my position with an analysis of the material in the text.

4.3.4.3 Under-analysis through over-quotation or through isolated quotation

I aimed to balance the presentation of chapter three by offering illustrative quotations, permeated by my comments. I found myself less able to be as systematic with the visual material (see 4.3.1.1).

On some occasions I presented stand-alone sentences; however, the examination of these (as with all the quotations) was conducted within the discursive context of the extract in its entirety.

4.3.4.4 The circular identification of discourses and mental constructs

In my analysis I have referred to 'discourses' within the text; most commonly the 'biomedical discourse'. However, on introducing this discourse I sought evidence *beyond* the specific extract (Antaki et al., 2003). The aim was thus to show how "wider patterns of talk are mobilized by the speaker in the particular context of the interview or conversation that is being studied" (Antaki et al., 2003, p.24). Further questions ensued in relation to why particular statements were being made and what the speakers were doing by using these discourses. This led back to further examination of the text; thus avoiding the "dangers of circularity and mere summarising" (Antaki et al., 2003, p.24).

4.3.4.5 False survey - extrapolating from one's data to the world at large

As previously stated, I am not intending to claim generalisability of my results (see 4.3.2).

4.3.4.6 Analysis that consists of simply spotting features

For each rhetorical device identified in the text, I attempted to describe what it accomplished within its specific context; as opposed to "simply spotting features" (Antaki et al., 2003, p.6).

4.4 Implications for Research

4.4.1 Adaptations and Developments of the Current Study

4.4.1.1 A complementary analysis: Membership Categorisation Analysis

Following the insights of Schubert et al. (2009) future research could integrate membership categorization analysis (MCA) (Eglin & Hester, 2003; Sacks, 1992; Schegloff, 2005, 2007a, 2007b; Stokoe, 2003, 2012) into the hybrid framework used in this study[21].

Using MCA, would allow the researcher to examine the ways women talk about, manage and promote their membership within the social category of 'ADHD sufferer'; as well the ways 'professionals' endorse ADHD as a desirable social category for females to acquire. A discursive psychology framework would complement MCA as it adds to the 'how' by asking whose interests are being served in such categorisations (Schubert et al., 2009, p509).

4.4.1.2 An alternative corpus of data

A similar hybrid approach to that used in this study could be employed to analyse other sources of ADHD 'information' orientated to women; such as magazines, official websites or patient-information leaflets (Hansen et al., 2003).

4.4.1.3 Involving women

Women could be invited to watch and deconstruct the YouTube videos used in this current study; thus privileging the interpretations of the intended audience over those of the researcher. Following the lead of Singh (2012)[22], women's

[21] See Appendix 12 for a fuller description of MCA and why it was not included in this present study.

[22] Children's views on identity, childhood, ethics and stimulants.

views could also be sought on the ethical concerns surrounding ADHD and the use of stimulant medication.

4.4.2 Depression Vs ADHD: The Ills of Women

The expansion of the ADHD diagnosis and its overrepresentation in the adult female population follows similar trends to those observed in other psychiatric diagnoses, such as depression[23] (Healy, 2004; Moncrieff, 2010). However, it may be argued that the expansion of ADHD is particularly notable given that the original diagnosis was applied mainly to boys.

The language of 'depression', and more recently 'ADHD', has become incorporated into lay discourse; helping to shape the way women construct themselves and their experiences (Moncrieff, 2010; Healy, 2004; Rose, 2004). Furthermore, the popularisation of these 'labels' has created a class of psychiatric diagnoses that women actively fight to receive (Moncrieff et al., 2011).

The 'symptomatic' presentation of ADHD and 'depression' are theoretically contrasting; ADHD more commonly described as an 'externalising disorder', and 'depression' an 'internalising disorder' (Simos, 2002). 'Treatment' is also divergent, with 'depression' usually 'managed' with 'selective-serotonin-reuptake-inhibitors' (NICE[24], 2009) and ADHD with controlled substances such as Methylphenidate (NICE, 2009a). However, there are clear similarities in their appeal and promotion to women (Moncrieff et al., 2011; Rowe, 2003). Moreover, both diagnoses appear to raise questions pertaining to 'selfhood' and 'authenticity' in the 'sufferer' (Stepnisky, 2007).

Future research could take a discursive approach in examining and contrasting the constructs of these two diagnoses in a variety of texts intended for women. Alternatively, within the framework of a *Foucauldian genealogy*, one may choose to explore the conditions of possibility that have led to the emergence of the 'ADHD-woman' and the 'depressed-woman'. Using this approach would allow

[23] Twice as many women are diagnosed with depression than men (WHO, 2013).

[24] National Institute of Clinical Excellence.

the exploration of the numerous complex processes surrounding the emergence of these constructs in both 'professional' and 'lay' texts (Tamboukou, 1999).

4.5 Implications for Clinical Practice

4.5.1 Working with Women: Empowering, Educating and Developing a 'Critical Filter'

In considering the potential practical applications of discourse analytic findings, Miller (1980) described the process of *popularisation*, in which knowledge is made freely available to the public. Thus, following the assumption that *knowledge is power*[25], it may be that through the process of making people aware of the use of rhetorical devices to persuade and influence; they may develop their own critical 'filter' through which they can interpret the information they receive.

This filter need not be limited to the use of rhetoric; an increased awareness of distal influences, such as culture and the media, on experiences (Smail, 2005), could also help women begin to think beyond the realm of the *neurochemical self* (Rose, 2004).

In discussing the discourses of femininity, Stoppard (2000) described the way women continue to be judged against old ideas of what it is to be 'female' (e.g. housewives) as well as now needing to be successful career-women and look eternally young and attractive. Ussher (1991) also described the "discourse of madness" which "serves to divert attention away from the problems within society, focussing attention onto the individual, who is suffering only as a direct result of societal pressures" (p.148). As long as these discourses are hidden they also remain unquestioned. By consistently engaging women in conversations as outlined above, these limiting discourses may be brought to the surface, deconstructed and challenged.

Some would argue, however, that this work should move away from individual conversations, placing more emphasis on a drive for *social action* (Ettorre, 1994).

4.5.2 Lobbying for Change and Political Action

An important motivation behind drawing on the principles of CDA is the impetus to contribute to "social change through critical analysis" (Wooffitt 2005, p.139). Psychiatric diagnosis has been described as a "political device" (Moncrieff, 2010, p.370) and part of the framework "that supports the existing social response to certain problematic behaviours" (Moncrieff, 2010, p.381); involving both psy-professionals and the "chemical cosh" (Miller, 2010, p.103). However, the political nature of the 'solutions' offered to situations labelled as 'mental illness' (such as ADHD) are concealed within the discourse of 'diagnosis'; and therefore difficult to question (Moncrieff, 2010).

ADHD is consonant with the consumerist and competitive values of a late capitalist society. It both pathologises underperformance (Conrad & Potter, 2000) and underproductivity; and offers the solution in the form of stimulant drugs. Moreover, the ADHD-model appears to produce an identity that favours the interests of both the *psy-complex* and pharmaceutical companies. In bringing such discourses to the surface, they may subsequently be challenged and revealed as "a 'practical moral enterprise' (Coulter, 1979, p.151), that requires democratic participation and control" (Moncrieff, 2010).

According to Ettorre (1994), an important focus for action would be to raise public awareness of the relationship between patriarchal society and women's use of substances. A starting point might then be to begin publishing relevant critical literature in more high-profile, mainstream journals or popular media outlets (Leo & Lecasse, 2009). We could also take a more assertive approach in utilising social media and networking platforms (e.g. YouTube, Facebook, Twitter) to disseminate alternative discourses of female distress. This could involve constructing alternative YouTube material, using (for example) the current analysis to embody an alternative story; a 'not-ADHD' video about 'ordinary' pressures and 'ordinary' responses, devoid of the need for labels, medication or the involvement of the 'psy-complex'.

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[25] From the Latin "Scientia potentia est"; usually attributed to Sir Francis Bacon.

More generally, attention needs to be paid to lobbying websites such as YouTube; requesting stricter regulations on the covert promotional material used, noting the illegality of DTCA in the UK (WHO, 2009), and drawing attention to the relevant clauses of the Advertising Standards Authority (Appendix 13).

4.6 Final Reflections

This thesis has highlighted some of the *rhetorical tropes* used to persuade women of the 'currency' of ADHD in helping to 'conquer' the multiple demands and responsibilities of the modern-day 'superwomen' (Wilkinson & Kitzinger, 1996). ADHD has been offered, indeed promoted, to women as a formulation of their 'underperformance' and a 'key' to the solution (Conrad & Potter, 2000).

It has been particularly remarkable to note that a 'disorder' which was once considered almost entirely limited to 'boys' (Timimi, 2005), is now being readily applied to women. This reinforces the notion that ADHD is serving as another means via which women may reframe their discontent (Moncrieff et al., 2011).

Completing this study has been both captivating and awakening; especially as there are numerous aspects of the idealised 'superwoman' which at times I feel I also aspire to. I have felt energized by the possibility that, as researchers, we may contribute to "social change through critical analysis" (Wooffitt 2005, p.139); even if our current context is making this increasingly challenging.

According to Newnes (in press), the *act* of diagnosis is now omnipresent; with the implication that "increasingly refined descriptors of conduct will be incorporated into professional *and* public discourse" (p.26); regardless of the active protesting of those who dissent. In spite of this, I do feel hopeful about the work we can do to 'push back' against such hegemonic discourses.

> *As citizens we have a bond of common humanity to respect and, as a society, we have a responsibility to understand what drives people mad and to help people to take back what they can of their lives.*

Rapley et al. (2011, p.258).

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6.0 APPENDICES

6.1 Appendix 1: Literature Review

I began my literature review by searching on EBSCO, an international online research database. I completed searches using the following terms under the parameters of *all databases* and *all years available*. I began with the relatively broad search term of 'ADHD'. However, this came back with 41,746 papers identified; I therefore began to focus more specifically on topics relevant to my research, as listed below:

- 'Adult ADHD'
- 'ADHD and gender'
- 'ADHD prevalence'
- 'ADHD and women'
- 'ADHD and feminism'
- 'Women and mental health'
- 'ADHD online information'
- 'ADHD and the media'
- 'ADHD marketing'
- 'Diagnosis marketing'
- 'ADHD discourse analysis'
- 'ADHD discursive psychology'
- 'ADHD critical discourse analysis'

EBSCO requires subscription and therefore access is generally limited to students and 'professionals'. To ensure I also attended to resources openly available to the public, I used the above terms to carry out searches on Google and Google Scholar.

I selected relevant texts by reading through the abstracts and downloading full text articles. As well as for ease of reading, authors have recommended downloading documents for analysis due to the frequently changing nature of the internet (Strong & Gilmour, 2009). I excluded search results which either had no

clear relevance to this study or focused specifically on issues which I did not intend to cover. For example I excluded articles which focused on ‘co-morbidity’, such as, ‘Attention-deficit hyperactivity symptoms and disorder in eating disorder inpatients’ (Yates et al., 2009). As this study progressed I continued to search EBSCO and Google to stay abreast of recent developments, the latest publications and novel lines of enquiry.

In addition to the above, I used reference lists to identify relevant articles and took recommendations from professionals working and researching in the area of ADHD and/or discourse analysis.

6.2 Appendix 2: ADHD in the popular media

- **2000: *South Park*[26]; 'Timmy 2000'.** All the children were prescribed Ritalin after being diagnosed en masse with ADHD. Subsequently, teachers and parents also began to take the drug, obtaining tablets from the children's prescription. This episode also included images of a pharmacist and prescribing doctor counting their profits as the whole of Southpark became 'obedient' until the antidote 'Ritalout' is distributed.

- **2004: *Desperate Housewives*[27]; 'Running to Stand Still'.** One of the main characters, Lynette Scarvo, resorts to taking her sons Ritalin tablets to help her complete her household chores.

- **2011: Private Practice[28]; 'If I Hadn't Forgotten...'.** A mother gives her son unprescribed ADHD medication in order to improve his academic grades and get him extra time on his tests.

- **2012: *Ricki Lake Show*[29]; 'Addicted Housewives'**. Mothers spoke about taking their children's medication to become 'more productive' and to help them to catch up on their housework.

[26] American animated sitcom created by Trey Parker and Matt Stone

[27] American television comedy drama-mystery series created by Marc Cherry

[28] American medical drama television programme created by Shonda Rhimes

[29] American television talk show hosted by Ricki Lake

6.3 Appendix 3: Video Census: September 2011 – July 2012

Searches conducted approximately every 6 weeks using the search term 'ADHD Women'.

*Indicates videos used in analysis.

	Top 7 Results								
Video	**Time 1**	**Time 2**	**Time 3**	**Time 4**	**Time 5**	**Time 6**	**Time 7**	**Time 8**	**TOTAL**
ADHD: Myth or Reality (Parts 1 & 2) http://www.youtube.com/watch?v=dxNxlJ7rzw8 and http://www.youtube.com/watch?v=SbfXdODPySk&feature=relmfu	✓	✓	✓	✓	✓	✓	✓	✓	**8***
CBS News Report: Women and Attention Deficit Hyperactivity Disorder (ADHD) http://www.youtube.com/watch?v=ri2BagoDwvI	✓	✓	✓	✓	✓	✓	✓	✓	**8***
Ritalin vs. Adderall by a Women Entrepreneur with ADD (Arie) http://www.youtube.com/watch?v=-2KhHgL_mFE&feature=related	✓	✓	✓	✓	✓	✓	✓	✓	**8***
Dr Sarkis: My Life with ADHD http://www.youtube.com/watch?v=X4_KG9utB2A&feature=related	✓		✓	✓	✓		✓		**5***
ADHD Women's Retreat http://www.youtube.com/watch?v=5uAWMIXMbhU	✓	✓				✓			**3**
Webinar Video: ADHD & Women http://www.youtube.com/watch?v=5ztE94XdKrA	✓	✓	✓						**3**

Dr. Aleya Karim (parts 1 & 2) Interview on ADHD in Females http://www.youtube.com/watch?v=3ttaSBVrC3Y&feature=relmfu and http://www.youtube.com/watch?v=NNOiC5QRZ8s&feature=relmfu	✓		✓	✓					**3**
College Student: ADD is Real (Ashley) http://www.youtube.com/watch?v=rybVzoKOwWA&feature=related		✓		✓	✓	✓	✓	✓	**7***
ADDitude Video: Dr Sarkis on ADD and ADHD Women http://www.youtube.com/watch?v=1zP3jACILhE		✓	✓	✓	✓	✓	✓		**6***
Dr. Carolyn Long: Women and ADHD www.youtube.com/watch?v=1j4gyG3M_Bw					✓	✓	✓	✓	**4***
My Experience with Adderall http://www.youtube.com/watch?v=Y-Vi9HgElL0&feature=fvwrel								✓	**1**
ADHD/ADD For Girls & Women Only http://www.youtube.com/watch?v=GxFV4_xEc4Y								✓	**1**

6.4 Appendix 4: Final Video Selection Based on Frequency of Appearance

1. Video 1: ADHD: Myth or Reality (Parts 1 & 2)
   http://www.youtube.com/watch?v=dxNxIJ7rzw8
   and
   http://www.youtube.com/watch?v=SbfXdODPySk&feature=relmfu
   Appeared 8 times during the census period.

2. Video 2: CBS News Report: Women and Attention Deficit Hyperactivity Disorder (ADHD)
   http://www.youtube.com/watch?v=ri2BagoDwvI
   Appeared 8 times during the census period.

3. Video 3: Ritalin vs. Adderall by a Women Entrepreneur with ADD ('Arie')[30]
   http://www.youtube.com/watch?v=-2KhHgL_mFE&feature=related
   Appeared 8 times during the census period.

4. Video 4: College Student: ADD is Real ('Ashley')
   http://www.youtube.com/watch?v=rybVzoKOwWA&feature=related
   Appeared 7 times during the census period.

5. Video 5: ADDitude Video: Dr Sarkis on ADD and ADHD Women
   http://www.youtube.com/watch?v=1zP3jAClLhE
   Appeared 6 times during the census period.

6. Video 6: Dr Sarkis: My Life with ADHD
   http://www.youtube.com/watch?v=X4_KG9utB2A&feature=related
   Appeared 5 times during the census period.

7. Video 7: Dr. Carolyn Long: Women and ADHD
   www.youtube.com/watch?v=1j4gyG3M_Bw
   Appeared 4 times during the census period.

[30] ADD and ADHD are used interchangeably throughout these videos

6.5 Appendix 5: Transcription Key

Adapted from Banister et al. (1994) and Hepburn and Potter (2009).

Transcription Key

~grandson~	Wobbly voice – enclosed by tildes.
(.)	Pause
(2)	Length of pause/music in seconds
[inaudible]	Inaudible section of transcript
Emphasis	Word spoken with more emphasis than others
[laughter]	Laughter during the interview
sto(h)p i(h)t	Laughter within speech is signalled by h's in round brackets.
she wa::nted	Colons show degrees of elongation of the prior sound; the more colons, the more elongation.

6.6 Appendix 6 Glossary of Popular Rhetorical Devices

These 'toolkits' were collated by Alexa Hepburn, Reader in Conversation Analysis in the Social Sciences Department at Loughborough University.

6.6.1 Action Production Toolkit: Focused on Action and Accountability

1. Categorization of persons and events. Construct yourself and others in ways appropriate to the action. One of the reasons we have such an elaborate set of categories for describing people is that they are bound up with the elaborate set of actions we take part in. *Jane is a slut; Kevin is heroic.* As Billig shows, categorizations may be complemented or countered by particularizations. *Pete is a very unusual Rastafarian…*

- Billig, M. (1985). Prejudice, categorization and particularization: From a perceptual to a rhetorical approach. *European Journal of Social Psychology,* 15, 79-103.
- Billig, M. (1996). *Arguing and Thinking: A Rhetorical Approach to Social Psychology* (2nd edn.). Cambridge: Cambridge University Press.
- Edwards, D. (1991). Categories are for talking: On the cognitive and discursive bases of categorization. *Theory and Psychology, 1* (4), 515-542.
- Edwards, D. (1997). *Discourse and cognition.* London and Beverly Hills, CA: Sage (especially ch. 8-9).
- Lepper, G. (2000). *Categories in text and talk*. London; Sage.
- Stokoe, E.H. (2003). Mothers, single women and sluts: Gender, morality and membership categorization in neighbour disputes. *Feminism & Psychology, 13* (3), 317-344
- Potter, J. & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage (especially ch. 6).

2. *Packaging actions in descriptions*. Embed a blaming, say, inside a description of events. This can vary from something quite direct to something highly indirect. *Brian only waited 5 minutes…*

- Edwards, D. (1995). Two to Tango: Script Formulations, Dispositions, and Rhetorical Symmetry in Relationship Troubles Talk, *Research on Language and Social Interaction, 28*, 319-350.
- Edwards, D. (1998). The relevant thing about her: Social identity categories in use. In C. Antaki & S. Widdicombe (Eds). *Identities in talk* (pp. 15-33). London: Sage.
- Edwards, D. and Potter, J. (1992) *Discursive Psychology.* London: Sage (especially ch. 4, 5 and 7).

- Potter, J. (1996). *Representing reality: Discourse, rhetoric, and social construction*. London and Thousand Oaks, CA: Sage (especially ch. 4 and 7).

3. *Emotional thesaurus* – angry, upset, etc.. Describe yourself as angry or upset, say, to build a criticism of another's actions. *I was distraught after he walked out.*

- Buttny, R (1993) *Social Accountability in Communication* London: Sage (especially ch. 6)
- Edwards, D. (1997). *Discourse and cognition.* London and Beverly Hills, CA: Sage.
- Edwards, D. (1999). Emotion discourse, *Culture & Psychology, 5,* 271-291.
- Locke, A., & Edwards, D. (2003). Bill and Monica: Memory, emotion and normativity in Clinton's Grand Jury testimony, *British Journal of Social Psychology*, 42, 239-256.

4. *Cognitive thesaurus* – memory, understanding, etc.. Construct what you remember or understand as a part of managing your responsibility for events. *I don't recollect being given any money…*

- Edwards, D. (1997). *Discourse and cognition.* London and Beverly Hills, CA: Sage (especially ch. 5).
- Edwards, D. and Potter, J. (1992) *Discursive Psychology.* London: Sage (especially ch. 2, 3).
- Edwards, D. & Potter, J. (2005). Discursive psychology, mental states and descriptions. In H. te Molder & J. Potter (Eds). *Conversation and cognition* (pp. 241-259). Cambridge: Cambridge University Press.

5. *Script formulations*. Describe actions that treat them as standard or what anyone would do, and therefore not the responsibility of the individual. Scripting is often woven in with other kinds of business, and may be marked grammatically. *We would have arguments, like married people do*.

- Edwards, D. (1994). Script Formulations: A Study of Event Descriptions in Conversation, *Journal of Language and Social Psychology*, *13* (3), 211-247.
- Edwards, D. (1995). Two to tango: Script formulations, dispositions, and rhetorical symmetry in relationship troubles talk. *Research on Language and Social Interaction*, *28*(4), 319-50.
- Edwards, D. (1997). *Discourse and cognition.* London and Beverly Hills, CA: Sage (especially ch. 6).

6. *Dispositional formulation*. Describe actions in ways that construct them as motivated by the individual and their dispositions or wants. Scripts and dispositions are rhetorically opposed. *Jimmy is a very jealous person*.

- Edwards, D. (1995). Two to tango: Script formulations, dispositions, and rhetorical symmetry in relationship troubles talk. *Research on Language and Social Interaction*, *28*(4), 319-50.
- Edwards, D. (1997). *Discourse and cognition.* London and Beverly Hills, CA: Sage (especially ch. 6).

7. *Extreme case formulations* (vs minimizers). Use these to strengthen arguments or display investment in the arguments. *Everyone who is married has arguments*. Contrast minimizers. *Only a couple of windows were broken, hardly anything was burning*.

- Edwards, D. (2000). Extreme case formulations: Softeners, investments and doing nonliteral, *Research on Language and Social Interaction, 33,* 347-73.
- Pomerantz, A.M. (1986). Extreme case formulations: A new way of legitimating claims. *Human Studies*, 9, 219-30.

8. *Three-part lists.* Use these to construct something and normal or standard. They can be part of script formulations.

- Jefferson, G. (1990). List construction as a task and resource. In G.Psathas (Ed.), *Interaction competence*. Lanham, Md: University Press of America.

9. *Narrative*. These descriptive elements are often organized together in broader narratives that may develop their own logic (of tragedy or comedy, say). Can construct instances of general patterns.

- Edwards, D. (1997). *Discourse and cognition.* London and Beverly Hills, CA: Sage (especially ch. 10).
- Potter, J. (1996). *Representing Reality: Discourse, Rhetoric and Social Construction*. London: Sage (especially ch. 6).

6.6.2 Reality Production Toolkit: Focused on Epistemics

1. *Category entitlement*. Construct your talk as coming from a category that is credible or knowledgeable in a way that is relevant to the claim. Various direct and indict ways can be used to build category relevance.

- Potter, J. (1996). *Representing Reality: Discourse, Rhetoric and Social Construction*. London: Sage (especially ch. 5).

2. *Stake inoculation*. Construct your talk as coming from someone whose stake in that talk is counter to what you would expect when making the claim. 'I used to be sceptical, but experience of [the death penalty/ workers cooperatives/ alien abduction/ etc.] leads me to think…'

- Edwards, D. and Potter, J. (1992) *Discursive Psychology.* London: Sage (especially ch. 6, 7).
- Potter, J. (1996). *Representing Reality: Discourse, Rhetoric and Social Construction*. London: Sage (especially ch. 5).
- Wooffitt, R. (2005). *Conversation analysis and discourse analysis: A comparative and critical introduction*. London: Sage (especially ch. 5).

3. *Corroboration and consensus*. Construct your description as corroborated by an independent witness (preferably from an appropriate category) and/or something that everyone agrees on. 'Two or three other people started to look scared…'

- Edwards, D. and Potter, J. (1992) *Discursive Psychology.* London: Sage (especially ch. 5).
- Potter, J. (1996). *Representing Reality: Discourse, Rhetoric and Social Construction*. London: Sage (especially ch. 6).
- Smith, D. (1978). K is mentally ill: The anatomy of a factual account. *Sociology*, *12*, 23-53.
- Wooffitt, R. (1992). *Telling Tales of the Unexpected: The Organization of Factual Discourse.* London: Harvester/Wheatsheaf.
- Wooffitt, R. (2005). *Conversation analysis and discourse analysis: A comparative and critical introduction*. London: Sage (especially ch. 5).

4. *Active voicing*. Use quotations and reports of thoughts to present the views and impressions of others as corroborating, or to show the vivid or unexpected nature of what is described. ‘Karen turned to me and said ‘what the hell’s that?’’

- Hepburn, A. (2003). *An introduction to critical social psychology*. London: Sage.
- Wooffitt, R. (1992). *Telling Tales of the Unexpected: The Organization of Factual Discourse.* London: Harvester/Wheatsheaf.
- Wooffitt, R. (2005). *Conversation analysis and discourse analysis: A comparative and critical introduction*. London: Sage (especially ch. 5).

5. *Footing shifts*. You may need to change footing – quoting people, or presenting yourself as merely a reporter of another’s views. This is closely bound up with active voicing.

- Dickerson, P. (1997). ‘It’s not just me who’s saying this…’ The deployment of cited others in television political discourse, *British Journal of Social Psychology, 36*, 33-48.
- Potter, J. (1996). *Representing Reality: Discourse, Rhetoric and Social Construction*. London: Sage (especially ch. 5).

6. *Vivid description*. Make your description rich with vivid detail, careful observation, and things that 'in themselves' would not be surprising. Vivid description invokes a powerful category: witness.

- Hepburn, A. (2003). *An introduction to critical social psychology*. London: Sage.
- Potter, J. (1996). *Representing Reality: Discourse, Rhetoric and Social Construction*. London: Sage (especially ch. 7).
- Smith, D. (1978). K is mentally ill: The anatomy of a factual account. *Sociology*, *12*, 23-53.

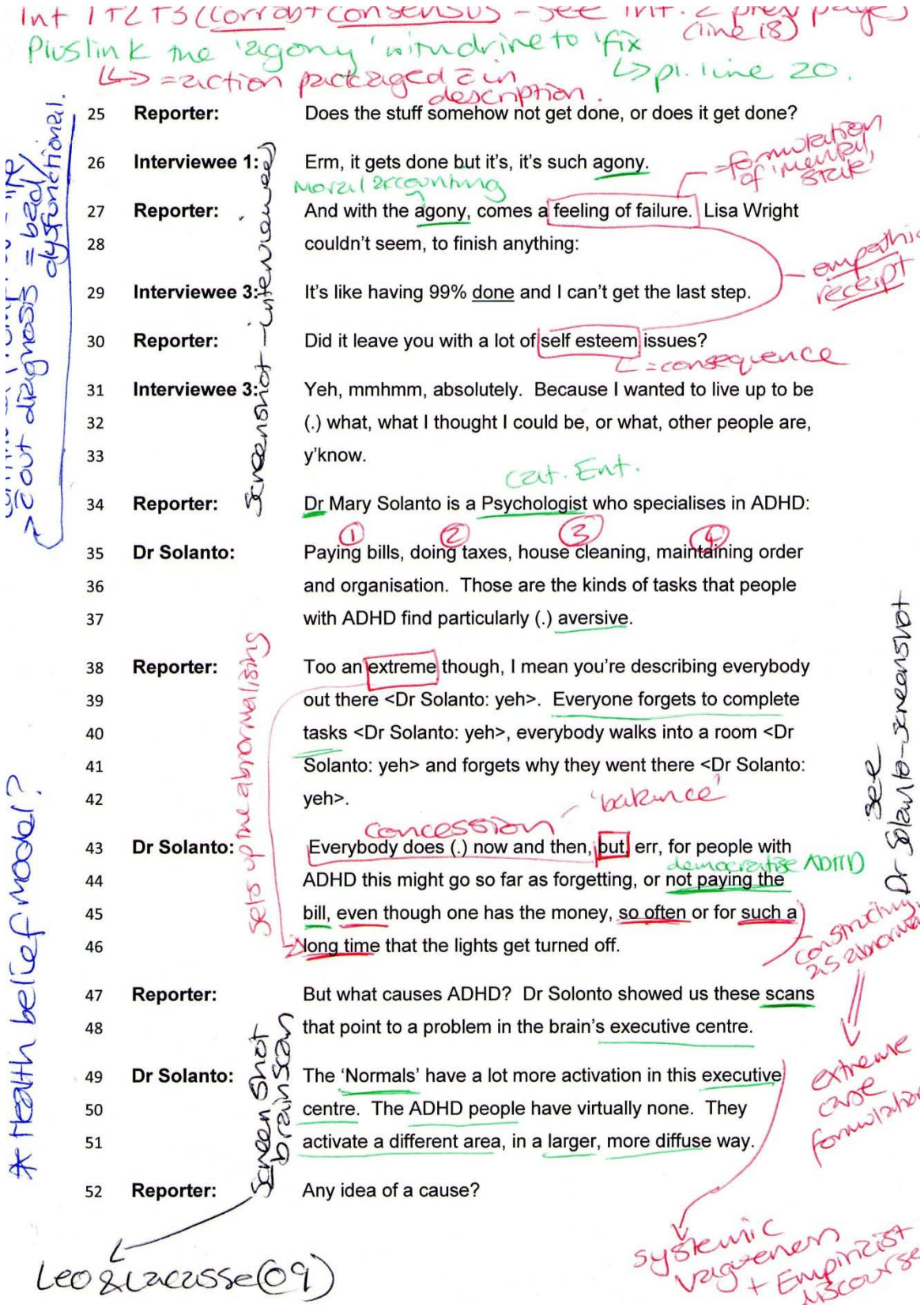
7. *Systematic vagueness*. You may need to be systematically vague about features of descriptions that do not add up or which draw attention to your stake and interest in the claims you are making.

- Edwards, D. and Potter, J. (1992) *Discursive Psychology.* London: Sage (especially ch. 7).

8. *Narrative*. Using different narrative constructions can be an important part of presenting something as real, solid or factual.

- Edwards, D. (1997). *Discourse and cognition.* London and Beverly Hills, CA: Sage (especially ch. 10).
- Potter, J. (1996). *Representing Reality: Discourse, Rhetoric and Social Construction*. London: Sage (especially ch. 6).

6.7 Appendix 7: Worked Example of Transcript



Reporter: Does the stuff somehow not get done, or does it get done?

Interviewee 1: Erm, it gets done but it's, it's such agony.

Reporter: And with the agony, comes a feeling of failure. Lisa Wright couldn't seem, to finish anything:

Interviewee 3: It's like having 99% done and I can't get the last step.

Reporter: Did it leave you with a lot of self esteem issues?

Interviewee 3: Yeh, mmhmm, absolutely. Because I wanted to live up to be (.) what, what I thought I could be, or what, other people are, y'know.

Reporter: Dr Mary Solanto is a Psychologist who specialises in ADHD:

Dr Solanto: Paying bills, doing taxes, house cleaning, maintaining order and organisation. Those are the kinds of tasks that people with ADHD find particularly (.) aversive.

Reporter: Too an extreme though, I mean you're describing everybody out there <Dr Solanto: yeh>. Everyone forgets to complete tasks <Dr Solanto: yeh>, everybody walks into a room <Dr Solanto: yeh> and forgets why they went there <Dr Solanto: yeh>.

Dr Solanto: Everybody does (.) now and then, but, err, for people with ADHD this might go so far as forgetting, or not paying the bill, even though one has the money, so often or for such a long time that the lights get turned off.

Reporter: But what causes ADHD? Dr Solonto showed us these scans that point to a problem in the brain's executive centre.

Dr Solanto: The 'Normals' have a lot more activation in this executive centre. The ADHD people have virtually none. They activate a different area, in a larger, more diffuse way.

Reporter: Any idea of a cause?

6.8 Appendix 8: Loughborough Discourse and Rhetoric Group

6.8.1 DARG: Summary

ADHD: 'BECAUSE YOU'RE WORTH IT'.

THE MARKETISATION OF ADHD TO ADULT WOMEN.

DARG, Loughborough University.

20th June 2012

Summary of Research

The market for ADHD is growing and we are seeing a rapid increase in the sale of stimulant medication (Kendall, et al., 2008). With the introduction of the DSM-5 in 2013, and the more inclusive diagnostic criteria for adults, this trend looks likely to continue.

Unlike childhood, in adulthood it is women who are showing the highest rate of prescription growth and highest intensity of treatment (Castle et al., 2007). It would appear that pharmaceutical industry promotional material is both exploiting and encouraging this trend (Moncrieff et al., 2011).

Moynihan & Henry (2006) have described 'disease mongering' as 'the selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments' (p425). I am interested in considering the multi-media mechanisms through which 'disease mongering' and marketing may work in relation to the promotion of ADHD to adult women, as well as the implications of this.

Data

I have begun to collect data via the online video search engine 'YouTube'. There is an increasing interest in the analysis of visual images in research (Floch, 2000, Emmison and Smith 2007). Therefore, as well as dialogue and written text, I have been focusing on what visual images are presented.

I have focused on the results for 'ADHD and Women' which offer either:

- Personal "testimony" from the 'sufferer'
- A news report on the 'condition'
- Doctors' reports on the 'condition'

I would like to present to DARG an American News Report which covers all of the above. It was uploaded to YouTube in 2007 and has since been viewed 25,024 times. It sits at the top of the YouTube search results for 'ADHD and Women'.

In this news report we are introduced to three female 'sufferers' and we hear about their journey. There is also a brief interview with Dr Mary Solanto who is an Associate Professor of Psychiatry and Head of the ADHD Centre at the Mount Sinai School of Medicine in New York.

I would like to focus on lines 54-80 (minute 2:55-4:19). However, it may be helpful to watch the whole clip (4 minutes 41 seconds) to understand the context of the report.

Link to the YouTube Video: http://www.youtube.com/watch?v=ri2BagoDwvI

Thank you in advance for your time and thoughts.

Helen Winter, Trainee Clinical Psychologist (University of East London)

Director of Studies: Professor Mark Rapley (University of East London)

External Supervisor: Dr Joanna Moncrieff (University College London)

References

Castle, L., Aubert, R., Verbrugge, R., Khalid, M. & Epstein, R. (2007). Trends in medication treatment for ADHD. *Journal of Attention Disorders, 10(4),* pp. *335-342*

Emmison, M. & Smith, P. (2007) Researching the Visual. London: Sage.

Floch, J. (2000). Visual Identities. London: Continuum.

Kendall, T., Taylor, E.,Perez, A. & Taylor, C. (2008). Diagnosis and management of attention-deficit/hyperactivity disorder in children, young people, and adults: summary of NICE guidance. British Medical Journal, 337, pp. 751-753.

Moncrieff, J., Rapley, M. & Timimi, S. (2011) The construction of psychiatric diagnoses: The case of adult ADHD. Journal of Critical Psychology Counselling and Psychotherapy, 11 (1), pp. 16-29.

Moynihan, R. & Henry, D. (2006) The fight against disease mongering: Generating knowledge for action. PLoS Medicine, 3(4), pp. 425-428.

6.8.2 DARG: Transcript Presented

CBS New Report: ADHD Women

http://www.youtube.com/watch?v=ri2BagoDwvI

Length: 04:41

News Reader: The typical hyperactive child is a little boy who cannot sit still. But little girls can have ADHD, only they're not as disruptive so they may not be diagnosed. As adults they never quite fit in and life can get really tough. CBS news correspondent Susan McGuiness spoke with 3 women who went through it.

Interviewee 1: I always felt different and outside of things because, I just though differently than most people.

Interviewee 2: I thought something was wrong with me. I honestly thought I was crazy, I did.

Interviewee 3: There're so many things that I always attempt to do, or want to do or think of doing, and I can't quite make it.

Reporter: These women and many others have lived their lives not understanding what's wrong with them. That's because all three suffer from a condition typically associated with children. Attention Deficit Hyperactivity Disorder, or 'ADHD'.

Evelyn Pope Green went to College on a scholarship but once there she couldn't keep up, and she dropped out.

Interviewee 2: I can remember sitting in my apartment for days at a time in the dark, because once I fell behind, I didn't know how to catch back up. I didn't know what to do, erm, to fix it.

Reporter: Kirsten Boncher found daily life overwhelming:

Interviewee 1: It's every little task that you have to do in a day; making breakfast, making lunch, making dinner and you see something else that you have to do so then you do that to.

Reporter: Does the stuff somehow not get done, or does it get done?

Interviewee 1: Erm, it gets done but it's, it's such agony.

Reporter: And with the agony, comes a feeling of failure. Lisa Wright couldn't seem, to finish anything:

Interviewee 3: It's like having 99% done and I can't get the last step.

Reporter: Did it leave you with a lot of self esteem issues?

Interviewee 3: Yeh, mmhmm, absolutely. Because I wanted to live up to be (.) what, what I thought I could be, or what, other people are, y'know.

Reporter: Dr Mary Solanto is a Psychologist who specialises in ADHD:

Dr Solanto: Paying bills, doing taxes, house cleaning, maintaining order and organisation. Those are the kinds of tasks that people with ADHD find particularly (.) aversive.

Reporter: Too an extreme though, I mean you're describing everybody out there <Dr Solanto: yeh>. Everyone forgets to complete tasks <Dr Solanto: yeh>, everybody walks into a room <Dr Solanto: yeh> and forgets why they went there <Dr Solanto: yeh>.

Dr Solanto: Everybody does (.) now and then, but, err, for people with ADHD this might go so far as forgetting, or not paying the bill, even though one has the money, so often or for such a long time that the lights get turned off.

Reporter: But what causes ADHD? Dr Solonto showed us these scans that point to a problem in the brain's executive centre.

Dr Solanto: The 'Normals' have a lot more activation in this executive centre. The ADHD people have virtually none. They activate a different area, in a larger, more diffuse way.

Reporter: Any idea of a cause?

Dr Solanto: All the evidence indicates it's genetic, in origin.

Reporter: Evelyn learned she had ADHD when her eldest son was diagnosed. It was as if the therapist was talking about her:

Interviewee 2: It was a light bulb and it was a sense of relief. Erm, y'know, I'm not crazy, lazy, stupid. There was a <u>reason</u> all that stuff was going on.

Reporter: Yet, being diagnosed with a disorder that many people think is over-diagnosed isn't easy.

Interviewee 1: It is painful when people say to you: "oh you don't have anything wrong with you". They wouldn't <u>judge</u> whether I had a heart condition or not. It's an invisible disorder.

Reporter: All 3 women got help from medication, which works by stimulating the area of the brain that <u>isn't</u> active. Doctors say this is the <u>best</u> form of treatment, but Lisa struggled with the idea:

Interviewee 3: Then I went through a phase where I was very, err, unhappy: I have a problem that requires that I take medication for the rest of my life. Erm, and that, that wasn't a good phase at all.

Reporter: So Lisa compromised; taking medication to help her finish her work through the week, but not using it on the weekends.

Interviewee 3: I like to be myself on the weekends. I'm creative, I'm fun and outgoing. My impulsivity happens to be a thing that most people, who I know, like about me.

Reporter: Today, with the right diagnosis and treatment all three women are doing well; Kirsten can now enjoy her family more, Lisa started her own business and Evelyn is a school administrator in Chicago. It's not always easy, but that's ok.

Interviewee 2: Most days, I feel really good about myself; not every day but most days I do feel really good about myself. And those days that I don't I always feel like there's hope.

Reporter: For the early show, Susan McGuiness, CBS News, New York.

News Reader: It's important to note that ADHD medication is <u>not</u> addictive as long as it's taken as prescribed. Doctors also recommend specialised therapy to help women develop coping skills.

<u>Transcription Key</u>

~grandson~	Wobbly voice – enclosed by tildes.
(.)	Pause
(2)	Length of pause/music in seconds
[inaudible]	Inaudible section of transcript
<u>Emphasis</u>	Word spoken with more emphasis than others
[laughter]	Laughter during the interview
sto(h)p i(h)t	Laughter within speech is signalled by h's in round brackets.
she wa::nted	Colons show degrees of elongation of the prior sound; the more colons, the more elongation.

6.9 Appendix 9: Video 'Demographics' table

VIDEO	URL	VIDEO PRÉCIS	VIDEO DESCRIPTION PROVIDED
Video 1 **'ADHD: Myth or Reality' (Parts 1 & 2)** **Published by:** Constanze78 **Date Published:** 15 Sep 2009	http://www.youtube.com/watch?v=dxNxIJ7rzw8 http://www.youtube.com/watch?v=SbfXdODPySk&feature=relmfu	This two part 'documentary' is presented by Constanze, a woman who has been diagnosed with ADHD in her home country of Germany. In the video, Constanze visits Liverpool (England) and speaks to women who have either been diagnosed with ADHD or want to be; including women attending an adult ADHD support group. She also includes a brief interview with Professor Philip Asherson. **Length:** Part 1 - 09:46, Part 2 – 05:14	*Attention Deficit Disorder - ADHD - is considered to be a condition which teenagers grow out of once they reach the age of 16-18. In wide parts of our society - and even in some professional circles - this is believed to be the case. This documentary examines whether Adult ADHD really is a myth or has, in fact, become a stark reality.* *The documentary "Adult ADHD - Myth or Reality?" was my final film/work for my University course.* *If you like this film, please forward the link to as many people as possible - this is the only way to raise awareness.* *Category:* Education *Licence: Standard YouTube Licence*
Video 2 **'Women and Attention Deficit Hyperactivity Disorder (ADHD)' (CBS News)** **Published by:**	http://www.youtube.com/watch?v=ri2BagoDwvI	In this American CBS news report, three women with a diagnosis of ADHD are interviewed about their life pre and post diagnosis. The video also includes an interview with Dr Mary Solanto (Head of the ADHD Centre at the Mount Sinai School of Medicine, New York) on the topic of women and ADHD.	*Attention deficit hyperactivity disorder, or ADHD, makes people think of the young boy who can't sit still in class. But what about the young girl with ADHD who isn't so disruptive and doesn't get diagnosed? This report talks with three women who suffer from ADHD and with Dr. Mary Solanto, head of the ADHD Center at the Mount Sinai School of Medicine.* *Category:* News & Politics

msolanto **Date Published:** 16 May 2007		**Length:** 04:41	*Licence: Standard YouTube Licence*
Video 3 **'Ritalin vs. Adderall by a Women Entrepreneur with ADD'** **Published by:** Ariadna Jacob **Date Published:** 22 Feb 2009	http://www.youtube.com/watch?v=-2KhHgL_mFE&feature=related	In this video 'Arie' compares her experiences on Ritalin and Adderall with a personal endorsement for the latter. She also discusses medication in relation to the positive effects it has had on her career and personal life. **Length:**05:26	http://www.prettyceo.com *This video is for career women with ADD attention deficit disorder or any woman in business who thinks she may have it. If comparing ritalin and adderall this may help you decide.* *Category:* People & Blogs *Licence: Standard YouTube Licence* **Note:** By clicking on the 'prettyceo' link the user is redirected to: http://www.addtabz.com/promo/?a_aid=00124576&chan=prettyceo . A website for 'ADDTabz – The new Smart Pill', described as 'the worlds leading Adderall alternative'. The website states: *The absolute need for enhanced mental performance in today's academic and business society is undisputed. Scholastic requirements are as intense as the most competitive corporate environments and the world is simply demanding more and higher levels of performance* (Appendix 10).
Video 4 **'College**	http://www.youtube.com/watch?v	This video presents a female college student 'Ashley Carey', asking her	*ADD is not an excuse, misbehavior, or a result of laziness. ADD is what happens when there is*

Student: ADD is Real' **Published by:** BrokeTheInterweb **Date Published:** 21 Nov 2009	=rybVzoKOwWA&feature=related	audience to accept the reality of ADD as a diagnosable disorder. **Length:** 09:01	*physically something wrong with your brain. ADD medication is what adjusts the chemicals so they function just like anyone else would. Hopefully this video can help people and parents of people struggling with the real thing. ADD is a real chemical disorder, and it's not funny when you tell people that you have it just because you're feeling hyperactive. This is what it's actually like to live in a body actually diagnosed with the actual disorder. It's not something you want to have, or even pretend to have.* *TEDTalk:* http://www.youtube.com/watch?v=iG9CE55wbtY *Category:* Education *Licence: Standard YouTube Licence*
Video 5 **'ADDitude Video: Dr Sarkis on ADD and ADHD Women'** **Published by:** ADDitude Magazine **Date Published:** 16 Aug 2011	http://www.youtube.com/watch?v=1zP3jAClLhE	This video is presented by Dr Stephanie Sarkis (author and psychotherapist based in Boca Raton, Florida). In the video she describes how ADHD presents differently in women compared to men. Dr Sarkis explains this video has been made for ADDitude (quarterly magazine aimed at children and adults with a diagnosis of ADHD). **Length:** 03:30	*Is attention deficit disorder (ADD ADHD) different for females? Stephanie Sarkis, Ph.D., an ADHD expert and author of four books on the subject, explains why females are often diagnosed later in life than males, how their symptoms can be different, and how women can learn to manage their symptoms.* *Learn more about Dr. Sarkis* http://www.stephaniesarkis.com/ *This video was made for* http://www.additudemag.com/adhdblogs/11/index.html *Category:* Education *Licence: Standard YouTube Licence*

Video 6 **'Dr Sarkis: My Life with ADHD'** **Published by:** DocADHD **Date Published:** 8 Jul 2008	http://www.youtube.com/watch?v=X4_KG9utB2A&feature=related	This is another video by 'Dr Stephanie Sarkis'. I this video she presents her own story of how she was diagnosed with ADHD. She discusses the impact ADHD has had n her life and the positive effects of Adderall. **Length:** 02:38	*Here's a little summary of how ADHD has affected my life and how treatment has helped me.* *Featuring Dr. Stephanie Sarkis, the author of "10 Simple Solutions to Adult ADD" and "Making the Grade with ADD: A Guide to Succeeding in College with Attention Deficit Disorder".* http://www.stephaniesarkis.com *Category:* People & Blogs *Licence: Standard YouTube Licence*
Video 7 **'Dr. Carolyn Long: Women and ADHD'** **Published by:** DrCarolynTLong **Date Published:** 12 Apr 2012	www.youtube.com/watch?v=1j4gyG3M_Bw	In this video, 'Dr Carolyn Long' begins by listing some of the symptoms associated with ADHD in childhood. She goes onto explain that many women have been left undiagnosed and suffering. She then lists symptoms associated with ADHD in adult women and urges women to seek further information about the 'disorder' in order to get the help they need **Length:** 06:41	*This video list the criteria for the diagnosis of ADHD in women, and recognizes that until l996, 99% of all research related to AD/HD was done on males.* *Category:* People & Blogs *Licence: Standard YouTube Licence*

6.10 Appendix 10: ADDTabz

The link from YouTube is given as follows:

> **Published on 22 Feb 2009**
>
> http://www.prettyceo.com This video is for career women with ADD attention deficit disorder or any woman in business who thinks she may have it. If comparing ritalin and adderall this may help you decide.

However, once clicked on the link redirects to:

http://www.addtabz.com/promo/?a_aid=00124576&chan=prettyceo

6.11 Appendix 11: Reflexive Diary Extract

At regular intervals throughout this study, I wrote notes in my reflexive diary. Many of these were in note form; the following is an example extract.

After watching Myth or Reality the first few times (10/09/11)

Watched MorR a few times and then watched with Mark. 14538 views since uploaded in 2009. Some very interesting 'comments'- lots of people sharing 'their stories'. Link to facebook group (note popped up on screen).

The video seems to have been put together as a documentary. The presenter is from Germany and came to the UK to see 'how it is here'. Starts with 'emotive' music – not sure how could include this in my analysis. The presenter talks about wanting to show that ADHD is not a MYTH it is a REALITY – clear intentions. Includes a brief interview with 'Professor Asherson' (adult ADHD service in SLAM). Googled him and came up with the following declaration of interests:

- *Has been a consultant for Jannsen-Cilag*
- *He has been a consultant for Eli-Lilly, Shire and Flynn Pharma.*
- *Prof. Asherson has received a research grant from Shire.*
- *He has received grants related to ADHD from Wellcome Trust, The Medical Research Council, US National Institute of Mental Health and the National Institute of Health Research.*
- *He has received an educational grant from Janssen-Cilag.*
- *Prof. Asherson has developed educational programs for Janssen-Cilag.*
- *He has given educational talks at meetings sponsored by Janssen-Cilag, Shire and Flynn-Pharma.*
- *Prof. Asherson has been a member of the NICE guideline development group for ADHD.*

Making me think of the Declaration of Interests in the Timimi/Taylor (2004) paper.

In the video there is a real sense of DEMAND YOUR DIAGNOSIS – almost as if it is a 'human right'. These women appear to feel deprived of something – they are missing out in some way. Some frustration at 'professionals' who encourage broader formulations of 'problems'. These women don't want that – they want a diagnosis of ADHD (and treatment? - 'Benefits' of stimulant meds for women?

Weight Loss? Also making me think of Desperate Housewives in which one of the main characters takes meds to get all her housework done. Also Ussher (1991) quote "only as a wife is one safe").

Also interesting to note how different the appeal of ADHD is compared to less 'desirable' diagnoses e.g. 'PD'/'Schizophrenia'. Why is that? What are the different discourses around these diagnoses....also what are the different 'treatments'.

Really poignant thought at the end:- "if there is no ADHD – what's wrong with me then?!" Making me think of Ilena Singh's bioethics/ADHD research (go back and read). Also interesting to hear the mum speak about her experience of 'realising' she 'has' ADHD when she took her son to be assessed. I saw this a lot when in the ADHD team – I think the team even referred some parents to a new adult ADHD research project.

Watched the video again with Mark (first few minutes). He was struck by the visual environment and setting – e.g. waterfall. He signposted sections of Emmison and Smith to read and also Visual Identities (Alec McHoul translated). Mark asked me to think about connotations of the waterfall and the 'natural environment'. Thought about ideas of 'nature' and other places I have seen it used in advertising (Herbal Essences advert?). Makes me think about what it is suggesting – ADHD/meds = natural, pure, etc.

Need to transcribe. Also need to think more about how I will incorporate the visual with the verbal in my analysis. Started to think about semiotic analysis but think that might be a bit too ambitious for this thesis. I will read Mark's suggested texts and discuss with him again next time.

6.12 Appendix 12: Membership Catergorisation Analysis

Previous studies have drawn on the traditions of MCA (Eglin and Hester, 2003; Sacks, 1992; Schegloff, 2005, 2007, 2007a; Stokoe, 2003, 2012) within a discursive psychology framework (cf. Schubert et al., 2009). As described Schubert et al. (2009), MCA "can be employed to identify the discursive devices, practices and techniques by which people place themselves and others into social categories" (p.501).

Every member of society can be described in a multitude of ways. For example the same person could be described as 'mother', 'woman', 'academic', 'Beatles fan' and so on. Because there are a number of categories available to a person, the actual category used 'can do subtle inferential work' (Benwell and Stokoe, 2006). MCA is centred on the recognition and examination of Membership Categorization Devices (MCDs) (Stokoe, 2012). MCDs are a collection of categories used to refer to individuals, for example the MCD of 'sex' which contains the categories 'male' and 'female' (Sacks, 1992). Sacks (1972) lays out certain rules for the application of MCDs. For example, each category belonging to a MCD is mutually exclusive. Therefore, if someone is described as belonging to the category 'male' then we know they cannot be described by another category within that MCD (e.g. female). Other rules also apply.

We may gain an understanding of how certain social identities (with both moral and interactional implications) are achieved through the examination of which categories an individual adopts as well as how they use certain discursive devices (Edwards and Potter, 2001). For example, Schubert et al. (2009) observed the way members of the category 'illicit amphetamine user' may now effectively draw on the 'adult ADHD' category to explain their inattention, trouble with concentration and irritability as well as to attain access to prescribed amphetamines (p. 511). From a discursive psychology perspective, via the management of social identities, the individual can construct motives behind utterances and actions as well as manage and construct their own 'moral reality' (Edwards, 1998; Schubert et al., 2009, p 501).

Using MCA, would allow the researcher to examine the ways women talk about, manage and promote their membership within the social category of 'ADHD sufferer'; as well the ways 'professionals' endorse 'ADHD' as a desirable social category for females to acquire. A discursive psychology framework would complement MCA as it adds to the 'how' by asking whose interests are being served in such categorisations (Schubert et al., 2009, p509).

Originally I had intended to incorporate MCA with CDA and DP into the hybrid analytic approach of this current study (as stated in my thesis proposal). Mark Rapley had previously conducted a hybrid study using CDA and DP (cf. McHoul & Rapley, 2005) and another using MCA with DP (cf. Schubert et al., 2009). However, without Mark's supervisory support and experience, I felt combining all three may be too ambitious for my doctoral thesis; although I have not ruled this out for future academic endeavours.

6.13 Appendix 13: The Advertising Standards Authority

DTCA is illegal in the UK (Leo & Lacasse, 2009). However, if it was legal then there would be strict advertising guidelines to follow. For example; according to the 'Advertising Standards Authority'(ASA) and the Committee of Advertising Practice (CAP): "before distributing or submitting a marketing communication for publication, marketers must hold documentary evidence to prove all claims, whether direct or implied, that are capable of objective substantiation" (ASA, 2012) and that "no marketing communication should mislead, or be likely to mislead, by inaccuracy, ambiguity, exaggeration, omission or otherwise" (CAP, 2013).

However, due to the current lack of transparency (with regards the marketing agenda), it is assumed that these cannot currently be reinforced.