Voices Behind and Beyond the Label

The Master Narrative of ADHD (De)constructed
by Diagnosed Children and Their Parents

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ABSTRACT

The dominant understanding of attention deficit hyperactivity disorder (ADHD) is that of diagnosed children "suffering" from neurodevelopmental condition owing to which they are prone to develop adverse life trajectories. This master narrative of ADHD and psychomedical and normative discourses it adheres to and employs have been integrated into the daily activities of homes and schools. This compilation dissertation study employs a social constructionist discourse framework and is located in the intersection of the disciplines of disability studies and special education. The aim of the dissertation is to further our understanding of "life with ADHD" from the viewpoint of the families in Finland who supposedly live the master narrative. By conducting interviews for 13 young Finnish teens (aged 11–16 years) diagnosed with ADHD and 18 Finnish mothers of diagnosed children, it analyzes the meanings given to and built around ADHD in the context of the compulsory schooling. The data are analyzed using both discourse and narrative analysis methods.

The study finds that the mothers and youth positioned themselves differently in relation to ADHD. For mothers, *the voice behind the label*, their strong endeavor to explain their child's traits, behavior, and performance by adhering to and advocating psychomedical discourse functioned as a counter-means to school practices. For them, the ADHD label entailed a cultural *promise of recognition* of their child and themselves: it was expected to promote the match between the child and school and translate as a mediator between parents and teachers. Children, *the voice beyond the label*, on the other hand, constructed the label as a priori stigmatizing and thus, adherence to psychomedical discourse as potentially impeding the process of identity building. Instead, they constructed themselves in relation to ADHD, and vice versa, in the vortex of discourses internalized by them providing deeply embedded varying and contradictive cultural meanings.

The results problematize the master narrative as unproductive. Further, the uncritical reproduction of psychomedical discourse in educational practices is questioned, as it is oversimplified and insufficient to understand the experiences of "life with ADHD". As regards school practices, this study provides theoretical implications for inclusive education. It suggests a change in discourses employed in everyday school practices and the conceptualization of educational special need in order to truly live up to the values of inclusive education.

Keywords: Attention Deficit Hyperactivity Disorder (ADHD), Mothers, Parents, Children, Young People, Teens, Discourse Analysis, Narrative Analysis, Interview, Social Constructionism, Inclusive Education

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III   Honkasilta, J., Vehmas, S., & Vehkakoski, T. (2016). Self-pathologizing, self-condemning, self-liberating: youths' accounts of their ADHD-related behavior. *Social Science & Medicine*, 150, 248–255. doi:10.1016/j.socscimed.2015.12.030

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Description of the writer's contribution to the individual articles:

Taking into account the instructions given and comments made by the co-authors, the author of the thesis is the first author of all four individual articles. He has played an active role in the manuscript design and preparation and literature research in Study I. Further, he has largely contributed to the study design, data collection, analysis and interpretation, manuscript preparation, and literature research of empirical studies II, III, and IV.

FIGURES

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CONTENTS

1   INTRODUCTION: CONSTRUCTING THE MASTER NARRATIVE OF ADHD

1.1 Identifying educational needs by labeling deviance

The dominant conversation regarding Attention deficit hyperactivity disorder (ADHD) – a neurodevelopmental disorder characterized with uncontrollable impairing behavioral features, such as distractibility, restlessness, and impulsiveness (American Psychiatric Association, 2013) – is based on the biomedical model of understanding human diversity: behavior deviating from what is deemed "normal" is explained by neurobiological abnormality. ADHD is strongly associated with disadvantageous life trajectories. These trajectories are characterized by adverse psychiatric outcomes, such as elevated rates of antisocial and anxiety disorder, and academic and social difficulties (Crundwell, 2005; Biederman et al., 2006; Scholtens, Rydell, & Yang-Wallentin, 2013), including those in peer relations (e.g., Taylor & Houghton, 2008), behavior and conduct issues (e.g., Frankel & Feinberg, 2002), and adult criminal activity and marginalization (e.g., Savolainen et al. 2010). In addition, ADHD is associated with timely concern as regards disciplinary problems (Loe & Feldman, 2007) and struggles with classroom management (see Kos, Richdale, & Hay, 2006). Indeed, based on the estimated worldwide prevalence of ADHD[1] (5.29%), it is probably safe to state that every ordinary classroom is likely to feature at least one pupil manifesting behavior regarded as symptoms of the disorder (Polanczyk et al., 2007, 2014). Thus, the early recognition of the disorder for prevention and intervention strategies is highly accentuated in this line of literature.

Built upon the above threat of adverse life trajectories is what I refer to here as *a master narrative of ADHD*. It consists of deeply embedded cultural understanding of what is deemed "normal" and commonly shared rhetoric regarding how to account for traits, behavior etcetera when such normative crite-

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[1]   In Finland, among adolescents in Northern Finland birth cohort 1986 the estimated prevalence of ADHD is 8.5% with a male/female ratio of 5.7:1 (Smalley et al., 2007).

ria seem unobtainable. The master narrative, as it currently stands, asserts the nature-rooted origin of human deviance and mostly creates a negative image of ADHD if not "treated" adequately. This is well pointed out by Freedman (2016) in his analysis of the discourse of ADHD in textbooks of special education programs in the USA. He concludes that the overwhelmingly medicalized narrative presented children diagnosed with ADHD "as inherently dysfunctional" who are "devoid of positive characteristics" (p. 32). The master narrative has gained momentum in explicating problems in school conduct and performance and adequate remedial practices to meet the special needs of the so-called "ADHD students." It is an illustration of institutional commitment to explain a child's undesirable behavior through psychomedical explanations while disregarding its contextual and social origins. In fact, it is a construct of such commitment and related practices.

This commitment, coined as *the medical model of disability* (Gresham, 2002; Thomas & Loxley, 2007), provides a simplified, reductionist approach to explain complex social and educational problems using individual psychopathology. It serves as a guide to limiting educational responses and policy making for practices defined by the medical knowledge of human diversity (Whitt & Danforth, 2010; Freedman, 2016). Institutional, pedagogical, and social school practices strongly adhere to diagnostic and psychomedical discourses imposing social problems as solely individual based (Thomas & Glenny, 2000; McHoul & Rapley, 2005; Harwood, 2006; Lloyd, 2006; Vehmas, 2010; Brunila, 2012; Bailey, 2014). This trend is particularly notable in dramatic increases in diagnoses of students with behavioral and emotional disabilities (Slee, 2014). Paradoxically, these practices are inconsistent with the goal of inclusive education, which is to embrace human diversity.

> Calling ADHD a "neurochemical disorder" with a "biological cause" implies that it has nothing to do with how a child thinks, feels, reacts, intends, perceives, adjusts and responds. It implies that the behaviors are not under the control of the child or those within the child's world and have nothing to do with how the child finds and makes meaning in that world. That is a fundamental error contradicted by those of us who, like you, also work very closely with children and families every day. (Galves et. al., 2003, pp. 6-7)

> Hyper-awareness of an increasing catalogue of behavioural and attention disorders has diminished the analysis of the pathology of schooling in the production of student disengagement. (Slee, 2014, p. 446)

The emergence and pervasiveness of the master narrative of ADHD is strongly contingent on school pedagogical practices and discourses. The western school system is the prime initiator for parents seeking to diagnose (and medicate) their children (e.g., Cohen, 2006b; Davis, 2006; Singh, 2008; Adams, 2008, 2010; Tait, 2010). School institution is one of the most important socialization agents that give meaning to normative values, beliefs, and expectations such as "good" behavior and "normal" development. In the Foucauldian sense, schools practice social governance over acceptable student diversity by labeling deviance; labels

serve a social and administrative function of governing behavior and maintaining order within classrooms and society (e.g., Tait, 1999, 2010; Bailey, 2014).

> The ADHD child […] represents an object of study who could not fit into the institutional frameworks of everyday life, and needed, in one way or another, to be molded to meet the demands of these institutions. (Rafalovich, 2001, p. 102)

Indeed, labels such as ADHD have several functions in school practices. First, unlike in Finland, in many countries, such as Australia, Canada, and the USA, the diagnostic label is regarded as a basis for remedial or special education practices (e.g., Itkonen & Jahnukainen, 2010; Graham & Jahnukainen, 2011; Björn, Aro, Koponen, Fuchs, & Fuchs, 2016; see sub-study 1 in this thesis). Thus, even if the school staff does not imply or overtly suggest the initiation of a diagnosis process, the parents of "disorderly" children are inclined to do so because of exclusive educational policies and so that their children's educational needs would be recognized (Sax & Kautz, 2003; Graham, 2006; Hjörne & Säljö, 2004, 2014a, 2014b; Prosser, 2008; Hjörne & Evaldsson, 2015; sub-study 2 in this thesis). Second, the internalization of the meanings of labels (e.g., "good," "bad," or "ADHD student") is "a crucial step in the process of creating the concept of the ideal" (Hempel-Jorgensen, 2009, p. 444; see also Priyadharshini, 2011). Students who do not fit into the normative frame are at the risk of becoming labeled according to moral judgments, such as lazy or malicious. Therapeutic and psychomedical approaches have been harnessed as a counter-discourse to protect students from such judgments. Thus, and third, the label ADHD normalizes the perceived anomaly by asserting that the student "suffers" social consequences owing to compulsive biological, neurological, and psychological conditions (e.g., Tait, 1999, 2010; Rafalovich, 2001; Slee, 2010)—a legit cultural account for deviancy.

Finally, as Reid and Maag (1997) conclude, ADHD is *a label of forgiveness* (also Lloyd & Norris, 1999). In line with this conclusion, Bailey (2014) analyzes how teachers' reactions toward a student's maladaptive classroom behavior construct a social reality in which a certain kind of nature-rooted malevolence cannot be nurtured at school, that is, the student "has" ADHD. Thus, even if a school promotes student diagnoses to identify and nurture the "need," it can simultaneously distance itself from the responsibility of adequately meeting the need, since the diagnosis, per se, is legitimate medical proof that the problem lays within the child, not the social environment and its everyday practices (e.g., Vehmas, 2005, 2010; Adams, 2008; Brunila, 2012; Mehan, 2014). Finland is not an exception to this trend. A recent study suggests that principals from eight European countries, including Finland, regard students' school failure to child and family factors (Rinne, Järvinen, Tikkanen, & Aro, 2012). This is a globally held view among school personnel (e.g., Poulou & Norwich, 2000; Mavropoulou & Padeliadu, 2002; Kulinna, 2007–2008). Thus, sustaining the medical model of disability facilitates the maintenance of school institutions' sanctity by placing the blame of failure on the child and/or family.

This compilation dissertation is located in the intersection of the disciplines of disability studies and special education. ADHD is thus approached as a culturally, societally and politically constructed phenomenon. From this point of departure, the present master narrative of ADHD widely integrated into the daily activities of homes and schools proves problematic. It maintains the narrative as an objective, ahistorical take on state of affairs devoid of ideology, value judgments and power relations. The master narrative regards undesired life trajectories and threats associated with ADHD as an unfortunate causality between individual nature-rooted vulnerability to develop such trajectories (owing to genes, neurobiology etc.) and psychosocial risk factors of operating environment (e.g., home or school life). The focus of intervention is thus on the treatment of individual condition, and subsequently, adequate adaptation of the operating environment. Instead, how the structures (policies, power relations etc.), conventions (laws, rules, traditions, principles etc.), and ideologies and related discourses and practices of operating environment per se *form* the risk in the first place, and thus, construct the deviant, disabled individual is not reckoned with.

1.2 Objectives and scope

> [I]t is the vocabularies of pathologisation which now constitute the most significant elements of the education/difference nexus. (Tait, 2010, p. 13)

This discourse study voices the experiences of families who live the master narrative of ADHD and furthers our understanding of the complexity of the concept "living with ADHD". Thus far, the meaning of ADHD for the diagnosed youth remains largely unclear. There is a growing number of studies on the experiences and voices of young individuals diagnosed with ADHD, although related research in the educational literature remains scant. In particular, there is a dearth of research focusing on the discursive practices of those classified into the diagnostic category beyond the psychomedical interpretative frame of analysis. This lack is striking considering the volume of literature addressing issues associated with ADHD in the realm of education from a psychomedical and behavioral management viewpoint, but with a tendency to fundamentally subdue students' voice and experience in their sociocultural contexts. The experience of students who potentially become labeled as disordered owing to the mismatch of their actions/reactions and the classroom environment, its normative expectations, and teacher classroom management strategies is central to understanding the pivotal nature of the relationship between school and those deemed troubled and troubling.

Drawing on several scholars, I conceptualize the *discourse* as a socioculturally constructed and shared representation of social, political, cultural, and institutional realities. These realities are based on the specific domains of knowledge, including the norms, beliefs, ideals, and values of a given sociocul-

tural context (see Foucault, 1972; Fairclough, 1992; Gee, 2004). There are two further characteristics for discourse that guide the phrasing of my research questions. First, agents have limited access to discourse(s) (van Dijk, 1996). For instance, a child diagnosed with ADHD may not have an access to discourse(s) that would view him/her as "normal" in a classroom setting because of his/her actions, performance, traits, or mere labels that contradict the normative ideal, unless classroom practices employ such discourse(s) that embrace affinity and acceptance and thus, reconstruct the prevailing norm. Second, discourse(s) "form the objects of which they speak" (Foucault, 1972, p. 49). Pedagogical discourses based on the psychomedical understanding of ADHD are pervasive throughout a child's schooling. Indeed, explaining school behaviors, executing pedagogies, and planning educational interventions, as well as involving parents in school may be built on the idea of an object formed by the psychomedical discourse, namely an "ADHD student" (e.g., Hjörne, 2006; Hjörne & Säljö, 2014a; sub-study 2). When complex social and educational problems are reduced to a psychomedical deficit using the language of disorder and dysfunction, one may internalize problems as solely based in the individual (see, e.g., Brady, 2005; Harwood, 2006; Graham, 2007a, 2007b, 2015b). The question now becomes what are the types of identities—i.e., being recognized as a certain "kind of" person in authentic interaction situations (Gee, 2000–2001)—made available to those diagnosed other than "ADHD child/student"?

This dissertation study tackles this empirical, but scantly researched, issue by focusing on the linguistic construction of ADHD spontaneously provided in the interview interactions with 13 young people (aged 11-16 years) diagnosed with ADHD and 18 mothers of diagnosed children in Finland. It studies the meanings given to and built around ADHD in the context of compulsory schooling. The research questions overarching each separate sub-study are presented in Table 1 below.

TABLE 1   Research questions overarching the sub-studies

	Research questions	Sub-studies
1.	How are children diagnosed with ADHD positioned in the interviews with them and their mothers?	(I) II–IV
2.	What types of functions does the diagnosis of ADHD serve in the interviews?	(I) II–IV
3.	How do the children diagnosed with ADHD and their mothers position teachers and school in their interviews?	(I) II–IV

1.3 My journey of understanding ADHD (dissertation structure)

I gained my years of experience with ADHD from adaptation coaching courses organized by Finland's ADHD association. I have been privileged to work in multidisciplinary teams and with a vast variety of children, youth, and young adults diagnosed with ADHD and their families. During my years of working, I adopted the same psychomedical understanding of ADHD as that taken by parents—the same discourse adaptation coaching courses were built on and to which, to some extent at least, I strove to adapt when working with the young people. For instance, the first step of the course tradition was to read parent and expert reports about the child, thus forming an image of how the child is at his/her worst and the areas in which the family was struggling the most. Never did we read the reports written by the children. *The master narrative is narrated by the adults*.

Combining these experiences with my PhD dissertation project, I have, however, come to reflectively de- and reconstruct my experiences and knowledge of ADHD. In the process of doing so, I have come across core questions that are yet to be formally asked: what is the approach that should be adopted and for whom? This question has guided my writing of the theoretical frame of this study (chapter 2), in which I attempt to reveal sociocultural premises upon which the master narrative is constructed, and by so doing contribute to the ongoing ontological debate on ADHD. Although the guiding question remains unanswered, I believe I provide the reader tools for further reflection. In chapter 2.1, I problematize the dominance of a psychomedical paradigm over socioculture to explain ADHD; what delineates ADHD as a disorder is fundamentally shaped by social and cultural factors. In chapter 2.2, I employ this social interpretation frame to discuss the experiences of children and youth diagnosed with ADHD. I argue that psychomedical understanding alone is insufficient in understanding individual experiences associated with ADHD.

During my years of experience, I learned the ideologies of the master narrative and to apply them to practice, such as talking about young people I worked with, observing their behavior and performance during the course activities, and preparing formal reports in which I related the observed behavior to the disorder to help offer societal support for families and their children. However, despite being aware of and using the term ADHD, I did not learn to identify the characteristics that make an individual "be" ADHD, that is, an "ADHD child". If we characterize *them* as members of a certain group, should *they* not then possess certain common characteristics and traits that clearly homogenize *them*, clarify *their* deviant group identity, and thus, differentiate *them* from *us*, "normal people" or experts who strive to provide help? However, I encountered individuals, some of whom were clearly misunderstood and mistreated by adults, mainly school staff, the best students of their class, and students and young people with various unfortunate or fortunate life trajectories. The only common characteristics these individuals shared were the ADHD di-

agnosis and their parents being concerned. In chapter 2.3, I discuss the meaning and meaningfulness of the diagnosis, particularly the label ADHD, by introducing my understanding of ADHD as a social construct – as a cultural need. Further, understanding the nature of this label has been the thread of separate sub-studies I-IV that form the main findings of this dissertation, of which sub-studies II-IV are empirical studies. I summarize the research rationale, focus, relevant concepts, and main findings of each sub-study in chapter 4. The methodological decisions of the empirical research are further discussed and reflected upon in chapter 3.

The discourse I adopted in adaptation courses entails the idea of agentless victims suffering from ADHD and the consequences it causes (see sub-study 2). There have been instances in which I have been threatened with a screwdriver, caught up with runaway participants, prevented a young participant from hitting my colleague with a chair, held youth down until they calmed down so that they do not hurt anyone including themselves, and witnessed stones being thrown at my colleagues and spat at. Yet, I have never witnessed transgressions *because of* ADHD; there have always been triggers in the social environment and interactions prior to a child's seemingly emotional turmoil and reaction. Power struggles have not been the least of these triggers. I would only choose to accept such phrasing by talking about the children who suffer because of the consequences of how their actions are interpreted and reacted to by their social environment (see sub-study 4). I realize the pitfall of this clause. Although the pathological focus is not on the individual but on social practice, it still constructs diagnosed individuals as irresponsible, innocent victims. This, however, is not what I advocate. Instead, in the Discussion section in chapter 5, I strive to look beyond pathology and blame (chapters 5.1 and 5.2) to build pedagogical practices toward more inclusive schools (chapters 5.3 and 5.4). I strive to de-pathologize ADHD by drawing focus on individual needs.

Another idea the discourse I adopted entails is that a diagnosis helps understand the diagnosed individual. This idea is a fallacy. I have never during my work met a young individual who introduced him/herself as "being" ADHD (see sub-study 3); instead, I have met adults who introduce themselves and their children as such. The only way to understand an individual is to listen to and empathically connect with his/her needs (chapter 5.4). The diagnosis and its psychomedical premises have provided me with the tools to make a certain type of conduct and performance of young people more understandable (i.e., eased my reasoning and attitude towards it) and direct and give directions in ways that are cognitively easier to receive, regardless of diagnoses. However, I have never gained an understanding of a person and his or her motives or reasons for certain actions on the basis of a diagnosis (chapter 5.3). Human lives take form in social interaction.

2 SOCIAL CONSTRUCTIONIST DISCOURSE FRAMEWORK

The theoretical framework of this study is guided by the question of what is at issue when we talk about ADHD and the objective of discussing this in further detail from the viewpoint of a sociocultural approach to disability and disorder. I ground my theoretical approach to understand ADHD in a social constructionist discourse framework, coined by Danforth and Navarro (2001). My ontological understanding of ADHD and epistemological approach to the phenomena are rooted in social constructionism with emphasis on the centrality of language and other semiotic forms of communication, thought, interaction, and their reciprocal interconnection with prevailing culture (e.g., Berger and Luckmann 1966; Danforth & Navarro, 1998; Fornäs, 1998; Hacking, 1999). I focus on the relationship between language and society: "language use is entirely practical, [intentional, social] and political as it reflects a situated cultural state of affairs" (e.g., Danforth & Navarro, 2001, p. 169, comment added; also Gee, 1996, 2004; Wetherell, Taylor, & Yates, 2001; Nikander, 2008).

The dominant discourse in the realm of education treats ADHD as a medical disorder independent of value-laden cultural practices, and thus, an objective attribute identifiable through the analysis of human biology (e.g., genes) and physiology (e.g., neurology). The present social interpretation framework rejects the uncritical acceptance and deployment of this psychomedical discourse in educational practices since a disorder and its disabling nature gain meaning in certain cultural, political, and social contexts (Cooksey & Brown, 1998). ADHD is fundamentally a value-laden cultural construct that serves certain cultural functions. In this chapter, I strive to point out that, first, a sociocultural approach to ADHD is not subordinate to that of a psychomedical one, rather they are complementary. In fact, the legitimacy of a psychomedical approach to understanding the phenomenon in question and an individual's experience "with" ADHD cannot be fully understood without understanding sociocultural preconditions and provision (chapter 2.1). Second, it is important to also consider a sociocultural approach as an interpretative frame to fully understand individual experience associated with ADHD (chapter 2.2). Third, the

ontological debate on the existence and realness of ADHD is fallacious, futile, and unproductive in the realm of education; instead, a transdisciplinary approach to fully understand ADHD and harness knowledge into educational practices is needed (chapter 2.3).

2.1 Critical historical approach to ADHD

2.1.1 Advent of psychomedical discourse: medicalizing the morality of the young

> Medical history is [-] presented in triumphalist terms: the heroic unmasking of the hidden realities of nature, the shedding of light into the mysteries of the human body and mind, and the identification and control of independent disease entities. (Tait, 2010, p. 17)

The definition and concept of the diagnostic term ADHD have remained controversial throughout its trajectory, given that the conceptualization of the symptoms and etiology as well as the diagnostic criteria has changed over the years. To this effect, various nomenclatures for the phenomenon has been applied in the western world, such as minimal brain damage, later minimal brain dysfunction (MBD), deficits in attention, motor control and perception (DAMP), attention deficit disorder (ADD), and hyperkinetic disorder (HD). I introduce a brief development of this terminology in the sub-study 1. Here, I further focus on the conceptualization process of deviant behavior and performance associated with the current concept of ADHD, during which the connecting thread has remained the same: the aim to understand and explain children's unfavorable behavior, or in Szasz's (1960) terms "problems in living" in their social surroundings through medical criteria.

The following brief historical review falls short of both critiques Rafalovich (2001) poses about the historical accounts of ADHD: it is ideological as it is written to introduce the agenda of this dissertation and is markedly brief and does not provide in-depth inquiry. However, in line with Rafalovich, this brief overview is written under the assumption that the medical discourse of the history has been integral in present shaping of how child misbehavior is medicalized and conceptualized. The current conceptualization of ADHD conveys the contemporary zeitgeist, which bears the hallmarks of the psychomedical understanding of human differences regarding unwanted behavior (see, e.g., Klimkeit & Bradshaw, 2007; Laurence, 2008). This, however, has not always been the prevailing interpretive framework for deviant (child) behavior, but results from cultural, medical, and scientific paradigm shifts that have taken place over the course of more than two centuries (see e.g., Suominen, 2003; Mayes & Rafalovich, 2007).

The first medical descriptions or hypotheses of attention deficits are traced back to the 18th century through the works of German physician Melchor Adam Welkard on *attention volubilis* (lack of attention) in 1775 (Barkley & Helmut, 2012)

and Scottish physician Alexander Crichton on *mental derangement* in 1798 (Palmer & Finger, 2001). They both described attention deficits similarly to the current conceptualization of inattentiveness related to ADHD and strived to theorize cause and effect between physical illness and psychological defect. Both Welkard and Crichton took a stand on the relationship between social environment and the defect. Welkard seemed to regard poor upbringing or child rearing as causing physical illness that leads to attention deficit, whereas Crichton regarded it more as a mediate factor (Barkley & Helmut, 2012). In their era, however, mental problems were strongly regarded and treated as moral and spiritual, not physiological or biological (Palmer & Finger, 2001; Barkley & Helmut, 2012).

Rafalovich (2001) analyzes that medicine's focus on children's moral savoir-faire in the late 19th and early 20th centuries through mental health nosology of idiocy and imbecility was the early discourse widely recognized among clinicians, from which the current psychomedical discourse of ADHD has gradually developed. The lectures of an English pediatrician Sir George Frederic Still on *defect of moral control* in 1902, a century after Welkard and Crichton's works, are widely considered as the scientific starting point of the history of ADHD; he described impulsive children with a lack of inhibitory volition (e.g., Conners, 2000; Mayes & Rafalovich, 2007; Lange et al., 2010). Barkley (2006) notes that Still's attempt to differentiate between the clinical cases of moral defect and mental retardation was in line with concurrent modern science of child psychopathology in terms of differential diagnostics. Still's work marked the beginning of considering immoral children as objects of medicine and medical research (Rafalovich, 2001).

Still's ideas about neuro-pathophysiology of childhood immorality became widely supported in the 1920s because of a pandemic of encephalitis lethargica, also known as sleepy sickness, as child motor impulsivity, excitability, aggressiveness, and uncontrolled emotionality became explained by a brain damage (Connors & Kinsbourne, 1990; Rafalovich, 2001). Consequently, the concept of minimal brain damage evolved and for decades continued to be characterized by features such as restlessness, impulsivity, emotional volatility along with various intellectual and perceptual motor disturbances (Michelsson, 2001). Many of these symptoms are today placed under the rubric of ADHD. Although the concept of a brain syndrome fell into disfavor owing to the lack of evidence of brain damage, and consequently, was changed to minimal brain dysfunction and, later to the hyperkinetic reaction of childhood, theories about the causes of childhood immorality in the early 20th century played a central role in mental health history. First, they fortified the neuropsychological discourse that persistently deviant childhood behavior represents psychological pathology. Ever since, clinicians have theorized that deviant child behavior reflects cognitive and behavioral impairments rooted in biological and neurological pathophysiology (see, e.g., Conners, 2000; Rafalovich, 2001; Mayes & Rafalovich, 2007; Lange et al., 2010). Second, they created a premise for the *medicalization* of immoral child behavior (see Conners, 2000)—that is, medical

boundaries or the extension of medical jurisdiction expanded into the domains of daily existence (Conrad & Potter, 2000).

Bradley's work on the therapeutic use of amphetamine to modify the behavior of deviant children in 1937 strengthened the biomedical commitment of psychiatry. For instance, Laufer, Denhoff, and Solomons (1957) suggested that until the symptoms of hyperkinetic impulse disorder, such as hyperactivity, impulsiveness, and poor academic performance, were overcome by the normal maturation process, the use of amphetamine had an ameliorating effect and psychological and psychodynamic implications (also Bradley & Bowen 1941). The medicalization of immoral child behavior that deviates from valued, statistically frequent normal behavior emerged to remain, turning "immaturity" into a mental disorder. Medicating "immature" behavior and poor academic performance is still a modern-day phenomenon. Amphetamine is globally and widely used in "treating" ADHD among both child and adult population, despite the lack of a disorder-specific effect; amphetamine enhances performance regardless of the symptoms being related to ADHD (e.g., DeSantis, Webb, & Noar, 2008). In fact, one line of critical theory criticism of ADHD and other mental illnesses regards pharmaceutical industry a modern day western world drug cartel behind growing numbers of such diagnoses among children and young (e.g., Cohen, 2006a; see also Frances, 2013[2]). This cartel could not have triumphed without an alliance with psychiatry, since no psychotropic drugs would have gotten to market without psychiatry's assent.

Psychodynamic theory, however, was closely related to the mainstream premise of understanding and treating deviant behavior in psychiatry much after the 20th century, until the paradigm shift to biomedical, or the biopsychiatric medical model, emerged in 1980 along with introduction of 3rd edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (Kutchins & Kirk, 1997; Cooksey & Brown, 1998; Conrad & Potter, 2000). Cooksey and Brown (1998) write:

> DSM leaders proudly claimed the creation of DSM-III to replace DSM-II as a "revolution," and a leading biopsychiatry proponent wrote glowingly of the publication date of DSM-III: "On July 1, 1980, the ascendance of scientific psychiatry became official." (p. 529)

As for diagnosing ADHD, this shift to scientific psychiatry was somewhat ambivalent. Since no evident involvement of neurobiological dysfunction in deviant child behavior could be identified, diagnosing relied purely on observed behavior to avoid unproved etiological assumptions. Diagnostic symptoms became descriptive, rendering it more similar to psychiatric (not to mention cul-

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[2]   Interestingly, one of the critics of pharmaceutic industry and diagnosing "immaturity", Emeritus professor Allen Frances (2013), has for one's part set the whole project of pathologizing childhood and profiting from it in motion as he served as chairman of the task force that created the 4th edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) in 1994, in which the diagnostic net of ADHD was expanded from its previous volume (for further reading, http://behaviorismandmentalhealth.com/2015/12/08/allen-frances-still-trying-to-excuse-psychiatrys-and-his-own-role-in-the-adhd-epidemic/)

tural) than medical entity. However, this alliance between medical theory and psychiatric practice sealed the advent of the medical discourse of ADHD, which is by far the most dominant discourse through which deviant behavior, ranging from childhood to adulthood is accounted for (see Norris & Lloyd, 2000; Danforth & Navarro, 2001).

Till date, the etiology of ADHD has been widely approached from biological (e.g., Ilott et al., 2010, Nikolas & Burt, 2010), cognitive (e.g., Barkley, 1997b), neuropsychiatric (e.g., Sasayama et al., 2010), and psychosocial viewpoints (e.g., Clarke et al., 2002; Briscoe-Smith & Hinshaw, 2006). Literature suggests that ADHD is a multifactorial disorder caused by the joint effects of nature (e.g., genes and neurobiology) and nurture, that is, environmental risk factors (e.g., Faraone & Doyle, 2001; Biederman, Faraone, & Monuteaux, 2002; Laucht et al., 2007). However, neurobiological, cognitive, and genetic research is currently three main areas that theorize and explore the etiological premises of ADHD (Tannock, 1998; see also Faraone, 2005), thus scanting and omitting the psychosocial viewpoint from the prevailing dominant discourse regarding the etiology of ADHD: nature triumphs over nurture and culture.

2.1.2 Consensus on ADHD: false juxtaposition

> While we can say that ADHD is not fictional, it is not a "natural kind" and it is misleading to talk about disorders as ahistorical and acultural entities. They are always a function of values about what forms of life are desirable, about the ends people have for themselves and others. (Bowden, 2014, p. 434)

> [The] tidal wave of modern behaviour disorders has much more to do with the pathologisation of conduct, and the governance of populations, that it has with any ontological validity. (Tait, 2010, p. 72)

From a realist viewpoint, the medical history of ADHD can be regarded as the progress of modern clinical practice (see, e.g., Barkley, 1997a, 2014; Conners, 2000; Sharkey & Fitzgerald, 2007; Lange et. al., 2010) which is "slowly honing its nomenclature to greater levels of scientific validity and practical effectiveness" (Rafalovich, 2001, p. 95). For instance, Fitzgerald, Bellgrove, and Gill (2007) note that one of the reasons ADHD is regarded a controversial psychiatric disorder is public's perception of it as a new condition. They cite Crichton's work as reassurance that this is not the case; ADHD has always existed without scientists being aware of it.

Tait (2010, p. 58) points out that the reasoning underlying this type of reading of history, in which ADHD is regarded an objective fact of nature that existed long before contemporary psychologists named it, is fallacious (also Rafalovich, 2001; Bowden, 2014). From an anti-realist viewpoint, the psychomedical society is re-writing the history of ADHD as they please, provided it supports their realist understanding and ends (Hacking, 1999; Smith, 2010; Tait, 2010; Freedman & Honkasilta, under review). Although scientific explanations are rarely ever definitive in nature, but self-reconstructive and interrelated, the medical knowledge domain holds the despotic position over other interpretive frameworks in explaining ADHD. As argued by Bowden (2014), even sociologi-

cal analyses on ADHD as a disorder have at times ambivalently allocated their explanations to an auxiliary position in relation to medical explanations, as though sociological premises were subordinate to those of medical and thus, did not stand alone as a valid, scientific approach.

This juxtaposition of medical and anti-medical[3] explanations is especially clear when the validity of ADHD is the topic in question. The clearest example of how dogmatic medical explanations of ADHD are expected to straightforwardly downplay dissenting explanations is presented in the *international consensus statement on ADHD*, issued by 86 prominent healthcare professionals (Barkley et al., 2002), as well as the subsequent debate on the consensus statement between Timimi and 33 co-endorsers (2004) and Barkley and 20 co-endorsers (2004) (for the response to the consensus statement, see also Jureidini, 2002; Double, http://www.critpsynet.freeuk.com/replyconsensus.htm). The following excerpt illustrates the nature of the debate.

> We fear that inaccurate stories rendering ADHD as myth, fraud, or benign condition may cause thousands of sufferers not to seek treatment for their disorder. It also leaves the public with a general sense that this disorder is not valid or real or consists of a rather trivial affliction […] We cannot overemphasize the point that, as a *matter of science*[4], the notion that ADHD does not exist is simply wrong. (Barkley et al., 2002, p. 89, emphasis added)

> Why did a group of eminent psychiatrists and psychologists produce a consensus statement that seeks to forestall debate on the merits of the widespread diagnosis and drug treatment of attention deficit hyperactivity disorder (ADHD) (Barkley et al., 2002)? If the evidence is already that good then no statement is needed. However, the reality is that claims about ADHD being a genuine medical disorder and psychotropics being genuine correctives have been shaken by criticism. (Timimi et al., 2004, p. 59)

> In rebuttal to Timimi et al., we show that their critique is not a form of reasonable scientific debate with informed, constructive criticism, but merely a misrepresentation of the existing scientific literature on ADHD apparently designed to convince the scientifically uninformed of its nonexistence and of the misuse of medications for its management. We show their argument to be based on faulty logic, selective citation, misrepresentation of individual studies, ignorance of the vast literature on ADHD, and innuendo that maligns the integrity of scientists studying the disorder. (Barkley et. al., 2004, p. 65)

Barkley and colleagues (2004) righteously counter the sociocultural criticism presented by Timimi and colleagues (2004) by demanding positivist proof for their claims. Although important cultural and critical commentary is made, no significant empirical data supporting claims that invalidated ADHD are presented. This does not, however, mean that social sciences were the antithesis of science or had nothing to contribute toward understanding ADHD. By contrast,

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[3]   Anti-medical might be a rather simplistic expression because it entails different disciplines (e.g., sociological, anti-psychiatry, philosophy, and disability studies) with varying focus and epistemological underpinnings. However, ontologically, they share the same anti-realistic disposition as opposed to that of a realist, medical worldview.

[4]   In sum, the two-page consensus statement represents a revolution in rhetoric rather than in science. This becomes evident in the copious deployment of the words "science" or "scientific" to assert the legitimacy of the medical approach to ADHD.

the whole phenomenon cannot be comprehensively understood without the contribution of sociocultural approaches. For instance, the core of the consensus statement is apparently to frantically protect the idea of the medical concept of ADHD from "unscientific stories," which are claimed to disregard the individual experiences of "sufferers" of ADHD and their families, and hold those experiences in contempt and against them. Such claims represent poor popularization and the slandering of critical and sociocultural research on ADHD and primarily serves as a rhetoric function than a scientific value (granted that Timimi et al. are equally guilty of similar rhetoric). Critical examinations and research on the social, cultural, and philosophical aspects of ADHD or similar disorders do not (or ought not to) blame parents or other education institutions, but rather regard blame as a social and cultural incentive that partly explains the contemporary strong reliance on psychomedical labels and explanations within those institutions. Indeed, the psychomedical approach to unwanted behavior and performance does provide meaningful responses to human difference and *pragmatic value* for stakeholders, such as aid, support, solace, understanding, and recognition as a certain "kind of" person (I further discuss this issue in chapter 2.3). Sociological approaches, on the other hand, have generally failed to offer what the practice, process, and outcome of deviance labeling has offered. However, all the aforelisted favorable outcomes of "scientific" approach are fundamentally cultural in nature. In other words, the *cultural need for diagnoses* and psychomedical explanations derive from and reproduce the *culture of blame*.

In his reply to the consensus statement, Jureidini (2002) points out the falsity of this juxtapositional stance and the redundancy of despotism of medical science advocated by the assignees of the consensus statement:

> [E]ven the universal acceptance of a point of view does not ensure its validity, as is shown by their own historical example of certain authorities' acceptance of a flat earth. Critical views of the ADHD concept may or may not be correct, but such criticisms are not unscientific merely by virtue of differing from the prevailing view (p. 240)

Jureidini makes a valid point regarding the universal acceptance of the medical concept of ADHD, which itself forms a complex sociological research phenomenon. If, for instance, psychosocial development theories were dominant in explaining ADHD, I dare claim that the diagnosis rates were lower. This is a reasonable claim, given that psychosocial development theories regard ADHD as resulting from, for instance, an unaffectionate mother-child dyad (e.g., Halasz et al., 2002) or mother psychopathology (e.g., Biederman, Faraone, & Monuteaux, 2002; Banks et al., 2008). Asserting that a child "suffers" from a neurobiological disorder is not as delicate matter as asserting that the child manifests unwanted ADHD-like symptoms owing to an unsteady home life, because the latter assertion absolutely entails judgments about "good" parenting and "normal" home life. There is a growing body of empirical research literature to support the claim that the psychomedical understanding of ADHD absolves cultural blame. These findings deal with, for instance, conventional beliefs of mothering (Singh,

2002b, 2004; Blum, 2011; see also Foster-Galasso, 2005), the use of medical diagnosis as a means of the normalization of self (Schubert et al., 2009; Singh, 2011; sub-study 3 in this thesis), and negotiations of recognition between home and other education and care institutions (Emerald & Carpenter, 2010; Bailey, 2014; sub-study 2 in this thesis; see also Foster-Galasso, 2005).

An increasing amount of critical literature and research on ADHD suggests that the emergence and maintenance of ADHD as an objective medical category is highly influenced by sociocultural factors and perhaps, best reflect responses to societal and social problems, rather than an individual illnesses, as discussed in books edited by Lloyd, Stead, and Cohen (2006) and Graham (2010a). There is as much a clear consensus among social scientists and philosophers on ADHD being a cultural construct as that on it being a medical, psychological, and psychosocial entity among scientists of medical or psy-sciences. Further, the realm of western psychology and psychiatry remains undecided on the concurrent development of psychopathologization of human differences frantically advocated in the consensus statement on ADHD. In its response to the American Psychiatric Association (APA) while the current 5th edition of DSM was still in the making, the British Psychology Society (2011) stated its concern over the continuous medicalization of natural human responses, which, although distressing and in demand of helping responses, reflect the rather normal variation of individual behavior than medical illness. Similar critique is also presented from within the DSM apparatus itself by Frances (2013), the former chairman of the task force that created DSM-IV and set the further expansion of the diagnostic net of ADHD in motion. In addition, there is a consensus among a body of renowned practicing psychologists on ADHD being based on "a reflection of cultural and societal forces that have influenced our theoretical, research, professional, and practicing agendas" (Galves et al., 2003, p. 20).

Indeed, no all-encompassing evidence is presented on unique genetic, biological, or neurological pathology that would reliably legitimate ADHD as a primarily neurobiological medical disease entity (American Academy of Pediatrics, 2000; Faraone & Biederman, 2000; Overmeyer & Taylor, 2000; Baumeister & Hawkins, 2001; Nigg, 2005; Lange et al., 2010), although it may live up to the criteria of valid psychiatric entity (Faraone, 2005). This does not, however, discredit the advances of medical science in terms of understanding ADHD phenomenon and, importantly, providing pragmatic value for stakeholders. Medical and anti-medical viewpoints do not axiomatically juxtapose or exclude one another, although the above presented debate insinuates so (for more on the debate, see Timimi & Taylor, 2004). Both fields research and explain the phenomenon from different ontological and epistemological premises; they complement our understanding of the phenomena in question. That is, of course, if one accepts that the scientific worldview reaches beyond that of medicine and psychology and that human life inevitably takes shape in complex social realities in which the psychomedical model is but one way of striving to puzzle out human behavior. If this premise is unacceptable, then indeed, the juxtaposition is warranted.

It is not the task of social sciences to invalidate the findings of medical sciences or vice versa. It is, however, the onus of social sciences to unmask various structures of power, normalization, and governance regarding psychiatric disorders like ADHD and analyze how and why people consent to or dissent from collective belief and interpretative systems that legitimate such structures.

2.1.3 Diagnosing ADHD: notes on quasi-objectivity

> The syndromes in DSM are codified for health insurance purposes, making it a particularly powerful catalogue of human identity. (Slee, 2014, p. 459)

Since unambiguous etiological validity is still lacking ADHD is understood as a valid disorder based on *clinical validity*. This means that ADHD, as many other psychiatric disorders, gains its validity if it "hangs together statistically (as a syndrome), is exhibited by impaired children who need help, responds to treatment, and has other meaningful external correlates (such as family or biological findings, differential long-term outcomes, and differential treatment response) at the group level" (Nigg, 2006, p. 4). Given that ADHD diagnoses have skyrocketed over the past few decades in the western world, clinical manuals guiding diagnostic and related practices have gained momentum as a legitimate account for student non-compliance with normative behavior and performance expectations. Thus, it seems reasonable to critically examine the construction of so-called "impaired ADHD children" in the texts of the two bibles of mental and behavioral disorder diagnoses: the American Psychiatric Association's (2013) 5th edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the 10th edition of International Classification of Diseases (ICD-10) issued by the World Health Organization (WHO) (1993a, 1993b).

There are several differences between the two manuals as regards the phenomenon in question, such as the diagnostic name and category. DSM-V presents ADHD as a neurodevelopment disorder, whereas its European counterpart ICD-10 refrains from using the term ADHD because, as in terms of attention deficit, the term "implies a knowledge of psychological processes that is not yet available" (World Health Organization, 1993a, p. 206). Instead, ICD-10 uses the term Hyperkinetic Disorder (HD) and categorizes it under behavioral and emotional disorders. However, given the endeavor to harmonize the forthcoming ICD-11 (expected due by 2018) with DSM-V, it is reasonable to expect that ICD-11 will more closely resemble DSM-V.

In the following analysis, I strive to point out how (1) these manuals function to reduce the complex issues of behavior and performance into individual deficits by claiming homogeneity of the group of people falling under the ADHD category and objectivity of the category, and by doing so, (2) paper over the cultural issues of power, control, and ideas of man as if they were objectively explainable through the medical understanding of human behavior. The analyzed descriptions of symptoms of ADHD in DSM-V can be found in chapter 'Neurodevelopmental Disorders' under the section entitled 'Attention Deficit Hyperactivity Disorder' (APA, 2013, pp. 59–66). They entail 18 descriptions of

symptomatic behavior, of which 9 are indicative of a symptom of inattention and 9 of symptoms of hyperactivity and impulsivity. As for ICD-10, all 22 descriptions of problems in attention, activity, and impulsivity related to HD can be found in the sub-manual entitled 'Diagnostic criteria for research' (WHO, 1993b) under the section 'F90 Hyperkinetic Disorder' which appears in chapter entitled 'F90–F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence' (pp. 188–190). I refer to both disorders using the term ADHD, since despite the use of ICD-10 in Finland, it has become established in Finnish language as both jargon and nomenclature. Importantly, both manuals currently deploy highly subjective, value-laden language in a similar manner to constitute the idea of healthy expressions of human behavior and performance.

Diagnosing ADHD is premised on the desire for "normality" as opposite to "abnormal levels of inattention and restlessness" (ICD-10, p. 188). The boundaries of preferable behavior and performance are based on the *judgment of reality* and *judgment of value*: the former refers to statistical value with normal defined as that which is statistically frequent, whereas the latter defines it as that which is valued and desired (Kittay, 2006). I demonstrate this claim with the following excerpts on the diagnostic criteria for ADHD:

> Six or more of the following symptoms of inattention [or hyperactivity and impulsivity] have been present for at least six months to a degree that is inconsistent with a developmental level and that impact directly on social and academic/occupational activities (DSM-V, comment added)

> Demonstrable abnormality of attention, activity and impulsivity at home [and at school or nursery], for the age and developmental level of the child, as evidenced by (1), (2) and (3): (ICD-10, comment added)

Evaluating behavior as inconsistent or abnormal with an age and developmental level is based on a statistical norm that represents socially devalued behavior as an objective, naturalistic truth (judgment of reality). Assessing "demonstrable abnormality" or the direct impacts of an individual's behavior "on social and academic/occupational activities" derive from value judgments regarding unfavorable and/or unprofitable behavior. Indeed, ADHD is mainly diagnosed on the basis of professionals' and caregivers' subjective judgments about behavior with respect to social norms (e.g., Cohen, 2006a; Stead & Lloyd, 2008). Take for instance the following criteria for hyperactivity.

> Often runs about or climbs excessively in situations in which it is inappropriate (DSM-V)

> Very often runs about or climbs excessively in situations where it is inappropriate; seems unable to remain still (ICD-10)

The use of vague, interpretive words such as "often," "very often," "excessively," and "inappropriate" are meaningless without the further specification of the situation (Abbey & Valsiner, 2005), that is, without the understanding of the norms and social and discursive practices that produce a particular reality

through affirming or negating certain ways of being. For instance, "leaving seat" itself cannot be regarded symptomatic, but its occurrence "in situations when remaining seated is expected" (ICD-10; DSM-V) validate it as such. In other words, actions or reactions of the one being observed are not symptomatic per se. What constitutes them being symptomatic is their being perceived as incongruous (Freedman & Honkasilta, under review).

The manuals are characterized by value-laden moral judgments, evaluations, and interpretations that, especially when given about someone else rather than oneself, are far from objective observations. Claiming that someone else is inattentive and/or restless is fundamentally based on contextually situated evaluations, interpretations, or positions the observer subjectively (and judgmentally) forms. Following is a hypothetical example of a *pure observation*[5] that includes a teacher who observes, a student who is being observed, and the rest of the persons present in the classroom situation:

> The child stands up and walks towards the sink for the fifth time within the past 30 minutes after I have set an assignment on math

The observation checklist provided by the manuals offers the following interpretation regarding this objective observation:

> Often leaves seat in classroom or other situations when remaining seated is expected (ICD-10)

> Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place) (DSM-V)

There are two considerable differences between the afore-presented example of pure, made-up observation, which does not entail any normative claims or evaluations, and the normative interpretation imposed by the manuals. First, it is subjective whether teachers find student's walking in the classroom during an assignment problematic, not to mention the number of repetitions that qualify as often enough before it being considered a potential symptom of a medical disorder. Such criterion makes it impossible to report a "direct observation" as explicitly demanded in ICD-10—not to mention objective observations. In agreement with Levy and colleagues (1997), it would seem that the real criterion being used here is the annoyance threshold of the observer/evaluator. This is further illustrated in both the manuals through expressions such as "avoid," "dislikes," "is reluctant," "inappropriate," "unable," "restless," "excessively," "cannot wait," "has difficulty," "interrupt/intrude," and "inability." Authentic

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[5]   I ground my differentiation between observation and interpretation, and thus, the conceptualization of the two, in the fundamental premises of the globally renowned theories of interaction, such as those of Marshall. B. Rosenberg (2003a) and Thomas Gordon (1974). I regard observation as true for all participants present in the interaction situation (e.g., swinging legs back and forth under the table), whereas the interpretation is already influenced by situational factors, such as personal emotions, needs, and (normative) belief systems brought alive in interpersonal interactions (e.g., inappropriate and excessive restlessness).

behavior (e.g., standing up and walking toward the sink) is tied to motivation or emotion of the observer, and thus, is reconstructed as a symptom manifestation of the one being observed (e.g., excessive restlessness, inability to stay still, inappropriate act, and reluctance to toe the line). Further, expressions such as "*seems* unable to remain still" (ICD-10, emphasis added) and "may be *experienced* by others as being restless or difficult to keep up with" (DSM-V, emphasis added) overtly fortify the absolute social, cultural, and subjective nature of the disorder being diagnosed, since one's allegedly medical-rooted deviancy is based on the associative perceptions of the so-called moral gatekeepers.

Another difference concerns the predetermined conditions regarding teacher–student power relations and student agency implicitly implied in the manuals by the recurrent use of the verb "expect." To transform the former pure observation into the latter interpretations, the observer must accept the idea that *normal/able/ordered* pupils obey expectations set by the teacher and, thus, play their orthodox role of a pupil, whereas *abnormal/disabled/disordered* pupils (very) often disobey. Further, as for the agency of "disordered persons" being observed, descriptions about actions against modal expectations emphasize them as mere acts governed by genes or brain dysfunction rather than moral, agentive decisions. The ones observed are de-agentilized, as if they possessed no intentionality or free will over their actions (Freedman & Honkasilta, under review), as demonstrated through the following symptom descriptions:

> Often *unable* to play or engage in leisure activities quietly (DSM-V, emphasis added)

> Often blurts out an answer before a question has been completed (e.g., completes people's sentences[6]; *cannot* wait for turn in conversation) (DSM-V, emphasis added)

The use of dynamic modal verbs "unable" and "cannot" emphasize the inner state of the observed individual inhibiting her/his agency: the observed actions are *not* indicative of conscious or healthy decision making but pathological responses to external stimulus. Subsequently, the influence the observer (e.g., parent and teacher), other social actors (e.g., peers), or situational circumstances (e.g., interactional, emotional, socio-emotional, experienced history, physical) may bear on how one's reaction to contextual stimuli is disregarded. For instance, according to DSM-V, if the child "often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework […])," he or she manifests a symptom of inattention. The postulation is that the afore-described behavior has nothing to do with an individual's self-efficacy beliefs regarding the task in question. The neuropsychiatric hypothesis papers over the potential influences of earlier experiences of failing to meet the criteria of fast and accurate performance regarding schoolwork and emotional experiences evoked by earlier history or the present moment. In other words,

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[6] If I am asked, my wife tends to complete my sentences "often" — "very often" on occasion — in situations where mere listening is expected (by me) and frankly, I find it annoying and disturbing. Regardless of my "observation" of this seemingly pervasive and persistent behavior and experienced discomfort, it hardly qualifies for the symptomology of a disorder.

both the failure and avoidance of failing are tracked down to brain functioning. The fundamental assumption is that student behavior and performance are somewhat independent of contextual (e.g., spatial), social, and emotional factors.

Evidently, the manuals emphasize the pervasiveness of behavior across situations and its persistence over time as requirements of considering behavior symptomatic, thus ruling out sporadic incidents. Despite various contexts being offered (e.g., church, classroom, play activities, and conversation), they are viewed as vacuums in which non-compliance with normative expectations occurs because of individual deficits. The vague descriptions of one's behavior throughout the manuals guide their readers to ignore the uniqueness of individuals being observed and evaluated—an issue reported problematic by clinicians themselves (Rafalovich, 2005). The authors strengthen the assumption of homogeneity of individuals manifesting "symptomatic" behavior by presenting a set of decontextualized quantifications of certain outcomes the reader finds easy to identify with and apply to any situation (see Abbey & Valsiner, 2005). In van Leeuven's (2009) terms, what the authors of the diagnostic manuals perform is "recontextualizations of social practices" (p. 148), through which actual, authentic actions of one context are rearticulated in another context so that they translate as objective pervasive symptoms of the disorder. This is done by omitting descriptions of certain contextual elements of practices; the rationalization of pathologization is made possible by disregarding cultural, systemic, and social problems that potentially manifest themselves as, for example, misbehavior at school (also Freedman & Honkasilta, under review; Graham, 2007b). This pegs the question of whether it is a child with certain characteristics that ought to be diagnosed or perhaps, the learning environment that, to some extent, engenders or intensifies the characteristics while being intolerable to them (e.g., Kohn, 2000; Galves et al., 2003).

Notably, behavior descriptions presented in both of the manuals of mental and behavioral disorders follow Szasz's (1960) analogy provided over 50 years ago, when he famously argued that mental illness is a myth, and thus, refuted the position dominant till date, which holds these "disorders of thinking and behavior" (p. 113) as a sign of brain disease: "this position implies that […] *[a]ll problems in living* are attributed to physicochemical processes which in due time will be discovered by medical research" (p. 113, author's emphasis). He criticized the vague logic of mental illness as analogous to physical (or bodily) diseases. The fallacy is that whereas a bodily disease in an organ system (e.g., liver) manifests itself as observable signs (e.g., fever) or symptoms (e.g., pain), mental disorders manifest brain dysfunction by means of mental symptoms that cannot be objectively observed. Further, his notions resemble diagnostic criteria for ADHD:

> [T]he statement that "X is a mental symptom" involves rendering a judgment. The judgment entails, moreover, a covert comparison or matching of the patient's ideas, concepts, or beliefs with those of the observer and the society in which they live. The notion of mental symptom is therefore inextricably tied to the *social* (including *ethical*) *context* in which it is made in much the same way as the notion of bodily symptom is tied to an *anatomical* and *genetic context* […]. (Szasz, 1960, p. 114, author's emphases).

To conclude, symptomatic behavior described in DSM-V and ICD-10 regarding ADHD is analogous to Szasz's (1960) critique on mythical mental symptoms that are open to various interpretations tied to sociocultural value-laden conventions. The diagnostic criteria are professed to premise on demonstrable abnormality through direct observations. However, the manuals offer no confirmatory physical evidence on biological causation and the use of descriptive criteria to diagnose an alleged medical condition is questioned on the grounds of their reliability and validity (Kirk & Kutchins, 1994; Kutchins & Kirk, 1997). Regardless, the manuals are considered to present objective descriptions of physical symptoms and provide readers with scientific rationale and formal logic to identify factual disease entities and disorders. Sociocultural factors shaping what is delineated as a disorder are ignored by presenting "a strange mix of social values, political compromise, scientific evidence and material for insurance claim forms" (Kutchins & Kirk, 1997, p. x; see also Cooksey & Brown, 1998; Slee, 2014).

Cooper (2008, p. 465) noted that criticizing diagnostic criteria of resting on value-laden, culturally-specific judgments about behavior or cognitive norms is not only self-evident but also absurd, since "culture reflects the values, attitudes and beliefs of a social group" and taking a culture-free stance is impossible for human beings. There is more to this than meets the eye. Stating that the diagnosis criteria are value-laden recognizes substantial contextual and cultural traces of behavior and interpretations drawn from it as well as the agenda of observers who intentionally engage in diagnostic practices (see also Conrad & Barker, 2010). Thus, the issue at hand is not reflecting cultural values, attitudes and beliefs but instead *maintaining* and *reproducing* them. A detailed analysis of the diagnostic criteria makes the logic of constructing deviancy and deficit transparent. Thus, it enables the user of the diagnostic manuals to *choose* to either accept, reject, or critically apply the imposed understanding of human behavior presented in the manuals (see also Kutchins & Kirk, 1997; Rafalovich, 2005).

2.2 ADHD as an embodied experience

> It is not that objective physical states are identifiable as disorder, only then to provoke moral quandaries, or then translated into "lived experience." Rather, any demarcation of behavior as disorder is meaningful only because of a normative context. (Bowden, 2014, p. 434)

> It is better for everyone for the child to be "sick" rather than "bad". (Meadmore, 1998, p. 1, in Tait, 2010, p. 31)

I find that a brief discussion on embodiment of ADHD-related symptoms is in order. Approaching disabilities, disorders, or illnesses in relation to sociocultural convictions and conventions runs the risk of entirely ignoring individual experiences and providing little contribution to the lives of the stakeholders (Vehmas & Watson, 2014). Feminist disability studies, for instance, dispute the

approach of explaining a disability or illness solely in relation to one's social environment and encourage elucidating their embodied nature, such as feelings of pain or being depressed (e.g., Wendell, 1996). Further, in their study on children's perceptions, given meanings, and experience of "living with ADHD," Kendall and colleagues (2003) state that "the continual debate about the authenticity of ADHD only further victimizes families [and teachers] who are in desperate need of services"(p. 114, comment added). I briefly address how I posit the embodied experience of ADHD in relation to an epistemological approach to understanding ADHD as sociocultural meaning-making processes and practices (chapter 2.3).

A plethora of medical research has identified physiological, neurological, and cognitive differences associated with ADHD that are related to various types of "psychological deficits," as expressed by Barkley and colleagues (2002, p. 90) in the international consensus statement on ADHD (for a further review, see e.g., Barkley et al., 2004). Indeed, young people diagnosed with ADHD associate the disorder with social and educational difficulties and children and youth are reported to view themselves as if something were fundamentally wrong in them (e.g., Cooper & Shea, 1998; Krueger & Kendall, 2001; Kendall, Hatton, Becket, & Leo, 2003; Travell & Visser, 2007; Singh, 2007; 2011; Brady, 2014). In line with this, children and youth have been found to view medication as valuable as it increases the ability to self-manage behavior and improves academic performance (Cooper & Shea, 1998; Kendall et al., 2003; Loe & Cuttino, 2008; Singh et al., 2010; Singh, 2013b). These findings suggest that children and youth perceive the authentic self as fundamentally bad, problematic, or incapable and welcome medication as an empowering, normalizing, and enabling factor (Loe & Cuttino, 2008; Singh, 2013a, 2013b).

It is given that the decreased activity of a dopamine neurotransmitter manifests itself in various embodied ways, for instance, the urge to be on the move is potentially experienced as a feeling of restlessness or anxiousness. However, this physical modality rooted in human physiology is unlikely to be negatively experienced without it being associated with a certain degree of commitment to contextual sociocultural modal expectations regarding behavior and performance by self (i.e., internalized modal expectations), others (i.e., imposed modal expectations), or institutions (i.e., institutionalized modal expectations). Thus, when it comes to behavior or performance associated with the so-called "invisible disabilities"—such as ADHD, learning disabilities (LD), and obsessive, and oppositional and conduct disorders (ODD)—it is these expectations that fortify their pathological nature over the normal variation of human behavior and performance and name their moral and ethical outcomes. In other words, physical, embodied feelings are given a contextual meaning, relevance, and significance in social interaction vis-à-vis sociocultural expectations and requirements as well as self-efficacy beliefs regarding the competence to act or perform accordingly. In the context of a classroom, a teacher's awareness of how neurotransmitters affect human functioning and performance enables a teacher to harness that information into teaching so that each individual in the

classroom is able to adapt to the facilities to maximize academic learning. In this case, enabling a movement may ease this inner urge and maintain concentration, and thus, contribute to the academic learning process. Neither diagnoses nor diagnostic explanations are needed for this.

How the youth voice their experiences is likely to entail intertextuality with expert explanations they have direct or indirect access to because of the parents' and schools' strong adherence to the medical model of ADHD (see, Brady, 2005; Emerald & Carpenter, 2010; Hjörne & Säljö, 2014a; sub-study 2 in this thesis). This, however, is culture-specific. For instance, the study of Koro-Ljungberg and colleagues (2008) of culturally situated narratives of the daily life experiences of ADHD diagnosed African-American teens shows that the experiences had very limited overlap with medical discourse characterizing ADHD.

Hacking (1995) famously argued that psychiatric diagnoses may produce a *looping effect* of human kinds, which is a process in which "people classified in a certain way tend to conform to or grow into the ways that they are described; but they also evolve in their own ways, so that the classifications and descriptions have to be constantly revised" (p. 21). However, once labeled as belonging to a neurodevelopmental psychiatric diagnostic entity, the behavior is widely regarded to allude to natural (as opposite to cultural), and thus, ahistorical and objective state or condition of an individual. For laypersons, at the very least, psychomedical explanations represent a somewhat static, all-exclusive, and scientific knowledge domain, as if it was immune to alternative interpretations of human behavior. Thus, the negative constructs of conduct, performance, and selves that youth reveal do not testify as much to the biological origins of ADHD or existing "illness" (cf. Kendall et al., 2003) as to the dominance of the deterministic belief that social and behavioral issues are reducible to individual pathology (Cooper & Shea, 1998; Travell & Visser, 2007).

Indeed, as much as findings on the voice of youth diagnosed with ADHD support the medical model of ADHD, they also contradict it. For instance, young people are reported to attribute the severity of manifestation, and even the existence of the problems associated with ADHD, to environmental factors (both favorable and unfavorable), especially teacher and peer conduct, emphasizing the importance of classroom interactions over the diagnostic explanations and their supposed value (e.g., Cooper & Shea, 1998; Gallichan & Curle, 2008; Prosser, 2008; sub-study 4 in this thesis). In addition, children and youth have reported the downsides of medical treatment, varying from unwanted side effects to the changes medication causes in one's authentic self (Cooper & Shea, 1998; Loe & Cuttino, 2008). These diverse findings call into question the simplistic perspective that reduces young people's behavior or performance regarded as symptoms solely derived from a neurological dysfunction or impairment in cognitive processing.

My approach to understanding ADHD by no means deprecates or ignores the experiences embodied by individuals associate with the disorder. I do not renounce that children manifesting behavior associated to the diagnostic category of ADHD may have—as children (and adults) in general—difficulties

sensing their own physical or emotional state and knowing how to contextually deal with them. In addition, I do not renounce their (or children's and adults' in general) individual needs for understanding and support and the guidance of various forms (for my approach to conceptualize individual need, see chapter 5.4). Align with Graham (2010b), I argue that labels and the consequent forms of psychomedical explanations that pathologize the so-labeled individuals are not necessary to help children make sense of their world or reactions; by contrast, empathic interactions with adults are important. As the empirical part of this thesis further demonstrates (chapter 4), I consider experience to play a valuable role in studying the internalized sociocultural aspects of what is deemed a neurodevelopmental (DSM-V) or behavioral and emotional disorder (ICD-10) in educational and closely related practices of contemporary society. Following Davis' (2008) critical cultural analysis of obsessive compulsive disorder (OCD), it can be stated that ADHD "is real, and so are the circumstances that surround it, and bring into our clinical and social focus" (p. 6). I discuss this issue further in the next chapter.

2.3   Existence and realness of ADHD

> I do not by any mean question whether all diagnosed children really have ADHD; the answer is embedded in the very clause. Nor do I question whether children manifesting behavioral traits as introduced in the diagnostic criteria of the disorder really have ADHD; the truth is the eye of the beholder. (Author)

Regardless of the opposition to the current conceptualization of ADHD and its validity as a medical disorder, ADHD undoubtedly exists and is real because it is recognized to adhere to certain "kinds of" things (note plural), such as "kinds of" categories of people, persons, traits, performances, and conditions that are characterized and (expected to be) followed by certain "kinds of actions" (e.g., Hacking, 1999). That is, the object of discourse becomes intentionally articulated and manifested in recognizable forms of a certain kind. ADHD is recognized in both perception and action; the former giving significance to the various "kinds of" forms ADHD exists in and the latter referring to the "kinds of" ways ADHD is manifested as being real. By using the form "is manifested" instead of "manifests itself," as advocates of psychomedical model may put it, I emphasize the interconnectedness of perception and action (see Figure 1). Although one may say that ADHD manifests itself, the very manifestation and perceived actions are assigned ambiguous meanings in different contexts. What is perceived as the lack of attention or inhibition in one context becomes the ability to multitask in other. My point here is not to oversimplify cognitive research on executive functioning or other theories of ADHD, but to highlight the role of and place for sociocultural approaches to the phenomena in question. That is, any natural "thing" would exist without a cultural imprint, yet human awareness and conceptualization as well as interpretation and mobilization of the "thing" in practice becomes mediated by cultural premises. Only a normative interpretative

framework on human beings allows material differences to be perceived as an individual dysfunction and pathology explained by natural causes.

I argue here that ADHD *exists* in an abstract space of *text* and becomes *real* in the concrete space of *practice*. By text, I refer to verbal, non-verbal, and written language, semiotics occurring in different forms of communication and interactions (Fairclough, 1992, 2004). In other words, the concept of ADHD carries cultural meanings, conventions, and beliefs constructed, maintained, and reconstructed in text. These meanings are irremovable parts of practice—actions or what people do. Practice is central to representing, conceptualizing, and understanding the aspects of reality (e.g., Berger & Luckmann, 1966; van Leeuwen, 2009). Actions people take are inextricably interwoven with their ways of communicating about and by their actions (i.e., use of text) with one's social environment. Meanings originate in action but also (de)legitimize the forms of action and, thus, shape action as well as how it should be perceived. I next elaborate on text and practice as well as perception and action.

Abstract space of text Concrete space of practice

Perception of a certain kind | Recognition as a certain kind | Action of a certain kind
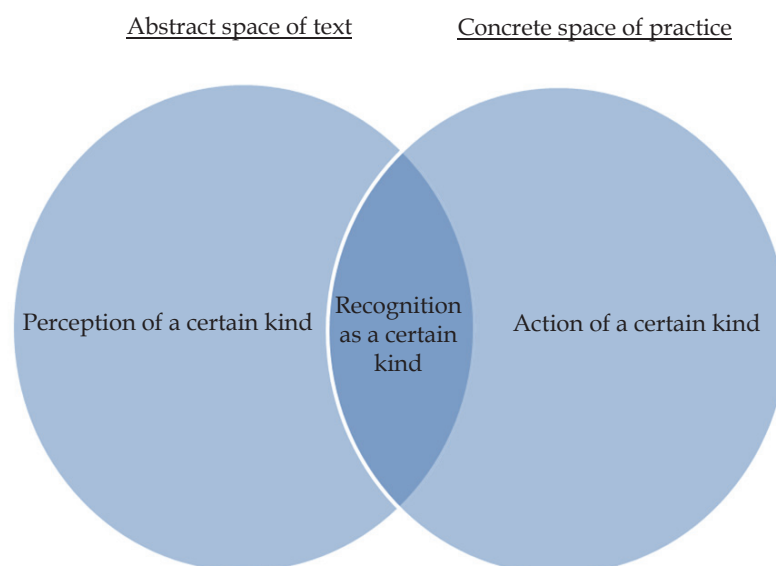
FIGURE 1 Recognition as a certain kind within intertwined spaces of text and practice

2.3.1 ADHD exists in text

Here, I draw attention to three interrelated perspectives on the existence of ADHD by adapting Gee's (2000–2001) conceptualization regarding recognition, namely nature, institution, and discourse perspectives, each of which has a distinct source and process of recognition. Take for example the frequently used concept of "ADHD child." From the *nature perspective*, ADHD signifies a fixed internal state of the child caused by forces of nature. Literature, such as the international consensus statement on ADHD (Barkley et al., 2002), psychomedical jargon, and colloquial language may refer to this state using the verb "suffer,"

and subsequently, to a child as a "sufferer." ADHD signifies a development process (e.g., genes and neurobiology) over which the child, society, or culture has no power.

This internal state of a child rooted in natural causes gets its "official" recognition through the authorization process of acknowledged authorities such as clinicians bound by various laws, rules, traditions, principles, and ideologies. Thus, from *the institution perspective*, ADHD exists as an institutionally recognized position. As for the concept of "ADHD child," the prefix ADHD signifies a diagnostic label along with which the child becomes a legal and paralegal subject and object eligible for adequate societal measures of support, such as remedial or special education and medication. The two perspectives, thus, support and sustain each other. For example, the measures of support are to compensate dysfunctions rooted in nature, in principle at least. As I illustrate later in this chapter, the union of the two perspectives is intentionally harnessed to serve certain societal and sociocultural functions in practice.

Given that nomenclature comes down to culture-specific conventions. Today, the mere combination of the letters ADHD evokes a set of associations, regardless of whether people are familiar with the psychomedical concept recognized from the perspective of nature or institution (e.g., it is used as a curse word). In everyday use of colloquial language or vernacular, it can signify, for instance, medical or socially situated lay diagnosis (c.f., "I'm diagnosed with ADHD" vs. "I'm such an ADHD"), compulsive illnesses or disorders (i.e., medical condition), disability support services or the so-called "special need" (i.e., legal or paralegal entitlement for goods and services), deviant behavior (i.e., normative judgment), or child characteristics (i.e., social label). From *the discursive perspective*, the concept "ADHD child" is recognized in varying ways in dialogue processes, that is, how people talk with or about the child or about the concept as well as how they interact to and treat the child or the concept. "ADHD child" refers to various sets of assumptions about a child of a "certain kind," defined by the prefix ADHD in that her/his personal traits, behavior, and performance become attributed to varying beliefs and ideologies the concept ADHD represents and imposes (e.g., a child characterized with a set of un-/flattering stereotypes). These attributions may or may not adhere to the conventional understanding on ADHD promoted by nature and institutional perspectives. In fact, the construction and sustainability of the two perspectives rely on the discourse perspective (Gee, 2000–2001).

It is not uncommon to see parents' updates in social media, in which they overtly label the children, and by doing so, advocate for the recognition of ADHD as an internal state rooted in nature as a basis for recognition in dialogue. I elaborate on this further using an imaginary clause "my ADHD child plays the piano beautifully." Although imaginary, the clause resembles parents' updates, given that the prefix may vary from ADHD, autistic, special (in reference to a student receiving special education) to similar potentially stigmatizing labels that impose a certain kind of conventional recognition for the label bearer. The clause can be paraphrased in two ways at least: "despite ADHD, my child

plays the piano beautifully" or "because of ADHD, my child plays the piano beautifully." The former paraphrase emphasizes the against-all-odds nature of the child playing the piano beautifully, while the latter premises upon the idea of the so-called "neurodiversity movement" (e.g., Armstrong, 2012) in that since the child's brain is "wired differently" than the "normal" brain, he/she is able to passionately focus on his/her interest, in this case, playing piano and master the art[7]. Although different in their emphases, both paraphrases entail presupposition that prefix ADHD inevitably stigmatizes the child. If the unflattering stereotypes were not internalized as cultural consensus beliefs that inevitably characterize the child, there would not be any need to label the child in the first place (i.e., "my child plays piano beautifully"). Neither would there be any reason to strive to detach him/her from the stigmatizing stereotypes the label entails (e.g., underachiever) or change the view to a more positive one (e.g., gifted). This negotiation with stereotypes, a practice I further focus on in sub-study 3 of this thesis, brings us to recognizing ADHD as a certain "kind of thing" in practice.

2.3.2 ADHD is real in practice

Thus far, I have dealt with perspectives in which ADHD legitimately exists and the processes of development (nature perspective), authorization (institution perspective), and dialogue (discourse perspective), all of which provide us with a different perception of what ADHD as a certain "kind of" concept or an explanatory prefix to concepts signifies. These perceptions are made real through practices. For instance, ADHD as a natural state and/or institutional position that supports the natural perspective is real solely if recognized as such in practices of institutions (e.g., law, healthcare, welfare, education, and parenting), pertinent professionals (e.g., clinicians, physicians, educators, and social workers, etc.), or laypersons (e.g., family members, peers, or the one being diagnosed). ADHD becomes real in material interactions with ideological conventions and power relations, with agents empowered to see these ideologies to action (e.g. teachers and parents) and the ones being diagnosed and thus, potentially determined by ideologies and subsequent practices (for further reading on how ideologies determine and produce a diagnosed individual in school social practices, see, e.g., Harwood, 2006; Hjörne, 2006; Bailey, 2014; Evaldsson, 2014; Hjörne & Evaldsson, 2015).

I classify four interrelated sociocultural forms of practices in which ADHD is recognized as real: *cultural*, *institutional*, *social*, and *discourse practices*. This division of practices is far from distinct. Institutional and discourse practices are forms of social practice, which in turn is as much shaped and given meanings by institutional and discourse practices as it shapes and gives meanings to them. Eventually, culture comes to life through different situational forms of the three

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[7]   This manner of interpreting a child's performance echoes the empowering mantra I have come across and engaged in during my work in adaptation coaching courses organized by the ADHD association in Finland.

aforementioned practices, which are fundamentally both constructs and components of certain cultural practices. Thus, the practices are interwoven and interdependent. However, I find it useful to clarify how ADHD becomes maintained, negotiated, and recognized as being real.

The diagnosing process itself is a cultural practice regarded particularly significant in western culture. The end product of the process, ADHD diagnosis, initiates another set of cultural practices, simply put, a plethora of negotiation processes. A recent follow-up study by Wallach-Kildemoes and colleagues (2015) among a cohort group of school-aged children without previous psychiatric conditions (N = 813 416, age: 5–17 years) in Denmark explored whether regional variations in the initiation of ADHD medication, especially in socially adverse children (e.g., low parental education and single parenthood), were explained by differences in sociodemographic composition and/or ADHD prescribing practice. The results show that despite the sociodemographic composition did not play significant role in the regional variations of prescribing practices, large regional differences prevailed. The authors conclude that such differences indicate that local culture shapes the way children's ADHD-like behavior and performance is interpreted and dealt with (Wallach-Kildemoes et al., 2015; see also Koro-Ljungberg et al., 2008). The label ADHD reads and communicates in various ways across different culturally situated contexts. Thus, it is not solely perceived as certain "kinds of" things but intentionally mobilized to serve certain "kinds of" functions, that is, things done with the diagnosis. Inspired by the broad social model of diagnosis set out by Duchan and Kovarsky (2005b) in their edited book called Diagnosis as Cultural Practice, I regard *cultural practice* as intentional, contextually situated communication and negotiation processes in which certain sociocultural beliefs, norms, and ideals are summoned upon to advocate the certain "kind of" perception related to ADHD, whereas it simultaneously detaches from certain kinds of sociocultural entities.

Adapting from Gee (2000–2001), by *institutional practice*, I mean action and meaning-making processes of authorities within institutions who, authorized by various laws, rules, traditions, rituals, principles, or ideologies, author the "kind of" recognition in question. Diagnosing ADHD followed by remedial or special need education resolution at school is a typical sequence of events in institutional practices, which school curriculum bind by laws and statutes promotes. I refer to *social practice* as actions taken when interacting with the social environment according to certain sociocultural conventions, norms, ideologies, and beliefs. For instance, once ADHD is institutionally legitimized, adequate recognition is expected to take place in school social practice, such as teaching and implementing remedial or special education according to embedded ideologies, beliefs, and knowledge of the diagnostic label (i.e., structured instructions and undisturbed learning environment). The expectation of teachers recognizing the child and his/her remedial needs after the diagnoses is one of the mainstays for families to seek for diagnosis for their child in the first place (e.g., Austin & Carpenter, 2008; Emerald & Carpenter, 2010; Bailey, 2014; sub-study 2

in this thesis). Foster-Galasso (2005) aptly remarks about the intentional, dynamic, and situationally sensitive use of psychiatric diagnoses as a gateway for navigating social institutions and everyday interactions to negotiate for means of societal support and recognition of "certain kind." Institutional practice is, thus, expected to shape social practice at school.

These particular sociocultural ideologies, beliefs, norms, and power relations are naturalized in *discourse practices*, which Fairclough (1992, 2004) describes as processes of text production, distribution, and consumption (also Woodside-Jiron, 2004). Long before any forms of institutional or social practices are implemented, ADHD becomes a part of reality in discourse practices, typically in interactions between and among school representatives and parents regarding the child failing in school. Discourses among educators are likely to draw on psychomedical conventions that promote ADHD as an account for school failure owing to a naturally occurring deficit in brain functioning (see Sax & Kautz, 2003; Hjörne & Säljö, 2004, 2014a, 2014b; Hjörne, 2005; Bailey, 2014). In addition, since the diagnosis testifies to a legally recognized disorder, ADHD is viewed as a legal entity that overrules the student's legal accountability of his/her actions; the diagnosis becomes an entitlement for goods and services. Along with this process of recognition, the identity construction of the child and parent in the meaning of becoming recognized as a certain "kind of person" becomes altered (Gee, 2000–2001). Now, the child is invited to become recognized as an agentless, neuro-governed victim "suffering" from a compulsive disorder instead of, for example, a malicious vandal and a moral agent (for how youth diagnosed with ADHD negotiate with the label and associated moral responsibility, see sub-study 3 in this thesis). The parent, on the other hand, fends off potential cultural blame of a so-called poor parent by becoming a guardian of a disabled child (see Singh, 2002b, 2004; sub-study 2 in this thesis).

To conclude, the ontology of the claim about ADHD existing and being a real disorder does not solely rest in the nature. In addition, its epistemology does not unanimously point to clinical practices successfully identifying the condition. Rather, as Duchan and Kovarsky (2005a) highlight, diagnosis "is a way of experiencing, doing, and thinking that is pervasive in Western culture" (p. 1). The ontology and epistemology of ADHD rest in the processes of recognition negotiated in institutional, social, and discursive practices (see Figure 2). ADHD is a natural (e.g., developmental dysfunction) and psychomedical entity (e.g., medically or psychiatrically recognized disorder) as much as it is an institutional (e.g., legally recognized disorder) and social one (e.g., disorder recognized in material interaction), and thus, a discourse entity (e.g., disorder contextually recognized as such in culturally specific semiotics). But first, ADHD is a cultural entity since its fundamental ontology premises on the conventions of human interaction and meaning making; on "the social reasoning that people go through to make sense of their worlds, and (perhaps) impose that sense on other people" (Antaki, 1994, p. 1).

Abstract space of text
(Perception of a certain kind)

Concrete space of practice
(Action of a certain kind)

Nature, institution, &
discursive perspectives of
ADHD

**Recognition
of ADHD as
a certain
"kind of"
thing**

Cultural, institutional, social,
& discourse practices
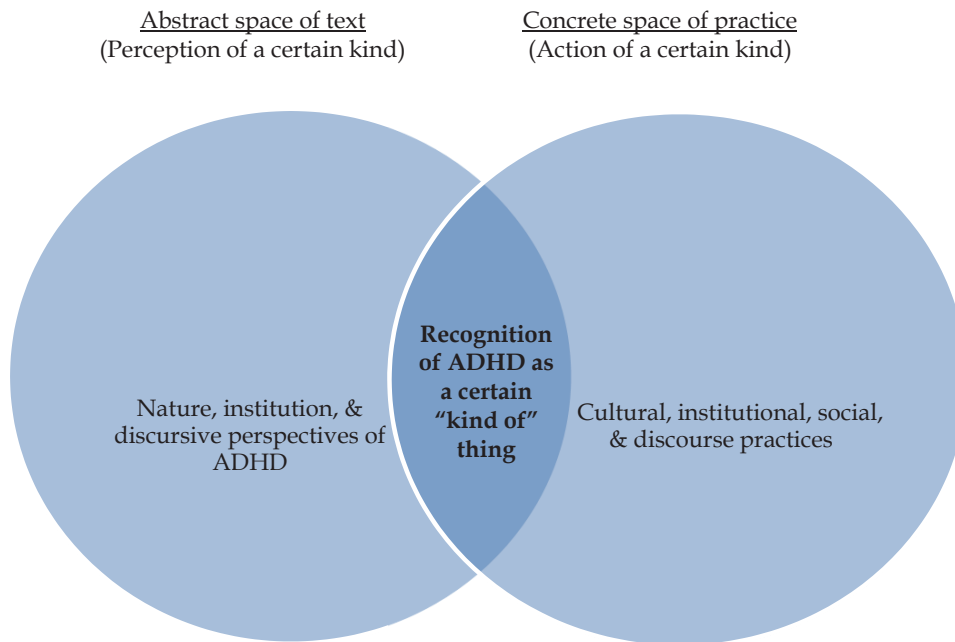
FIGURE 2   Recognizing ADHD as a certain "kind of" thing within intertwined spaces of
text and practice

2.4   Summary: In need of the label—ADHD and cultural practice

> Perhaps the biggest impact so far of neurobiological studies has been intangible: the
> provision of a validity to the concept of ADHD that has disarmed some of society's
> fears about the over-medicalisation of children's problems. The apparent validation
> is, in part, spurious. A genetic origin of behaviours clearly does not of itself imply
> their pathological nature. Nevertheless, it has had powerful effects – sometimes help-
> ful, as in liberating the problem-solving abilities of parents when they feel no longer
> culpable; sometimes unhelpful, as when teachers construe the problems of ADHD as
> medical and therefore outside their scope. It will increasingly be necessary for scien-
> tists to engage in debate and discussion with the public and consider the social im-
> pact of their discoveries. (Bellgrove & Taylor, 2007, p. 498)

The above excerpt relates to the threads of last two chapters. The citation recog-
nizes ADHD as a certain "kind of thing," rather than an unequivocal neurobio-
logical fact and reaches out, tentatively at least, toward social sciences by em-
phasizing the need to further recognize and understand by what means and
effects is ADHD still increasingly achieving fame as a psychomedical entity in
western culture. The provided examples for the pros and cons of neurobiologi-
cal studies implemented in sociocultural practices within institutions (home
and parenting or school and teaching) by laypersons (parents) and pertinent
professionals (teachers) are purely sociocultural phenomena, as previously cov-
ered. Interestingly, they are openly recognized here by authors who can be re-

garded as the advocates of the psychomedical model in understanding ADHD. Professor Mark A. Bellgrove is one of the editors of the *Handbook of Attention Deficit Hyperactivity Disorder*, which discusses ADHD from the perspectives of clinical, neurobiological, and treatment practices. Despite cultural perspective being omitted from the handbook, the above quote is cited at the very end of the handbook as future directions for ADHD research. As for Professor Eric T. Taylor, he is one of the signatories of the international consensus statement on ADHD.

Even though ADHD may fulfill the set requirements of being a clinically valid entity, as pointed out by Faraone (2005), it goes without saying that the concept and understanding of the *disorder* cannot exist without its conceptual counterpart *order*—they produce each other and cease existing without each other. Neurobiological diversity does not point to the pathological nature outright. The disorder of attention and hyperactivity is absolutely conceptualized in relation to behavior and performance that are at peace with contemporary contextual order, that is, values, norms, and moral standards. Thus, behavior and performance associated with ADHD are in principal devalued and regarded abnormal and immoral up to a point that they qualify for a disorder (see, e.g., Szasz, 1960; Ereshefsky, 2009; Bowden, 2014; Freedman & Honkasilta, under review).

The issue here has not been to reject the veracity of ADHD. Quite the contrary, I strived to point out that negating the existence and realness of ADHD is fundamentally fallacious and of little use. When new canons of judgment are employed, new realities are produced. Whether the etiology of ADHD can be reliably or unequivocally traced back to biological and/or physiological dysfunctions caused by nature is peripheral in terms of the existence and realness of ADHD. Psychomedical understanding of, and thus, the "natural" explanation for the human behavior label ADHD alludes to is not universally accepted because "science" dictates so but because there is a fluctuating demand and desire mainly among adult educators (e.g., parents and teachers) for such explanations and subsequent psychomedical labels and categories of difference. There is a need for a theory and practice that leads to an internalization of the idea that societal and par excellence social problems, such as adaptation or behavioral difficulties at school or school failure, are in fact individual based. Thus, the process through which ADHD has become a recognized disorder has been, and continues being, as much top-down as it is bottom-up in nature (see Tait, 1999; Singh, 2002b; Suominen, 2003; Duchan & Kovarsky, 2005b; Mayes & Rafalovich, 2007; Laurence, 2008). If ADHD "ceased existing," so will societal support (institutional practice), understanding and taking the child/family situation into account in, for instance, interaction with school representatives (social practice), and release from cultural blame of being a "poor" mother, teacher, or student (discourse practice). ADHD exists and is real due to the structures and practices of societal and social governance of "normality" (e.g., Foucault, 1977; Tait, 1999, 2010; Bailey, 2014).

3 METHODOLOGY

3.1 Data

3.1.1 Participant recruitment

Participant recruitment was conducted with the help of the Finnish ADHD association and its member associations, which provide support and information for persons with symptoms of ADHD and their social networks. The recruitment process was executed in two phases. The first phase was accomplished by spring 2010 in concert with the ADHD association of Middle Finland, as part of my master's thesis research (Honkasilta, 2011) on parents' (including 12 mothers and one father) experiences of school trajectories for their children diagnosed with ADHD. After the board of trustees gave their approval to conduct the research, the recruitment was realized by giving a short presentation about the purpose of the research at the seasonal meeting of the association, publishing a research announcement on their homepage, and sending a research handout to member families by the secretary and volunteers of the association. Approximately half of the participants were reached through the aforementioned methods, whereas the rest were reached through the snowballing method (Patton, 1980): participants were recruited among acquaintances of the ones already participated.

The second phase, with a similar research agenda, involved both parents and their children diagnosed with ADHD. It was executed in spring 2012 in concert with the ADHD association of metropolitan area and included 13 mothers, 6 fathers, and 13 young diagnosed with ADHD). Adding to the aforementioned recruitment methods, two distinct research handouts were sent to member families, one targeting parents and the other their children diagnosed with ADHD. A research announcement was also published on the homepage and magazine of the ADHD association in Finland and that of the Finnish Parents' League. Research handouts were also shared at ADHD center, which provides low-threshold support for families who experience challenges with their chil-

dren or youth in their everyday life. The family participation required that the child was formally diagnosed, aged 11–16 years, and willing to participate; the latter was also verified face-to-face by the researcher. These criteria were to ensure that participant families had experience of the diagnosing process and life before and after it, as well as substantial experience of compulsory schooling. In both phases, participant anonymity was protected during the recruitment process as families voluntarily contacted me in person if they were willing to participate.

3.1.2 Participants

Originally, 25 Finnish families (including 25 mothers, 7 fathers, and 13 young aged 11–16 years diagnosed with ADHD) participated in the research. However, due to the requirements of a compilation dissertation to narrow down the research focus, so that the main findings can be presented in research articles, the data had to be reduced. As a result, 18 families are included in the empirical part of the dissertation (sub-studies 2–4). Because of fathers' low participation, sub-study 2 focuses on 18 mothers who were interviewed without their spouses. The decision to opt out fathers' voice reflects earlier research findings indicating that mothers are dominantly in contact with educational professionals (e.g., David, 1998) and more engaged in their ADHD diagnosed child's schooling than fathers (Rogers et al., 2009). Although fathers who did participate with their spouses did not express dissenting views and experiences from those of the mothers in terms of child's schooling, previous findings have shown differing views on how fathers and mothers perceive their child's behavior associated with ADHD (Singh, 2003, see also Bailey, 2014), thus making the fathers' voice an important for future study. Further to limiting families from 25 to 18 in sub-study 2, sub-studies 3 and 4 focus on the voice of thirteen youth diagnosed with ADHD, thus excluding 12 families of the first recruitment phase. I next describe the participants in further detail.

Sub-study 2. Apart from the common ADHD association background, the families formed a heterogenic group in terms of parents' educational and work background, activeness in the association, relationship status, diagnoses, health, and the diagnosis and comorbidity of their child. Table 2 presents an overview of the education, employment, and family-type statuses of parents who participated in the research with their children diagnosed with ADHD (recruitment phase 2). Parents' background information regarding the families who participated in the research in the first recruitment phase is not available since, as a young researcher conducting a master's thesis, I failed to inquire about such basic information. Note that mothers formed a heterogenic group in terms of age, educational, and work background, activeness in the association, relationship status, diagnosis, health, and the diagnosis and comorbidity of the child, which is similar to the mothers of the second recruitment phase. As for the analysis presented in sub-study 2, this lack of information is, however, somewhat irrelevant since the study aimed at examining how mothers constructed agency by language use in relation to their school related involvement (see An-

taki et al., 2003; Burck, 2005). Further, in this type of maximum variation sampling, shared emerging patterns are of interest as they capture the core experiences of the one aspect common to all: a child diagnosed with ADHD (Patton, 1990).

TABLE 2   Background information of the parents of young participants diagnosed with ADHD

Parents' level of education (%)				Parents' employment situation (N)		Family type (N)			
Basic	Voca-tional	Col-lege	Univer-sity	Em-ployed	Unem-ployed	Nu-clear fami-ly	Blend-ed family	Di-vorced	Single parent
8	44	20	28	24	1	10	1	1	1
Total 100%				**Total 25 parents**		**Total 13 families**			

Sub-studies 3 and 4 focus on the voice of two girls and 11 boys aged 11–16 years (mean age 13.7) diagnosed with ADHD. Like the mothers, the young participants formed a heterogenic group in terms of diagnostic comorbidity, age at diagnosis (varying from 5 to 12 years, mean age 8.3), educational trajectories and form of implementation of education. Table 3 summarized the participant information.

TABLE 3   Background of 13 young participants diagnosed with ADHD

Participant's name	Age	Grade and cur-rent form of educa-tion	IEP	Diagnoses as presented in ICD-10	Age at ADHD dg	ADHD medica-tion/ experi-ments	Age at starting medication
Arthur	13	7–9th grade, Steiner school, small group	N/A	Other specified behavioral and emotional dis-orders with an onset usually occurring in childhood and adolescence[8]; other childhood emotional dis-orders	12	No/No	N/A

(continues)

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[8]   ICD-10 classification puts more emphasis on hyperkinetic than attention regulation deficit form in its terminology of ADHD. The diagnosis of other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence (diagnostic code F98.9) is often used to refer to attention deficit disorder (formerly ADD) without hyperkinetic disorder. This was also the case of Arthur.

Table 3 (continues)

Participant's name	Age	Grade and current form of education	IEP	Diagnoses as presented in ICD-10	Age at ADHD dg	ADHD medication/ experiments	Age at starting medication
Thomas	13	6th grade, Integrated with normal, music-orientated class	Yes	Disturbance of activity and attention; Mixed disorder of scholastic skills	8	Yes	8
Susan	16	9th grade, small group, some subjects integrated with normal class	Yes	Disturbance of activity and attention	7	No/Yes	Experiments when under 14 years of age
Laura	15	8th grade, normal class	Yes	Disturbance of activity and attention; anxiety disorder, unspecified; unspecified disorder of psychological development	7	Yes	9
Dave	12	6th grade, normal class	No	Disturbance of activity and attention; conduct disorder (withdrawn)	9	Yes	9
Pete	16	1st grade at vocational school; finished compulsory school in a small group	Yes	Disturbance of activity and attention; oppositional defiant disorder; sensory defensiveness	7	Yes	7
Michael	16	8th grade, integrated normal class	Yes	Disturbance of activity and attention	8	Yes	8

(continues)

Table 3 (continues)

Participant's name	Age	Grade and current form of education	IEP	Diagnoses as presented in ICD-10	Age at ADHD dg	ADHD medication/ experiments	Age at starting medication
Jacob	11	5th grade, integrated normal class	Yes	Disturbance of activity and attention; emotional disorders with an onset specific to childhood; specific developmental disorders of scholastic skills	7	Yes	9
Wilhelm	14	7th grade, normal class	No	Disturbance of activity and attention; specific developmental disorders of scholastic skills	12	Yes	12
Marcus	15	9th grade, normal class	Yes	Disturbance of activity and attention; oppositional defiant disorder; developmental disorder of speech and language, unspecified	5	No/No	N/A
John	12	5th grade, normal class	Yes	Other hyperkinetic disorders; other mixed disorders of conduct and emotions; obsessive-compulsive disorder	8	Yes	8

Table 3 (continues)

Participant's name	Age	Grade and current form of education	IEP	Diagnoses as presented in ICD-10	Age at ADHD dg	ADHD medication/ experiments	Age at starting medication
Jack	14	7th grade, normal class	Yes	Disturbance of activity and attention; mixed disorders of conduct and emotions; nonorganic sleep disorder	10	Yes	11
Matt	11	5th grade, integrated normal class	Yes	Disturbance of activity and attention	8	Yes	9

3.1.3 Interviewing as a data collection method

Data were collected through interviews conducted mainly in the participants' homes; however, some of the interviews were conducted on other premises as per the parents' wishes, such as at the university or work place. Parents and young people were interviewed separately, except on three occasions. Susan and Dave both took the initiative to participate during their parents' interview. I had already interviewed Dave before his parents', but Susan came home and joined the interview while I was still interviewing her parents; so, I decided to interview her with them. Wilhelm, on the other hand, eventually declined to participate alone, so he was also interviewed with his parents. In all these cases, the way to proceed with the interview was negotiated and verified with all present parties.

This type of joint interview does, however, raise ethical concerns, mainly regarding participants' potential vulnerability owing to being exposed to topics that require more intimacy. The interviews dealt with compulsory school experiences, so the realm of schooling became the subject common for all and experiences regarding home life remained intact. Also, although the discussion about schooling evoked negative and emotional experiences, they became constructed as an experience of the family, as something they had gone through together. This became evident in the way young participants co-constructed the stories with parents by confirming parents' experience or furthering it by adding own side of the story. As an interviewer, I took it as my responsibility to be alert to check on the young participants during the interview to enable their participation and, most of all, confirm their willingness to participate.

In general, the interviews of parents and their young participants remarkably differed from each other. Parent interviews were based on a loose, themat-

ic interview outline concerning mothers' conceptions of children's comprehensive schooling and home–school interaction. The intention of the interviews was to enable participants to make free, intuitive associations to actively construct meanings and talk about experiences they considered relevant and were willing to share. Thus, the interviews were conducted using narrative interview methods (summarized in Hollway & Jefferson, 2008), such as open narrative questions to elicit perceptions and experiences. I started each of the parent interviews by asking why they agreed to participate in the research, which was enough to elicit their stories and allow me to take a minimalistic role in the course of the interview. I took the role of taking notes of things said that I found relevant for further elicitation and directed the talk toward those issues (e.g., "Earlier you said that x, could you tell me more about it?"). The interviews were audio-recorded and lasted, on average, for around 104 minutes.

Apart from the three interviews, young participants were interviewed at their homes. In these cases, the interview arrangements were chosen by the youth, including, for instance, the room the interviews took place and sitting order. At least one parent from each family was met with for discussion prior to the interviews with the young participants. I was careful to explain/remind them about the objective and process of the interview and also reassure them that they are not obligated to answer if they do not wish to. Like in parent interviews, the idea was to enable free, intuitive associations and construction of meanings given to experiences they considered relevant and were willing to share with me. The broad semi-structured interview topics covered the participants' representations of school, own school attendance, teachers, and ADHD. I did not follow the strict structure on how to proceed in any of the interviews executed with the youth, but strove to pick up on clues provided by the participants along the way. For example, I had coffee with Matt and his mother before I started interviewing them separately. While doing so, Matt's mother mentioned in an ironic way that they had come up with principles for Matt to follow at school to avoid running into trouble with the teachers, such as never question the teachers and to do what teacher requests immediately. So, I used these principles as a starting point for my interview with Matt. The audio-recorded interviews of the young participants lasted on average, for around 90 minutes. I ensured that sufficient breaks were provided during the interviews, none of which were, however, taken.

The topic related to ADHD was discussed with participants using narrative interview methods (e.g., "What does ADHD mean to you?" or "How would you explain ADHD to someone unfamiliar with what it means?"). Also, I used functional methods to provide different means for participation and self-expression (Clark, 2005). The functional methods included a drawing task and the use of feeling cards. The drawing task was used to elicit discussions on the self-perception of school life and had six phases, in the following order: 1) draw a boat and think of (and write) adjectives about "how am I at school" (the use of feeling cards as help was enabled); 2) draw a sail and think of (and write) what "keeps me going" at school; 3) draw a waterline and an anchor and think of

(and write) what "slows me down at school"; 4) drawing of a dolphin following the ship and think of (and write) what school memory/memories "follow with me"; 5) draw a rock in front of the ship and think of (and write) "the possible pitfalls in my schooling"; and 6) draw a shining sun in the sky and think of (and draw) "what do I dream of" with regard to schooling. Each phase was followed up by open narrative questions (e.g., "you wrote 'calm' inside the boat, would you be willing to tell me more about it?"). The drawings or writings per se were not used as a means for analysis; the sole purpose of the method was to elicit further discussion and meaning making.

This method has been part of a "toolkit" used as means to share experiences and enable peer support in small group conversations during the adaptation coaching courses organized by the ADHD association in Finland. I have found this method useful in group conversations in a course setting as it provides clear structure and enables the voicing of experiences and perceptions (if one is willing to share). This functional method has the potential to enable the voice of children/young people in a research setting as well. However, not surprisingly, the depth of shared experiences and perceptions greatly vary between participants and this method proved to be helpful in most cases for further analysis as the elicitation remained cursory. The fact that I used this method in the beginning of the interview after having chatted with participant for a while may also have to do with this; since we had not become acquainted with each other earlier, this method functioned as an "ice-breaker" for further elicitation in the interview.

Feeling cards[9], with a wide range of positively, neutrally, and negatively charged feelings (e.g., happy, bewildered, and frustrated) were used with assignments on the perception of self and teachers. I used a deck of cards provided by Pesäpuu ry, a nationwide child welfare association that contributes expertise to the field of child welfare. The deck is planned by and produced in close collaboration with the children and youth placed into a foster care. Thus, I chose to use this particular deck of feeling cards because it better represented the worldview and experiences of young people than any other card deck I was familiar with.

The assignment on the young participants' perception of their teachers had six phases. They were asked to think of a teacher or teachers they regarded as "good" (phase 1) or "bad" (phase 4). Then, they were asked to go through the deck of feeling cards with thought and pile up cards that, in their opinion, represented the "good" (phase 2) and "bad" teacher(s) (phase 5). After this, each of the selected cards were reviewed (phases 3 and 6) using open narrative questions (e.g., "You chose [feeling card x]; could you tell me more about what it brings to your mind?"). Further, each of these spontaneous elicitations evoked by a feeling card was followed through until no new elicitations were

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[9] An example of a feeling card can be found on Pesäpuu ry's webpage: http://verkkokauppa.pesapuu.fi/data/dth/to/toiveikas_tunnetyyppi_vybkokzfji.jpg_860x860.jpg [accessed 3.5.2016]

provided (e.g., "You said x; would you be willing to share a bit more what you mean by that?"), that is, until the narrator was "ready" to proceed. Before executing the task, I introduced the overall idea and all the phases. Thus, in reality, most of the participants piled two stacks of cards at once, one for "good" and one for "bad" teacher(s).

The assignment on self-perception had four phases and was executed using the feelings cards and cardboard box of the tape recorder. The participants were asked to go through the feeling cards deck one more time with thought, and 1) put inside the box cards they perceived as describing their personal traits but of which their peers may not be aware of and 2) put on top of the box cards that represented the way their peers may perceive their traits. The selected cards were not considered in the analysis; the sole purpose of these functional interview methods was to enable free, intuitive meaning making, followed up in the same way as previously described.

These methods and the use of feeling cards, in general, proved to be useful to elicit participants' voice and intuitive meaning making. Also, they were easy to use fluently as auxiliary means without using any of the two aforementioned methods. For instance, I gave the deck to Wilhelm, who declined the one-to-one interview, at the beginning of the family interview and let him become familiar with it. Then, after half an hour or so, while still interviewing his parents I started checking whether he was more willing to participate and used the cards as auxiliary means to do so. Eventually, he did actively participate in the family discussion by commenting on his own initiative or when asked to join by either his parents or me. I did not use the afore-mentioned functional methods with him and restricted myself to the cards and narrative interview methods.

The use of functional methods (drawing task and feeling cards) were negotiated with the interviewees and, in some cases, they were eventually omitted. In two cases, the participants expressed their comfort and confidence in talking without any auxiliary means, thus, all functional methods were omitted (Susan who independently participated during the parent discussion is one of them). In two other cases, the participants showed signs of tiredness because of which I decided to not use these methods, although I did use the cards. In one of the two cases, the young participant arrived home 15 minutes after the agreed time and was seemingly restless. He told me that he had not been sleeping well for a week and that he would like to go back to riding motorcycles with his friends, thus, the timing for the interview was not favorable. In another case, the cord for the tape recorder broke during the interview and it took us (the young participant and me) time to fix it; thus, we agreed to go through the main topics we had previously talked about one more time. This, understandably, wore the participant off. In retrospect, in both of these cases, I as a researcher was blinded by my ambition to obtain data at once. Instead, I could have agreed to reschedule the interview. In fact, the young participant who was eager to go back to his friends even suggested we do so. Regrettably, I was discouraged to do so because scheduling family interviews had already proven to be a challenge and I was required to work within a limited timeframe.

Undoubtedly, the interviews cannot be method driven; the familiarity of the interviewer, interview setting, meaningfulness of participating and the adult–child/researcher–participant interaction play a tremendous role in what and how the young participants are willing to share (Gollop, 2000). I was acquainted with three of the young participants beforehand since I had worked with them and their families in adaptation couching courses. As for the rest, I tried my best to gain the participants' trust and diminish my position as an adult researcher with power over the young participants. For instance, at the end of his interview, Marcus complemented me by stating that I was easy to talk with because I "didn't seem to be there putting on airs by telling how difficult ADHD students are at school." Marcus was one of the young participants with whom I did not use any of the functional methods as per his request.

However, to truly understand the depth of the experiences of youth, repeated interviews would have been in order. This would have also made it possible for me to become acquainted with the participants. Also, methods that would have enabled them to introduce their everyday significant life experiences, such as taking photos prior to interviews as a base for further conversation, could have been useful (Clark, 2005). Given that this study focuses on the reproduction of the prevailing cultural norms and values through talk-in-interaction, interview methods that elicit spontaneous, intuitive responses such as those used in this research were in their place.

3.2   Analysis and methodological underpinnings

Broader methodological frames guiding the ontological and epistemological premises of this research project are located within the characteristic of western philosophy coined as a linguistic turn, which focuses on the interdependent relationship between language and, broadly, social reality: language constitutes reality instead of reflecting it (see, e.g., Riessman, 2005; Tait, 2010). It constructs, deconstructs, and reconstructs social order, norms, values, power relations, among other fundaments of society. Thus, studying how ADHD is linguistically constructed in interview interaction provides "a window" to study the nature of the prevailing society and the (available) way(s) participants negotiate self and make meanings within it. Apart from the first sub-study, which was not empirical in nature, I adapted different analysis methods stemming from the broad discipline of discourse studies in each of the sub-studies.

The second sub-study examined the narrated agentive possibilities of 18 Finnish mothers of children diagnosed with ADHD being involved in their child's schooling. The theoretical framework to process the data was drawn from the tradition of critical discourse analysis (CDA), which focuses on the relationship between language and society and, particularly, how social institutions, power relations, and the exercise of power are discursively constituted (e.g., Fairclough & Wodak, 1997; Rogers, 2004b). The focus of the *third sub-study* was on how 13 Finnish youth aged 11–16 years and diagnosed with ADHD

provided accounts of conduct, performance, and traits they spontaneously associated with ADHD during interviews. The theoretical frame of the study was premised on discursive psychology (DP), which highlights the action orientation and functionality of language and how participants orient themselves to the cultural meaning-making process (Jokinen, Juhila, & Suoninen, 1993; Wetherell, 2001; Hammersley, 2003). The focus was on the ways particular sociocultural norms and identities were contextually naturalized in interactions (e.g., Edwards & Potter, 1992). The *fourth sub-study* voiced the experiences of 13 Finnish students (aged 11–16 years) diagnosed with ADHD regarding teacher-reactive classroom management (CRM) strategies by employing a narrative framework. The worlds in which students live can be understood and interpreted through their narratives (Connelly & Clandinin, 1990; Pinnegar & Hamilton, 2011), which simultaneously elicit individual experiences and illuminate social realities in terms of rights, duties, and expectations; a narrative provides a sociocultural means to make sense of and/or account for the experience (Bakhtin, 1986; Drew, 1998; Wetherell, 2001; Gubrium & Holstein, 2009).

These methodologies maintain different orientations and emphases for data interpretation. For instance, in term of interpreting power relations, CDA approaches discourse from top-down by reading the data from the viewpoint of the reproduction of unequal power relations. In the two other approaches, on the other hand, a discourse is approached from bottom-up, in which the power relations are a legit focus of analysis if they are explicitly constructed. Despite their differences, all of the methodological approaches share the following underpinnings in terms of language use: 1) close study of language use is required to study how actions and meanings are constructed through text and talk; 2) language use is action oriented and serves occasioned and situated functions, that is, people do certain things with words (e.g., blame, make excuses, account for, explain, and use cultural categories); and 3) language use entails persuasive and morally consequential aspects that result in the argumentative organization of text and talk (Nikander, 2008). Although these common themes introduced by Nikander are typically premised on the varying forms of discourse analysis (DA) approaches, I found them to be helpful guidelines in conducting a narrative analysis as well. It was central for me to analyze how participants made sense of and used references to experienced emotional memories during interactions. In this sense of a broad narrative research framework, I posit myself toward what is called the small story approach to analyze narratives (e.g., Bamberg, 2006; Georgakopoulou, 2006, 2007). This positioning remains unstated in sub-study 4; however, as the coding of the data followed the traditional narrative analysis, its final reading and interpretation were guided by this approach referred to as narratives-in-interaction (Georgakopoulou, 2006). In all the sub-studies, the participants were regarded as active meaning makers, who, while expressing personal experiences, construct selves by drawing on cultural representations and discourses that afford and occlude certain moral opportunities and responsibilities.

Approaching data from different methodological premises in each of the sub-studies was not an end in itself, but a decision was made after reading and a tentative analysis of the data. Thus, the methods were chosen to measure up the research agenda. Next, I outline the analysis process of this study. Methodological decisions of each of the empirical sub-studies are summarized in Table 4. Each methodological concept is explained in chapter 4 to introduce the main findings of this study.

I conducted each of the sub-studies in the same order they are presented in this thesis. I had already begun analyzing the data for sub-study 2 using the data collected during the first phase. Thus, executing the study was a simultaneous process of data analysis and conducting interviews. Since the interview data of sub-studies 3 and 4 is the same, I categorized youth interviews roughly into two themes during the first reading of the transcribed data: discussion about ADHD and school life. To conduct a detailed linguistic analysis, one needs to code the transcribed text into manageable data that can be analyzed. I next illustrate the analysis phases of the sub-studies. Contrary to the manner in which the analysis process is presented in the paper, in reality, the process of transitioning from one phase to the next can be described as heuristics achieved by trials and errors.

TABLE 4   Summary of methodology of the empirical sub-studies

	Sub-study 2	Sub-study 3	Sub-study 4
Research questions	1. How do mothers of children with ADHD diagnosis construct their agency with respect to their children's schooling? 2. What types of images of school institution and its exercise of power do mothers create?	1. How do youth diagnosed with ADHD account for the ways of behaving, performing, and being in relation to ADHD? 2. What types of preconditions of moral responsibility do these accounts meet?	1. How do Finnish adolescents diagnosed with ADHD narrate the reactive CRM strategies of their teachers? 2. How do they position themselves and their teachers in these narratives?
Participants	18 mothers of children diagnosed with ADHD	13 young diagnosed with ADHD (aged 11–16 years)	13 young diagnosed with ADHD (ages 11–16)
Methodological framework	Critical discourse analysis	Discursive psychology	Narrative research
Data collection method	Loose, thematic interview outline and narrative interview methods	Semi-structured interview outline, narrative interview methods, and functional methods	Semi-structured interview outline, narrative interview methods, and functional methods
Focus of analysis	Spontaneous constructs regarding school involvement	Spontaneous talk about traits, conduct, and performance explicitly associated with ADHD	Spontaneously narrated stories about teacher's reactive CRM strategies
Analysis method	Critical discourse analysis and positioning theory	Discursive psychology inspired by conversation analysis	Narrative analysis
Methodological concept	Agency and subject position	Account	Stories and narrative
Unit of analysis	Form and function of utterances	Form and function of utterances	Narratives, positioning within the story, and narratives-in-interaction

The analysis of each of sub-study was conducted on a cross-case basis. In all of the sub-studies, the first step was to strictly code the part of the text that dealt with the focus of the analysis, that is, spontaneous/intuitive discussions about one's own actions toward school (sub-study 2), traits, conduct or performance explicitly associated with ADHD (sub-study 3), and teacher's reactive CRM strategies provided in the form of a narrative (sub-study 4), as presented in Table 4. The context of these coded utterances ranged from a sentence to a whole turn. The youths' interview proved tricky in this regard. Whereas mothers' turns were easily identifiable as they provided more or less unbroken texts and complete lines of thought, the youths' turns were broken but short and required my attempts to elicit further elaboration. For example, while analyzing the narratives for sub-study 4, a story about a teacher's conduct started in lines 76–118 of the interview transcript and then continued in lines 700–764. Occasionally, I realized a part of text I had coded was insufficient to conduct a further analysis of the function of the utterance, but yielded further context. Thus, I found myself going back and forth audio records and transcripts to comprehend the full context of the utterance.

Once the data were more manageable, I continued further categorizing it on the basis of my knowledge and understanding of the methodological concepts of each of the sub-studies: agentive subject positioning (sub-study 2), ways of account giving (sub-study 3), and evaluations of teacher conduct provided in the narratives (sub-study 4). This coding phase was tentative and served mainly as a function of getting further acquainted with the data to deepen the analysis. Thus, having performed a tentative categorization, I read through each of the coded utterance or narratives by paying close attention to the unit of the analysis (Table 4). The thread of the analysis overarching each of the sub-studies has been to direct the analytical reading of the text (audio-taped and transcribed interviews) beyond the expressed words. This was done by analyzing the form and function of language use (as per sub-study 4; see Table 4), with focus on what is done with language use in interview interactions, how it is done, and for what contextual reason and purpose (e.g., Rogers, 2004a). Form refers to morphemes, word choices, phrases, or other syntactic structures such as function to meaning or the communicative purpose a form carries (Gee, 2004). The depth of a detailed analysis of forms varied across the sub-studies depending on the research methodology. The most detailed and demanding analysis of language form was performed in sub-study 3, in which the final categorization of data was done on the basis of the analysis of the uses of passive voice, zero personifications, agentive single first persons, tenses, modalities, agentive forms, adverbs, and pronouns, whereas the use of verb expression was the primary form analyzed in sub-study 2.

Analyzing language use has been essential to gain an understanding of what ADHD means to participating family members, how they posit each other and themselves in relation to the given meanings, and under which discursively constructed moral and cultural circumstances are certain meanings summoned into being and, alternatively, denied. The functions of utterances in each of the

sub-studies dealt with negotiating one's own identity construction and moral responsibility within the constructed framework of normative expectations regarding mothering (sub-study 2), "normality" (sub-study 3), and teaching (sub-study 4).

3.3 Trustworthiness and methodological shortcomings

The trustworthiness, rigor, and quality of the qualitative study can be assessed from various aspects depending on the paradigm. Perhaps, the most pioneering and established criteria are those of Lincoln and Cuba (2000), which consider credibility, transferability, dependability, and confirmability of a study, each of which can be strengthened using various provisions and means along the research process. However, as Morrow (2005) argues, these criteria are provided as parallel to those of quantitative research. They point to post-positivist qualitative research paradigm and are not straightforwardly adaptable to a socio-constructionist research paradigm and design given their fundamentally different ontological and epistemological premises. Morrow (2005) presents three broad criteria for trustworthiness across qualitative research paradigms and design, namely subjectivity and reflexivity, adequacy of data, and adequacy of interpretation. As for the two latter, I provided a detailed description of participants and data collection and analysis earlier in this chapter, so that the reader can assess the rigor of used methods and adequacy of participant sampling. Further, in each of the empirical sub-studies, I critically examined negative cases that deviated from the dominant line of results, discussed my findings in relation to previous research in the field, and expressed the authentic voice and experience of the participants followed by detailed analysis and reasoning so that the reader assess their credibility. Thus, in this subsection, I focus on the trustworthiness and methodological shortcomings of my study in terms of subjectivity and reflexivity.

As Patton (2002) emphasizes, it is important that a researcher as a primary research instrument is transparent about one's subjectivity throughout the research process and reflectively reports how one may have influenced the study results. Qualitative interviews as a means of data collection have been debated within the discursive social-scientific field, mainly because of their researcher-provoked nature (for an outline, see Nikander, 2012). As a response to this critique, the interviews were conducted in a manner that enabled spontaneous reactions and constructs. Further, and importantly, the analysis of each of the empirical sub-studies focused on topics or phenomena that were not explicitly inquired in interviews (i.e., agency, account giving, and CRM narratives). In fact, they were not even on the present research agenda when I conducted the interviews, but rather became the focus of each of sub-study as I became more acquainted with the data and timely research topics regarding ADHD. Thus, each phenomenon analyzed in the sub-studies was evoked by face-to-face interviews and certain sociocultural expectations and conventions participants

intentionally related and associated to in a given situation, rather than a particular interview question. I consider interviews and their analysis as a collaborative production of discussions in which identity, moral, and cultural order and norms of social interaction are negotiated (e.g., Bakhtin, 1986; Potter, 1996; Bamberg, 2006; Georgakopoulou, 2006; Stokoe & Edwards, 2006). Both parties are active agents and agenda setters, and thus, the issue does not boil down to the nature of the data but the researcher's skills and sensitivity to the approach, and accordingly, analysis and data interpretation (Nikander, 2012). However, I do agree that the use of naturally occurring data obtained through, for example, video observations of classroom interactions or sent messages and other interaction between the home and school would have provided a stronger data base for a research design such as the present one.

Spontaneously provided constructs and experiences can be assumed as having been of particular importance for the participants during interview interactions, and not the least, their identity constructions. Legitimizing the research focus of each of the sub-studies using such a data-originated approach to analysis forms the methodological strength of this dissertation study. This, along with the presentation of the authentic voices, also answers to the concern Denzin and Lincoln (2000) present regarding representation, that is, "whose reality is represented in research" (Morrow, 2005, p. 254). It is given that as a researcher, I eventually rewrite and retell the participants' narratives to my audience guided by my research agenda. The representation of participants' reality could have been strengthened by conducting the research with them and/or through member checks by sharing the text to confirm the analysis and interpretations (i.e., performing participant checks) (Morrow, 2005; Patton, 2002). However, these methodological improvements were omitted owing to lack of resources (e.g., time and difficulties to contact). Although this is a shortcoming in the name of the fairness of representing results (Morrow, 2005), it can be partly justified by the methodological premise that participant constructs are to be located at a sociocultural level, rather than solely at the level of an individual mind, thus representing culturally and socially shared and upheld discourses (Hammersley, 2003).

The possibility of biased interpretations was diminished through the systematic coding of the grammatical and contextual features of the utterances. This systematic coding contributed to the controllability and, if possible, non-judgment of the analysis (Wetherell, 2001). Here, note that the analysis was conducted in Finnish. The data excerpts of each of the sub-studies have been translated to English with assistance from a language consultant and an emphasis on idiomatic translation and replicating the original verbatim records as precisely as possible. The analysis and interpretations of the study were further strengthened and confirmed using analyst, source, method, and perspective triangulation, as introduced by Patton (2002). First, I used two types of analyst triangulations: expert audit review and audience review. I cross-read the data with my supervisor during the coding phase of the analysis process for each of the sub-study. In addition, my supervisors read and commented on the manu-

script drafts, enabling a critical and sustained discussion along the research process. This expert audit review enabled the comparison of the interpretation of data within the chosen methodological and theoretical frames of each study (Patton, 2002; Bogdan & Biklen, 2006). Each of the sub-studies underwent peer-review processes, which is a rigorous, critical expert audit review process. In addition, I presented the preliminary findings of my research at international educational conferences, allowing it to be subject to audience reviews. Further, the formation of the main findings and conclusions of this dissertation study that overarch the findings of each sub-study required the triangulation of sources, methods, and conceptual perspectives, as illustrated in Table 4 (Patton, 2002).

3.4   Ethical issues

Since vulnerable participants were included in the study, a discussion on ethics is in order. The University of Jyväskylä Ethical Committee, which is committed to complying with the ethical principles of research drafted by the National Advisory Board on Research Ethics in Finland (TENK), was consulted prior to executing the research interviews. The Ethical Committee representative confirmed by e-mail that no ethical review of the research plan was needed, despite the fact that the youth participants interviewed were diagnosed with ADHD. Further, adequate information of the research, including the use and retention of the data during and after the research project, was provided and participant assent was confirmed by the interviewer when becoming acquainted with the participant (Kuula & Tiitinen, 2010). Here, I accentuate that oral and written research consent was requested from both parents and young participants individually; they were sent to their homes before the interviews took place and the participants were reminded to become acquainted with them.

To protect the participants' anonymity and integrity, all names used in this thesis are pseudonyms and minor descriptive details about participants' lives have been either changed or omitted. The chosen pseudonyms do not carry any specific associations of meanings (e.g., ethnicity and religious conviction). Rather, I chose them randomly and translated them to English to make it easier for the (non-Finnish speaking) readers to identify the sex of the participant.

Given my work experience with children and adolescents with various (medical) backgrounds and (school) trajectories, I felt confident in conducting interviews based on potentially vulnerable topics. One has to be sensitive to the participants' current situation and ensure to not pressure them into to providing an answer, irrespective of how fruitful it would be for the purpose of the research. For instance, one of the participants who was, according to his mother, eager to share his experiences with me prior to the interview seemingly avoided talking about certain school experiences he brought up in the interview, and advised me to ask further information from his mother. This suggests that the topic brought forth painful memories he did not want to relive with an unfamil-

iar interviewer or that talking about it potentially posited him in an unwanted position in a face-to-face interaction. It can also indicate discomfort of the interview interaction as he also mentioned that his mother would be able to explain the experience better than he could; it is possible that he was apprehensive about providing me with a "wrong" answer. Regardless of how experienced the interviewer is, potential threats lead a participant to perceive the situation as uncomfortable. This threat can be, however, minimized by familiarizing oneself with the participants, which was not done in my case.

Another ethical issue that should be addressed is teachers' "right to reply" to the largely negative character of this study which, by no means, is neutral or unbiased. By contrast, I have striven to present the participants' (mothers and student) voice to the best of my ability and have not presented the teachers' (or any other) perspective. I emphasize that this study does not take a stand on teachers' actual behavior or seek to establish or invalidate the "truth" of any particular perspective, but focuses on emotionally charged experiences and the related sociocultural meaning making of participated family members regarding the school life of a child diagnosed with ADHD. Voicing these experiences, regardless of the effect—that is, whether they are found poignant or disturbing—is important as it may further the conversation of how home and school can support each other as well as the child in his/her school. It should be mentioned that individual teachers and adults were praised in the interviews in general, although this is outside of the present study's interest.

Conducting research is not an objective- or ideology-free project. To this effect, one of the ethical issues I was faced with is my responsibility as a researcher to these families in terms of respectfully presenting their experiences. I positioned myself as being on their side, advocating their cause and sharing their view of ADHD. However, in the course of this research, I changed my approach to understanding ADHD. Nevertheless, I intend to detail the parents' experiences about struggling with their child's schooling in future publications. This thesis, however, does contradict their endeavor to advocate the psychomedical interpretation framework of ADHD. The findings do not show improvements in their child's school wellbeing as a result of adhering to and reproducing the psychomedical model of ADHD. Finally, I position myself as advocating the voices of these families, especially of the children who have become labeled and have been (mentally, emotionally) mistreated in their experiences of everyday school practices.

In conclusion, since I have not been either diagnosed or labeled with ADHD and have not embodied experiences associated with the disorder, my researcher position as an outsider to the disability category in question can be questioned. Thus I, a member of the majority, interpret the experiences and worlds of "them" and "others." The role of a "non-disabled" researcher advancing the cause of the disability movement has been debated in the field of disability studies. For instance, Branfield (1998), who explicitly posits herself into the disability category, argues that since the values and culture of the "nondisabled" is the object of study and the subject of demands of change, it is im-

possible for a "non-disabled" researcher to comprehend where "they" come from: "our oppression is their ['non-disabled'] responsibility" (p. 144) (for further reading, see debate between Drake [1997], Branfield [1998] and Duckett [1998]). Similarly, Teo (2010) discusses the epistemological violence of social scientist toward "others." By epistemological violence, he refers to interpretations drawn about empirical data on the "other" that shows inferiority to or problematize the "other" and has a negative impact on the "other" even when the data allow for alternative viable interpretations. These issues, I find, are a matter of rigor in conducting research and reflexivity in the reporting of it. Further, in line with Vehkakoski (2006), I find that at best, my research can contribute to a further discussion about social and discourse practice that negatively impact "others" and provide the (theoretical) tools to create change in operating environments in the realm of education.

4   MAIN FINDINGS: REPRODUCING THE CULTURE OF BLAME

> It is important not to deny the reality of some of the difficulties faced by some families, children and their teachers. I am *not* arguing that these difficulties do not exist, but rather that we need to generate a wider understanding of the range of factors that may contribute to them. (Lloyd, 2006; p. 220, author's emphasis)

4.1   Sub-study 1: obscure position of ADHD diagnosis in the context of Finnish basic education

Sub-study 1 presents an overview of how ADHD diagnosis is regarded in the context of Finnish basic education (grades 1–9 and age 7–15 years). It describes the current state of implementation of remedial and special education (SE) for children in need of special support at school and how the diagnosis of ADHD and symptoms associated with it are regarded in light of special education provisions.

Despite the rapid growth of the diagnosis of ADHD among school-aged children in Finland, the status of students "with" ADHD in the Finnish basic education is still unclear. This may be partly because in Finland, the assessment of remedial or SE provision is made on the basis of observed individual educational need(s) and behavioral characteristics, rather than diagnosed disabilities (e.g., Itkonen & Jahnukainen, 2010; Graham & Jahnukainen, 2011; Björn et al., 2016). That is, a diagnosis (or lack of it) does not directly entitle a student to or disqualify him or her from the SE provision or any other form of implementations of education. This policy and practice narrows down the gap between the professions of teachers and special educators and psychologists and accentuates teachers' responsibility in executing individualized education and collaboration between the professions.

Students diagnosed with ADHD are often categorized under a category 'varying degrees of cerebral dysfunction, physical disability or similar' (Jahnukainen, 2010) indicating that perceived problems are grounded in neurological

deficit. On the basis of the comparison of the prevalence and population served in SE, this paper concludes with assuming that this group of students is probably underserved in the Finnish school system. Although some students may well survive with the help of a regular class teacher, this is not always the case. It is also clear that the teachers need more focused courses in this area. During basic teacher education, this topic is met only occasionally. However, this raises a set of questions, which I tackle in the following chapters, such as what is this underserved group, presumably unobserved underserved needs, criteria for observations and their legitimation, and the topic that more focused courses should pay attention to?

To conclude, this study outlines the national context on which the subsequent empirical sub-studies are premise. The Finnish compulsory school provides an auspicious context to study the meanings given to ADHD. With respect to school policy, the diagnosis per se does not play a predetermined role in a student's school path. It is, thus, other forms of cultural, institutional, social, and discursive practices that constitute prevalent strong adherence to the psychomedical discourse of ADHD within the context of children's schooling in Finland.

4.2 Sub-study 2: agency construction of the mothers of children with an ADHD diagnosis in their narrated school involvement

The contemporary education paradigm highlights the interdependency of home and school expertise. This study focused on analyzing the interviews of 18 mothers of young people diagnosed with ADHD that were based on their influence on and involvement in the schooling of the children in collaboration with school. Particularly, it examined how they constructed an agency in relation to the possibilities and limitations of their involvement.

The agency was conceptualized as mothers' "socioculturally mediated capacity to act" (Ahearn, 2001, p. 112) discursively performed within certain cultural possibilities and constraints (e.g., Fairclough, 2004). The margins of agency construction became constituted by certain discourses (e.g., normative discourse of "good" parenting and psychomedical discourse of ADHD), through which mothers contextually displayed themselves as agents of a certain kind. Emanating from the positioning theory, the agency was examined through subject positioning with reference to discursively constructed social identities that entail a "cluster of rights and duties to perform certain actions" (Harré & Moghaddam, 2003, p. 6). That is, the subject is positioned to act in accordance with the cultural norms that ultimately legitimate her position, for example, as a good mother or educational expert (Tirado & Gálvez, 2007; Harré et al., 2009).

A mothers' agency positioning and the nature of their school involvement took varying forms. Forced strong agency, which was the most dominant form

of agency constructions, was expressed by positioning themselves as *advocates* and *mother lions* engaging in a power struggle with their children's schooling. In contrast, mothers' submission to a school institution was constructed through forced weak agency, which entailed subject positions of *a powerless bystander*, *a worn-out mother*, and *a withdrawing mother*. The last available, and the most scant form of agency construction, was the volitional strong agency, which emphasized the collaboration between home and school and positioned mothers as *educational partners*.

In positioning their agentive possibilities, the mothers also embodied various conventions of power in relation to their own position and the policies and practices of the school. Although mothers legitimately claimed their position of an expert concerning her child's disorder, their capability to act accordingly in the context of home–school collaborations was far more limited than intended because of unequal institutional power relations between home and school. Teachers were constructed as possessing power over the mothers' agency by either empowering the mother's volitional involvement in a partnership characterized by reciprocal trust and openness or by enabling a submissive, weak agency as a result of a domineering exercise of power. In contrast to their negative construction of the school, the mothers opposed any possible portrayal of themselves as "difficult mothers" in the interview interactions, thus highlighting their victimization by the school.

4.3   Sub-study 3: accounts of youth diagnosed with ADHD of their ADHD-related behavior

The diagnosis of ADHD serves many functions in the adult world, yet thus far, the meaning of ADHD from a youth perspective is still not fully understood. This study aimed to further our understanding by analyzing the accounts of 13 Finnish youth aged 11–16 years and diagnosed with ADHD on conduct, performance, and traits they spontaneously associated with ADHD during interviews.

An *account*, in the tradition of linguistic discourse analysis, is conceptualized as a discursive practice that individuals use to construct their otherwise undesirable behavior as culturally acceptable in relation to others and social norms (e.g., Garfinkel, 1967; Edwards & Potter, 1992). The accounts protect the self-image from valuative questioning about a supposedly undesirable act (Scott & Lyman, 1968; Sterponi, 2003) and are used in face-to-face interviews to negotiate self-acceptance along with a socioculturally shared understanding of moral norms and ADHD. Studying the accounts of the youth through qualitative interviews allows us to study ADHD as a discursive entity and thus, a sociocultural construct.

Socially undesirable behavior or traits that the youth explicitly associated with ADHD were demonstrated through three types of accounts: 1) excuses by

externalizing personal responsibility, 2) moral self-disclosures by assuming mainly retrospective responsibility through self-condemnation, and 3) justifications by resisting constructed social stigmas and re-categorizing the self in relation to them. The first two accounts reproduced the ADHD medical model as a priori premise to construct self; however, the degrees of control over the condition and desirability of adhering to the psychomedical discourse varied. The use of *excuses* ensured the accountability of behavior or traits that would otherwise be questioned because the medical condition liberated actors, at least partly, from moral responsibility. Conversely, when accountability was ensured through *moral self-condemnation*, the participants positioned themselves as rational, moral agents with the capacity to make free choices. The attributions to ADHD contradict the embodied normative ideals of behavior and being, and thus, ADHD-related characteristics are either judged or explained as absent or under control; ADHD was constructed as something to be controlled. In contrast to the first two accounts, *justifications* were derived from an inclusive discourse and advocated for an individual's unique existence by challenging the normative criteria of and the psychomedical discourse on ADHD-related behavior and the self. In terms of responsibility, justifications for one's own way of behaving are being enacted as a self-liberating counter-argument to expectations to take moral responsibility for something that is imposed and that the youth have difficulty relating to. The moral evaluative part of this account is more society- than self-oriented.

4.4   Sub-study 4: narratives of students diagnosed with ADHD of teachers' reactive classroom management strategies

In the literature on classroom management (CRM), an issue "ADHD students" are strongly associated with, the experience and voice of the children and youth diagnosed with ADHD are somewhat absent. This lack is striking considering the volume of literature addressing the issue of "managing ADHD" in the classroom from a behavioral management viewpoint with a tendency to fundamentally subdue students' voice and experiences as it did not matter or contribute to the issue at hand. This study addresses this gap in the literature by voicing the experiences of 13 Finnish students (aged 11–16 years) diagnosed with ADHD regarding teacher reactive CRM strategies, that is, remedial practices resulting from student behavior considered inappropriate (Safran & Oswald, 2003; Clunies-Ross et al., 2008). Taking a narrative approach here should contribute to a fuller understanding of the CRM phenomena in terms of ADHD.

The essence of adolescent experiences can be captured and constructed in the form of a *story* (e.g., Connelly & Clandinin, 1990; Pinnegar & Hamilton, 2011). In this study, the story is conceptualized as a sequence of events shared through a *narrative*, which is as a discursive practice of telling a story in interaction with the interviewer (e.g., Brockmeier, 2004). Stories provide a means to

elicit and relive experiences (Pinnegar & Hamilton, 2011) and the way in which stories are narrated provides a sociocultural means to make sense of and/or account for the experience (Bakhtin, 1986; Wetherell, 2001). The narrative serves, thus, as an interactional function among interlocutors or an audience, because the narrator deliberately positions not only his or herself but also the other actors of the story in relation to a socially accepted, right-and-wrong moral framework.

Five narrative types were identified, in which teacher behavior was evaluated as disproportionate, traumatizing, neglectful, unfair, and understanding. All of the narrative types provided different emphases in describing and evaluating teachers' reactive CRM strategies and in producing the accounts of one's behavior in relation to the teachers and peers. The dominant storyline involved included the construction of the narrator's classroom misbehavior as minor or contingent on the disproportion of teachers' actions or reactions (e.g., verbal abuse, punishments, and exclusion)—teacher actions were constructed to provoke, legitimize, and account for the narrators' so-called misbehavior. The way students positioned themselves in their narratives could be divided into two main types of student reaction, resistance or submission. Resistance appeared clearly in the *narrative types of disproportionate* and *traumatizing* sanctions of the teacher in that the narrators constructed resistance as the only remaining source of self-actualization for students because of the teachers' unconstructive stance and practices. Instead, in *the narratives of neglect* and *unfair sanctions*, submission became evident in the ways in which youth positioned themselves as victimized, abandoned, or intimidated in relation to teachers' action. In these narratives, including that of traumatizing, the fragility experienced was relived through the narration of long-lasting emotional (e.g., grief and shame) and social consequences (e.g., exclusion and stigma) teacher conduct had on them. Third, a receptive form of reaction occurred in the narrative of teacher's *understanding behavior*. This was the most passive characterization of one's own behavior, in which the narrator's role was expressed as content conformation to teachers' reactive strategies than active collaboration, which was longed for in the negative narrative types. It is noteworthy that ADHD had minimal significance in these spontaneous narratives and no role in narrating one's own behavior. In fact, ADHD was only referred to as being unjustly treated (i.e., stigma) in the narratives of unfair sanctions and as teachers' interpretation framework for student actions in the narratives of teachers' understanding behavior. Thus, from the narrative viewpoint, ADHD only stood out in student experiences with respect to their evaluation of teacher behavior.

5 DISCUSSION: DECONSTRUCTING THE MASTER NARRATIVE OF ADHD

> If we see the hyperactivity, impulsivity and "disinhibition" that characterize ADHD as driven by genetics and random biological dynamics, we call it a disorder and treat it with drugs and techniques of operant conditioning. If we see that same behavior as a functional response of the child to a situation that is difficult, off-putting, oppressive, abusive, irrelevant, discounting, disaffirming, and/or inhumane, we can call it a normal and understandable reaction and treat it by helping the child, family, and caretakers to fashion a better, more adaptive and life-enhancing response. (Galves et. al., 2003, p. 18)

This study aimed to further our sociocultural understanding of what it means to "live with ADHD" by researching spontaneous meanings given to and built around the concept using data from interviews of 13 young participants diagnosed with ADHD (aged 11–16 years) and 18 mothers of diagnosed children. Both mothers' and their children's narrations evidenced that the narrators internalized the idea of the young participants diagnosed with ADHD not meeting the normative expectations for "normal." However, also accentuated was the school's failure to meet a home's normative expectations. Mothers, *the voice behind the label*, expected the teachers to live up to the expectations of educational experts with willingness to support and collaborate with homes, and with adequate know-how to meet their "ADHD child" with "special needs." For youth, *the voice beyond the label*, on the other hand, it was within their normative rights both as children to be raised and empathically guided by adults acting as adults and as students to be involved in more open and respectful reciprocal interactions with teachers.

Although no conclusions on actual school practices that indicate the reproduction of deviance labeling or internalization of deviant identity can be drawn on the basis of the current research framework (cf. Hjörne, 2005; Bailey, 2014; Evaldsson, 2014; Hjörne & Evaldsson, 2015), this study corresponds with earlier arguments on the school's role as a catalyst for the growth of ADHD diagnoses and persistence of the phenomenon (e.g., Graham, 2008; Singh, 2008; Tait, 2010). This is an important notion given that the enactment of remedial or special education, or pedagogical practices in general, in Finland are not bound

to disabilities or disorders legitimized by diagnoses. As for the Finnish educa-
tion policy, thus, there are no grounds for the school institution to be positioned
as a reason to initiate a diagnosing processes of behavioral and emotional (see
ICD-10, World Health Organization, 1993a, 1993b) or neurodevelopmental dis-
orders (see DSM-V, American Psychiatric Association, 2013) or for the parents
to reproduce the medical model of disability for that matter. Despite this, the
decision to start the ADHD diagnosing process was constructed as an outcome
of normative cultural and social processes that foreground the clash of norm
expectations and maintain the contemporary values of the culture of blame. The
culture of blame gets its very vitality from moral judgments and the beliefs of
right and wrong, which following Bailey's (2014) reasoning, become naturalized
and internalized as part of one's perception of reality through school's routines,
discipline, and rituals. This study indicates the reproduction of the unequal dis-
tribution of power between home and school and social order in terms of a
school governing the performance of valued social identities (Graham, 2008;
Tait, 2010). Table 5 below summarizes the main findings of this dissertation.

The results raise two interrelated issues, which I discuss in the following
four chapters. In chapter 5.1, I cover the conflicting ways ADHD is constructed
in the narratives of mothers and their diagnosed children. I challenge the domi-
nant understanding of young people with a diagnosis of ADHD by arguing that
the psychomedical discourse mothers so strongly adhered to, relied on, and
advocated is oversimplifying to understand youth experiences of "living with
ADHD" and is not necessarily desirable. To this effect, the school plays a cen-
tral role in *the premise, promise, and betrayal of deviance labeling*. In chapter 5.2, I
discuss the norm expectations of classroom interaction as constructed by the
youth diagnosed with ADHD. I problematize the core assumption of the master
narrative of ADHD regarding school misbehavior as unconstructive. This study
accentuates the social and interactional nature of classroom misbehavior and
questions potentially predetermined and straightforward moral assumptions
on ADHD symptoms. I then further this discussion in chapter 5.3 by presenting
theoretical implications in terms of changing social and discursive practices
from the reproduction of psychopathology to promoting inclusive values. From
on this, in chapter 5.4, I problematize the dominant psychomedical approach to
cater to student needs and the entire concept and understanding of educational
need, which I argue is more about imposing institutional needs on individuals
than student's human needs. I suggest practical implications by re-
conceptualizing the concept of educational needs in everyday practices.

TABLE 5   Summary of results, conclusions and practical implications

	Sub-study 1 Overview of Finnish school system	**Sub-study 2** Mothers' agency construction	**Sub-study 3** Young participants' accounts of ADHD	**Sub-study 4** Young participants' CRM narratives	**Conclusions**
RQ 1: How is the young participant diagnosed with ADHD positioned in the interviews for them and their mothers?	A student with potential special needs	A "disordered" student with special needs A misunderstood and neglected victim	As an individual actively weighing the advantages and disadvantages of the ADHD label	As a child expecting care and respect from adults and teachers	Psychomedical discourse insufficient in providing an understanding of "life with ADHD"
RQ 2: What types of functions does the diagnosis of ADHD serve in the interviews of the youth diagnosed with ADHD and their mothers?	The diagnosis should not play a significant role in student's school life	The diagnosis is laden with the promise of recognition of a child and mother	The diagnosis is constructed either as a moral disclaimer and a priori stigma or as an excuse, i.e., made use of interactions	The significance of the diagnosis is dwarfed by the quality or importance of teacher–student interaction	Diagnosis is utilized for many purposes in social and discursive practices taken out of its original psychomedical meaning
RQ 3: How do the youth diagnosed with ADHD and their mothers position teachers and school in their interviews?	Teachers as gate-keepers to pedagogical and educational support by identifying individual needs	Teachers as hegemonic agents potentially victimize both child and mother	Schools are a venue for socialization in certain norms, values, discourses, and identity constructions	Teachers are accountable for student classroom compliance or non-compliance	Culture of blame between children, mothers, and teachers
Practical implications	Call for early intervention and need-based pedagogy	Call for knowledge-based pedagogical and socio-emotional support and empowering parent participation in home–school collaboration	Call for critical, informed, and sensitive employment of various cultural and professional narratives for one's identity construction	Call for critical inspection of the microculture of school and student–teacher interaction	Need for truly inclusive education. "School for all" in terms of (self-)acceptance, not solely accessibility for education

5.1 Premise, promise and betrayal of deviance labeling

> Ultimately, the child is a pawn on the board of recognition in this power game—and the one that is victimized. (Honkasilta, Vehkakoski, & Vehmas, 2015, p. 686)

Premise. The diagnosis process of ADHD was primarily engaged in as a response to continuous concerning feedback for a child's school behavior and performance perceived by mothers as drawn blame. Being a mother of a so-called "ADHD child," thus, became constructed as a "*project* of parenting according to medically conceived truths of behavioural disorder" in which "blame is reframed as pathological inheritance" (Bailey, 2014, p. 99, author's emphasis). That is, the child's school behavior or performance that is worrying to the mother grounds its etiology in natural rather than social conditions. Undoubtedly, engaging in this project, which subsumes the wellbeing of their child, was an act of love and care on the parents' behalf. Disturbingly, it was also strongly constructed as a school-driven necessity, leaving the mothers with no choice but to medicalize and pathologize human diversity while their attempts to enhance more inclusive understanding were disregarded.

Promise. The mothers' strong adherence to psychomedical discourse functioned as a counter-means to school practices. It was expected to promote the match between the child and school and translate as a mediator between parents and teachers through the recognition of various kinds. The mothers constructed ADHD to be recognized as follows:

1. A risk; nature-rooted deficit potentially undermining the child's life trajectory if adequate means of support are not provided.
2. A psychomedical disorder explicating the nature-rooted origins of a child's school behavior and performance.
3. The label of forgiveness (Reid & Maag, 1997; Lloyd & Norris, 1999), a value-neutral instrument of normalization dispelling counterproductive blame and establishing a setting for more a constructive approach to collaboratively support the child's schooling (see Carpenter & Austin, 2007; Austin & Carpenter, 2008; Bailey, 2014; also Singh, 2002b, 2004).
4. A para-/legal entity, an entitlement for adequate remedial or special education means due to institutionally ratified condition (see also Carpenter & Austin, 2008; Gallichan & Curle, 2008).
5. The label of humanization in terms of meeting the child with empathy and protecting their identity from being constructed upon non-valued traits.
6. The label of empowerment in terms of available resources of mothers to negotiate their agency, expertise, and identity in the realm of their child's schooling and thus, to get involved (see also Carpenter & Austin, 2008; Bailey, 2014).

The premise of labeling deviance and subsequent promise of recognition did not thus solely concern the status of the child nor advocating her/his well-being at school but the status of parents and parenting as well. Along with acquiring and internalizing, and deploying and advocating generally established psychomedical expert knowledge of ADHD takes place a transformation process from a *natural* to *professional parenting*. Being a mother of a so-called "ADHD-child" thus comes across as a necessity in terms of being recognized as a knowledgeable, "good" parent. From the viewpoint of this research, the process of deviance labeling does not tell that much about the child or the parents as it tells about our culture and society, and practices maintaining its status quo.

Betrayal. Putting aside possible societal support, the only advantage of a diagnosis that can be read from the family interviews is the absolution of blame and received understanding and support within the family (among the parents at least), which is not the case in the context of a child's compulsory schooling. As per schooling, mothers and the youth positioned themselves in relation to ADHD in divergent ways. The diagnosis, which is considered valuable for parents in terms of being involved in their child's schooling and advocating for their interests, are given conflicting meanings and effects on moral selves by those being advocated (see also Prosser 2008; Brady, 2014). As a medical entity, ADHD was simultaneously constructed as uncontrollable, controllable, and to be controlled. As a sociocultural entity, it exempted the youth from moral questioning while posing a threat of being perceived as morally questionable.

Unlike their mothers, the youth did not lay as much hope on the psychomedical explanations in terms of understanding their school experiences and who they are. Instead, they strove to distance themselves from the imposed disability category. However, escaping the category so strongly present in their family lives is unfeasible and inconceivable. The youth, thus, admitted to "having" ADHD and thus, found ways to mobilize the psychomedical discourse to their own advantage so that they are recognized in a certain way, although they did not identify themselves as being an "ADHD child" (see also Prosser, 2008; Singh, 2011; Brady, 2014; cf., Krueger & Kendall, 2001; for negotiation with other identity labels imposed in school practices, see Priyadharshini, 2011; Graham, 2015b). The diagnosis did not project value-neutral self-image for those so-labeled. Quite the contrary, it was constructed as a priori stigmatizing and thus, as something upon which the youth were reluctant to build their identities.

This study demonstrated that understanding ADHD phenomena cannot be reduced to knowledge domain of medical science since, clearly, the prevalence and *cultural need* for deviance labeling is constituted in institutional, social and discourse practices. The psychomedical discourse advocated by adults is insufficient to understand the youth experiences of "living with ADHD" and is not necessarily desirable. The youth intentionally constructed their selves in relation to ADHD, and vice versa, in the vortex of discourses internalized by them providing deeply embedded varying and contradictive cultural meanings for ADHD. The results question the uncritical use of a psychomedical interpretation framework in professional practices such as explaining the school behav-

iors of the youth diagnosed with ADHD or planning educational interventions for them (see also Harwood, 2006; Whitt & Danforth, 2010; Bailey, 2014; Freedman, 2016). First, the dominant, reductionist essentialist meaning making promoted by psychomedical discourses disregards the meaningfulness and desirability of such explanations in the young people's lives. Second, the dominant approach disregards the complexity of social interaction. It is in social interaction and discourse practices that the youth actively engaged with the label, instead of passively accepting ADHD as an imposed, unequivocal characteristic and weighed what it meant in their lives. If the experience of young people not fitting into the diagnostic category gains widespread acceptance, it might highlight the need to revise the classification, or at the very least, social practices built around it.

Since medical and normative discourses are deeply rooted in the educational comprehension of variation between individuals' behavior, *the promise of ADHD* seems to remain salient and self-sustainable in everyday social practices. The diagnostic label per se cannot be considered fundamentally undesirable, yet if the educational and pedagogical understanding of a child with difficulties in "adequately" regulating attentiveness, impulsiveness, activeness, and self-control is solely diagnosis driven and medicalized, there remains little room for the critical constructive (re-)evaluation of fundamental educational values, such as the ideas of man, learning, and power. Indeed, there are other equally important processes alongside learning in which the children need to be jointly supported by adults both within and outside the school, such as the development of social skills and a "healthy" self-image. Thus, as significant as it is to consider the academic outcomes and related means of achievement, the interaction in a school setting deserves similar positioning of significance.

5.2 Classroom management and shortcomings of the master narrative of ADHD

> [T]his is the assumption of the diagnosis of ADHD; it represents a child denied a purpose, their action is not made meaningful by the diagnosis, their purposes for misbehaviour are denied, buried beneath a language of biological determinism. (Bailey, 2014, p. 138)

ADHD is associated with teacher stress (Greene et al., 2002) and struggle with classroom management (CRM) (Kos et al., 2006). Students diagnosed with ADHD or manifesting behavior associated with it are more likely to be subjects of coercive disciplinary actions (e.g., detention and expulsion) than their peers (Loe & Feldman, 2007), regardless of such measures being reported ineffective in managing unwanted behavior related to ADHD (DuPaul & Weyandt, 2006). It would be naïve to assert that behavior related to ADHD mediate teacher-coercive strategies. It has been reported that informed knowledge and experience of ADHD can be a double-edged sword. It may promote positive attitude

and a sense of competence among teachers; however, it may also promote *less* favorable emotions toward and expectations of diagnosed children as well as *less* confidence in teacher's own competence to manage their behavior (e.g., Kos et al., 2006; Ohan et al., 2008; Anderson et al., 2012). Further to the naïve assertion, knowledge of ADHD may increase teachers' perception of ADHD symptoms as being disruptive in the classroom (Greene, 2002; Ohan et al., 2008), thus guiding their perception of behavior in terms of dysfunction that may otherwise have assumed a framing of normality (individual differences). The label itself may carry negative connotations, stereotypes, and stigma for in- and preservice teachers (Kos et al., 2006; Ohan et al., 2011) and thus, become self-fulfilling in terms of mediating teachers' (coercive reactive) CRM strategies.

Disturbingly, the dominantly negative associations of behavioral, social, and academic problems with ADHD are shared by diagnosed students (Kos et al., 2006; Eisenberg & Schneider, 2007; Travell & Visser, 2007; Advokat, Lane, & Luo 2011; Kent et al., 2011; Singh, 2011, 2013a). This bears potentially damaging effects on diagnosed students' self-esteem, motivation, and performance (Eisenberg & Schneider, 2007). While the concurrent education paradigm highlights the need to modify teacher education curricula, such that it better prepares teachers to comply with inclusive education by applying the knowledge of special educational needs (e.g., Kikas & Timoštšuk, 2015), the master narrative of ADHD is insufficient to constructively respond to the above-described self-fulfilling vicious cycle of negative interaction owing to the following three shortcomings.

First, as for CRM, a plethora of literature addresses the issues associated with ADHD, from classroom environment planning to structured pedagogy and interaction, characterized with the positive reinforcement of behavior in terms of praise, rewards, and punishments as well as relationship-based strategies built upon individual strengths and emotional support (for an extensive review of literature, see, e.g., Kos et al., 2006). This line of literature that explicitly directs to "managing ADHD" instead of meeting an individual's situational *needs* strikingly promotes the behaviorist nature and the medicalized and reductionist view of disorder, disability, and dysfunctionality of the student (e.g., Freedman, 2016). Paradoxically, however, as Cooper (2008) also notes, such pedagogical interventions that help students "with" ADHD at school help all the students as well. Thus, why allocate them to meet the "special needs" of particular, reputedly homogenous group of students (see Lloyd, 2006)? The master narrative promotes *social change through psycho-pathologization*, although such change could be carried out without deviancy-labeling processes.

Second, ADHD is determined as both the object of management and the subject of an act to be managed, positing the student as mere *neuro governed actors*, instead of intentional agents of acts deemed discordant with what is expected. Such assumptions (implicitly) adopt a stance toward the philosophical consideration of disability and moral responsibility and posit students diagnosed with ADHD as actors with no moral accountability for their actions (see Tait, 2003, 2010; Vehmas, 2011; Vehkakoski, Teittinen, & Vehmas, 2012). As I

have shown, this assumption is flawed. Instead, the youth diagnosed with ADHD proved to be moral agents aware of their actions. The issue at hand is rather that students become acquainted with several discourses (psychomedical being one of them), which they intentionally adhere to during social interactions to attain certain functions. While the master narrative promotes a *moral disclaimer through psycho-pathologization* successfully utilized by the young participants diagnosed with ADHD, the psychomedical discourse it derives from also maintains predetermined and straightforward moral assumptions on ADHD, which the youth have difficulty relating to because they do not fit into their worldview and lived experiences, as discussed in the previous chapter.

The third shortcoming of the master narrative of ADHD deals with the problematic nature of deficit-based representation. It tends to hold the knowledge and understanding of the medical condition as the fundamental starting point of constructive teacher–student relationship (see also Whitt & Danforth, 2010; Freedman 2016), and thus, promote *empathy through psycho-pathologization*. It is noteworthy that for young participants of this study, ADHD had minimal significance in narrations of the so-called "classroom misbehavior." It was merely portrayed as an offshoot of narratives that emphasized the relationship and interactional nature of classroom misbehavior over the psycho-pathology of self (see also Kendal et al., 2003; Hughes, 2007; Gallichan & Curle, 2008; Prosser, 2008; Singh et al., 2010; Singh, 2011). The master narrative guides adults to understand transgressions through a set of psychological and medical assumptions that point to dysfunctional child characteristics. For instance, emotional outbursts imply the manifestation of the impulsivity condition of ADHD. Instead, youth experiences revealed transgressions as a contextual set of interaction in which emotional turmoil was explained by teacher breaking ranks with norm expectations for adult/teacher conduct (e.g., negligence or unfairness). Further, if a teacher regards the so-called "student misbehavior" as mere maliciousness or a manifestation of a psychiatric disorder, whereas a student acknowledges his/her non-compliance with teacher's expectations as a justified reaction of frustration or anger to establish a more respectful interaction on the teacher's behalf (or due to the need for fairness, integrity, acceptance, or help), approaches to adequate intervention are problematized from the beginning.

The experience of students who potentially become labeled as disordered because of the mismatch between their actions/reactions and classroom environment, its normative expectations and teacher CRM strategies is central in understanding the pivotal nature of the relationship between teachers and those deemed troubled and troubling. The way transgression itself was occasionally constructed as "a logical, even rational response to […] behaviour management" (Priyadharshini, 2011, p. 127) points to a fundamental issue in classroom culture and practices and calls for a critical dialogue between students and teachers about norms guiding CRM discourse and practices.

5.3 Reconstructing the dominant discourse at school: theoretical implications toward inclusion

> When we unconsciously and uncritically act within our Discourses, we are complicit with their values and thus can, unwittingly, become party to very real damage done to others. (Gee, 1996, p. 190)

The findings of this study emphasize the importance of transdisciplinary approach to fully understand ADHD and harness this knowledge into practice. To this effect, Cooper (2001, 2002, 2008) applies an auspicious biopsychosocial (BPS) perspective to ADHD, in which he synthesizes psychomedical and sociocultural factors to build a complete understanding of it. This approach brings forth a more pragmatic value into the field of education than mere medical, psychological or (especially) anti-medical or sociological approaches. However, this approach as it currently stands is biased toward biopsycho-factors and would benefit from adding further weight to sociocultural factors (Singh, 2002a; Bowden, 2014; Slee, 2014, 2015).

For instance, Cooper (2008, p. 466) suggests "learning from the lesson that ADHD (for example) teaches" regarding certain children's biological predisposition "to develop ADHD" owing to their disadvantageous position vis-à-vis cultural expectations in schools and classrooms. This, he continues, could promote more inclusive education practices over factory-style mass schooling. This approach is widely utilized in the form of traditional special education in which the diagnosis is (expected to be) followed by adequate distinctive pedagogical approaches tailored to the disability or disorder (Lloyd, 2006). Such an approach can be humanizing in that it provides informed knowledge of the disorder and subsequent psychomedical understanding and means to enhance interactions, relationships, and learnings. However, treating behaviors as symptomatic can also be dehumanizing, as it may prevent stakeholders (e.g., child, family members, and teachers) and the social environment (home or school) from examining the nature of relationships and interactions or other factors being fostered that may cause or provoke the unwanted behavior in the first place[10].

I do not trivialize the important pedagogical understanding and tools developed in the realm of education guided by the psychomedical paradigm which, most importantly, have for one's part enabled the steps taken toward what Ainscow, Booth, and Dyson (2006) term *the narrow definition of inclusion*. It has provided equal opportunities for learning by promoting participation and learning of specific group of students, such as students with certain impairments or labeled gifted, and thus, towards "school for all." In this regard, in line

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[10]   A striking example of this is a tendency to explain social concerns such as criminal conduct by unidentified and untreated ADHD, thus enabling retrospective "had we known better" epiphanies and absolutions (for such explanations, see, e.g., Kewley, 1999; Siltanen, 2009; for further discussion, see e.g., Tait, 2003).

with Kikas and Timoštšuk (2015), I emphasize the importance of special educational knowledge and the know-how of teachers to live up to the ideas of inclusive education in practice. It is however the discourses of norm and deficit, and mainstream and special adhered to and reproduced in the very practice of grouping and labeling students of "specific kinds" that simultaneously poses barriers to *the broad perspective of inclusive education* by turning a blind eye to some of its quintessential values (see Ainscow et al., 2006). Inclusive education agenda arose to protest the status quo fabric of schooling that creates and maintains dichotomies such as mainstream–special, able–disable, and fundamentally, normal–other. Thus, while emphasizing the importance of special educational knowledge domain in terms of enhancing learning skills, I simultaneously withdraw myself from advocating special education practice in its traditional form which, while enabling inclusion in terms of providing "education for all" may, at worst, foreground student's weaknesses and thus, go against the tide of inclusion in terms of embracing diversity by practicing inclusion through exclusion (Graham & Slee, 2008; Armstrong, Armstrong, & Spandagou, 2011; Slee, 2013; Graham, 2015a). Slee (2013) further notes, that

> [w]e can tread the traditional special educational path and call it inclusion, but we will create more strangers, more surplus children and more exclusion. This means that we need to carefully examine proclamations of inclusive education. Many of those who describe themselves as inclusive educators are not looking for education or social reform to build engaging communities; they seek clients to practice on. (p. 906)

By exclusion, I refer to 1) *social practices* that deny the benefits of a particular classroom or school owing to the perceived attributes of the student (e.g., ADHD) (Mills, Riddell, & Hjörne, 2015) or 2) *discourse practices* that deny the establishment of a social operating environment in which human diversity and acceptance of others and self are embraced. This concern is especially timely in the case of "special needs" of students being deemed emotionally and/or behaviorally disturbed (e.g., Slee, 2014; Graham, Van Bergen, & Sweller, 2016; Honkasilta, Ylärakkola, & Kuorelahti, under revision).

BPS approaches tend to fall short in that they adapt psychomedical knowledge and individual psychopathology as a premise for interaction and thus, avoid the scrutiny of the school environment (Slee, 2014, 2015). Instead of asking to what extent negative teacher–student interaction is the source, rather than the outcome of CRM problems, this fundamentally dysfunction-based approach to CRM allows one to account for perceived student misbehavior by their condition, thus regarding the classroom environment and teacher–student interaction simply as mediating factors in the manifestation of student deficit. However, as I pointed out throughout this thesis, ADHD is a far more complex entity than a medical condition. It is also rooted much deeper in our cultural practices than to be perceived as mere forms of neurobiology-rooted reactions to external stimuli. Social practices dominantly directed by the psychomedical discourse not only maintain the psychopathology of certain cognitive and behavioral traits (e.g., lack of self-regulation, fidgeting) that could be educational-

ly intervened regardless of diagnoses, but also harness such psychopathology as a means of *social normalization* (Cohen, 2006a; Tait, 2006; Slee, 2010). That is, an individual who manifests certain otherwise indefensible traits, behavior, and performance is supposed to appear as more acceptable to the rest of the members of society once diagnosed with a somewhat compulsive, nature-originated condition. This is not enough to promote inclusive education in terms of (self-)acceptance.

A potential way to weed out some sociocultural practices hindering inclusive education practices, and perhaps, strengthening the mobilization of the BPS perspective of ADHD into education practices, is to pay serious attention to discourses employed in explaining and characterizing the individual traits of behavior, performance, and self in everyday interactions and practices. The dominant cultural everyday discourses pose problems of child activity as individual phenomena subject to medical diagnosis and intervention (Norris & Lloyd, 2000; Danforth & Navarro, 2001). When complex social and educational problems are uncritically and straightforwardly reduced to a psychomedical deficit using the language of disorder and dysfunction, one may internalize problems as solely based on the individual (see Krueger & Kendall, 2001; Harwood, 2006; Graham, 2007b). The internalization of deficit-based language and discourses as part of one's worldview and self-perception can be harmful for the child's identity construction as they may perceive themselves as fundamentally defective—a view the diagnostic label alone promotes (also e.g., Cooper & Shea, 1998; Brady, 2005; Singh et al., 2010). Further, the discourse analysis study of Graham (2015b) about how boys in "behavior" schools negotiated their self-characterizations against the negative characterizations they faced in everyday language use highlights the powerful role language plays in shaping perceptions of self and others. Therefore, given that the discourse practices of the youth in interview interactions reproduce unquestioned cultural values and reflect and shape available social identities, it is not the psychomedical but the inclusive discourse in terms of values of embracing human diversity that should be mobilized in everyday educational practices to free individuals from experiencing difficulties due to cultural (self-) blame.

To conclude, inclusion cannot be achieved only through pedagogical practices but through changes in social and discursive practices shared by home and school. It cannot be fully achievable if one of the forms of practice—cultural, institutional, social, or discourse (see chapter 2.3)—does not cohere with the values of inclusion. Thus, inclusion is about not only directive or material changes but also, and fundamentally so, a change of mindset manifested into practices (see e.g., Dyson, 1999; Saloviita, 2001; Ainscow, 2005, 2007; Ainscow, et al., 2006; Graham, 2015a; Jahnukainen, 2015). Along with the change of mindset, discourses adhered to in everyday education practices ought to be changed. This means, that discourses currently referred to as inclusive are referred to as normative in the future. As long as labels such as ADHD used in vernacular are recognized and internalized as stigmatizing, the inclusive principle of "school for all" does not come true, as those who inhabit the space of abnormal do not

have entry into the space of those marked as normal (Kittay, 2006). In this regard, the question guiding (reputedly) inclusive education practices is: what are the types of identities made available to those deemed having "special" needs?

5.4 Reconstructing educational (special/remedial) need: practical implications toward inclusion

> Well [my teacher] was kind of like that; she was cheerful and so it helped […] in a way she could see the bright side of things, she didn't immediately think negatively […] so it was easier to control myself. (John, 12 years old)

Catering to students' individual educational (remedial/special) needs has become an emergent trend in contemporary compulsive education policy-making rhetoric and practices. In theory, this seems to live up to the ideals of inclusive education, which is recognized as a guiding paradigm of providing compulsive schooling by The United Nations General Assembly (1993). This reading depends however on which of the many interpretation frames or discourses of inclusion and inclusive education one adheres to (see, Dyson, 1999; Armstrong, Armstrong, & Spandagou, 2011; Walton, 2015). The core of inclusive education in its "broad" sense is to respond to *learner diversity* and barriers experienced by the learners arising fundamentally from existing ways of thinking (Ainscow, 2005, 2007; Ainscow et al., 2006). Paradoxically, inclusion and need rhetoric have merged with traditional special education practice and rhetoric, and the contemporary education paradigm reads more as responding to the *diversity of learning* (e.g., Graham & Slee, 2008; Miles & Singal, 2010). It embraces learning mainly as an assessable and measurable academic process, progress and performance, and (identifying) the need for customized learning has become a merchandise of science eligible to be harnessed by commercial vendors (Adams, 2010; Armstrong et al., 2011; Tomlinson, 2012; Slee, 2014). One of the challenges in education is cultivating social change that promotes the growth of self-accepting and self-actualizing social agents, or the so-called soft outcomes of learning.

As Vehmas (2010, p. 91) notes, defining something as a "special need" in educational practices is not a matter of an empirical fact or objectivity, but "a matter of making normative value judgements of what is good and valuable for pupils, and people in general." To this effect, I propose a way to conceptualize needs in educational practices that are devoid of value-laden normative judgments. Glasser (1996, 1997) took a contradictory position to mainstream approaches of psy-sciences to deviance and mental disorders and CRM by emphasizing that individuals (can only) control their own behavior and are willing to comply if their basic needs for belonging, power, freedom, and fun are satisfied. The argument of his *choice theory* is that changes in behavior must be made freely, and not as a result of rewards, threats, or punishments (Glasser, 2000; Bucher & Manning, 2001/2002; see also Kohn, 1999; Deci, Koestner, & Ryan,

2001; Lewis, 2001; Roache & Lewis, 2011). Similarly, the self-determination theory (SDT) focuses on contextual social conditions that either facilitate or forestall the natural processes of self-motivation and "healthy" psychological development. SDT maintains the interrelatedness of innate basic psychological needs for competence, autonomy, and relatedness and human motivation (Deci & Ryan, 2000; Ryan & Deci, 2000). These basic psychological needs "constitute the nutriments that are required for proactive, optimal development, and psychological health of all people" (Deci & Vansteenkiste, 2004, p. 25).

My conceptualization of need is derived from a communication process called *nonviolent communication* (NVC) established by Rosenberg (2003a, 2003b), which emphasizes the importance of everyday social interaction. The process maintains two premises: 1) people strive to fulfill their needs "alive" in them (e.g., need for respect) in every situation they are in (e.g., classroom), by every action they do or do not (e.g., does not comply with teacher's request), and through different strategies they choose (e.g., shout at teacher); 2) people are willing to promote others' wellbeing, that is, strive to fulfill the situational needs of others, as long as it is voluntary. Thus, although a theory of empathic interaction, not motivation, this approach entails similarities with afore humanistic psychology approaches by accentuating the importance of freedom of choice as a premise for willingness to comply with the requests of others and by considering needs as a universal and humane force underlying every human action. NVC does not, however, approach the needs by limiting to the somewhat hierarchical categorization of basic needs but applies a broad vocabulary of varying situational needs. Often, the *chosen* strategies (e.g., shouting at a teacher) may not be reckoned socially acceptable by other participant(s) or self or either result in satisfying the need in question (e.g., need for respect) for that matter. I find, however, the focus of the NVC approach on face-to-face interaction applicable here for further discussion on the concept and practice of educational (special or remedial) need.

A psychomedical approach guides knowledgeable social agents to see beyond the actual act through the lenses of psychomedical pathologization in order to react accordingly (e.g., student shouts at the teacher because of ADHD's impulsion condition). However, students who have ADHD, or some other diagnosis, share the same humane needs as the other students, school personnel, and parents in terms of everyday interaction, such as the need for affinity, friendship, security, acceptance, trust, joy, happiness, support, learning, help, respect, recognition, being heard, among numerous others. This is the universality premise of understanding human needs (e.g., Rosenberg, 2003a, 2003b). Regarding the unwanted act as a manifestation of unmet situational need(s) (e.g., need for more respectful interaction) rather than a manifestation of individual psychopathology provides a more constructive here-and-now approach to CRM and a basis for the further implementation of interactional and pedagogical (intervention) strategies to enhance the classroom climate and academic learning. The focus is on striving to understand the individual instead of her/his behavior.

I explain this with an example. Alex moves non-stop on a chair and feels restless and bored because of his situational needs for action and meaningfulness are not met at the moment. Having seen Alex's constant movement, the teacher might feel annoed because of the need for order and structure, and concerned owing to need for contributing to students' learning. Simultaneously, some of the students might feel joy because their need for fun is met by Alex's movement; they might even intentionally provoke him further to fulfill their need for fun as well as affinity with other students taking part into provocation. By contrast, some students might feel annoyed because these actions disturb their learning, or unsecure because they have a need for certainty that the actions of others do not end in chaos in classroom. I argue that this way of conceptualizing everyday classroom interaction is more constructive than the one deriving from disability discourse (Alex "has" ADHD or manifests symptoms of the hyperactivity condition of the disorder) or normative discourse (Alex and his provokers are malicious and disrespectful), because it provides more constructive basis for further implementation of pedagogical and CRM strategies, in this case, to address the needs for action, meaningfulness, structure, affinity, security and learning. At simplest, many of these needs could be addressed by agreeing with the class on terms of movement that enables the learning of those in need of action while respecting peace and order required for learning by others.

A more in-depth understanding and conceptualization of educational (special or remedial) need or needs for customized learning is in order. Their current conceptualization and realization into practice do not regard the actual needs of students, such as the need for being heard, respected, or accepted by self and others. Instead, the concept of educational (special or remedial) need signifies different strategies to achieve certain imposed educational, mainly academic (or behavioral) learning goals. The concept represents society's *institutional need*, for instance, for social order and survival disguised in needs rhetoric and imposed as student's needs for learning when, in reality, we are talking about the apparatuses of socialization.

Indeed, there is a definite difference between learning as an institutional objective imposed by others (e.g., teachers and parents) and demanded from the student, and learning as an endogenous need according to which an individual directs one's actions (see Deci & Ryan, 2000; Ryan & Deci, 2000; Deci & Vansteenkiste, 2004). In this vein, in her study on effects of therapeutic interventions in project-based educational practices dealing with young adults who were on the margins of society in Finland, Brunila (2012, p. 460) aptly concluded that "the focus of therapeutic intervention seems to be on working towards an ideal individual who is flexible in accordance with the needs of the economy." The educational need ethos disregards students' actual human needs in the context of everyday interactions and authorizes experts such as special need teachers, teachers and psychologists to possess power over parents' and students' voice and agency in deciding what students "need."

In the Foucauldian sense, the educational (special or remedial) need ethos authorizes the power of governance toward maintaining the idea of "normality." The pious idea and rhetoric about educational, remedial, or special need or special need education absolutely construct a reality in which the one in need deviates from those who are not, since the sense of need is constructed in relation to ideas of the so-called "normal" development, "normal" behavior, "normal" cognitive functioning, "normal" performance, and "normal" home life (Vehmas, 2005, 2010; Tait, 2010). Ones who cannot obtain the position within the frameworks of "normality" become absolutely positioned outsiders, also by themselves (Kittay, 2006). At worst, the need as it is currently conceptualized and executed in practice is nothing but a pious henchman of blame.

For instance, if the student experiences the transition from a mainstream classroom to a remedial one stigmatizing, it cannot under any circumstances be considered fulfilling his/her needs for acceptance, appreciation, or integrity, although it might fulfill the teacher's needs for respect and competence. This hardly meets the teacher's, principal's and parents' needs for contributing student's socioemotional wellbeing at school either. When the student's (special or remedial) educational needs such as learning are at stake, it could be beneficial to recognize and account for those whose other needs are (indirectly or unintentionally) affected as well, such as a student's need for affinity and respect, teacher's needs for control, competence, and respect, and parent's need for collaboration, support, and respect. It would especially be of importance to distinguish between institutional (imposed) "needs," other hidden motives, and actual individual needs and focus on those of individuals while executing the curriculum in everyday interactions (for such hidden motives, see e.g., Van Bergen et al., 2015). Thus, the question those practicing inclusive education ought to ask is: whose and which needs are they catering for and by what means and ends?

Students, parents and teachers positing each other as the antagonists of CRM stories by invoking the sociocultural role and norm expectations do not bring about solutions; on the contrary, this only distances both parties from each other and from taking joint responsibility for CRM and strengthens the culture of blame. Instead, it would be beneficial, humane even, to base everyday interaction upon *independency* and *reciprocity*; the former refers to the ability to recognize and express one's own situational needs and find strategies to fulfill them while still respecting others; the latter means the ability to understand others' situational needs and adjust one's own behavior according to those of others (see Rosenberg, 2003a, 2003b). In other words, it is necessary to recognize and become conscious of students', parents', and teachers' basic human needs that need to be acknowledged and fulfilled in everyday interactions, without reciprocal normative condemnation in the practices of the other party. Following Rosenberg (2003b), needs are not discordant with another but imply strategies to meet them by means of varying CRM strategies (see also Roache, 2009).

To conclude, I have provided a moral judgment-free conceptualization of situational educational need that does not reproduce normative (e.g., student is

malicious), deficit (e.g., student lacks certain valued abilities) or disability (e.g., student "has" ADHD) discourses and, thus, fortify able–disable and normal–other dichotomies. I have aimed to create basis for need rhetoric and practice that goes beyond normative expectations and psychomedical explanations and that regard needs of individuals rafter than apparatuses of socialization. As regards classroom misbehavior, I have shed light upon *the nature of interaction* at the core of the execution of various CRM and pedagogical strategies, whether they derive from the knowledge domains of psychomedical or special educational understanding or mere common sense. Resonating with this, two recent Finnish doctoral dissertations focused on how young prisoners (Äärelä, 2012) and students labeled underachievers (Kautto-Knape, 2012) (both group characteristics being attributed to "ADHD life trajectories") gave meanings to their comprehensive school experiences. Longing for a nurturing and caring school culture and teacher–student interaction played key roles in the participants' perception in both studies; empathy, equity, and respectfulness were some teacher traits emphasized in the young prisoners' narratives (Äärelä, 2012). Given the emotional, social, moral, and normative spaces of the narratives of mothers and the youth, the experiences recounted here call for a deepening of the conversation of CRM to address the empathic nature of home–school and teacher–student relationships. A relationship built on reciprocal openness, sensitivity, trust, and respect as well as individual needs is fundamental to the healthy and efficient execution of CRM strategies and home–school collaboration (e.g., Angell, Stoner, & Shelden, 2009; Roache, 2009). Perhaps, meeting human needs could also be adopted as the basis for the so-called "ADHD management guidelines" to truly hear the voices beyond the label.

> THERE IS A TIME to admire the grace and persuasive power of an influential idea, and there is a time to fear its hold over us. The time to worry is when the idea is so widely shared that we no longer even notice it, when it is so deeply rooted that it feels to us like plain common sense. At the point when objections are not answered anymore because they are no longer even raised, we are not in control: we do not have the idea; it has us. (Kohn, 1999, p. 3)

5.5 Significance of the study and recommendations for future research

Earlier ethnographic research on how school policy and practice direct deviance diagnoses (e.g., Hjörne & Säljö, 2004, 2014a) and the deployment of psychopathology in everyday social and discourse practices (e.g., Hjörne, 2006; Bailey, 2014; Evaldsson, 2014; Hjörne & Evaldsson, 2015) has provided valuable insight into understanding how the master narrative of ADHD and related discourses attain their legitimacy in school practice. This study complements this line of research by providing theoretical tools for questioning the premises asserted in the master narrative of ADHD and sufficiency and desirability of deploying psychomedical discourses to make sense of individual traits, behavior, and per-

formance related to ADHD (and other so-called invisible disabilities) and human needs. With connection to this, I have posed two guiding questions for educators who (claim to) practice inclusive education:

1) What are the types of identities made available to those deemed having "special" needs?
2) Whose and which needs are they catering for and by what means and ends?

Explaining the undesirable conduct using psychopathology is a value choice and so is critiquing such a practice. In future, as far as it is possible, research design that goes beyond researcher's value judgments is needed. Especially research on classroom and home–school interaction, CRM strategies, and facilitation of discourses and practices that may distract educators from meeting individual needs in the name of special education needs could benefit from interdisciplinary mixed method approach. To become conscious of each party's individual needs, future research on CRM issues and ADHD would tremendously benefit from studying video observations of natural everyday classroom interactions and using the obtained video data to voice both students and teachers' viewpoints and experiences. In this way, both parties could have access to each other's experiences and interpretations as afforded by the same (objective) observation. This could deepen the dialogue between teachers and students and guide them to jointly find CRM strategies, which both parties are willing to commit to. Thornberg (2009) concludes his fieldwork in two Swedish primary schools by stating that students are seldom given a voice in creating, modifying, or abolishing formal rules by adults, but their inclusion in school democracy with adults is rather illusory, thus directing them to merely confirm authorities' proposals. This suggested research design could provide a promising base for intervention toward a more democratic and respectful collaboration between teachers and students, which promotes student responsibility over CRM.

Another contribution this study makes is to give a voice to the families "living with ADHD" in terms of home–school collaboration in Finland (see also Sandberg, in press). Given that in Finnish education policy diagnosis does not play a predetermined role in a student's school path, it was parents who especially wanted their voice to be heard—who pleaded for them and their children to be recognized. The most dominant answer to the question of why parents wanted to participate in the study was to help other families, so that they would not have to follow the same trajectories. These experiences remained marginal in this study and should be detailed in future research. In addition, the subjective views of guardians, teachers, and children diagnosed with ADHD as well as their siblings should be closely considered to get a fair and full picture of home–school collaboration in the context of ADHD or other "remedial needs," which in part are derived from the requirements of school institutions. It would be of importance to harness this knowledge into educational practice in a way that does not subdue the voice and agency of either party.

TIIVISTELMÄ

Äänet ADHD:n takana – Diagnoosille annetut merkitykset diagnosoitujen nuorten ja heidän vanhempiensa puheessa

Tämä tutkimus on vetoomus niiden lasten puolesta, jotka tulevat piilotetuiksi stereo-typioiden ja leimojen taakse – jotka lopulta itse piiloutuvat niiden taakse – sekä ve-toomus sellaisten vuorovaikutuskäytänteiden puolesta, jotka ottavat lasten tunteet ja tarpeet huomioon ja siten tukevat heidän kasvuaan ja kehitystään. Lapsen kohtaami-seen ei tarvita diagnooseja eikä muita identiteettileimoja.

Keskustelu aktiivisuuden ja tarkkaavuuden häiriön (ADHD) ympärillä pohjau-tuu pitkälti lääketieteelliseen diskurssiin, joka on yleisesti hyväksytty kodin ja koulun arjen käytänteisiin: lapsen toimintaa ja niin sanottua erityisen tuen tar-vetta selitetään neurobiologisella poikkeavuudella. Tämän diskurssin ympärille on rakentunut kulttuurisesti hallitseva kertomus (master narrative) "adhd - oppilaista", joilla on pakottavien oireidensa vuoksi hankaluuksia koulun aka-teemisilla ja sosiaalisilla osa-alueilla ja tämän vuoksi vertaisiaan suurempi syr-jäytymisriski – oppilaista, jotka ovat "hankalia opettaa". Lasten ja nuorten adhd -diagnoosien määrän jatkuva kasvu kertoo kuitenkin ennemmin kulttuuris-samme ja yhteiskunnassamme valloillaan olevista arvoista, normeista, asenteis-ta ja käytänteistä kuin lääketieteen kehittymisestä saati lasten tai nuorten lisään-tyneistä, ainoastaan yksilön synnynnäisistä ominaisuuksista johtuvista vaike-uksista. Tämä artikkeliväitöskirja sijoittuu yhteiskuntatieteellisen vammaistut-kimuksen ja erityispedagogiikan tutkimustraditioiden risteykseen. ADHD:ta tutkitaan kulttuurisesti, yhteiskunnallisesti ja poliittisesti rakentuneena ilmiönä empiirisesti sellaisten perheiden näkökulmasta, jotka elävät "ADHD:n kanssa" tämän rakentumisprosessin keskiössä. Tutkimuksen fokuksena ovat 18 ADHD - diagnosoidun lapsen äidin ja 13 diagnosoidun nuoren ADHD:lle rakentamat spontaanit merkityksenannot diagnosoidun nuoren koulunkäyntiä koskevassa haastattelupuheessa.

Tutkimuksen pääkysymykset olivat:

1. Kuinka diagnosoitu nuori positioidaan nuorten ja äitien haastattelu-puheessa?
2. Minkälaisia funktioita ADHD -diagnoosille rakennetaan nuorten ja äitien haastattelupuheessa?
3. Kuinka opettajat ja koulu positioidaan nuorten ja äitien haastattelu-puheessa?

Tutkimuksen teoreettinen viitekehys pohjautuu sosiaaliseen konstruktionismiin ja diskurssianalyysiin sen laajassa viitekehyksessä. Näin ollen puhe nuoren adhd:seen liitetyistä piirteistä sekä kouluun liitetyistä kokemuksista ei kerro pelkästään puheen kohteen piirteistä, vaan puhujan ymmärryksestä koskien tiettyjä kulttuurisia konventioita, normeja, ihanteita ja niin edelleen, joihin hän tilanteisesti haastatteluvuorovaikutuksessa kiinnittyy ja joita hän puheellaan

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tuottaa (esim. Nikander, 2008). ADHD:n lingvistisen rakentumisen tutkiminen on ikkuna tarkastella ja ymmärtää koti- ja kouluinstituutioiden sosiokulttuurisia rakenteita, ei yksilön ominaisuuksia. Näin ollen, mitä viime vuosikymmeninä kiivaana käytyyn debattiin ADHD:n olemassaolosta ja todellisuudesta tulee, tämän tutkimuksen tieteenteoreettinen lähtökohta on että 1) ADHD on olemassa oleva abstrakti, kielellisesti tuotettu ilmiö, joka 2) saa todellisen, konkreettisen merkityksensä kulttuurisissa, institutionaalisissa, sosiaalisissa ja diskursiivisissa käytänteissä.

Haastatteluaineisto analysoitiin lingvistisen diskurssianalyysin perinteitä soveltaen. Analyysi keskittyi tuotetun puheen kielellisiin piirteisiin, puheen tuottamisen tapoihin ja tuotetun puheen tilanteisiin funktioihin haastatteluvuorovaikutuksessa, joilla neuvoteltiin identiteetin rakentumisesta ja moraalisesta vastuusta kulttuuristen normiodotusten viitekehyksessä (esim. Gee, 2004). Analyysimenetelmät solsivat kriittisen diskurssianalyysin, diskursiivisen psykologian ja narratiivisen analyysin traditioita. Kriittinen diskurssianalyysi pitää sisällään oletuksen siitä että se, mitä puheella tuotetaan ja tehdään, tapahtuu tiettyjen reunaehtojen, kuten valtasuhteiden määrittämänä, ja että analyysin fokus tulee olla näiden valtasuhteiden paljastamisessa (esim. Fairclough, 1992). Diskursiivinen psykologia sitä vastoin omaksuu lähtökohdakseen puheella tuotettujen todellisuuksien olevan valtasuhteista riippumatonta, jolloin analyysi kohdistuu kulttuuristen merkitysantojen ja eri toimijoiden keskinäisten suhteiden ymmärtämiseen ilman kriittistä, auttamatta ideologista asennoitumista (esim. Potter, 1996). Narratiivinen analyysi taas pyrkii ymmärtämään puhujan kokemuksia niiden kulttuurisessa viitekehyksessään (esim. Bakhtin, 1986).

Äitien ja nuorten tavat rakentaa merkityksiä adhd:lle ja sen ympärille olivat ristiriidassa keskenään. Äidit kiinnittyivät vahvasti lääketieteelliseen diskurssiin. Lapsen diagnosoiminen näyttäytyi koulun sanelemana kulttuurisena tarpeena, joka piti sisällään lupauksen tunnustetuksi tulemisesta niin heidän lapselleen kuin äideille itselleen. Lapsesta rakentui "ADHD -oppilas", äideistä "ADHD -lapsen" vanhempia. Kyseinen etuliite on kulttuurisesti värittynyt; se sisältää erilaisia olettamuksia kosken lapsen piirteitä, toimintaa ja "tarpeita", institutionaalisia oikeuksia, vastuita ja velvoitteita, moraalista vastuuta, ja sosiaalisen kanssakäymisen luonnetta. Se, että koulu näyttäytyi tunnustetuksi tulemisen pelikenttänä, on jo itsessään mielenkiintoinen havainto ottaen huomioon, etteivät suomalaisen peruskoulun tuen tarjoamisen järjestelyt kiinnity lääketieteellisiin selitysmalleihin van lapsen yksilölliselle tuen tarpeelle. Foucault'laisen ajattelutavan mukaisesti tämä ei ole kuitenkaan yllättävää, onhan koulu portinvartija "normaaliuden" ja "erilaisuuden/erityisyyden" maailmojen välissä (esim., Tait, 2010).

Nuoret sitä vastoin neuvottelivat aktiivisesti identiteettiään suhteessa diagnoosiin ja lääketieteelliseen selitysmalliin sen sijaan, että olisivat passiivisesti hyväksyneet ADHD -etuliitteen identiteettinsä rakennuspohjaksi. Nuoret rakensivat ADHD:n samanaikaisesti lääketieteelliseksi oireyhtymäksi joka vapauttaa moraalisesta vastuusta, kulttuuriseksi "erilaisuudeksi", josta tuli ottaa moraalinen vastuu, sekä ulkoapäin määrittyneeksi a priori stigmaksi, josta mo-

raalisen vastuun ottaminen merkitsisi sellaisten vallitsevien normien hyväksymistä, joihin nuorilla on hankala samaistua ja jotka heidän on hankala saavuttaa. Siinä missä äidit (voices behind the label) rakensivat yksilöpatologiaa lapsensa edun nimissä, nuorten (voices beyond the label) puheessa rakennettiin myös yhteisöpatologiaa.

Sekä äidit että nuoret rakensivat adhd:seen liittämäänsä "erilaisuutta" suhteessa koulua ja opettajia koskeviin normatiivisiin rooliodotuksiin. Äitien puheessa opettajuuteen sisälletyt asiantuntijuus ja kasvatuskumppanuus odotukset tulivat petetyiksi. Nuorten puheessa opettajiin kohdistetut rooliodotukset olivat kaksijakoiset: ammattinsa puolesta opettajien odotettiin mahdollistavan kunnioittava ja osallistava vuorovaikutusilmapiiri oppilaiden kanssa, opettajiin kohdistuneet aikuisen rooliodotukset taas edellyttivät heidän kohtaavan oppilaat, lapset, empaattisesti. Sekä äidit että lapset rakensivat pääsääntöisesti negatiivista kuvaa koulusta, jossa opettajat olivat epäonnistuneet turvallisen, sosioemotionaalista kasvua tukevan ympäristön luomisessa.

Tämä tutkimus asettaa psykolääketieteelliseen selitysmalliin kritiikittömästi kiinnittyvät käytänteet kyseenalaiseksi kasvatuksen kentällä, sillä se on yksistään riittämätön selittämään havaittuja ja koettuja ongelmia kouluvuorovaikutuksessa ja ymmärtämään diagnosoitujen lasten ja nuorten kokemusmaailmaa, saati heidän tarpeitaan. Se on myös riittämätön muodostaaksemme kokonaiskäsityksen siitä, mistä ADHD:ssa on kyse. Tämä tutkimus korostaa poikkitieteellisten selitysmallien tärkeyttä ymmärtääksemme ilmiöitä kuten ADHD (ja muut ns. näkymättömän vammaisuuden kategoriat) ja tarjoaa teoreettisia työkaluja poikkitieteellisten selitysmallien käytäntöön panemiseksi inklusiivisen koulun kentällä.

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ORIGINAL PAPERS

I

ADHD IN THE CONTEXT OF FINNISH BASIC EDUCATION

by

II

POWER STRUGGLE, SUBMISSION AND PARTNERSHIP: AGENCY CONSTRUCTIONS OF MOTHERS OF CHILDREN WITH ADHD DIAGNOSIS IN THEIR NARRATED SCHOOL INVOLVEMENT

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III

SELF-PATHOLOGIZING, SELF-CONDEMNING, SELF-LIBERATING: YOUTHS' ACCOUNTS OF THEIR ADHD-RELATED BEHAVIOR

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IV

**"THE TEACHER ALMOST MADE ME CRY"
– NARRATIVE ANALYSIS OF TEACHERS' REACTIVE
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BY STUDENTS DIAGNOSED WITH ADHD**

by