

Children's Attention Deficit/Hyperactivity Disorder Self-Help Books and the Politics
of Correction

by

Rachel Gold

B.A. (Hons.), McMaster University, 2002

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of
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Abstract

AD/HD is a prevalent medical diagnosis given to 3-7% of children in British Columbia. Since the diagnosis' inception in 1902, children's behaviour has been described in similar ways, but labels to define it have continuously changed, reflecting the diagnosis' mutability and connection to shifting discourses of normativity. An analysis of moments in the text of 13 children's self-help books illuminates that the process books refer to as correction is actually a disciplinary process exercised in children's social relations, which guide them to act according to socially constructed notions of normative behaviour. I draw two conclusions from my research: (a) the correction of AD/HD-diagnosed children is a political process supported by a complex network of power relations and (b) diagnosed children's lives are emmeshed in practices of disciplinary power that establish, and maintain, their state of being normalised.

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I am in awe now, more than ever, of the intricacy and power of a network of social relations.

Dedication

Dr. Dan Offord, with his humility and passion, showed me how change is possible.
To Dr. Dan and his gaggles of kids, I dedicate this thesis.

Frontispiece

*The Story of Fidgety Philip*¹

Let me see if Philip can
Be a little gentleman
Let me see, if he is able
To sit still for once at table:
Thus Papa bade Phil behave;
And Mamma look'd very grave.
But fidgety Phil,
He won't sit still;
He wriggles
and giggles,
And then, I declare
Swings backwards and forwards
And tilts up his chair,
Just like any rocking horse; -
"Philip! I am getting cross!"

See the naughty restless child
Growing still more rude and wild.
Till his chair falls over quite.
Philip screams with all his might.
Catches at the cloth, but then
That makes matters worse again.
Down upon the ground they fall.
Glasses, plates, knives, forks and all.
How Mamma did fret and frown.
When she saw them tumbling down!
And Papa made such a face!
Philip is in sad disgrace.

Where is Philip, where is he?
Fairly cover'd up you see!
Cloth and all are lying on him;
He has pull'd down all upon him.
What a terrible to-do!
(continued on next page)

¹ A poem medical historians cite as the first description of what is currently referred to as Attention Deficit/Hyperactivity Disorder (AD/HD) (National Institute of Mental Health, 1996; Thome & Jacobs, 2004).

(The Story of Fidgety Philip, continued from previous page)

Dishes, glasses, snapt in two!
Here a knife, and there a fork!
Philip, this is cruel work.
Table all so bare, and ah!
Poor Papa, and poor Mamma
Look quite cross, and wonder how
They shall make their dinner now.

(Hoffman, 1844)

Chapter 1 - Introduction

Practices of correction are pervasive. Whether to mend a broken bicycle, fix a failed mathematics examination, or get out of a depression, individuals are constantly in pursuit of a state of correction. What it means to correct is based on particular standards of normativity. One fixes a bicycle based on a common understanding of how it is supposed to work, one re-writes a failed mathematics examination because a college policy manual explains that a mark of B is acceptable to move to the next course, and one goes to counseling to achieve the widely portrayed expectation of what it means to be happy.

In some cases, though, normativity is difficult to define. Take the example of depression: What is a normal mood? What does it mean to be happy? Smiling or laughing from morning until night? Depression and other biomedical diagnoses, such as Anorexia, Fibromyalgia, or Obsessive-Compulsive Disorder, are based on the medical profession's definition of what it means to be normal. Yet definitions of diagnoses are often in flux, changing as new diagnostic manuals are published and as new research emerges. As well, discourses that shape the formation of medical diagnoses are constructed from only particular individuals' and institutions' ideas of what it means to be normal. Medical diagnoses are simply an effect of discourses of normativity. In her articulation of this notion, Moss writes: "diagnosis is, in itself, a social construct, a category full of meaning derived from multiple practices within biomedicine" (forthcoming, p. 261). Because medical diagnoses are specific to particular knowledges, they cannot be seen as markers of definitive bodily states.

Rather, diagnoses signify bodily states that are constructed as disordered through the circulation of particular discourses.

Although there are many ways to measure and understand bodies and behaviour (even from culture to culture, the same bodily state can be interpreted in a multitude of ways) medical diagnoses in western society are predominantly accepted as decreed (Lupton, 1997; Timimi, 2005). Once ascribed to an individual, a medical diagnosis activates the implementation of corrective activities in an individual's life so that he or she can change to adhere to the definition of normativity to which his or her diagnosis subscribes. Correction for problems deemed to be medical can involve enhanced observation (by a doctor, parent, or counselor); confinement to particular spaces; and engagement in activities such as filling out symptom tracking charts, or engaging in behavioural modification programs. Almost always, processes of correction are attached to the use of labels that demarcate the individual as *other*, enabling him or her access to particular resources or exempting him or her from particular activities.

Medical diagnoses, once given to an individual, add two dimensions of a subject positioning into the life of that individual beyond their already complex empirical subject positioning². The first additional dimension is the *abnormal subject positioning*, which extends an individual's empirical subject positioning to include an additional set of discourses of normativity that both frame the individual as

² I use the term *empirical subject positioning* to describe an individual before he or she is ascribed with a medical diagnosis. I understand empirical subject positioning to include a host of competing and complementary power relations that are inevitably positioning the subject and acting through, upon and with it. I do not intend my use of the term empirical to imply that the individual can ever be separate from power relations.

disordered, and suggest that through the engagement with particular practices, the individual can become corrected. The second additional dimension added after diagnosis is the *normalised subject positioning*, which extends the abnormal subject positioning to include an engagement with practices of correction for individuals to adhere to socially constructed norms of bodily or behavioural activity. Correction processes activated by medical diagnosis guide abnormally-positioned individuals to take up a normalised positioning.

Scholars influenced by Michel Foucault have shown the ways in which power shapes and produces the correction that individuals experience once they are ascribed with a medical diagnosis (e.g., Harding, 1997; Lock, Epston, Maisel, & de Faria, 2005; Sik-Ying Ho, 2001). In this thesis, I use the medical diagnosis of Attention Deficit/Hyperactivity Disorder (AD/HD) as a site to explore the organization of power in diagnosed children's lives. I explore how power relations guide children's movement from being positioned as abnormal to being positioned as normalised. AD/HD is a constructed concept. Its very nature is political because as a label, it activates disciplinary power to enforce particular ways children are expected to engage in their world. My thesis is located within, and builds upon, a politics of correction. I set out to explore the web of power relations that shape the correction of AD/HD-diagnosed children.

AD/HD: An entrée into the politics of correction

AD/HD is the most commonly diagnosed childhood psychiatric disorder in the United States (Singh, 2004). Three to seven percent of children in British Columbia are diagnosed as having AD/HD (British Columbia Ministry of Education, 2001).

Discussion of AD/HD is prevalent in academic literature, in fact there is an academic journal dedicated exclusively to its study (*Journal of Attention Disorders*, Sage Publications). Articles about the AD/HD diagnosis appear in journals of many disciplines including medicine, educational psychology, psychology, counseling, nursing, criminology, and sociology. The examination of AD/HD saturates popular media as well – it is the subject of television specials (e.g., Erbe, 2007), magazine articles in women’s journals (e.g., Hodges, 2007), newspaper columns (e.g., Shapiro, 2007), and radio shows (e.g., Handman, 1998).

AD/HD’s formal history spans just over 100 years. Although the diagnostic category’s name has changed since its formal genesis in 1902, all of its iterations have consistently defined children’s behaviour as abnormal and have prompted techniques for its correction. Drawing on Foucault’s argument that power saturates all relations and knowledge (including concepts like AD/HD and the discourses that support them), AD/HD is an effect of normative discourses of childhood behaviour. As an effect of one particular way of understanding bodies and behaviour, AD/HD is something much more complex than a category by which children can be objectively measured and in which they can be formally placed (Foucault, 1990). Rather, AD/HD is a label that measures children based on a socially constructed notion of normativity.

Furthermore, Foucault’s notion that power imbues all relations suggests that once given to children, AD/HD activates the deployment of power to shape their unruly behaviour into socially acceptable behaviour. While the diagnosis itself transforms a child’s empirical subject positioning to an abnormal subject positioning,

the power relations that are produced by the diagnosis articulate a space for the child to shed his abnormal subject positioning and embody a normalised subject positioning. This is correction. The correction process is comprised of the deployment of power through explicit interventions, and also its deployment in more subtle ways in the child's daily social life. The deployment of power in both explicit and subtle ways effects correction of children's behaviour so that it has the capacity to reach the normative threshold for social behaviour defined by the AD/HD diagnostic category. In addition to the circulating relations of power with which most children engage in their empirical subject positionings (e.g., gendered, familial, social, peer, educational, class-based, and racialized), AD/HD evokes an added set of power relations that infuses the day-to-day lives of diagnosed children as they learn to become normalised.

To those who accept medical discourses without dispute, an AD/HD diagnosis labels a medical dysfunction and precipitates intervention so that the diagnosed child becomes corrected. My research is based on a different premise. I begin with the notion that medical discourses, like all discourses, are socially constructed. Accordingly, I see that AD/HD stems from particular and highly mutable discourses of normativity. Once given to a child, the diagnosis triggers social relations that both incite and compel him³ to adhere to the manufactured threshold of normativity defined by the AD/HD diagnostic category. While described as a correction process,

³ In this thesis I deliberately use the male pronoun when I refer to singular children. Using "his/her" glosses over gender as a social process and the power relationships within those gendered dynamics. While I save a study of the gendered aspects of AD/HD for another project, I cannot ignore that AD/HD is a gendered category that, at least on the surface, affects more boys than girls (Kelly, 2000).

this movement toward a particular threshold of normativity is actually the social construction of acceptable behaviour, which is comprised of power relations that shape a disciplinary process to enforce socially constructed ideals of childhood behaviour. This project is about the politics associated with the social construction of children with AD/HD diagnoses. It is about the politics of correction.

Motivation for research

My interest in exploring the circulation of power in children's lives is motivated by my experiences working with AD/HD-diagnosed children. As a youth and family counselor in elementary schools, summer camp staff for children labeled *at risk*, and educational assistant, I discovered that the AD/HD diagnosis infiltrated children's identities. AD/HD informed the way children understood themselves; the way they interacted with their peers and siblings, teachers, and parents; and their day-to-day activities. The extent to which AD/HD saturated the lives of the children with whom I was working felt problematic to me. I saw children who had lots of energy, whereas others saw them as disordered. This discrepancy piqued my curiosity and concern about the ways in which normative discourses of childhood behaviour were infiltrating the day-to-day lives of children.

Although my motivation for conducting this research is grounded in my concern about the extent to which AD/HD becomes entwined in diagnosed children's identities, the purpose of this thesis is to develop an understanding of AD/HD-diagnosed children's correction by framing that correction as a practice of power and learning more about the operation of that power. My discomfort about AD/HD might emerge in this project, though it is with every intention that I attempt to remain

focused on the question-at-hand (until chapter 5, *Conclusion*, where I freely discuss future research directions). Once I have a clearer sense of the operation of power in diagnosed children's lives, I will be in a better position to explore the actual affects of AD/HD on children themselves.

Research query

My research investigates how the deployment of disciplinary power guides AD/HD-diagnosed children to conform to a normative standard of social behaviour through their existing social relations. To address this question I study children's storybooks and guidebooks about AD/HD because, like many texts, these books freeze moments in time. I examine these moments as sites wherein the deployment of power might influence children's behaviour so that unruly children will act in socially acceptable ways. Because scholars have shown that self-help books represent the social world, my study also lends itself to general inferences about the exercise of power in the lives of real AD/HD-diagnosed children (e.g., Hochschild, 1994).

Overview of chapters

In Chapter 2, *The Literature as Context*, I review the academic literature relating both to AD/HD and ways of understanding how it activates the exercise of power in children's lives. I begin by describing the history of AD/HD through an examination of its transformation from simple description of a lively child in a short 1844 poem to today, when messages about AD/HD as a biomedical disorder saturate everyday life. Then, I explore literature on AD/HD drawing specifically from three disciplines that dominate academic research on the diagnosis: medicine, educational

psychology, and psychology. I find that literature in these three disciplines emphasizes social intervention strategies intended to correct children. Next, I turn to the ideas of Michel Foucault to consider another way to understand correction.

In chapter 3, *Methodology*, I outline my use of Gore's (1995) Foucaultian analytics of power, a methodological approach well-suited to my study of power. Then, I describe my source of data – 13 books for children about AD/HD. Finally, I recount my process of data collection and address methodological limitations.

Chapter 4, *Analysis*, includes a presentation of my data. First I offer my analytical findings, touching on general hegemonic, or prevailing, descriptions of children in the books, detailing the results of my research, and introducing the analytical concepts I developed to help me understand normalisation in text. Next, I describe the two major analytical insights that I gathered from my data: (a) AD/HD activates the political disciplinary process of correction and (b) the correction process that AD/HD activates transforms the very nature of diagnosed children's lives.

In chapter 5, *Conclusion*, I summarize my project, offer final commentary, and detail future research directions that can follow from my research.

Before I move to chapter 2, two words demand definition: “power,” and “normal.” I rely on Foucault's understanding of *power* as signifying the circulating energy that flows between, and within, individuals and institutions (Foucault, 1990). This energy is produced by intricate networks of relations and goes on to produce the ways in which individuals and institutions relate to themselves and to one another. *Normal* refers to the socially constructed idea of a standard that defines what is

typical or expected. I use the word normal to describe the state of behaviour from which AD/HD signals a departure, and to which processes of correction aim.

Chapter 2 - The Literature as Context

Much has been written about AD/HD in academic literature. The abundance of literature on this topic is not surprising given the prevalence of children who receive the diagnosis. Although some current North American studies note a 3% prevalence rate (National Institutes of Health, 1998), others claim that up to 16.1% of children have the disorder (Faraone, Sergeant, Gillberg, & Biederman, 2003).

AD/HD, while prevalent today, is rooted in a history dating back to the early 1900s.

AD/HD's history shows that labels for particular behavioural tendencies come from society's changing expectations of the way children should act. Since the first public declaration that unruly behaviours were a medical problem, in 1902, and continuing today when AD/HD infiltrates academic literature and popular media, children's behaviour has been described in similar ways. What has changed is how individuals and institutions regard, understand, and react to that behaviour. As the formal labels and hypothetical aetiologies for the behaviours have transformed since 1902, one idea has remained constant: children with restive behaviours are abnormal and need to be corrected.

After over 100 years as a topic of study and after numerous transformations in name and definition, the diagnosis currently called AD/HD is discussed predominantly in three academic disciplines: medicine, educational psychology, and psychology. (Discussions in educational psychology and psychology tend to accept that the diagnosis is a medical phenomenon and take it up as a medical problem within their individual disciplines.) Current academic literature on AD/HD in these

three disciplines focuses primarily on intervention strategies for AD/HD. An emphasis on intervention signals the importance that medical discourse places on correcting the behaviour of diagnosed children. In its discussion of interventions, literature points to social interventions as particularly popular means of correcting children's behaviour. There are four sites within which social interventions can be enacted: education and the school system, familial relations and extended family, daily interactive social network, and the individual himself.

Intervention strategies are intended to correct a child deemed by his diagnosis to be abnormal. Interventions work by replacing AD/HD-associated behaviours with behaviours understood to be normal. Using Foucault's concepts of power and discipline as a guide, I see the correction of the individual as a disciplinary process whereby the individual learns to conform to socially constructed expectations of what it means to be normal (Foucault, 1995, p. 184). As I will explain in the section *Correction and Foucault's theory of power*, later in this chapter, Foucault's notion of disciplinary power suggests that a productive network of social relations underlies the correction process. I am interested in exploring the power dynamics in AD/HD-diagnosed children's lives as they engage with practices of correction.

What makes the correction process of children with AD/HD diagnoses a particularly dynamic object of study is that the goal of correction, normativity, is defined based in society's changing definition of normal childhood behaviour. AD/HD's history indicates that children's behaviour has remained relatively consistent since the diagnosis' inception – rather, societal tolerance for particular

behaviours has shifted. That is to say, the diagnosis is a social construction, not an individual pathology.

History

Compared to many illnesses that have been documented for hundreds to thousands of years, the diagnostic category of AD/HD has a relatively short history. The text commonly cited as the first documented case of AD/HD (dated 1844) is *The Story of Fidgety Philip* about one child and his active behaviour (Hoffman, 1844; reproduced in the frontispiece of this thesis; National Institute of Mental Health, 1996; Thome & Jacobs, 2004).⁴ The poem depicts a child, Philip, at his family's dinner table. Philip is described as rude and wild, and has trouble sitting still. He breaks glasses, yells loudly, and at the end of the poem, tumbles to the ground with the tablecloth in tow. This short poem has been retroactively designated as the first case of AD/HD, though it was not a medical document but simply one poem in a children's poetry anthology.

In 1902, 58 years after the publication of *The Story of Fidgety Philip*, doctors began developing medical labels to describe children's inattentive and unruly behaviour. Although the hypothesized causes of the behaviour described by those medical labels have shifted since 1902, the assumption that such behaviour is a problem rooted in the individual has remained unaltered.

In my review of the literature recounting AD/HD's history, I found four distinct junctures in its evolution. The first juncture was in the early 1900s when

⁴ In his history recounting the evolution of AD/HD, Helmerichs (2002) describes the diagnosis' origin in the work of Plato (428 – 347 BCE) who wrote about moral behaviourism. For fuller explanation, see Helmerichs (2002).

society began to see inattentive childhood behaviour as a medical problem; the second juncture took place over the subsequent 40 years as medical practitioners endeavoured to locate the aetiology of unruly behaviour; the third juncture is marked by the discovery of chemical intervention to alter behaviour; and the fourth juncture is characterized by the diagnosis' placement in the American Psychiatric Association's *Diagnostic and Statistical Manual*, with an increasing number of diagnosable children with each new diagnostic descriptor.

AD/HD's History: Junctures 1, 2, and 3, 1902 – 1940s

The first juncture of AD/HD's formal history took place in 1902 when George Still gave three public lectures called *Some Abnormal Psychical Conditions in Children*, in which he described energetic and inattentive childhood behaviour as a medical problem (Still, 1902a, 1902b, 1902c). Still's lectures, which were subsequently published in *The Lancet*, a popular medical journal, claimed that unruly behaviour is a defect in moral direction wherein children had no "control of action in conformity with the idea of the good of all" (1902a, p. 1008). Still described his study subjects using adjectives such as passionate, angry, spiteful, deceitful, shameless, unruly, indecent, slow, inattentive and overactive (all of these adjectives pervade current descriptions of diagnosable children).

The subsequent 35 years mark the second juncture in the development of AD/HD during which the medical community drew a connection between particular behaviours and brain injury, and began to label these behavioural conditions. From the early 1900s through the 1930s, medical practitioners maintained that an individual's lack of behavioural control was a medical problem related to physical

impairment. Doctors were becoming increasingly attuned to how brain-related impairments including the effects of the 1917-1918 encephalitis outbreak, birth trauma, head injury, toxin exposure, and infections, were effecting children's behaviour. Consequently, doctors developed the label *brain-injured child syndrome* to describe children identified as suffering from a brain injury and exhibiting unruly behaviour. To describe similar unruly behaviour in children both with, and without, brain injury, psychiatrist Alfred Strauss re-named the phenomenon *minimal brain damage* (Strauss & Lehtinen, 1947). This diagnosis remained uncommon for some time, though. In fact it was not included in the 1957 publication of a commonly used text called *Child Psychiatry* (Lakoff, 2000).

The third juncture in the evolution of AD/HD began with the initiation of pharmaceutical intervention to correct children's behaviour deemed abnormal. In 1937, Dr. Charles Bradley experimented with amphetamines on children living in a home designated for those with behavioural problems (Lakoff, 2000). Bradley found that benzedrine, a type of amphetamine, reduced the unruly behaviour in children who were diagnosed with *minimal brain damage*. Bradley was amazed with the effects of benzedrine. He wrote:

To see a single dose of benzedrine produce a greater improvement in school performance than the combined efforts of capable staff working in a most favorable setting, would have been all but demoralizing to the teachers, had not the improvement been so gratifying from a practical viewpoint. (Bradley, 1937, p. 582)

Bradley's astonishment at the ability of benzadrine to enable children to fit into their school environment was soon mirrored by other doctors; his discovery prompted the widespread use of pharmaceutical intervention to alter children's behaviour (Bradley 1937; Conrad, 1975). Bradley's discovery reinforced the underlying premise of the evolving diagnosis - that a child's unruly behaviour is a problem rooted in the child himself. Accordingly, Bradley's discovery about the effects of amphetamines represents the prevailing notion that in order to alter a child's behavior, the child, rather than the child's social context, should be the target of intervention (Moynihan & Cassels, 2005; Moynihan, Heath & Henry, 2002).

AD/HD's History: Juncture 4, 1940s - today

The fourth, and current, juncture in the development of AD/HD sustains the idea that behavioural problems are rooted in the individual. Characteristic of this stage is a process of multiple shifts in the diagnostic category's name and a rapid increase in the number of children who fit the criteria for diagnosis. By the 1950s, the diagnosis *minimal brain damage*, was renamed *hyperkinetic impulse disorder* and was formally entered into the American Psychiatric Association's (APA) Diagnostic and Statistical Manual (DSM), the most commonly used source for mental health diagnoses (Baumeister & Hawkins, 2001; Brandau & Pretis, 2004; Psychosocial Paediatrics Committee, 2002). The introduction of *hyperkinetic impulse disorder* formalized the shift from describing the hypothetical *origin* of the symptoms (as *brain-injured child syndrome* explicitly did, and *minimal brain dysfunction* alluded to) to describing the *symptoms* of the disorder (Barkley, 1997), a shift supported by the research of psychiatrist Stella Chess in 1960 (Chess, 1960). The 1968 edition of

the DSM (DSM-II) included the diagnosis *hyperkinetic reaction of childhood*, which maintained, in its name, the focus on the behaviour's symptoms. This second edition of the DSM was based in psychodynamic theory, which suggested that psychiatric struggles were a product of early life circumstances (American Psychiatric Association, 1968). The theoretical focus of DSM-II acknowledged an individual's immediate environment as a factor in producing behavioural struggles, but, like all other previous formal documentation of behavioural diagnoses, ignored the role of broader social context in shaping individual's behaviour. By 1975, *hyperkinetic reaction of childhood* was the most commonly diagnosed childhood mental health condition (Conrad, 1975).

The incipient recognition of the role of an individual's social environment in affecting behaviour in the DSM-II disappeared in 1980 when the medical community's conceptual shift to biomedicine underpinned the DSM's next manual, DSM-III. In DSM-III the diagnosis was renamed *Attention Deficit Disorder (ADD)* (American Psychiatric Association, 1980). Biomedicine views psychiatric struggles as originating within the individual which means that an individual's health and/or behaviour is not seen to be connected to social, personal, or environmental influences (Karnik, 2001; Moss & Dyck, 1999; Rogler, 1997). Alongside its representation of the DSM's theoretical shift to biomedicine, ADD expanded the diagnostic category's reach to include disturbance of attention, in addition to the disturbance of activity. In the DSM-III, ADD had three significant dimensions: attention deficit, hyperactivity, and impulsivity (American Psychiatric Association, 1980).

In the fourth edition of the DSM (DSM-IV; American Psychiatric Association, 1994) the medical community renamed the diagnosis *Attention-Deficit/Hyperactivity Disorder* (AD/HD), the current name for the diagnosis. This new name explicitly encompasses the separate dimensions of ADD. As well, its broadened definition expands the number of diagnosable behavioural characteristics, which has led to an increase in the number of diagnosable children. As with ADD, three core behaviours characterize AD/HD in the DSM-IV: inattention, hyperactivity, and impulsivity (American Psychiatric Association, 1994). The DSM-IV elaborates on each of these behaviours. Inattention is described as ignoring detail, having challenges understanding instructions and exhibiting difficulty organizing plans and categories (American Psychiatric Association, 1994; Flick, 1998). Impulsivity is considered impatient and interruptive behaviour that lacks self-control (American Psychiatric Association, 1994; Flick, 1998). Hyperactivity is defined as an inappropriate (given the person's age or environment) level of activity, including fidgeting and restlessness (American Psychiatric Association, 1994; Flick, 1998). The AD/HD diagnostic category also includes associated behaviours such as aggression, poor self-esteem, memory problems, and inconsistent behaviour (American Psychiatric Association, 1994; Flick, 1998).

As the name of the diagnosis has changed from *hyperkinetic reaction of childhood* in the DSM-II to AD/HD in DSM-IV, so have the number of children who meet the diagnostic criteria (Conrad & Potter, 2000). The change in diagnostic criteria from the DSM-III to the DSM-III-R (a 1986 revised edition of the manual that further expanded the definition of ADD), resulted in a 100% increase in the number

of children who were diagnosable with ADD (Lindgren et al., 1994, as cited by Timimi, 2002). Subsequently, the expansion of diagnostic criteria from the DSM-III-R to the DSM-IV increased the number of diagnosable children from 10.9% of the general populace to 17.8% – an increase of approximately two-thirds (Baumgaertel, Wolraich, & Dietrich, 1995). In other words, in 1980 a population of 1000 would have 50 diagnosable children (DSM-III), while in 1986 the same population would have 109 diagnosable children (DSM-III-R), and in 1994 the population of 1000 would have 178 diagnosable children (DSM-IV).

The history of AD/HD reveals an incremental appropriation of childhood behaviours by the medical community. Fidgety Philip, in Hoffman's (1844) poem, held one general subject positioning – his empirical subject positioning. Today, Philip would be diagnosed with AD/HD and subject to interventions meant to correct him. The diagnosis itself would add to his empirical subject positioning with an abnormal one, producing another dimension to his existence as an active child - one of engagement with correction. Then, Philip's correction would focus on changing his behaviour and body from his abnormal subject positioning (as a restive, active, loud child deemed dysfunctional) to a normalised subject positioning (as a calm, attentive, quiet child that the socially constructed definition of AD/HD determines he could, and should, be). As well, AD/HD's history suggests that not only are children with particular behaviours deemed dysfunctional, but their dysfunction is seen to be a problem rooted in one place: the individual himself. Based on the individualized focus of AD/HD and its previous iterations, Fidgety Philip's correction today would be focused exclusively on altering him.

Conventional Literature

To learn more about the process I wish to deconstruct, namely, the exercise of power in the lives of children who are diagnosed with the socially constructed label of AD/HD, I examine conventional literature in the realms of medicine, educational psychology, and psychology – three disciplines that extensively examine the diagnosis. I consider conventional literature to be the journal articles and books that accept, as a foundation, that AD/HD is a medical disorder. Although the conventional literature on AD/HD focuses extensively on the diagnostic process and the relationship between AD/HD and other biomedical labels (e.g., comorbidity), it is predominantly centered on discussions of correcting children’s behaviour through intervention. Intervention signifies the immediate entrance of particular practices of correction into the lives of AD/HD-diagnosed children. As such, an exploration of the conventional literature’s focus on intervention is useful to pursue an understanding of how power relations infuse the everyday lives of diagnosed children.

Biomedicine as a backdrop

Biomedicine is widely accepted as authoritative knowledge on bodies and behaviour (Lupton, 1997). Currently, in the realm of mental health, the biomedically grounded DSM-IV is the standard guide from which medical practitioners, who act as conduits of biomedical information, make diagnoses (National Institute of Mental Health, 2006). Yet, the literature on how physicians make an AD/HD diagnosis is limited. In describing the diagnostic process of AD/HD one medical text concludes “[i]n the final analysis, the decision as to whether the child has ADHD is always subjective” (Accardo, 1999, p. 880). However, a diagnosis of AD/HD, once made,

generally becomes an indelible label; it is a biomedical diagnosis that can make a permanent mark on a child's life. My inquiry into how power circulates in diagnosed children's lives accepts the biomedical framing of AD/HD as a given and delves instead into the social dimensions of the process of correcting AD/HD-diagnosed children.

Intervention strategies in the conventional literature

Conventional academic literature about AD/HD focuses on child-centric, or individualized, intervention strategies to correct the behaviour of AD/HD-diagnosed children. Intervention strategies are techniques used to correct children's behaviour so that it meets particular expectations of normative childhood behaviour. Many interventions are biochemical, involving pharmaceuticals to change AD/HD-defined behaviour (Shukla & Otten, 1999). Other interventions are enacted within the context of a child's many social networks, through their relations with others (Bussing, Koro-Ljungberg, Williamson, & Garvan, 2006). Often a blend of biochemical and social interventions are proposed.

The conventional literature approaches intervention in two ways: researchers explore *types* of intervention, or ways of correcting children's behaviour (e.g., medical, policy, social), and they describe *sites* of intervention, or the contexts in which children's behaviour can become fixed (e.g., doctor's offices, education and the school system). I will review types of intervention (medical, policy, social) and then focus on the sites where *social* interventions take place. I examine sites of social intervention because of my interest in how the AD/HD activates particular exercises

of power in children's existing social relations (relations they had before being given the diagnosis of AD/HD).

Types of Intervention

Interventions meant to correct children with AD/HD take three main forms: medical, policy, and social. Medical interventions, which are mostly pharmaceutical, alter the biochemistry of an individual, and are a popular approach for modifying behaviour associated with AD/HD. In fact, between 1990 and 2002 there was an 800% increase in the production of Ritalin, a drug commonly prescribed for AD/HD (Moynihan & Cassels, 2005). Alongside Ritalin, some of the more popular prescription drugs prescribed for AD/HD are Adderall (by Shire), Dexedrine (by GlaxoSmithKline) and Concerta (by McNeil) (Flick, 1998). Conventional literature highlights that pharmaceutical drugs can change an incorrigible child into a manageable child by reducing restlessness, lengthening attention span, and increasing self-esteem (Flick, 1998). As well, pharmaceutical drugs have been shown to effect a short-term decrease in aggressive behaviour, reduction in anti-social behaviour and improvement in academic performance as well as heightened focus and attention (Hinshaw, 1994; Singh, 2002). Side-effects associated with pharmaceutical interventions include appetite suppression, disrupted sleep, headaches, and tics (Hinshaw, 1994). Other less-prescribed, but still common, medical interventions are EEG neurofeedback (e.g., Doggett, 2004) and diet regimes (e.g., Johnson, 1988; Feingold, 1974; Schnoll, Burshteyn, & Cea-Aravena, 2003). Medical interventions are intended to transform AD/HD-associated behaviours into normative behaviours by directly targeting and changing children's bodies.

Policy interventions, like medical ones, focus on changing the individual. Unlike medical interventions though, policy interventions operate in a less physically intrusive way. Policy interventions mediate the interface of the individual and society by establishing guidelines and expectations to which children are expected to adhere. Policy guides how individuals interact with their environments. For example, British Columbia's Ministry of Education makes explicit in its *Special Education Policy Framework for BC* (1995) that "Individualized Education Plans" (IEPs) are to be established for children with special education needs (often including children diagnosed with AD/HD). The Ministry describes an IEP as: "a documented plan developed for a student with special needs that describes individualized goals, adaptations, modifications, the services to be provided, and includes measures for tracking achievement" (BC Ministry of Education, 1995, np).

The BC Special Education Policy Framework (1995) focuses on changing the individual's (and teachers' and parents') expectations for learning through adapted learning plans so that the individual will fit into a preexisting, inflexible system that defines the AD/HD-diagnosed child as having special needs. Policy, as a type of intervention, although less intrusive and explicit than medical intervention in that it is not about directly modifying a child's body, still emphasizes the goal of changing the child to adhere to normative behavioural outcomes (in this case, a standard of what it means to be successful in school). The policy disregards any notion that if the general school environment were different, the individual child might not have special needs at all.

In contrast to less-prevalent policy interventions for AD/HD, social interventions are a widespread means of modifying the behaviour of children with AD/HD diagnoses (Bussing, Koro-Ljungberg, Williamson, & Garvan, 2006). Social interventions employ behaviour-modifying techniques based in children's relations with others to correct AD/HD-associated behaviour so that it meets socially acceptable standards. Conventional literature proposes a variety of social interventions to correct children. These include enhanced observation, behaviour-tracking charts, special therapeutic groups, removing unruly children from the classroom, classroom-wide interventions, and social-skills training. Social interventions emerge in all arenas of children's lives – from the classroom to the playground, from the breakfast table to the homework desk. While medical interventions directly modify a child's biochemistry, and policy interventions have a more abstract role in a child's life, social interventions have the capacity to infiltrate seemingly all of a child's daily interactions. In the next section I step aside from medical and policy interventions and exclusively examine sites of social intervention, as I narrow in on my exploration of the powerful relations that are an effect of a child's ascription with AD/HD.

Sites of Social Intervention

My interest is how a child's daily social life is mediated by their AD/HD diagnosis. To explore the effects of AD/HD on children's lives, I need to understand more about how their everyday interactions change once they are diagnosed. An examination of social interventions proposed by the conventional literature is one way to do that. From my review of the literature I find four sites within which social

interventions can take place: education and the school system, familial relations and extended family, daily interactive social networks, and the individual. The literature frames each site as an avenue through which behaviour deemed abnormal can become normalised through a particular type of social interaction.

Intervention techniques in education and the school system include: classroom management techniques (e.g., Harlacher, Roberts, & Merrell, 2006; Ladd, 1971), effective teaching strategies for children with AD/HD diagnoses (e.g., Berthold & Sack, 1974; Kos, Richdale & Hay, 2006), and general school behaviour management such as *Positive Behaviour Supports* (see Harlacher, Roberts, & Merrell, 2006) and *The ADHD Classroom Kit* (see Anhalt, McNeil, & Bahl, 1998). Positive Behaviour Supports, for example, involves a three-tiered management system that includes altering the AD/HD-diagnosed child's location in the classroom, removing external classroom distractions, and continuously managing the child's behaviour (Harlacher, Roberts, & Merrell, 2006). The ADHD Classroom Kit outlines school-based social interventions that include "corrective strategies, environmental adaptation, positive programming and teaching, and emotional bolstering" (Anhalt, McNeil, & Bahl, 1998, p. 154). Interventions in the education and school system such as Positive Behaviour Supports and The ADHD Classroom Kit indicate how correction seeps into a wide range of facets in children's school day - from shifts in the child's physical environmental to continuous emotional engagement.

Children spend a significant portion of their day-to-day lives in the school setting, which suggests that schools play a vital role in children's development. The prevalence of interventions enacted in education and the school system suggests that

schools also play a major role in correcting AD/HD-diagnosed children's behaviour. From this site of intervention alone it is evident that AD/HD-diagnosed children's daily lives are infiltrated with social interactions that are explicitly meant to change their behaviour so that it meets a socially constructed threshold of normativity – from regulatory techniques like “positive programming” and “corrective strategies,” to distributive techniques like changing a child's classroom location and “environmental adaptation,” to individualizing techniques like continuous behaviour management and “emotional bolstering” (Anhalt, McNeil, & Bahl, 1998; Harlacher, Roberts, & Merrell, 2006). Corrective measures infuse all aspects of the social environment of the school.

Alongside education and the school system's involvement in correcting children, the conventional literature explores a child's daily interactive social network as an avenue through which children with AD/HD diagnoses can learn to behave like non-diagnosed children. A child's daily interactive social network refers to the peers the child encounters on a day-to-day basis. The literature describes peer tutoring (e.g., DuPaul & White, 2006; Harlacher, Roberts, & Merrell, 2006), peer coaching (e.g., DuPaul, Ervin, Hook, & McGoey, 1998; Plumer & Stoner, 2005), peer monitoring (e.g., Harlacher, Roberts, & Merrell, 2006), and peer assessment (e.g., Hoza, 2005) as means to correct children. Some of the specific techniques involved in the above peer-based interventions include enhanced monitoring (having students “catch” one another displaying particular behaviours and scoring behaviour on daily goal form), and intricate regulation (scripted tutoring and rewarding both peer and AD/HD-diagnosed student for improved behaviour) (Harlacher, Roberts, & Merrell, 2006;

Plumer & Stoner, 2005). Techniques that reward both the peer and diagnosed child for the diagnosed child's improved behaviour illuminate the extent to which peers become invested in the correction process. Peers themselves get rewarded for behavioural improvements of the diagnosed child they are helping to correct. Evidently, the social lives of children are subject to a significant shift after an AD/HD diagnostic ascription. The diagnosed child's peers can become deeply invested in his normalization.

In addition to the school system and interactive daily social networks as sites of intervention, there are social interventions that take place in a child's network of familial relations and extended family. In particular, researchers focus on two types of familial social intervention: parental training and tutoring (e.g., American Academy of Family Physicians, 1997; Hook & DuPaul, 1999) and behaviour modification in the family (e.g., DuPaul & White, 2006; Flick, 1998; Pelham Jr., Wheeler & Chronis, 1998). Specific means of correction in the family include detailed monitoring of behaviour using daily charting techniques (DuPaul & White, 2006) and the establishment of clearly articulated family rules, including posted punishments for misbehaviour (American Academy of Family Physicians, 1997). After a long day at school where they are engaged in corrective relations, children with AD/HD diagnoses return home to another site where correcting their behaviour seems to be a priority.

With three sites of social intervention (school and the education system, daily interactive social network, and familial relations and extended family) the correction process seemingly encroaches every aspect of a child's daily life. It is difficult to

imagine any other part of a child's life from which interventions can come. Yet the conventional literature suggests one more site of social intervention – the individual. Although the individual intervening on himself is less explicitly a social intervention since it only involves one party, I identify it as social because it is about how the child relates to, and interacts with, himself in the context of his everyday life. In its discussion of self-interventions, the literature seemingly establishes a fourth subject positioning of the child beyond his empirical subject positioning, abnormal subject positioning, and normalised subject positioning: a monitoring subject positioning. When positioned to self-monitor, the child becomes responsible for his own transformation from abnormal to normalised by exercising power in particular ways. Interventions that are to be directed by the self include self-regulation training (e.g., Kühle, et al., 2007; Reid, Trout, & Schwartz, 2005), self-monitoring (e.g., Harlacher, Roberts, & Merrell, 2006; Reid, Trout, & Swartz, 2005), and self-discovery programs (e.g., Cullen-Powell, Barlow, & Bagh, 2005; Frame, Kelly, & Bayley, 2003). Some of these interventions include a child learning to notice and record a target behaviour during and after an activity (Reid, Trout, & Swartz, 2005), and sensory awareness (e.g., self-hand massage) (Cullen-Powell, Barlow, & Bagh, 2005). Interventions that individuals engage in to correct themselves are based in the child understanding that there is an achievable normalised subject positioning. Through the exercise of corrective practices, such as self-regulation, a self-monitoring child can work towards bringing his abnormal subject positioning to a state of normalisation.

Education and the school system, extended social network, familial relations and extended family, and the individual are the four main sites of social intervention

presented in the conventional literature. These sites of intervention comprise a child's entire social network and infuse his daily life with very specific, detail-oriented, body-modifying means of behavioural correction. Before I access a theoretical framework through which to make sense of the infusion of intervention in children's lives, I am curious about scholarship that takes up AD/HD in non-conventional ways; ways that question the diagnosis' position as an accepted, decreed truth.

Non-conventional AD/HD literature

There is a growing literature that undermines AD/HD as an objective, medical descriptor, and instead views it as a product of medicalization and/or as a cultural construct. A medicalization critique posits that AD/HD emerged out of, and is perpetuated by, a growing trend to turn everyday bodily, psychological, and social conditions into medical problems (Lupton, 1997). This critique suggests that looking at AD/HD as a medical problem "often fails to acknowledge that researchers who 'discover' childhood disorders and professionals making diagnoses of those disorders operate within a constructive and contested discursive field of political and normative meanings about the lives of children" (Danforth & Navarro, 2001, p. 167). Many researchers follow this perspective about AD/HD as a function of medicalization (e.g., Conrad 1975; Karnik, 2001; Malacrida, 2003; McHoul & Rapley, 2005; Searight & McLaren, 1998). McHoul and Rapley (2005), for example, point out how readily doctors diagnose children with AD/HD even with only negligible correlation between children's behaviours and the formal diagnostic criteria. Seemingly, there are reasons beyond simple diagnostic criteria that factor into a doctor's decision to give a child an AD/HD diagnosis.

Other researchers build on the medicalization critique by looking at AD/HD as a cultural construct, a product of specific cultural contexts (e.g., Cherkes-Julkowski, Sharp, & Stolzenberg, 1997; McHoul & Rapley, 2005; Schmidt, Neven Anderson, & Godber, 2002; Timimi, 2005). This research posits that AD/HD is a phenomenon based on culturally-constructed notions of how children should behave. For example, Timimi (2005) offers a cross-cultural examination of perceptions of children's behaviour and finds that in some cultures, restive and unruly children are revered and given special privileges. This is a far cry from North America where the same restive and unruly behaviours are seen as a child's individual medical problem requiring a label (AD/HD) that connotes that the child is abnormal and activates multiple and intrusive interventions that have the capacity to infiltrate a child's entire social existence. Likewise, McHoul and Rapley (2005) point out that AD/HD is "not only all-but confined to Anglophone nations, but is also similarly confined to the institution of the Anglophone school" (pp. 420-421). There is a strong case, from the examples above alone, that AD/HD is a product of particular discourses circulating exclusively in particular cultures.

A third group of researchers use the idea of AD/HD as a medicalized diagnosis to consider how it manifests in the empirical world. For instance, Danforth & Navarro (2001) find that everyday language use constructs how people come to develop their own understandings of AD/HD as a medical problem. This research highlights the diagnosis' mutability even as it is understood in daily discourse.

The research focused on AD/HD as a medicalized, culturally-constructed category highlights that correction might be moot – that the problems that practices of

correction set out to fix do not actually exist, but rather are a product of the medical or cultural appropriation of unproblematized bodily states. This means that interventions are charged with dynamics that run deeper than simply correction. Collectively these works, alongside my fascination with the numerous social interventions presented in the conventional literature, reinforce my curiosity about how AD/HD, itself an unstable, fabricated label, activates social relations meant to correct children so that they come to embody a normalised subject positioning.

The growing prevalence of diagnosable children, as I exhibited in *AD/HD's History: Juncture 4 – 1940s – today*, demonstrates an ever-increasing number of children who fit into the diagnosis' expanding diagnostic criteria. It also indicates that although the biomedical community claims to understand what it means to have normal behaviour and then propagates this notion, in fact, the definition of normal is highly mutable (Baumgaertel, Wolraich, & Dietrich, 1995; Lindgren et al., 1994, as cited by Timimi, 2002). The set of critical literature that positions AD/HD as a medical and/or cultural phenomenon further disrupts the notion that the diagnosis is an innocuous label that simply identifies children with an inherent problem. Instead, it reinforces the argument that AD/HD is a manufactured label based on certain medical and cultural standards of normativity. If the diagnosis is far-reaching but also unstable in its definition of normal, then the many children who are given the diagnosis are characterized by a label deemed to claim a truth about them but actually is based only on a flexible notion of what it means to be normal.

Even though the hypothetical aetiology of behaviour and the specific diagnostic definitions have shifted over time, the similarities between the behaviours

that Hoffman described in relation to his son in 1844 and the behaviours described in the DSM-IV's AD/HD diagnostic criteria are striking. Yet, there is a fundamental difference between framing of the two sets of behaviours witnessed over a century apart. The child in Hoffman's 1844 poem was considered unruly. Today, in 2007, similarly unruly children are considered dysfunctional and ascribed with an AD/HD diagnosis. While Philip, in 1844, embodied an empirical subject positioning similar to children in 2007 before they are diagnosed with AD/HD, unruly children today come to be positioned as abnormal and then engage in correction so they can take up a normalised subject positioning. This shift in understanding children brings me to ask: now that unruly behaviours are considered symptoms of the AD/HD diagnosis, how does that abnormal subject positioning established by AD/HD affect the daily lives of today's children? To explore this question, I turn to Michel Foucault whose notion that power infuses all relations offers a different way to think about correction.

Correction and Foucault's theory of power

Foucault regards all individuals, institutions, and knowledge as a product of the exercise of power. Power is the energy that characterizes all relationships between and amongst individuals and institutions, and is inseparable from the concepts and ideas that a given society uses to understand the world. Foucault defines power as follows:

Power is everywhere; not because it embraces everything, but because it comes from everywhere. And 'Power,' insofar as it is permanent, repetitious, inert, and self-reproducing, is simply the over-all effect that emerges from all these mobilities, the concatenation that rests on each of them and seeks in turn

to arrest their movement ... power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society. (Foucault, 1990, p. 93)

Foucault's theory suggests that power infiltrates the workings of society. As such, individuals are embedded in a social context rife with power that is constantly producing them and transforming them (Foucault, 1990; Foucault, 1995). My application of Foucault's ideas to my account of AD/HD leads me to two premises about the relationship between power and AD/HD: (a) individuals might not *have* an objective condition signified by the term AD/HD but rather are ascribed with the diagnosis because of external constraints, ideals, and discourses that have formed AD/HD into a category (see also, Mills, 1997) and (b) individuals with AD/HD diagnoses are produced in certain ways because of the power that their diagnosis deploys.

Given my first premise that AD/HD is a social constructed category, it is intriguing to consider how power manifests in diagnosed children's lives based on an activator (AD/HD) which has a questionable existence. I focus on the second premise about AD/HD because it illustrates that AD/HD affects the ways in which individuals with the diagnosis interact with their world and is thus commensurate with my interest in how AD/HD manifests in children's daily lives through practices of correction.

Foucault's discussion about the productive nature of power helps me to understand how AD/HD (as a vessel of power) might affect children: "power

produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production” (Foucault, 1995, p. 194). These ideas about power suggest that AD/HD produces the lives of diagnosed children – it produces their sense of self, sense of conduct, and sense of their own relationships. It is the exercise of power that brings children from the empirical self they embody just before they are diagnosed with AD/HD to the normalised self that takes shape once they have engaged in correction.

Correction as discipline

Foucault’s ideas about power offer a meaningful way to understand the effects of AD/HD on diagnosed children’s lives. In particular his understanding of power highlights two features of social interventions and the correction process described by the conventional literature. The first feature of power when applied to correction, is that the process of correcting children who have AD/HD is structured by a broader network of power relations that both shape what correction means, and define the ultimate goal of the correction process. In other words, practices of correction that lead a child to have normative behaviour (as activated by the AD/HD diagnostic category), is a product of certain discourses, and only exist because particular ideas about what it means to be corrected have formulated its definition. This idea indicates that correction, a notion that implies a binary relationship of broken/whole, is loaded; what it means for a child to be corrected actually means that a child is to be produced by power relationships that are directly informed by biomedically-grounded discourses that formulate only one way to understand normativity.

The second feature of power's relationship to correction is that the correction process constitutes and is constitutive of power relations that produce AD/HD-diagnosed children's behaviour to be normative. Social interventions for AD/HD alter the child so that he meets the threshold of what constitutes socially acceptable behaviour and comes to embody his normalized self. Examples of social intervention techniques, above, highlight the intricacy and micro-focus of corrective measures (e.g., self-massage, daily behaviour chart completion, peer monitoring). Interventions take place at the level of the AD/HD-diagnosed child's body and are instruments of making that body normal; following Foucault, I call this *normalisation* (Foucault, 1995).

Normalisation is the process through which children learn to conform to manufactured notions of what constitutes normal behaviour. In other words, it is an operation of relational activities, events, and interactions in a diagnosed child's life that guide him to act in ways that are deemed to be normal by particular discourses. The term normalisation implies that normal does not actually exist, but rather, like the notion of correction, is a socially constructed idea. Foucault's *Discipline and Punish* (1995) focuses extensively on normalisation, a phenomenon Foucault suggests is one of *discipline*. Discipline, which is an effect of the deployment of power, is about changing the operations of the body at a micro-scale (Foucault, 1995). Discipline is the detailed operations of power, the specific processes in which the body partakes in order to transform. For Foucault, disciplinary power, in its interaction with bodies "may be calculated, organized, technically thought out; it may be subtle, make use neither of weapons nor of terror and yet remain of a physical order" (Foucault, 1995,

p. 26). A normalisation process is disciplinary because it is about the altering of a child's body (a micro scale subject of change) through detailed and subtle operations of power. Disciplinary power is deployed through the internal conditions of all relationships, in particular as the effect of relational divisions, inequalities and disequilibriums (Foucault, 1990). In the context of AD/HD, discipline refers to the social relationships that foster, perpetuate, and produce the processes through which children engage to behave in ways that are socially acceptable.

Because of its social construction, there is a politics to the correction process. Correction is based on the organization of a web of power relations that shape how children come to adhere to normalised expectations of behaviour. Power, which is exercised from everywhere, and which produces domains of reality (Foucault, 1990, p. 93), permeates every aspect of a child's correction. Given biomedicine's history of widespread acceptance as labeling objective facts about bodies and behaviour in particular societies, correction is situated as necessary in order to fix individuals' dysfunctions. Yet, correction is a socially constructed notion. Correcting AD/HD-diagnosed children is not about fixing them but rather is about transforming them so that their behaviour adheres to a socially constructed notion of what it means to be normal.

Normalisation: where to find it?

Learning a child's biographical story, reading teachers' manuals, studying television specials about AD/HD, and analyzing medical school curricula are some of innumerable means through which it is possible to consider how power operates to discipline AD/HD-diagnosed children into normativity. Another place to access the

normalisation process is children's books. Children's books about AD/HD are written to tell stories about how children with AD/HD diagnoses can become corrected. In fact, some are explicitly written as instruments to correct child-readers. Using children's books about AD/HD to study the circulation of power in the lives of AD/HD-diagnosed characters is an ideal way to begin an inquiry into how disciplinary power operates. First, and most commensurate with my project, books freeze moments in time making a child's correction process particularly accessible. Second, books have been shown to reflect social processes, so when I study the process of correction in books, I can infer that what I locate in them is a reflection of what is going on in the broader world. Third, scholars have found that books actually affect their readers. While I confine my research to the study of books themselves, not their readers, my study of the circulation of power in books will lay the groundwork for future research into way books impact the lives of those who read them.

By applying Foucault's theories of disciplinary power to a study of children's books, it will be possible to explore how discipline is deployed in the normalisation of AD/HD-diagnosed children as they learn to behave according to socially constructed standards of normativity. In its illumination of the mechanics of the socially constructed concept of normalisation, this research will emphasize how the lives of diagnosed children are shaped by the political process of correction. In the next chapter, *Methodology*, I describe the children's books I studied to learn more about the web of power relations that shape normalisation of diagnosed children. Then, I detail the methodological approach I used to analyze the books.

Chapter 3 - Methodology

Foucault's ideas about power and discipline challenge the notion that AD/HD-diagnosed children are broken and need to be corrected. Rather, these children can be understood as being subject to socially constructed ideals of normativity that label them as dysfunctional. Once labeled as dysfunctional, disciplinary power relations engage children in a transformation such that their unruly selves learn to adhere to normalized behavioural expectations so that they act like non-diagnosed children. To explore how power constitutes the normalisation of AD/HD-diagnosed children, I have chosen to examine children's AD/HD self-help books.

Self-help books as data

Self-help literature is one genre of books that scholars have used to examine a breadth of research questions, particularly about medical and social phenomenon. By their very existence, self-help books imply that the issues they address are problems that can be overcome. In their presentation of social or medical problems, self-help books imply a standard of bodily or behavioural normativity, and then suggest to readers how they can change from their current empirical state, to achieve that normalised state. Self-help books are written to produce individuals to adhere to socially constructed ideals of normativity by engaging in processes of correction.

Scholars study self-help books for three general reasons. First, they study self-help books to analyze the books' messages, for example to gain insight into the construction of medical or social phenomenon (e.g., Anderson, George, & Nease, 2002; Markens, 1996; Taylor, 1999), or to look at representations of individual

subject formation and methods of self-discipline (e.g., Barker, 2002; Hazleden, 2004; Lichterman, 1992); second, scholars study self-help books to examine how they represent the social world, for example by considering books' cultural manifestations of medical or social phenomenon (e.g., Hochschild, 1994; Krafchick, Zimmerman, Haddock, & Banning, 2005; Larsson & Sanne, 2005); and finally, scholars study how self-help books impact readers, for example to study how books' instructions for self-improvement actually inform readers' self-conception and decisions (Lichterman, 1994).

Following the research of scholars like Anderson, George, and Nease (2002) and Markens (1996) who analyze text to understand its messages, the purpose of my research is to study how power relations manifest in storybooks' and guidebooks' depictions of children's processes of correction. Yet, following in the path of scholars like Hochschild (1994) and more generally in a Foucaultian tradition (Mills, 1997, pp. 22-23), I study text captured on a page in hopes of getting a glimpse into the social world of AD/HD-diagnosed children. I infer that the books in my sample reflect the social world because they are self-help books. Self-help books self-consciously intend to address real children and real children's experiences so that readers can relate to them. As such, I deduce that self-help books are written in order to create accounts that accurately reflect the way medical diagnoses and the power relations they effect, present in the world. Finally, research shows that books have an impact on the way readers interact in their world (Lichterman, 1994). Analyzing the effects of books is an object of study beyond the scope of this project, it is a notion that I address when I discuss future research in chapter 5, *Conclusion*.

Self-help books are not exclusively for adults, in fact many are written for children. To describe self-help books for children I replace the term self-help with the terms *guidebook* or *storybook* to describe more accurately this subset of children's books. Children's storybooks and guidebooks address numerous issues that affect children, from medical diagnoses (e.g., Autism – Wrobel, 2003) to familial struggles (e.g., divorce – Ransom, 2000). Few scholars study children's storybooks and guidebooks and yet their relevance is immense. In their depiction of social worlds, these books offer an opportunity to explore the intricate web of power relations with which children engage as they experience practices of correction. As I discuss above, while I cannot actually assess the accuracy of the books' representation of real children's correction processes, I infer that by studying children's storybooks and guidebooks I am illuminating some portion of broader social processes that constitute the lives of children.

AD/HD self-help literature for adults is pervasive, ranging from parenting manuals and memoirs (McClusky & McClusky, 2001; Morris, 1998) to self-help books for adults with AD/HD diagnoses (Novotni, 2003). Likewise, self-help books about AD/HD written for children in the form of storybooks and guidebooks are abundant. Storybooks are fictional narratives that generally depict the life of a child diagnosed with AD/HD, *showing* his process of becoming corrected. Children's AD/HD guidebooks are information manuals that offer anecdotes, facts, and explanations intended to help child-readers understand their diagnosis and learn techniques for correction. Text in guidebooks is often explicitly instructive. To study the disciplinary power relations that constitute processes of correction in children's

storybooks and guidebooks, and to surmise about the organization of discipline in the lives of real children, I selected 13 books to analyze (see Table 3.1).

Data

Identifying children's self-help books did not prove challenging. I chose to access books readily available to the public through the library.⁵ I searched the juvenile databases of the public libraries in Victoria and Vancouver, British Columbia using a set of keywords I developed: "AD/HD," "ADHD," "ADD," "attention," "attention deficit" and/or "hyperactive". This search generated 32 hits from the Victoria Public Library and 47 hits from the Vancouver Public Library of books that I determined to actually be about AD/HD (the search itself also generated hits that were unrelated to AD/HD).

Next, I created a comprehensive list of all of these storybooks and guidebooks, and narrowed it down based on two criteria: the books' accessibility in used or discounted form from amazon.com or abebooks.com, and the books' intended audience as children ages 5 to 11 years old. In the end, my sample consisted of the 13 storybooks and guidebooks (see Table 3.1). The age-span of 5 to 11 is particularly dynamic and influential for children because their social networks grow exponentially as they enter into institutions beyond their family and begin to engage more actively in texts (British Columbia Learning Resources, 2006; British Columbia School Act, 1996). As such, children in this age group are shaped by discourses coming into their lives through their own engagement with the world beyond their immediate social

⁵ Books are relatively expensive and can be considered a luxury for some families depending on their financial situation.

realm of siblings, parents, parental friends, and other family members. This seemed like an appropriate filter to select books to study.

Table 3.1. List of storybooks and guidebooks used in analysis

<u>Storybooks</u>	
Galvin (2001)	<i>Otto Learns About His Medicine</i>
Gehret (1991)	<i>Eagle Eyes</i>
Gordon (1991)	<i>Jumpin' Johnny GET BACK TO WORK!</i>
Lears (1999)	<i>Waiting for Mr. Goose</i>
Penn (2003)	<i>A.D.D. not B.A.D.</i>
Smith (1997)	<i>Pay Attention Slosh!</i>
Weiner (1999)	<i>Taking A.D.D. to School</i>
Zimmet (2001)	<i>Eddie Enough</i>
<u>Guidebooks</u>	
Nadeau & Dixon (2005)	<i>Learning to Slow Down and Pay Attention</i>
Nemiroff & Annunziata (1998)	<i>Help is on the Way</i>
Quinn & Stern (1991)	<i>Putting on the Brakes</i>
Rotner & Kelly (2000)	<i>The A.D.D. Book for Kids</i>
Silverstein, Silverstein, & Silverstein Nunn (2001)	<i>Attention Deficit Disorder</i>

Method

With my selected books in hand, my next step was to analyze them to look for circulating power relations shaping the lives of AD/HD-diagnosed children in text, both as shown through narrative and as suggested through instruction. To study how normalisation operates in text I developed a methodological approach that dovetailed with Foucault's notion of power relations. In short, my process of developing an appropriate methodology happened in two stages. First I contemplated conducting a Foucaultian genealogy (e.g., Carabine, 2001), and then settled on a more micro-focused methodology, which, with some customization, was an ideal fit for my research inquiry.

At the outset of my research, I was planning to conduct a Foucaultian genealogy to learn about AD/HD and discipline. There is no doubt that a study guided by Foucault's theories of power lends itself well to a genealogical analysis, which is about "describing the procedures, practices, apparatuses and institutions involved in the production of discourses and knowledges, and their power effects" (Carabine, 2001, p. 276). Although considering how normalisation manifests in children's storybooks and guidebooks sparked my desire to apply a genealogical analysis to my data, I soon realized that a genealogy would focus my analysis on discursive shifts in defining inattentive and active children over an extended period of time. Although a laudable project, I was interested in understanding the subtleties and complexities of how disciplinary power shaped the lives of AD/HD-diagnosed children. For me, understanding the mechanics of disciplinary power was an important first step in understanding the effects of AD/HD. A straightforward genealogy was not what I was after for this project.

With a clearer sense that I was seeking out children's processes of correction informed by the circulation of disciplinary power relations, I needed to shift to a micro-scale analysis to examine the minutiae of disciplinary power. My analytical priority was accessing and analyzing the exercise of disciplinary power in order to assess how AD/HD-diagnosed children assume a normalised positioning. After reviewing methodological literature to locate an appropriate approach to guide my more clearly articulated analytical focus (e.g., Baker-Sperry & Grauerholz, 2003; Clark & Fink, 2004), a colleague recommended one technique as particularly applicable: Jennifer Gore's (1995) methodological approach, which she called a

Foucaultian analytics of power (p. 185). Gore's approach identifies eight specific techniques of disciplinary power (surveillance, normalisation, exclusion, classification, distribution, individualisation, totalisation, and regulation) that she locates in Foucault's *Discipline and Punish* (1995) in order to analyze power relations in social settings.

A Foucaultian analytics of power

The purpose of a Foucaultian analytics of power is to analyze ways that power, as something invisible (it is impossible to materially locate) and yet pervasive (it permeates all social relations), infuses the interactions between and within individuals (Gore, 1995; Gore, nd). A Foucaultian analytics of power helped Gore (1995) to clarify a micro-focus for her research: "Foucault's concept of disciplinary power explicitly shifts analyses of power from the 'macro' realm of structures and ideologies to the 'micro' level of bodies" (Gore, 1995, p. 167). With this micro-scale approach, Gore accessed the intricacies of individuals' engagement in the circulation of power in social settings.

A Foucaultian analytics of power involves locating the eight techniques of disciplinary power (which I define below) to textual documentation that captures social relations, be that interview transcripts, books, or other documents. In her study, Gore (1995) investigates the existence of disciplinary power relations in transcripts of four pedagogical settings: a women's discussion group, a high school physical education class, a first year teacher education cohort, and a feminist reading group. With a Foucaultian analytics of power as her guiding methodological approach, Gore

sets out to demonstrate the utility of the eight techniques of disciplinary power in locating the exercise of power in transcripts from the four pedagogical settings.

Although Gore's (1995) research topic is different from my own, the methodological approach fits well with my inquiry. The main difference between the projects is that Gore analyzes transcripts for the exercise of disciplinary power between individuals in pedagogical settings, whereas I am interested in analyzing moments frozen in text as expressions of the exercise of disciplinary power that contributes to the normalisation of AD/HD-diagnosed children. Regardless, I was confident that using Gore's methodology would illuminate the circulation of power shaping practices of correction in children's storybooks and guidebooks about AD/HD.

Before I go on to define the eight techniques of disciplinary power that guide a Foucaultian analytics of power, I want to note that I have already addressed two of the techniques of power in this thesis: normalisation and individualisation. My use of these terms throughout the thesis is consistent with their definitions that follow. Akin to a kaleidoscope that encompasses many images but allows for a magnification of one or two, I address all eight techniques of power in my thesis, but draw on normalisation and individualisation with greater depth than the others because of their conceptual *and* empirical relationship to my project. In their specific definitions, I address their applicability as thesis-wide concepts and as techniques of disciplinary power circulating in children's books.

Surveillance

Surveillance is the act of watching, observing, supervising, threatening to watch, or being watched (Gore, 1995). The exercise of surveillance makes it possible to collect information about individuals in order “to alter behaviour, to train or *correct* individuals” (Foucault, 1995, p. 203; emphasis added). As an example of surveillance, Foucault describes Jeremy Bentham’s Panopticon, a model penal structure. In the Panopticon, a single tower placed centrally fosters the sense of a permanent gaze for detainees below, whether or not a guard is on duty (Bentham, 1995; Foucault, 1995). Foucault describes that the Panopticon’s surveillance is effective because

it is possible to intervene at any moment and because the constant pressure acts even before the offences, mistakes or crimes have been committed.

Because, in these conditions, its strength is that it never intervenes, it is exercised spontaneously and without noise, it constitutes a mechanism whose effects follow from one another. (Foucault, 1995, p. 206)

With an atmosphere of ever-present surveillance, individuals can be prevented from behaving in unacceptable ways, thereby becoming trained to act normatively. In the context of children’s storybooks and guidebooks about AD/HD I am looking for moments when children, once they are diagnosed with AD/HD, are kept in closer vicinity of a teacher, parent, or supervisor and/or learn how to self-observe to avoid engaging in unaccepted behaviour. I seek evidence of how surveillance prevents behaviour that does not meet normative expectations and serves as a teaching tool to reinforce behaviour that does.

Normalisation

One of power's many effects is its definition of what it means to be normal. Normalisation is the technique of disciplinary power that establishes a threshold of normativity by differentiating individuals through the continual referencing of a minimal threshold, an expected average, or an expectation of reaching an optimum (Gore, 1995). When normal behaviour is defined and then used as a locus of comparison, an excuse for differentiation, or a standard by which rules are made, normalisation is at work (Gore, 1995). Foucault describes normalisation as enacted when the judgment of individuals and institutions defines socially acceptable behaviour:

The judges of normality are present everywhere. We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the 'social worker'-judge; it is on them that the universal reign of the normative is based; and each individual, wherever he may find himself, subjects to it his body, his gestures, his behaviour, his aptitudes, his achievements. (Foucault, 1995, p. 304)

The diagnostic category of AD/HD is rooted in a normalising judgment that informs a notion of expected and accepted childhood behaviour. With normalisation as the focus of my thesis, I investigate how AD/HD activates techniques of disciplinary power in an attempt to bring children "back to normal," and how these normalising relations infuse the life of children once they are diagnosed with AD/HD. Although normalisation drives my larger inquiry, I am also looking for normalisation as it plays out on a micro-scale, in textual depictions of the everyday lives of children once they are diagnosed with AD/HD.

Exclusion

For Gore (1995), exclusion is complementary to normalisation in that exclusion defines what is pathological, what is abnormal, and what does not fit into a standard norm. Exclusion is the act of defining the boundaries of difference and highlighting what sits outside a zone of normativity. In fact, exclusion is the first step of normalisation – individuals must be differentiated in some way before they can be transformed by normalising relations. In the storybooks and guidebooks I look for exclusion enacted when children are removed or remove themselves (physically or figuratively) from a situation where they would otherwise be situated if they were calm and attentive. I am curious about how the child's removal from a group or setting feeds how children learn to behave in normative ways.

Classification

Disciplinary power is often exercised based on the “classification” of individuals, which Foucault describes as the meticulous demarcation of individuals based on the impression of their superiors (Foucault, 1995, p. 181). Practices of classification are grounded in a set of values that reinforce, perpetuate, or create assumptions about individuals, groups, ideas, or concepts, which go on to serve as the basis for sorting. While similar to normalisation in its action of perpetuating particular characteristics, and similar to exclusion in its effect of triggering the removal individuals from a group, classification is the outright act of marking individuals and placing them in categories. For example, an individual's ascription with a diagnosis is an act of classification enacted within the discourse of biomedicine to mark the individual who is inattentive or hyperactive as ill, diseased,

and abnormal. Although Foucault (1995) discusses the ascription of class through the physical labeling of individuals with clothing markers, in my data I look for discipline enacted based on the classificatory concept of AD/HD. I consider how, in children's storybooks and guidebooks, the deployment of classification through a child's label of AD/HD identifies him and activates disciplinary social relations that shape his process of learning so that he behaves in a normalised way.

Distribution

Distribution, which is exercised on the basis of an individual's classification, is the technique of power that directly impacts an individual's location in space. Distribution is the change in location of bodies to serve disciplinary or organizational ends, be that through arrangement, isolation, separation, or ranking. As well, power relations are evident in distribution: depending on the setting, some individuals make more active or macro decisions about distribution (e.g., in a classroom, the teacher), while others make more reactive or micro decisions about distribution (e.g., in a classroom, students), exposing that power is often exercised based on disequilibriums, or divisions within relationships (Foucault, 1990). Foucault says that distribution has two roles: "it marks the gaps, hierarchizes qualities, skills and aptitudes; but it also punishes and rewards" (1995, p. 181). Unlike exclusion, which is focused on separation (both physical and otherwise), distribution is the alteration of an individual's location in space, not necessarily about removing them from a group or space. In the study of children's AD/HD storybooks and guidebooks, I look for the exercise of distribution in the way a child's physical location at any given moment is dependent on disciplinary agendas related to how close the child's behaviour is to

normative expectations. As with all techniques of power, I am curious about distribution as it is exercised directly through the child himself or through the child's relations with others.

Individualisation

In its most minute form, disciplinary power circulates in acts of individualisation. Individualisation is not about seeing individuals as separate, autonomous beings, but rather as constantly engaging with, and exercising, power in a sort of choreography wherein the individual is never removed from power's reach (Foucault, 1980; Gislason, 2006). Unlike surveillance, which is the constant observation of individuals, individualisation surfaces in the measurement of one individual against another (Foucault, 1980; Gore, 1995). Individualisation is also the naming, characterizing, and defining of processes that produce abstract categories within which individuals are forced to fit (Gore, 1995). I used the term individualisation extensively in chapter 2, *The Literature as Context*, to describe an effect of the AD/HD diagnostic category. AD/HD, as a label, defines certain childhood behaviours, places the behaviours in abstract categories, ascribes children to that category, and then activates processes that guide children to behave like non-diagnosed children. The act of defining behaviours and producing associated categories is one of individualisation whereby children are specified, measured against one another, and targeted as the site for shifting power relations. In chapter 2, I discussed how the predominant focus on solving the problems associated with AD/HD is addressed by specifically targeting the power relationships of the individual and ignores how power circulating in the child's social context affects the

child's behaviour. In my analysis of the storybooks and guidebooks, I look for individualisation when children are specified and compared – both through their own and others' exercise of individualisation.

Regulation

Regulation is the *explicit* exercise of, or allusion to, control, restrictions and rules (in the form of sanction, reward or punishment) in relation to individuals, groups, or knowledge (Gore, 1995). Although all eight techniques of disciplinary power have regulating effects because they have the capacity to direct and guide (Gislason, 2006), regulation is the overt exercise of governing. Gore focuses on three types of regulation: regulation in the form of rules, self-regulation, and regulation in the knowledge-transfer between individuals. In my research, I look specifically for how storybooks and guidebooks depict the exercise of regulation in the form of rules, restrictions, and controls in diagnosed children's lives. I also remain attuned to children's self-regulation and restrictions guiding knowledge-transfer that contributes to their process of normalisation.

Totalisation

Totalisation refers to “the specification of collectivities, [and] giving collective character” (Gore, 1995, p. 179), so that, for example, the framing of the individual as having AD/HD prevails in the way he understands himself and/or how others relate to him. Examples of totalisation are expressed in the use of the word *we* or *their* in text or conversation. Words, such as these, suggest a notion of collective thinking or expression of thought. Examples of totalisation can also take more complicated shape in the construction of, description of, or claims made about a

group that erases the identity of the individuals from the group. For Foucault, totalisation “refers individual actions to a whole that is at once a field of comparison, a space of differentiation and the principle of a rule to be followed” (1995, p. 182). I look for totalisation in the books in the form of an imposed collectivity on children diagnosed with AD/HD. In other words, I am looking for moments when children are assigned to a collective group based on a principle that their behaviour, like others in the group, does not reach a normative threshold.

Description of analysis: A four-part process

Once I acquired the 13 books as my data, I set out to analyze each one. After experimenting with an informal genealogical analysis looking for trends, consistencies between books, and historical significance, I applied Gore’s (1995) Foucaultian analytics of power to more effectively focus on the subtleties of normalisation. It took a number of attempts at coding before I ended up with results that satisfied my interest in looking for discipline in the lives of AD/HD-diagnosed children in text. In the end, my formal analytical process took place in four distinctive steps. First I attempted a direct coding of the books for the eight techniques of disciplinary power; second, I did a thematic analysis of the books modeled loosely on a genealogical method; third, I coded the themes for the eight techniques of power; finally, I used various techniques to experiment with my analytical findings and to generate analytical insights.

My first analytical step involved coding the storybooks directly for the eight techniques of disciplinary power (surveillance, normalisation, exclusion, classification, distribution, individualisation, regulation, and totalisation), looking for,

and labeling, instances of the exercise of the techniques. I attempted to code the guidebooks using the same method but quickly became stifled – something about the way I was coding and the format of the guidebooks did not resonate. I was not able to code the guidebooks directly for the eight techniques of disciplinary power. In hindsight, I recognize that the limitation I experienced when I attempted to code guidebooks for the first time was due to the way I understood the meaning of the exercise of power. My initial attempt at coding was for techniques of disciplinary power manifest in how books *depict* social relations, something that saturates storybooks but is less apparent in guidebooks. For example in a storybook, it is straightforward to label an instance of distribution when the text describes, or shows, a teacher asking a child to sit at the front of the class (e.g., Galvin, 1990). By contrast, in a guidebook, it is difficult to label an instance of distribution because it is often not shown, but rather described (e.g., Rotner & Kelly, 2000). As such, in guidebooks, only a portion of a disciplinary technique is present – the *instruction* to engage in discipline. What I neglected in this first stage was an analysis for how disciplinary power manifests in the text’s direct instructions. Alongside my challenge in coding guidebooks, I found my initial coding of storybooks limiting because I felt I was constricting my data by imposing only eight possible ways to understand it. While this initial practice of coding was insightful in that it exposed the existence of disciplinary power in text, I felt particularly confined by the rigidity of the eight techniques of power. I needed an approach that would allow for two things: (a) to access both the depiction and the *description* of the normalisation of diagnosed children and (b) to engage a critical reading that would enable my data to speak out.

To begin a more comprehensive exploration of my data, I chose to code the text in the books a second time using an exploratory technique loosely modeled after the genealogical mode of inquiry's open-ended approach to data collection (see Carabine, 2001). I took all 13 books and coded them for themes, of which I ended up with 64 (see Appendix 1). Specifically, I was looking for messages that emanated from the books, for example, "children with AD/HD have trouble making friends" or "children with AD/HD have a dysfunctional brain." Upon completion of my coding for themes, I noted each theme and its corresponding book(s) on separate cue cards. Next, I reflected on each book in what I refer to as a memo. Some of my memos were short and cursory, while others engaged with the contextual issues I was grappling with at the time, particularly empirical and theoretical literature as well as the other books. I stored my memos on my computer and referred back to them as I conducted my analysis. The memos served as a journal-style account of my analytical experience and although I do not explicitly address them in chapter 4, *Analysis*, they helped to lay the groundwork for the final stage of my analytical process.

After coding all 13 books for themes and writing individual memos for each, I had a general understanding of the existence of disciplinary power in all the storybooks and guidebooks. Yet, I recognized that in order to understand the complexities of normalising power relations in the lives of children in the books, I needed to come back to the exercise of disciplinary power. I returned to a Foucaultian analytics of power (Gore, 1995), this time to code the themes that I found in part two of my analysis. This time the process of coding for the eight techniques of disciplinary power was fluid and inclusive. Unlike my first attempt at coding, I had

incorporated all 13 books into the process. Finally, I had found a way, through hybridizing a Foucaultian analytics of power with a genealogy, to access the circulation of disciplinary power in my data. The process had come full circle.

After engaging with the storybooks and guidebooks in three methodological coding stages, I took a hiatus from analysis and focused on writing a preliminary draft of my thesis. After completing my first thesis draft I recognized that my analysis was still missing depth; there were nuances in the data that I had yet to uncover. I decided to explore my data in an unrestricted way, hoping that this would highlight what seemed to be missing. I talked about my findings with my thesis supervisor, colleagues, friends, and family. I wrote down ideas and utilized mind-mapping, a non-linear method of thought development and expression. Through this flexible and organic process I discovered more intricacies in the textual representation of children's correction than I had found after stage three of coding. In particular, it was through this process that I developed concepts that helped me to understand how power circulates in the lives of AD/HD-diagnosed children in text. In chapter 4, *Analysis*, I discuss the nuances of my findings – the culmination of my four methodological steps.

Delving into the data: Some observations on the techniques of disciplinary power

As a segue into my analysis, I offer some general findings about the way in which power circulates in the textual representation of the normalisation of AD/HD-diagnosed children. In my analysis, I found two general sites at which the techniques of disciplinary power were exercised: directly through the realm of biomedicine (e.g., by doctors or nurses), and through daily social relations with individuals who were

part of the child's life before he was diagnosed with AD/HD (e.g., individuals at school, parents). As I discussed in chapter 2, *The Literature as Context*, biomedicine is directly involved in the diagnostic experience of an individual and subsequent diagnosis-related decisions. In my research, themes such as "doctors are the authority on AD/HD," show how the realm of biomedicine emerges in children's storybooks and guidebooks. In this project, I set aside the realm of biomedicine and look, instead, at how diagnosed children engage in interactions like enhanced observation, removal from their group, and formalized regulation, in their daily social interactions with individuals who are existing parts of their social fabric. In particular, I remain attuned to the role of education and the school system, daily interactive social networks, familial relations and extended family, and the individual himself (sites the conventional literature formalized as sites of correction) in the interventions meant to bring children to embody a normalised self. I am curious about both the formalized and subtle ways children's social relations within these social sites are shaped by the circulation of power activated by their AD/HD diagnosis.

The techniques of disciplinary power are mutually reinforcing as they shape the normalisation of diagnosed children. For example, surveillance and regulation are often intertwined. A situation in text when a child learns to impose a gaze onto himself to keep his behaviour in line with expectations of others (surveillance) and act based on that gaze by regularly filling out behaviour charts (regulation), becomes an avenue to document his perceptions of his own behaviour (surveillance and regulation). Another example of the mutual reinforcement of techniques of disciplinary power is the relationship between exclusion and classification. Often the

books describe children diagnosed with AD/HD as shunned by their peers (exclusion), and in many cases this happens in concert with their peers claiming that there is something wrong with the child or even explicitly naming their AD/HD in their teasing (exclusion and classification). When techniques of disciplinary power are exercised in the process of a child's normalisation, it is difficult to find any of them working entirely in isolation. I emphasize this to touch upon the texture of the process through which children become corrected – it is not straightforward, simple, or easy to define.

As well, the techniques of disciplinary power and the individuals in the child's life are fundamentally interconnected. This appeared predominantly in depictions and/or descriptions of the collaboration of parents and teachers, but was evident in other relations, as well. In the books, parents and teachers communicate about improvements and setbacks in the child's behaviour. They also collaborate on intervention strategies. The books emphasize the value of ongoing communication and strategy-development between parents and teachers. Another common interaction was the child learning from both parents and teachers how to self-discipline. In the books, children are dependent on the guidance of adults in their lives to learn the processes through which they can become normalised.

A short passage from a guidebook describing AD/HD-diagnosed children exhibits the complexity of the interplay among techniques of disciplinary power and a child's social relations:

Kids with ADD, whether they are hyperactive or quiet, have a hard time controlling their behavior. They usually do not know when they are getting

out of control so they may have trouble learning in school, behaving at home, or making and keeping friends. (Silverstein, Silverstein, & Silverstein Nunn, 2001, p. 7)

In this passage, the text expresses many techniques of power: totalisation (“[k]ids with ADD...”), self-regulation (“hard time controlling their behaviour,” “do not know when they are getting out of control”), normalisation at school (“trouble learning in school”), normalisation at home (“trouble ... behaving at home”) and exclusion by peers (“trouble...making and keeping friends”). The child, as presented, is embedded in web of disciplinary power and social relations that come together to position him as abnormal and requiring correction. Storybooks and guidebooks illustrate the intersection of multiple techniques of disciplinary power shaping how AD/HD-diagnosed children learn (or can learn) to adhere to socially constructed notions of normal behaviour. The mutual reinforcement of each technique of disciplinary power on the others, and their connection to the child’s social relations illuminates the complexity of the effects of power. In their deployment through social relations, it is rare that techniques of disciplinary power are enacted in isolation.

Research limitations

Before I turn to the analysis, in chapter 4, *Analysis*, I need to address the limitations of my research design. Empirically, my research is limited by the boundaries I imposed on my data selection. The books that I selected were available in the catalogues of two Canadian public libraries, and then accessible for purchase discounted or used. First, I recognize that there might be specific reasons the Victoria and Vancouver public libraries selected the books to be in their collections, reasons of

which I am unaware. Second, libraries generally do not have newer books in their collections. Excluding more recent books from my research could affect the scope of my data. Newer books such as *The Survival Guide for Kids with ADD or ADHD* (Taylor, 2006) and *ADD and ADHD* (Capaccio, 2007) might exhibit certain trends that reflect more recent, and potentially different, thinking about AD/HD that older books do not. Yet by using books readily available in the library, I am using storybooks and guidebooks that are accessible to a greater number of people. My data are limited in scope but representative of more accessible texts to which more children have the potential to be exposed (which is significant, if, as Lichertman [1992] discusses, individuals are influenced by the books' messages).

Alongside empirical limitations, my work also has methodological limitations. Gore (nd) addresses a dilemma in her process of transforming, or "taming" (para. 25) Foucault's work into a clean methodological process. The dilemma is that simplifying Foucault's theoretical work for empirical use itself requires the exercise of the technique of disciplinary power, classification. Gore sees a contradiction in the necessity of assimilating Foucault's thoughts on discipline into tidy categories (the techniques of disciplinary power) in order to uncover the operation of power in social settings. For Gore this contradiction represents the coinciding repressive and productive effects of power that Foucault himself emphasizes as being power's most important features. The classification of types of power is repressive because it forces clean boundaries on an intricate and difficult-to-define web of disciplinary power relations. Yet, in spite of this limitation, the results of the analysis are productive in that they illuminate how power shapes disciplinary processes.

Gislason (2006) extends this discussion of the taming of Foucault when she notes that research inquiries that treat each technique of power as a distinct and static strategy do not address the breadth, depth, and complexity of the relations among the techniques of power. Gislason finds that the techniques of power are often enacted simultaneously in unstable and vague ways. In my research this is particularly evident in my substantive focus on normalisation.

Like Gore (1995) and Gislason (2006), my methodological process has both repressive and productive elements. On the one hand, it is repressive in that I came into my analysis ready to find disciplinary power in books using the tidy categories that Gore established. I was not open to other potential findings in my data. On the other hand, my analysis is productive because it illuminates the mechanics of the normalisation of AD/HD-diagnosed children in text and will be useful as a foundation for further research that can take a variety of directions. The empirical and methodological limitations of my research suggest the restricted potential for my analytical conclusions. Yet, the limitation presented by the taming of Foucault, created an opportunity for me to adapt a Foucaultian analytics of power by sculpting it using some elements of a genealogy. This fusion enabled me to loosen the extent to which Foucault is tamed in Gore's (1995) methodological approach. Rather than coding the data directly, I chronicled it first and then coded it, allowing it to speak out before applying a rigid methodological frame.

An entrée into analysis

Foucault concludes *Discipline and Punish* with a vision that the book will “serve as a historical background to various studies of the power of normalization and

the formation of knowledge in modern society” (1995, p. 308). My study contributes to Foucault’s larger project. By grounding my work in an extended version of Gore’s (1995) Foucaultian analytics of power, I investigate how 13 children’s self-help books depict and describe the process wherein children diagnosed with AD/HD engage in the political process of correction. In the next chapter, *Analysis*, I present a fuller reading of my understanding of this correction.

Chapter 4 - Analysis

Children's storybooks and guidebooks about AD/HD depict and describe AD/HD-diagnosed children learning skills, behaviours, and emotions so that they can come to act in ways that adhere to socially constructed ideals of normativity. The storybooks and guidebooks, as well as conventional literature on AD/HD, treat this process as one of correction. My analysis of the books' themes, and then *moments of production* (a term I define later in this chapter), suggests that correction is a political process. Correction is actually about individuals engaging in a complex network of power relations that shape them into a state of normativity. Children with AD/HD diagnoses learn through disciplinary social interactions to behave in ways that medical discourses define as normal; the process of correction happens through children's daily social interactions. When an individual in one of a child's *social realms of influence* (school, peer, family, or self) deploys at least one of the eight techniques of disciplinary power (surveillance, normalisation, exclusion, classification, distribution, individualisation, totalisation, & regulation) a *disciplinary mechanism* forms. Disciplinary mechanisms are processes that facilitate normalisation. In the section *Analytical Findings*, I offer my research discoveries and define the concepts I developed to help me organize my conceptualization of the operation of power in the books. In *Analytical Insights* I draw two major research conclusions.

Section 1: Analytical Findings

Guided by a Foucaultian analytics of power (Gore, 1995), a methodology that enables the access and analysis of the exercise of disciplinary power in text (see Chapter 3), I uncover how *power relations are organized* as they shape the normalisation of AD/HD-diagnosed children. I begin this section by describing the books' prevailing parallel narratives about the diagnostic journey. Then, I summarize my findings beginning by articulating the books' themes. Next, I show fundamental connections between the themes and the techniques of disciplinary power, highlighting the influence of social relations in the deployment of disciplinary power in the lives of AD/HD-diagnosed children. Finally, I illustrate how correction actually happens, by describing disciplinary mechanisms. My presentation of each of the five analytical findings is cursory as my intention is to present an anatomized depiction of the data. In the next section, *Analytical Insights*, I elaborate on my findings and offer deeper analysis. Before I continue with the substance of this chapter, I address two issues that appeared as I studied the storybooks and guidebooks. The first is a comment on the books' portrayals of normativity based on discourses less explicitly related to behaviour. The second is simply a note on language.

Although my research focus is the production of normalised behaviour, I cannot ignore how the books' hegemonic description of children and their lives might contribute to a broader representation of normativity, the image of a state of being corrected. All of the 13 books in my data represent children's race, gender, family make-up, and class in similar ways. All of the storybooks in my sample are about white male protagonists (with the exception of one, an anthropomorphized car whose

name, Otto, and illustrated appearance, could also lead the reader to assume the car's masculinity and whiteness), living in two-parent, heterosexual families. Although the guidebooks had a more equitable racial and gender representation and did not imply an assumption of heterosexual couples leading families, both storybooks and guidebooks predominantly depict and describe families with economic privilege. These observations raise the question (beyond the scope of this thesis) of how AD/HD is caught up in race-based, gendered, and class-based assumptions of normative behaviour⁶ – does the labeling of behaviour remain exclusively in the domain of the white, middle-class? When children who are racialized or live with fewer financial resources exhibit the behaviours defined by AD/HD, are their behaviours expected and therefore less of a reason for concern (i.e., are books with which racialized, less economically advantaged children can identify, not necessary)? These are meaningful questions in the wider study of the social construction of correction and should be the subject for future research.⁷

Finally, not all storybooks and guidebooks use the term AD/HD to describe the diagnostic category that I am studying. I use the term AD/HD because it is the most updated label in circulation. When I discuss books that use a different iteration of the label (e.g., ADD), I match that iteration in my writing.

Analytical Finding 1: Books show parallel lead-ups, starting points, and ending points to correction

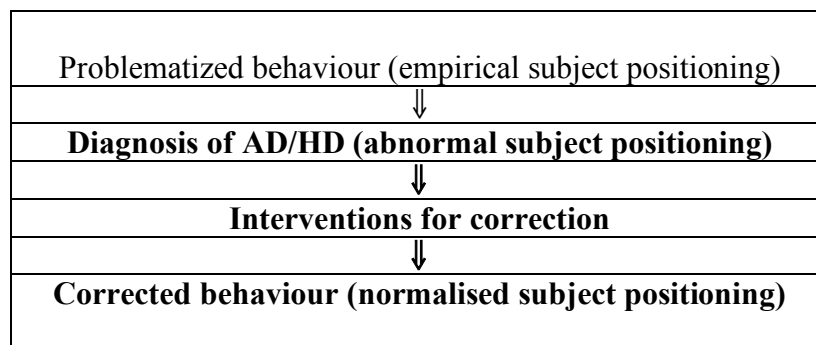
At the outset of the storybooks and guidebooks, children are depicted with behaviour deemed to be inappropriate, including characteristics such as restive,

⁶ For a discussion of raced and classed assumptions of anorexia nervosa, a socially constructed feminized illness category, see Gremillion (2003).

⁷ For further reading on diversity and AD/HD, see Gingerich, Turnock, Litfin, and Rosén (1998).

forgetful, messy, loud, and active. Then, children are given an AD/HD diagnosis activating the child’s process of correction. Once children engage in corrective activities they learn to behave like non-diagnosed children, a subject positioning that the books frame as a goal of unprecedented importance. In Figure 4.1, I illustrate the steps that comprise a child’s movement from displaying problematized behaviour (their empirical subject positioning), through their diagnostic ascription (abnormal subject positioning) to displaying corrected behaviour (their normalised subject positioning).

Figure 4.1 From problematized behaviour to corrected behaviour, as depicted and described in data



The focus of my project is the circulation of power in children’s lives after they are diagnosed with AD/HD to discern how the lives of children are shaped by that diagnostic ascription. In Figure 4.1, I use bold lettering to illustrate the steps of the process on which this project focuses. To demonstrate how the books generally depict and describe the process from diagnosis to correction, I summarize the characteristics the books use to show children at both stages in their correction process. The books exhibit four prominent characteristics of a recently-AD/HD diagnosed child: the child with AD/HD needs to be disciplined in school, has trouble

making friends, does not get along with his family, and has a dysfunctional brain.

These characteristics highlight particular traits that, according to the books, are abnormalities that should, and can, be corrected. Table 4.1 illustrates these four characteristics as shown in the storybooks and guidebooks

Table 4.1 Common characteristics of the child recently diagnosed with AD/HD as depicted and/or described in storybooks and guidebooks

Characteristic	Storybooks	Guidebooks
Needs to be disciplined in school [10 books]	Galvin, 2001; Gordon, 1991; Smith, 1997; Weiner, 1999; Zimmet, 2001	Nadeau & Dixon, 2005; Nemiroff & Annunziata, 1998; Quinn & Stern, 2001; Rotner & Kelly, 2000; Silverstein, Silverstein, & Silverstein Nunn, 2001
Has trouble making friends [9 books]	Galvin, 2001; Gordon, 1991; Penn, 1999; Smith, 1997; Weiner, 1999; Zimmet, 2001	Nadeau & Dixon, 2005; Nemiroff & Annunziata, 1998; Quinn & Stern, 2001; Silverstein, Silverstein, & Silverstein Nunn, 2001
Does not get along with family [8 books]	Gehret, 1991; Gordon, 1991; Smith, 1997; Zimmet, 2001	Nadeau & Dixon, 2005; Nemiroff & Annunziata, 1998; Quinn & Stern, 2001; Silverstein, Silverstein, & Silverstein Nunn, 2001
Has dysfunctional brain [7 books]	Galvin, 2001; Gehret, 1991; Gordon, 1991; Lears, 1999	Nadeau & Dixon, 2005; Nemiroff & Annunziata, 1998; Quinn & Stern, 2001; Silverstein, Silverstein, & Silverstein Nunn, 2001

I turn to *Attention Deficit Disorder* (Silverstein, Silverstein, & Silverstein Nunn, 2001) to offer an example of the description of a recently-diagnosed child in text. The following quotation from a section describing what ADD is “all about” illustrates the books’ framing of the child as broken and needing to be corrected:

[i]t’s not easy to deal with people who have ADD. Can you imagine trying to talk to someone who acts like a space cadet and doesn’t seem to listen to you? Do you have a friend who can’t wait for his or her turn when you’re playing a

game? Sometimes it seems like people with ADD are unfriendly, strange, too talkative, or mean. That's why some kids with ADD have trouble making and keeping friends. They are often fun to be around because they have a lot of imaginative ideas and a great sense of humor, but it can be hard to spend a lot of time with them. (pp. 14-15)

This passage suggests that there is something inherently wrong with the child by describing the child's characteristics with a tone of criticism. In particular, the use of words such as "can't" or "too" reinforce the notion there is something amiss with the child's behaviour, something that needs to be corrected. Another example is the reference to the child as a "space cadet," a term that implies that a child who is immersed in thought is deficient or "out of it." The passage suggests that the child's behaviour is, by nature, problematic. Once a child is deemed to be abnormal, practices of correction ensue so that the child can become normalised. In the books, this emerges as a frequent process.

In the books, when a child acts in socially unacceptable ways, parents, in collaboration with teachers, turn to a doctor whom they see as the authority on childhood behaviour. Doctors are shown to be useful because they have access to diagnostic categories like AD/HD, which formally identify and label the child's problem. Teachers, parents, and children are reassured by this diagnostic ascription because it indicates to them that there is a reason why the child is abnormal. In *Otto Learns About His Medicine* for example, once Otto (the protagonist) gets a diagnosis the narrator says: "Otto liked the idea of having his own pit crew that included his parents, his teacher, and Dr. Wheeler" (Galvin, 2001, p. 18). Likewise in *Help is on*

the Way, after a multi-page description of how children come to acquire an A.D.D. diagnosis, two entire pages hold the text “HELP IS ON THE WAY,” a phrase that is also the title of the book (Nemiroff & Annunziata, 1998, pp. 28-29). The books generally present all individuals involved in the child’s life as comforted by their ability to find ways to correct the child’s dysfunction so that the child can take up the subject positioning of a normalised self.

Once the books establish *who* can help the child become corrected, the books describe *ways* children can become corrected. They propose far-reaching social interventions like positive reinforcement strategies, and behaviour management. They also address more specific interventions such as time-outs for inappropriate behaviour, moving a child’s desk to the front of the classroom to be closer to the teacher, and skills for friendship development. Two sections of the book *Learning to Slow Down and Pay Attention*, are focused on correction: the first section is called *Things Other People Can Do To Help Me* and the second is entitled *Things I Can Do To Help Myself* (Nadeau & Dixon, 2005). These two sections describe in detail the specific ways in which children can be corrected. The table of contents of the two sections (represented in Table 4.2) offers a snapshot of the intricacy of how the books outline AD/HD-diagnosed children’s correction. The breadth of section two illustrates the book’s emphasis on ways children can help themselves (an issue I address in more detail in *Analytical Insight I*).

Table 4.2 Representation of Table of Contents of parts two and three from Nadeau and Dixon (2005), highlighting techniques of correction emphasized in book

<p>Things Other People Can Do To Help Me – part two People Who Help with School People Who Help with Friends and Feelings People Who Help My Parents Understand Me Doctors Who Help with Medicine</p>	<p>Things I Can Do To Help Myself – part three Ways to Remember Getting Ready in the Morning The Easy Way to Clean a Bedroom Ways to Pay Better Attention at School Things to Do If I Feel Fidgety Help with Homework Learning to Control My Anger Learning to Ask for Help Talking Out Problems at Home Problem Solving Learning Not to Interrupt Ways to Make and Keep Friends Things to Do When Someone Hurts My Feelings Learning to Relax When I have Trouble Going to Sleep Things I Want to Change Ways to Feel Good About Me</p>
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The underlying message in the table of contents from Nadeau & Dixon (2005) (represented in Table 4.2), is that there are multiple ways children can learn to adhere to normative behavioural expectations. The book specifies that professionals who work in schools can have a large impact on correction, both by helping parents learn skills to fix children, and by supporting children to act in socially acceptable ways. Like many books, *Learning to Slow Down and Pay Attention* (Nadeau & Dixon, 2005) emphasizes ways children can correct themselves. It goes into as much micro-detail as instructing kids how to breathe (p. 58) and when to sit and when to stand (p. 54). Following Nadeau and Dixon (2005), the other 12 books include suggestions for how AD/HD-diagnosed children can learn the skills and behaviour necessary to

become normalised. These techniques range from broad behaviour management interventions to micro-management at the level of the minutiae of bodily functions.

Across the 13 books, children who have engaged in enough practices of intervention become, what the books position as, corrected. Table 4.3 illustrates the four characteristics of a corrected child: the child is successful in school, able to make and keep friends, open and honest about his feelings with family members, and knows how to regulate his own behaviour. The books' depictions and descriptions of corrected children reveal the optimal outcome of interventions, the child who acts like his non-diagnosed peers.

Table 4.3 Common characteristics of a *corrected* child diagnosed with AD/HD, as depicted in storybooks and guidebooks

Characteristic	Storybooks	Guidebooks
Successful in school [10 books]	Gordon, 1991; Penn, 1999; Smith, 1997; Weiner, 1999; Zimmet, 2001	Nadeau & Dixon, 2005; Nemiroff & Annunziata, 1998; Quinn & Stern, 2001; Rotner & Kelly, 2000; Silverstein, Silverstein, & Silverstein Nunn, 2001
Able to make and keep friends [6 books]	Smith, 1997; Weiner, 1999	Nadeau & Dixon, 2005; Nemiroff & Annunziata, 1998; Quinn & Stern, 2001; Silverstein, Silverstein, & Silverstein Nunn, 2001
Open and honest about feelings with family [7 books]	Gehret, 1991; Weiner, 1999	Nadeau & Dixon, 2005; Nemiroff & Annunziata, 1998; Quinn & Stern, 2001; Rotner & Kelly, 2000; Silverstein, Silverstein, & Silverstein Nunn, 2001
Knows how to regulate own behaviour [11 books]	Galvin, 2001; Gehret, 1991; Gordon, 1991; Smith, 1997; Weiner, 1999; Zimmet, 2001	Nadeau & Dixon, 2005; Nemiroff & Annunziata, 1998; Quinn & Stern, 2001; Rotner & Kelly, 2000; Silverstein, Silverstein, & Silverstein Nunn, 2001

In their description of normalised children, the books imply that the characteristics of a corrected child are concrete – that they can be clearly and quantitatively measured. Yet, “successful in school,” “making and keeping friends,” “getting along with family”, “able to self-regulate” are constructed notions that can only be defined based on arbitrary thresholds of what it means to be normal. Regardless, in the storybooks and guidebooks, children with AD/HD diagnoses are deemed abnormal and are expected to conform to these characteristics by engaging in particular normalising activities. In the same way that the four characteristics of a recently-diagnosed child (see Table 4.1 above) mark behaviours that are socially constructed as abnormal and warrant the child’s engagement with disciplinary power so that he can become normalised, the four characteristics in Table 4.3 are socially constructed as normal and mark the end-point of correction.

Analytical Finding 2: Books emphasize what happens post-diagnosis

With a sense of how the storybooks and guidebooks illustrate children’s correction from the start (a recently-diagnosed child) to the end (the child who has learned to act in a socially acceptable way) I am in a position to examine the nature of the relations in which children engage that guide them along this process. To begin my analysis of the circulation of power that drives correction, I coded all 13 books to look for general themes, of which I found 64 (see Appendix A). The themes fall into four main groupings: aetiology of AD/HD, diagnostic utility, defining the AD/HD-diagnosed child, and post-diagnosis. In Table 4.4, I present two representative themes from each grouping.

Table 4.4 Groupings of themes with corresponding thematic examples

Grouping	Examples of corresponding themes
The aetiology of AD/HD	Children with AD/HD have dysfunctional brains
	AD/HD comes from environment during pregnancy
Diagnostic Utility	Diagnosis helps child be seen as a child
	Diagnosis confirms a problem children know they have before they are given the diagnosis
Defining the AD/HD-diagnosed child	Children with ADHD have trouble making and keeping friends
	AD/HD can lead to a child's low self-esteem
Post-diagnosis	Team approach is necessary to help child
	Children with AD/HD should be separated from peers to complete school work

My initial thematic analysis highlighted that a disproportionate number of themes (29) fall into the *post-diagnosis* grouping. This discovery reveals the books' emphasis on the correction process and reinforces that the books are ideal sites to explore the representation of the circulation of power that comprises correction. In my next analytical finding I discuss how the techniques of disciplinary power manifest in the post-diagnosis grouping.

Analytical Finding 3: Practices of the eight techniques of disciplinary power are prevalent in the books

My coding of the 29 themes in the *post-diagnosis* grouping using a Foucaultian analytics of power (Gore, 1995) highlights how power pervades the lives of AD/HD-diagnosed children; each theme can be classified into at least one of the eight techniques of disciplinary power. Post-diagnosis-related themes were particularly prevalent in theme groupings of two techniques of power. They formed 85% of the themes that related to normalisation, and 100% of the themes that related

to distribution. Table 4.5 exhibits the relationship of the themes to disciplinary power by listing two applicable themes for each technique of disciplinary power.

Table 4.5 Techniques of disciplinary power with corresponding themes

Technique of disciplinary power	Corresponding themes
Surveillance	Children are aware of the emotion that their <i>bad</i> behaviour brings to their parents
	Classmates should see what AD/HD looks like
Normalisation	Friends, family, and teachers can help correct the child
	With enough desire, success [being corrected] is possible
Exclusion	Teachers need to remove the child from the group when he is not behaving
	Parents can place children with AD/HD in a separate room so they effectively complete school work
Classification	After diagnosis, adults treat the child differently
	Diagnosis helps others see the child as a child
Distribution	Children must learn where to study to be most productive
	Children can learn how to control their movement in school
Individualisation	AD/HD is genetic
	AD/HD is associated with many feelings – both positive and negative
Totalisation	Children with AD/HD have lots of troubles
	Children with AD/HD have trouble making and keeping friends
Regulation	There are calculated ways for children to help themselves
	Restriction and reward will change a child’s <i>bad</i> behaviour

The relationship between the books’ themes and the eight techniques of disciplinary power offers a general demonstration of the way disciplinary power relations are organized in depicted and described practices of correction, something that I will address in much more detail in section 2, *Analytical Insights*. The themes reveal that the exercise of disciplinary power has a social element – they all (either explicitly or implicitly) address an individual in a child’s life. The theme “teachers

need to remove the child from the group when he is not behaving,” for example, describes that teachers deploy exclusion to teach the child when his problematized behaviours must be corrected. The theme “children must learn where to study to be most productive,” shows that children can deploy distribution to adhere to the normative expectation that studying should be done in a particular way and should generate particular results. The examples above illustrate that what the books call correction is a process rife with disciplinary power relations in a social context.

Before discussing my next analytical finding, I want to address one theme from my thematic analysis that did not accord with the exercise of disciplinary power: “many factors affect children’s behaviour (i.e., ear infections, sad things at home).” This theme emerged in one book and was the only acknowledgement in my entire data that children’s behaviour can be affected by their external environment - that context, rather than the individual, can be the source of socially unacceptable behaviour (Silverstein, Silverstein, & Silverstein Nunn, 2001). The book did not elaborate on the idea of context as a factor in behaviour. It simply suggested it as the less extreme of two possible roots of problematized behaviour, the other being biological dysfunction manifesting in an abnormal brain. This anomaly stands out because it was the only case, in all 13 books, of an aetiological hypothesis for incorrigible behaviour based in social context. When I consider future research possibilities in chapter 5, *Conclusion*, I address the role of context.

Analytical Finding 4: In the books, correction is a social process

As my analysis into the deployment of disciplinary power in AD/HD-diagnosed children’s lives progressed, I shifted my source of data from the 64 themes

to moments of production. *Moments of production* are snapshots in text that expose critical incidents that disclose something important about children’s lives. In particular, they capture the exercise of disciplinary power as it circulates to guide children to act in socially acceptable ways. An examination of moments of production alongside the themes offers a more textured sense of how disciplinary power is deployed through children’s relations than an examination of the 64 themes. In fact, it was not until I studied moments of production that I was able to extend my discovery from *Analytical Finding 3* about the deployment of power through social relations. An analysis of moments of production in the books revealed the enactment of disciplinary power in four specific realms in children’s lives: school, peer, family, and self. I call these social realms of influence because they are specific networks of relations that comprise a child’s social context. They shape, influence, guide, perpetuate, reinforce, and construct the child’s normalisation. My analysis shows that in all four social realms of influence, power relations discipline children into normativity. Using moments of production, Table 4.6 presents the relationship between social realms of influence and the books’ representation of the correction process.

Table 4.6 Social realms of influence captured in books’ moments of production

Social realm of influence	Moment of production
School	“‘Keep your hands to yourself! You will take a five-minute time-out this instant!’ ‘But—‘ Josh started to say. ‘Time-out!’ said Mrs. Conrad (Smith, 1997, p. 26)
Peer	“‘I don’t think he did a very good job at all,’ said Simon Showoff. ‘I can sit in a chair for hours. Jimmy’s always jumping around the room.’” (Penn, 2003, p. 13)
Family	“If the child does not follow these rules, he or she should be taken to a quiet area to think about the situation. The parent should keep an eye on the child and not talk to him or her until the time is up” (Silverstein, Silverstein, & Silverstein

	Nunn, 2001, p. 35-36).
Self	“The following checklist is a collection of things that other kids with ADHD have said about themselves. Going through this checklist can help you think more clearly about yourself-at school, with your friends, and at home. It will help you understand the things that you are very good at and the things that you’re having problems with.” (Nadeau & Dixon, 2005, p. 16)

To elaborate on the ability of a moment of production to capture disciplinary power relations, I draw on the peer example from above, which shows the deployment of disciplinary power through the protagonist’s classmate. In this passage, Simon Showoff exercises individualisation and normalisation (two of the eight techniques of disciplinary power) by articulating his judgment of Jimmy, the protagonist’s, behaviour, and implying that it needs to be corrected. Simon Showoff’s criticism of Jimmy’s behaviour represents a judgment that suggests Simon does not think Jimmy is normal. Accordingly, Simon Showoff’s criticism has the capacity to have normalising effects on Jimmy’s behaviour (Penn, 2003, p. 13). This interaction, like the other moments of production in Table 4.6, exposes the dependency of the deployment of disciplinary power on individuals in the diagnosed child’s social life. Discipline is a social process that can be captured by looking at frozen moments in text. These are moments of *production* because they reveal diagnosed children being *produced* into a normalized subject positioning.

Analytical Finding 5: Correction has a disciplinary nature

When disciplinary power is exercised in one of the four social realms of influence, a *disciplinary mechanism* forms. Disciplinary mechanisms maintain, produce, or perpetuate disciplinary processes of correction (Foucault, 1995, p. 197). In the context of my project, disciplinary mechanisms are the ideas, actions, and

statements in the storybooks and guidebooks that produce an AD/HD-diagnosed child’s normalisation. For example, Simon Showoff’s criticizing of Jimmy’s behaviour forms a disciplinary mechanism in that it is a statement that marks Jimmy’s difference, and has the potential to reinforce Jimmy’s process of correction because it signals to Jimmy that he is not adhering to socially acceptable ways of behaving (Penn, 2003, p. 13). This disciplinary mechanism is comprised of individualisation and normalisation exercised in the social realm of influence, peer. Table 4.7 shows moments of production from the books and demarcates the associated technique of disciplinary power, social realm of influence, and disciplinary mechanism. Many of the guidebooks’ moments of production expose two disciplinary mechanisms.

Table 4.7 Textual depictions of the eight techniques of power with corresponding social realm of influence

	Storybook Moment of Production	Social Realm & Disciplinary Mechanism	Guidebook Moment of Production	Social Realm & Disciplinary Mechanism(s)
Surveillance	“I missed the first three words so I looked at Rachel’s paper. Miss Perfect Rachel told Mrs. Pinck that I was cheating. Honestly I wasn’t! I just wanted to see what words I missed” (Zimmet, 2001, p. 7)	PEER Blaming child for cheating	“Before you start a task, take a guess at how long you think it will take to complete. Then time yourself and compare this time with your first guess. With practice, you will get better at figuring out how long things take. You can keep a record of your progress on a piece of paper or the computer” (Quinn & Stern, 2001, p. 57).	SELF Logging time for task completion and Instructing children to log time for task completion
Normalisation	“ ‘I don’t think he did a very good job at all,’ said Simon Showoff. ‘I can sit in a chair for hours. Jimmy’s always jumping around the room.’” (Penn, 2003, p. 13)	PEER Pointing out that child does not fit behavioural norm	“Imagine a sleek red sports car driving around a track. It’s flying down the stretches, speeding around the curves, smooth and low to the road, the engine racing...BUT...it has no brakes” (Quinn & Stern, 2001, p. 11).	SELF Suggesting something is missing from the child
Exclusion	“‘Keep your hands to yourself! You will take a five-minute time-out this instant!’ ‘But—’ Josh started to say. ‘Time-out!’ said Mrs. Conrad (Smith, 1997, p. 26)	SCHOOL Teacher giving child time-out	“Discipline is also important. Kids with ADD need to know that there are consequences for their behaviors. Many people use time-outs. The child should be told what kind	FAMILY Sending child to quiet area as consequence and

			of behavior is not acceptable. If the child does not follow these rules, he or she should be taken to a quiet area to think about the situation. The parent should keep an eye on the child and not talk to him or her until the time is up.” (Silverstein, Silverstein, & Silverstein Nunn, 2001, pp. 35-36)	Suggesting teachers/parents send child to quiet area as consequence
Classification	“Dr. Lawson... told me I have Attention Deficit Disorder, which is often called ADD for short. ADD means that my body doesn’t have enough of the chemicals that help me control how I move and think” (Gehret, 1991, p. 13).	SELF Acquiring the AD/HD diagnosis	“This boy has ADD, also known as ADHD. He is too distracted to concentrate on his homework” (Silverstein, 2001, p. 11)	SELF Labeling child’s behaviours that fit definition of AD/HD
Distribution	“Then Mrs. Arrow said that the paper was too messy and, you got it, back to my desk to do it over. I never did make it to the computer” (Gordon, 1991, p. 2)	SCHOOL Teacher directing child’s location in classroom based on her assessment of his work quality	“Amanda’s teacher finds her a quiet work corner” (Rotner & Kelly, 2000, p.17)	SCHOOL Teacher directing child’s location in classroom and Suggesting that teachers should send children to quiet work corner
Individualisation	“A lot of times, I would raise my hand and ask my teachers to tell me again what they had said. They were always saying, ‘Ben, pay attention,’ or ‘Ben, try to concentrate!’ (Weiner, 1999, p. 5)	SCHOOL Teacher identifying child’s struggle with comprehension as his own problem	“In ADD, the brain works a little differently. Sometimes it feels as if it works too fast; sometimes it feels as if it doesn’t work fast enough. And sometimes that’s a problem.” (Nemiroff & Annunziata, 1998, p. 25)	SELF Identifying dysfunctional brain as a problem
Totalisation	“... when people can’t pay attention and they need to move around a lot, we say they have Attention Deficit with Hyperactivity, or ADHD” (Smith, 1997, p. 35).	SELF Identifying that all children with similar behavioural patterns have a problem called AD/HD	“The following checklist is a collection of things that other kids with ADHD have said about themselves. Going through this checklist can help you think more clearly about yourself - at school, with your friends, and at home. It will help you understand the things that you are very good at and the things that you’re having problems with.” (Nadeau & Dixon, 2005 p. 16)	SELF Compiling characteristics that are meant to suggest a person has AD/HD and Instructing child to complete checklist to become more self-aware
Regulation	“We came up with this special program we decided to call ‘Magic Marbles.’ Every morning Mrs. Arrow puts 8 marbles in a cup that she puts on my desk. She also taped a piece of paper to	SCHOOL Using Magic Marble program in school	“Doctors say, ‘A.D.D. is not your fault. It doesn’t mean you’re not smart.’ ‘You can learn to manage it, though it doesn’t go away.’ (Rotner & Kelly, 2000, p 19)	SELF Children learning to manage the problem of AD/HD and

	<p>the cup with these three rules written on it: 1. No disturbing the class by talking out of turn or getting out of the seat at the wrong time, 2. No work left unfinished because of daydreaming, 3. No slobby work. I get to keep all the marbles as long as I don't break any of the rules" (Gordon, 1991, pp. 13-14).</p>			<p>Instructing children to learn to manage the problem of AD/HD</p>
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In the books, disciplinary mechanisms manifest in a variety ways, including a behaviour management program (Magic Marbles, in Gordon, 1991), peer stigmatization (blame-placing, in Zimmet, 2001) a parent sending a child out of the room (time out, in Silverstein, 2001), and self-awareness exercises (checklist, in Nadeau & Dixon, 2003). Each of the disciplinary mechanisms in Table 4.7 reflects the instrumentality of social relations in a child's correction process: the Magic Marble program is dependent on the teacher-child relationship; self-awareness exercises only happen when a child engages in disciplinary relations with himself; a time-out at home reflects a particular relation of power between a parent and a child.

Alongside depicting disciplinary mechanisms the way storybooks do, many of the guidebooks actually have the capacity to activate disciplinary mechanisms by explicitly instructing children to engage in normalising relations with themselves. Guidebooks are different than storybooks because they are self-consciously about instructing children to behave in ways deemed normal by the books. In general, guidebooks outline a number of things: (a) that there is something happening in the AD/HD-diagnosed child's body, (b) that the reader must find a way to live with an abnormal body, and (c) that the guidebook, itself, can be useful in the child learning to change, by engaging readers through its reproduction of anecdotes, lessons, guidesheets, tests, and practice opportunities.

For instance, the passage above that describes a method for children to log their task completion time (Quinn & Stern, 2001, p. 57) depicts a disciplinary mechanism (logging time for task completion), and *is* a component of a disciplinary mechanism (instructing children to log time for task completion) – what is missing in the formulation of this instruction into a disciplinary mechanism is the child-reader who engages in self-logging once he reads the book. Normalisation takes two forms in the 13 books – as formulated through depiction (storybooks and guidebooks) and as suggested through instruction (guidebooks). Guidebooks explicitly describe how a diagnosed individual is expected to live. My research did not include live child subjects, so I cannot know the impact of instructions, like the one in Quinn and Stern (2001), on self-normalisation or whether children actually take up the subject positioning of self-monitoring. However, I do not doubt that storybooks, like guidebooks, have the capacity to engage child-readers in self-normalisation by enticing them to mimic the disciplinary activities of characters in the books. Because the research did not address the capacity of varying rhetorical tools to activate self-discipline in readers, I can only suggest that guidebooks more overtly comprise disciplinary mechanisms in the way they explicitly instruct children in how to act in normative ways.

My analytical findings highlight how correction is a practice of power in children's storybooks and guidebooks. Moments of production capture the deployment of power through disciplinary mechanisms. These disciplinary mechanisms are comprised of at least one individual in one of the diagnosed child's social realms of influence exercising a technique of disciplinary power. I also

discover that the books themselves, when read, have the capacity to become disciplinary mechanisms. In the next section, I connect my findings to broader analytical insights about the social construction of correction.

Section 2: Analytical Insights

The events that bring a child from the start-point of abnormality (see Table 4.1) to the end-point of being normalised (see Table 4.3) in the books comprise the child's process of correction wherein he learns to adhere to a socially constructed idea of normative behaviour. Correction unfolds when disciplinary power circulates in children's social relations as deployed by disciplinary mechanisms. My findings about the operation of correction lead me to two analytical insights about correction. The first is that AD/HD activates children's engagement in a political process of correction; the second is that AD/HD transforms the very nature of diagnosed children's lives by infusing those lives with an additional layer of disciplinary power. This second insight builds upon the first by suggesting that the lives of AD/HD-diagnosed children are, by nature, political.

Analytical Insight 1: AD/HD activates diagnosed children's engagement in a political process of correction

The conventional literature about AD/HD describes how the diagnosis is a biomedical problem of individuals that can be corrected through interventions. Interventions focus on shaping a child's behaviour so it adheres to normative expectations. My sample of children's storybooks and guidebooks mirrored the conventional literature's trajectory of correction – a child's unruly behaviour is labeled with AD/HD, which leads to correction so the child comes to embody a

normalized subject positioning. AD/HD is a socially constructed category. As such, the correctional practices that it activates are rife with power relations and thus shape a political process.

Using *Pay Attention Slosh* (Smith, 1997), a storybook that uses active and straightforward language, lively description, and animated questions, it is possible to examine how the protagonist's (Josh's) process of correction is infused with disciplinary power such that I can re-frame his behaviour (at the end of the book) not as corrected, but as socially acceptable. In Josh's story, after he is given the diagnosis of AD/HD, his social relations with his teacher, peers, family, and himself become centered on correcting him. Disciplinary mechanisms in Josh's life become the determinant of his interactions with others: a behaviour program implemented by his teacher and parents means that many of his conversations with them are about the behaviour program itself; his teacher's movement of Josh's desk in the classroom establishes that Josh interacts with his teacher more regularly than before he was diagnosed; and his exclusion in the lunchroom by lunchroom monitors puts him in greater contact with adults during his lunch recess. These focused social relations are an effect of power, produced by Josh's AD/HD diagnosis and the process of correction that follows from it. The relations are calculated (movement of desk), technical (behaviour program), and organized (exclusion at lunch) – three characteristics that Foucault uses in his description of discipline (Foucault, 1995).

Foucault (1995) suggests that discipline is exercised both overtly and subtly. In Josh's life, while explicit disciplinary activities are present, more intricate, subtle exercises of discipline prevail. A short series of moments of production when Josh is

in his classroom, for example, is rich with subtleties of the circulation of disciplinary power. First, Josh frustrates one of his classmates, which leads her to complain to the teacher. Second, Josh satisfies his teacher with better behaviour, which triggers her to add a sticker to his sticker chart (a behavioural reinforcement tool). Third, Josh disrupts the classroom, which leads to the loss of a sticker. Then, Josh begins learning how to self-survey because he has come to understand that the more cooperative he is, the greater chance he will be rewarded. Finally, within this chain of events, Josh's stirring leads to his teacher repeatedly tapping him on the shoulder to remind him to stay focused (Smith, 1997, pp. 41-42). These moments of production expose five specific disciplinary mechanisms: Josh's peer complaining to their teacher, Josh getting a sticker added to his sticker chart, Josh getting a sticker removed from his sticker chart, Josh self-surveying, and Josh's teacher tapping him on shoulder. In these moments of production, discipline appears in the detailed operations of power, the specific processes in which Josh engages to become corrected (Foucault, 1990).

Josh's ADD diagnosis produces how others understand him and relate to him. Josh's social interactions with his teacher are shaped by her knowledge of his ADD diagnosis (she interacts with him differently once he is diagnosed) and her intention to correct him. His social interaction with his peer shows that she perceives him as a child who needs to be corrected. Furthermore, Josh's efforts at self-control reflect his growing conception of himself as a child who can self-monitor to become fixed. Discipline, therefore, is deployed through the conditions of all of Josh's relationships (Foucault, 1990), and by the end of the book, disciplinary mechanisms have changed Josh so that he excels in school, makes friends, gets along with his family, and has a

confident sense of self – behavioural characteristics that are portrayed in the books as comprising what it means to be normal. Jean-Baptiste de La Salle articulates that the deployment of disciplinary power “make[s] it possible to ‘derive, from the very offences of children, means of advancing their progress by correcting their defects’” (as cited in Foucault, 1995, p. 179). Josh’s process of correction exhibits the change that de La Salle describes. Josh’s unaccepted behaviour is seen as defective, is labeled as ADD, and is corrected through the deployment of power through disciplinary mechanisms. As de La Salle suggests, Josh’s correction is an effect of power. The power that shapes his correction is triggered by the socially constructed category of ADD, which, in itself, is an effect of power. Josh’s correction produces him as a creation of social relations that are based on power relations organized to normalise him.

Like *Pay Attention Slosh* (Smith, 1997), *Attention Deficit Disorder* (Silverstein, Silverstein, & Silverstein Nunn, 2001) focuses on the correction of ADD-diagnosed children and has a particularly engaging style by virtue of its clarity of organization and unique presentation of information (through text boxes and “highlights” sections). In addition to showing how children can become corrected, this guidebook exhibits the organization of power relations that shape an ADD-diagnosed child’s life in its direct instructions for correction. The guidebook’s instructions for correction are, for the most part, forms of social intervention. For instance, the book says that teachers can help children with ADD by showing empathy (Silverstein, Silverstein, & Silverstein Nunn, 2001, p. 29; as described in Harlacher, Roberts, & Merrell, 2006), teaching them much-needed skills (p. 33; as

described in Kos, Richdale, & Hay, 2006), and training them to behave appropriately (p. 34; as described in Anhalt, McNeil, & Bahl, 1998). It also suggests that parents learn “behaviour modification” techniques (p. 34; as described in DuPaul & White, 2006), that they offer extra support to their child (p. 32; as described in Hook & DuPaul, 1999), and they keep a close eye on the child (p. 35; as described in Pelham Jr., Wheeler, & Chronis, 1998). This guidebook illuminates the social interventions discussed in the conventional literature as useful for “managing the symptoms of ADHD” (Harlacher, Roberts, & Merrell, 2006, p. 6). Yet, as an analysis of the moments of production in this guidebook makes evident, these interventions are about mandating children to behave in socially acceptable ways. As children learn socially acceptable manners and patterns of behaviour through interventions, such as the ones above, they are engaged in correction, a constructed process based on one way of understanding normativity.

The social interventions in *Attention Deficit Disorder* (Silverstein, Silverstein, & Silverstein Nunn, 2001) are disciplinary mechanisms. For example, the description of teachers teaching children much-needed skills shows a form of regulation based on a certain notion of what comprises *essential* behavioural skills. The idea that there are “essential skills” is rooted in discourses of normative behaviour. When children are engaged in a corrective process that is based only on a particular set of discourses’ conceptualization of behaviour, correction is actually a powerful, disciplinary process. The binary of broken/whole that *Attention Deficit Disorder* implies is actually a binary of socially constructed “bad” behaviour/socially constructed “good” behaviour.

The disciplinary mechanisms in *Attention Deficit Disorder* (Silverstein, Silverstein, & Silverstein Nunn, 2001) formulate a complex network of power relations that is as much dependent on the role of the child as the role of the teacher. Foucault's ideas emphasize the role that children play in their own normalisation: "power is not exercised simply as an obligation or a prohibition on those who 'do not have it'; it invests them, is transmitted by them and through them" (Foucault, 1995, p. 27). *Attention Deficit Disorder's What You Can Do* section outlines specific activities in which children can engage to "help" themselves listen better, "remember things better, and get things done" (p. 37). The book uses instruction to suggest that child-readers become invested in the circulation of power that disciplines them to adhere to hegemonic notions of normativity.

As the self becomes involved in correction, the diagnosed child assumes a fourth subject positioning beyond the empirical subject positioning (which the child embodies before he is diagnosed), the abnormal subject positioning (which the child embodies once labeled dysfunctional) and the normalised subject positioning (which the child *can* embody if corrected) – a monitoring subject positioning. The monitoring subject positioning puts children in the role of actively partaking in their own processes of correction. This monitoring subject positioning, which the storybooks show by depicting self-normalising characters, and the guidebooks' instructions imply is necessary, plays a crucial role in children's own correction process. When books depict or describe children engaging in activities like the ones suggested in *Attention Deficit Disorder's What you can do* section, they are positioning diagnosed children to establish and maintain an ongoing level of self-

awareness. This (enhanced) self-awareness is positioned as crucial in order for the child to become corrected.

The idea of coming to know the self in detail that comes from this self-monitoring subject positioning, relates to Foucault's notion of technologies of the self. Foucault (1988) says technologies of the self

permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality. (p. 18)

While correction of AD/HD-diagnosed children, as enacted in *all* social arenas, is a technology of the self in that it is about affecting the operation of children's bodies and conduct, Foucault uses the term to emphasize the role of individuals in their own production. The monitoring subject positioning as depicted in storybooks like *Pay Attention Slosh* (Smith, 1997) and suggested by guidebooks like *Attention Deficit Disorder* (Silverstein, Silverstein, & Silverstein Nunn, 2001), exhibits the extent to which children are drawn into being invested in power relations that shape them to become normalized. It also exhibits the extent to which diagnosed children are vessels through which power flows as they learn to adhere to socially acceptable standards of behaviour (Foucault, 1995). While the monitoring subject positioning is not evident in the two books I discuss next, it re-emerges in my discussion of the infusion of discipline in the lives of AD/HD-diagnosed children in *Analytical Finding* 2.

In two of the storybooks, the circulation of normalising relations diverges from the parallel narratives of the other books, but is still prevalent. There is no explicit depiction in Penn (2003) of the protagonist with an ADD diagnosis engaging in normalising relations. In fact, the protagonist's teacher suggests that rather than needing to be corrected, the child's *different* behaviour should be celebrated. He says: "it can be very helpful to understand what it's like to walk in someone else's shoes" (Penn, 2003, p. 7). Yet, the teacher's decision to single out the child to display his difference to his classmates is also an exercise of power that perpetuates a notion of normativity. That the child's behaviour is highlighted in front of his entire class casts him as abnormal. Although not overtly about correction, this story contributes to the notion of normativity in its exhibition of the protagonist's behaviour as dysfunctional.

Like Penn (2003), and all the other books, *Waiting for Mr. Goose* (Lears, 1999) perpetuates the very basis of the AD/HD diagnosis – the broken/whole binary that is grounded in particular discourses' notion of normativity. *Waiting for Mr. Goose* relays the message that AD/HD is a problem: a diagnosed child is deficient in his ability to self-control. Yet, the book also approaches normalisation in a unique way. The book was written to show that although children "who have AD/HD contend with greater obstacles in their quest for self-control ... they possess a tenacity that is unstoppable" (p. i). This passage suggests that in some situations, children with AD/HD diagnoses act just like non-diagnosed children. The books' message has elements of resistance to some of the conventional discourses about AD/HD. Unlike most books, this story emphasizes positive attributes of an AD/HD-diagnosed child who has not evidently engaged with practices of correction. Although the content of

the book is clearly grounded in normative discourses of behaviour (as is evident in the preface), it does not emphasize the diagnostic category as a marker of dysfunction, nor cause for focus on correction. Yet, even under the veil of a focus on the child rather than his diagnostic category, the book is disciplinary in nature. It centers on a child's ability to exercise disciplinary power such that he excels beyond normative expectations.

AD/HD, as depicted and described in *Pay Attention Slosh* (Smith, 1997), *Attention Deficit Disorder* (Silverstein, Silverstein, & Silverstein Nunn, 2001), *A.D.D. Not B.A.D.* (Penn, 2003), and *Waiting for Mr. Goose* (Lears, 1999) is a diagnostic category that activates disciplinary relations that shape children's lives. In Smith (1997) and Silverstein, Silverstein, and Silverstein Nunn (2001), children in the books interact in complex networks of power relations where discipline is pervasive. It is through disciplinary mechanisms deployed by others and themselves, that diagnosed children learn to act according to constructed notions of normativity by assuming a normalized subject positioning. In Penn (2003) and Lears (1999) discipline is subtle, emerging in the power relations that are exercised when the books' position AD/HD-diagnosed children as different. In all 13 books, discipline involves the diagnosed child as much it involves other individuals in the child's life.

The disciplinary mechanisms that drive the process of correction in the books are dependent on the circulation of power: "power is exercised rather than possessed; it is not the 'privilege,' acquired or preserved, of the dominant class, but the overall effect of its strategic positions - an effect that is manifested and sometimes extended by the position of those who are dominated" (Foucault, 1995, pp. 26-27). Children in

the books are as involved in their own normalisation as others in their lives. In fact, their role in exercising power through disciplinary mechanisms is more detailed than the role of others because children are constantly with themselves, able to monitor each and every bodily movement, verbal utterance, and breath. Correction, as a socially constructed process, is intimately connected to children's monitoring subject positioning.

I acknowledge that those who accept medical diagnoses as descriptive fact about individuals might agree that AD/HD activates discipline, and based on that discipline, children learn to behave in acceptable ways. What I have set out to illustrate in this section is that the exercise of discipline that follows an individual's ascription with an AD/HD diagnosis is focused on shaping that individual so that he learns to adhere to a *socially constructed* notion of normativity. Every individual is engaged in networks of disciplinary power most of the time. Positionings such as customer, teacher, woman, or patient, are all connected to an engagement with discipline to behave in particular ways. I suggest that in the books, the discipline that flows through the lives of children diagnosed with AD/HD as they engage in correction, is based exclusively on their identification with a label constructed from only particular ways of thinking about normativity. In the next section I use examples from the 13 books to elaborate on the far-reaching effects of this political process of correction in diagnosed children's lives.

Analytical Insight 2: AD/HD transforms the nature of diagnosed children's lives

My first analytical insight emphasizes that AD/HD activates diagnosed children's engagement in a political process of correction through their widespread,

and moment-to-moment engagement in disciplinary power relations that affects them on multiple levels including their location in space and their physical activities. In this section I explore how these disciplinary power relations seep into each, and every, temporal and social aspect of the lives of diagnosed children. The existence of disciplinary relations related to behavioural correction that bring children to a manufactured level of normative behaviour is a dimension of day-to-day existence that is not present for non-diagnosed children. Furthermore, once children become corrected, disciplinary power continuously circulates to maintain their behaviour at socially acceptable standards. In other words, there is no *cure* for AD/HD-diagnosed children. Although diagnosed children are capable of becoming normalised, they are never themselves capable of being “normal”, as they constantly require disciplinary support to enable them to replicate the behaviour of non-diagnosed children. AD/HD-diagnosed children’s lives are perpetually imbued with an added layer of surveilling, normalising, exclusionary, classificatory, distributive, individualising, totalising, and regulatory relations. These techniques of disciplinary power transform children’s social lives into a series of functional and corrective interactions.

The four social realms of influence (school, peers, family, and self) through which power circulates in the books, comprise a child’s entire social network. The books show how power infiltrates these social relations all the time - from the moment a child wakes up in the morning (e.g., Gehret, 1991) to the time he falls asleep at night (e.g., Galvin, 2001). In fact, the books show all of the following events infiltrated with disciplinary power: children’s days at school (e.g. Weiner, 1999), their sports activities (e.g. Nemiroff & Annunziata, 1998), their visits with friends

(e.g. Galvin, 2001), their mealtimes (e.g. Smith, 1997), and their alone-time (e.g. Silverstein, Silverstein, & Silverstein Nunn, 2001). The books depict and describe children's correction as something that pervades moment-to-moment life.

Disciplinary power relations, which correct AD/HD-diagnosed children, become an ever-present factor in a diagnosed child's life.

Once a child has become corrected, that state of adhering to normative expectations of behaviour is *maintained* by the circulation of disciplinary power. In the books, relations of power that are based in correction never cease following a diagnosis. For instance, at the end of the *Pay Attention Sloss* (Smith, 1997) the text suggests that Josh has been corrected because he behaves like non-diagnosed children: he does well in school, has positive friendships, gets along with family, and likes himself a lot. Yet, Josh is never exactly like children who do not have AD/HD diagnoses because his life is saturated with disciplinary mechanisms that maintain his semblance of normativity. The story ends: "by the end of the week, he [Josh] had earned twenty-three stickers and almost finished the chart. The second week was even better. He earned thirty stickers. His father told him how proud he was and took Josh to the toy store on Saturday to trade in his sticker chart for a baseball cap. Josh has lots of caps, but he was proudest of this one because he had earned it himself" (p. 42). This reflection on a series of moments of production suggests that even when Josh's behaviour accords with normative expectations, his life is filled with activities that maintain that behavioural state.

In the storybooks and guidebooks, AD/HD-diagnosed children are always in production. They are endlessly engaged with disciplinary mechanisms to become and

then remain corrected. Foucault describes this persistent aspect of discipline when he writes that society “assures both the real capture of the body and its perpetual observation” (1995, p. 304). In my sample of 13 children’s storybooks and guidebooks, diagnosed children are represented as perpetually engaged with discipline to help them achieve and maintain a state of correction or normativity. Once diagnosed, their social lives are constituted by power. Both correction, and the state of being corrected, are permeated with disciplinary power, which enforces ways of being in the world that are based on social constructions of normativity.

Analytical Conclusion

Themes and moments of production in children’s storybooks and guidebooks illuminate the social processes that AD/HD-diagnosed children engage in as they learn how to behave in ways constructed as normal. The social nature of what happens to children once they are diagnosed with AD/HD is evident in the five analytical findings: 1) books show parallel lead-ups, starting points, and ending points to correction; 2) books emphasize what happens in children’s lives post-diagnosis, 3) practices of the eight techniques of disciplinary power are prevalent in the books, 4) in the books, correction is a social process, and 5) in the books correction has a disciplinary nature. Accordingly, the two analytical insights reveal that AD/HD activates diagnosed children’s engagement in a political process of correction and that AD/HD transforms the very nature of diagnosed children’s lives.

In other words, my analysis highlights what I understand to be the *politics of correction* – what the conventional literature and children’s storybooks and guidebooks put forth as correction is a process that is produced by the circulation of

disciplinary power relations that define AD/HD and the threshold of normativity it activates. In the books, circulating relations of power between and within children and individuals in all realms of their social life form the disciplinary process of correction that is about shaping the child to behave like non-diagnosed children. Disciplinary power pervades children's lives and even once they achieve normative behaviour, relations imbued with discipline maintain their positioning as corrected. The books showed that AD/HD-diagnosed children, even once corrected, are emmeshed in a web of disciplinary relations. Children cannot separate themselves from this complex network of relations for as long as they continue to subscribe to conventional notions of normal behaviour. Although AD/HD is based on a constructed notion of normativity, the books indicate that the diagnosis triggers a very real and tangible process of correction to which children given the diagnosis are expected to adhere.

With a new understanding that AD/HD activates children's engagement in a political process of correction and that children's lives, which become characterized by disciplinary power relations, transform into lives saturated with politics, I am curious about how the lives of AD/HD-diagnosed children would look different without the label that comes to characterize them. How would Josh's life, for example, unfold if he were not singled out and labeled as being dysfunctional? How would his life transform if his loud speech and sense of humour were reinforced rather than criticized? Or, how would Josh's life be different if his energy and quick attention span were seen as normal and met by the world around him? And what if, should his unruly behaviours continue to be seen as abnormal, his surroundings were

deemed dysfunctional rather than him being seen as dysfunctional? How would Josh understand himself differently if he never had to experience the added layers of surveillance, normalisation, exclusion, classification, distribution, individualisation, totalisation, and regulation that were activated by his diagnosis? How would his relationships with his teachers, peers, family, and even himself, be different? If the disciplinary relations activated by AD/HD ceased to exist, what other relations might take shape in the lives of children like Josh? I now turn to chapter 5, *Conclusion*, where I discuss some of these questions and the research directions they kindle.

Chapter 5 - Conclusion

As children grow up, circulating discourses guide them to understand and enact behaviour that is accepted as normal. Children who do not conform to these hegemonic ideas are often given behavioural diagnoses like AD/HD. Not only are these children, like all children, subject to learning what it means to be normal, but they are also perpetually reminded that there is something wrong with them, and perpetually engaged in relations that correct them.

Practices of correction take form in social interventions and other more subtle normalising interactions everywhere in a diagnosed child's life – in the classroom, on the playground, at home, in the library. Correction infuses social relations of diagnosed children. With an understanding that power is ubiquitous (Foucault, 1990; 1995), the idea of correction can be more accurately framed as a socially constructed notion imbued with relations of power. As such, correction is actually normalisation, a disciplinary process that guides children to act in socially acceptable ways. Disciplinary mechanisms, such as classroom behavioural charts, tattle-telling peers, parents who survey, and even books themselves, are inextricably linked to social relations. By engaging with disciplinary mechanisms in their day-to-day social relations, AD/HD-diagnosed children learn to reach the normative standard of behaviour to which AD/HD subscribes. They are engaged in a technology of self that affects the detailed operation of their bodies.

Guided by an extended Foucaultian analytics of power to access the normalisation of children in text, my research identifies and analyzes moments of

production that capture children learning to adhere to the socially constructed notion of being corrected. My findings demonstrate the mechanics of disciplinary power in portrayed children's lives, that this disciplinary power is everywhere, and that its circulation does not cease even after children's behaviour becomes corrected. My research contributes to the growing literature that explores the normalising effects of hegemonic discourses.

Closing thoughts

My study shows that, in books, AD/HD is a diagnostic category that labels individuals' behaviour as abnormal and triggers technologies of the self - complex and intricate disciplinary power relations that effect children's conduct. These relations have the capacity to define children's entire lives. Silverstein, Silverstein, and Silverstein Nunn (2001), for example, not only describe AD/HD-diagnosed children using individualising and essentialising language like "strange" and "mean", but also discuss how teachers, parents, siblings, peers, and children themselves can correct the abnormal behaviour described by AD/HD through detailed management of the child's body and behaviour. Practices like tracking activities on post-it notes, taking the child to a quiet space for contemplation, and friends helping teachers manage a child's behaviour, are examples of how power infiltrates the lives of AD/HD-diagnosed children.

My insights about disciplinary power and the correction of AD/HD-diagnosed children lead me to four queries: How might my findings apply to the lives of real children? How could change on a macro-scale be introduced to shift the hegemonic conception of normativity? If particular behaviours continue to be constructed as

abnormal, can the locus of blame be shifted away from the individual? How many children have to exhibit “abnormal” behaviour before it is seen as “normal”?

I am concerned about the impact of AD/HD on children in the real world. My research findings reveal the problematic possibility that disciplinary social relations based on a singular definition of normativity pervade real children’s lives. Children might be experiencing the same disciplinary process of normalisation that children in the books are shown to be experiencing. If they are, then children’s lives may also be significantly shaped by their diagnosis in ways that involve their social relations becoming infused with discipline that never ends even once children become corrected.

The discipline that infuses the lives of AD/HD-diagnosed children in books is troublesome because it is based on blaming the individual for behaviours that do not accord with a particular social context. This blame comes from the individualized nature of AD/HD. Doctors see children who have particular behaviours. These doctors then find those behaviours to be abnormal (based on the DSM’s diagnostic criteria). Then, doctors give children the AD/HD diagnosis that, by definition, labels the child as disordered. All responsibility for the behaviours is placed on the child. All efforts to change the behaviour are directed toward the child. This straightforward and all-too-common process ignores the manifestation of social context in two ways: first, I wonder how social context contributes to the perception that particular behavioural characteristics signify that a child is dysfunctional and second, if behaviours continue to be constructed as abnormal, what role does social context play in creating and perpetuating those behaviours?

If the storybooks and guidebooks in my study represent what is going on in the real world, then there is an overarching ignorance of the influence of the meso (e.g., school) and macro (e.g., education policy, government agenda, political context) on constructing the behaviour at issue. I wonder how schools and other institutions could be structured to accommodate energetic children so that the behaviours that currently define them as abnormal would cease to be viewed as such.

The storybooks and guidebooks make no mention of the possibility that meso-scale factors or macro-scale factors could be complicit in perpetuating the biomedical notion of normativity. On a macro-scale, education policy could shift from allocating resources based on diagnostic identifiers (which label children and then are affiliated with resources to help them fit in), to a focus on building upon students' strengths by allocating resources to individual children based on their particular needs. The *Yukon Education Act*, for example, does not consider medical diagnoses when offering resources, but rather assumes a flexible approach so that schools can adapt to children's strengths and needs (e.g., Yukon Education Act, pp. 19-20).

If the behaviours described by AD/HD continue to be seen as dysfunctional, then it would be worthwhile to shift the focus from the problematic behaviours as inherent in the individual, to considering how social context is constructed in a particular way that produces or perpetuates behaviours labeled as disordered. Other than one cursory statement in Silverstein, Silverstein, and Silverstein Nunn (2001), the 13 storybooks and guidebooks I studied did not acknowledge the possibility that behaviours deemed abnormal could be the result of the construction of children's social context. Accordingly, the books did not consider that children's social context

- including culture, economic stability of the family, family dynamics, nutritional habits, racialized relations, gender expectations – could be the target of intervention rather than the individual. What would that mean for the AD/HD diagnosis if social context was considered to be the root of problematized childhood behaviour?

Following a consideration of the role of social context in construction particular behaviours as problematic, I want to acknowledge that upwards of 20% of children are diagnosable with AD/HD (Faraone, Sergeant, Gillberg, & Biederman, 2003); close to one in five children struggle to fit into the normative expectations placed upon them. I wonder about the point when what is considered abnormality becomes so common that it is “normal”? I hope that as more and more children fall into AD/HD diagnostic criteria, it will become widely recognized that the behaviours associated with the diagnosis are not a problem of the individual but rather rooted in the construction of children’s social context. It is also my hope that the study of correction, which is so common in the conventional literature, will shift toward the study of the politics of correction – a look at how the correction process is laden with assumptions about normativity.

Future Research Directions

Future research can build on my queries about AD/HD and the politics of correction by addressing questions that blend the empirical with the theoretical:

- How does power play out concretely in the lives of AD/HD-diagnosed children?
- How does the politics of correction take shape in self-help books about other behavioural diagnoses?

- What effects do self-help books have on children's subjectivity?
- How do institutions take up the notion of AD/HD and tie that into the way they deal with individuals with the diagnosis?
- How do children with the AD/HD diagnosis govern themselves?
- How does AD/HD affect the way institutions, like schools, manage the bodies of children?
- How is AD/HD, as a diagnosis, constituted in the first place?
- How has AD/HD become the prevalent diagnosis that it is today?

Foucault's notions of disciplinary power, subjectivity, biopower, governmentality, and discourse can guide an exploration of these issues. In this section I describe future research possibilities by laying out the above empirical directions and weaving in how theory could guide them.

Further research guided by Foucault's notion of disciplinary power could explore my query about the application of my findings to real life by studying the effect of the circulation of disciplinary power in real children's day-to-day social relations. This research could be done through interviews with teachers, other school professionals, peers, parents, and/or children themselves. It could also take shape in further textual analyses, for instance a study of school documents about resource allocation, teacher-training curricula, classroom management tools, parent support group manuals, and/or children's support group manuals.

Another way to further my study on power and discipline, would be an exploration of the politics of correction using other diagnoses as entry points. I would

be particularly interested in how messages about normativity circulate in discourses about other childhood behavioural diagnoses such as Oppositional Defiant Disorder (ODD) or Obsessive Compulsive Disorder (OCD). Even looking at the politics of bodily states such as Anorexia (following Gremillion, forthcoming), depression (following Teghtsoonian, forthcoming), Myalgic Encephalomyelitis (following Moss, forthcoming), or menopause (following Crisler & Caplan, 2002) would contribute to a broader understanding of the politics of correction. Using texts, institutional documents, or interviews with individuals themselves, it would be possible to think more widely about the socially constructed nature of correction as posited by discourse surrounding other medical diagnoses.

I wonder, too, about the impact of AD/HD-focused storybooks and guidebooks on child-readers. Foucault's concept of subjectivity emphasizes "how it is that subjects are gradually, progressively, really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts etc. ... We should try to grasp subjection in its material instance as constitution of subjects" (Foucault 1980, p. 97). It would be fascinating to engage with AD/HD-diagnosed children to learn about how the circulation of power through reading of text impacts their lives. This research would illuminate children's subject formation, their understandings of AD/HD, the way they engage in disciplinary relations with others, the ways self-normalisation becomes a part of their lives, as well as how they understand and resist their identities as children with AD/HD diagnoses (e.g., Currie, 1997).

Foucaultian concepts of governmentality, biopower, and discourse offer an opportunity for future research to move from a micro-scale of analysis (technologies of the self) to a macro-scale of analysis (technologies of power). Governmentality is the study of the political rationality that underscores techniques of power, and is about understanding the “conduct of conduct” (as discussed in Burchell, Gordon, & Miller, 1991). Governmentality can provide a framework for exploring the underlying assumptions that children, once diagnosed with AD/HD, use to mediate their own behaviour, as well as illuminate the set of knowledge that institutions use to manage the bodies of AD/HD-diagnosed children.⁸

Biopower, which is “the controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of population to economic processes” (Foucault, 1990, p. 141) in order to “maximize life” is a theoretical lens through which to examine the technologies of power that produce AD/HD-diagnosed children. In other words, biopower can offer insight into the way institutions affect the production of AD/HD-diagnosed children in particular ways. This research could focus on, for example, how AD/HD is positioned in medical schools, government ministries of health, boards of education, or teachers’ unions, as a way to access and then utilize diagnosed children for particular agendas. Unlike my micro-oriented project, which is focused on technologies of the self, biopower lends itself to a macro-

⁸ For a comprehensive exploration of governmentality, see Burchell, Gordon & Miller, 1991; Lemke, 2000.

oriented study of the technology of power – how AD/HD infiltrates society at the level of policy and institutions.⁹

As I previously discussed, there are many opportunities to explore how AD/HD manifests in the world, from its effects on a micro-scale to its effects on a macro-scale. But what about how the diagnostic category came to be in the first place? What are the values with which it is imbued? While I offer a cursory overview of the answers to these questions in chapter 2, *The Literature as Context*, and address AD/HD as a socially constructed label throughout my thesis, these questions can be more thoroughly explored through research dedicated to discourse. This research can focus on the interaction of discourses that transform reality to create another “practical field in which it is deployed” (Foucault, 1991, p. 61) – AD/HD is a practical field that is produced by discourse and that deploys discourse. Looking at the discursive underpinning of AD/HD would offer two distinct research foci: (a) a historical account of the discourses that have shaped AD/HD and (b) a current account of the discourses that shape AD/HD. The first focus would illuminate the multiple relations (e.g., political, economic, social, religious, class-based, gendered, medical) that coincided at different points along AD/HD’s chronological trajectory to shape it to be what it is today. This research would highlight the competing and complementary ideas and notions that contributed to AD/HD’s formation. The second focus, taking a current snapshot of the diagnosis to explore the competing discourses (such as psychological, educational, psychiatric, and alternative) inscribed on the

⁹ Biopower is explained in detail in “Right of Death and Power over Life,” Foucault, 1990, pp. 135-159; for a current overview of biopower see Rabinow & Rose, 2003.

body of the child diagnosed with AD/HD, would allow for a study of contemporary thought and practice.

My inquiry into the politics of correction using 13 children's AD/HD storybooks and guidebooks as data offers grounding for numerous future research inquiries. Clearly, there is much to be explored to understand the nuances and breadth of correction as it permeates society. My research sheds light on the politics associated with the social construction of children in children's self-help books who have AD/HD diagnoses. The normalisation process in which children in books are expected to engage is fraught with a particular kind of power – disciplinary power that guides children to adhere to normative expectations of behaviour. For Foucault, “the power of normalization imposes homogeneity” (Foucault, 1995, p. 184). My study points to the need for studies that explore how society could be organized differently. A society wherein individuals are not juggling their empirical subject positioning with a quest for a normalised subject positioning. A society based on an ethos of heterogeneity – where correction is a concept used in fixing bicycles, not people.

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Appendix 1

Original themes from books grouped by techniques of disciplinary power

Bold = theme in more than one technique of power

1. Surveillance
 - a. Children with AD/HD don't know when they are getting out of control
 - b. Children are aware of the emotion that their 'bad' behaviour brings to parents
 - c. Children know something is wrong pre-diagnostic ascription
 - d. Children are aware of the gaze of their parents/teachers
 - e. Children understand expectations of obedience
 - f. Parents and teachers must observe child's behaviour and communicate with teacher/parent so everyone is kept informed of child's behaviour
 - g. Classmates should see how AD/HD manifests in the body of the diagnosed child

2. Normalisation
 - a. Friends, family and teachers can help
 - b. Therapy is helpful
 - c. Team approach is necessary to correct child
 - d. Lots of resources to help correct child
 - e. Home and school will help correct child
 - f. Medication can help
 - g. Medication is the solution
 - h. Physicians help with medicine**
 - i. Physicians are in charge of medicine**
 - j. Behaviour modification is useful to correct child
 - k. With enough desire, success [being corrected] is possible
 - l. Children with AD/HD look the same as 'normal' children
 - m. Children with AD/HD are "too much"
 - n. Tutors are helpful

3. Exclusion
 - a. Children with AD/HD have trouble getting along with family**
 - b. Children with AD/HD have trouble making and keeping friends (teasing, singled out)**
 - c. Children with AD/HD want to remove themselves from their environment
 - d. Parents can place diagnosed children in a separate room so they effectively complete school work
 - e. Teachers need to exclude child from the group when he is not behaving

4. Classification
 - a. AD/HD comes from environment during pregnancy
 - b. AD/HD can lead to low self-esteem
 - c. Parent is the first to identify the that there is a problem
 - d. Teacher is the first to identify the problem
 - e. Diagnosis helps others to see the child as a child
 - f. Without AD/HD diagnosis, teacher gets annoyed with behaviour (doesn't understand it)
 - g. After diagnosis, adults treat child differently (better solutions in class, better treatment from parents)
 - h. Children with AD/HD are not alone
 - i. Children with AD/HD have dysfunctional brains
 - j. Children with AD/HD have lots of troubles**
 - k. Children with AD/HD have lots of good attributes
 - l. Children with AD/HD can pay attention to interesting things
 - m. Diagnosis confirms a problem children know they have before they are given the diagnosis

5. Distribution
 - a. Solution is controlling child's location in classroom**
 - b. Solution is sending child to room**
 - c. Children must learn where to study to be most productive
 - d. Behaviour modification involves guiding child's movement/activity
 - e. Children can learn how to control their movement in school

6. Individualisation
 - a. AD/HD is different for all
 - b. AD/HD is genetic
 - c. AD/HD is associated with many feelings
 - d. Life with AD/HD is difficult
 - e. Problem is the brain
 - f. Something is missing in the composition of children diagnosed with AD/HD
 - g. Problem is not child's fault

7. Totalisation
 - a. Children think medication is helpful
 - b. AD/HD is like an overrunning motor
 - c. Most children have some characteristics that children with AD/HD have
 - d. Children with AD/HD have trouble getting along with family**
 - e. Children with AD/HD have trouble making and keeping friends (teasing, singled out)**
 - f. Children with AD/HD have lots of troubles**

8. Regulation

- a. AD/HD is a condition that is impossible for a child to control
 - b. There are calculated ways for children to help themselves
 - c. Children know what helps them to concentrate
 - d. Children should take responsibility for their AD/HD
 - e. Children with AD/HD want to change
 - f. Restriction and reward will change a child's 'bad' behaviour
 - g. Children who take medication get better
 - h. Scientists are experts on child's behaviour
 - i. Doctor is authority on AD/HD
 - j. Physicians help with medicine**
 - k. Physicians are in charge of medicine**
 - l. Solution is controlling children's location in classroom**
 - m. Solution is sending children to room**
9. All techniques of power
- a. Discipline is important
10. Difficult to categorize
- a. Many factors affect children's behaviour (i.e. ear infections, sad things at home)