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**ATTENTION DEFICIT IDENTITY DISCOURSE: EXPLORING THE ABLEIST
LIMITATIONS AND THE LIBERATIVE POTENTIAL OF THE CONTESTED ADHD
SELF**

by

NATHAN T. STEWART

DISSERTATION

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

2017

MAJOR: COMMUNICATION

Approved By:

Advisor

Date

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DEDICATION

To my Uncle Mark: You were here when I began this journey. For reasons we will never understand, you decided to leave this world on your own terms before I completed it. You, along with grandpa, were the only worthy father figures I had. For better or for worse, your decision challenged me to grow and adapt – to transform who I am and who I will become. In this project about self-development, I think it only fitting that I dedicate it to you. There is much of the person that I became as a consequence of your actions, that pursued certain perspectives in this project. It is my desire that this work can provide hope for those that struggle, as I want to always remember that there is never a struggle that is too great for hope.

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While it is impossible to account for every individual influence that has allowed me to complete this extensive and momentous part of my life, I want to acknowledge those that have been the most instrumental in my journey.

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Thanks to my experience on the collegiate debate circuit, Dr. Kelly Young was the first faculty member from Wayne State University that I met. Even before I began my Ph.D. work, Kelly was a friendly face that I could reach out to. Once at Wayne, he helped me kick around and weed out project ideas. His contributions to this project have been invaluable in helping me to understand the difference between what I was writing and what I wanted to argue. He helped cut

through these complex topics effectively. His suggestions for how to move beyond the dissertation are invaluable. Even more, Kelly has been someone that I trust to provide an additional perspective when I needed it academically or professionally.

Without the guidance of Dr. Heather Dillaway, I would not have taken my project in some of the directions that I did; I would not have pushed some of the particular theoretical boundaries that helped make my project what it is. Heather introduced me to and guided me through the health sociology literature related to biomedical discourse and medicalization. She agreed to add to her already extensive workload by supervising me in an independent study even though I was outside of her department. Her contributions throughout my comprehensive examinations, the prospectus, and the final dissertation have helped refine my arguments and how they apply to my overarching objectives.

Despite having never met each other, Dr. Kelly Jakes agreed to join my committee just prior to the prospectus. The idea of having someone completely unknown was a source of some apprehension. However, Kelly provided invaluable critiques of my work that helped me crystalize the arguments I was trying to make. Having worked on this project for such an extensive time and being immersed in the literature, I had become so familiar with what I wanted to say that I lost track of how I needed to say it for others to understand. Kelly provided a critical, fresh eye to the project. I especially appreciated all of her suggestions for taking this project beyond the dissertation. She exhibited a passion for my project that I am grateful for.

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in me the belief that every person has value and should be treated as such. My grandmother has always been my biggest supporter and my fiercest critic. In contrast to other people that say “you can accomplish whatever you want,” she taught me that I can always do it better if I need to. I know no matter what, I can always get a straight, well-thought out perspective to anything that I ask. She has perfected the art of lovingly saying “I don’t think that’s a very good idea.” She’s also perfected the way of showing “I’m so proud of you.”

My mother has given me more than she will ever understand or acknowledge. Despite substantial hardship, she always made sure that I had what I needed, and more of what I wanted than I probably deserved. She sacrificed her health to make sure that she made ends meet. She made sure that my opportunities were a priority. While I didn’t understand at the time, I am now very grateful that she gave me those opportunities even though she couldn’t always be there to witness them. Which is why it was a privilege and honor to have her with me for the final dissertation defense; so that she could see what came of all of her work, sacrifice, and determination when my advisor told me “congratulations, Dr. Stewart.” My mother always believed that I could accomplish anything that I put my mind to. No one could ask for a more supportive person in their life.

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CHAPTER 1: SCATTERED IDENTITY: AN INTRODUCTION

It is almost impossible to watch television, open a magazine, or surf the internet without seeing an advertisement for a miracle drug on the market to cure the newest ailment. Infomercials inundate us with fads and gimmicks claiming to make us healthier. Legal pyramid schemes self-labeled as “multi-level marketing” peddle vitamin shakes and detoxifying wraps with the promise of getting rich by recruiting others to do the same. News articles and broadcasts warn us of new research that calls into question common, decades-long behavior as unhealthy and potentially deadly. Facebook memes by people called “Food Babe” and “David ‘Avocado’ Wolfe” pose as experts to warn of the health risks of consuming GMOs and ingredients we cannot pronounce. People find them credible because they appeared on an episode of *The Dr. Oz Show*. Healthcare professionals advise parents having their second or third child to do or monitor something that was not a concern for their first child. It is as if everyone around us is getting treatment or taking something for “problems” that seemingly never existed before.

With the proliferation of both scientific and pseudoscientific discourse, it is not hard to understand why many express skepticism when confronted with information indicating a legitimate health issue. As Peter Conrad explains, “the impact of medicine and medical concepts has expanded enormously in the past fifty years.”¹ While some pass into social acceptance more readily than others (e.g., sexual performance and baldness), the medical treatment of issues that typically fall under the purview of mental health is often fraught with controversy. Examples abound in public discourse. Despite the general acceptance of battle-induced Post Traumatic Stress Disorder (PTSD), the diagnosis still carries associations of weakness and cowardice.² Blaming the “refrigerator mother’s” supposed emotional detachment as cause for her child’s autism still lingers.³ Depression is still too often seen as the treatment of minor sadness and “cabin fever”

instead of a neurobiological condition.⁴ These controversies are problematic for those that have experiences associated with these diagnoses and that could benefit from treatment. Regardless of receiving formal diagnosis, people whose individual experiences identify with these labels are often stigmatized as a consequence of these controversies.

Much has been written on the stigmatization of and risks associated with the medicalization of issues related to mental health.⁵ What has been more challenging is understanding how to destigmatize controversial mental health issues while also affirming the utility of access to medical professionals/services and reclaiming a positive sense of self. Working from a Disability Studies perspective, I refer to these controversial experiences as *contested disabilities*. These might include medicalized “illnesses” or “disorders” such as Asperger’s Syndrome, anorexia, PTSD, learning disorders, and many others that some might argue as to whether or not they should fall under the umbrella of legitimate medical concern, and subsequently, legitimized as disability identities. Even more endemic is the reluctance of some medical professionals, and many laypeople, that are hesitant to entertain the belief that these “illnesses” and “disorders” exist as a distinct, embodied experience for those that are diagnosed. For those living with a contested disability, there is a limitation on rhetorical resources from this subject position. When denied the opportunity to claim disability, many attribute the experiences of that individual to personal character/moral flaws and/or symptoms of social deficiency. Claiming a contested disability, receiving medical treatment, and accommodations afforded by the Americans with Disabilities Act (ADA) allows many to do much that they might not be able to do otherwise. However, when these individuals experience “competence” or success, they can be made into examples of why the contested disability is not “real;” according to this logic, they just changed the way they think and worked harder. To others, there is no inherent or “real” disability. The problems already mentioned

associated with the stigmatization of mental disabilities just adds another limitation on the existing identity resources. The result is a subject position that has few resources available to form a positive sense of self.

At issue here is a tension that exists for individuals with contested disabilities.⁶ Ableist assumptions, within the medical model and the larger culture, force those with contested disabilities to either endure stigmatization by accessing resources only available through healthcare professionals, or they can continue with limited functionality and also risk stigmatization by others attributing their “failings” to moral deficiencies. The problem with medical treatment of mental disabilities is the ableist assumption underlying the medical model that necessarily pathologize what is being medicated. The concept of referring to a category or observed criteria for a diagnosis as a “symptom” is not the problem. The issue arises from the assumption that a “symptom” is necessarily abnormal. Seeking access for resources to augment existing function (e.g., going to the doctor, getting a prescription) should not be an issue. From the perspective of the disability studies adherent, there should be no value or structural difference between using a car or a wheelchair to augment movement. In short, the issue with medicalization is the rhetorical emphasis on abnormality and impersonality ingrained in the medical model.

Even the term *medicalization* becomes complicated by this rhetorical praxis, and some disciplines interpret its connotations quite differently. In disability studies, Simi Linton explains that its use of the term medicalization arose out of the strong opposition to the practices of medical intervention and discursive framing of disability issues as necessarily deficient through the traditional medical model.⁷ The origins for equating medicalization with the obstructionist/ableist paradigm arises from the early medical sociology literature from scholars like Ivan Illich and Irving Zola.⁸ Engaging the medical profession or certain practices of the medical profession as

“institutions of social control” and “nemeses” necessarily frames much of what the medical profession does negatively. In other words, the disability studies perspective emphasizes that the medical profession has a long history of contributing to the pathologization of disability experiences.

However, discussions of medicalization emanating from medical sociology reframe the word to emphasize the liberative potential for those of us discussing related issues in disability studies. These perspectives slowly evolved to see the process as more complex, dynamic, and diffuse with respect to the agents that are involved in the movement from nonmedical to medical. As Conrad states: “Far from medical imperialism, medicalization is a form of *collective* action.”⁹ While the authority of the medical profession is implicitly necessary for medical legitimacy, this conceptualization acknowledges that the sources of influence are not reducible to a “top-down” analysis of institutional power. Collaboration between patients and laypeople have been instrumental in not only seeking medicalization of previously nonmedical problems, but also in shaping the diagnosis of medical conditions throughout the process of medicalization.¹⁰ This perspective emphasizes that medicalization is a “sociocultural process” that does not *necessarily* require involvement or intent on the part of the medical profession. Extending this argument, Frederic Hafferty claims that in some respects, the “top-down” process of medicalization has been replaced by a “bottom-up” influence that represents the emergence of the “expert patient” and legitimacy of lay experience.¹¹

In medical sociology, the collaborative socio-culturally dynamic version of medicalization has been used to reframe perceptions of individuals as morally deficient to deserving of resources and access to potential life-saving care – not because of the medical profession, but in spite of it.¹² As I will explain in later chapters, this is a similar process that disability studies scholar Margaret

Price describes in her interaction with the mental health profession.¹³ This is especially important because, while disability studies scholars derive their understanding of medicalization from such as Illich and Zola, similar scholars of these “hard” varieties would deny the legitimacy of the embodied experiences of many that we openly accept as important in disability studies.

Rather than becoming entangled in an argument over different perceptions of medicalization, I work to embrace both of these positions in my own use of the term medicalization.¹⁴ On the one hand, I reject the ableist assumptions that can be built into the medical model, and I do not attempt to rehabilitate medicalization as many in disability studies understand it. But I also argue that many who experience contested disabilities benefit from what the medical sociology literature calls medicalization by gaining access to resources found in the medical and mental health professions. Regardless of the understanding of the nomenclature, my stance is to undermine the ableist assumptions both within the mental health profession and society that stigmatize those that experience these contested disabilities regardless of whether they access and accept mental health resources or deny them.

Throughout the course of this project, I argue that there are potential rhetorical resources available to cultivate a positive sense of self that also function politically to challenge stigmatizing perceptions and ableist assumptions for those with contested disabilities. My project works toward that end through a case study of discourse surrounding Attention Deficit/Hyperactivity Disorder (ADHD). ADHD is an extremely contested medical issue since it became part of public discourse in the 1970s.¹⁵ Its status as a medicalized entity is currently secure as a psychological diagnosis. However, as I will demonstrate throughout this project, it is fraught with resistant and skeptical discourse from lay, media, and professional sources. In addition to skeptical discourse, there is also a large body of discourse from similar sources that promote advocacy of ADHD. This project

utilizes a rhetorical approach to better understand some of the more insidious ways that skeptical ADHD discourse stigmatizes and proposes discursive strategies to negotiate the tensions between those marginalized positions. More specifically, I propose the need to attend to narratives that both constitute a positive ADHD subject position and accomplish the political objective of challenging stigmatizing discourse.

While a scholarly endeavor, this project is also a personal project of self-discovery and expression of agency. The ideas presented here represent seven years of personal and academic study on a diagnosis I received eleven years ago. At one time, my perspectives about ADHD aligned with some of the skeptical discourse that I will discuss here. It took almost failing out of my undergraduate studies at twenty-two years old and exhausting all other explanations that I finally took the mounting advice of a few around me. After going through extensive evaluation from both a medical and psychiatric professional, I received my diagnosis of ADHD, predominantly inattentive subtype. Throughout a three-to-four month period, my physician and I explored different medication options and dosages until we settled on one that seemed to work well for me. My academics turned around substantially to the point that in two years from almost failing out of college, I was admitted into a graduate program. Unfortunately, while medication helped substantially, it was insufficient on its own. I was not counseled on complimentary treatment options through therapy or other behavioral techniques. Much of how I learned to adapt to my new condition was trial and error. While my academic life improved, my personal life did not. Once I began my Ph.D. studies, I stumbled upon both life-changing information and a research agenda. This project represents a life-altering process that has allowed my own shift in self-concept in spite of active and inactive attempts to stigmatize and belittle who I am and what I can do.

Before I continue, I feel it necessary to address an unavoidably controversial aspect of this project. Whenever dealing with marginalized groups, naming and other forms of identification are always fraught with numerous competing perspectives regarding what is “appropriate.” There are both ideological and practical concerns that need to be addressed. While I recognize that there is no perfect moniker, I have chosen to refer to the individuals that are diagnosed and those that may or could be diagnosed with ADHD as “ADHDers.” ADHDer is a commonly used self-reference to someone that experiences ADHD. Many of the blogs and associated advocate literature adapted the older term “ADDer” after the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) discontinued using the acronym for Attention Deficit Disorder (ADD) in favor of ADHD. While this does risk emphasizing a reductionist approach to the complex articulation of self and identity that I will elaborate later in this project, common alternative approaches also have limitations. “Person First” language (person with ADHD) is the prominent alternative. As James Cherney, Kurt Lindemann, and Marie Hardin note, “rhetorically, [person first] terms prioritize the humanity of those who have disabilities, as it identifies the subject as a person before noting their disability. But it also risks reifying negative connotations of disability because it implicitly accepts the ableist idea that disability lessens value.”¹⁶ Person first language justifies an implicit or explicit assumption that having a disability is inherently bad or undesirable. As such, in attempting to recognize humanity and resist reduction of the individual to their disability, person first language simultaneously reifies disability as an inherently negative and relatively powerless subject position. This project seeks, in part, to find ways to reframe ADHD as a subject position in which the individual can find potential for positive self-identification. Approaching that project by implicitly reinforcing that subject position from an ableist logic would be counterproductive. As I

will explain later in Chapter Four, the ADHDer subject position only need take the forefront when it is discursively relevant. When not relevant, it is still there, but one among many.

Throughout the rest of this chapter, I present relevant literature to elaborate what I introduce here and frame the rest of the project. The next section explains a brief background of how ADHD was medicalized and stigmatized. I then turn to discuss the basis of how stigma is rhetorically constituted. Next, I address the theoretical foundations for conceptualizing the self in the context of ADHD. I conclude by previewing the subsequent chapters of the text.

The Medicalization of ADHD

In order to get a sense of the unique discursive challenges related to ADHD, it is important to understand the nature of the controversy surrounding the diagnosis. The contemporary popular interpretation of ADHD is fraught with disconnected and fragmented discourses associated with its initial medicalization and then subsequent expansion into what is often perceived as larger social problems. Medical interest in “fidgety” and inattentive children is typically attributed to British pediatrician George Frederic Still and the medical lecture series he began in 1902 London.¹⁷ Even earlier still, in 1798 Scottish physician Sir Alexander Crichton observed and described the equivalent DSM diagnostic criteria for ADHD as a discrete psychological affliction after practicing during his European medical tour.¹⁸ Peter Conrad explains that the current medical concept can be traced to the 1950s.¹⁹ Throughout this period the relative equivalent of ADHD has been referred to as “minimal brain damage/dysfunction,” “hyperactive syndrome,” “hyperkinesis,” “hyperactive disorder of childhood,” “attention deficit disorder,” and now “attention-deficit hyperactivity disorder.”²⁰ By the end of the 1960s, the contemporary equivalent of ADHD became increasingly known to the public through media coverage of controversies surrounding the use of

Ritalin, a stimulant-based medication. By the mid-1970s, ADHD was known as “the most common childhood psychiatric problem.”²¹

Lacking a biological understanding of the mechanisms that caused ADHD, most children were diagnosed at school using behavioral criteria – typically hyperactive and disruptive behaviors. While originally considered a childhood disorder that one “outgrew,” there was a growing belief that, in some cases, hyperactivity continued into adulthood. Additionally, there was the belief that even though hyperactivity abated at adolescence, other perceived symptoms such as impulsivity and inattention sometimes persisted in adulthood. Thus, the decision by the American Psychological Association (APA) to rename the diagnosis “attention deficit disorder” in 1980 “expanded the diagnostic criteria in terms of necessary ‘symptoms’ while allowing for the possibility for persistence in adulthood.”²² The final incarnation of the diagnostic nomenclature came in 1989 when the APA changed the title to ADHD in order to reflect both a hyperactive and non-hyperactive diagnostic category.²³ Following the 1990 release and subsequent national media attention of a National Institute of Mental Health study published in the *New England Journal of Medicine* that examined adults that had been diagnosed with ADHD as a child, the public became aware of adult ADHD.²⁴ In 1994, the fourth edition of the DSM (*DSM-IV*) acknowledged adult ADHD by including diagnostic criteria that could be applied to both children and adults.²⁵ While the designation of ADHD and the acknowledgement that adults experience ADHD has not changed in the fifth edition (*DSM-V*), there has been an attempt to refine and clarify diagnostic criteria.²⁶

Since the increased prominence of the diagnosis in the 1970s, various speculative explanations have emerged attributing the rise of ADHD to various social, cultural, and environmental changes. These have included theories related to increased food additives and preservatives, television consumption, video game playing, and two-income households.²⁷

However, beginning in the mid-1980s and gaining media notoriety in the 1990s, medical researchers and clinicians advanced a narrative, eventually accompanied by empirical evidence, which claimed a neurobiological cause of ADHD. Specifically, it was often reported to be “attributable to brain underactivation and a problem with the regulation of dopamine.”²⁸ Responding to clinical observations of familial inheritance, the last decade has seen media reports that discuss the research focus pertaining to a “genetic cause” of ADHD.²⁹ These all have been attempts to “re-biologize” or distance psychiatry from critiques of Freud and quackery by making it as similar to medical science as possible.³⁰

However, despite these narratives of scientific and medical progress, there still seems to be a great deal of skepticism about the “medicalized legitimacy,” or from an ableist context, the legitimacy of the ADHD diagnosis. Both social scientific and popular observations support this claim. One study examined “224 language events” to understand how meaning about ADHD is constructed and “utilized within the everyday language of laypersons and media in nonprofessional settings” in comparison with dominant discourse.³¹ While not monolithic in representation, the researchers were “struck by the efforts of those resisting the medical and school discourses to carve out a space for a broader brand of moral conversation that views problems of child misbehavior as opportunities for parents, schools, and communities to openly discuss better ways of living together.”³² Another study examined popular culture portrayals of ADHD and revealed predominantly negative representations and skepticism of ADHD’s legitimacy as a medical diagnosis. Commenting on the findings as they relate to mass-mediated tendencies to reflect dominant cultural beliefs, the author claimed that “the fact that they are almost the only representations of ADD in media . . . may indicate that the culture at large does not take this diagnostic category seriously.”³³ Finally, in a TIME.com article, a psychology commentator

responded to a series of articles and public commentary that explicitly question the legitimacy of ADHD in particularly stigmatizing ways.³⁴

The public perception of ADHD's expanded criteria and treatment plays a significant role in the controversies discussed here. Discourses that challenge the legitimacy of ADHD similar to those above seem to erupt in the public particularly when the media reports on the expansion of ADHD diagnostic criteria. The new clinical practice guidelines issued by the American Academy of Pediatrics (AAP) in October of 2011 renewed the controversy.³⁵ The 2011 guidelines expanded the appropriate age range for diagnosis and treatment of ADHD from the 2001 standard of 6-12 years old to 4-18 years old. While not responding to the controversy, *The New York Times* published two independent articles in their "Opinion" section within weeks of each other.³⁶ These articles questioned and criticized the use of psychostimulant drugs such as Ritalin and Adderall to treat ADHD. Beyond commenting on the treatment of ADHD, these op-ed pieces challenge the medicalized legitimacy of ADHD by disputing the notion that it is a neurobiological or genetic brain dysfunction, and arguing that it is a behavioral problem that stems from larger social and cultural situations.

The irony here is that narratives of scientific and medical progress might exacerbate public perception of medical uncertainty and diagnostic instability. These narratives seem to clash with what many see as frequent changes to what they think (or have heard/read) causes ADHD. For those who believe that medical proof of the condition constitutes certainty, and that such proof is necessary for the condition to be real, the evidence linking ADHD to biological explanations using cautious wording of scientific reports grounded in larger narratives of objectivity and certainty can create more uncertainty and instability. Expansion of a medicalized condition creates a tension between lay assumptions about diagnoses as an ontological/biological certainty of a "disease"

entity and the instability of “established” criteria, let alone a biological explanation.³⁷ As Russell Barkley explains, ADHD symptoms lack “static pathological states or absolute deficits in formerly typical functioning.”³⁸ This tension becomes increasingly strong when there are potentially no distinct observable characteristics or traits to compare as “normal” (as opposed to a “prominent” or stereotypical case of Tourette’s syndrome, Autism, or Asperger’s syndrome), coupled with ongoing media attention given to the significant increase in ADHD diagnosis and stimulant prescriptions. Within other discourses that challenge the legitimacy of ADHD, there seems to be an implicit anxiety associated with what could be seen as a decreasing faith in medical science. Related to this anxiety, many of the controversies and lay theories about ADHD seem to share some interesting qualities with larger critiques of contemporary social/cultural conditions.³⁹

Vocal ADHD skeptics within this vein seem to implicitly and explicitly premise their objection to medical diagnosis and treatment on the belief that contemporary society exists in a state of entropy or social decline as a result of our desire for “progress.” For example, Richard DeGrandpre argues in his book *Ritalin Nation*, that ADHD is symptomatic of the “hurried society,” a “seemingly chronic *cultural* affliction,” rather than a biological state.⁴⁰ DeGrandpre references the popularity of cocaine and other stimulant narcotics, as well as the “rise of coffee/caffeine culture” and compares them with psychostimulant drugs prescribed to treat ADHD to claim that our technologically-saturated, speed-obsessed society has produced a need and market for the drug in order to overcome the inherent “paradox” associated with modern existence; we are expected to engage in increased goal-driven behavior in order to succeed, but at the same time our goals are stymied due to overstimulation. Perceived as a uniquely cultural problem, DeGrandpre sees the diagnosis of ADHD as a social response that identifies those that are deemed socially incompatible

with modern “progress,” while simultaneously masking the associated problems through the treatment of drugs like Ritalin.

In the preface to the paperback edition of *Ritalin Nation*, DeGrandpre laments that his overall argument has frequently been reduced to the above articulation. He claims that another important component to his thesis is that “another effect of accelerated lifestyles is on adults, where parents have come to rely more and more on ‘quality time’ with their children and less and less on ‘quantity time.’ Both quality and quantity are of course necessary to shape children into well-adjusted and intelligent moral citizens.”⁴¹ ADHD is also an excuse for the feelings of inadequacy or lack of motivation to engage in the “mundane” aspects of social and family life. As such, Ritalin provides a convenient solution for maintaining disciplinary order without resorting to “proper” parenting. Wrapped up in this criticism is the charge that technology and rejection of the leisure society in favor of perpetual “rapid-fire days” and “jetlag nights” has resulted in the dislocation of the individual from the community, the teacher from the student, and the parent from the child. Even more, there are implications that only a very limited notion of “family values” will produce “moral” children.

John Rosemond and Bose Ravenel focus on how the “symptoms” of ADHD are essentially products of larger social/cultural changes in discourse on children that produce bad parenting practices.⁴² Their unique contribution is an emphasis on corporal punishment as a curative to ADHD. They devote a significant amount of text attempting to disprove any and all validity to neurobiological factors as an explanation for what they see as a completely manufactured “disease:” “these childhood behavior disorders are manifestations of dysfunctions of discipline and lifestyle that are endemic to today’s family culture.” Instead, the reason for the ADHD “epidemic” is because parents are not attending to the “simple” explanation that “children are bad,”

a supposed “fact” that has been “drowned in a deluge of postmodern psychobabble.”⁴³ The solution, they claim, “is not rocket science. It’s a commonsense combination of good, old-fashioned discipline, removing electronic media . . . , and restoring a healthy lifestyle in terms of good nutrition and exercise.”⁴⁴ Further, they claim that “once corrected, the behavior of the ADHD . . . child usually recovers to a state of normalcy within a relatively short period of time.”⁴⁵

Despite the fact that these arguments make relatively weak associations between ADHD and social causes, the tension between medical certainty and uncertainty are easier to resolve with these arguments because people find it easier to believe social explanations for phenomena rather than medically scientific explanations in public discourse.⁴⁶ However, the greater problem lies in that the public “need” to resolve the tension does not necessarily reside in the actual subject of ADHD per se, but rather in their faith in the medical practice as a whole; in this case particularly, they need to resolve the relationship between the practice of medicine and its ability to define and determine disability from an ableist context of normality/abnormality. People need to believe that doctors are able to *accurately* diagnose something if it is present, and prescribe a treatment certain of success. This relates to the production and acceptance of ADHD controversies in that the public, those not involved with the subject or diagnosis of ADHD nor afflicted by this anxiety, are more motivated to accept the alternative explanations as the perceived failure of medical science to account for ADHD. In other words, weak arguments that question ADHD’s medicalized legitimacy are entertained more, if not outright accepted, because they provide a way to avoid critically thinking about the incongruity between medicalization and the perception of (un)available knowledge.

While certainly not exhausting all related types of challenges to the legitimacy of ADHD as a neurobiological condition, these representative situations demonstrate some interesting

aspects of this type of discourse that is relevant to my project. My first observation is that attempting to challenge ADHD as a “valid” neurobiological medical diagnosis via these types of appeals seems to also invoke and/or “urge” certain judgments about larger social/cultural conditions in the present. Even when attempting to invalidate only treating ADHD with psychostimulants these arguments are still supported by critiques of perceived deficiencies in society. Second, these underlying social critiques seem to function like rhetorical topoi that allow the “audience,” or those exposed to this type of discourse, to make evaluative inferences in the argument – they function as a warrant.⁴⁷ While not ubiquitous, these critiques seem to be involved in the justification of ADHD related counter-claims that implicitly or explicitly contend a range of ideas: from the more commonplace idea that ADHD symptoms are exacerbated by fragmented media images or food dyes, to the more potentially dangerous idea of advocating discipline as Rosemond and Ravenel do as *the* curative course of action for what has been “falsely” interpreted as a neurobiological disorder. This leads me to my third observation that these topoi seem to have potent rhetorical force given the extent of skepticism and controversy associated with ADHD. This controversy is extremely puzzling considering the cultural perceptions of objectivity and reliability in medical science⁴⁸ and the empirical research suggesting, at minimum, a biological difference in those diagnosed with ADHD.⁴⁹ These observations raise questions about the discursive and rhetorical “force” of these types of appeals that, at least in part, contribute to the intensity of the controversy.⁵⁰

The relevance of the controversial nature of ADHD discourse, and the rhetorical forces that propel it, is in the potential consequences that it has on child and adult ADHDers, their parents, and those that would benefit from diagnosis of treatment. The next section addresses literature that demonstrates the stigmatizing nature and outcomes of this discourse.

Reduction, Misunderstanding, and the Implications of Stigma

While the intersection between stigma, rhetoric, and mental illness is fairly well established,⁵¹ it is an important component of the current project. Understanding the ways discourse stigmatizes ADHD is important due to the potential for stigma to undermine identity. In other words, stigmatizing ADHD discourse has the potential to situate the diagnosed individual into inherently negative conceptions of self.

Stigmatizing discourse often reinforces perceptions that ADHDers suffer from a character flaw as a consequence of poor upbringing, social circumstances, or other sources of learned behavior.⁵² There is a concern that despite media attention given to increasingly sophisticated and well-designed studies that demonstrate the neurobiological and genetic links to ADHD, the overall public perceptions of alternative social causes that stigmatize the diagnosis have not changed or decreased much in the last decade.⁵³ Much of the more nuanced technical discourse related to ADHD acknowledges that contributing factors related to its presence exist on a range between the biological and social realms. However, many of the positions stated in public discourse oversimplify the situation into one of the two dichotomies as an either/or scenario. While rarer, when the complexity of the nature/nurture divide is addressed, the position is interpreted by those that engage the discourse as one dichotomous aligning with existing beliefs.

However, when the public or professionals acknowledge the neurobiological legitimacy of ADHD, other potential stigmatizing discursive trends can emerge. The public is more likely to associate ADHD, and those that are diagnosed with it, with failure, struggle, and potentially social deviance.⁵⁴ In response to this phenomenon, Scot Danforth and Virginia Navarro examined layperson discourse related to ADHD and discovered that individuals typically ascribed personality traits associated with ADHD as inextricable from the identification of the “ADHD

patient.” Typically, the layperson’s discourse represents the ADHD patient as a collection of oversimplified behaviors representing some of the *DSM-V*’s criteria: inattentive, hyperactive, impulsive, and forgetful.

These perspectives of ADHD represent the medical model which is the “dominant ideology in psychiatry and psychology,” and “highlights the notion of individual deficiency from a primarily biological perspective.”⁵⁵ Michel Foucault demonstrates how the problem of conflating the individual as a whole with a subset of symptoms is a consequence of the clinical gaze that is influential in the modern medical model.⁵⁶ For Foucault, the practitioner’s gaze is the scientific, systematic, and rational perception of the body (its parts) in relation to the disease. Instead of treating a patient, the medical gaze figures the doctor’s role as diagnosing (discerning) disease. It is through understanding the relationship between the (dys)function of bodies and disease as a constellation of symptoms, as opposed to the previous clinical focus on merely understanding symptoms as dysfunction, that distinguishes the analytical gaze from previous approaches to medicine and body.⁵⁷ However, there seems to be a deeper issue that resembles Foucault’s account of the discursive influences that shape our current understandings of mental illness in general. Foucault’s *History of Madness* outlines how mental illness became discursively and ideologically framed as a condition other than human and beyond reason.⁵⁸ Foucault argued that mental illness was rationalized through a moral lens that saw “madness” as contrary to the capitalist work ethic. As such, the mentally ill were cast as morally deviant because they were not “productive” members of society. Foucault’s central argument was that the concept of madness, and the negative value judgment placed on it, only existed within socially created and defined conceptions of “normal,” “rational,” or more specifically, preferred behavior.

Foucault also discusses the influence of power on the social construction of madness, and the social and political elite that exert influence. Similar to Foucault, Peter Conrad argues that medicalization of socially perceived deviant behavior has resulted in “the expansion of the sphere where medicine now functions as an agent of social control. In the wake of . . . the increasing acceptance of deterministic social and medical concepts . . . more and more deviant behavior has come into the province of medicine.”⁵⁹ While Foucault emphasizes the social construction of mental illness by elites that reflect dominant ideologies, Conrad indirectly focuses on the ways that medicalization of “deviant” behavior has contributed to the stigmatization of ADHD. Extending both of these positions, Adam Rafalovich argues that while discourse contributes to the way that ADHD is framed, it is a medical concern. While he acknowledges that “criteria describing mental disorders are intertwined with a variety of social forces,” his primary objective is to understand how those social forces (medicalization and discourse) problematize and stigmatize ADHD.⁶⁰ The primary contribution that Rafalovich provides is an explicit acknowledgement of the tension between discourse representations of, and actual experiences with, ADHD that reflect and perpetuate underlying ideological perspectives through a dominant narrative of ADHD as a mental illness.

Various disciplines have contributed to the understanding of how mental illness is stigmatized through representations in literature,⁶¹ mass media,⁶² and medical discourse.⁶³ These analyses seem to implicitly support a mental illness dominant narrative similar to the ADHD narrative implied by Rafalovich. For example, in an analysis of personal narratives by individuals diagnosed with mental illness, Elizabeth Young found that perceptions of the dominant narrative are that mental illness is a weakness, shameful, and socially disenfranchising.⁶⁴ While literature examining ADHD discourse is less prevalent than mental illness in general, many of the

implications for how that discourse reinforces the dominant narrative and contributes to its primary characteristics remain similar. Specifically, I will discuss how this discourse promotes reductionism, misunderstanding, and the implications of such stigmatization.⁶⁵

Reductionism, as both product and implication of ableism, often occurs through both media framing and layperson discourse. Since media framing (re)presents the medical perspective of ADHD in a format suitable for public, non-clinician consumption, the issues surrounding the affirmation and negation of ADHD as a “real” affliction become oversimplified and reduced to basic negative generalizations applicable to anyone that is diagnosed. Since these media portrayals are likely the only exposure to ADHD that the general public receive (save an experience with, or anecdote about, a “troubled” ADHDer), the discourse produced by laypersons is understandably representative of the limited exposure to the subject. The production and reproduction of this essentializing discourse reinforces the stigmatization of ADHD.

Examples of this type of discourse and its implications can be seen through studies in media framing that show there is an interesting discursive dynamic that fuels two primary ADHD related negative stereotypes within the layperson population over the last thirty years: ADHD is not a real condition (they are being treated for laziness), and ADHDers will never be “normal,” productive members of society.⁶⁶ Additionally, one study found that media representations of ADHD have a tendency to use *danger terminology* to associate physical violence and emotional abuse with ADHD.⁶⁷ Framing, or the way in which something is portrayed to an audience, is important to analyze because it helps shape the social construction of the issue(s) being framed. Shanto Iyengar states: “The manner in which a problem or choice is ‘framed’ is a contextual cue that profoundly influences decision outcomes.”⁶⁸ The social construction of ADHD and those that are diagnosed

with it is important to address because of the potential negative stereotypes and associations that accompany the various frames.

However, medical discourse focusing on defining ADHD also influences the way the media frames issues. Medical publications and clinical professionals can shape the way that the media and layperson “understands” and discusses what ADHD is and how it affects diagnosed individuals. While addressing the social construction of mental illness in general, Allan Horwitz argues that the clinical diagnostic process of identifying symptoms involves the reliance on identifying a behavior or pattern of behaviors that are implied to be negative relative to social expectations. “Terms such as ‘inappropriate,’ ‘dysfunctional,’ ‘irrational,’ and ‘unreasonable’ that are used to define various mental illnesses do not refer to aspects of natural entities themselves, but are cultural definitions placed on behaviors that in other times and places may seem normal, functional, rational, and reasonable.”⁶⁹ For Horwitz, the problem with the diagnosis process arises from the application of these and similar terms to define an individual with a medicalized disorder. “The classification of symptoms into discrete disease entities is perhaps the most essential component of diagnostic psychiatry because precise diagnostic schemes presumably distinguish particular conditions from one another in ways that matter for their etiology, prognosis, and treatment.”⁷⁰ The ableist assumption is that these differences in human behavior carry different inherent value judgements. “Symptoms” establishes abnormality associated with illness and implicitly reifies the “appropriateness” or normality of behaviors that are not symptoms; whereas a characteristic or category avoids the pathologization of the disability.

The medicalization and diagnosis of “deviant” or “abnormal” behaviors treat the symptoms as evidence of a disease – a foreign “entity” inside the person that can be treated with modern medicine, similar to the concept of drug therapy for an infection.⁷¹ However, mental illnesses

typically cannot be eradicated with a drug that functions like an antibiotic. The perceived influence of the clinical diagnostic process on mental illness ultimately reinforces it as a socially unacceptable and incurable disease. Specific to ADHD, Scott Danforth and Virginia Navarro explain that the representative discourse found in the general population “suggests a Foucauldian gaze on individual behaviors that are barriers to success, not on behaviors that are potential strengths, thus reifying the association of pathology [to] the label.”⁷² (177). The clinical gaze employed by medical professionals and lay individuals that are acculturated into the medical gaze and overemphasize their expertise facilitates the rhetorical shift from mental condition to mental illness. The process of medicalization – which utilizes the clinical gaze to turn characteristics into abnormal “symptoms” – pathologizes different human functioning to abnormal functioning.

While the pathology or disease stigma has obvious potential negative effects on those diagnosed, medicalization was necessary for the acknowledgement of the psychological effects and subsequent theorization of biological explanations for ADHD.⁷³ Prior to the clinical acknowledgement of ADHD in the *DSM*, many individuals that were affected with the disorder were viewed as social pariahs and deviants for their unexplainable behavior.⁷⁴ While most went untreated, those that were treated were diagnosed with different disorders. In defense of diagnostic psychiatry, as Horwitz acknowledges, the intent of the medicalization and diagnosis schemas of mental illnesses was meant to secularize previous conceptions of mental illness symptoms grounded in religion or mysticism so that the individual was no longer demonized, while concurrently overcoming social and institutional biases against the treatment of those with mental illnesses.

The second rhetorical characteristic that poses a challenge related to addressing the stigmatization of ADHD is the misunderstanding created by much of the discourse. This is

particularly difficult because there are opposing positions with legitimate claims about both the over *and* under diagnosis of ADHD, and subsequently the over *and* under prescribing of psychostimulant medication. The perception that the world's children are unnecessarily being diagnosed and medicated is a prominent theme in ADHD discourse. It is reasonable to acknowledge that there is a potential problem associated with some children being improperly diagnosed and medicated when there are many whom a general practitioner or pediatrician diagnoses in a single office visit.⁷⁵ This is a legitimate concern and an emphasis needs to be made so that productive discourse can occur without further stigmatization of ADHDers. However, there is a lesser talked about issue related to the stigmatization of ADHD that results in a subsequent underdiagnosis.⁷⁶ This problem overlaps with many other stigmatized or contested diagnoses.⁷⁷

Regardless if what is being addressed is related to discourse denying the existence of neurobiological causes for ADHD or reinforcing them, they both have the potential to frame ADHDers as an "Other," someone whom, regardless of whether it is reality or not, no one wants to ever be or "become." This can affect individuals that need to be diagnosed by influencing their perceptions of what it means to be an ADHDer, or in the case of children, it can influence what it means to be the parent of an ADHDer. While the latter aspect is influential regardless of what type of discourse is addressed, it becomes particularly relevant when addressing discourse that attempts to delegitimize ADHD as a neurobiological reality in favor of a narrative that blames larger social/cultural issues, such as having two parent households. If being diagnosed with or having a child diagnosed with ADHD is so abject, then even if there was a need, the relevant individuals would likely reinterpret their experiences or the experiences of their child as something other than needing a medical diagnosis or treatment.⁷⁸

Finally, the psychological consequences of stigma related to mental illness in general, and ADHD specifically, are salient to the justification for challenging status quo ADHD discourse.⁷⁹ Mark Schmitz and colleagues explain that: “[R]epresentations of the illness and self, individuals may experience a reduction of self-esteem, perhaps a compounding of symptoms related to ADHD, and the resulting increased difficulties in social relations.”⁸⁰ The rhetorical construction of ADHD through existing discourse has the potential to compound psychological affliction, thus creating a vicious cycle that reinforces stigmatization. I now turn to discuss this phenomenon.

Stigma: Process and Consequence of Discursive Trends

As alluded to before, ADHD discourse not only has a reductionist character, it is also constitutive in nature. The constitutive character extends far beyond the obvious diagnostic “label” used by clinicians as an imposed identity. Like the rhetoric that constituted the Québécois identity that advocated sovereignty for Quebec in the 1980 referendum on that concern, ADHD discourse rhetorically constitutes “the character or identity of the” ADHDer, as well as the negative valence of behaviors that define them.⁸¹ Again, studies in stigma regarding mental illness more generally provides foundation for the current study. For example, Amy Kroska and Sarah K. Harkness discuss how “the negative consequences of psychiatric labeling arise . . . when an individual is diagnosed with a mental illness, [because] cultural ideas associated with the mentally ill (e.g., incompetent, dangerous) become personally relevant and foster negative self-feelings.”⁸² Similar to how Maurice Charland demonstrates that discourse surrounding Quebec independence created identification by asserting a Québécois subject position, the clinician interpellates the patient into “participating” in the stigmatizing discourse from a subjective position via diagnosis. Charland further explains that for “interpellation . . . the very act of *addressing* is rhetorical . . . this rhetoric of identification is ongoing, not restricted to one hailing, but usually part of a rhetoric of

socialization.”⁸³ Regardless of whether the patient has been exposed to the media/layperson discourse prior to diagnosis, or the medical discourse received/procured at the time of diagnosis was the informational primer, any previous, current, and future encounters with ADHD discourse will be interpreted through the subjective identification position.

For those not diagnosed with ADHD, regardless of whether they do not have ADHD or they are just pre-diagnosis, ADHD discourse also has an influence in constituting stigma. As Jenell Johnson explains via the case of Thomas Eagleton’s short vice-presidential candidacy in 1972, stigma is not only created rhetorically, but becomes a rhetorical force in itself. Johnson demonstrates how the public and political reaction to Eagleton’s disclosure of past hospitalization for depression was more about how the stigma associated with mental illness rhetorically imbued Eagleton with *kakoethos*, or bad character; “mental illness is considered by many not just to be the sign of a bad character, but *caused* by bad character.”⁸⁴ The stigmatization of mental illness thus becomes a rhetorical “mark” on those that are diagnosed with it. One does not simply “have” a mental illness, rather they “are” mentally ill regardless of current treatment or management. “A diagnosis of mental illness, no matter how far in the past, no matter the severity of the condition, no matter the circumstances, is a permanent identity.”⁸⁵ As explained before, you do not just take an antibiotic to “cure” mental illness.

Stigma, as its own rhetorical force, constituting the character of others, functions via collected perceptions created by discourse that creates and reinforces stigmatizing perceptions of a particular “condition” and transfers those perceptions onto the affected individual. This is demonstrated via the Eagleton case again in the public discourse that occurred after the announcement. Prior to the announcement, discussion focused on his credentials to serve the office of Vice President. After the announcement, the only factor that seemed to matter to the media and

the public was the fact that he had been hospitalized and treated for depression. More telling was the subsequent tendency for the media and public to engage in what Johnson refers to as “‘diagnostic hermeneutics,’ an interpretive frame in which the audience takes on the diagnostic gaze of the physician, searching body and speech for symptoms.”⁸⁶ Stigma imbues the qualities of “bad character” on the individual, and hypervisualizes the signs of that perceived defect. While this has obvious implications for how identity of the diagnosed is influenced, it also plays a role in the perpetuation of stigma, which fuels the constitution of the “Other.”

However, as should be obvious, the interpellation of the subject and the creation of the “Other” are not monolithic rhetorical forces that (pre)determine the individual concept of self. As with medicalization and biomedical discourse that attempts to legitimize the existence of ADHD, neither of these are static forces. Part of what I hope to demonstrate throughout this project is the ability of the diagnosed individual to negotiate their concept of self, and in so doing, negotiate what it means to experience ADHD for the self and others. While not a complete control of individual or rhetorical agency, there is some influence that can be exerted under certain rhetorical conditions. I argue that these rhetorical conditions are strongly tied to ableist assumptions represented in public, media, and medical/scientific discourse on ADHD. The ability to reinterpret the concept of self as something that limits the implications of stigmatization of ADHD on an individual is related to the interpretive opportunities available related to public, media, and medical/scientific discourse. More than just the presence of positive interpretive options for the diagnosed individual, the rhetorical conditions also relate to the rhetorical force of the interpretive options. Like mentioned earlier, if the general public finds social explanations more believable than medical ones, due to a lower evaluative threshold, then only altering or creating positive interpretive options from a biomedical perspective without addressing the social attribution of

ADHD and all of its negative interpretations is not sufficient. The self's ability to negotiate is still hampered by public/media discourse and the subsequent stigma. Some of these rhetorical conditions and forces are what I hope to examine and demonstrate in this project. I am interested in examining their potential influence on the individual's ability to negotiate the self, with the objective being to propose potential rhetorical correctives to the conditions/forces in order for the potential of a more positive negotiation of self.

Conceptualizing ADHD

Thus far, I have been intentionally vague about what I mean about "self" and identity. This is because discussing the intersection of ADHD and identity poses some interesting challenges worth discussing independently. As alluded to earlier and will be expanded upon in subsequent chapters, the process of creating ADHD as a legitimate medical condition required its medicalization. The brain differences themselves may be real and objective, but the way that we think about them certainly is not. As James Cherney explains: "Complicating the simple materiality of things does not necessarily entail rejecting material existence: things can exist as simultaneously material and rhetorical constructs."⁸⁷ This is in line with scholars such as Judith Butler that challenge the "naturalness" of the biological by emphasizing the social, cultural, and discursive influences on our understandings of what is both natural and biological.⁸⁸ Butler does not deny the materiality of a penis or vagina, she challenges their dichotomous existence and their assignment as *inherently* natural and outside of any cultural/social practice or norm. In fact, the embodied experiences of genitalia influence the self; however, the self is not limited to the genitalia. How we embody or perform the self provides some opportunity to challenge social influences that say otherwise.

Disability studies have also taken on similar challenges. Drawing on Foucault's

articulation of biopower, Shelley Tremain embarks on a deconstructionist project that challenges the social model's binary distinction between impairment and disability. She argues that physical impairment (not its materiality, but what we consider impairment) is discursively constructed. Tremain takes this argument even further when arguing that discursively constructed impairments are the source of social/institutional exclusion. However, the more important distinction that Tremain makes is the unstable status she ascribes to impairment:

[T]he governmental practices into which the subject is inducted and divided from others produce the *illusion* that they have a prediscursive, or natural, antecedent (impairment), which in turn provides the justification for the multiplication and expansion of the regulatory effects of these practices. That the discursive object called "impairment" is claimed to be the embodiment of a natural deficit or lack, furthermore, conceals the fact that the constitutive power relations that define and circumscribe "impairment" have already put in place broad outlines of the forms in which that discursive object will be materialized.⁸⁹

This passage demonstrates the "naturalness" of impairments, and subsequently the impaired subject, are biopolitical constructs.

This resonates with both the analytical and political objectives of this project. The political objective for this project aligns with some disability studies approaches to the critique of the medical model, which gives rise and legitimacy to medicalization, and "highlights the notion of individual deficiency from a primarily biological perspective."⁹⁰ Many disability scholars argue that the medical model casts impairment and disability as something that must be cured or accommodated by the individual in order to experience a reasonable quality of life. As such, the disabled individual is constructed as an object that undermines the impetus for social changes, and subsequently reifies the mythical norm that disabled (and non-disabled) people can never represent.⁹¹ As such, even though I acknowledge and reference literature produced by those entrenched in the medical model to justify the existence of a neurobiological difference in ADHDers, I challenge the model's rhetorical framing of ADHD as *necessarily* a deficit in human

functioning. Part of this project will be to address the tension between the need for the medical model to legitimize and subsequently treat what *can* be a limiting impairment for individuals, and the model's discursive focus on inherent deficit. There are not only certain differences in functioning that can be interpreted as beneficial, but I also contend that there are ways to frame these differences as something that should or can be treated by the medical profession without succumbing to the tendency for the medical model to cast something as *only* a deficit.

Tobin Siebers contends that, even though social constructionist approaches to disability, the body, and identity provided a way to circumvent the essentialism associated with ascribing identity to biological determinants, there is another risk of (re)producing a disability identity-related essentialism – disability as “mere” social constructions.⁹² What is “mere” is reducing social constructionism to an absence of association with the material. Susan Peters takes this further when she argues that the “oversocialised” perspective risks denying the “bodily identity, personhood, and transformative potentials” of those marked with stigma.⁹³ An important challenge for this project is that despite the potential for stigmatization via discursive practices associated with biomedical discourse, there are advantages (both material and social) to acknowledging and emphasizing the embodiment of ADHD. Similar to Butler's approach, I am attempting to negotiate a space that challenges the “naturalness” that deficiency (and subsequently, stigmatization) necessarily follows engagement with mental health services, without abandoning the need for an emphasis on embodiment – especially when addressing the (re)constitution of the self. Interestingly, in contrast to avoiding the problems associated with challenges posed by medical discourse, I also have to contend with both lay and medical perspectives on the other end of a spectrum that essentially believes in the “naturalness” of ADHD as only a discursive construct, purely

created by the medicalization of nonmedical deviance.⁹⁴

Moving Forward

What I intend to do with this project is examine these rhetorical conditions and forces as they specifically relate to ADHD. A focused context is necessary because rhetorical conditions and forces would be unique in its larger discursive characteristics. While the specific implications discussed about ADHD discourse are not inherently translatable to other contested disabilities, the process of understanding the need to examine skeptical discourse in such a way is beneficial. This project will examine the extent that discourse of different types, each with unique rhetorical force and conditions, pose challenges to the self's ability to negotiate more positive interpretations of identity; not only from individual exposure to discourse, but from the systemic representations that become constructed via the "Other," abject non-subject that creates the "normal" in relation to it.⁹⁵ The culmination will be a discussion of how a better understanding of the rhetorical force in these conditions can utilize rhetorical means to renegotiate parts of the self to challenge stigmatizing discourse. While the context will produce unique implications for the specific rhetorical strategies proposed to address ADHD, the larger process of understanding the systemic components of how self and "Other" are constituted, and most importantly, the limited but essential ability of the self to partially negotiate the meaning of certain subject positions will provide potential insight into other contested disabilities.

The second chapter will examine media and layperson discourse that challenges the existence of ADHD as a unique neurobiological reality in favor of interpretations that emphasize social inadequacies. This will expound on my earlier claims that much of the discourse in this vein implicitly or explicitly draws on larger critiques of contemporary society as deficient. Specifically, I will analyze an advertisement for the YMCA of Greater Vancouver printed in two Vancouver

metro-area newspapers on April 15, 2010. While I have been explicitly denied permission to reproduce the ad for publication, in the notes I provide the web addresses to the two known places on the internet that still have the ad published. It can also be found using a basic Google search. Using this advertisement, I will elaborate on the connections to aforementioned social critiques as they relate to ADHD by demonstrating the common rhetorical means found in the evocation of restorative nostalgic appeals – arguments that propose a curative found in past action that is supposedly proved effective by virtue of it being found in an idealized past. The curative arguments justified via nostalgia, by proposing specific moralistic solutions that seem obvious, encourage the public and media to circumvent the question of whether ADHD is a “real” neurobiological reality. The critique demonstrates how these types of restorative nostalgic appeals are found in fragments of public discourse about ADHD, and therefore, the implications of minimization are not unique to this advertisement. This has implications for the agency of the ADHDer to not only renegotiate parts of the self, but more importantly, to challenge their “Otherization” – whether that diagnosis represents an actual neurobiological difference or not.

The third chapter will expand on the process of medicalization and biomedical discourse while elaborating its relevance to ADHD. What is particularly relevant here is how, despite acknowledging and even ardently advocating for the medical legitimacy of ADHD, the rhetorical nature of professional diagnostic discourse can problematize the ability for the ADHDer to negotiate parts of the self as positive. For those that are not diagnosed, there are still implications for how the stigma is constituted rhetorically. Here, I address issues related to disability studies that elaborate this complication. I elaborate on challenges posed by medicalization and biomedical discourse on disability issues generally and ADHD more specifically. Implications are drawn regarding the challenges of trying to balance the need for medical legitimacy with encouraging a

discourse that facilitates positive interpretations of the self. I analyze a transcript of a presentation at the 2011 annual international conference of Children and Adults with ADHD (CHADD). The two presenters – Doctors Russell Barkley and Ned Hallowell – advertised the presentation as a debate between their two respective “camps” regarding ADHD. Dr. Barkley is often associated with particularly deterministic perspectives on ADHD representative of the medical model. Dr. Hallowell often gets associated with an overly optimistic view of ADHD presented by the neurodiversity movement. However, rather than a debate, this presentation provided an opportunity to understand how professional discourse can be challenged to avoid both extremes. The chapter argues that the medical profession can be challenged and participate in challenging stigmatizing discourse.

The fourth chapter will draw on the implications from the previous two chapters to finally begin examining rhetorical resources for developing the limited agency to not only challenge the rhetorical forces involved in these conditions, but also for renegotiating parts of the self that are relevant to ADHD. I demonstrate how a viable counternarrative can be constructed that provides a positive sense of self to resist stigmatizing discourse. This counternarrative, once multiplied in public discourse, becomes a challenge to larger “master” narratives that stigmatize ADHD. It is important to challenge these master narratives because they are the primary sources of ADHDer identity. The counternarrative is constituted of fragments of existing advocate narratives.

In the concluding chapter I will elaborate connections between the larger rhetorical process here and its potential generalizability to other contested disabilities found in different identity issues. I utilize this discussion to demonstrate not only the utility to addressing disability identity issues from a rhetorical perspective, but also the potential applicability as an interdisciplinary tool that is needed to address the implications of stigmatizing discourse in these situations. While there

will be examples provided to demonstrate potential applicability, this chapter will serve as more of a discussion section that brings the previous chapters into direct conversation with each other.

Notes

1. Peter Conrad, *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* (Baltimore, MA: Johns Hopkins University, 2007), 4.
2. Pauline Arrillaga, "Branded a Coward, Sgt. Fights for PTSD Victims," *CBS News*, April 19, 2010, <http://www.cbsnews.com/news/branded-a-coward-sgt-fights-for-ptsd-victims/>.
3. Refrigerator mother or refrigerator parents was a phrase originating in the '50s to refer to the theory that certain disorders like autism were a result of "cold" or emotionally distant parents. See, David E. Simpson, J.J. Hanley, and Gordon Quinn, "Refrigerator Mothers," *PBS*, July 16, 2002, <http://www.pbs.org/pov/refrigeratormothers/>.
4. Loren Mosher, "Behaviors are not Diseases," *CCHR International*, November 17, 2016, <https://www.cchrint.org/psychiatric-disorders/behaviors-are-not-diseases/>.
5. See Conrad, *Medicalization*. Allen V. Horwitz, *Creating Mental Illness* (Chicago, IL: University of Chicago Press, 2002).
6. The use of this phrase is not an attempt to utilize "person first" language considering the issues associated with that. I use "individuals with contested disabilities" because it is the least awkward way to phrase it.
7. Simi Linton, "Disability Studies/Not Disability Studies," *Disability & Society*, 13, no. 4 (1998): 525.
8. See Ivan Illich, *Medical Nemesis: The Expropriation of Health* (New York: Random House, 1976), and Irving Zola, "Medicine as an Institution of Social Control," *The Sociological Review* 20, no. 4 (1972): 487-504.
9. Conrad, *Medicalization*, 9, emphasis added.

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10. See Karen Ballard and Mary Ann Elston, "Medicalisation: A Multi-Dimensional Concept," *Social Theory & Health* 3, no. 3 (2005): 228-241.
11. Frederic W Hafferty, "Medicalization Reconsidered," *Society* 43, no. 6 (2006): 41-46.
12. Wilbur J. Scott, "PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease," *Social Problems* 37, no. 3 (1990): 294-310.
13. Margaret Price, *Mad at School: Rhetorics of Mental Disability and Academic Life* (Ann Arbor, MI: University of Michigan Press, 2011).
14. The argument that I think is worth having at another time is whether the ableist assumptions are necessarily inherent in the discursive and disciplinary processes of medicalization. While it is beyond the scope of this project, I contend that understanding medicalization as a more open, collaborative process that allows individuals with condition-related experiences access to resources that allow them to augment their functioning and existence is more in line with what many contemporary scholars of both disability studies and medical sociology are pursuing.
15. Conrad, *Medicalization*.
16. James L. Cherney, Kurt Lindemann, and Marie Hardin, "Research in Communication, Disability, and Sport," *Communication & Sport* 3, no. 1 (2015): 18. See also, Brendan Gleeson, *Geographies of Disability* (New York, NY: Routledge, 1999).
17. George F. Still, "Some Abnormal Psychological Conditions in Children: The Goulstonian Lectures," *The Lancet* 159, no. 4103 (1902): 1008-12. For a comprehensive history see: Klaus W. Lange, Susanne Reichl, Katharina M. Lange, Lara Tucha, and Oliver Tucha, "The History of Attention Deficit Hyperactivity Disorder," *ADHD Attention Deficit and Hyperactivity Disorders* 2, no. 4 (2010): 241-55.

18. Alexander Crichton, *An Inquiry into the Nature and Origin of Mental Derangement: Comprehending a Concise System of the Physiology and Pathology of the Human Mind. And a History of the Passions and Their Effects*. Vol. 2: T. Cadell, junior and W. Davies, 1798.; Lange et al., "The History of Attention."

19. Conrad, *Medicalization*, 49.

20. Ibid.

21. Ibid., 49-50.

22. Ibid., 51.

23. Ibid., 51

24. Ibid., 53

25. Ibid., 57

26. American Psychiatric Association, *Highlights of Changes from DSM-IV-TR to DSM-5* (Arlington, VA: American Psychiatric Association, 2013).

27. Adam Rafalovich, *Framing ADHD Children: A Critical Examination of the History, Discourse, and Everyday Experience of Attention Deficit/Hyperactivity Disorder* (Lanham, MD: Lexington Books, 2004), 167-74.

28. Ibid., 55.

29. Sajjad A. Khan and Stephen V. Faraone, "The Genetics of ADHD: A Literature Review of 2005," *Current Psychiatry Reports* 8, no. 5 (2006): 393-97.

30. Thomas S. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (1961; repr., New York: Harper Perennial, 2010).

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31. Scott Danforth and Virginia Navarro, "Hyper Talk: Sampling the Social Construction of ADHD in Everyday Language," *Anthropology & Education Quarterly* 32, no. 2 (2001): 167-90.
32. Ibid., 187.
33. Elizabeth England Kennedy, "Media Representations of Attention Deficit Disorder: Portrayals of Cultural Skepticism in Popular Media," *The Journal of Popular Culture* 41, no. 1 (2008): 103.
34. Judith Warner, "ADHD: Is Stigma Back in Style?" *Time*, February 3, 2012, <http://ideas.time.com/2012/02/03/adhd-is-the-stigma-back/>
35. Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement, and Management, "ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents," *Pediatrics* 128, no. 5 (November 1, 2011): 1007-22.
36. Hanif Kureishi, "The Art of Distraction," *New York Times*, February 19, 2012, SR1; L. Alan Sroufe, "Ritalin Gone Wrong," *New York Times*, January 29, 2012, SR1.
37. Conrad, *Medicalization*.
38. Russell A. Barkley, *Attention-Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment* (New York: Guilford, 2014), 265.
39. Rafalovich, *Framing*, 177-8.
40. Richard DeGrandpre, *Ritalin Nation: Rapid-Fire Culture and the Transformation of Human Consciousness* (New York: W. W. Norton, 1999), 15. Emphasis added.
41. Ibid., 10.

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42. John Rosemond, and Bose Ravenel, *The Diseasing of America's Children: Exposing the ADHD Fiasco and Empowering Parents to Take Back Control* (Nashville, TN: Thomas Nelson, 2008).
43. Ibid., 240.
44. Ibid., 190.
45. Ibid., 189.
46. Anat Klin, and Dafna Lemish, "Mental Disorders Stigma in the Media: Review of Studies on Production, Content, and Influences," *Journal of Health Communication* 13, 5 (2008): 434-49.
47. Michael Leff contends that the role of Aristotelian topoi was to "link . . . the data from which an argument begins and the conclusion with which it ends." Topoi fulfill this function through an inferential justification that resonates with some type of belief or value. Topoi, then, access specific values through the argument to help justify a particular evaluative choice when more than one is possible. Michael Leff, "I. Topical Invention and Metaphoric Interaction," *Southern Journal of Communication* 48, no. 3 (1983): 214-29. See also Michael C. Leff, "The Topics of Argumentative Invention in Latin Rhetorical Theory from Cicero to Boethius," *Rhetorica: A Journal of the History of Rhetoric* 1, no. 1 (1983): 23-44.
48. Jane Gregory and Steven Miller, *Science in Public* (Cambridge, MA: Basic Books, 1998).
49. I am not claiming that all medicalized concepts are accepted by everyone in the Western world simply because the American Medical Association says it is legitimate, nor because medical scientists study it – nor should they; society still negotiates these discourses and subsequent meanings with experiential and localized knowledge. A longitudinal randomized

poll-based study, with about 1400 survey respondents each time, was conducted to compare changing public perceptions of people with mental illnesses from 1996-2006. Despite rampant levels of stigma towards those with psychiatric disorders such as Schizophrenia and depression, public perception of a neurobiological basis and the acceptability of medical intervention and drug therapy increased over the time interval. Andrew R. Payton, and Peggy A. Thoits, "Medicalization, Direct-to-Consumer Advertising, and Mental Illness Stigma," *Society and Mental Health* 1, no. 1 (2011): 55-70.

While I'm not aware of similar polls for ADHD to compare, the qualitative and quantitative differences in controversies over ADHD versus depression or Schizophrenia indicate that there is something unique about ADHD-related discourse. For a review of literature on medical research pertaining to the neurobiological aspects of ADHD see: Russell A. Barkley and Kevin R. Murphy, *Attention-Deficit Hyperactivity Disorder: A Clinical Workbook* (New York: Guilford Press, 1998).

50. I recognize that there are other considerations that contribute to the controversy than the type of discourse I present in this project. For example, a significant source of the controversy relates to the perceived potential dangers of giving psychostimulant medication to children when their brains are going through significant developmental processes. However, as I will develop later in this essay, I contend that the type of discourse I analyze contributes to the conflict even in deliberations that do not invoke the rhetorical topoi I am examining due to the many different aspects of the controversy where these larger critiques are used. In a way, they make the argumentative *stasis* difficult to determine. For discussion on the concerns related to children receiving psychostimulant medication, see: Grace E. Jackson, "The Case against the

Stimulants," In *Rethinking ADHD: From Brain to Culture*, ed. Sami Timimi and Jonathan Leo (Basingstoke, Hampshire, UK: Palgrave and Macmillan, 2009), 255-86.

51. David Farrugia, "Exploring Stigma: Medical Knowledge and the Stigmatisation of Parents of Children Diagnosed with Autism Spectrum Disorder," *Sociology of Health & Illness* 31, no. 7 (2009): 1011-1027; Michel Foucault, *History of Madness*, trans. Jean Khalfa, (New York: Routledge, 2006); Erving Goffman. *Stigma: Notes on the Management of Spoiled Identity* (New York: Simon & Schuster, 1963); Davi Johnson, "Managing Mr. Monk: Control and the Politics of Madness," *Critical Studies in Media Communication* 25, no. 1 (2008): 28-47; Jenell Johnson, "The Skeleton on the Couch: The Eagleton Affair, Rhetorical Disability, and the Stigma of Mental Illness," *RSQ: Rhetoric Society Quarterly* 40, no. 5 (2010): 459-78; Klin and Lemish, "Mental Disorders," 434-449; Katie Rose Guest Pryal, "The Genre of the Mood Memoir and the Ethos of Psychiatric Disability," *RSQ: Rhetoric Society Quarterly* 40, no. 5 (2010): 479-501; Barbara Riddick. "An examination of the relationship between labelling and stigmatisation with special reference to dyslexia," *Disability & Society* 15, no. 4 (2000): 653; Amy Vidali. "Rhetorical Hiccups: Disability Disclosure in Letters of Recommendation," *Rhetoric Review* 28, no. 2 (2009):185-204; James C. Wilson. "Evolving Metaphors of Disease in Postgenomic Science: Stigmatizing Disability." *Rhetoric Review* 22, no. 2 (2003): 197.

52. Margarita Tartakovsky, "Breaking the Silence of ADHD Stigma," *Psych Central* (blog), April 2, 2012, <http://psychcentral.com/blog/archives/2012/04/02/breaking-the-silence-of-adhd-stigma/>

53. Ibid.

54. Danforth and Navarro, "Hyper Talk."

55. James E. Levine, "Re-Visioning Attention Deficit Hyperactivity Disorder (ADHD)," *Clinical Social Work Journal* 25, no. 2 (1997): 200.

56. Michel Foucault, *The Birth of the Clinic: An Archeology of Medical Perception*, (New York: Vintage, 1994).

57 Ibid., 100. Foucault explained in relation to the eighteenth-century French clinical settings, the practitioner's objective analysis of disease required "analogies on which the clinical gaze rested in order to recognize, in different patients, signs and symptoms are of a different order; they 'consist in the relations that exist first between the constituent parts of a single disease, and then between a known disease and a disease to be known.'" Foucault distinguishes between the simple morphology of a single symptom such as trouble breathing, which he states, in isolation, could be seen in conditions as divergent as asthma and scurvy. In contrast, the use of analogy, in conjunction with the clinical gaze's lens through disease models, "identifies a symptom . . . in relation to other functions or other disorders" that "form a constellation in which the co-existence of elements designates a functional interaction peculiar to" a specific disease entity as opposed to others.

58. Michel Foucault, *History of Madness*, trans. Jean Khalifa (New York: Routledge, 2006).

59. Conrad, *Medicalization*, 4-5.

60. Rafalovich, *Framing*, 2.

61. Allen Thiher, *Revels in Madness: Insanity in Medicine and Literature* (Ann Arbor: University of Michigan Press, 1999).

62. Otto F. Wahl, *Media Madness: Public Images of Mental Illness* (New Brunswick, NJ: Rutgers University Press, 1995).

63. Horwitz, *Creating*.

64. Elizabeth Young, "Memoirs: Rewriting the Social Construction of Mental Illness," *Narrative Inquiry* 19, no. 1 (2009): 52-68.

65. For discussion of how the dominant narrative of mental illness leads to reductionism, misunderstanding, and stigmatization, see: Alexandra L. Adame, and Roger M. Knudson, "Beyond the Counter-Narrative: Exploring Alternative Narratives of Recovery from the Psychiatric Survivor Movement," *Narrative Inquiry* 17, no. 2 (2007): 157-78.

66. See England Kennedy, "Media Representations"; Mark F. Schmitz, Prema Filippone, and Elaine M. Edelman, "Social Representations of Attention Deficit/Hyperactivity Disorder, 1988–1997," *Culture and Psychology* 9, no. 4 (2003): 383-406.

67. Lindsay Ray and Amanda Hinnant, "Media Representation of Mental Disorders: A Study of ADD and ADHD Coverage in Magazines from 1985 to 2008," *Journal of Magazine and New Media Research* 11, no. 1 (2009): 1-21.

68. Shanto Iyengar, *Is Anyone Responsible?: How Television Frames Political Issues* (Chicago: University of Chicago Press, 1994), 11.

69. Horwitz, *Creating Mental Illness*, 6.

70. *Ibid.*, 3.

71. Medicalization refers to the "extension of medical jurisdiction or the expansion of medical boundaries" to address emerging patterns "of deviance and social problems" as treatable medical and/or psychological conditions. Peter Conrad and Deborah Potter, "From Hyperactive Children to ADHD Adults: Observations on the Expansion of Medical Categories," *Social Problems* 47, no. 4 (2000): 559. See also Horwitz, *Creating Mental Illness*, 6-10 for a general discussion of how medicalization socially constructs mental illness.

72. Danforth and Novarro, "Hyper Talk," 177.

73. For discussion on the psychological components of ADHD see: Edward M. Hallowell and John J. Ratey, *Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood through Adulthood* (New York: Anchor, 2011); Gabrielle Weiss and Lily Trokenberg Hechtman, *Hyperactive Children Grown Up: ADHD in Children, Adolescents, and Adults* (New York: Guilford, 1993). For discussion on the biological evidence, see: Russell A. Barkley, Kevin R. Murphy, and Mariellen Fischer, *ADHD in Adults: What the Science Says* (New York: Guilford, 2010).

74. Conrad and Potter, "From Hyperactive Children."

75. Rafalovich, *Framing*.

76. Ylva Ginsberg, Javier Quintero, Ernie Anand, Marta Casillas, and Himanshu P. Upadhyaya, "Underdiagnosis of Attention-Deficit/Hyperactivity Disorder in Adult Patients: A Review of the Literature," *The Primary Care Companion for CNS Disorders* 16, no. 3 (2014).

77. See: David Allen Karp, *Speaking of Sadness: Depression, Disconnection, and the Meanings of Illness* (New York: Oxford University Press, 1997); Margaret Price, *Mad at School: Rhetorics of Mental Disability and Academic Life*. (Ann Arbor: University of Michigan Press, 2011); Terrence Real, *I Don't Want to Talk About It: Overcoming the Secret Legacy of Male Depression* (New York, NY: Simon and Schuster, 1998).

78. Additionally, the reductionist and oversimplified media and layperson discourse often narrowly interprets ADHD to hyperactivity due to older medical conceptions of the diagnosis. This means that many of the inattentive incarnations that lack the combined hyperactivity subtype often get missed even by general practitioners. As a consequence, this accounts for the disproportionate number of males that are diagnosed (and potentially overdiagnosed) as having

ADHD and many females are missed until adulthood or misdiagnosed as depressed. Ginsburg et al., "Underdiagnosis." There is a gender bias that is influenced by interpretive means as well.

79. For discussion on the psychological effects of mental illness in general, see Fred E. Markowitz, "The Effects of Stigma on the Psychological Well-Being and Life Satisfaction of Persons with Mental Illness," *Journal of Health and Social Behavior* 39, no. 4 (1998): 335-47.

80. Schmitz, Filippone, and Edelman, "Social Representations," 401.

81. Charland, Maurice. "Constitutive Rhetoric: The Case of the Peuple Québécois." *Quarterly Journal of Speech* 73, no. 2 (1987): 136.

82. Amy Kroska and Sarah K. Harkness, "Stigma Sentiments and Self-Meanings: Exploring the Modified Labeling Theory of Mental Illness," *Social Psychology Quarterly* 69, no. 4 (2006): 193.

83. Charland, "Constitutive Rhetoric," 138.

84. Johnson, "The Skeleton," 468. Italics in original.

85. Ibid., 468.

86. Ibid., 470.

87. James L. Cherney, "The Rhetoric of Ableism," *Disability Studies Quarterly* 31 (2011), <http://dsq-sds.org/article/view/1665/1606>

88. Judith Butler, *Bodies That Matter* (New York: Routledge, 1993).

89. Shelley Tremain, "Foucault, Governmentality, and Critical Disability Theory: An Introduction," In *Foucault and the Government of Disability*, ed. Shelley Tremain (Ann Arbor: University of Michigan Press, 2005), 11. Emphasis in original.

90. Levine, "Re-Visioning," 200.

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91. Simi Linton, *Claiming Disability: Knowledge and Identity* (New York: New York University Press, 1998).
 92. Tobin Siebers, *Disability Theory* (Ann Arbor: University of Michigan Press, 2008).
 93. Mulvany, "Disability," 587.
 94. Peter Conrad, *Identifying Hyperactive Children: The Medicalization of Deviant Behavior* (Burlington, VT: Ashgate, 2006).
 95. Butler, *Bodies*.

CHAPTER 2: RESTORING NOSTALGIA, MINIMIZING ADHD

On Thursday, April 15, 2010, the YMCA of Greater Vancouver ran an advertisement in two Vancouver metro-area newspapers, *24 Hours Vancouver* and *Metro Vancouver*, which have a combined circulation of approximately 250,000 copies, as well as a full online version.¹ The ad, as part of the YMCA's "Where Did Community Go" campaign, which was launched to promote the reopening of the Vancouver-based Robert Lee YMCA center, consists of a black-and-white photo that seems to be a circa 1950s archive shot of twelve young boys and an adult male coach on a basketball court. The accompanying text, which seems reminiscent of writing on a chalkboard, reads: "Before video games, before Facebook, before Ritalin, there was basketball." At the bottom of the ad, there is a website address for the Vancouver YMCA and the "Y" logo. The ad prompted a response from some members of the community who were concerned about the way it stigmatized those implied in the text. However, as explained by ADHD blogger Douglas Cootey, it was not Facebook, Playstation, or X-Box users that felt inappropriately represented.² The only people objecting to the ad were those diagnosed with ADHD or parents of children with ADHD.

To the YMCA's credit, they pulled the ad the day they received complaints. In addition, the organization published an official response on their website, which apologized if the wording of the ad offended anyone. However, during a televised interview about the ad, a representative for the YMCA stated: "We don't see this really as a mistake, we see this as our organization is inclusive and open to everyone. We see this as us being responsive to the concern."³ The representative also stated that the purpose of the larger ad campaign was meant "to invoke some conversation and to invoke some interest in people and the community around getting back to their, our values and getting back to a bit, [sic] a healthy lifestyle."⁴ However, considering the dissonance between the YMCA's approach and the reception of those personally involved with

ADHD, the question seems to be what kind of conversation, and about whose values, does this particular advertisement elicit?

I engage this discourse to demonstrate the rhetorical challenges in developing and/or maintaining a productive ADHDer subject position. In this chapter, I contend that much of the public discourse that challenges the neurobiological/medical legitimacy of ADHD functions as a form of “antirhetoric” due to its implicit and explicit nostalgic justification. Similar to Michael McGee and John Lyne’s analysis of how scientific discourse positions itself as anti-rhetorical – a rhetorical position in itself – social antirhetorics reinforce the “obviousness” and objectivity of social explanations for phenomena.⁵ The vehicle for these problems, I argue, can be found in exploring the attachment of nostalgic logic to ADHD. Specific to the advertisement, nostalgia is found in both the visual and verbal modalities of the image. Fred Davis explains contemporary nostalgia as a sociological phenomenon that contributes to “the sometimes pedestrian, sometimes disjunctive, and sometimes eerie sense we carry of . . . past and of its *meaning* for present and future.”⁶ Inextricably tied to the concept of nostalgia is an associated perception of anxiety about the present or future; there is a mutually reinforcing relationship between the idealization of the past and current anxiety. I propose that the image’s nostalgic rhetoric demonstrates with unusual clarity similar forms of discourse littered throughout interpersonal and mediated communication. These rhetorical features, I argue, discourage concern about ADHD stigma alluding to larger public anxiety of modern society and culture, and the perceived solution to those anxieties found in idealized past “traditional” values and practices. As such, nostalgia has rhetorical characteristics that frame ADHD as a quintessential “problem” with modern society that can and must be fixed. As I argue at the end of this chapter, this has implications for the project’s larger focus on subjectivity and identity.

This chapter develops in four parts. The first section develops the social and rhetorical relevance of nostalgia as an analytical and functional lens for discourse. Expanding on conventional conceptualizations of nostalgia, I begin to develop the pertinent restorative or curative aspects associated with nostalgic rhetorical appeals. The second section uses the “Ritalin” ad in order to exemplify the explicit nostalgic appeals and their function. The third section distinguishes the different but related form of nostalgia found in conspiracy narratives to demonstrate how the mainstream and fringe elements reinforce each other through their mutual nostalgic appeal. The fourth section argues how restorative nostalgia complicates addressing the stigmatization of ADHD by minimizing the ability to claim a legitimate subject position.

Nostalgia and the Yearning for Yester-Myth

The topic of nostalgia as a concept of literary musing and academic inquiry has a rich and varied history.⁷ While scholars from many disciplines have given a great deal of consideration to the function and significance of nostalgia in contemporary society, there is little agreement as to its conceptualization.⁸ The term nostalgia is originally attributed to a Swiss physician named Johannes Hofer in the 17th century to medicalize what was considered the unusual longing and fantasizing experienced by homesick Swiss soldiers while on tours of duty.⁹ The word itself is derived from the Greek roots *nostos* (home or homecoming) and *algia* (painful longing or yearning).¹⁰ Since this original conception, nostalgia has been discursively de-medicalized and demilitarized, and further developed into a critical concept to understand its perceived ubiquity in individual and social experiences. In contrast with the emphasis on a geographical place, contemporary considerations of nostalgia are conceived of as uniquely temporal.¹¹ As Janelle Wilson claims, nostalgia is not a desire to go back in time, rather “it is more a longing to recapture a mood or spirit of a previous time.”¹²

Popular culture is becoming ever more central to how nostalgia is experienced and interpreted because it is increasingly filtered through the media's lens.¹³ More than its increasing influence, however, there is a sense that the media has fundamentally changed the nostalgic experience: "technological progress has made it possible for nostalgia to consist of retrievable events called upon by viewers and listeners at command."¹⁴ These commodified and mass mediated, on-demand representations of the past, in both their dramatic and fantasy-documentary style,¹⁵ introduces the idea that nostalgic experiences are increasingly vicarious.¹⁶ As opposed to previous conceptions of nostalgia, the vicarious experience of nostalgia challenges the idea that a person can only be nostalgic for a time/place that she or he has personally experienced.¹⁷ In other words, people can experience nostalgia for time periods "in which [they] have not lived and/or periods that they only have secondhand knowledge of through popular culture and media."¹⁸ "[M]any Americans believe that the 1950s were a 'simpler time' because . . . families seemed closer, and life was supposedly much more predictable. In other words, many people long for the 1950s of the 'Leave it to Beaver' mythology" regardless of whether they lived during that time or not.¹⁹ This is especially problematic when considering the lack of diversity, with the occasional exception of very strictly maintained portrayals of race/ethnicity, gender, ability, and other roles subordinate to the dominant roles. The purpose of exemplifying popular culture and the media is not to argue that we *only* experience or derive nostalgia from these texts. Rather, because of the intersection of the media and nostalgia, there seems to be a tendency to *experience* nostalgia differently – more vicariously and related to mediated tropes.²⁰

Many of these lines of inquiry take nostalgia to be a given state experienced by those living in a so-called "postmodern condition."²¹ In this vein of thought, nostalgia is conceptualized as a type of affective rhetorical resource or commonplace that influences how we negotiate perceived

uncertainty in the present by engaging with texts and places that simulate a stable past; and, subsequently, the idealized representations of values, practices, and/or identities are presumed to be uniquely espoused in that past.²² Being exposed to, or exposing ourselves to these communicative nostalgic representations, there is a temporal and temporary process of identification with certain mythic narratives constructed about the past that functions as a symbolic escape from a present that seems to suffer from an analogic deficiency.²³ Nostalgia is conceived of as a type of rhetorical topoi that serves as a hermeneutic lens in which to perceive public memory that produces an affective and ethical (re)interpretation of the present.²⁴ Collectively, this literature demonstrates how nostalgia can function rhetorically as a negotiation of perceptions related to both the past and present. More than just how nostalgia is experienced, rhetorical explanations of nostalgia emphasize that both past and present can be subject to discursive influences that both induce and respond to fanciful conditions of longing.

Also arising from literature is an understanding of how nostalgia is used to evaluate the present in terms of how much the perceived condition aligns with the idealized past that is longed for. Nostalgia is sometimes used as topoi through a “narrative of the past-in-memory that argumentatively resurrects and glorifies bygone times and is communicated to achieve an emotional response.”²⁵ Nostalgic topoi provides a particular lens to either praise or blame a person, institution, situation, or context in the present.²⁶ Nostalgia facilitates reinforcing, revealing, and constructing values and beliefs in which a group can use as criteria to evaluate both present and future situations.²⁷ Nostalgic tropes found in arguments, narratives, and/or imagery infuse texts with idealized conceptions of socially normative and ethical standards that “teach us much about the values desired of and encoded in everyday . . . life.”²⁸ Finally, nostalgia negotiates identity and identification within the present.²⁹ Nostalgic texts often idealize groups or communities

through their “historic” portrayal exhibiting or embodying virtues and values that may not be perceived to exist in such a manner in the present.³⁰ These texts facilitate individual and group identification through the nostalgic link to the past as opposed to the present. Through this link, identity is negotiated through perceptions of the present structures and the values of the past to both enact and individualize those structures.³¹

Collectively, this form of nostalgic rhetoric describes how the collective memory of those that directly and vicariously experienced particular time periods and/or events is reframed to perceptions that are far more simplistic, optimistic, and naïve. Individuals and groups then use these perceptions to derive mechanisms to evaluate the quality/condition of the present and/or constitute identification based on values claimed to have an inherent “preferable pastness.” While this discussion helps understand the rhetorical nature of nostalgia regarding its relationship to the past and present, there is another aspect that helps understand the antirhetorical influence alluded to above.

Svetlana Boym identifies a unique form of nostalgia that she refers to as *restorative* nostalgia.³² Whereas nostalgia is acknowledged *as* nostalgia, those involved in the restorative variety do not; “they believe that their project is about truth.”³³ “Restorative nostalgia puts emphasis on *nostos* and proposes to rebuild the lost home and patch up the memory gaps.”³⁴ Boym explains that restorative nostalgia is in part the synthesis of two primary narratives: “the restoration of origins” and a “conspiratorial” perception of being “under siege.”³⁵ More specifically, restorative nostalgia involves advocating for a return to some past “tradition” that is somehow both lost to history and under attack from larger social/cultural/economic forces. Tradition, or “invented tradition,” as Boym refers to it, “does not mean a creation *ex nihilo* or a pure act of social constructivism; rather, it builds on the sense of loss of community and cohesion and offers a

comforting collective script for individual longing.”³⁶ There is a rhetorical connection made between a characteristic of those “good ole days of yesteryear” and a perceived deficit in the status quo. While perhaps engaging in a fantastical time warp, this project most likely reflects a conscious or unconscious desire to make the future more like specific past social conditions.³⁷

However, what ultimately motivates restorative nostalgia is “the anxiety about those who draw attention to historical incongruities between past and present and thus question the wholeness and continuity of the restored tradition.”³⁸ Anxiety is critical for this conceptualization of restorative nostalgia: in addition to a desire for the enactment of an “invented tradition,” there must also be an implicit or explicit anxiety perceived about current social or cultural conditions that the past can “cure.” As such, anxiety and tradition, as well as their synthesis as the “cure,” become rhetorically constituted through the circulation of more recognizable discourses.

In contrast to the past/present orientation of nostalgia, restorative nostalgia is future-oriented; not in its appeal to progressive ideals and continuity between present and future, but rather the perceived discontinuity between the past and present, and the desire to make the future contiguous with the past. The temporal distinction between traditional and restorative nostalgia arises from the tension between the past and a complementary orientation that is *primarily* emphasized: the past-present tensions and the restorative past-future tensions. In order to draw out the temporal characteristics of nostalgia and their implications for the stigmatization of ADHD, I now turn to the YMCA’s “Ritalin” ad.

Restoring Nostalgia, Inventing Traditions

“Ritalin” provides an opportunity to exemplify underlying nostalgic topoi that accompany some of the ADHD discourse that challenge it as a neurobiological condition. Both the verbal and visual characteristics provide an opportunity to observe the interplay between temporal elements of nostalgia within ADHD discourse. As Sonja Foss claims: “Images thus do not determine their own interpretation but require interpretation.”³⁹ This analysis draws on similar principles to Cara Finnegan’s *image vernaculars* to highlight the connection between complementary rhetorical practices in the ad and other related ADHD discourse.⁴⁰ What is of interest here is the way that the ad, as a juxtaposition of visual and verbal nostalgic modalities, draws on existing nostalgic tropes found in skeptical ADHD discourse. As such, the articulations of others’ interpretations of this ad become part of rhetorical understanding of the text. As Lawrence Prelli explains, “Visual depictions rhetorically constrain our verbal responses, much as verbal depictions rhetorically constrain what we are prompted to see.”⁴¹ But more importantly, this analysis demonstrates the relationship between the explicit nostalgic topoi in the image and articulated connections to external discourse that possess similar topoi. It is this process of working through the hermeneutic aspect of the image that the relevant rhetorical characteristics become clearer. Prior to elaborating on these characteristics, I ask the reader to indulge me in virtual narrative of the ad to contextualize the interplay of the verbal and visual modalities.⁴²

Imagine if you will, leaving your house, newspaper in hand, ready to face your typical Thursday morning commute. Or, instead, you have just poured yourself a fresh cup of coffee, and sat down in front of your computer to see what your local metro-area newspaper says about the world today. You begin flipping or clicking through the pages, news stories with full-color photos accompanying the byline; the pages littered intermittently with various margin-filling colorized

advertisements. And then you turn to page 5 of your paper, and filling the bottom third of the vertically oriented page is a black-and-white photograph depicting 12 boys facing a man holding a basketball. The setting appears to be a typical basketball gymnasium, the boys lined up somewhat around the arc at the top of the key, indicating that they are aligned together as they should be. The boys' presence dominates the length of the image – their clothes and hairstyles scream “retro” ‘50s or ‘60s. The man, positioned at the very right of the image – with his front mostly turned away from you, showing a skewed, featureless profile – dominates the height of the image. He faces the children as the children face him. Above the children and to the left of the man's head, there are words written across the top of the image, two lines, reminiscent of chalk scrawled on a chalkboard. The first line, beginning at the near left edge of the image and continuing about seven-eighths of its length, reads: “Before video games, before Facebook, before Ritalin,” The second line is justified right of the first line, slightly askew to the left: “there was basketball.” At the bottom of the image, the lone, bleed-through of color, in an otherwise colorless world: the “Y” symbol for the YMCA.

There exists an interesting tension within the ad. In both the visual and verbal modalities there is an allusion to absence and excess that begins to highlight the relevance of larger public discourse. The ambiguous relation of Ritalin to Facebook and video games is entrenched in larger public discussions about social excess – emersion in “false” community and addiction to “mind-numbing” games. Ritalin, however, is made salient through its seemingly incongruous placement with the other two, and as such, also raises its own excess found in public discourse – ADHD diagnoses and prescribed stimulant consumption continue to increase dramatically. The emphasis on Ritalin's excess seems to frame the way the image as a whole is viewed. However, instead of typical depictions of hyperactive excess, the children in the image seem to portray an absence of

hyperactivity. More specifically, they could be considered an antithesis of hyperactivity. Each boy is lined up shoulder to shoulder, arms seeming to be placed dutifully at their sides – palms purposefully on or close to the thighs like an anchor point. Their posture indicates a sense of rigidity. As we gaze at the children, they do not look back. Rather, their eyes are directed towards the basketball; as if the image had captured the moment after the ball was snapped into its current position by the man watching over them. What might be relevant is the allusion to the phrase “keep your eye on the ball” – a metaphor for goal driven, mental focus; in other words, *attention*. However, despite the uniformity, not every boy looks excited at the prospect of the activity. What is consistent is that each boy is complying regardless of desire to play. The image is important as an antithesis to hyperactivity in that it is a freeze-frame of disciplinary restraint and acquiescence on the part of the children; each of them is the “model” child. We seem invited to view the almost militaristic attention of these children. In a way, the impersonal orientation of the man invites the viewers to “stand-in” for the adult and vicariously observe the children through his authoritarian gaze.

The interplay between the verbal and visual allusions to absence and excess takes on additional meaning through the lens of nostalgia. The verbal message’s use of “before” indicates that there is an interest in not just basketball itself, since the game still prominently exists today – concurrent with Facebook, video games, and Ritalin. Rather, the verbal indicates that it is alluding to a time prior to the perceived social excesses. This becomes increasingly salient when read through the juxtaposition of nostalgia invoked by the visual image.⁴³ While the “retro” style seems to communicate a nostalgic tone, the black-and-white quality of the photo also exudes unique nostalgic characteristics. Paul Grainge argues that the explosion of color-saturated media in a “crowded visual marketplace” has given the monochrome or black-and-white image unique

salience in accessing visual nostalgia: “The black-and-white image has become an idiom of visual pastness, an aesthetic of memory, and the [aura of the] archive.”⁴⁴ The monochrome aesthetic accesses nostalgic mindsets and urges us “to consolidate ideas (and images) of permanence, stability, [and] cultural foundations. . . . In one sense, the black-and-white image served to arrest meaning within, and suggest something outside, an image world of color simulacra.”⁴⁵ That which is representative of the image – the absence of hyperactivity and presence of attention – becomes associated with notions of the past as embodying stability and foundationalism. This becomes contrasted with the excess of modern society’s polychromatic masking of the “good” in “the good ole days.” As such, nostalgia shifts the dynamic of absence and excess from spatial to temporal.

Emphasizing the incongruity of past and present creates a longing for a time when children are presumed to have embodied the model, correlated with a time that the “ADHD” label, and more importantly, Ritalin did not *perceptually* exist. The invitation to view the children through the adult asks us to engage in surveillance both in bodily discipline and communally acceptable values that are perceived to be absent in modern time and space. Through the temporal interplay of absence and excess, these idealized values and beliefs of yesteryear construct not only the “golden age” of the past; they also shape perceptions of the present as deficient and the future as uncertain. This perception of certainty belonging to the past and associated with uncertainty in the present, ultimately rhetorically induces anxiety of the future.

This nostalgic anxiety creates possibility for the restorative characteristics to manifest. This type of nostalgia implicitly or explicitly proposes a return to “traditional” practices that serve as a symbolic curative to fill the perceived “void of social and spiritual meaning” that is associated with the progression of modern society.⁴⁶ Giddens provides a potential explanation of how

restorative nostalgia functions to rhetorically resolve the tension between tradition (past) and the contingency or uncertainty of practices (future):

[T]radition has a key role in articulating action and ontological frameworks; tradition offers an organizing medium of social life specifically geared to ontological precepts. . . . [It] orders time in a manner which restricts the openness of counterfactual futures. . . . But . . . where traditional modes of practice are dominant, the past inserts a wide band of ‘authenticated practice’ into the future. . . . In addition, tradition creates a sense of firmness of things that typically mixes cognitive and moral elements. The world is as it is because it is as it should be.⁴⁷

Values, beliefs, and particularly practices associated with the past and “tradition” become a “cure” for uncertainty associated with a modern social reality that is increasingly “post-traditional.” Restorative nostalgia is able to function as an “obvious” solution to resolve anxiety induced by the traditional nostalgic narrative.

In the “Ritalin” ad, the restorative narrative co-exists and plays off the nostalgic narrative and has its own tension between absence and excess. The perception of excessive video games and television consumption, and the absence of discipline, good parenting, and “family values,” becomes the problem with modern society and the “cause” of ADHD. Since ADHD did not exist in the past, at least according to this logic, the solution to the ADHD “epidemic” must be unique to that past – something absent in the present and found in excess in the past. The logic of the restorative nostalgic shift thusly articulates the solution as an absence of video games and television, and an excess of discipline, good parenting, and “family values.” In this text, basketball functions as synecdoche for the restorative appeal to return to “traditional” values and practices that espouse the idealized model child, as well as the mythologized time-period, associated with the image. As Boym states: “The past for the restorative nostalgic is a value for the present; the past is not a duration but a perfect snapshot.”⁴⁸ The appeal to traditional frameworks and practices are persuasive in this context through the affect associated with nostalgic longing for the past and

anxiety for the future; that affect becomes transferred as a warrant for the associated logic of restorative nostalgic topoi.

In the aftermath of the ad's publication, ADHD advocates and interested individuals engaged in the hermeneutic problem. There were certainly different ways of reading the caption, but most interpreted the text by selecting Ritalin as the entry point into seeing the image. Peter Quily, commenting on "Ritalin" as the focus of one of his weblog posts, explained that "Ritalin is not just a word for the actual medication itself, it's also used many, many times to denigrate, trivialize, stigmatize and demonize the actual neurobiological condition."⁴⁹ Another person commented on Quily's blog: "There are times when I value ADHD, and there are days where I wish I did not need ritalin [sic] to make my day work. YMCA bugs me today."⁵⁰ This implies that the advocates associated external stigmatizing discourses within the interpretation of the ad. In fact, Quily makes a point to state: "It's not just about Ritalin. It's not just about ADHD medication. It's not just about the YMCA. There are many common myths, misconceptions, and stigma surrounding ADHD."⁵¹

While these responses to "Ritalin" acknowledge the influence of larger ADHD discourse in interpreting the image, the reactions above do not quite make the connection between the ad and its nostalgic appeals. Sandy Alletto-Corbin, an ADHD advocate and mother, noticed how the "Ritalin" ad exemplifies these themes in a very poignant blog post:

There is a very strong sub text implying that with "good ole hard work," or if you would just "tighten those boot straps" and get these kids involved with some healthy exercise, and a little strong discipline, then that is the KEY to success with "these KIDS", which implies the stereotype that these kids are just lazy and/or just not being raised properly, which is the other stereotype, to lay all the blame on home and upbringing. Of course that usually lands on the shoulders of the MOM!⁵²

There seems to be a tendency to ignore and dismiss the consequences of skeptical ADHD discourse that draws on nostalgic topoi.

The presentation of the model child as literally embodying everything the hyperactive child is not seems to stand in stark contrast with the allusion to “lazy” parents over-medicating children. Rather than being seen as a legitimate, neurobiological condition that *may* require pharmaceutical treatment, the absence of the tell-tale bodily behavioral signs, frozen in unending time, implicates the assumptions of some that discipline and “good” parenting can “cure” ADHD.

While the “Ritalin” ad is particularly demonstrative to understand the roles that restorative nostalgia play in constructing a persuasive and pervasive logic, it is important to understand that “Ritalin” is not an isolated text. As mentioned in Chapter One, critics often integrate ADHD into larger critiques of social/cultural conditions. To see where much of this anxiety intersects with the warrant constructed via restorative nostalgia, it is important to see just how they articulate some of these arguments in other discourse.

Nostalgic Conspiracy

Boym explains that while more extreme, restorative nostalgia has another form that emphasizes a proscriptive return to origins: the conspiracy theory. “The conspiratorial worldview reflects a nostalgia for a transcendental cosmology and a simple pre-modern conception of good and evil. . . . ‘Home’ . . . is forever under siege, requiring defense against the plotting enemy.”⁵³ In a way, the conspiracy theory is an extreme extension of the comparatively more mainstream restoration of origins plot. In exploring texts that demonstrate this more fringe ADHD discourse, there is the opportunity to understand how the mainstream discourse can be even more problematic when taken to its extreme conclusion. Additionally, the fragments of conspiracy narratives and nostalgia narratives can be understood to implicitly reinforce each other when not necessarily explicitly connected.

Conspiracy Fragments

As the name implies, many of the characteristics observed in traditional conspiracy rhetoric can be seen in this type of nostalgia. As with any other narratives, conspiracy seeks to organize and interpret textual fragments in order to impose an interpretive understanding. As Thomas G. Goodnight and John Poulakos explain, conspiracy typically arises as a way to explain a troubling event or series of events when attempts to “explain and assimilate it within familiar parameters” are not sufficient.⁵⁴ Doubt remains in the budding conspiracy theorist. However, this doubt requires an additional element to lead the mind towards conspiracy. In the search for alternative causes to allay doubt, the conspiracy theorist typically creates common connections to other events that the individual deems to deny coincidence. Those that become narrators of conspiracy rhetoric – regardless of whether they are interpreters or producers of public texts – typically begin with questions and a yet unsolved mystery. As the individual attributes increasingly seemingly unrelated fragments/events as associated with the initial event, questions turn to certainty.

At this point, “conspiracy suspicions are voiced in terms which attribute social evils to powerful, secret alliances.”⁵⁵ Here, the parent/doctor/Big Pharma characters become those involved in the secret alliance, and the “social evils” they are attributed with are a result of the attacks on a range of values that the (re)producer of the narrative perceive as important but deficient.⁵⁶ In these narratives, for example one expressed by Joel Taylor of Joel Taylor Ministries, there are “5.4 million children ‘diagnosed’ with an imaginary, invented ‘disease’ to boost pharmaceutical profits. . . . 5.4 million children who were normal, but are no longer normal due to parents who, in their ignorance, pump amphetamine drugs into their children’s bodies 24-7, day-in, day out. . . . 5.4 million children whose sin is being treated as a disease.”⁵⁷ While the conspiratorial elements shine through many of these examples, the nostalgic components are

harder to observe. However, as I mentioned above, these fragments interact throughout various other narratives that demonstrate an implicit nostalgic longing for an invented tradition that no longer is due to perceptions of being under siege.

The reference to children's sin being treated as disease often alludes to and overlaps with not merely religious implications, but a particular religious worldview. One which sees "America, and Western civilization is dying" because "unregenerate men love darkness more than light. In other words, they hate God. It's that simple."⁵⁸ A worldview that sees "the great and glorious truth that in these New Testament times, it is the Church of Jesus Christ, and the Church alone, who is the 'Israel of God. Any other teaching . . . is false doctrine, having its origin in Hell."⁵⁹ The relevance to the discussion arises from the similar overlapping fragments that can be found in other restorative nostalgic conspiracy rhetoric. Andrew Murphy demonstrates how the "Christian Right" invokes narratives of a society under siege due to an absence of a particular subset of interpreted religious values.⁶⁰ Specifically, Murphy provides the example of Jerry Falwell lamenting the moral decline of society as a consequence of "outlawing" religion in schools.⁶¹ More generally, he claims that the Christian Right narrative emphasizes a pre-Equal Rights Amendment and *Roe v. Wade* era family and social structure. The conspiratorial siege is not, therefore, on religion itself, but a particular religious justification that subjugates a form of nostalgia, desiring a return to origins.

A particular set of religious values perceived to correlate with an invented ideal of past family values is not the only form that these fragmented associations occur. One author blames ADHD on the loss of parental responsibility induced by the "socialistic system of education" that has become the American K-12 system.⁶² The claim is that there has been a subsequent decline in discipline and self-control that lead to "our modern technocratic society" learning how to "hit kids on the head with a chemical rock. . . . In many government school systems, such drugs are actively

promoted by the administration as a means of keeping order in the classroom.”⁶³ However, the explicit restorative element augments this excess/absence tension between past/present in both values and actions. The restorative element builds off the past/present to create a connection between the actions taken in the past as a corrective to use in the future for the decay and deficiency of the present.

One of the more insidious strands of anxiety over social conditions can be found in the more extremist forms of this already extreme discourse that overlap with those that perceive an existential threat on a very narrow-minded way of life. That way of life is romanticized and constructed into the social consciousness of its adherents in a way that becomes almost religious. This extremist mindset is often associated with hate groups. One excerpt comes from the website of known white supremacist and former Ku Klux Klan Grand Wizard, David Duke. In this example, the threats in excess in the present that was absent in the perceived past - or at least relative to today - are movements that fight for social equality like the feminist movement. As ADHD is more often diagnosed in boys than in girls, these individuals perceive a threat to traditional masculinity as a casualty in the “unreasonable” feminist perspective. “Progressives and Feminists are on what seems to be a campaign to ‘dismantle’ any sense of ‘American’ masculinity. . . . The first step in solving social ills is to pathologize boyhood and numb it into oblivion”⁶⁴ Taking this argument a step further, Milo Yiannopoulos accuses feminism of creating “drugged up young men” that commit mass shootings.

Millions of young American men are prescribed powerful drugs after being diagnosed with the phantom condition “ADHD,” better known as a mixture of natural boisterousness and poor parental discipline. The mere fact of being male has become pathologised. . . . Feminists like to bang on about “toxic masculinity” in wake of atrocities like Charleston. But it’s not masculinity that’s toxic: it’s the chemicals we’re pumping into our young men’s bloodstreams.⁶⁵

And, completing the hat trick, there is the intersection of racism, gender discrimination, and progressive ideology when another author argues “fake” ADHD brands children like “scarlet letters.”⁶⁶ Children are “guinea pigs” for the “social engineers that run our warped leftist government schools.”⁶⁷

They are, in a word, “deballing” our young boys in America, and with the help of pills and pharmaceuticals, are making them pliable and submissive servants of the one-worlder agenda that the Jews are forcing on us, whether we like it or not. . . . They must be feminized, softened and weakened so that they can be controlled. They must become more like girls and women, because girls and women are more submissive, and are more governed by feelings, rather than logic and the “will to power.”⁶⁸

While most do not take the tone that the previous excerpt demonstrates, what is similar throughout these examples are authors attempting to advance conspiracy nostalgic appeals to address perceived anxiety about the present. As Boym explains,

The conspiratorial worldview is based on a single transhistorical plot, a Manichaeian battle of good and evil and the inevitable scapegoating of the mythical enemy. Ambivalence, the complexity of history and the specificity of modern circumstances is thus erased, and modern history is seen as a fulfillment of ancient prophecy. ‘Home,’ imagine extremist conspiracy theory adherents, is forever under siege, requiring defense against the plotting enemy. . . . Paranoid reconstruction of home is predicated on the fantasy of persecution.⁶⁹

Nostalgic conspiracy then sees a plot implemented by nameless, faceless authorities actively eroding the present, shifting individuals away from the inherently “virtuous” and/or “natural” life that necessarily existed in the past.

While the conspiratorial elements of these nostalgic appeals demonstrate how fragmented associations are constructed to turn ADHD into synecdoche for the perceived siege, what is still missing is how the restorative conclusion of that siege looks. Next, I turn to discuss how ADHD nostalgic conspiracy discourse takes the cure to an extreme.

Restorative Conspiracy

While conspiracy is an alternative to the more mainstream restorative nostalgic narrative, they both involve the restoration of some imagined past condition. While the mechanism for that cure may be the same in either form, nostalgic conspiracy seems to more explicitly attach a “psychotic substitution of actual experiences with a dark conspiratorial vision: the creation of a delusionary homeland”⁷⁰ to the way in which the proposed restoration will address the problem of ADHD; both the nostalgic return to origins and conspiracy theory propose corporal punishment, “natural” diet, exercise and fresh air, recess – all actions that these individuals perceive to be absent in the present and abundant in the past. However, for the nostalgic conspiracy, the proposed curative is not just a desire to reclaim an idealized version of the past. The conspiratorial cure is a reaction to a perceived active threat: “‘We’ (the conspiracy theorist) . . . project our dislike on them and begin to believe that they . . . wish to persecute us. ‘They’ conspire against ‘our’ homecoming, hence ‘we’ have to conspire against ‘them’ in order to restore ‘our’ imagined community.”⁷¹

This presents an additional challenge to the more common restorative nostalgic narrative. While the “Ritalin” ad demonstrates how restoration of origins appeals construct and reinforce the “naturalness” or “obviousness” of the nostalgic absent/excess warrant, the conspiracy narrative constructs ADHD curatives as necessary to implement as a defense to the nameless/faceless “they.” Due to the fragments that overlap with both types of restorative nostalgic appeals, the associated values that are under siege do not necessarily need to be explicitly stated in every iteration. A narrative need only indicate that medicating young children is wrong in reference to stimulant medication for children with ADHD. In that statement, the narrative attaches the implicit warrant of a variety of value deficiencies that someone else already familiar with the various fragments and/or finds the implicit nostalgic warrant appealing – lack of discipline, respect,

nurture, responsibility, and the like – which implies the cure. Much of this will depend on the frame of reference of who experiences those fragments. Someone of the David Duke/Milo Yiannopoulos persuasion could hear that same utterance and still interpret a different set of unstated warrants – lack of masculinity, freedom, heteronormativity, and whiteness. In either scenario, you can imagine another hypothetical interlocutor in this narrative exchange follow up with some similarly generic, but powerfully (and damaging) reaffirming statements like: *We just need to beat our children like we did in the good ‘ole days,’ or, Kids don’t need no pills, they need feminazis to get out of their learnin’ and let boys be heteronormative, hyper-masculine boys!*

An implication of considering the influence that the nostalgic conspiracy version of restorative nostalgia has, is that even though the conspiratorial narrative is far less common than the restoration of origins narrative, the fragments of both reinforce the other. Even the individual that does not go so far as to claim some form of “conspiracy” against heteronormative/biblical/conservative masculinity can look at the associated narrative regarding the restorative solutions to ADHD intertwined and agree that there is at least some “sense” in it. This sense is then used to justify the “naturalness” of the ADHD-excess/punishment-absence in the present juxtaposed with the perceived ADHD-absence/punishment-excess in the past. It is this issue with “naturalness” and the challenges it poses that I turn to conclude.

Antirhetorical Minimization of ADHD

Both versions of restorative nostalgia challenge ADHD as a legitimate diagnosis by invoking “curative” practices. These practices are associated with a past that values communal absence of public ADHD bodies and the larger social ills assumed to be associated with the production of those bodies. These values and practices cloak the concern for stigmatization associated with nostalgic ADHD discourse in an implicit ignorance of the “true causes” of what

society attributes to the perceived increase in ADHD. There seems to be an implied understanding between these discourses and those that accept them that if those diagnosed or the parents of diagnosed children were not “duped” by what they seem to perceive as the ubiquitous acceptance of ADHD as a neurobiological condition – and instead accepted the “truth” that ADHD is a consequence of social and cultural deficiencies – then these discourses would not be stigmatizing. To put it another way, their position is that those that feel stigmatized by nostalgic appeals are stigmatizing themselves by not accepting the “obvious” conclusion. Taken a step further, many view that what is “obvious” to them is a consequence of purposefully evil ‘they’s’ attempting to dupe the public through conspiracy. The outcomes of these nostalgic topoi are that they not only diminish the impetus to attend to how their own implied assumptions stigmatize ADHD; but more importantly, restorative nostalgia naturalizes the more substantial stigmatization of ADHD as synecdoche for the perceived deficiencies in modern society: the metaphorical poster child of perceived uncertainty, instability, and risk associated with anxiety of our “deficient” present.

As alluded to at the beginning of the chapter, there is a sense in which restorative nostalgia can be conceptualized as a form of “antirhetoric.” McGee and Lyne introduce this term to highlight the almost ironic notion that the “appeal to objective knowledge and its accompanying denunciation of rhetoric is one of the most effective rhetorical strategies available.”⁷² The authority, and to some extent the utility, of expert knowledge relies on the public perception that it is relatively objective. I contend that the restorative nostalgic topoi compete with scientific objectivity through a form of *social antirhetoric*. Making sense of the continual revision of scientific knowledge, and the associated search for alternative etiologies associated with ADHD, can confound audiences that lack technical expertise. In effect, the “simplicity” associated with restorative nostalgia’s logic privileges social explanations of ADHD. More importantly, this social

antirhetoric arises from nostalgia itself; recognizing the contingent, revisable nature of both social and scientific knowledge, in addition to the anxiety experienced with increasing change in modern society and perceived discontinuity between past and present, makes the appeal to narratives of stability and certainty in traditional values and practices seem obvious, “natural,” and incontestable as “common sense.” As such, it produces a type of certainty that is “antirhetorical” in much the same way as McGee and Lyne’s conception of antirhetoric in scientific discourse.

Similarly, those adherents of nostalgic conspiracy experience a similar consequence of antirhetoric. Nostalgic conspiracy adherents have a tenuous relationship with “evidence.” As Goodnight and Poulakos explain, conspiracy narrators engage in a reinterpretation process of traditional rhetorical appeals to fit the larger narrative. The amount of evidence, the source of evidence, and emotional appeals that violate the core of the conspiracy narrative are cast as suspicious and are likely produced by the very conspirators trying to erode the values they perceive as under siege. Unfortunately, attempting to normalize ADHD by explaining it is a neurobiological condition is common. The problem lies in the association of medical studies, prolific information, and the governmental/corporate structure as something necessarily of the present and not the past. The nostalgic conspiracy adherent has a distrust of the present and prefers the “simplicity” of the values found in the constructed past. This makes traditional evidence-based appeals challenging for the purposes of reducing stigma and stigma-inducing discourse that draws on these narratives. Much of the framework can be related to the values and moralizing elements that these narratives (re)constitute. The implication of the framework is not simply that the values are preferable, but that they are “under siege” in whatever specific context is being provided as evidence of that siege.

This social antirhetoric produces a metonymic shift that reduces a host of possible complex “causes” of ADHD-related behaviors into one or a few social loci that become representative of

not just the problems with contemporary society as it relates to ADHD, but rather, ADHD becomes synecdoche for the changing social conditions causing anxiety of the present. This is particularly exemplified in the expansion of the ADHD diagnosis to extend into adulthood. This expansion introduces the association of performance-based limitations to a previously exclusive behavioral disorder. Lawrence Diller explains: “The simple fact of hyperactivity or impulsivity is not the chief concern for teens and adults: rather, it’s their disorganization, irresponsibility, procrastination, and inability to complete tasks.”⁷³ Conrad cynically refers to this as “the medicalization of underperformance.”⁷⁴ While DeGrandpre’s *Ritalin Nation* addressed issues related to Ritalin as a performance enhancer in a performance-based society, Conrad’s articulation highlights a different but central critique: the medicalization of underperformance absolves personal responsibility and, in a way, devalues the “wheat from the chaff” mentality of the “American Dream-like” fantasy promoted by modernist conceptions of individual agency. The (in)ability to achieve is no longer seen as entirely agentic in nature – as it was perceived to be in the past. However, the larger perceived threat seems to come from traditional assumption that in order to achieve social progress and maintain order, there must be social (dis)incentive to motivate the masses. The absolution of personal responsibility diminishes motivation by scapegoating either biology or society (depending on the perspective) as the cause of insufficient performance. DeGrandpre’s criticism reinforces this perspective, because now the perception is that the individual does not need to try in order to succeed: rather, the only thing necessary for success is a prescription for Ritalin.

The ironic element is that the restorative nostalgic “solutions” implicitly and explicitly proposed both reify a medical issue by referring to “cures” such as a belt or self-control, while also attempting to deny disability. If there were no solutions, there would be a type of disability. If there is a “cure,” there is a simple prescription. However, the solution such as the belt and self-control

are antirhetorical, rhetorical constructions. They are provided as self-evident solutions – couched in the restorative nostalgic logic – that reinforce a specific “naturalness” that is only natural if someone assumes a “normal” or unique form of individual. This is why, as Chapter One explains, underlying ableist assumptions create a problematic tension that must be addressed in order to move forward. In conjunction, the social antirhetorical nature of restorative nostalgic discourse that results in the associated metonymic shift minimizes ADHD stigmatization by circumventing its relevance.

Notes

1. Pete Quily, "YMCA Stigmatizes ADHD Families. Acceptable to Stigmatize Children with Mental Health Conditions for Money?" *Adult ADD Strengths*, (April 24, 2010)

<http://adultaddstrengths.com/2010/04/24/ymca-stigmatizes-adhd-families/>.

2. Douglas Cootey, "YMCA Ad Triggers ADHD Firestorm," *ADDaboy! Health Place*, (June 19, 2011) <http://www.healthyplace.com/blogs/adultadhd/2010/05/ymca-ad-triggers-adhd-firestorm/>

3. Pete Quily, "Pete Quily Interviewed on CBS Vancouver's Early Edition on the Vancouver YMCA ADHD Stigma Ads," *ADD Coach 4 U*, (April 21, 2010)

<http://www.addcoach4u.com/media-room/radio/cbc-vancouver-april212010.html>

4. Ibid.

5. Michael Calvin McGee and John R. Lyne, "What are Nice Folks Like You Doing in a Place Like This?" in *The Rhetoric of the Human Sciences: Language and Argumentation in Scholarship and Public Affairs*, ed. John S. Nelson, Allan Megill, and Donald N. McCloskey (Madison, WI: University of Wisconsin Press, 1987), 389. Cherney explains that "Practitioners of anti-rhetorics deny their own rhetoricity so as to appear value neutral, mere messengers of the truth, who by being above the sticky political world of rhetoric are not tainted with its excesses." James L. Cherney, "The Rhetoric of Ableism," *Disability Studies Quarterly* 31, no. 3 (2011): np.

6. Fred Davis, *Yearning for Yesterday: A Sociology of Nostalgia*, (New York: Free Press, 1979) 6, emphasis added.

7. For good discussions on the various interdisciplinary perspectives on nostalgia and the various historical treatments see: Svetlana Boym, *The Future of Nostalgia* (New York: Basic

Books, 2001); Davis, *Yearning*; Kimberly Smith, "Mere Nostalgia: Notes on a Progressive Parathory," *Rhetoric & Public Affairs* 3, no. 4 (2000).

8. Susan L. Holak and William J. Havlena, "Feelings, Fantasies, and Memories: An Examination of the Emotional Components of Nostalgia," *Journal of Business Research*, 42, no. 3 (1998).

9. Boym, *Future*, 3-4; Davis, *Yearning*, 1-3.

10. Davis, *Yearning*, 1.

11. Malcolm Chase and Christopher Shaw, "The Dimensions of Nostalgia," in *The Imagined Past: History and Nostalgia*, (Manchester: Manchester UP, 1989) 2-3. Boym explains that during the 18th and 19th centuries, medical experts began to rule out the spatial dislocation of a specific "place" as the "root cause" of nostalgia due to the observation that frequently the return home of someone "suffering" from nostalgia did not "cure" the individual. Rather, the individual might become nostalgic for the place where she or he just came from or for a different, past "version" of home. This led many interested in the nostalgia phenomenon to consider it "a historical emotion" and turn for explanations external too medicine and psychology. Boym, *Future*, 6-7.

12. Janelle Wilson, *Nostalgia: Sanctuary of Meaning*, (Bucknell University Press, 2005) 26.

13. Fredrick Jameson, *Postmodernism, or the Cultural Logic of Late Capitalism* (Duke University Press, 1991) 279-96

14. Diane Lamude, "A Cultural Model of Nostalgia and Media Use," *World Communication* 19, no. 2 (1990), 41.

15. Jameson, *Postmodernism*, 279-96.

16. Carlita P. Greene, "Towards a Rhetoric of Nostalgia and Cultural Memory," in *Sporting Rhetoric: Performance, Games, and Politics* ed Barry Brummet (New York: Peter Lang, 2009).

17. Davis explicitly, and Boym implicitly, makes this claim. Boym, *Future*; Davis, *Yearning*.

18. Ibid. Referring to a similar phenomenon, Wilson shows how "Gen Xers" express an affinity for the 1950s ("because of the association with a more safe, relaxed, stress-free life") and 1960s ("perception . . . as a time of real social change") despite not possessing firsthand experience of those time periods. Janelle L. Wilson, "Generation X: Who are They? What do they Want?" *NEA Higher* (1998) 10-11.

19. Ibid., 69.

20. Greg Dickinson, "Memories for Sale: Nostalgia and the Construction of Identity in Old Pasadena," *Quarterly Journal of Speech*, 89, no. 1 (1997) 213-17.

21. I think it pertinent here to address a troubling distinction I see between various contemporary accounts of nostalgia. While one camp sees nostalgia as ubiquitous throughout history, others see it as a uniquely modern and/or postmodern phenomenon. While I think both positions have some merit, I am always suspicious of the irony involved in declaring such grand metanarratives. While Davis places nostalgia with the uncertainty associated with transition from pre-modernism to modernism, and Bryan Turner discusses the "ontology of nostalgia" as a condition attributed to cultural alienation associated with any major social paradigm shift, as many scholars argue that nostalgia is unique to the emergence or presence of the postmodern condition. Bryan S. Turner, "A Note on Nostalgia," *Theory, Culture, & Society*, 4, no. 1 (1987). More than that, nostalgia is considered an inevitably increasing "reality" due to the inherent

instability of social categories, production of meaning, conceptualization of time and space, and, most significantly, history and memory. Dickinson, “Memories”; Greene, “Towards.” The argument, taken to its most fundamental articulation, seems to be that nostalgia is everywhere because postmodernism is everywhere. I don’t doubt that something we might call a postmodern sociality is emerging or exists in certain extreme contexts; and, I do not dispute that there are good arguments that implicate the role of technology in changing the way we perceive the world around us – “destabilizing” certain pillars of modernity. What I do question is the claim that postmodernism is all encompassing and ever-present. More importantly, I dispute the claim that nostalgia and its social influence is ubiquitous even if it were possible to be completely consumed in a postmodern society. The ubiquity would seem to preclude the influence that nostalgia would have, especially as a rhetorical strategy. It would functionally cease to be what we consider nostalgia and operate aesthetically as “retro” or “kitsch,” and socially as reminiscing or public memory. Frank J. D’Angelo, “The Rhetoric of Intertextuality,” *Rhetoric Review* 29, no. 1 (2010).

22. Roger C. Aden, “Nostalgic Communication as Temporal Escape: When it was a Game’s Re-Construction of a Baseball,” *Western Journal of Communication*, 59, no. 1 (1995).
Dickinson, “Memories for Sale.”

23. Aden, “Nostalgic”; Dickinson, “Memories;” Greg Dickinson, “The Pleasantville Effect: Nostalgia and the Visual Framing of (White) Suburbia,” *Western Journal of Communication*, 70, no.3 (2006).

24. Dickinson, “Pleasantville”; Shawn J. Parry-Giles and Trevor Parry-Giles, “Collective Memory, Political Nostalgia, and the Rhetorical Presidency: Bill Clinton’s Commemoration of the March on Washington, August 29, 1998,” *Quarterly Journal of Speech* 86, no. 4 (2000). Ron

Von Burg and Paul E. Johnson, "Yearning for a Past that Never Was: Baseball, Steroids, and the Anxiety of the American Dream," *Critical Studies in Media Communication*, 26, no. 4 (2009).

25. Parry-Giles and Perry-Giles, "Collective," 420.

26. Expressing praise or blame relates to the *encomium*, a subset of epideictic speech. Edward Schiappa, "Gorgias's Helen Revisited," *Quarterly Journal of Speech* 81, no. 3 (1995).

27. Chaim Perelman and Lucie Olbrechts-Tyteca advance the claim that "epideictic oratory has significance and importance for argumentation because it strengthens the disposition toward action by increasing adherence to the values it lauds." Chaim Perelman and Lucie Olbrechts-Tyteca, *The New Rhetoric: A Treatise On Argumentation*, trans John Wilkinson and Purcell Weaver, (Notre Dame, IN: University of Notre Dame Press, 1969) 49-50. In contrast, Lawrence Rosenfield argues that the epideictic speech derives from the Greek *epideixis*, which means "to shine or show forth" which "suggests an exhibiting or making apparent." Lawrence Rosenfield, "The Practical Celebration of Epideictic," in *Rhetoric in Transition: Studies in the Nature and Uses of Rhetoric* (State College, PA: Pennsylvania State University Press, 1980) 135. While Rosenfield argues that epideictic functions as some revelatory "truth," Robert Danisch draws in Michel Foucault's works on power and the self to extend traditional rhetorical theory concerning epideictic speech to conceptualize its function in constituting values and subjects. Robert Danisch, "Power and the Celebration of the Self: Michel Foucault's Epideictic Rhetoric," *Southern Communication Journal*, 71, no. 3 (2006) 293. The concept of providing evaluative criteria also resonates with Celeste Condit's observation that epideictic speech facilitates definition and understanding "when some event, person, group, or object is confusing or troubling." Celeste Michelle Condit, "The Functions of Epideictic: The Boston Massacer Orations as Exemplar," *Communication Quarterly*, 33, no. 4 (1985) 288.

28. Dickinson, "Pleasantville," 217.

29. Condit explains that epideictic speech shapes values and beliefs in order to facilitate identification with a community; "the community renews its conception of itself and of what is good." Condit, "Functions," 289. This also resonates with Kenneth Burke's perspective on persuasion as identification by making one "consubstantial" with another. Kenneth Burke, *A Rhetoric of Motives*, (Berkeley, CA: University of California Press, 1969) 20-21. With respect to identity, Danisch contends that epideictic rhetoric can be a potential resource for understanding how subjectivity is both structured and negotiated: "Practicing epideictic rhetoric can now mean telling the history of the present and helping the individual negotiate his or her relationship with the dominant social structures of the present moment." Danisch, "Power," 304.

30. Aden, "Nostalgic."

31. Dickinson, "Memories."

32. Boym, *Future*, 41.

33. Ibid.

34. Ibid.

35. Ibid., 43.

36. Boym, *Future*, 42. While never using the term "nostalgia," Giddens also echoes this point. Giddens, *Consequences*, 36-39.

37. Giddens explains that: "Today, we see a definite tendency to seek to re-establish vanished traditions or even construct new ones. . . . Tradition loses its rationale the more thoroughly reflexivity, coupled to expert systems, penetrates to the core of everyday life. The establishment of 'new traditions' is plainly a contradiction in terms." Giddens, *Modernity*, 206-7.

38. Ibid., 44-45.

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39. Sonja K. Foss, "A Rhetorical Schema for the Evaluation of Visual Imagery," *Communication Studies*, 45, no. 3-4 (1994) 216.
40. Image vernaculars are a "way of talking about photographs" that exhibit "social knowledge about photography." Cara A. Finnegan, "Recognizing Lincoln: Image Vernaculars in Nineteenth-Century Visual Culture," *Rhetoric & Public Affairs* 8, no. 1 (2005) 33-34.
41. Lawrence Prelli, *Rhetorics of Display*, (Columbia, SC: University of South Carolina Press, 2006) 13.
42. I was denied permission to reproduce the ad for publication by the YMCA of Greater Vancouver's general manager of marketing and communications in April of 2012. After contacting the ad agency for permission, the agency understandably deferred to their client's decision. In that personal communication, the YMCA representative intimated to the controversy that arose from the ad as the justification for denying my request. However, at the time this manuscript was submitted, the ad is still accessible online from various sources: *Metro Vancouver* newspaper still has their online version of the paper, where the ad appears on page 5 of the April 15th, 2010 edition. The link to the specific page is:
http://reader.metronews.ca/digital_launch.aspx?id=18339e69-220e-4915-90e8-775a8f7c771c&pnum=5 The ad is also displayed as part of a weblog post about the controversy: Quily, "YMCA Stigmatizes." <http://adultaddstrengths.com/2010/04/24/ymca-stigmatizes-adhd-families/> Another alternative is to go to Google Images and search using the terms: Ritalin YMCA.
43. Susan Sontag claims that images and their affective appeal change with distance: "The particular qualities and intentions of photographs tend to be swallowed up in the generalized pathos of time past." Susan Sontag, *On Photography*, (New York: Picador) 21. She

further argues that “photographs actively promote nostalgia” because “by slicing out this moment and freezing it, all photographs testify to time’s relentless melt” Ibid., 15. It seems as if the image, taken of a moment that can never again exist, is a constant reminder that time is a relentless constant in social existence – further heightening the nostalgic anxiety of the present.

44. Paul Grainge, *Monochrome Memories: Nostalgia and Style in Retro America*, (Praeger, 2002) 3.

45. Ibid., 184.

46. Ibid., 41.

47. Giddens, *Modernity*, 48.

48. Boym, *Future*, 49.

49. Quily, “YMCA”

50. Ibid.

51. Ibid.

52. Quoted in Quily, “Greater Vancouver YMCA.”

53. Boym, *Futures*, 43.

54. Thomas G. Goodnight and John Poulakos, “Conspiracy Rhetoric: From Pragmatism to Fantasy in Public Discourse,” *Western Journal of Speech Communication* 45, no. 4 (1981), 303.

55. Ibid.

56. This is not to dismiss the fact that drug companies and doctors do in fact act unethically and illegally to the detriment of their customers and patients. Martin Shkreli, CEO of Turing Pharmaceuticals, purchased the rights to the 60+ year old drug Daraprim; it is commonly used to treat AIDS and cancer. Almost overnight, Shkreli directed his company to raise the price

from \$13.50 to \$750 for a single pill. See Long, Heather, and Matt Egan. 2015. Meet the Guy Behind the \$750 AIDS Drug. *CNN Money*. Accessed January 29, 2015.

Former physician Andrew Wakefield continues to adversely affect thousands by publishing fake data in 1998 on the connection between the MMR vaccine and Autism. After mass circulation, public hype, and numerous studies unable to replicate any of Wakefield's conclusions, 10 of the 12 co-authors of the original paper retracted the conclusion and admitted that Wakefield et al. failed to disclose financial ties to a law firm recruiting parents for law suit against vaccine manufacturers. See T. S. Sathyanarayana Rao and Chittaranjan Andrade, "The MMR Vaccine and Autism: Sensation, Refutation, Retraction, and Fraud," *Indian Journal of Psychiatry* 53, no. 2 (2011): 95-96.

However, the distinction that needs to be made is that these are examples of specific instances. These are not master narratives. People draw on these narratives to reinforce master narratives like "Big Pharma is out to get us." Additionally, despite retracting the findings of Wakefield's study, it still continues to be used to reinforce the same master narrative.

57. Joel Taylor, "A Cure for ADD/ADHD," *5 PT. Salt*.

<https://5ptsalt.wordpress.com/2011/04/15/a-cure-for-addadhd/>

58. Joel Taylor, "America, and Western Civilization is Dying," *5 PT. Salt*

<https://5ptsalt.wordpress.com/2015/03/16/america-and-western-civilization-is-dying/>

59. Joel Taylor, "The Only 'Israel of God,'" *5 PT. Salt*

<https://5ptsalt.wordpress.com/2014/06/16/the-only-israel-of-god/>

60. Andrew R. Murphy, "Longing, Nostalgia, and Golden Age Politics: The American Jeremiad and the Power of the Past," *Perspectives on Politics* 7, no. 1 (2009): 125-141.

61. *Ibid*, 128-129.

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62. Paul Tautges, "ADHD and the Drugging of America's Children," *Worldview Weekend*, <http://www.worldviewweekend.com/news/article/adhd-and-drugging-americas-children>.
63. Ibid.
64. N.A., "The Hegemonic Misandry Continues: ADHD" *School Info System*, <http://www.schoolinfosystem.org/2014/04/07/the-hegemonic-misandry-continues-adhd/>.
65. Milo Yiannopoulos, "To Stop Mass Killers, We Have to Stop Drugging our Young Boys," *Breitbart* <http://www.breitbart.com/big-government/2015/06/19/how-our-touchy-feely-feminised-society-creates-young-male-killers/>
66. Patrick Grimm, "Spitzer and the 'Deballing' of Masculinity," *David Duke* <http://davidduke.com/medicating-children-and-the-add-adhd-scam/>
67. Ibid.
68. Ibid.
69. Boym, *Futures*, 43.
70. Ibid.
71. Ibid.
72. McGee and Lyne, "What are Nice Folks," 393.
73. Lawrence Diller, *Running on Ritalin*, (New York: Bantam Books, 1997).
74. Conrad, *Medicalization*, 64.

CHAPTER 3: NEITHER GIFT NOR CURSE

Many in the ADHD advocacy community consider Russell Barkley one of the pre-eminent professors of clinical psychology (the scientist), and Ned Hallowell as one of the prominent doctors of psychiatry (the clinician). By many accounts, these two individuals are responsible for increasing the legitimacy of ADHD in the scientific and medical community. Additionally, they both contributed independently to the clinical and then diagnostic recognition of Adult ADHD. Barkley and Hallowell are far from ADHD skeptics. Dr. Hallowell was diagnosed with ADHD at age thirty-one (then more commonly referred to as ADD).¹ Dr. Barkley's twin brother struggled with ADHD until his untimely death at fifty-six in a single-car accident; Barkley attributes the cause of this accident to his ADHD symptoms.² However, according to both, those within the ADHD advocacy community have often portrayed their positions as opposing, mutually-exclusive perspectives about what it means to have ADHD. Critics of Dr. Barkley argue that his perspective casts those with ADHD as doomed to a life of misery. On the other end of the spectrum, Dr. Hallowell's critics claim his perspective is overly idealistic by describing ADHD as a neurological gift that people should desire; they raise legitimate concerns about the potential consequences to necessary accommodations and services if the public and politicians start to believe that ADHD is desirable or a benefit to the individual.

In November of 2011, the Children and Adults with ADHD (CHADD) organization's 23rd annual international conference hosted a panel featuring both Barkley and Hallowell.³ Hundreds of attendees filed into a large conference room in Orlando, Florida at 8 a.m. on a Saturday to watch these "giants" debate the merits of the camps they supposedly represent in the larger ADHD community – gift vs curse. However, Barkley, the first to speak, was quick to declare that there would be no debate. Instead, both men had considered the panel's advertised objective an

opportunity to collaborate and clarify many of the ways that they claim their positions had been misrepresented by many in both the media and the ADHD advocacy community. While underscoring their friendship and past collaborative endeavors, Barkley and Hallowell not only addressed points of legitimate scholarly disagreement between themselves, but also how their views regarding ADHD are much more similar and nuanced compared to how many misrepresent them.

Discussions of medical and psychiatric influences on ADHD are a prominent fixture in the controversial nature of the disorder's history in both lay and scholarly sources. From the most ardent critics to the well-intentioned advocate, there is agreement that the medical profession is a substantial source for how ADHD is understood and diagnosed. The origins, evolutions, and contemporary variations of professional thought on ADHD is well documented.⁴ Similar to the previous chapter, literature has identified problems in how the range of clinician perspectives on ADHD can influence how it is framed for the "patient."⁵ In this chapter, I want to approach the challenges and complexities that scientific and clinical discourse poses for the person diagnosed or potentially diagnosed with ADHD when that discourse comes from professionals that advocate for ADHD as a legitimate condition that may lead to treatment. I argue that while there are justifiable concerns regarding professional/medical ADHD discourse, there are elements that may be harnessed for liberative outcomes due to the contested/embodied experience of ADHD.

This discussion – "Gift or Curse" – provides an opportunity to address one of the more complex and controversial elements of understanding how external forces influence identity. Throughout the controversial history of ADHD diagnosis, social and scholarly sources have advanced critiques against the medical profession equivalent to "medical imperialism" and "social control."⁶ However, many nonmedical ADHD advocates identify the liberative potential of

medical diagnosis and treatment. Drawing from disability studies, I suggest that despite justifiable skepticism of traditional medical models of thought, the influences of advocate medical discourse on mental disabilities like ADHD can be polysemic; there is potential for both empowerment and disempowerment. As Margaret Price explains in her discussion of rhetorics of mental disability in academia, negotiating the influences of medical and psychiatric discourse on those directly affected by it is in some instances a nonlinear, liminal experience.⁷ As Price and other disability studies scholars focused on mental disabilities argue,⁸ “although discursive alliances can be drawn between physical and mental illness, important differences exist as well.”⁹ As a text, this panel discussion provides an opportunity to compare the different ways that these two individuals - thought leaders in the evolution of ADHD as an entity and diagnostic concept – ultimately frame ADHD. Additionally, it also facilitates a way to interrogate some of the complexities of what it means to incorporate a medicalized component into one’s identity compared to emphasis on a condition with individual and political implications. While not intending to create divisions, I will also contrast more prominent disability studies perspectives on the relationship between medical discourse and identity.

I preface my analysis of “Gift or Curse” by presenting relevant perspectives on the rhetoric of medical and scientific texts. I then move to discuss disability studies concerns with the medical texts from a more traditional focus on physical impairments. As a way to understand the complication this creates for ADHD and similar “contested” mental disabilities, I explain the distinction made between impairment and disability that is created by the traditional critical view of the medicalization of disability. I finally provide arguments that demonstrate how the traditional focus on the physical, impairment/disability distinction is problematic for mental disabilities. After the analysis, I draw on Tobin Siebers’ theory of complex embodiment as extended to mental

disabilities by Price to elaborate how the “Gift or Curse” text provides a way to frame ADHD so that the individual can both engage and resist the mental health system to accomplish necessary goals.

Neither Fact nor Fiction

In contrast to those that engage and entertain discourse discussed in the last chapter, there are others that perceive science and medicine similarly to how McGee and Lyne originally articulated the antirhetorical rhetorical features of scientific discourse.¹⁰ This brief overview of the rhetorical studies of science and medicine helps establish the genres’ rhetoricity.

Alan G. Gross notes that many disciplinary investigations of the sciences in the 1980s became infused with “rhetorical consciousness.”¹¹ Often referred to as the *rhetorical turn*, rhetoric of science studies enhanced and challenged both science and technology studies, as well as rhetorical theory in general. As evidenced by this and the participation of scholars such as Gustav Bergmann, Thomas Kuhn, and Richard Rorty in the Project on Rhetoric of Inquiry (POROI), the rhetoric of science project has benefited from an established engagement with interdisciplinary conversations.¹² Since that time, rhetoric of science has established itself as an area of study within the larger rhetorical and interdisciplinary community. Judy Z. Segal explains that the study of “rhetoric of health and medicine is now at a place analogous to the place of rhetoric of science over twenty-five years ago.”¹³ Segal notes that many of the scholars entering into this new(er) conversation are not rhetoricians by trade (although some are), but rather scholars in fields as diverse as anthropology, sociology, history, cultural studies, and even the medical profession itself.

The type of discourse that is most relevant within the ADHD controversy is medicalization. As Conrad explains: “The key to medicalization is definition. That is, a problem is defined in medical terms, described using medical language, understood through the adoption

of a medical framework, or ‘treated’ with a medical intervention.”¹⁴ Medicalization as a type of biomedical discourse is situated within larger cultural structures and material practices of the medical profession that influence and are influenced by the knowledge frameworks used to understand both the object and method of medical practice.¹⁵ The way that medical professionals conceptualize and communicate what constitutes both health and illness, the role they play in treating patients, and the paradigms that constitute the clinical gaze – the predominant ideological perception of the patient in relation to illness – are both reflected in and by larger social institutions.¹⁶ As such, the medical model, “like any socially generated pattern of language, is a ‘discourse:’ that is, a coherent set of words and ideas that is shaped according to the social functions that it serves for the community that uses it.”¹⁷

These texts are rife with rhetorical features. An important element to understand is that scientific and medical discourse, despite popular belief, are *not* simply the advancement of neutral scientific observations about illness. As Leah Ceccarelli argues: “Scientific texts, like public texts, are hermeneutically complex. That is not to say that there is *no* difference between the way that scientists [and medical professionals] interact with texts and the way that public audiences interact with texts.”¹⁸ Obviously, central to this issue are questions of the relationship between text and audience. With respect to how scientists and other professionals interact with the rhetorical nature of texts, Davida Charney demonstrates that these individuals read scientific texts rhetorically – evaluating the strength and value of claims in comparison to their own perspectives and experiences.¹⁹ Additionally, Ceccarelli argues that in order to understand how lay audiences read these hermeneutically complex texts, the critic can seek out “textual fragments” of public discourse that react to a primary medical or scientific text, and analyze the rhetorical components compared to various ways that text is interpreted. I now turn to discuss the unique challenges that disability

studies have attempted to address regarding the ableist implications of these fragments. As the body and the associated embodied experiences play a substantial role in how the individual conceptualizes the self, medical discourse that frames those experiences can be influential in framing identity.

The Medicalized (Disabled) Body

Disability studies has long recognized the rhetorical qualities of biomedical and medicalization discourse. As Simi Linton explains: “disability studies has emerged as a logical base for examination of the construction and function of ‘disability.’”²⁰ As such, disability becomes an “epidemic of signification” that attempts to contain and control through multiple converging discursively constructed “dominant meanings.”²¹ Even more significant, the disabled body is “strongly ‘imbued’ with a meaning that not only points to the personal but actually restricts thinking about disability in any other way.”²² What seems to be common in these approaches to understanding how meaning about impairment is created, is examining “schemas” or “relics of societal discourses - emanating from expert and lay knowledge, reproduced in institutions” that range from the family to the medical profession.²³

One way to understand disability studies’ skepticism towards the medicalization of disability can be understood through the distinction some disability studies scholars make between impairment and disability; while impairment is the medicalized bodily and/or mental difference, disability represents the social attitudes and barriers that make impairment disabling.²⁴ Despite the observation that disability and the medical profession are intertwined, disability studies scholars have maintained a degree of skepticism regarding the influence of the medicalization of impairment. The medical model, which gives rise and legitimacy to medicalization, “highlights the notion of individual deficiency from a primarily biological

perspective.”²⁵ Many disability studies scholars argue that the medical model casts impairment and disability as something that must be cured or accommodated by the individual in order to experience a reasonable quality of life.

Through biomedical discourse and the medicalization of impairment, the disabled individual is constructed as an object that undermines the impetus for social changes, and subsequently reifies the mythical norm that disabled (and non-disabled) people can never represent. Linton argues that medicalized perceptions of disability created some of the most oppressive and ableist discourse through pathologizing impairment and casting the disabled body as the abnormal “Other” that justified and perpetuated the notion of normality born out of the clinical gaze.²⁶ Even within mental disabilities, Lisa Blackman discusses her experiences working with the Voice Hearers Network – an organization of and for psychiatric systems survivors that experienced extreme dehumanization and physical harms as a consequence of “treatment” associated with a diagnosis of various schizophrenic disorders.²⁷

The implications for how some treat identity within traditional disability studies literature is also in the distinction between impairment and disability. Impairment (physical and/or mental difference, as opposed to deficiency), while acknowledged as a material condition, is rejected as a tenable source for conceptualizing the self. However, this rejection is based on the premise that formations of the self, based on the medical model, inhibit the political objectives of the disability rights movement; instead of examining the role of the medical model on identity, and impairment on experience, the issues are ignored in favor of focusing on how to conceptualize identity as consonant with and conducive to the emancipatory goals associated with disability.²⁸ This perspective on what constitutes disability is often referred to as the social or British model of disability. Since its elaboration and application by Michael Oliver as a theory

of disability in academic work, the social model has come under scrutiny and criticism by scholars that see problems with the binary created through distinguishing impairment as separate from disability.

For other disability studies scholars, there is a problem with the separation of impairment from disability related to the denial of how the everyday-lived-experience of impairment influences identity and the subsequent subjective experience of disability.²⁹ Tobin Siebers contends that, even though social constructionist approaches to disability, the body, and identity provided a way to circumvent the essentialism associated with ascribing identity to biological determinants, there is another risk of (re)producing a disability identity-related essentialism – disability as “mere” social constructions.³⁰ The “oversocialized” perspective risks denying the “bodily identity, personhood, and transformative potentials” of those marked with stigma.³¹

This materialist/essentialist dichotomy has more recently been abandoned in favor of an embodied approach to theorizing identity and disability.³² From a rhetorical standpoint, the embodied approach to disability and identity focuses on the experiential interaction with rhetoric that shapes how self and other experience the disabled individual, and vice-versa. These perspectives influence what “counts” as disability (publicly and academically), as well as the stability or fluidity of “impairment.” The outcomes of these debates directly implicate identity because impairment, regardless of where someone stands on the impairment/disability continuum, is in part foundational for disability identity. Put another way, even the social model concludes that you cannot be disabled without first having an impairment.³³ The relevance here is that in some ways, this tension plays out in both the medical and layperson perspectives on whether or not ADHD is a “real” condition.

The tension here is representative of the tension that I address in this project. Medicalization of disability influences what is considered a disability while also pathologizing that “impairment.”³⁴ The embodied perspective provides an opportunity to avoid or alter this tension.

While the embodied perspective provides a unique way of conceptualizing the self in relationship to disability, disability studies has sometimes struggled to conceptualize and address issues of mental disabilities due to disability theory’s bodily origins. More importantly, when talking about medicalization, conceptualizing the contested disabled individual’s relationship with the self and medical profession can have somewhat different challenges. The next section attempts to clarify these challenges with respect to the rhetorical potential found in medical texts.

The Disabled Mind

The common disability studies criticism of the medical model and medicalization of disability primarily focuses on physical, bodily, and/or sensory conceptualization of impairment.³⁵ As Joseph Straus points out: “disability studies, and its social model of disability, have been notably less concerned and successful with cognitive impairments and developmental disabilities.”³⁶ Shakespeare seems to agree with these sentiments when analyzing the historical influence of the Union of Physically Impaired Against Segregation (UPIAS) political agenda on the social model’s development. “Arguably, had UPIAS included people with learning difficulties, mental health problems, or with more complex physical impairments, or more representative of different experiences, it could not have produced such a narrow understanding of disability.”³⁷ This limited conception of disability has implications for who scholars and activists consider “disabled” by focusing on a narrow conception of what constitutes impairments.

Highlighting the tendency in both disability studies and medical sociology to critique medicalization as medical imperialism or professional dominance, Julie Mulvany argues that these debates are problematic at best because access to healthcare resources can provide a hermeneutic resource, as well as a source of legitimacy, for the embodied experiences of those living with mental impairment.³⁸ However, this should not be equated with unquestioning acceptance and docility on the part of the individual seeking resources. The argument that engaging with the mental health profession creates “docile” patients that unquestioningly acclimate to the ableist assumptions built into the medical model flattens the liberative potential that “patients” have experienced by challenging those same assumptions.

The hermetically complex nature of medical texts implicates another contribution that could overcome the problems associated with contested disabilities like ADHD. Since medical texts are hermeneutically rich, that means that there is potential, not only for multiple interpretations, but for polysemic interpretations – the possibility for both empowering and disempowering interpretations of a text.³⁹ Ceccarelli demonstrates how a “resistive reading” of biologist Edward Wilson’s *Sociobiology: A New Synthesis* arose from another group of scientists. Wilson argued that social traits could be determined by the genetic make-up of an individual – a purely biological essentialist argument.⁴⁰ Scientists countered Wilson’s study in part on the grounds of poor method, but also based on the political and social conclusions *implied* within the text. The relevance here is that, despite the appearance of objectivity, scientific and medical texts are not always read as such by the audience. This is both a benefit and disadvantage for this project’s objectives. Skeptics in the general public and the medical profession alike can resist and reject medical texts that support the justification for access to resources just as easily as a “patient” can resist ableist texts.

Despite the complication, this discussion indicates that medical texts are not *inherently* disseminated through the objectifying lens associated with the medical model. For contested disabilities, access to medical resources can be empowering instead of exclusively objectifying. This is no different than how access to a wheelchair can be empowering for a paraplegic if we view both the need of that resource and the resource itself as similar to an individual impaired by a lack of effective public transit needs a car. Nikolas Rose argues that as both a product and result of an increasingly fractured, decentralized, and technological medical field, “this field itself is being reconfigured by a profound ‘molecularization’ of styles of biomedical thought, judgment, and intervention.”⁴¹ This new(er) knowledge framework presents an unknown variable in the discursive matrix that will change the way ADHD and mental illness is interpreted at varying points of tension. One such tension that Rose addresses as changing is the perception of the utility of stimulant drug treatment.

Many earlier criticism of the use of psychiatric drugs claimed that they were used as ‘chemical coshes’ in control strategies seeking to pacify and normalize. But today, I suggest, such drugs do not so much seek to normalize a deviant but to correct anomalies, to adjust the individual and restore and maintain his or her capacity to enter the circuits of everyday life. . . . [A]s research has shown, parents, teachers, and even the children themselves speak frequently of the consequences of the drug not as imposing an external and alien constraint upon the child, but the reverse – as enabling the child to take control of him or herself, restoring the child to his or her true self again.⁴²

Despite objection to Rose framing ADHD as an “anomaly” and conceptualizing a return to a “true” self, he establishes the influence of shifts in medical practices and knowledge that influence the styles of thought that frame many of the questions and possible answers related to contested mental disability that I will discuss later. More importantly, he demonstrates how experience plays a role in interpreting ADHD in contrast with biomedical discourse. From the ADHDer’s experiential-based perspective, medication (or other forms of treatment) is not control, but agency.

Having established the controversy regarding biomedical and medicalization discourse regarding disability studies perspectives and the potential for a different interpretation for contested mental disabilities, I now turn to analyze the “Gift or Curse” text.

Scattered Minds

The “Gift or Curse” panel discussion between Barkley and Hallowell provides an opportunity to analyze a trajectory for rhetorically framing ADHD.⁴³ The rhetorical study of science, health, and medicine indicates a fundamental shift in understanding the epistemological nature of scientific and medical discourse, as well as its social, political, and cultural implications.⁴⁴ Not only does the rhetorical treatment of science/medicine/health emphasize the epistemic potential of rhetoric discussed by Alan Gross and others, but it also shows how these texts are a rhetoric: “a discourse strategy spanning and organizing numerous discourses, and acting as a trajectory for discourses yet unorganized.”⁴⁵ The implication here is that scientific and medical texts possess a hermeneutic quality that influences the frames of future discourse that arise implicitly or explicitly from the original text. The text I analyze here is one of these future-framing discourse strategies. Additionally, there are references to (fragments of) preceding discourse that indicate framing of the current text. As a snapshot of one of the ways that the scientific and clinical community conceptualize ADHD and those diagnosed with it, it provides an opportunity to see which elements are empowering and which are disempowering for constituting the ADHDer self.

An initial reading of the transcript can easily reinforce the idea that the ableist implications of the medical model pervade the perspectives of both men. And as such, some might argue, any incorporation of this medicalized subjectivity into identity will necessarily reify those ableist implications. As Barkley explains, ADHD “has strong neurological and genetic roots to it as both Ned [Hallowell] and I have acknowledged in many publications.” Barkley continues:

[T]he very term “ADD” or “ADHD” trivializes what is a very profound disturbance in one of the brain’s capacities that makes us uniquely human compared to other primates and other species. And I’m referring here to the human capacity for self-regulation; what people call Executive Functioning. . . . This is the most impairing outpatient disorder that we see in outpatient clinics. And that is not an opinion that is a fact. . . .

There are some legitimate concerns from a disability studies perspective regarding these excerpts. When Barkley refers to the label of ADHD as something that “trivializes” what is “a very profound disturbance in one of the brain’s capacities that makes us uniquely human,” there is a clear allusion to a deficit or dysfunction model that disability studies scholars and some mental disability advocates reject. Peter Beresford, Gloria Gifford and Chris Harrison explain that many that consider themselves psychiatric system survivors “associate disability with the medicalisation of their distress and experience. They reject biological and genetic explanations of their distress imposed by medical experts. They may not see themselves as emotionally or mentally distressed either, but instead celebrate their difference and their particular perceptions.”⁴⁶ More importantly, they argue that it is medical discourse and the profession that forces them to see themselves as anything but “broken.”

More specifically to ADHD, Barkley is underscoring what has become the dominant unifying neurological theory regarding why ADHD “symptoms” manifest in individuals. In a paper published the same year as this presentation, Barkley explains that Executive Functioning is related to the human ability for self-regulation or “those neuropsychological processes needed to sustain problem-solving toward a goal.”⁴⁷ Barkley argues in greater depth that a more appropriate label for ADHD would be EFDD – Executive Functioning Deficit Disorder.⁴⁸ “ADHD therefore involves deficits in self-restraint, self-awareness, self-speech, self-sensing and imagery, self-control of emotion, self-motivation, and self-directed play for problem-solving.”⁴⁹ In “Gift or Curse,” Barkley’s association of executive functioning with “humanness” is both telling and

misleading. The human ability for executive functioning is one neurological element that neuroscientists attribute to less reliance on and resistance to neurophysiological instinct; however, animals possess a degree of executive functioning.⁵⁰ The implication here, however, is that there is a less-than-human quality to ADHDers. The inverse implication is that those without ADHD are “normal.” With its proliferation in the 19th century, and taken to its extreme conclusion in eugenics discourse, the idea of normalcy as an ideal standard is especially problematic for disability studies scholars and activists.⁵¹ Beyond the reality that no individual could fit into every norm regarding physical and mental categories, the basis for the ideal is founded on ableism.

While Hallowell does not directly engage the topic of a genetic link in “Gift or Curse,” his 2006 book coauthored with psychiatrist John Ratey supports a genetic link to ADHD. Citing a 2003 study, Hallowell explains that “if one parent has ADD, the odds of her children inheriting it are about 30 percent for each child. If both parents have ADD, the odds increase to more than 50 percent for each child.”⁵² While these two disagree as to the implications of a genetic link, they both endorse the idea that ADHD is wired into the brain at the genetic level. James Wilson, in his analysis of the implications of the genomics project on disability, explains that disability becomes interpreted as “flawed genetic text.” Structuring it in such objective, scientific language can mask the underlying ab/normal binary. “The point here is that this binary construction masks a social hierarchy (with those who are “abnormal” at the bottom) and therefore reinforces the stigma attached to disability.”⁵³

Further reinforcing the concern about normalcy and genetic determinism, Barkley associates ADHD with a host of negative outcomes that could be seen as casting ADHD as impossible to create a source of anything positive. Mentioning that Hallowell agrees, Barkley lists at length some of the consequences of ADHD:

[F]rom motor delays, the risk for seizure disorders, to a greater risk of language problems, as well as medical/dental problems, sleep difficulties, co-occurring learning disabilities, difficulties with friendships with peer relationships, a 3-to-5 times if not higher the greater risk of accidental injuries and poisonings. . . . [A] large percentage of children getting special educational services, experiencing grade retention, suspension, expulsion. . . . Oppositional Defiance Disorder, conduct disorder, comorbid anxiety and depression, as well as bipolar disorder. . . . ADHD is associated with risk for substance use. . . .

[S]imply risky sexual activity as one would come to understand from an individual who is highly impulsive, and doesn't always value the future as much as they should. We know that ADHD is the single best predictor of teenage pregnancies. [F]inancial problems that people can have, difficulties with childrearing, in marriage, and with an unhealthy lifestyle that may predispose to coronary heart disease.

Being told that ADHD can lead an individual to experience substantial challenges in life does not come close to comparing how someone might perceive themselves or someone else after being exposed to that litany of harm. It is hard to conceptualize an ADHDer as having anything but a horrible existence. The list seems to cover a wide swath of different life experiences – from educationally developmental issues, mental health, sexual promiscuity, and a lifetime of failed relationships. Framing ADHD in such a way provides little in the way of potential resources to conceptualize a positive sense of self.

Given the way that some interpret Hallowell as being overly optimistic about ADHD, someone might imagine that the crowd expected something much more nuanced or less pathologizing from Hallowell's remarks. Again, an initial reading would indicate the opposite. Hallowell makes sure that the audience will not misunderstand his position from the very beginning: "Well let me be very clear, very clear ADD. Is. Not. A. Gift. Okay? As defined in the *DSM-IV*, ADD is horrible. It is a collection of really yucky, terrible, disgusting, repulsive symptoms. How can I be more clear, okay? Nobody would want to have that." To put it even more bluntly, Hallowell states "please do not think I look at ADHD as a gift. Looking at those symptoms,

they are a *curse*.”⁵⁴ He then continues to reinforce how much of a “curse” ADHD is by, similarly to Barkley, providing his own list of consequences:

[I]t ruins kids in school, the prisons are full of people with undiagnosed ADD, careers. It's terrible to see these brilliant people who never deliver, never achieve, never get the level of success they are to get because they don't know about ADD. Marriages flounder, divorces, the whole of the substance abusers.

Hallowell is attempting to distance himself from the oversimplification that people should want to experience ADHD. Regardless, his contribution further demonstrates problematic associations from a disability studies perspective by reinforcing an overly deterministic perception of ADHD subjectivity.

Contrasting with this initial framing of ADHD, Hallowell continues to juxtapose the narrative potential to overcome these “flaws.” As he is an ADHD advocate and makes a living from treating ADHDers, his perspective could not consist of only the deterministic framing. However, while attempting to frame an alternative possibility for ADHDers, he inadvertently stumbles into another problematic narrative from a disability studies perspective. Hallowell is advocating for and reinforcing a “supercrip” narrative as a curative to ADHD. The supercrip narrative often includes “concepts of overcoming, heroism, inspiration, and the extraordinary,” while also emphasizing “individual attitude, work, and perseverance rather than on social barriers, making it seem as if all effects of disability can be erased if one merely works hard enough.”⁵⁵ The supercrip narrative and medical model of disability are indirectly mutually reinforcing; the medicalized impairment is only disabling if the individual with that impairment does not subscribe to the “cure” found in the supercrip narrative. From this logic, disability is a consequence of not trying hard enough. Here, Hallowell directly infuses the two:

Now, what I say to people is, I'm not in the business of treating disabilities. I'm in the business of unwrapping gifts. The reason I phrase it that way is that one of the key elements in a successful outcome of a treatment . . . is hope. . . .

And in that context, challenge them. I'm not a fan of accommodations. Some accommodations are fine. I don't want to set the clock back. But, I think we put way too much emphasis on that, and not enough emphasis on challenge. . . . In the context of connection, challenge.

The metaphor of unwrapping a “gift” that is something other than ADHD, that is used to “quell the damage” is potentially concerning. Hallowell is functionally separating ADHD from all other characteristics and attributes of the individual. Just like the supercrip that tackles Mt. Everest by harnessing her/his other “natural” or “innate” abilities, they are able to conquer their disability and the heroic feat. Barkley echoes the heroism theme when he explains:

Sometimes individuals need to be presented with a challenge, and it causes them to call upon personal resources the strengths and abilities that would not necessarily have been called upon had life been easier for them. And that the ability of people with ADHD to struggle against their disorder and to overcome the incredible odds are acts of heroism that need to be celebrated, even if these are not the results of the disorder.

The important element for Hallowell, Barkley, and others that represent people with disabilities in this way is not the impressive act itself, but the overcoming of the disability through effort and the bootstrap mentality. Rather than representing ADHD as something that is part of the individual, ADHD becomes something to conquer instead of work with. ADHD is abject, it is other, it is the gangrenous phantom limb that can never be amputated.

You Mean I'm Not Lazy, Stupid, or Crazy?!⁵⁶

While not wanting to dismiss any of the real concerns these excerpts represent within the larger discursive biomedical structure and their implications for other areas of disability studies literature, I do want to challenge the inherently negative interpretation of the text's entirety. I continue by demonstrating other parts of the “Gift or Curse” text that do not erase the above concerns, but I think complicate the inherently disempowering nature of the text and the associated ideology that accompanies it. If nothing else, I believe that this text demonstrates a shift in medical

discourse about ADHD that can be beneficial to how the subject incorporates this as part of the self. Additionally, I think it allows for a more complex view of mental disabilities.

Recognizing the hermeneutically rich qualities of different medical texts, as well as the potential to read a text as both empowering and disempowering, Barkley demonstrates a degree of rhetorical understanding when he states:

I want to also thank Ned for pointing out the fact that sometimes I can be my own worst enemy in the way I cover this information. So, it's not so much that I might be wrong in what I say or wrong in the facts of the matter; but that it may have to do with particular ways that information gets presented to audiences such as this. So, I will concede a certain amount of turf to Ned if you will in this discussion, a certain number of points of view that I have come to actually agree with that have been voiced not only by Ned but by members of this organization.

While still couched in the terms of fact and McGee and Lyne's original antirhetoric⁵⁷ discussed in the previous chapter, Barkley acknowledges that the (re)presentation of these "facts" can influence their interpretation and the implications drawn from them. Throughout this portion of the presentation, Barkley makes many distinctions between the analytic, scientific language of his research and the ways that language may not translate well into public discourse. Most importantly, he discusses the distinction between aggregate, group-level data that his methods and analysis focus on, compared to what that means for the individual. "We compare groups of individuals with ADHD against control groups and we come up with an average. We come up with a portrait of no one because no one is characterized by the averages across all of these findings." Reflecting a challenge in disseminating technical, statistical discourse to the public, he acknowledges that there is "a tendency for people to take these averages as composites, as representing each individual with ADHD in their entirety - as far as strengths and weaknesses are concerned." Lennard Davis argues that it is the emphasis on such statistical analyses in the nineteenth century that created the modern concept and understand of "normal" and what society thinks that means with regard to

human experience.⁵⁸ This relates to concepts of physical prowess, beauty, mental competence, and many other human traits that we consequently and artificially constitute as distinctly ab/normal. While problematic on its own for the vast majority of human experience that functions on a continuum rather than an artificially designated quartile, those that are cast as more extremely abnormal or abject find this discourse troublesome due to the extreme discursive conclusion found in eugenics. As such, Barkley is identifying an important distinction that must be emphasized regarding the rhetorical concerns of how medical professionals represent ADHD.

When we write our papers, when we do our presentations, when we show slides of impairments like the ones I just showed, there was a tendency for people to take these averages as composites, as representing each individual with ADHD in their entirety. . . . So, I admit that the focus on group level data can homogenize the disorder at the individual level, and make it seem as if everybody is the same and carries the same risks. And of course, that approach easily masks the one that Ned has championed. And that is to look at individuals and their incredible range of not only symptoms and deficits as I tend to do, but also their incredible range of strengths, of talents, of personality characteristics, at this individual level.

While there is value in the statistical work that Barkley accomplishes regarding raising awareness of the legitimacy of ADHD as a unique lived experience, he also begins to understand the potential implications of how he represents that information to the public. Barkley presents an interpretation of ADHD that is based on a scale of difference rather than necessarily one of the ab/normal dichotomy.

Barkley continues to explain that his previous comments interpreted as denying any potential positive experiences with ADHD is a misunderstanding of his particular use of specific discourse styles.

Ned has sometimes said that ADHD is associated with high intelligence or giftedness. These are claims of main effects associated with the disorder. Unfortunately, I can tell you that at this group level, there is no evidence available that would support the fact that ADHD in and of itself produces main effects in these areas. Now that does not mean that it might not be associated with benefits.

What I will concede, . . . you can have a complex interaction of disorder by talent, by resource and by supportive context, and that when one looks at these four factors . . . one might find a subset of individuals who are in fact talented or who have benefited from having the disorder. That is something that I cannot contest.

There is a complex understanding of the interaction between the genetic/neurological and the environmental that resists reducing ADHD to one oversimplified factor. Barkley seems to indicate that he is the statistician who has a specific vernacular that he strictly abides by when he claims that he is making a distinction between main effects and interaction. The difference between main effects and interactions is relevant to factor analysis, which is what Barkley used in his influential longitudinal “Milwaukee” study.⁵⁹ A main effect is an observed outcome of the independent variable on a dependent variable. For simplicity sake, in this case the independent variable would be the diagnostic presence of one of the ADHD criteria. The dependent variable is the prevalence of an outcome being tested such as success in school. When looking at main effects, there is only a measure of one independent variable on the dependent variable. Interactions are when the effect of an independent variable on the dependent variable changes due to the presence of an additional independent variable. Barkley’s argument is essentially that there are likely non-ADHD related independent variables that can interact with, for example, inattention to produce a positive outcome not represented in the factor analysis ADHD related main effects.

Further demonstrating the importance of not reducing ADHD to a deterministic either/or is Barkley’s refutation of what Barkley perceives as Hallowell’s oversimplification of environmental factors when he claims that modern culture may contribute to ADHD symptoms.

There is no question that Ned is right that we are having to cope with a greater variety of sources of information that is coming at us more quickly than any prior generation humans have had to cope with. Now, whether or not that results in some altered effects on attention span and so on, I am not sure.

It is Barkley's commitment to his discourse style that resists this oversimplification to something similar to DeGrandpre's "rapid fire" culture critique mentioned in Chapter One. He claims that no study finds a main effects relationship between ADHD and the influence of our information and technologically saturated society. Beyond the lack of data, as Barkley claims, claiming that technology or other environmental factors could lead to ADHD in the "normal" population, eschews any attribution to a neurological difference interacting with the environment. Barkley clarifies this by discussing Michael Phelps, who, as Barkley states has won numerous gold medals for swimming and has "raging ADHD." While some may try to conclude that Phelps is talented because of his ADHD, Barkley explains instead that he succeeds because he has a mother and coaches who "structure his day beyond belief." They help Phelps manage his ADHD so his other talents can come out. And, "when Michael goes outside of these guardrails, he gets in trouble, he smokes marijuana at our University, and someone has a cellphone, and he loses a million-dollar endorsement from General Mills." Barkley is quick to clarify that this incident should not "detract from Michael's talents or gifts." However, he wants the audience to understand that the evidence of his talents cannot substantiate that ADHD is the "cause" of all those gold medals, "or that he might be impaired in other areas of his life as well." Barkley attempts to emphasize that there is room to acknowledge that there are people that he knows where "ADHD might have actually helped them to some extent." However, it is only through the help of support systems surrounding these individuals that they were able to experience that success. This is similar to Hallowell's explanation that "creativity is impulsivity gone right," but for that to happen, the individual must see "structure as their ally." Here, the interaction between environment and impairment is underscored both in terms of habit and context. While not eliminating the concerns related to biomedical and medicalization discourse reinforcing normalcy and genetic determinism, there is

an opportunity to demonstrate both discourse sensitive to those concerns and the ability for those that immerse themselves in those discourse structures to resist the more extreme conclusions.

Despite understanding the implications of how this discourse can be (mis)represented/understood, Barkley emphasizes the necessity of that discourse. Both individuals seem to agree that the difference in their approach to conceptualizing ADHD lies in their *roles*, not in their personal beliefs on the issue. Each person fulfills an essential element in the larger ADHD community. Barkley reinforces that the difference in discursive emphasis can be accounted for by what they each study. His role is the scientist. “I look for what is associated as a main effect of ADHD: what are the difficulties, the symptoms, the complexes. What is the nature of the beast at this group level? And of course, what are the impairments that are associated with it.” Whereas he explains that Hallowell’s role is substantially different, but both roles are mutually reinforcing: “Ned is an extraordinary clinician, advocate, and therapist. And as such Ned focuses on individuals. . . . He sees the people that present themselves to him every day in the clinic with their own unique profile of symptoms, of deficits, of strengths and weaknesses, and even of gifted abilities.” Hallowell explains this perspective similarly when he claims that, “we really are two sides of the same coin. Russ [Barkley] is the researcher, I’m the clinician - both points of view are indispensable in the effort, and the help we’re trying to provide you, and all the folks whom you represent.”

These individuals emphasize that even though they are working at a very technical level of discourse, both of which are influenced by a larger discursive structure, their different roles and objectives influence how they talk about the same subject. The fractured and fragmented nature of similar discourse styles indicates that the hermeneutic process is complicated by examining the same subject from different perspectives. The resulting discourse from those different perspectives

can create competing interpretations to those that are unfamiliar with the different technical style. Without the group-level data that Barkley provides, there is a lack of legitimacy for ADHD in the medical community. Without the emphasis on how ADHD functions on the individual level, the medical profession is left with an inaccurate and dangerous representation of ADHDers. This recognition of potentially competing yet complementary roles and discourse is important. Again, while not without their potential consequences, a more complex understanding of biomedical discourse as it relates to advocacy might provide opportunity to influence it. This mutually reinforcing understanding of discourse helps to realize the importance of the embodied approach to understanding the self from the disability studies perspective. The individual's experience, both good and bad, are a part of who that individual is. It helps to present the relevance of the individual in representing the limitless expressions of the human experience. It emphasizes the relevance of overlapping and individuating experiences.

While it is important to understand how medical discourse can be presented and interpreted to identify a more productive way forward regarding its relationship to the self, it is also important to understand what medical discourse can do to help the individual produce a more positive sense of self. The next section attempts to provide a more productive relationship between the idea of "success" and "hope."

Delivered from Distraction⁶⁰

If we need a more complex understanding of the relationship between impairment and mental disabilities regarding medical texts, we also need a more complex understanding of what it means to interact with these services. Barkley's primary contribution is to frame a more complex understanding of ADHD. Hallowell, as the other side of the same coin, helps us to complicate what it means to interact with the "treatment." In order to address how we can utilize elements of this

text to that end, I turn to discuss the roll of embodiment in mental disabilities, particularly contested disabilities.

Mental disabilities seem to problematize contemporary thinking in disability studies because, like embodiment, they seem “caught between competing models of disability.”⁶¹ Tobin Siebers advances a “theory of complex embodiment” as a way to deal with this problem; and I contend that it could assist in navigating the complexities of understanding mental disabilities in relationship to medical discourse. I quote Siebers at length:

The theory of complex embodiment raises awareness of the effects of disabling environments on people’s lived experience of the body, but it emphasizes as well that some factors affecting disability, such as chronic pain, secondary health effects, and aging, derive from the body. These last disabilities are neither less significant than disabilities caused by the environment nor to be considered defects or deviations merely because they are resistant to change. Rather, they belong to the spectrum of human variation, conceived both as variability between individuals and as variability within an individual’s life cycle, and they need to be considered in tandem with social forces affecting disability.⁶²

The emphasis on “natural” or “normal” bodily limitations – age, pain, illness – as a similar concept of socially-induced disability – mobility, hearing, and/or sight impairment – reinforces that it does not matter if the body or society induces the disability. The relevance to experiences and to how those experiences constitute the self are the same. What matters is how we conceptualize those experiences. Emphasizing the continuum of human experience means that the distinction of “normal” impairments is irrelevant. How we interpret them influences how we experience them, which influences how we and others constitute the self.

As indicated before, it is difficult to work within and utilize the entirety of disability theory to apply to every potential disability issue. In addition to what it means to “have” or “be” ADHD, part of the subjectivity that is incorporated into identity relates to what it means to “treat” or accommodate ADHD. Demonstrating how complex embodiment applies to mental disabilities and “treatment,” Price demonstrates the complexities of navigating academic life while “mad” – in this

context, a connotation for those that struggle to fit the various normalizing conditions of academic life influenced by the common topoi like *rationality*, *collegiality*, and *productivity*.⁶³ Price views the term *mad* as more flexible than the limitations imposed by what is typically referred to as *mental illness* or *cognitive disability*. Specific to this conversation is the relationship between those that are considered mad and the mental health system – the term *survivor*. Price explains that when she first encountered the term *survivor*, it referred to those that experienced horrific violations of rights and dignity at the hands of the mental health system.⁶⁴ This perspective reflects the traditional disability studies rejection of the medical model. A more inclusive version of this identification is the *patient/consumer/survivor/ex-patient* (p/c/s/x). However, this still carries with it an assumption that individuals that were or are a part of the mental health system were/are “forced into this objectified and passive role.”⁶⁵ Additionally problematic of the survivor designation and its variants is a reliance on a “heroic survivor narrative;” through great sacrifice and despite overwhelming odds, the individual overcomes a great trap or obstacle. While the narrative helps to build solidarity within the larger psychiatric survivor movement, the narrative also implicates that the outcome of the heroic act is “cure.” This is problematic in that, similar to the social model of disability, it denies the embodiment of impairment.

The assumed opposite to being a survivor is to succumb to the lack of agency and individuated suffering of the medical model. However, in Price’s own words, “This doesn’t describe my experiences. I make regular use of the psychiatric system, and I consider myself the agent and director of my treatments; for example, I interviewed and discarded psychiatrists until I found one who agrees with my approach to my bodymind. However, there is no avoiding the fact that he, not I, wields the power of the prescription pad.”⁶⁶ As such, Price presents a more complex understanding of the term *survivor*: “rather than thinking of a survivor as one who has undergone

and emerged from some traumatic experience, it can also denote one who is actively *and* resistantly involved with the psychiatric system on an ongoing basis.”⁶⁷

This idea of being active and resistant at the same time helps to conceptualize the application of complex embodiment to understanding mental disability’s relationship to medicine and its discourse. The mental health industry’s discourse typically implies a dichotomous un/wellness. There is an implication that one can be “cured” rather than existing on a spectrum of both experience and time. Mental disabilities, especially when receiving treatment, can vary in effect over time. From my own experience, in one meeting, I can be on task and able to follow/contribute flawlessly. In others, I struggle to put two words together. Mental health discourse does create risk for the “patient” to perceive “illness” as tragic and something that must be “cured.” In that sense, resistance must be a part of engaging with the medical/psychiatric system and its associated discourse. However, a resistance-only approach denies the embodied experiences of the individual that shape and are shaped by the environment around them. By that, I mean that denying that there is any bodily source of impairment by placing the onus entirely on the immediate and/or social/cultural milieu, denies both a more complete understanding of self/environment and the unique social perspective that understanding provides. There needs to be better understanding about how to incorporate this theory of complex mental disability for those that experience it.

This discussion leads us back to a potential limitation in the text discussed earlier. When addressing the topic of “treatment,” there is the potential to inadvertently emphasize a supercrip narrative as the “ideal” or even “necessary” way that a “good” disabled person must “overcome.” However, there are those in disability studies that advocate for a reconceptualization of both what it means to interact with the mental health industry, and how to utilize these narratives differently

than in past disability studies theory. Demonstrating this complication, Catherine Prendergast recounts her experience on a discussion panel addressing similar issues as this analysis. While discussing ideas derived from personal experiences, she began to cry. During the audience question and answer period, an attendee asked why Prendergast cried “at *that* point.”⁶⁸ “That point” was when she discussed how someone close to her took medication that allowed her “albeit still schizophrenic, to pursue a Ph.D. in recombinant DNA technology, instead of being homeless, hospitalized, imprisoned, or in any other position that would render her at high risk of being the victim of (yet another) rape.”⁶⁹ The questions raised in reflection to this interaction address issues of appropriate emotional involvement in our analysis of experiences. It extends the idea that disability studies discussions of narrative “overcoming” and medical intervention is more complicated than what much of the disability studies literature accommodates. Wendy Chrisman explains that the role of inspirational narratives can be especially helpful for individuals who have mental disabilities. “Taking into account that ‘to inspire’ means also to push to action, inspiration can be a vital means to learn, to raise awareness, and to connect with others. I am hoping to inspire here a particular action: not just a recuperation of inspiration, but also an investigation of what role inspiration plays in the lives of those people whose narratives are missing from the landscape of disability studies.”⁷⁰

What disability studies needs to allow, within the model of “actively *and* resistantly” engaging the mental health industry, is a conceptualization of disability that acknowledges imperfection – imperfection in theory, imperfection in living, imperfection in advocacy. There can be a liminal space where I and those like me can acknowledge the complex interaction between environment and self; I can acknowledge that I can participate and resist at the same time. Participation does not equate to reinforcement. I can understand that my experience is not going

to be the same day-to-day. I can acknowledge that despite the obvious limitations of ableist discourse, I can help change that through interaction.

Rather than interpret Hallowell and Barkley as reinforcing a supercrip narrative with all of its associated consequences, I see a beginning framework for a complex understanding of mental disability that resists a purely tragic interpretation of experience while also engaging in disability politics. Hallowell explains that he wants practitioners to move to a “strength-based model of diagnosis.” Again, while not without problems, Hallowell describes how someone can engage with a more agency-oriented mental health industry. He explains how he attempts to help his clients find ways to empower themselves while emphasizing the work and effort they will have to accomplish in order to empower themselves. One metaphor he uses is having a “Ferrari engine for a brain” but only “bicycle brakes.” The power and prestige associated with the Ferrari brand is a way to allow the individual to conceptualize themselves as empowered. The comparison of that Ferrari brain working with bicycle brakes is a creative way of saying that they need to learn how to drive differently and/or learn how to upgrade those brakes. There is also an interesting juxtaposition between the uniqueness of that Ferrari brain. It is easy to imagine that you can extend that comparison to say that even though others have regular brakes, they also have regular engines. As Hallowell explains: “But my point is when I say it to these kids and adults in no way am I saying it’s great to have this brain that’s out-of-control, that has no brakes I’m saying we’ve got a lot of work to do. But my way of putting it brings hope into the process. I say you’re a champion in the making.” While this may seem like more of the same from the previous discussion, this strength-based model of diagnosis functions as a more agency-centered perspective on mental disability that emphasizes the need to understand the self and the environment. The distinction I see between purely emphasizing individual struggle and the “ideal” supercrip is accomplished

through the complex embodied approach to disability. Instead of emphasizing that this individual is going to have to do a lot of work compared to “normal” children, the embodied perspective acknowledges that every individual has to do a lot of work in many different parts of their lives in order to overcome various inherent challenges or differences. Some individuals have to do a lot of work on one aspect. Others have to do a lot of work spread across many different parts of their experience. And, there are some that do end up needing to work harder than others to do something well. However, the point is that the continuum of human experience emphasizes that hard work is ubiquitous. The difference is that we conceptualize some work as “ab/normal.”

Part of the next excerpt was included earlier in the chapter when discussing the potential supercrip interpretation. I purposefully only showed part of the excerpt because I think it is important to see how conceptualizing all of the elements demonstrates the complexities of the discourse and its interpretation. The original text is italicized.

Now, what I say to people is, I'm not in the business of treating disabilities. I'm in the business of unwrapping gifts. By that I mean my work as a clinician is to find the talents whatever they might be in a given person. They are not part of the ADHD, they are there as that person's greatest ally. We have to quell the damage being done by the ADHD in order to unwrap those gifts. That's what I mean when I say I'm in the business of unwrapping gifts. The reason I phrase it that way is that one of the key elements in a successful outcome of a treatment . . . is hope. And you don't get hope by simply reciting all the damage that you could get into in your lifetime because of this condition that you've inherited. You get hope by pointing out if we do the following work together this is the good place you might get to. And then I tell true stories of people who have done that.

I'm always at pains to present it in a way where they take it seriously but, also have hope. Because, if we only present, in the office, in the clinic, if we only present how bad it can be, then you see what you instill or what in my opinion are the real disabilities, the real damaging disabilities in addition to the damage that can be done by the ADHD. Mainly shame, and fear, and loss of hope, and believing you're a loser, and buying into the notion that you were a broken defective human being. That's what holds people back in life. It's like that old saying “whether you think you can or you think you can't you're right.” And the damage done by that can last a lifetime.

The reality is that ableism abounds. This concept of hope, of inspiration, facilitates the individual to be able to engage what does exert external influence on mental disability while acknowledging the self – the internal elements that are part of the individual. From the clinician’s position, framing ADHD as something that can be addressed while also providing inspiration can, as Chrisman indicates, motivate for action that is externally directed instead of just internal.⁷¹ However, denying that the neurological difference exists or embracing the impairment as necessarily tragic, both have the consequence of making it difficult for the individual to engage in externally oriented, political activity. “And so again, I’m not saying the challenge is a gift. But I am saying to help that person who has that challenge you need to also show them that if they do some significant work they may tap into significant talent.”

Now the question may be, why not simply frame ADHD as something positive? Many in the neurodiversity movement do exactly this. The neurodiversity movement is deeply entrenched in the social model of disability. They emphasize that there is no such thing as neurotypical people.⁷² We all exist on a spectrum, with most points in between being represented in all of humanity. Many in the neurodiversity movement emphasize not just difference but also highlight unique benefits to autism, mood disorders, and ADHD. Some go farther to argue that the search for “cures” or “treatments” are tantamount to genocide in that it would erase the existence of these uniquely beneficial states of neurological existence. As Price argues, while beneficial in challenging ideas of neurotypicality, “the rhetoric of neurodiversity . . . reads as overly chipper (like a “Celebrate Diversity!” bumper sticker); its optimism can flatten individual difference.”⁷³ More importantly, as both Barkley and Hallowell indicate, celebrating ADHD as a benefit runs the risk of inhibiting individual agency.

But I do want to point out that for those of you in the audience who might take an oversimplified view of ADHD as a gift that you have to be aware of the downside. . . . The

public doesn't have time to hear about how great your disorder is. You can't walk the halls of Congress lobbying on the one hand for IDEA and ADA accommodations, and on the other hand screaming down the hallway what a wonderful disorder you have. It isn't going to cut it.

If individuals have gifts but no impairments they may have an ADHD personality but they do not have a disorder. Because a disorder is a failure in an adaptation that leads to serious consequences; the functional ineffectiveness in one or more major life domains. So, while it is possible for individuals to have unique areas of gifts, to have a disorder there also must be various areas of impairment, and if there aren't, there ain't no disorder there.

This is where the complementary nature of both Barkley and Hallowell, or more accurately the different discursive styles and rhetorics they represent, becomes clearer. Without Barkley's discourse that emphasizes the extent of difference, Hallowell's strength-based diagnosis that emphasizes agency is ignored. Without acknowledging the risk to individuals that do not get diagnosed and treated, there is no benefit from people like Hallowell attempting to navigate these issues.

The embodied approach to conceptualizing disability demonstrates why this works. Acknowledging that there is an impairment is only a problem due to the ableist assumption that an impairment is inherently an abnormal/abject thing to possess. To ignore the lived experiences of individuals with impairments as complex and challenging regarding those areas of their lives impacted by that impairment is to deny the need for disability studies in the first place. Acknowledging that these experiences exist across a continuum of human existence is essential. It also allows the recognition that difference experiences require different considerations in a society that does function with an underlying ableist structure. This is the importance of emphasizing equity in access regarding accommodations. The approach to addressing the underlying ableist social, structural, and ideological challenges to all disabled individuals cannot be accomplished without also simultaneously acknowledging the experiences of those that must live in the present. Particularly for those with contested and mental disabilities that must engage with the medical

profession to access equity, it is essential to find a way to accomplish these objectives, to provide an opportunity for the individual to frame a positive sense of self.

Thus far, this project has focused on discursive limitations on the individual to create a positive sense of self and subsequent political challenges to public stigmatization of ADHDer subjectivity. While this chapter presented some potential openings for utilizing professional discourse to cultivate that subjectivity, more extensive application would rely on the medical profession to alter its discursive styles consciously and voluntarily. In the next chapter, I finally want to address rhetorical resources that individuals can use to move towards a more agentic conceptualization of self as a whole, and to incorporate the ADHDer subjectivity into that whole. From there, I want to develop a starting point to challenge stigmatizing discourse in the public and professional domain via narrative means.

Notes

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1. Edward Hallowell and John J Ratey, "Preface," in *Delivered from Distraction* (New York, NY: Ballantine Books, 2005): ix.
 2. Russell Barkley, "I Lost my Brother to ADHD," *ADDitude Magazine*, accessed January 4, 2012, <http://www.additudemag.com/adhd/article/9673.html>. Barkley explains that studies indicate older adults with ADHD are more prone to car accidents due to inattention and distractibility.
 3. Karen Sampson-Hoffman and Pamela Mercer, "ADHD: Neither Gift nor Curse" *Attention Magazine* February 2012: 10-12.
 4. See Klaus W. Lange, Susanne Reichl, Katharina M. Lange, Lara Tucha, and Oliver Tucha, "The History of Attention Deficit Hyperactivity Disorder," *ADHD Attention Deficit and Hyperactivity Disorders* 2, no. 4 (2010): 241-55; Adam Rafalovich, *Framing ADHD Children: A Critical Examination of the History, Discourse, and Everyday Experience of Attention Deficit/Hyperactivity Disorder* (Lanham, MD: Lexington Books, 2004), 167-74; Matthew Smith, *Hyperactivity: The Controversial History of ADHD* (London, UK: Reaktion Books, 2013).
 5. Adam Rafalovich, "Exploring Clinician Uncertainty in the Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder," *Sociology of Health & Illness* 27, no. 3 (2005): 305-323; Rafalovich, *Framing*, 35-61.
 6. Conrad, "Medicalization and Social Control," Peter Conrad, "Medicalization and Social Control," *Annual review of Sociology* 18 (1992): 209.
 7. Margaret Price, *Mad at School: Rhetorics of Mental Disability and Academic Life* (Ann Arbor, MI: University of Michigan Press, 2011): 9-20

8. Julie Mulvany, "Disability, Impairment, or Illness? The Relevance of the Social Model of Disability to the Study of Mental Disorder," *Sociology of Health & Illness* 22, no. 5 (2000): 582.

9. Price, *Mad*, 14.

10. Michael Calvin McGee and John R. Lyne, "What are Nice Folks Like You Doing in a Place Like This?" in *The Rhetoric of the Human Sciences: Language and Argumentation in Scholarship and Public Affairs*, ed. John S. Nelson, Allan Megill, and Donald N. McCloskey (Madison, WI: University of Wisconsin Press, 1987). While McGee and Lyne emphasize the characteristics of practitioners that utilize this rhetorical strategy, it is important to recognize that there are also those that are influenced by these appeals.

11. Alan G. Gross, *Staring the Text: The Place of Rhetoric in Science Studies* (Edwardsville, IL: Southern Illinois University Press, 2006), 9.

12. Lyne, "Rhetorics." John Lyne, "Rhetorics of Inquiry," *Quarterly Journal of Speech* 71, no. 1 (1985).

13. Segal, "Interdisciplinarity," Judy Z. Segal, "Interdisciplinarity and Bibliography in Rhetoric of Health and Medicine," *Technical Communication Quarterly* 14, no. 3 (2005). 312.

14. Conrad, *The Medicalization*, Peter Conrad, *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* (Baltimore, MA: Johns Hopkins University, 2007). 5.

15. Crinson, "Sociological." Iain Crinson, "Sociological Conceptualisation of Medical Knowledge and Power," HealthKnowledge.org.uk.

16. Foucault, *Birth*. Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Vintage, 1994).

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17. Salmon and Hall, "Patient," Peter Salmon and George M. Hall, "Patient Empowerment and Control: A Psychological Discourse in the Service of Medicine," *Social Science & Medicine* 57, no. 10 (2003). 1969.
18. Ceccarelli, "Rhetorical," Leah Ceccarelli, "Rhetorical Criticism and the Rhetoric of Science," *Western Journal of Communication* 65, no. 3 (2001). 319
19. Charney, "A Study." Davida Charney, "A Study in Rhetorical Reading: How Evolutionists Read 'the Spandrels of San Marco'," in *Understanding Scientific Prose*, ed. Jack Selzer (Madison: University of Wisconsin, 1993).
20. Linton, *Claiming*, Simi Linton, *Claiming Disability: Knowledge and Identity* (New York: New York University Press, 1998). 2
21. McRuer, "Critical," Robert McRuer, "Critical Investments: Aids, Christopher Reeve, and Queer/Disability Studies," *Journal of Medical Humanities* 23, no. 3 (2002). 221; See also, Treichler, "AIDS." Paula A. Treichler, "Aids, Homophobia and Biomedical Discourse: An Epidemic of Signification," *Cultural Studies* 1, no. 3 (1987).
22. James C. Wilson and Cynthia Lewiecki-Wilson, "Disability, Rhetoric, and the Body," in *Embodied Rhetorics: Disability in Language and Culture*, edited by James C Wilson and Cynthia Lewiecki-Wilson (Carbondale, IL: Southern Illinois University Press, 2001), 2.
23. Dan Goodley, *Disability Studies An Interdisciplinary Introduction* (Thousand Oaks, CA: Sage, 2011), 103.
24. As Dan Goodley explains: "disability studies are a broad area of theory, research and practice that are antagonistic to the popular view that disability equates with personal tragedy. . . . [D]isability studies place the problems of disability in society" Goodley, *Disability*, xi. As a critical discourse, these scholars often take as a paradigmatic, fundamental assumption

the cultural, social, political, and/or material exclusion of those deemed physically or mentally deficient in comparison to a concept similar to Audre Lorde's "mythical norm." As such, the literature typically makes a distinction between impairment and disability; the former is usually conceptualized as the functional limitation of the body or mind, and the latter represents the physical and/or social barriers to access, participation, or productivity. Another way to understand this distinction is that impairment is the medicalized state of the biological and mental limitations, whereas disability is the politicized dimension of impairment.

25. James E. Levine, "Re-Visioning Attention Deficit Hyperactivity Disorder (ADHD)," *Clinical Social Work Journal* 25, no. 2 (1997): 200.

26. Linton, *Claiming*.

27. Lisa Blackman, "Psychiatric Culture and Bodies of Resistance," *Body & Society* 13, no. 2 (2007): 1-23.

28. Lennard J. Davis, "The End of Identity Politics: On Disability as an Unstable Category," in *The Disability Studies Reader*, edited by Lennard J. Davis (New York, NY: Routledge, 2010): 301-315.

29. David T. Mitchell and Sharon L. Snyder, "Introduction: Disability Studies and the Double Bind of Representation," in *The Body and Physical Difference: Discourses of Disability*, edited by David T. Mitchell and Sharon L. Snyder (Ann Arbor, MI: University of Michigan Press, 1997): 1-31.

30. Tobin Siebers, *Disability Theory* (Ann Arbor, MI: University of Michigan Press, 2008).

31. Mulvany, "Disability." 587. Refer back to the discussion in Chapter One.

32. See: Price, *Mad*; Siebers, *Disability Theory*; Wilson and Lewiecki-Wilson, *Embodied Rhetorics*.

33. Shelley Tremain, "Foucault, Governmentality, and Critical Disability Theory: An Introduction," in *Foucault and the Government of Disability*, edited by Shelley Tremain (Ann Arbor, MI: University of Michigan Press, 2005).

34. Refer to Chapter One, endnote 6 for discussion on my perspective on the term medicalization versus my usage of it in this project.

35. Mulvany, "Disability."

36. Joseph N. Straus, "Autism as Culture," in *The Disability Studies Reader*, edited by Lennard J. Davis (New York, NY: Routledge, 2010), 537.

37. Tom Shakespeare, "The Social Model of Disability," in *The Disability Studies Reader*, edited by Lennard J. Davis (New York, NY: Routledge, 2010), 269.

38. Mulvany, "Disability." See also, Peter Conrad and Deborah Potter, "From Hyperactive Children to ADHD Adults: Observations on the Expansion of Medical Categories," *Social Problems* 41, no. 4 (2000): 559-582 ; Ivan Illich, *Medical Nemesis: The Expropriation of Health* (New York: Random House, 1976); Thomas S. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (1961; repr., New York: Harper Perennial, 2010).

39. Leah Ceccarelli, "Polysemy: Multiple Meanings in Rhetorical Criticism," *Quarterly Journal of Speech* 84, no. 4 (1998), 415.

40. Leah Ceccarelli, "Science and Civil Debate: The Case of EO Wilson's Sociobiology," in *Rhetoric and Incommensurability*, edited by Randy Allen Harris (Anderson, SC: Parlor Press, 2005).

41. Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton, NJ: Princeton University Press, 2007), 11.

42. Ibid., 211.

43. Unless otherwise stated, all excerpts cited from “Gift or Curse” are a personally transcribed version of the panel session recording titled “SG1: ADHD Gift or Curse?” which can be obtained from:

http://www.dcprovidersonline.com/chadd/?event_id=CHADD104&search_filter=&pageno=5

44. Alan G. Gross, “The Rhetoric of Science *Is* Epistemic Rhetoric,” *Quarterly Journal of Speech* 76, no. 3 (1990), 304-306; Joan Leach and Deborah Dysart-Gale, “Why Ask Rhetorical Questions? Asking Rhetorical Questions of Health and Medicine,” in *Rhetorical Questions of Health and Medicine*, edited by Joan Leach and Deborah Dysart-Gale (Lanham, MD: Lexington Books, 2011).

45. John Lyne, “Bio-Rhetorics: Moralizing the Life Sciences,” in *The Rhetorical Turn: Invention and Persuasion in the Conduct of Inquiry*, edited by Herbert W. Simons (Chicago, IL: University of Chicago Press, 1990), 37-38.

46. Peter Beresford, Gloria Gifford, and Chris Harrison, “What has Disability got to do with Psychiatric Survivors,” in *Speaking Our Minds: An Anthology of Personal Experiences of Mental Distress and its Consequences*, edited by Jim Read and Jill Reynolds (New York, NY: Palgrave Macmillan, 2006), 209.

47. Russell A Barkley, “The Important Role of Executive Functioning and Self-Regulation in ADHD,” *Journal of Child Neuropsychology* 113, no. 21 (2011), 42.

48. Ibid., 43.

49. Ibid.

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50. Yogita Chudasama, "Animal Models of Prefrontal-Executive Function," *Behavioral Neuroscience* 125, no. 3 (2011), 327.
51. Lennard J. Davis, "Constructing Normalcy," in *The Disability Studies Reader*, edited by Lennard J. Davis (New York, NY: Routledge, 2010).
52. Hallowell and Ratey, *Delivered*, 149.
53. Wilson, "Disability," 58.
54. Emphasis mine.
55. Sami Schalk, "Reevaluating the Supercrip," *Journal of Literary & Cultural Disability* 10, no. 1 (2016), 73.
56. Kate Kelly and Peggy Ramundo, *You Mean I'm Not Lazy, Stupid or Crazy?!: The Class Self-Help Book for Adults with Attention Deficit Disorder* (New York, NY: Simon and Schuster, 2006).
57. Michael McGee and John R. Lyne, "What are nice folks like you doing in a place like this? Some entailments of treating knowledge claims rhetorically," In *The Rhetoric of the Human Sciences*, edited by John S. Nelson, Allan Megill and Donald N. McCloskey (Madison, WI: University of Wisconsin Press, 1987).
58. Lennard J. Davis, *Enforcing Normalcy: Disability, Deafness, and the Body* (New York, NY: Verso, 1995).
59. Russell A. Barkley, Kevin R. Murphy, and Mariellen Fischer, *ADHD in Adults: What the Science Says* (New York, NY: Guilford Press, 2010), 112. The "Milwaukee" study, in addition to another study referred to as the "UMASS" study, helped to substantiate the existence and prevalence of different ADHD symptoms that persist into adulthood.

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60. Edward M. Hallowell and John J. Ratey, *Delivered from Distraction: Getting the Most out of Life with Attention Deficit Disorder* (New York, NY: Ballantine Books, 2005).
61. Siebers, *Disability*, 25.
62. *Ibid.*, 25-26.
63. Price, *Mad*, 5 and 10.
64. *Ibid.*, 10.
65. *Ibid.*, 11.
66. *Ibid.*
67. *Ibid.*, 12, emphasis added.
68. Donaldson and Prendergast, "Introduction," 129.
69. *Ibid.*
70. Chrisman, "A Reflection," 183.
71. *Ibid.*
72. Armstrong, *Neurodiversity*.
73. Price, *Mad*, 16.

CHAPTER 4: NARRATING THE SELF

The previous chapter demonstrated the potential for medical discourse to accommodate a more complex understanding of ADHD identity. As I stated, however, this trajectory represented by the two professional discourse leaders is one that is very much in process. Specifically, as Ned Hallowell states during the “Gift or Curse” panel discussion:

We really need to unite because the general public is still woefully, woefully misinformed, woefully unaware. Your average teacher God bless her or his soul doesn't get it. The average employer is still so misinformed that I strongly advise adults in the workplace not to disclose they have ADHD. We still live in a world that is permeated by stigma, and by shame, and above all by ignorance. . . .And particularly in the case of adults who are still living in a state where 80-90% of adults don't know they have it and 80-90% of doctors don't know that it exists.¹

In other words, there is a lot of work yet to be done not only in the public, as Chapter Two demonstrated, but also in the professional realm. While I argue that both Barkley and Hallowell’s mutually reinforcing voices/styles are essential to facilitate change within the mental health system, this cannot be a spectator sport for those with mental disabilities or their advocates.

The concept of agency can be complicated for people like ADHDers on a few distinct levels. As discussed in Chapter One, associated stigmatization of mental disabilities infuses individuals diagnosed with them as having *kakoethos*, or bad character.² In the case of Vice Presidential Nominee Thomas Eagleton, subsequent public discourse about his mental illness indicated that he should be precluded from public office as a consequence of his disclosure. As Cynthia Lewiecki-Wilson argues, those with mental disabilities lack rhetoricity due to public perception; to gain entry to public discourse, they are forced to either emphasize “abnormality” or “universality.”³ Both functionally undermine agency in a society that privileges an idealized rationality. This reinforces Catherine Prendergast’s argument when she says, “To be disabled mentally is to be disabled rhetorically.”⁴ Assumptions of incompetence and irrationality abound.

Stigma, as Erving Goffman argues, is the stain on the individual's character, rendering them either invisible or disruptive.⁵

For ADHD, the problem of rhetorical agency is exacerbated by the various nostalgically-induced assumptions about what ADHD "is," or rather, what it "is not." It would be easy to "simplify" the problem and say that the consequence of denying the medical legitimacy of an ADHD diagnosis merely erases the stigma (and, therefore render the previously diagnosed individual as competent and rational). However, the associated social anxiety-induced assumptions about the "real" problem still stain the character of the individual diagnosed. Those that argue society and not a legitimate neurological difference is at fault for the perceived "deficits" are still perceiving a problem. What is even more damaging, it infuses a *moral* deficiency or sanction on the cause of the "problem." Nostalgic appeals directly fuse the problem to an alternative social paradigm. Here, the ADHDer is stuck between one social model that wants to change social norms and practices that universalize experiences for everyone, and another social model that wants to revert to norms and practices that further preclude access. In this respect, the ADHDer is unable to find a source of functional, positive identity or agency in either approach.

In this chapter, I argue that the strategic use of personal narrative – or "counternarrative" more specifically – provides a starting point for challenging stigmatizing ADHD discourse in the public and professional realm, while also helping the ADHDer constitute a productive sense of self as a consequence of the counternarrative process. These counternarratives challenge the dominant perceptions of mental illness by articulating personal experiences and perspectives which contradict stigma, as well as foster agency for those that are stigmatized. While not exclusive to this group, many ADHDers and advocates utilize personal narratives when they write and speak about stigma and the need for better understanding. Developing and propagating that

positive sense of self, of character, of ethos, is an essential part of providing a way to exert a measure of individual agency in the face of overwhelming stigma. A strategic counternarrative approach attempts to not only challenge problems associated with restorative nostalgic appeals (and their adherents), but also demonstrate some of the challenges posed by ADHD regarding navigating the existing mental health system towards a more ethical, agency-oriented practice.

In order to demonstrate the potential utility of an ADHD self-counternarrative, I will present various narrative fragments of existing advocate discourse that can help demonstrate how ADHD subjectivity can be conceptualized and internalized for the individual as a resource of political agency.⁶ In effect, by understanding how to frame ADHD for the individual, subjectivity becomes the externalization of a complex mental disability political identity in which to coordinate with medical and scientific discourse. I begin by contextualizing how stigmatizing discourse functions as an overarching master narrative that finds purchase with both those that lack personal experience with ADHD and ADHDers that know no alternative interpretive resources for their experiences. I then move to elaborate the utility of counternarratives to renegotiate the self by presenting a framework to conceptualize how the self interacts with discourse and experience. I also explain how self-counternarratives propagate to challenge master narratives.

ADHD Master Narratives: Nostalgia as Conspiracy

In order to understand the importance and function of counternarratives, it is essential to understand how other discourse functions narratively. I begin by orienting the reader to relevant narrative theory regarding these larger discursive concerns and how they create master narratives. The concept of a narrative and its potential rhetorical role is broad. Individuals use narratives to order and understand the world around them.⁷ We experience and (re)produce stories to organize individual life moments into common themes. The relevance of a collection of life moments might

seem “natural” to the story-teller, but they are inherently an interpretation of the events relevant to a self or socially-imposed theme or climax – connecting events that happened before some perceived event(s) that give what comes after meaning. For example, when something unexpectedly bad happens, we often seek to impose order by ascribing a necessarily discernable external or uncontrollable “cause” preceding that negative event so we can interpret the aftermath as necessary but unavoidable. Similarly, when something good happens, we tend to ascribe meaning to life events preceding that event as necessarily, purposefully causing it to occur.

While narrators attempt to structure narratives into coherent wholes to make sense of the world, they are necessarily drawing from and organizing fragments of interpreted experience and/or other texts. In one of Mikhail Bakhtin’s posthumously published works, “Towards a Methodology for the Human Sciences,” he presents an extremely erudite discussion of the relationship between symbols, texts, narrative, and the subject. He explains that “each word (each sign) of the text exceeds its boundaries. Any understanding is a correlation of a given text with other texts.”⁸ Bakhtin indicates that a necessary characteristic of narrative is its intertextuality. In that, when part of one text is integrated as part of another, it takes on new contextual meaning. The narrator imposes their meaning on a textual fragment when another narrator can impose alternative meaning on the same fragment within a different collection of fragments and collection of past narratives. “The text lives only by coming into contact with another text (with context). Only at the point of this contact between texts does a light flash.”⁹ Narratives are necessarily always incomplete in that they are merely a collection of fragments interpreted from other texts, and their reinterpreted form will become fragments in other narratives. In creating the narrative, the narrator’s perception is necessarily influenced through the process of selecting, interpreting, and organizing the narrative.

This idea of using other narratives to interpret the world around us is problematic when considering that as a narrator, we are often not the sole or even necessarily the primary author of our own self-narrative. While not unique to ADHD, the limitations on the individual to fashion a positive self-identity are imposed by competing *master narratives*. Master narratives are “the stories found lying about in our culture that serve as summaries of socially shared understandings.”¹⁰ They are “often archetypal, consisting of stock plots and readily recognizable character types, and we use them not only to make sense of our experience but also to justify what we do. . . . [T]hey play a role in informing our moral intuitions.”¹¹ While not all master narratives are problematic, the ones that unfairly and irrationally depict others as morally deficient are. The restorative nostalgic tropes discussed in Chapter Two are such master narratives. There are common themes/plots in the stories that demonstrate issues with society, values, parenting, and external cultural/political “encroachments” that are a consequence of moving away from the practices of an idealized and sometimes imagined past. There are common characters consisting of, again, parents, but also “Big Pharma,” doctors, and schools. The first half of Chapter Three also demonstrates some medical master narratives that are problematic. For example, avoiding both the “gift” and “curse” master narratives are important to the patient seeking some sort of medical intervention while avoiding the ableist assumptions associated with utilizing the medical profession for mental disabilities. While attempting to avoid the morally deficient tone of the “curse” narrative, the “gift” narrative can also become a problematic master narrative; in its haste to cast off the deficiency, shame, and individualization of diagnosis, it also risks discharging the need for accommodations.¹²

Master narratives can be problematic for a variety of reasons. First, master narratives are generic in that they morally define an abstract group or groups. Throughout the framing of the

various generic characters, master narratives cast many interrelated actors in moral terms. As such, in attempting to resist and reframe a master narrative's framing of one character, other characters must participate in that process. For example, while the character of the person diagnosed with ADHD becomes stigmatized as synecdoche for the moral deficiencies of modern society, the parent character also becomes implicated as deficient and as contributor to moral decline. While the narrative might seem to shift the stigma from the child to the parent, it merely spreads the stain; in parenting poorly, the child (whether she or he is still a child or fully grown) is still deficient in her or his "conditioning." A slightly different but not mutually-exclusive master narrative is one that still includes the ADHD individual as synecdoche, but framed as a passive victim of the generic doctor in cahoots with "Big Pharma." Both generic characters are depicted as deplorable in that they prescribe supposedly dangerous stimulant medication, no different than crystal meth, to children for profit and professional dependence. In some versions of this narrative, the education system is either complicit or at least indifferent to the "nefarious" actions of the supposed medical industrial complex.

Another form of the master narrative relevant to ADHD identity arises from restorative nostalgic fragments that include narratives of conspiracy. As mentioned in Chapter Two, nostalgic conspiracy narrators have a tenuous relationship with "evidence" because they engage in a reinterpretation process of traditional rhetorical appeals to fit the larger (master) narrative.¹³ The amount of evidence, the source of evidence, and emotional appeals that violate the core of the conspiracy narrative are cast as suspicious and likely produced by the very conspirators trying to erode the values they perceive as under siege. In general, these individuals prefer social explanations of mental illness over neurobiological evidence. It demonstrates a general resistance to scientific information. Specifically for conspiracy rhetoric, there is an additional level of

resistance that must be overcome. This makes traditional evidence-based appeals challenging for the purposes of reducing stigma and stigma-inducing discourse that draws on these master narratives. Much of the framework can be related to the values and moralizing elements that these narratives (re)constitute. The implication in the framework is not simply that the values are preferable, but that they are “under siege” in whatever specific event the narrator applies a generic plot. These values, however, do not need to be explicitly stated in every iteration of the nostalgic conspiracy narrative. The warrant of “values under siege” becomes implicit in the chaining of fragments from similar existing narratives.

This chaining of fragments demonstrates an additional aspect of these master narratives. The generic nature of the master narrative replicates easily identifiable stock plots. Generic, replicated narrative plots reinforce associated assumptions as obvious because they are easily understandable templates for social relations and individual behavior. In considering the challenges posed by master narratives, it is important to understand not only the constitutive narrative components, but also the implicit moral framing of the generic characters through easily identifiable plots. The plots function to implicate the relevant values as warrant to reinforce how to frame future narrative fragments.

Regardless of the particular plots and/or characters that manifest in these master narratives, their generic nature makes them seemingly relevant and applicable to describe the life experiences of some that others lack experience and understanding. In addition to oversimplifying complex social and neurobiological processes, there is also the consequence of reducing the constitutive identity of the stock ADHDer into whatever fits the master narrative best. This is problematic considering the different implications raised in both Chapter Two and Chapter Three regarding the different fragments and logics associated with restorative nostalgia and the medical model. This

process will be explained in more detail. However, prior to accomplishing that task, I now turn to elaborate how counternarratives function in comparison.

ADHD Counternarrative: Narrating for the Self and Public

If the individual's perception is influenced through narrative, then the creation of self-counternarrative has the potential to influence the perception of self. Jens Brockmeir and Donal Carbaugh reiterate Bakhtin's perspective when they say, "In every person's life there always remain unrealized potentials and unrealized demands, unfulfilled options of identity. . . . Bakhtin's theory of narrative discourse suggests a view of human beings as always making themselves, as always able to render untrue any definitive version of identity."¹⁴ This, however, does not mean that an individual can construct a narrative to become whatever they want. If the textual fragments that the narrator utilize are interpreted within the context of other texts (narrative or otherwise), then the possible (re)interpretations into the self are necessarily constrained. Here we see the importance of identifying both the limiting and liberative potentials of various texts that the narrator can draw from.

Hilde Lindemann Nelson discusses the counternarrative as a form of resistance and corrective to stigma-inducing master narratives. Counternarratives function, she argues, "by interacting in a number of different ways with master narratives that identify the members of a particular group as candidates for oppression, counterstories aim to alter the *oppressors'* perception of the group."¹⁵ There is an obvious concern for the treatment of the ADHDer regarding damaging perceptions. In some instances, the student whose teacher is told they have been diagnosed with and treated for ADHD will perform worse than if the teacher is not told about the student's ADHD diagnosis. The difference is not in the child but how the child is perceived and treated by the teacher. The assumptions about ADHD influence the way that the teacher interprets

which textual fragments to incorporate into their narrative of what is occurring with the student. If the teacher is aware of the ADHD diagnosis, they may hypervisualize the signs of perceived behavioral defect.¹⁶ If the teacher is not aware of the diagnosis, she or he may focus on the marked improvement and attribute the behavior to a change in some environmental variable or developed maturity. This could easily translate into the workplace as well. Instead, the outcome could be the difference between getting fired in the former scenario and promoted in the latter.

Counternarratives can function to create a positive sense of self as a resource to resist problematic master narratives. In this sense, Nelson explains that the counternarrative allows the individual to *refuse* the moral framing imposed by the master narrative and *repudiate* the assumptions made by others in a case-by-case basis.¹⁷ The counternarrative provides a resource for the individual to resist the narrative value-framework that casts the character as morally deficient. Refusal is inherent in the counternarrative. While refusal is self-directed in its narrative influence, counternarrative can also be used to repudiate instances of the master narrative. Counternarratives “that repudiate master narratives offer a patchwork form of resistance, bucking the narratives to limit the amount of damage inflicted on the identity from a third-person as well as a first-person point of view . . . The audience for [counternarratives] that *repudiate* master narratives is not only the members of the subgroup who bear the oppressive identity, but also some members of the dominant group.”¹⁸ Using counternarratives for the purpose of *contesting* the master narrative requires a more systematic approach to utilizing the narratively-constituted self-understanding as a public, political challenge to dominant perceptions. This requires narrators to appeal to those that buy into the master narrative regardless of whether they are an ADHDer or just another individual.

Refusing and Repudiating ADHD Stigma

It is important to understand how counternarratives work to fulfill these functions (refuse, repudiate, and contest). Part of the value of utilizing the counternarrative is that it rhetorically reframes perceptions of self and other regarding ADHD identity. Refusing ADHD master narratives as an ADHDer by constructing a self-counternarrative will often require the individual to either complicate and/or reconceptualize how they think about who they are. This process of providing a framework for thinking about both how the self exists and how the self is influenced (either by self or other) is important for the counternarrative to work effectively.

While there are theoretical explanations of the relationship between rhetoric and identity/subjectivity, my search to find analytical and personal purchase has found that many of the often-cited resources are incomplete for this project. The closest useful theory I have found that relates rhetorical resources to identity is Maurice Charland's constitutive rhetoric.¹⁹ As discussed in Chapter One, Charland is focusing on how narratives function to create identification with a specific created identity by "hailing" others to participate in that identity discourse. While this is useful in considering how identity can be rhetorically created and altered, this essentially functions to construct characters in new or alternative master narratives. This character/identity is created to appeal to many, to encourage people to be able to attach themselves to the ideals represented by the label. This does not necessarily help explain how an individual can (re)conceptualize the self in order to (re)constitute identity/subjectivity.

While essential to this analysis and the understanding of identity in disability studies, Tobin Seibers' embodied concept of self also falls short of what I want to accomplish.²⁰ Embodiment allows me to incorporate the importance of individual experience as essential to the conceptualization of the self. That is foundational to the idea of utilizing personal narrative as

counternarrative. However, what is missing from Siebers theory is an understanding of how the individual can strategically conceptualize the self in order to more effectively influence the self-concept, particularly in the face of such stigmatizing master narratives. While Siebers provides an essential element by bringing to the forefront how identity is influenced by the unique disability experience, that does not provide a specific enough framework for someone, including myself, to conceptualize what goes into constituting my subject position. As disability is influential but not encompassing of the self, there needs to be a way to conceptualize the give and take between different experiences. More importantly, there needs to be a better way to understand what resources are available to the individual to utilize self-narrative to negotiate the self.

What I discuss here is a conceptualization based from my own exposure to literature that resonated with me when I used it as a tool in reinterpreting my concept of self. From that literature, the trajectory of this project became comprehensible for me as both a scholar and as an ADHDer. It answered many questions I have had since I began thinking about the relationship between mental disability, discourse, and identity/subjectivity seven years ago. More importantly, it provided a way for me to make sense of existing rhetorical theory regarding identity/subjectivity so that I could understand the movement from what the individual does when exposed to discourse; how that individual negotiates meaning of the discourse in relationship to existing subject positions. This helps me to understand how, if I do not completely lack agency, yet are not completely free to constitute myself in any way I wish, I then can conceptualize those possibilities and limitations. What I present here is a new but not necessarily novel way of understanding how existing theory interrelates. The central and conditional issue for the rest of the project to be rhetorically effective is that the ADHDer understands the process in which they can and cannot negotiate how they interpret relevant aspects of their identity and how to incorporate modifications

through that same negotiation process. As mentioned earlier, in addition to the typical challenges posed by trying to articulate agency as neither impossible nor unlimited, there is also a perceptual challenge for mentally disabled individuals to have agency – rhetorical or otherwise. Especially dealing with agency over the self, there is a necessary tension and complexity associated with exploring rhetorical resources that constitute who we are and our life experiences.

Bakhtin’s concept of polyphony as metaphor provides the mechanism that the *dialogic self* interacts with not only the external as part of the self, but also how the self interacts with its multiple selves.²¹ Bakhtin applied the musical concept of *polyphony*, where “multiple voices accompany and oppose one another in dialogical ways,” to describe the literary style of Fyodor Dostoevsky. Rather than a singular “voice” directing multiple characters towards a unified ideological perspective, a multiplicity of characters have their own voices, own agenda, and unique perspectives that interact dialogically within the narrative. These narratives also have the characteristics of externalizing what would normally be considered internal thought through the personification of characters’ dialogue that are structured through time-space relations: “This persistent urge to see all things as being coexistent and to perceive and depict all things side by side and simultaneously, as if in space rather than time, leads him [Dostoevsky] to dramatize in space even the inner contradictions and stages of development of a single person.²²”

The outcome is a dynamic interaction and negotiation of meaning expressed through multivocal expressions, irreducible to a single theme or character. If Dostoevsky’s novel was a person, the multiplicity of ideologically and motivationally independent characters are the various “voices” that make up that individual. What relates them together are the shared experiences when interacting with other characters. As Hubert Hermans explains, Bakhtin’s polyphony provides a mechanism to conceptualize the self as a “rivalry and conflict of the different selves” or

independent voices ...²³ These voices or self-positions engage in dialogic interaction with each other like characters in Dostoevsky's narrative. These characters, while potentially in agreement, are not always so. "Each of them has a story to tell about his or her experiences from his or her own stance. As different voices, these characters exchange information about their respective [externally known selves] resulting in a complex, narratively structured self."²⁴ As such, the self is characterized by both continuity and discontinuity as opposed to unity: the self is a "narrative juxtaposition," in Bakhtin's words, of conversing, contrasting, and sometimes opposing "characters;" an amalgam of internal and external representations of the self.

While this description may seem to privilege the "autonomous" role of the individual to self-fashion (to a degree) her or his own subjectivity, Hermans emphasizes that there are external social and cultural constraints and even power relationships that influence and limit the dialogic self. Additionally, these constraints do not inherently inhibit the self's ability to resist or even renegotiate meaning: "Because collective voices are not only outside but also in a particular self, the relationship between a collective voice may constrain or even suppress the meaning system of an individual, although the individual may fight back."²⁵ This approach distinguishes between individual and collective voices that coincide with personal and social positions: "the meaning system of this person is constructed in a field of tension between her social position and one or more of her personal positions."²⁶ Additionally, while external social positions have the ability to construct "definitions, expectations and prescriptions" that function metaphorically like utterances such as "you are *x*," and individuals being directly or indirectly addressed have the potential to "transform" those "you are *x*" statements to "I am . . ." statements, it is not a direct copy. It is the dialogic dynamic of the self's relationship with internal voices that provide the ability to negotiate

meaning, and the relationship between those decentered voices with the social/cultural institution/structure that exert influence on, but does not determine, identity.

This process provides the most basic function of the polyphonic metaphor with respect to identity formation; “people are continuously involved in a process of positioning and repositioning, not only in relation to other people, but also in relation to themselves.”²⁷ While people can “create” new positions through increased interaction with others or to resolve incompatible components of existing positions, this process is typically accomplished through the integration of old voices or self-positions.²⁸ Just as perceptions of the world are influenced by our experiences, the self is influenced by the mediated experience of the internal and external – between how I interpret my relevant voices, how I think others interpret “me.” As such, self-reflexivity (through narrative or otherwise) does not result in radical changes of identity, but revisions through dialogic interaction both within the self and between the self and society/culture. The dialogic interactions between the semi-autonomous voices provides for an intersectionality of identities within situations as an interaction between a “decentralized multiplicity” of voices.²⁹ “The self moves in an imaginal space from one position to the others, creating dynamic *fields* in which self-negotiations, self-contradictions, and self-integrations result in a great variety of meanings.”³⁰ The negotiation of integration and opposition between self positions provides an opportunity to understand how the individual as narrator can create a self-counternarrative that renegotiates existing relevant voices.

The application of this to the context of this project is important to understand. Bakhtin provides a way to conceptualize how discourse, particularly master narratives, can influence an individual through a gradual process of negotiating new subject positions into a collection of existing, semi-autonomous voices. While the process of diagnosis does create a form of

interpellation, the influence of that label depends not only on the type of discourse that the ADHDer has and will be exposed to, but more importantly, on the existing collection of voices that make up the self. For example, if an individual that has a multiplicity of voices/subject positions that are relatively successful, then the negotiation process between the newly acquired ADHD voice may be less likely to result in more voices to view the ADHD-self as dominantly influential. As Bakhtin indicates, these voices are semi-autonomous. They have their own agendas. At times, they may interact and influence each other as two individuals in the real world may. For example, if after the diagnosis, an individual experiences a series of poor experiences in different parts of their career – the self that is a productive worker may assume that the ADHDer self must play a role in the lack of productivity. As such, the worker self then incorporates that element into that specific voice. The influence of that can be to frame every bad experience that is work related in relationship to the newly dominant ADHD worker. If the only or dominant narrative resource to negotiate the ADHD identity comes from stigmatizing, oversimplified, and essentializing master narratives, then it is an inherent limitation on the ability to fashion a positive sense of self.

However, approaching the conceptualization of not just ADHD but mental disability in general, combined with the understanding of how the identity self-negotiation process functions provides an opportunity to refuse those master narrative stock characters as the only resource available. Intentionally acknowledging alternative possibilities and perspectives provides the individual with the opportunity to think about that negotiation process as something that can be actively participated in. As I will explain later, the reflection and participation by the individual when constructing their individual self-counternarrative facilitates this renegotiation process. More importantly, producing self-counternarratives provides alternative narrative resources for other ADHDers to engage in their own narrative renegotiation of self.

Contesting ADHD Master Narratives

By understanding the characteristics of the specific master narratives that stigmatize ADHDers, narrators can construct more effective/affective contesting counternarratives. Understanding that stigmatizing master narratives are about morals and values, and that those narratives (re)iterate those morals and values often indirectly via an unstated warrant derived from the generic plots, helps the narrator structure the counternarrative to challenge these warrants with their own specific plots and characters. Here, Bakhtin is again instructive in how this process can work. Bakhtin emphasizes the importance of specificity and context in understanding. One distinction that Bakhtin makes is a “first stage of understanding,” which is “understanding formal definition, not contextual meaning.”³¹ The analogy here is that the difference between definitional and contextual understanding is similar to the problem between the master narrative framework that stigmatizes others and the counternarrative that begins with the self and specific personal experiences, extending out to challenge the master narrative. Whereas the former concept is limited on both sides of the analogy necessarily by oversimplification and assumption based on the generic qualities, the latter benefits from nuance and application based on a personalized understanding. Also relevant here is Bakhtin’s emphasis on dialogic as opposed to dialectic forms of understanding. He explains,

if we transform dialogue into one continuous text, that is, erase the divisions between voices (changes of speaking subjects), which is possible at the extreme (Hegel’s monological dialectic), then the deep-seated (infinite) contextual meaning disappears (we hit the bottom, reach a standstill). Complete maximum reification would inevitably lead to the bottom and disappearance of the infinitude and bottomlessness of meaning (any meaning). A thought that, like a fish in an aquarium, knocks against the bottom and sides and cannot swim farther or deeper; dogmatic thoughts.³²

The framework for the master narrative functions like Bakhtin’s imaginary aquarium. It limits and constrains the understanding of the narrator, which inevitably limits what the narrative is able to

produce and become part of future narratives. The implicit value/moral as warrant that is (re)constituted in the master narrative leads to “dogmatic” thinking about the ADHD subject because, like a formal definition, it represents a limited understanding that emphasizes the primacy of a single idea, concept, or self – oversimplification, misunderstanding, and reductionism. From this perspective, the dialectic process as explained by Bakhtin is a depersonalized (lacks “speaking subjects”) and decontextualized understanding; a dialogic understanding does not erase this division, but allows for more complex, contextual understanding.

Combining Bakhtin’s and Nelson’s narrative perspectives, the beginning of a solution for the problems posed by master narratives is to use strategically constructed personalized counternarratives as alternatives to the impersonal master narrative framework. Focusing on constituting implicit values as warrants in the counternarrative that demonstrate, where appropriate, the presence of some values that, for example, restorative nostalgic narrators perceive as absent in the present and/or under siege. As there is no benefit to extremist ideological values associated with misogyny/white supremacy/nationalism, these are not appropriate values for narrators to use to frame counternarratives. However, in demonstrating that other values are still present, it may be more difficult for the more extreme restorative nostalgic appeals to gain purchase with others. If those fringe appeals are predicated on demonstrating an absence of values in the present, beginning to demonstrate that those values do exist through the specific context could help begin to destabilize that extremist logic for all but the most delusional of adherent. A counternarrative is ineffective if it reinforces a value (such as explicit or implicit ableism) that ultimately puts the narrator into a double-bind. However, it may be possible to reframe the value so that it is similar and acceptable to those believing it is degrading.

Narrating the ADHD Self Counternarrative: From Struggle to Hope

While not meant to be all encompassing, the analysis of others and my own in the previous two chapters help to identify strategic starting points for an ADHD self-counternarrative. This is not intended to be a universal narrative that meets all concerns or needs. This is not meant to reinforce a need for all ADHDers to fit within this narrative like some have accused advocates of the social model of disability of doing. This narrative does not avoid every possible contradiction or potential ableist assumption. This is a temporary foundation that will necessarily require adaptation and elaboration to meet shifting needs of both the individual and the larger social reaction. Many are already engaged in the work of counternarratives. What I hope to demonstrate is the need to strategically construct those counternarratives with the specific limitations/potentials of the master narratives in mind.

It is unfortunate that affirming counternarratives meant to challenge stigmatizing master narratives must necessarily begin from a position of struggle and failure. However, this necessity arises from the complications imposed by the nature of the condition. The way ADHD presents itself from a medicalized perspective requires “pattern[s] of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.”³³ While the DSM criteria are inherently imperfect and evolving, they represent a collection of 18 behaviors between the two different subtypes.³⁴ In addition to meeting six or more symptoms for children under 16 or five or more symptoms for 17 and older in one of the subtypes, symptoms must also be present prior to age 12, manifest in two or more settings, have clear evidence of interference of functioning, and are not explained by other mental disorders such as an anxiety disorder or schizophrenia.³⁵ As noted in the previous chapter Barkley and Hallowell claim that ADHD is a “spectrum disorder.” This means that there is a collection of interrelated characteristics that can manifest themselves

from beneficial to life-threatening. The problem posed by the embodiment of this spectrum, as those that fight the stigmatization of Autism also attest, is that there is no yes/no, black/white, pregnant/not pregnant test or indicator for the presence of a discrete “condition.” This is because like all human behavior, whether it is considered functional or dysfunctional, it exists on a spectrum.

The problems associated with the medical model and ableism work against ADHD by *denying* acceptance of something similar to abnormality. From the perspective of those convinced of or open to nostalgic conspiracy rhetoric regarding ADHD, there is nothing “actually” wrong with ADHDers other than self-imposed moral deficits, the consequences of poor parenting in its numerous discursive variations, or symptoms of a deficient society. Many people with disabilities struggle to be seen as valuable people in their own right and on their own merits instead of defined by an impairment that others mark as “abnormal” or “deficient.” In contrast, ADHDers and other spectrum disorders struggle to be seen as experiencing impairment which inhibits their ability to be seen as valuable people.

If we are to also resist an oversimplified “gift” narrative, this requires that both ADHDers and the public acknowledge that the condition exists. The necessity derives from the public perception that disability is “all-or-nothing” and unchanging.³⁶ The resultant challenge is to initially frame ADHD as an impairment that in certain important circumstances can prove to substantially limit functioning despite effort and desire. At thirty years old, one individual shares his story to demonstrate how, despite effort, motivation, and some success throughout his life, he struggled to accomplish many life milestones that influenced his future prospects. This thirty-year-old describes his experience with ADHD as “classic as the Rolling Stones were to Rock ‘n Roll.”³⁷ While able to accomplish good grades in the beginning of his education, as he moved forward, his

grades declined. Additionally, despite trying, his relationships declined. “I viewed myself as a loner, a recluse. My confidence was slipping, and I had begun to experience the awful taste of depression.”³⁸ Despite his desire to succeed and to please his parents, his effort and motivation was insufficient.

I would try to complete my assignments but would get bored and find something else more stimulating like a video game. I would try to read, but this made me fall asleep. Other issues began to seep into my academic life. I did not know how to manage my time. I could not sustain attention or plan out future activities. Projects in the future became a terrible task. I could not figure out ways to accomplish them. These abilities are crucial when you are grappling with learning about DNA or Julius Caesar.³⁹

Leading up to seeking help, many ADHDers describe feeling a mismatch between what they will themselves to do and the outcome. In many instances, it is not a lack of effort on the part of the ADHDer. Often the ADHDer exhausts their mental and physical energy by metaphorically spinning their tires endlessly in the mud due to the desire and motivation to succeed. One task becomes overwhelming for the ADHDer when multiple components or long-term focus is required. This is what Russell Barkley refers to when he mentions that ADHD is an issue with executive functioning.⁴⁰ While the will may be there, the individual struggles to organize the necessary process and complete each step from start to finish in a particular sequence. While different ADHDers experience this struggle in different ways and different intensities, it is a common situation.

However, what is relevant here for the sake of the counternarrative is to carefully emphasize to those that refuse to see ADHD as a legitimate condition that it is not merely laziness or lack of motivation. This individual also discusses how he did not give up despite how much he struggled and experienced “shame and also felt like I was a disappointment. I also had that feeling of being alone, a lifelong theme.”⁴¹ While both the internal and external sources of his feelings are a function of ableist assumptions, his perseverance demonstrates further struggle. He explains that

he barely got into community college, where it took him five years to complete his Associate's Degree because of his continued struggle to complete classes. Additionally, as he continued on in life, he began to experience struggle in other parts of his life; ADHD and the associated consequences of his struggles "affected my relationship with my new wife and at work."⁴² After being fired from two jobs in quick succession, his wife decided to leave him. As he narrates this in retrospect, he acknowledges the role that unrecognized and untreated ADHD played in these outcomes.

Another way that this counternarrative component can strategically challenge the master narrative stock assumptions is to demonstrate struggle and failure despite the presence of some of the nostalgic "cures:"

From my earliest years I recall the disapproving voices.
 "Little girls do not run up and down the block screaming."
 "Look at you, you got mud all over your dress!"
 "What were you thinking?"
 "What is wrong with you?!"
 "Why did you do that?"

I felt like a sacrifice to public opinion and as I watched the people who loved me, more than anyone else in the world, berate me, scold me and many times slap me for reasons I not only did not but could not understand.⁴³

This narrative demonstrates that discipline and punishment were not missing in childhood. This individual acknowledges that simple discipline is incompatible with complex issues. The personal accounts of past experiences that demonstrate contradictory outcomes with the presence of behaviors that align with values the nostalgic conspiracy narrative claim are absent in the present helps to disrupt the "obviousness" or naturalness of the association. The counternarrative exposes the fallacy in the warrant reinforced through nostalgia narrative.

A common assumption with those that deny the legitimacy of ADHD is that particular outcomes are the consequences of specific actions perpetuated by master narratives. According to

these master narratives, the outcome of failure is a consequence of not enough hard work and determination. This is the bootstrap fantasy that I reference in Chapter Two. Taken to its restorative nostalgic conclusion, hard work is a value that is absent in the present. These adherents believe that the reason that there are seemingly more struggling/failing people these days is because there is an associated absence of values related to hard work and pride in one's work. The conspiratorial adherent extends this to blame some scapegoat that is actively promoting the erosion of those values – liberals/progressives/socialists/etc. For the restorative adherent, the “cure” to ADHD is either purely individual and/or moral.

While I acknowledge the dangers of reinforcing individual struggle and failure and the potential to feed into ableist and stigmatizing fragments, this part of the narrative in combination with the subsequent components has the potential to challenge the perceptions found in master narratives. There is the risk that this reinforces the stigma and misunderstanding of those with not-always observable disabilities.⁴⁴ There are common criticisms in public discourse that identify an individual receiving an accommodation who does not appear to be disabled (e.g., legally parking in a handicap spot but walking into a store) and/or does something that seemingly defies the notion of a disabled individual (e.g., standing from a mobility device to reach something on a shelf). As such, there is the potential to reinforce the idea that there are “bad” individuals with disabilities that give up too quickly and do not fight their individual battle hard enough. If the counternarrative was limited to this part of the narrative, then the issue would be well taken. Demonstrating that the outcome is not the consequence of a perceived absent value, that in fact the value is abundant in this individual's experiences despite the outcome, is an important first part to getting these adherents to acknowledge the legitimacy of the condition. An important element of this strategy

to remember is that it is not merely one narrative that will accomplish the political objective – that requires the proliferation of individual counternarratives.

However, reframing the individual’s experiences by starting with this process is also important to renegotiate existing voices that have already been a limiting resource on the ability to develop a positive sense of self. Those resources are often previously brought into the master narratives’ justification for their outcome. It also helps other people to be able to see themselves in the narrative. It helps those that may be undiagnosed to realize that ADHD is not the same as the master narrative’s depiction of “every day,” “normal,” and ableist lived experience. More importantly, this part of the counternarrative provides an opportunity for (un)diagnosed ADHDers to absolve themselves of the self and other-imposed moral guilt that compounds the struggle that they experience. Since ADHD is something that typically does not just “happen” to someone or develop later in life (with the exception of some forms of traumatic head injury), many (un)diagnosed adults framed their past experiences or had their experiences framed for them signifying they were “lazy, stupid or crazy.” Reframing these experiences are essential.

Negotiating Work, Seeking Improvement

As I mentioned before, each of these strategically structured counternarrative components are just a part of the whole counternarrative. Telling only part of the narrative undermines the strategy that is developed for a positive sense of self and to challenge the master narratives. The next necessary complementary part of the ADHD counternarrative needs to demonstrate the possibility of *negotiating* manifestations of ADHD impairment. I now use the term *negotiating* instead of *treating*, which has a stronger connotation to the “cure” mentality of mental disability. I mean for it to communicate that like many other of life’s complications caused by existing, negotiation requires periodic but ongoing maintenance; in this necessary counterpart, the

counternarrative emphasizes both the similarities and differences to other forms of “treatment.” It is necessary to emphasize that a proper diagnosis is more than a 15-minute consult with a general practitioner, and management is not as simple as taking a pill.

Finding someone qualified to make a proper ADHD diagnosis is one challenge. It takes courage to be willing to look, to consider the possibility, and to admit that you are struggling, not coping, and in danger of going under. Courage, perhaps driven by desperation to embrace the diagnosis and start moving forward.

Ask any ADHD specialist about the huge difference treatment can make. Heck, ask me! An arsenal of ADHD-Friendly strategies continue to improve every area of my life: work, my family life, my health, my confidence and self-esteem.⁴⁵

More importantly to acknowledging that treatment requires effort and negotiation on the part of the individual, it is also important to negotiate the public perception about treatment. When the act of seeking help is stigmatized due to ableist assumptions about having mental disabilities, the individual that has those experiences is placed into a double-bind: If they get help, they are stigmatized, but if they do not get help, they are still stigmatized because of their behavior and the assumed moralistic causes of that behavior.

Negotiating how to manage ADHD can be very demanding. There is no “cure,” but neither is it hopeless. Negotiating how to individualize the best options takes time. However, despite not having a cure and taking time, the ability to increasingly accomplish (or avoid) some of the everyday tasks that others accomplish with ease can literally be lifesaving. “I have often been suicidal [sic] in my past. I have a long way to go, but I'm pretty sure if I hadn't started on medication I wouldn't live to 40.”⁴⁶ Not only can it benefit the individual, it can also be beneficial to those around when someone receives treatment. One parent discusses how he even struggled with this oversimplification when attempting to help his ADHD daughter by applying his own ADHD strategies.

When I first started to figure out my ADHD (and this wasn't easy, but that's another story) I thought I had solved the problem for my ADHD daughter as well. . . . With each new strategy or approach I tried that worked, I'd excitedly tell my daughter that, "From now on, you do it THIS way."

Together, somewhat painfully, we discovered that each person's ADHD is unique. . . . It wasn't until someone observing our relationship from the outside pointed out that I was assuming, as everyone had always done to me, that there was a right way and a wrong way of doing things. When it comes to ADHD, there are strategies that translate or adapt well from person to person, but there's no easy solution. You need to discover what works for you on your own, by trying things.⁴⁷

What these narratives share is that there is a complexity and challenge to negotiating ADHD even when seeking one of many options available. There is no one-size-fits-all approach. While this is not necessarily unique to ADHD or any condition in general, many often assume that a condition that they know nothing about is as simple to treat as taking a pill or a similar oversimplified description.

The narratives of ADHDers benefitting from treatment demonstrate that ADHD does not have to be a tragedy if the individual seeks appropriate assistance. By appropriate assistance, I do not mean assistance that is necessarily prescribed by a medical or psychiatric professional; although, in many cases that is part of appropriate treatment. Appropriate treatment is treatment that is sought if the individual feels it is needed considering their perceived experiences while negotiating parts of their world. Of course, part of being able to rely on the individual's perception of "appropriate" requires that the ableist assumptions about having conditions of any kind is inherently bad, and that receiving resources to provide equity in experiences is no different than any other resources. This demonstrates that there are many different approaches to serving individuals because individuals and their embodied experiences are complex. This also means what works for someone at one point in time might need modifying in the future.

Often, when I'm giving a talk, one of the first questions is about getting organized. People lament that they tried a particular organizer or agenda and, "it worked great for about 5 months and then I didn't use it."

They see the situation as a failure.

Not me.

I light up, "Wow, so you found that you can be organized. There are systems that can work for you. This one worked beautifully for 5 whole months. Then it didn't. So, just switch to a new one. Use that new one for as long as it works. And then switch to another. You may even find that you can switch back to the old one that stopped working."⁴⁸

One frustrating part of negotiating ADHD is that after seeing the difference that managing it can make, it is difficult to acknowledge that at some point, current management methods may become ineffective. However, in concept, this is similar to when a maintenance drug begins to lose its efficacy. In contrast to a maintenance drug, however, instead of merely replacing one pill with another, an entirely different battery of management techniques might need to be developed to replace an existing complex strategy. However, even more important is acknowledging that, just like many other management strategies for different aspects of life, their efficacy can be limited due to changing circumstances. The cause of the change is irrelevant.

Demonstrating a diminished struggle that emphasizes increased quality of life and happiness despite continued maintenance and effort helps to accomplish a few different goals related to the counternarrative. It helps to reduce the ease in which the public can simplify ADHD symptoms, causes, and treatments. While there will still be those that will claim conspiracy, conspirator, or victim no matter what someone says, many have a harder time dismissing the complexity of ADHD for *that* person in *that* instance. Ideally, the more counternarratives that people are exposed to, the more *that* evolves into *they* and *those*. Additionally, for those that are drawn to nostalgia-as-conspiracy narratives that experience anxiety due to the perceived absence of certain values in the present, elaborating the ongoing struggle and diligence required for

individuals helps to diminish the association of ADHD as synecdoche for the particular social anxiety relevant at that time. Proliferation of counternarratives about individuals that exhibit some of those values as present may help ease both stigma and some anxiety. Again, acknowledging the risk associated with this type of narrative framing, I contend that presenting a counternarrative that is honest about the need for struggle while appealing to that same value that others implicitly perceive as absent helps to provide the necessary positive sense of self that both helps the individual and projects an advantageous counternarrative to address the master narrative.

The Emotional Complexity of Hope

While it is important to incorporate these real, experienced parts in the counternarrative, it is also important to conclude the counternarrative with a sense of hope that I discuss using the “Gift or Curse” text in Chapter Three. This is hope without the trappings of ADHD oversimplified as “gift.” Hope is necessary for the self-narrative and the politically oriented narrative. In narrating hope, the counternarrative takes on the essential process of repair.⁴⁹ Regardless of whether someone is constructing or reconstructing their sense of self, repair is likely necessary in the face of the master narratives that provide poor interpretive self-resources.

Several years later, my life is alright. I own a condo and received my Bachelor’s degree, graduating Magna Cum Laude. It took me ten years to complete. . . .

I have some positive things in my life, which bring me hope. I dream of being married again but know how challenging it will be to find someone who is safe and understanding.

I am a volunteer with Big Brothers Big Sisters. My “little” has some medical problems, and I picked him for this reason. It has been a joy for me to spend time with him and give him things I did not receive as a boy. Big Brothers and Big Sisters has taught me boundaries to use when I interact with him.

My heart crumbled when my “little” told my supervisor he loved me.

The major joy in my life is my participation in an online community dedicated to people with ADD. I am among great people and finally feel like I am not alone. I finally have what I have always deserved regardless of what or how I did something.

This is love, support, and acceptance.⁵⁰

Part of hope is managing expectations. While it is important to have an ideal to work towards, it is essential to recognize what is realistic about what living with and negotiating ADHD is like. Hope is not about telling people with ADHD that they are an evolutionary neurobiological lost hunter/gatherer “Link” or the next Edison.⁵¹ Hope does not involve creating the “good” ADHDer as one that wins Olympic gold medals,⁵² Grammys,⁵³ Gold Gloves,⁵⁴ or entrepreneurial awards.⁵⁵ As Chrisman explains, there is an opportunity for disability studies to reclaim narrative inspiration without necessarily devolving into the supercrip genre.⁵⁶ Especially for disability issues like ADHD that are underrepresented in disability literature, there is an opportunity to explore the complexities of inspiration. Rather than narratives that are “flat” in the characterization of the “good” Crip overcoming adversity to do something grand despite her or his disability, there is an opportunity to narrate the complexly embodied ADHDer.

This subject position reclaims narrative hope as inspirational. From this subject position, hope is the mundane. Hope is the chance to choose. Hope is not the desire to fit some unrealistic ideal subject position. It is not a life enriched *by* ADHD; hope is a life enriched *in addition to* ADHD.

Tracing the Counternarrative: From Self to Public

This chapter attempts to demonstrate how counternarratives framed in particular ways can accomplish three different rhetorical functions, directed at three different audiences: the ADHD self, the restorative nostalgia narrator, and medical/psychiatric profession. In order to bring this chapter to a close before moving on to provide a conclusion for the project as a whole, I want to address the general ways the theoretical components explained throughout help to understand how this counternarrative accomplishes its objectives.

Self-Narrative: Resisting

The ability for the counternarrative to *refuse* and *repudiate* the master narrative as a source of self-identity is a complex process. Scholars struggle with explaining the challenges posed by developing the self that is limited by discourse. Prior to the knowledge of alternative narrative resources for the self, the ADHDer must rely on existing discourse. This necessarily comes from master narratives that position the individual in particular ways. Hermans explains that the dialogic interaction between the different voices as theorized by Bakhtin's concept of narrative polyphony ensures that the translation from "you are" to "I am" is not a direct copy of the master narrative's stock character. The introduction and acceptance of the ADHD self via professional or self-assumed diagnosis does constitute a form of interpellation or hailing to access the stock characters of the master narrative as part of the individual. However, the different voices also interact with and influence this position similar to the narrative interaction between characters. The interaction between characters can influence who those characters become. If part of the existing *Me* (the self-as-known or "empirical self) includes a plurality of positive attributes that conflict with the master narrative's stock character, then there exists some internal resistance to the master narrative.

However, the likely reason that the individual received diagnosis or assumes diagnosis is because she or he is perceiving failure. As such, the ADHD diagnosis does force the individual to also engage in some renegotiation of other existing voices. Additionally, the stigmatizing nature of the ADHD stock character also encourages those around the diagnosed to engage in "diagnostic hermeneutics" to hypervisualize signs of perceived deficiency.⁵⁷ The consequences of this are that those around the diagnosed begin to reconstitute past and present actions through the lens of the stigmatized stock character in order to renegotiate the self. Diminishing positive resources

available to the self and/or increasing negative resources also can have consequences for dialogic renegotiation.

The existence of other types of counternarratives in discourse demonstrates that the stigma associated with the diagnosis is not all encompassing. In many of the blogs and other advocacy resources, people that engage in counternarratives emphasize they experienced a negative self-renegotiation as explained above. What changed was being exposed to counternarrative resources that allowed individuals to re-narrativize the self. An essential part of refusing the stigmatization of the master narrative is to be able to provide an alternative self-narrative that more accurately “fits” the lived experiences of the individual. The renegotiation process of voices gives an alternative framework to dialogically renarrativize the self. This self-narrative begins the process of repudiating the master narrative when the ADHDer begins to tell their narrative instead of only self-narrate. Repudiating the master narrative is the individual process of interpreting the lived experience that renegotiates the self. Renegotiating the empirical self alters how someone is perceived. This process is essential because in order for counternarratives to function effectively for the external and political objectives, the observed self needs to be one that conflicts with the stock character of the master narrative.

Multiplicity of Counternarratives: Contesting Nostalgia

At the point where the *Me* begins to perform the counternarrative function necessary to challenge the master narrative is when the narrativized self is capable of undermining the moral arguments implicit in the master narrative. Considering the specific challenges posed by restorative nostalgia narratives, part of the solution lies in demonstrating commonality with a desired value that the nostalgia narrator believes is absent in the present but abundant in the past. What is essential to prevent cooptation into a different stigmatizing master narrative is controlling the way

that the ADHDer demonstrates the value through lived experiences that are conducive to the positive self-narrative. By identifying and focusing on the underlying, implicit values used as argumentative resources (medium) that produce and reinforce the master narrative (outcome), the counternarrative can reframe the absence/presence of those values; the plurality of counternarratives can emphasize a more specific narrative that challenges the generic nature of the master narrative.

The personalization of the counternarrative provides an additional advantage to countering the nostalgia-as-conspiracy master narrative. While the conspiracy rhetor is already suspicious of the data and studies produced by scientific and medical discourse, they are simply being asked to replace one master narrative with another. By nature, data collected by scientists are a generic explanation of a competing stock character to the nostalgia-as-conspiracy stock character. Especially for nostalgic conspiracy adherents that have a complicated relationship with traditional forms of evidence, the narratives help these individuals to renegotiate their assumptions by pressing beyond Bakhtin's "aquarium" or limited interpretive resources. Bakhtin explains that the way to address the limited understanding of the decontextualized and depersonalized master narrative is not through a functionally equivalent decontextualized and depersonalized master narrative. Instead, narrators must demonstrate implicitly that the values perceived as absent are present through contextual and personal accounts that become more difficult to explain away when confronted with the existing master narrative. While not a panacea, Bakhtin provides a viable starting point to thinking about contesting master narratives that rely on restorative nostalgic appeals. While I concede that the challenges posed specifically by nostalgic conspiracy adherents are substantial, beginning the process of disrupting the conspiratorial paranoia that is seemingly

“natural” or “inevitable” couched in nostalgic logic for those that experience these narratives, provides an additional resources not currently available.

Postpsychiatric Practice: Medium and Outcome

While not substantially elaborated in the above analysis, counternarratives help not only those that are already advocates, but also those deeply entrenched in the ableist biomedical model to rethink their understanding and articulation of what ADHD is, how it works, and subsequently how it affects ADHDers. While the stigmatization of ADHD emanates strongly from public discourse, using Barkley, I demonstrate in Chapter Three how those that use and are indoctrinated in medical discourse can contribute to the public’s perceptions. Furthermore, how medical professionals think about ADHD and their role in relationship to the patient will influence how much ADHDers takes an active role in negotiating their experiences. If the discursive resources limit the potential interpretations through the interpellation process, while not all encompassing, they do create a disadvantage.

As I explain in Chapter Three, there is a movement in the mental health field towards a strength-based approach to diagnosis and treatment. The approach to conceptualizing and attending to the needs of those with mental disabilities must shift towards what Patrick Bracken and Phillip Thomas refer to as *Postpsychiatry*.⁵⁸ Bradley Lewis describes the characteristics that constitute a postpsychiatric approach to mental disabilities: (1) a concern for “the role of language and power in shaping psychiatric thought and perception,” (2) an approach to the clinical encounter that would include “not only the modernist values of empirical diagnosis and rational therapeutics but also additional clinical values like ethics, aesthetics, humor, empathy, kindness, and justice,” and (3) recognition that in addition to a foundation in “medical sciences and neurosciences, postpsychiatry would join with the humanities, the arts, the social sciences, and an array of critical

postdisciplinary programs like disability studies, gender studies, postcolonial studies, gay and lesbian studies, and so on.”⁵⁹ These are changes that would need to be undertaken not just by individual practitioners but also on a Foucauldian discursive scale. While no practice, profession, or discipline will be a cohesive whole regarding discursive representations, looking at discourse leaders is a way to gauge what direction the discipline is taking. Through a postpsychiatric paradigm, elements of biomedical and medicalization discourse can be reclaimed and interpreted as empowering for the individual with mental disability. This is an essential project for helping the ADHDer develop discursive strategies that influence a positive conception of self; this allows for the individual to advance the larger political objective.

Strength-based practices attempt to reframe the focus of mental health care from the deficits associated with the diagnosed “patient” towards one that emphasizes maximizing the agency and potential contributions available to the “consumer.”⁶⁰ While not drastically dissimilar, a postpsychiatric approach emphasizes the more collaborative element between provider and consumer. Evidence-based medicine still plays a role with both the strength-based and postpsychiatric practice. The postpsychiatric practice of mental health considers a more holistic approach to negotiating ADHD and other mental disability concerns. This includes recognizing that while entirely possible, ADHD symptoms may not in all instances of someone’s life be a deficit. This is not the same as referring to ADHD as a “gift.” The postpsychiatric approach recognizes that negotiation instead of “treatment” is essential. However, that negotiation process need not necessarily require an assumption of inherent or necessary deficit. An essential element to this shift is understanding the circumstances unique to the individual through their narratives. The narrative functions as the contextualized and personalized element to frame the decontextualized and depersonalized elements of a more ethical master narratives.

While the postpsychiatric practice is desirable, many in the medical and mental health profession still interpret who they and their patients are through the stock characters in master narratives. As Huiting Xie explains, “Practitioners have been socialized to derive a diagnosis by means of their education and training. The common perception is that an accurate diagnosis helps practitioners to institute the appropriate medical treatment to the consumers. Practitioners are often comfortable and confident in their role as expert. Strengths-based approach requires that practitioners acknowledge that they may not be all significant in the life of consumers.”⁶¹ The medical practice as a cultural institution, while resistant to change, is also open to it. Many in health sociology have already demonstrated how the medical institution in general has shifted from one of medical authority to be more collaborative. Carol Boyer and Karen Lutfey observed many shifting trends in patient-provider relationships and help-seeking behavior.⁶² Of particular interest is the rise of the lay “expert” and the decreased autonomy of the medical professional. While the authors noted part of the professional’s decreased autonomy is a function of competing patient and employer interests, they also discussed the role of “dual agency” in the overall patient-provider interaction. Additionally, they noted how the medical professional’s authority is constituted through “joint interactional accomplishment between actors, not inherent in the professional role of doctor.”⁶³

As such, the patient is no longer a passive subject in the medical interaction, but a key participant that must be attended to in order to achieve health outcomes. A contributing factor to the rise of the lay expert is when the individual engages in “reskilling” or “the reacquisition or appropriation of knowledge and skills” obscured through institutions in modernity.⁶⁴ Boyer and Lutfey explain that the proliferation and increased accessibility of medical information on the internet has changed the doctor-patient dynamic.⁶⁵ The ability to engage in discursive exchanges

is a fundamental prerequisite to engage larger social structures. While not quite the same as the information alluded to in these studies, the availability and proliferation of counternarratives described in this project also provide an opportunity to further this existing recursive process towards a postpsychiatric approach to negotiating mental contested mental disabilities like ADHD.

Narrative Resolution: Setting up the Sequel

This chapter sought to establish how utilizing counternarratives that attend to the specific strategic opportunities found in master narrative can be a resource to challenge the stigmatizing limitations on the ADHDer's ability to generate a positive sense of self. This is a starting point for counternarrative to proliferate and accomplish a political objective of reframing damaging master narratives into more acceptable master narratives. These are master narratives that do not rely on ableist logics and stigmatizing fragments. The argument within this chapter is not that a single type of counternarrative will be sufficient now or in the future to address the stigmatization of ADHD via master narratives. Nor are counternarratives necessarily enough on their own. While discourse coming from scientific and medical experts are often not persuasive to nostalgic conspiracy narrators, the legitimacy that other people see in that knowledge is important. Those in the medical profession are narrators in their own respect. Medical discourse is needed to appeal to those that are still unfamiliar with and/or skeptical of ADHD as a legitimate neurobiological state.⁶⁶ While the types of narratives elaborated here will need to continue for the benefit of helping individuals instill a positive sense of self, their utility will become less useful as a counternarrative. Once individuals engage in this form of self-narrativization and the counternarratives proliferate, hopefully the master narrative will shift to incorporate the repaired ADHD identity. However, while hopefully reduced, this does not guarantee that stigma will be eliminated. Just as the ADHDer must engage in ongoing negotiation to manage the range of issues that may arise,

rhetorical strategies to address stigma will necessarily need to adjust over time depending on the situation. Rick Green demonstrates the overlapping similarities between attending to ADHD and rhetorical exigencies:

It's kind of like, well, if you're building the frame of your new house having hammers, circular saws, and plumb lines is great. Whereas having wire cutters, a keyhole saw, and screwdrivers will be more helpful when it comes time to put in the wiring. A drywall knife will be a better tool when it comes time to finish the interior. And when you're ready to paint the walls, a brush and rollers... Okay, right, you get where I'm going with this.

Obviously, the point I'm making is that some tools will stop working, or you'll no longer need them, because your situation changes. You've mastered one of your challenges—perhaps you're are finally managing your anger and mood swings.

Great! Now you're wanting to finally find a job you love. Or find a partner in life. Or, well, whatever it is you want next. Use tools that work. For as long as they work.

And when your situation changes next year or the year after you may be wanting well, ya just might need one of those strategies again, because you're back on the ground floor of a new challenge in your life, and wanting to move up.⁶⁷

The ability to attend to these yet-to-be-seen exigencies will depend on the inevitable response from those that still adhere to the stigmatizing master narratives. While capable of change over time, counternarratives cannot be seen as direct refutational arguments that will convince someone immediately to completely shift their thinking. The likely scenario is that counternarratives will create small shifts in the master narrative over time. This requires the ability to utilize rhetorical tools similar to those described throughout this project to identify existing discourse that needs to be changed. From that analysis, rhetors are better able to determine which tools might continue to redirect the master narrative. Like the ADHDer, ongoing negotiation is required.

Notes

1. Unless otherwise stated, all excerpts cited from “Gift or Curse” are a personally transcribed version of the panel session recording titled “SG1: ADHD Gift or Curse?” which can be obtained from:

http://www.dcprovideronline.com/chadd/?event_id=CHADD104&search_filter=&pageno=5

2. Jenell Johnson, "The Skeleton on the Couch: The Eagleton Affair, Rhetorical Disability, and the Stigma of Mental Illness," *RSQ: Rhetoric Society Quarterly* 40, no. 5 (2010): 468.

3. Cynthia Lewiecki-Wilson, “Rethinking Rhetoric Through Mental Disabilities,” *Rhetoric Review* 22, no. 2, 156.

4. Catherine Prendergast, “On the Rhetorics of Mental Illness,” in *Embodied Rhetorics: Disability in Language and Culture*, edited by James C Wilson and Cynthia Lewiecki-Wilson (Carbondale, IL: Southern Illinois University Press, 2001), 202.

5. Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity* (New York, NY: Simon & Schuster, 1963).

6. I feel it necessary to note that many of the ADHD advocate blogs and materials produced are done so to support and promote for-profit activities. While many are drawing on their personal experiences living with ADHD, there is also an attempt to sell services as ADHD “life coaches.” While not an immediate cause for alarm, it is important to note that ADHD non-profit advocacy organizations confer some ADHD life-coach certifications such as CHADD and the Attention Deficit Disorder Association (ADDA). These organizations self-admittedly receive donations from drug companies that produce medication indicated for ADHD treatment. See CHADD. "CHADD Funding Sources." CHADD, accessed January 12, 2017.

<http://www.chadd.org/About-CHADD/CHADD-Funding-Sources.aspx>. ADHD and other types of life coaches are controversial due to their unregulated nature and lack of required degree to “practice.” See Guay, Jennifer. 2013. Millennials Enter Growing, Controversial Field of Life Coaching. *USA Today College*. Accessed January 12, 2017. Unlike psychologists or therapists, these individuals are not required to have a degree let alone practice. See Pagliarini, Robert. 2011. Top 10 Professional Life Coaching Myths. *CBS Money Watch*. Accessed January 12, 2016.

More importantly, there is a perceived financial bias that some might see as problematic. While there are potential concerns about motive, these are beyond the concern and scope of this project. First, it is just as problematic to dismiss the information from these sources as inherently flawed as it would be to inherently dismiss information about ADHD produced by a drug company that produces stimulant ADHD medications. While a critical eye is absolutely necessary, the financial motive does not inherently discount the veracity or utility of the information.

Second, the motive or intent of the discourse producer is irrelevant to my rhetorical consideration of the fragments’ utility to produce counternarratives. McGee explains that discursive formations are collections of textual fragments that the critic combines in order to provide an interpretation of the text/context interaction. “[R]hetors *make* discourses from scraps and pieces of evidence. Critical rhetoric does not *begin* with a finished text in need of interpretation; rather, texts are understood to be larger than the apparently finished discourse...” Michael Calvin McGee, “Text, Context, and the Fragmentation of Contemporary Culture,” *Western Journal of Communication* 54, no. summer (1990), 279. Raymie McKerrow further argued that the fragmented nature of discourse and the subsequent “dense web” of discursive

formations require the critic to approach the textualization *and* interpretive process performatively. See Raymie McKerrow, "Critical Rhetoric and the Possibility of the Subject," in *The Critical Turn: Rhetoric and Philosophy in Postmodern Discourse*, edited by Ian Angus and Lenore Langsdorf (Carbondale, IL: Southern Illinois University Press, 1993), 51-67. Since the discourse is fluid and fragmented, the critic must *create* and *express* the text as a representation of the discourse in order to analyze it.

Most importantly, the objective here is not merely an analysis of the existing narratives and the relationship between those narrative and narrators, but to construct a narrative using the fragments identified in this chapter to demonstrate narrative elements that facilitate the objectives of this project. It is a repurposing and/or reclamation of existing narrative components. Additionally, I am not endorsing any other content produced by any of these authors. Looking through other content, some is concerning regarding its assumptions about ADHD. Additionally, some of the authors even have concerning social and/or political perspectives that could be considered counterproductive or alienating of the current project's objectives. However, after searching for years, I have yet to come across a source or text that is completely free of many of these concerns (my own included). The objective is to move towards a more productive discourse, not to emphasize the existing flaws we already know about. Referring back to the theoretical discussion regarding fragments, nor is it necessary to.

7. Catherine Kohler Riessman, *Narrative Analysis*, edited by Judith L. Hunter, Vol. 30, *Qualitative Research Methods* (Newbury Park, CA: Sage, 1993), 2.

8. Mikhail M. Bakhtin, "Toward a Methodology for the Human Sciences," in *Speech Genres and Other Late Essays*, edited by Caryl Emerson and Michael Holquist (Austin, TX: University of Texas Press, 1986), 161.

9. Ibid., 162.

10. Nelson, *Damaged*, 6.

11. Ibid.

12. In drawing on and replicating the “gift” master narrative in the form in personal narratives, there is also a problem associated with what Nelson calls the “we are who I am” narrative. See Nelson, *Narrative*, 181. If someone like Michael Phelps says that ADHD is a gift because he is so successful, he would be oversimplifying ADHD in much the same way that stigmatizing discourse oversimplifies it. It is a hasty generalization that is not able to represent all with ADHD pragmatically or ethically.

13. Thomas G. Goodnight and John Poulakos, “Conspiracy Rhetoric: From Pragmatism to Fantasy in Public Discourse,” *Western Journal of Speech Communication* 45, no. 4 (1981), 303.

14. Jens Brockmeier and Donal A. Carbaugh, *Narrative and Identity: Studies in Autobiography, Self, and Culture* (Philadelphia, PA: John Benjamins Publishing, 2001), 8.

15. Ibid., 7.

16. Johnson, “The Skeleton,” 470.

17. Nelson, *Damaged*, 169.

18. Ibid., 171.

19. Maurice Charland, “Constitutive Rhetoric: The Case of the Peuple Québécois.” *Quarterly Journal of Speech* 73, no. 2 (1987): 136.

20. Tobin Siebers, *Disability Theory* (Ann Arbor, MI: University of Michigan Press, 2008).

21. Hubert J. Hermans, "The Dialogical Self: Towards a Theory of Personal and Cultural Positioning," *Culture & Psychology* 7, no. 3 (2001), 243.

22. Ibid. Bakhtin, as cited in., 246.

23. Ibid., 246.

24. Ibid., 248.

25. Ibid., 263.

26. Ibid., 263.

27. Hubert Hermans and Agnieszka Hermans-Konopka, *Dialogical Self Theory: Positioning and Counter-Positioning in a Globalizing Society* (Cambridge, MA: Cambridge University Press, 2010).

28. Hermans, "The Dialogical," 244.

29. Ibid., 252.

30. Ibid., 252. Emphasis added.

31. Bakhtin, "Towards a Methodology," 162.

32. Ibid., 162.

33. CDC.gov. "Attention-Deficit/Hyperactivity Disorder (ADHD): Symptoms and Diagnosis." Centers for Disease Control and Prevention, accessed January 31, 2017.

<https://www.cdc.gov/ncbddd/adhd/diagnosis.html>

34. Ibid. **Inattention: Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:**

- Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.

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- Often has trouble holding attention on tasks or play activities.
 - Often does not seem to listen when spoken to directly.
 - Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
 - Often has trouble organizing tasks and activities.
 - Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
 - Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
 - Is often easily distracted
 - Is often forgetful in daily activities.

Hyperactivity and Impulsivity: Six or more symptoms of hyperactivity-impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person's developmental level:

- Often fidgets with or taps hands or feet, or squirms in seat.
- Often leaves seat in situations when remaining seated is expected.
- Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
- Often unable to play or take part in leisure activities quietly.
- Is often "on the go" acting as if "driven by a motor".
- Often talks excessively.
- Often blurts out an answer before a question has been completed.

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- Often has trouble waiting his/her turn.
 - Often interrupts or intrudes on others (e.g., butts into conversations or games)

35. Ibid.

36. Ernie Lightman, Andrea Vick, Dean Herd, and Andrew Mitchell, "Not Disabled Enough": Episodic Disabilities and the Ontario Disability Support Program," *Disability Studies Quarterly* 29, 3 (2009).

37. Dylan Rosen, "One Man's 'Rugged Reality of ADD,'" *ADHD Roller Coaster: News and Essays about Adult ADHD*, December 1, 2011, <http://adhdrollercoaster.org/tools-and-strategies/one-mans-rugged-reality-of-add/>

38. Ibid.

39. Ibid.

40. Russell A. Barkley, "The Important Role of Executive Functioning and Self-Regulation in ADHD," *Journal of Child Neuropsychology* 113, no. 21 (2011): 41-56.

41. Rosen, "One Man's."

42. Ibid.

43. Gina Pera, "On With My Vent In All its Offensive Glory," *ADHD Roller Coaster: News and Essays about Adult ADHD*, (August 28, 2010), <http://adhdrollercoaster.org/essays/on-with-my-vent-in-all-its-offensive-glory/>

44. Lightman, Vick, Herd, and Mitchell, "Not Disabled."

45. Rick Green, "They Don't Believe in ADHD." *Totally ADD*.
<http://totallyadd.com/they-dont-believe-in-adhd/>.

46. davesfakeaccount, "Has Medication/Therapy Changed your Life? Let's Hear Some Success Stories." *ADHD Reddit*.

https://www.reddit.com/r/ADHD/comments/1cphk3/has_medicationtherapy_changed_your_life_lets_hear/.

47. Duane Gordon, "ADHD is not One-Size-Fits-All." *Attention Deficit Disorder Association*. <https://add.org/adhd-is-not-one-size-fits-all/>.

48. Rick Green, "No More Agendas," *Totally ADD*, September 15, 2014, <http://totallyadd.com/no-more-agendas/>

49. Nelson, *Damaged*, 7.

50. Rosen, "One."

51. These are claims popularized by author and political commentator Thom Hartmann. Thom Hartmann, *The Edison Gene: ADHD and the Gift of the Hunter Child* (Rochester, VT: Inner Traditions/Bear & Co., 2005).

52. Michael Phelps. See Editors. May 5, 2014. "Can't Stop the (ADHD) Feeling!". ADDitude: Strategies and Support for ADHD & LD, accessed January 4. <http://www.additudemag.com/slideshow/67/slide-1.html>.

53. Justin Timberlake. Ibid.

54. Pete Rose. Ibid.

55. Sir Richard Bronson. Ibid.

56. Wendy L. Chrisman, "A Reflection on Inspiration: A Recuperative Call for Emotion in Disability Studies," *Journal of Literary & Cultural Disability Studies* 5, no. 2 (2011): 173-184.

57. Johnson, "The Skeleton," 468. Also see Chapter One.

58. Patrick Bracken and Philip Thomas, "Postpsychiatry: A New Direction for Mental Health," *British Medical Journal* 322 (2001), 724.

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59. Bradley Lewis, *Moving Beyond Prozac, DSM, and the New Psychiatry: The Birth of Postpsychiatry* (Ann Arbor, MI: University of Michigan Press, 2010), 17.
60. Huiting Xie, "Strengths-Based Approach for Mental Health Recovery," *Iranian Journal of Psychiatry and Behavioral Sciences* 7, no. 2 (2013): 5-10.
61. Ibid., 7.
62. Carol A Boyer and Karen E Lutfey, "Examining Critical Health Policy Issues within and Beyond the Clinical Encounter," *Journal of Health and Social Behavior* 51, no. 1 (2010), S80.
63. Ibid., S83.
64. Simon J Williams and Michael Calnan, "The 'Limits' of Medicalization?: Modern Medicine and the Lay Populace in 'Late' Modernity," *Social Science & Medicine* 42, no. 12 (1996), 1616.
65. Boyer and Lutfey, "Examining."
66. See Rafalovich, *Framing*, 35-62. Physicians and others that are medical professionals can also take part in the nostalgia-as-conspiracy narrative. There are some responsible for its reception in the public. For these individuals, there is an unusual challenge that goes beyond that this text is able to address. Not only are restoratively nostalgic medical professionals going to deny legitimacy to scientific discourse that attempts to legitimize ADHD, they will also claim their superior knowledge and experience to dismiss counternarratives that attempt to interject the complexly embodied experience of ADHD.
67. Rick Green, "The Least you Need to Know." *Totally ADD*, February 4, 2017.
<http://totallyadd.com/least-you-need-to-know/>.

CHAPTER 5: THE PERSONAL TOUCHES

Like many other underlying discursive power logics that pervade society (e.g., misogyny and racism), ableism creates complex webs of tension that make it difficult to address in any straightforward manner. However, that does not mean that attempting to work through and release some of that tension over time is hopeless. Far from it. While there is much work left to do, advocacy on the part of scholars and organizers have seen improvements in contemporary recognition, portrayal, and treatment of disabled people.

To an extent, this has been true of ADHDers and others with contested disabilities. For example, the legislation titled Individuals with Disabilities Education Act (IDEA) passed in 1990 did not include accommodations for ADHDers.¹ Successful lobby efforts on the part of advocacy groups lead to a revision of the legislation in 1991. Subsequent court cases throughout the 90s either upheld or lead to strengthening of language that guaranteed accommodations. While there are issues that abound, as this project demonstrates, many in the medical profession have begun to modify the way they address contentious issues in the media. Specifically, in 2011 the American Academy of Pediatrics (AAP) announced a revision to their clinical guidelines for diagnosing and treating ADHD.² This revision to the initial 2001 guidelines suggest that the appropriate age for diagnosis and treatment be expanded from 6-12 years of age to consider children 4-18 years of age. After the announcement, the primary public objection to the AAP's expanded criteria acknowledged ADHD as a legitimate concern and even the potential benefit of stimulant medication, but questioned the effect it would have on increasing improper diagnosis and stimulant medication use.³ This is a shift from earlier discourse that sounded similar to conspiracy and fear appeals advanced by those like Peter Breggin, MD.⁴

Despite these changes, tensions remain that contribute to the stigmatization of ADHDers. This project attempts to bring awareness to the complexity of some of these tensions, and to provide a way to conceptualize relieving some of them. Specific to ADHD, there are different, competing ableist assumptions; specifically, between the lay perspective reinforced by restorative nostalgia that claim ADHD is not real despite acknowledging “problems” attributed to social ills, and the medical profession that acknowledges ADHD while remaining entrenched in the medical model despite shifts towards more strength-based models of diagnosis. One of this project’s accomplishments is beginning a conversation on the problems created by these tensions regarding ADHD, while also examining what is and is not currently working.

Chapter Two demonstrates how the ableist assumptions of normal/abnormal in both human functioning and social values are exacerbated by the assumption that access to resources provided through the medical profession are qualitatively different than the proposed restorative nostalgic solutions. One has to question the depth and danger of ableist logics that advocate the use of a belt on a child as “natural” and “normal,” but taking a pill and/or seeking cognitive behavioral therapy is somehow ruining society. This is ironic considering the studies that indicate a correlation between what traditionally has been considered “acceptable” corporal punishment for children (open-handed spanking) and mental health issues.⁵ The tension that exists here is complicated in that from the perspective of many in the public, there is no alternative explanation of the embodied experience of the ADHDer that is not deficient in nature. If anything, the nature of the argument posed by nostalgia-as-conspiracy narrators uses the act of obtaining access to medical resources as further sign of social/individual deficiency. This drives even deeper the ableist assumption that access to medical resources is necessarily qualitatively different.

Chapter Three provides an opportunity to understand the challenges faced within the socialized perspective associated with ableist assumptions within medicalization and the medical model when medical professionals are invested in advocating for ADHDers. The discussion of Barkley and Hallowell examines both the opportunities and challenges when discussing how to address ableism within the mental health profession. The primary discursive style used by those in both the medical and mental health profession generally operates on implicit ableist assumptions of individual deficiency and abnormality that some “thing” needs to be “fixed.” These discursive styles and underlying ableist logics exacerbate the public assumption of deficiency if an ADHDer accesses mental healthcare. The problems related to the medical profession are complicated due to the current perceived need to medicalize something in order for the medical profession to provide resources to address an issue. What is promising is the opportunity to continue to reframe associated discursive styles and assumptions about accessing mental healthcare resources by pushing the trajectory demonstrated by some of Barkley and Hallowell’s comments towards a strength-based approach.

Chapter Four proposes a potential contribution to add to the rhetorical toolbox that hopefully helps alleviate some of the tensions presented above. The counternarrative is that starting point; it is an initial challenge to the ableist assumptions within these tensions. The counternarrative necessarily cannot avoid all potential reifications as it is impossible to predict what reactions existing ableist logics will lead people to transition to. The negotiation process between ADHDer counternarrative and master narrative necessarily means that this starting narrative “blue print” that I discuss will eventually need to adapt to evolving ableist logics. Just as the meaning of and problems associated with racism have evolved with methods used to combat that logic, so too does ableism resist. However, the counternarrative structure that I propose also

provides an opportunity to further evaluate the strengths and weaknesses of existing ableist discourse; what are the most resistant logics, and which assumptions are most exploitable to address the associated problems of ableism?

This project also sought to understand more about the external discursive influences that frame the ADHDer subjectivity, and what resources are available to help ADHDers influence their own subjectivity – however (in)substantial the ability to self-influence may be. Building on existing literature that addresses how discourse stigmatizes those with mental illnesses and ADHD specifically, I attempted to demonstrate how extensive and underlying the existing limitations can be in public discourse. While the nostalgia-as-conspiracy narrator might not be as prevalent as other forms of stigmatizing discourse, the influence of the nostalgia fallacy is influential in many cultural, political, and religious experiences. At the risk of extending the analysis beyond the scope of disability issues, I would suggest that some of the influence of restorative nostalgia can be observed in the reaction to the perceived “Blackness” and “Progressiveness” of Barack Obama (regardless of how, if at all, his race influenced his policies) and the relative success of a generic opposition, populist campaign defined by the idea of making America great “again.”

The limitations on the self that are associated with nostalgia are problematic enough when an ADHDer recognizes that the claims are a fallacy. The stigmatizing perceptions of the public can be fueled by the double-bind placed on the ADHDer, by the implication of a moral deficiency regardless of whether one accepts ADHD as “real” or not. However, the consequences become even more concerning when the nostalgic appeals convince an ADHDer to believe that, rather than a condition that exists on the spectrum of human experience, they are a morally deficient individual that just cannot work hard or care enough to overcome their failings. Considering the developmental and spectrum nature of ADHD, this position is problematic because it forces the

ADHDER into a cycle of tragedy and internalized guilt over their own perceived shortcomings. It is not difficult to see how that cycle creates substantially more problems for the ADHDER.

While acknowledging the limitations of the contemporary mental health profession, Barkley and Hallowell demonstrate that even within their more relatively progressive perspectives there are limitations on the ADHDER to create a positive subject position. Their discourse, while integrating qualifiers to mediate the extent of their claims, is still influenced by ableist assumptions within the medical model. This means that if an ADHDER unaware of an alternative paradigm uncritically engages the mental health profession, there is the risk of incorporating those ableist assumptions about the self.

As a personal comment, as this was my initial experience and introduction into my ADHDER subjective – self as patient – I have also struggled throughout this entire project trying to separate the long-held assumptions about what it means to have ADHD and the implications of ableist logics. As someone who is trying to help other ADHDers reframe their own subjectivity and challenge public and professional stigmatization, I am intimately familiar with how difficult that process is as I am unable to completely alter my own self-perception. Because of many social and professional assumptions about what is “appropriate,” I compare my experiences attempting to meet those expectations through a lens of my own deficiency. It is easy for me to look at Barkley and Hallowell’s arguments in “Gift or Curse” and applaud their “progressive” approach to conceptualizing the ADHD subject. In fact, when I initially encountered the text, I did. However, applying critical and discursive techniques to analyze the text helped to pull apart some of the ways to distinguish between aspects that hold potential and those that must still be challenged.

The potential for the counternarrative to provide discursive resources to reframe part of the self and to challenge the master narratives that reify ableist assumptions in various discourse is

both a promising and daunting concept. The benefit of the approach employed here is to demonstrate a way to probe those master narratives for strengths and weaknesses. The counternarratives must be strategically structured to expose the relative weaknesses with the hope that enough exposures make the stronger parts of the master narrative relatively weaker. This process, however, is necessarily imperfect. Considered as a starting point, the counternarrative's ability to resist requires the ability to narratively reframe previous experience. This reframing process alters the ableist logic likely imposed on the individual to something that acknowledges difference and accepts that utilizing resources meant to augment functioning is no different in this context than in any other. As counternarratives proliferate, this process becomes easier. However, everyone's experiences will be different. There are experiences that will necessarily be more recalcitrant to narrative reframing.

That being stated, the messiness of this process is exactly what negotiating and challenging these logics necessarily entails. Drawing on Bakhtin's narrative theory there is the potential for not only self-revision through modification of internal interpretations of identity components, but to utilize those intentional shifts to construct a personalized counternarrative that encourages contextualization and personalization of that individual to others. The proliferation of these self-narratives to as many in the public as will listen has the advantage of competing with the stock plots and characters of the various master narratives. Collectively, eventually, counternarratives have the opportunity to alter master narratives in ways that reduce stigmatization of those they necessarily decontextualize and depersonalize. Again, while I am not ignorant of the challenge this poses, what I suggest is a starting point of a strategy to facilitate a larger effort.

As such, this project provides an opportunity to demonstrate a similar process that could help address unique challenges regarding the stigmatization facing other contested disabilities.

While the concept of counternarratives is something that could contribute to that end as part of a larger coordination of rhetorical tools, the structure of the narrative should take into consideration the unique discursive strengths and weaknesses of those relevant master narratives. While there are similarities between contested disabilities, it is the differences that are relevant to identify. The unique history, public debates, social/cultural representations, and external issues attached to each contested disability will influence the counternarrative needs. However, the counternarrative objective remains generally the same – contextualize and personalize the lived experiences of those that are being stigmatized to reframe the decontextualized and depersonalized representations of stock characters and plots that are inherent to the master narrative.

Looking forward to what an ideal outcome or conclusion to these efforts might look like, I want to discuss what it means to reject or at least substantially modify the ableist logics that I address within this project. Following Margaret Price and Tobin Siebers, I have embraced a complexly embodied, experiential framework for understanding contested disabilities.⁶ As such, the emphasis on the impairment recognizes the potential for experiential limitations through a combination of social factors. However, the focus remains on how the individual and society frame and interpret the subsequent experiences of that individual. Acknowledging that all experience exists on a spectrum, so does all function. Regarding the engagement with the medical profession and public assumptions of that engagement, there is a shift away from a perception of individualized deficiency and tragedy. Access to medical resources as a way to negotiate those “symptoms” or experiences should shift away from the idea of treating a pathologized disease towards a model that recognizes different human conditions require different methods of accommodations. In the same way that using a wheelchair to gain access is not qualitatively different from using a motor vehicle, using medication to control a mental condition is not

qualitatively different from the insulin a diabetic person uses -- or even the caffeine that most Americans use to make it through their day.

The need to promote the postpsychiatric practice as a potential redress for ableist logics found in the medical model and pathologization of human functioning in medicalization discourse is grounded in the recognition that there is a technical expertise needed to facilitate appropriate resources. Just as there should be someone that determines whether the bodily condition and embodied experience would be harmed or helped by taking a vasoconstrictor compound, there needs to be someone that is capable of suggesting different potential resources that could augment that individual's functioning. The postpsychiatric practice acknowledges the influence of discursive styles on problematic logics.⁷ However, it is an ethos that reframes the technical education and application of the scientific practice of psychiatry. The problem that I explore here is not that a prescription is issued for stimulant medications. The problem is that both the doctor and the public stigmatize the prescribed individual because they either pathologize that individual or moralize the assumed cause of the behaviors of that individual.

Like Margaret Price, I am drawn to the rhetorical study of disability because "I am fascinated by the ways that rhetoric can affect (and effect) relations of power, but also because I am heartened by the belief that attention to rhetoric gives us opportunities to intervene in systems of oppression and change those systems for the better."⁸ As this project has been about both contributing to the available rhetorical resources and a personal enactment of my own agency within those systems, I feel it necessary to provide my own account of this experience. One part of this process that I found particularly uncanny and frustrating was the heightened awareness of my own ADHD related experiences as I researched and completed this project. By my experiences, I mean that I felt or noticed an intensification of the "symptoms" described in the DSM that initially

led me to originally seek diagnosed in the first place. Over the years since diagnosis and treatment, I have adopted various practices and strategies to negotiate those experiences – which includes a prescription for a stimulant compound. I also noticed the associated experiences of ADHD that, when not in the way of life experiences, can enhance them. The phenomenon known as hyperfocus describes an experience where the individual actually blocks out other distractions and fixates on a single task for an extended period of time – often at the detriment of other necessary tasks.

For example, demonstrating difficulty in executive functioning that leads to hyperfocus, while writing Chapter Two, I wrote a subheading for a section that reminded me of the title of a Prince song. Intrigued, I spend the next hour or so on the internet looking for other Prince song titles that I could use for other subheadings in that section. These sections had nothing to do with the songs. While related to content dealing with the implications of dangerous ideologies, arguable one could make an abstract relationship between the influence of Prince’s corpus to these topics. However, these titles did not necessarily relate or add anything to the project as a whole. More importantly, the way I came to the idea that I needed to incorporate these Prince-themed subheadings had nothing to do with an intent to create a relationship. My association with Prince’s work just now was after the fact. Subsequently, after I made substantial revisions to that chapter, that section was fundamentally restructured so that those subheadings were not necessary.⁹

Another surreal experience throughout this process is my own inability to step outside of a subject position limited by external stigmatizing discourse. My perspective on what it means to be “me” or someone like me was significantly influenced by the medical model both prior to and for most of my time after I was provided a diagnosis. I have been unable to remove the influence that there is something deficient. More telling, however, is that I have struggled to conceptualize what it means to engage with the mental health profession from anything other than my personal

experience with that system. However, much of the difficulty I have had separating the ableist assumptions within medicalization and my own experiences is that I resonate with how Margaret Price describes her interaction with the mental health profession. While I have experienced some professionals that demonstrate ableist and problematic assumptions, I have also been fortunate to be able to work until I found individuals that will participate in my own care instead of dictate to me. As Price says, ultimately, they hold the prescription pad, but they have collaborated with me instead of imposed their directives upon me. I recognize that I am privileged to experience my own care in this way. However, this also demonstrates that there are those within the medical and mental health profession that are open to and already influenced by principles conducive to a postpsychiatric practice. My own subjectivity, despite still maintaining some of the problematic elements, has also been influenced by supportive professional interactions after my diagnosis.

My own journey through diagnosis and treatment within the medical profession has also been augmented by my interaction with both ADHD advocate discourse and disability studies. While I still maintain some of the vestiges of existing discourse, I have also worked to reframe what it means to be me, which includes what it means to have ADHD. Being an ADHDer does not mean that one element defines me. It means that it is influential in my experience. It is one of my voices. It interacts with others as it is right now as I write this – the voices associated with my “self” as writer, scholar, and advocate. Part of my own counternarrative helps to structure my voice as it negotiates with other voices in a never-ending renegotiation of self over time. I now use that renegotiated self to construct my counternarrative – the exemplification of my advocacy through this project. This is my story:

As far back as grade school, I can recall instances where I knew something was different. One particular teacher seemed determined to shame me into paying attention. While there were times when one or two of my other classmates needed reminding to pay attention, I was often noticeably somewhere else mentally. I recall a specific time when I decided I

was through getting in trouble for not paying attention. I wanted to do well. I was going to do better for myself. And, of course, at that particular moment when I was making those intrapersonal declarations, I was supposed to be paying attention to something the teacher was saying. She noticed and proceeded to shame me in front of the class to an exceptional degree.

I usually got good enough grades to make honor roll. Despite not paying attention in class most of the time, I never found much too difficult. The subjects I had difficulty with were ones that learning about on my own time was too mundane and uninteresting. I failed spelling multiple times. The thought of typing class bored me, so I never completed the assignments. Science always engaged me, unless the teacher was more worried about how well-formatted my report cover was than the content that was actually in the report. I failed miserably when trying to learn basic division, however, for some reason I excelled when taught long-division.

As a junior in high school, I suspected that I had ADHD tendencies. I began to become more aware of my differences. My mind constantly bounced back and forth from one subject to another. My ability to focus on one thing for extended periods of time required high stimulation; and even then, the focus was often fleeting. I passed classes by getting good enough grades from taking the tests only and avoiding the homework, or I copied my friends' homework when they let me. I was able to recall and process what I heard when my mind actually engaged a subject. I couldn't be bothered to read most of the time. If I thought an assignment was pointless I didn't do it, or I did it in a way that I felt was less of a waste of time. One example I recall was when my composition teacher wanted me to handwrite out my references, one at a time, on an index card for a research paper as an assignment. The thought of the time spent on that for a pointless purpose irritated me. Instead, I turned in note cards that had the references typed, printed, hastily cut, and taped to them. Despite these challenges, I graduated high school in the top 25% of my class. Similar to grade school, there wasn't much I found difficult. I was able to get "decent" grades while not completing many of the minor assignments. However, I excelled at the high-stakes projects and exams.

I was drawn to high risk activities, some that I'm lucky to still be alive. My mind was constantly seeking stimulation, constantly craving some sort of adrenaline rush. I only felt alive when my heart rate was up, and the fight or flight instinct wanted to take over everything. Most other times I felt as if I was walking around in a haze, half asleep. Boredom and under-stimulation was my normal.

As such, my motivation and tolerance for mindless tasks was extremely low. So much so that I seemed defiant to my family when refusing to complete them or instead completed them poorly. In order to avoid completing the mundane tasks, I occasionally went off in search of "innovative" ways to do the same job with less involvement needed; those searches often ending up fruitless and taking far more time than would have been needed to complete the task. I was frustrated with myself because I wanted to care, I wanted to do well, I wanted to learn.

However, I was raised in a fairly rural, Midwestern area. While everyone was relatively polite about mental health issues, there was always this underlying sense of pity. It was as if those that were “normal” talked about those that “weren’t” with a slight wink, nod, or gentle nudge that signaled a mutual, unstated understanding.

In some cases, variations of this belief were held by healthcare professionals. In inquiring to one of my healthcare providers about my problems while still in high school, the provider’s solution was that I should take some ginkgo biloba. I also worked as a pharmacy technician while in high school and college. You would think that pharmacists, who, in a way, make money off of dispensing pills, would at minimum be ambivalent about ADHD medication. However, I encountered more than one pharmacist that rolled their eyes when an Adderall or Ritalin prescription would come in. While I never saw a pharmacist refuse to fill an ADHD prescription for illegitimate reasons, I heard many make comments to themselves and other pharmacy staff like “maybe her/his parents should try parenting before putting their kids on meds,” on the one hand, and on the other, “this is one messed up kid.” Unfortunately, I began to adopt some of those perspectives.

Fast forward to my fourth year of college where I am on the verge of failing out instead of graduating; my spring semester GPA was a 0.40. I struggled to understand why the distinct fear of failing out of school that I was experiencing wasn’t motivation enough to improve my grades. I wondered: “Am I lazy?” “Am I not smart enough to finish my college degree I started four years prior?” I understood that college isn’t for everyone – I was a first-generation college student. But throughout my primary and secondary school years, I heard often from family and teachers that college was where I should be despite my issues. I was told I was smart, but I lacked motivation and discipline to complete tasks. They thought it would have been a waste not to go if I could just “work hard enough.” How could so many people have been so wrong about me? More importantly, how could I have been so wrong about who I was? The experience shook me at the core. It was this experience, along with the advice and support of some friends and mentors that prompted me to seek answers from a different healthcare provider.

After numerous trips to the doctor, a referral to a psychologist, and a full battery of tests and evaluations, I went to the doctor for my final assessment. Seeing as how this was potentially a substantial change in my life, I asked my mother if she would like to come. She agreed, saying that would be a good idea. I was diagnosed with ADHD – Inattentive subtype. As is the case with many people that experience the Inattentive only subtype of ADHD, I was never suspected of having it because I lacked the stereotypical hyperactive component that most associate with ADHD due to its publicly visible nature. In that diagnosis, there was some relief. Perhaps there was something that could be done that could be changed.

For my mother, that diagnosis contained something unbelievable. She began arguing with the physician, questioning him about how the various conclusion couldn’t be indications of anything wrong – something must be wrong with the way they gathered their information. With the decision ultimately being up to me, I chose to accept the initial prescription for Strattera, a non-stimulant medication that, from my experience in the

pharmacy, I know had limited potential to improve ADHD symptoms. After leaving the physician's office, my mother was distraught. She lamented how she failed me. She blamed herself. She thought she must have been an incompetent mother if her son truly had ADHD. That was something that bad kids with bad parents had. That was something that meant she was deficient.

After spending 3-4 months trying four different medications and different dosages to determine what worked best for me, I was able to slowly but surely turn my grades around. My 0.40 GPA was replaced by a 3.0 and then a 3.5 GPA the following semesters. For the rest of my undergraduate experience after that first year, I was able to maintain a 4.0 GPA until graduation. I took six years to finish my Bachelor's degree. After undergrad, I went on to finish a Master's degree, and now I have completed my Ph.D.

Despite the medication that helped substantially, the process was painful. I had to learn how to learn. I had to learn how to study. I had to learn many of the basics that others either learned or figured out much earlier throughout grade school and high school. My spelling, grammar, vocabulary, and other basic concepts that others around me got were deficient. I had learned how to get by in school. I learned how to pass.

After I was diagnosed and received medication for ADHD, I struggled with my new identity. At first, I didn't want to be one of those "weak" people that thought they needed to take a pill in order to get by. After struggling with this, and after I started to see marked improvement in my studies, I started to change the way I thought about my medication. Rather than think of the medicine as "controlling" me, I began to see it like a tool that let me take control when I wanted to.

However, it wasn't until I stumbled across more information on ADHD as a discourse in 2010 that I truly begin to resolve issues that I had not addressed with my identity. For the first time ever, I started to see the benefits of my ADHD that, rather than holding me back, actually helped me achieve from time to time in the past. I began to undergo a gradual re-framing of both ADHD and my identity. However, I began to think of ADHD and my relationship to it as a balancing act: working to adapt and accommodate certain aspects that can be frustrating, while learning to work with my ADHD to maximize its productive potential. I slowly stopped thinking about ADHD as merely a deficiency and started seeing it as a potential, although sometimes unruly, ally.

Moving forward, challenging public and professional discourse requires both collective and collaborative action. This is why disability studies matters to me. Even though our differences can be substantial, even though we disagree on the best way to address our various issues, those that engage in these issues are there to support and challenge not just for themselves, but for all that collectively experience the challenges and discrimination posed by ableism. This coalition of

scholars, advocates, and those that have disabling experiences represents the best chance many of us have for addressing these issues. Finding overlap and common ground is an important part of disability theory. However, while addressing the whole of ableist logic is an important task, it is also important to interrogate our differences as well. I hope that this project provides a starting point not just specifically for ADHDers, but something that can also help others.

Notes

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1. PBS, "Federal Laws Pertaining to Adhd Diagnosed Children," <http://www.pbs.org/wgbh/pages/frontline/shows/medicating/schools/feds.html>. IDEA was a reauthorization of the original legislation, the Rehabilitation Act of 1973. However, IDEA also contained a substantial number of provisions that were not addressed in the Rehabilitation Act.
 2. Steering Committee on Quality Improvement Subcommittee on Attention-Deficit/Hyperactivity Disorder and Management, "Adhd: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents," *Pediatrics* 128, no. 5 (November 1, 2011).
 3. See Allen Frances, "Pediatricians Issue Dangerous New Treatment Guidelines for Attention Deficit Disorder," <http://www.psychiatrictimes.com/adhd/pediatricians-issue-dangerous-new-treatment-guidelines-attention-deficit-disorder.>; Claudia Gold, "Diagnosing Adhd under Age 6: A Mistaken Idea," *Child in Mind*, http://claudiamgoldmd.blogspot.com/2011/10/diagnosing-adhd-under-age-6-mistaken_16.html.
 4. See Peter R. Breggin, *Talking Back to Ritalin: What Doctors Aren't Telling You About Stimulants and Adhd* (Boston, MA: Da Capo Press, 2001).
 5. Tracie O Afifi et al., "Spanking and Adult Mental Health Impairment: The Case for the Designation of Spanking as an Adverse Childhood Experience," *Child Abuse & Neglect* (In Press); Elizabeth Gershoff and Andrew Grogan-Kaylor, "Spanking and Child Outcomes: Old Controversies and New Meta-Analysis," *Journal of Family Psychology* 30, no. 4 (2016).
 6. Margaret Price, *Mad at School: Rhetorics of Mental Disability and Academic Life* (Ann Arbor, MI: University of Michigan Press, 2011); Tobin Siebers, *Disability Theory* (Ann Arbor, MI: University of Michigan Press, 2008).

7. Bradley Lewis, *Moving Beyond Prozac, Dsm, and the New Psychiatry: The Birth of Postpsychiatry* (Ann Arbor, MI: University of Michigan Press, 2010).

8. Price, *Mad*, 231.

9. The subheadings were: “Parent Like it’s 1959,” “When Bigots Cry,” and “Sign o’ the Times.”

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ABSTRACT**ATTENTION DEFICIT IDENTITY DISCOURSE: EXPLORING THE ABLEIST LIMITATIONS AND THE LIBERATIVE POTENTIAL OF THE CONTESTED ADHD SELF**

by

Nathan T. Stewart**August 2017****Advisor:** Dr. James L. Cherney**Major:** Communication**Degree:** Doctor of Philosophy

The specific objective of this project is to elaborate general rhetorical resources and strategies that can allow ADHDers to both cultivate/reclaim a positive sense of self in the face of multiple forms of stigmatizing discourse and begin the process of challenging that discourse. Working from a disability studies perspective, I identify both challenges and opportunities to develop a positive sense of self through the examination of nostalgia in ADHD discourse, polysemic ADHD medical discourse, and the use of counternarratives as a resource to reframe stigmatizing master narratives. This project concludes by emphasizing that those with what I identify as *contested disabilities* – those with conditions like ADHD that some dispute whether they should be considered “legitimate” disabilities – can utilize a similar process of analyzing master narratives to determine strengths and weaknesses to strategically construct counternarratives. While each contested disability will have to address unique discursive/narrative challenges, this project provides an example of how that process can occur through the examination of ADHD.

AUTOBIOGRAPHICAL STATEMENT

Nathan T. Stewart will serve as Assistant Professor of Communication at Lakeland University in Plymouth, Wisconsin beginning in August 2017. He will be responsible for the communication program and implementing a new health communication track. Prior to this appointment, Nathan served as Assistant Professor of Communication and Assistant Director of Forensics at Parkland College in Champaign, Illinois from August 2014 to May 2017. Nathan returned home to Central Illinois in 2013 to help his family keep the 360-acre family farm running after the death of his uncle. Due to the devastating State of Illinois budget stalemate, he and many other educators were forced to find employment at other institutions outside of the state.

As a Ph.D. candidate at Wayne State University, Nathan received the competitive University Graduate Research Fellowship position. He was also selected as a research assistant for the Great Lakes Restorative Initiative Grant project, in association with the Michigan Department of Community Health, developing public health advisories. In addition to presenting on multiple Top Paper panels, he also received an award for the top competitive paper from the Disability Issues Caucus at the 2012 National Communication Association conference. He will receive his Ph.D. in August of 2017.

Nathan attended Illinois State University for his B.S. (2008) and M.S. (2010). As an undergrad, he also received minors in biology and chemistry. Throughout much of his time at Illinois State University, he was involved in competitive academic debate as a participant and coach. He also served as the Director of Debate for University High School in Normal, Illinois. Additionally, he worked part time as a healthcare provider throughout most of his undergraduate degree.