Psychiatric power and the ADHD experience

BY ABRAHAM JOSEPH

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In my adult life I have found counselling to be a useful tool for understanding my past in order to help me to shape my future. In October 2019, my counsellor recommended that it might be helpful if I were assessed for attention deficit hyperactivity disorder (ADHD). She suggested that the challenges that I was facing in navigating work, social, school, and romantic spaces could be a result of having ADHD. Coincidentally or not, at the time I was working toward completing my master's degree, which focused on the role of psychiatric power in ADHD.

Having struggled with attention and focus most of my life, I was not terribly shocked by my counsellor's suggestion. However, when she asserted that ADHD was a genetic disorder often passed down matrilineally, I was caught off guard, for two reasons. First, I have yet to find research that definitively supports this claim, and second, there is a significant body of research that says otherwise. There is a continued, consistent absence of research showing clear biological causal links between genes and ADHD (Timimi, 2017).

However, my counsellor's understanding of ADHD reflects the dominant biomedical thinking and decades of research that aims to claim that ADHD is a genetic disorder. This line of research has played a large role in the development and legitimization of ADHD care that prioritizes behavioural diagnostic criteria alongside pharmaceutical treatment.

WHY HAS THIS BIOMEDICAL VIEW OF ADHD CONTINUED TO DOMINATE?

The question then is, *Why has this biomedical view of ADHD continued to dominate?* I propose that answers to this question lie in better understanding the ways in which power shapes ADHD conceptualization, diagnosis, and treatment.

Attempts to improve population health through public health policy do not usually feature the concept of power as central to the discussion. ADHD and other mental health discussions are no different. Policy in this area generally disregards the role that societal power structures play in determining individual behaviours. As an alternative to much of this ADHD policy research, my research focuses on power. This is important because power dynamics play a central role in influencing how we think about ADHD support in mental health care and, therefore, how we decide to design our health care systems and policies to meet the needs of those experiencing ADHD symptomology.

In order to situate power at the centre of my analysis, I adapted the framework developed by Pulker et al. (2018) that illuminates the ways in which supermarkets hold power within the Australian food system. Pulker et al.'s framework explores how supermarkets have obtained, from various sources, power that functions across four areas of influence: instrumental power, structural power, discursive power, and political legitimacy. Each dimension of power overlaps with and reinforces the others. My adaptation of this framework (see figure 1) relates psychiatric power to the ADHD diagnosis rather than supermarket power to the food system.

The dimensions of power (instrumental, structural, discursive, and political legitimacy) retain their conceptual meaning in the adapted version of the framework. For each numbered example of supermarket power in the original framework, analogous categories in the adapted version are identified.

In the adapted framework, *instrumental power* is represented by the direct influence that psychiatrists have over the decisions of others, such as patients, caregivers, health care professionals, educators, and people like my counsellor. *Structural power* is embodied by agenda setting and rule making that limit an individual's range of choices. *Discursive power* is represented by messaging that influences societal norms and values related to ADHD. Lastly, *political legitimacy* functions mainly to give authority to the other forms of power.

ADAPTING THE POWER FRAMEWORK

Adapting the power framework was a process of creation and discovery. As I filled in the categories of psychiatric power to create the adapted power framework, my understanding of psychiatry's influence on the ADHD experience became clearer. Psychiatry plays a central role in influencing the dominant ways in which ADHD is conceptualized, diagnosed, and treated.

In terms of instrumental power, this process highlighted the coercive nature of surveillance carried out by teachers, administrators, and medical professionals in the name of medical treatment and support. Children experiencing ADHD

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symptomology seek out professional support to help them to better navigate their lives across domains (social, educational, familial, environmental) that are often quite challenging for them. One might think that the central aim of mental health support is to empower these children so that they are better equipped to be successful in their everyday lives. However, a tension arises when a child diagnosed with ADHD questions the "need" for medication, eliciting the psychiatric labels of "problematic" and "noncompliant." The irony here is that the very development of agency around personal care and mental health is what provokes psychiatric responses that are disempowering and dismissive. This tension uncovers the coercive nature of biomedical treatment plans common in ADHD care.

Structural and discursive psychiatric power shape the ADHD experience in less direct ways, by influencing the rules for diagnosis and treatment and creating and controlling notions of acceptable and unacceptable behaviour. One of the main ways this plays out is within the context of Canadian education systems, where the focus is often on fixing or controlling children's "unacceptable" individual behaviours. These are ultimately subjective, decontextualized determinations, and will be somewhat different from teacher to teacher.

The framework of the dimensions of power highlights access points for good social policy that could go a long way toward facilitating more supportive school and home environments. The creation of social policies that increase funding to education and reduce the material burden, such as guaranteed housing and health care that is truly universal and includes dental and psychological supports, would help relieve stress on individuals throughout society. This is important because when good supportive social policies are instituted, practitioners and parents are subsequently less overwhelmed, and teachers have smaller class sizes and are therefore able to spend more time being creative with their lessons and attuning to their students' needs in a more responsive way.

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FIGURE 1 Framework of the Dimensions of Psychiatric Power and Influence

	INSTRUMENTAL POWER	STRUCTURAL POWER	DISCURSIVE POWER	POLITICAL LEGITIMACY
	Direct power held over other actors' decisions	Rule making and agenda setting that limit decision making	Communication that influences societal norms and values regarding ADHD	Legitimizes dimensions of power (necessary for power to be wielded effectively)
	DIMENSIONS OF POWER OVERLAP AND REINFORCE ONE ANOTHER			
PSYCHIATRIC CHANNELS OF INFLUENCE AND STRATEGIES	1. Lobbying for policy that reinforces the dominant ADHD narrative 2. Research funding/sponsorship that prioritizes the biomedical framing of ADHD 3. Relationship building 4. Legal action 5. Gatekeepers and creation of acceptable knowledge conceptualization of ADHD 6. Ability to set terms of service for ADHD care delivery 7. Care professionals set limits on types of support available for children experiencing ADHD symptomology	8. Private governance subjectively determined rule sets for assessing ADHD (in continuous flux) 9. Highlighting regulatory burden and need for patient access to pharmaceutical treatment 10. Early intervention agendas normalize pharmacological treatment 11. Institutional guidelines for care lacking focus on psychosocial support 12. Health care set up in a way that limits children's participation 13. Deficit-centric ideas of agency and competency flow from dominant ADHD diagnostic tools 14. Governments limit support for those experiencing ADHD symptomology	15. Framing issues that support the dominant biomedical narrative of ADHD a. Normative child behaviour b. Societal values on risk/safety inclusion/exclusion acceptability thresholds c. Craft actor identities 16. Community involvement 17. Celebrity success stories 18. Research dissemination 19. Devalue alternative mental health/illness narratives	20. Authority (absence of challenge) 21. Trust, fairness 22. Democratic values a. Participation b. Transparency c. Accountability 23. Neoliberal values and policy formation

Source: Adapted from Pulker, C.E., Trapp, G.S.A., Scott, J.A., & Pollard, C.M. (2018). What are the position and power of supermarkets in the Australian food system, and the implications for public health? A systematic scoping review: Scoping review of supermarket power. Obesity Reviews, 19*(2), 198–218.*

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While my exploration of psychiatric power presented here is not exhaustive, it is meant to give a sense of how the power framework can be used and adapted to better understand how psychiatric power is structured and deployed to shape the ADHD experience.

Finally, this adaptation opens up possibilities for the creation and application of power frameworks in other important areas related to public health, including but not limited to policing, news media, and pharmaceuticals. Power dynamics are central in shaping how health policy is created and carried out. If we aspire to create more democratic, inclusive, and healthy societies, understanding how power functions should be a priority.

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