

## **Historical and Cultural Institutional Analyses of the Emergence of Attention-Deficit/Hyperactivity Disorder \***

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From the late sixties onward, the psychiatric illness attention-deficit/hyperactivity disorder (ADHD) rapidly emerged from relative obscurity to national prominence in the United States. Referring to a persistent problem with inattention, impulsiveness, and/or hyperactivity that begins in early childhood and may echo on into the adult years of life, ADHD is the most common behavioral disorder diagnosed in children today (estimates vary widely between 3% to 18%). While the increasing sophistication and specialization of medical knowledge and technologies have undoubtedly contributed to the increase in ADHD detection, an account that turns solely to science for the rise in the disorder overlooks the social and political construction of medical diagnosis. Its medical conception aside, the rise of the disease category has followed a distinctly political path. Tracing out the emergence of the medicalization of ADHD, more commonly known as hyperactivity, can reveal the very political processes – particularly between state-society relations – promoting its expanding medical jurisdiction as a disease category. To make sense of the political origins and the structural and cultural context contributing to the ascendancy of the medical designation of ADHD, the following analysis applies an historical institutional and cultural institutional approach to understanding the development and growth of the medicalization of ADHD. Comparisons across these two perspectives are then undertaken to illuminate the distinctive contributions each approach affords us in understanding the emergence of hyperactivity as a distinct medical concept and to reveal the multiple actors, sites, specific historical events, and ideologies that make up the contested arena.

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To make sense of the political origins and the structural and cultural context contributing to the ascendancy of the medical designation of ADHD, the following analysis first applies an historical institutional and second, a cultural institutional approach to understanding the development and growth of the medicalization of ADHD since its initial ‘discovery.’ Comparisons across these two perspectives are then undertaken to illuminate the distinctive contributions each approach affords us in understanding the emergence of hyperactivity as a distinct medical concept. To set the stage, the paper first elaborates on the problem of statecraft and the concept of medicalization before tracing the historical emergence of the disease category employing institutional approaches. In doing so, the paper draws together various strands of literature that as a whole articulate the two analytic perspectives to reveal the multiple actors, sites, specific historical events, and ideologies that make up the contested arena.

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<sup>1</sup> Without diminishing or denying the experiential reality of those who suffer from ADHD, the intent of this historical comparative perspective is to challenge and reorient our conceptualization of these medically defined problems without simply reducing them to abnormal neurotransmitters. Such an approach brings into relief the confluence of events and the convergence of interests that create a climate receptive to the medicalization of everyday life.

## **Statecraft and Legibility**

A ‘central problem of statecraft,’ according to Scott, is to make society legible to itself (1998; Scott, Tehranian, and Mathias 2002). Part of this task entails making sense of the human landscape through the creation of identity categories. Fashioning an administrative apparatus of identification – “where administration means the extraction of resources, control and coercion, and maintenance of the political, legal, and normative order in society” (Barkey and Parikh 1991:524) – enables the state to control the populations within its own borders and manage its welfare, improve its condition, increase its wealth, longevity, health, and other aspects of social life (Foucault 1991 in Nye 2003).

Modern forms of statehood, then, hinge on enfolding greater areas of social life within the purview and control of the polity. One means of expanding such regulatory scope involves mapping the social body through the bureaucratic categorization of identities – including medicalization, a process whereby conditions once considered normal features of daily life are transformed into pathologies and consequently, come to be treated in medical terms. Such cartographic practices enable the state to rein in the unintelligibility of the population over which it rules and manage its welfare. Categories, then, are imposed from above by the practices of rule. Assigning individuals to categories in such a way can transform society in the process.

To control and advance the welfare of the populace, then, the state can deploy technologies of knowledge, and in matters of health and illness – medicine. Since the turn of the last century, in fact, the medical profession has become the dominant authority over what may be officially defined as a medical problem and what treatment should be carried out (Schneider and Conrad 1980). Control over populations necessitates legitimacy, such as through juridical means. In the case of disease categories, the state extends medical rather than legal authority and the medical profession assumes the same privileges as if it were the rule of law.

Legitimization for most psychiatric disorders comes with their inclusion in the *Diagnostic Statistical Manual (DSM)*, the official handbook of the American Psychiatric Association. As the

authoritative reference for psychiatric conditions, the *DSM* has been used as an essential tool for sanctioning medicalized categories (Conrad and Potter 2000).

Despite its psychiatric claims, however, psychiatric diagnoses in the *DSM* are historically and culturally situated. Since its inception, the *DSM* has faced several revisions, each one reflecting the dominant psychoanalytic ideology of the time. With the third edition of the *DSM* in 1980, a major shift in psychiatric thought occurred, moving the understanding of human problems from a principally psychoanalytic orientation to a biomedical approach to diagnosis.

By defining deviant behavior or what was once viewed as normal processes of life as medical problems in biomedical terms, certain practices are then permitted to be carried out that would not have been considered otherwise before. In this case, a formal diagnosis of hyperactivity authorizes the prescription of psychoactive medications. Application of pharmacological technology, moreover, has proven to be a highly efficient method for controlling deviant behavior. In sum, treating unwanted behavior and experience with drugs can be a form of medical social control that cannot be applied without the medicalization of deviance (Conrad 1975).

## **Medicalization**

Central to the process of medicalization is a definitional issue. According to Conrad,

“Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ‘treat’ it. This is a sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession. Medicalization occurs when a medical frame or definition has been applied to understand or manage a problem...The interest in medicalization has predominantly focused on previously nonmedical problems that have been medicalized (and, often, thought to be inappropriately medicalized), but actually medicalization must include all problems that come to be defined in medical terms” (1992: 211)

To medicalize, then, is to treat what was once considered a nonmedical problem of life in medical terms. Doing so alters the way in which problems are described, understood, and addressed. Included in the arena for medicalization is deviant behavior, such as ADHD.

Medicalization, furthermore, may take place on the conceptual, the institutional, and the interactional levels, with each level implicating different parties. On the conceptual level, a medical model is applied to define the problem. Medical professionals and medical treatments are not necessarily involved. On the institutional level, specialized organizations may adopt a medical definition and approach to treat problems. Physicians serve as gatekeepers to benefits in this instance. On the interactional level, medicalization arises from doctor-patient interactions. Here, physicians give a medical diagnosis for a problem or approach a ‘social’ problem with medical treatment (Conrad 1992).

To illustrate the socially constructed nature of ADHD, we can look to the diagnostic process for the disorder. While the condition is classified as a neurobiological disorder – consequently lending an impression of objectivity – the diagnosis for ADHD relies entirely on subjective evaluations of mental and functional states. To date, the assistance of medical technology remains limited; imaging tests can be used to rule out other factors for symptoms related to ADHD for example, but PET scans are incapable of providing sufficient diagnostic verification. No definitive test, in fact, exists for the problem. Other complications in diagnosis involve the coexistence of ADHD with other medical problems – particularly, depression, anxiety, and learning disability. Such porous boundaries and expansive categorizations open ADHD to political incursions by interested groups.

### **Historical Institutionalism**

One of the principal analytic perspectives employed in studies of the state is historical institutionalism. According to this approach (which differed from earlier Marxian conceptions that viewed the state as reflective of society), the state is conceived as an autonomous actor formulating its own interests – independent of and sometimes even divergent from society – and perhaps more importantly, possessing the capacity to pursue those interests (Skocpol 1985). This analytic distinction allows us to analyze states as ‘configurations of organizations and actions that influence the meanings and methods of politics for all social groups and classes’ (Skocpol 1985:28). Indeed, in this account, the

institutional organization of the state plays a central role in structuring political outcomes and collective behavior (Campbell 1998; Hall and Taylor 1996; Skocpol 1985).

In what follows, we elaborate on and attempt to apply some of the mainstays of historical institutionalism to the case of ADHD. Of specific relevance here is history – particularly path dependence, critical junctures, and unintended consequences – and the institutional context – the complex of actors interacting and shaping political outcomes. Also critical is the relationship between institutions and individual action. Institutions, in this perspective, are broadly defined but generally include organizations, rules and procedures of organizations (Hall and Taylor 1996), and networks (class notes on Skocpol).

The present concept of attention deficit hyperactivity disorder is traceable to the more general history of behavioral disorders and similar categories. A historical institutional analysis reveals that underpinning the emergence of medical notions of these child pathologies was a complex interplay of various institutions, government agencies, professional groups, as well as agents outside the medical profession such as lay advocacy groups.

Child behavioral disorders first appeared as a medical concept in Europe between the end of the nineteenth century and the beginning of the twentieth centuries (Brancaccio 2000). In the United States, ADHD's roots can also be traced to this period but did not appear as a distinct diagnostic category until the 1950s (Conrad and Potter 2000). In the absence of available data for the U.S. for this analysis, however, an examination of the European experience can offer an informative guide to the preexisting conditions that also were likely to shape the rise of the medicalization of ADHD in America. From an historical perspective, furthermore, it is vital to look closely at events prior to as well as after the emergence of the medical concept in the U.S.

At the turn of the last century, a national system of compulsory education was implemented in Europe. Following that time, a new childhood disease was 'discovered' in Europe. The pediatrician George Frederic Still was among the first doctors to describe the new child pathology of behavioral disorders. Still found that an array of the disorder's symptoms – such as restlessness, impulsivity,

inattentiveness, and aggression – were most prominent in the school setting. Children displaying these symptoms, furthermore, seemed unresponsive to punishment exercised in schools (Still 1902 in Brancaccio 2000).

Prior to state involvement in education, arrangements for schooling varied by social background. Whereas upper and middle class children were trained at home by private tutors or in elite schools, education for children of the popular class largely meant learning the rudiments of literacy. Further, the content, location, and duration of schooling for this latter group of children were largely contingent on the dominant local church, local elites, local mores, and available community resources (Brancaccio 2000).

During that time, the experience of schooling was fairly varied, unstructured, and for some such as rural children, spurious. Teachers hailed from different statuses and backgrounds and often lacked specific qualifications and were dependent on the local parish and community. Classes were held wherever possible, including in private homes and were composed of children of varying ages who were each taught in turn by the teacher – ‘the independent method’ approach. In the meantime, other children engaged in a range of activities that were unsupervised (Brancaccio 2000).

Schooling then was not perceived as a significant or normal part of children’s lives. Rather, the demands of the seasons in relation to wage earning were more important for young people, especially for children from rural districts. At the time, full authority was still invested in parents to decide on children’s schooling. Barriers to sending children to school were the lack of economic utility of literacy for those residing in rural areas as well as the mediocrity of and even physical punishment exercised by teachers (Brancaccio 2000).

Rather than from the masses, however, the impetus for educational reform was fueled by the rising metropolitan elite who were interested in promoting a new order in social relations. State bureaucrats, enlightened intellectuals, moralists, entrepreneurs, members of the new ruling class including ascending political and economic groups, among others began advocating the idea that schooling could serve as a valuable tool for the moral improvement of the masses. At the time, the issue coincided with other public concerns such as the transformation of peasants into citizens and as well as the improvement of the home environment which together increased its political concern. Mass education then, served

several ends and with its imposition, the new ruling classes could extend their hold over the population (Brancaccio 2000).

Mass education also had the effect of altering and redefining the previously private relationship between parent and children. New duties were created; parents were to be providers and children were to depend on them and give priority to school attendance over work. It was in this context that the concept of ‘bad parents’ emerged. That is, when schools encountered resistance from children, they increasingly characterized the problems as being created by bad or irresponsible parents (Brancaccio 2000).

By the end of the nineteenth century, through the efforts of various agents, masses of children started to attend schools and school became an increasingly normal part of children’s lives. The imposition of mandatory national education ushered in a number of recalcitrant/rural children who were ill-suited to and unaccustomed to the school’s disciplinary requirements. Further, educational reform – focusing on order and efficiency in a formerly relatively carefree environment – created a structure of pedagogical relations that fostered the labeling of unruly behavior that could not be controlled in school children as pathological. Further, educational authorities called upon the medical profession – particularly doctors and psychiatrists – to establish criteria to identify ‘defective’ schoolchildren as a solution to managing unfit pupils without exceeding school budgets (Brancaccio 2000).

State involvement in education – through altering the existing structure of schools – and incursions from the medical professions served as critical preconditions for the eventual elevation of hyperactivity as a significant social and health problem. State and professional involvement in education, then, created the arena where identification of hyperactivity takes place and where it flourished (Brancaccio 2000).

In this way, the state played a central role in penetrating into the lives of its citizens and exerting control over the identities they took on. In implementing a system of universal education, the state not only reorganized the lives of children and parents but also affected relations between members within families. Identities – hyperactive child and bad parent – became shaped by state intervention.

It was the introduction of state involvement into schools, then, that created the setting for behavioral disorders to emerge. Moving toward mid-century onward and more specifically in the U.S., a

different set of actors begins to emerge to continue shaping the trajectory of hyperactivity. Agents affecting the discovery of hyperkinesis include government agencies, the pharmaceutical industry, and specialized interest groups, including the Association for Children with Learning Disabilities and Ch.A.D.D.

While ADHD has roots from the early part of the last century as noted earlier, the disorder did not emerge as a distinct diagnostic category in the U.S. until the 1950's. The disorder still remained unnamed or at various times was termed minimal brain dysfunction, hyperactivity, or several other similar and – in practice – interchangeable diagnostic classifications. It was not until Laufer, et al. described the condition as “hyperkinetic impulse disorder” in 1957 that the disorder appeared as a specific diagnostic category. These researchers, however, put forth a description of a disorder with no clear history or evidence of organic etiology (Conrad 1975).

During the early sixties, increasing research on the etiology, diagnosis and hyperkinesis appeared, with much of it concerned with the disorder's drug treatment. Additionally, the disorder experienced greater publicity in the mass media.

In 1966, the U.S. Public Health Service (USPHS) and the National Association for Crippled Children and Adults sponsored a task force to clarify the terms and symptoms in diagnosing children's behavior and learning disorders. Based on over thirty diagnoses, the term “minimal brain dysfunction” (MBD) was decided on as an overriding diagnosis. The label would contain hyperkinesis and other disorders (Conrad 1975).

The critical turning point occurred shortly thereafter with the inclusion of a constellation of behavioral problems in the *DSM*. In 1968, the *DSM-III* officially classified “minimal brain damage,” “hyperkinetic reaction” and other problems as a child disorder. Over the next three decades, two defining features of the psychiatric illness – hyperactivity and inattention – would persist in various combinations. The classification also allowed room for the disorder to continue on into adolescence. In 1980, *DSM* included Attention Deficit Disorder (Pozzi 2000) as an entity in its manual. Over a decade later, the disorder was expanded to include adults as well (Conrad and Potter 2000).

With respect to diagnosis, a child's hyperactive and disruptive behavior, especially at school, served as the most significant criterion. Stimulant medications, particularly Ritalin, were offered as major treatments. By the mid-1970s hyperactivity had become the leading childhood psychiatric illness (Gross and Wilson 1974 in Conrad and Potter 2000). Special pediatric clinics, moreover, were being established to identify and treat the disorder, although pediatricians and primary care physicians still mainly diagnosed children (Conrad and Potter 2000).

With respect to government action, at least two critical governmental reports were prepared following the publication of the USPHS report on MBD. First, the Office of Child Development (1971) sponsored a conference on the use of stimulant drugs in the treatment of child behavioral disorders. The Congressional Subcommittee on Privacy held hearings on prescribing medication for hyperactive children. The hearing revealed the ease with which the medication was being prescribed as well as the fact that for at least some children, general practitioners were prescribing drugs based on teachers' and parents' reports that the child showed poor performance in schools. Composed of professionals, many of whom were M.D.'s and already invested in drug treatment for children's behavioral problems, the H.E.W. committee recommended that only M.D.'s diagnose and prescribe treatment. In addition, it was advised that pharmaceutical companies promote treatment solely through medical channels. The report acted as approval for treating hyperkinesis with psychoactive drugs (Conrad 1975).

Also significant in advancing hyperkinesis as a disorder within the medical model were agents outside of the medical establishment, including pharmaceutical companies and the Association for Children with Learning Disabilities. Prior to the early sixties, medications for childhood disorders were rarely if ever advertised or promoted. Then after that time, two major pharmaceutical corporations started advertising in medical journals and direct mail, urging physicians to diagnose and treat children with hyperkinesis with Ritalin and Dexedrine. While the advertisements were chiefly directed to the medical community, some of the promotion was also targeted to the educational sector (Hentoff 1972 in Conrad 1975). These firms had a clear financial vested interest in the labeling and treatment of hyperkinesis (Conrad 1975).

The other influential but less powerful agent was the Association for Children with Learning Disabilities. Established in the early mid '50s, one of its central functions has been to disseminate information on learning disabilities. Much of the literature indicates that the organization, despite its more educational perspective, had adopted the medical model and sensitized teachers and schools to approach hyperactive behavior as a medical problem (Conrad 1975).

### **State-Society Relations**

Also important to consider in historical institutional accounts is state-society relations. Work by Skocpol (1985) demonstrates that political institutions and procedures have an effect on the identities, objectives, and capacities of social groups, who in turn become actively engaged in shaping political outcomes. It is here where we see relations between institutions and individual action unfold.

Endowed with the ability to regulate admission to social (and medicalized) categories and identities of populations, institutions open the possibility of state-society relations. Because membership accords certain rights and privileges to those defined groups, including health insurance or access to services, it offers an incentive for persons to mobilize to seek those benefits. Medical power is not simply a mechanism of state control, but it also legitimates claim on state resource and services. Consequently, matters of inclusion and exclusion become paramount.

Earlier comparative-historical scholarship (Skocpol 1985) has shown that the exclusion of groups from a category can fuel mobilization to seek access to political routines. After excluded groups gain access and are formally included, however, members may begin accommodating to standard political practices. In the case of medicalization – and the identity category of ADHD specifically – the process of inclusion and exclusion operates somewhat differently for collective action. Here, mobilization occurs subsequent to inclusion. Further, because the affected parties are mostly children, those who mobilize are largely parents/advocates and not the sufferers themselves. In other words, caregivers of the included groups begin to mobilize and seek access to new or more services. Currently excluded groups (as a collective), however, do not engage in this kind of diagnostic advocacy.

The idea of exclusion playing a role in mobilization, only begins to emerge when we consider adults' encroachment into the disease category and how the sufferers themselves can have an active role in the political process. A goal of lay activists, after all, is to expand and shape medical diagnoses and in doing so, embrace formerly excluded groups within the disease category. In the case of hyperactivity, affected parties were active collaborators in the expansion of ADHD to include adult sufferers.

Over the years, several parent and advocacy groups have arisen around the issue of hyperactive children, including those participating in the learning disabilities movement. One of the largest organized lay interest groups is Children and Adults with Attention Deficit Disorder (ChADD). Over the last decade, the ChADD owed much of its growth to its adult members with ADHD (Conrad and Potter 2000). In the 1990s, the organization, through its various activities and framing of ADHD, helped expand the disease category to include adults – advancing the notion that the disorder is not confined to childhood but echoes into the later years of life as well. In 1993, the organization incorporated “and adults” to its name to signal its broadened mission of the education and support of adults with ADHD. Some of its activities include lobbying for educational services for hyperactive children and advocating legislation that provides adult sufferers with workplace protection. Further, rather than position the disease category in psychiatric or behavioral terms, ChADD framed ADHD as a medical condition in order to gain greater perceived legitimacy in claiming disability entitlements (Conrad and Potter 2000).

Further, collective action can propel the disease category forward not only by working individually, but also by building alliances with other organizational stakeholders. The interaction between lay and professional claims-makers is best exemplified in the collaboration between the support group, ChADD and the pharmaceutical company, Ciba-Geigy. In this link, Ciba-Geigy offers significant financial assistance to ChADD. Further, ChADD is tied to a network of other actors in other ways as well, including the academic and business sectors of the ADHD community; the organization's board of directors is composed of academic researchers and physicians working on issues concerning ADHD (Conrad and Potter 2000). In these varied ways, particular alliances underlie the medicalization process and increase the capacity of actors to pursue their political ends.

In playing a major part in bringing together lay and professional stakeholders, ChADD helped to promote the existence, acceptance, and treatment of child and adult ADHD. The organization also plays a role in legitimating the illness for those who suffer from ADHD (Conrad and Potter 2000). In this way, we see how organizational claims-makers independently and collectively can be effective promulgators and champions of disease categories and their treatment.

While achieving political objectives depend on the opportunities consciously and strategically offered by existing institutions, other institutions may play an unwitting part in making ADHD a more likely diagnosis. In this case, the rise of managed care in the U.S. may have the unintended consequence of fueling the diagnostic expansion of ADHD.

Managed care affects psychiatric treatment in several ways. First, health insurance places strict caps on patients' use of psychotherapy. Also, psychiatrists must now avail themselves to utilization review, take part in the management and consultation of medication, or administer 'carve-out programs' (Domino et al. 1998 in Conrad and Potter 2000). Further, some researchers and mental health advocates have argued that under managed care, there is an increasing reliance on prescribing pharmaceuticals to treat all types of psychiatric problems (Johnson 1998 in Conrad and Potter 2000). Also, a study by Murray and Deardorff (1998 in Conrad and Potter 2000) has found that managed care may promote the pharmaceutical industry's growth. Psychiatrists and other physicians now have greater incentives to treat all possible psychiatric problems with pharmaceutical rather than with psychological therapy. Managed care is also more likely supplant psychiatrists with primary care physicians who are less familiar with psychotherapy. As a consequence, these doctors increase the likelihood that stimulant medications are prescribed as treatment. Further, some research evidence indicates that hyperactive children are treated exclusively with medication, removing the possibility of other 'talking therapies' (Woolraich, et al. 1990 in Conrad and Potter 2000). Lastly, diagnoses that are treatable with drugs are reimbursable under managed care. Such a payment scheme may promote the expansion of the diagnosis. As an example, problems viewed as life dissatisfaction or conditions that may have been previously diagnosed as a different disorder (such as adult adjustment reaction) can now be medically identified and treated as ADHD (Conrad and Potter 2000).

Given the context of managed care, ADHD becomes a more likely diagnosis. Although it was never the explicit intention of the infrastructure of managed care to increase the diagnosis of hyperactivity and its pharmaceutical treatment, the effect has been the growth in ADHD diagnosis and drug treatment. Further, this effect may arguably be viewed as the outcome of a struggle over the available set of alternatives.

The complex of institutional arrangements shaping the medicalization of ADHD are schools, government agencies, medical professions (the professional interests of doctors and psychologists), lay people, pharmaceutical companies and other stakeholders. Tying all of these actors is the biomedical model of ADHD. Independently as well as collectively, they acted in a mutually reinforcing fashion to propel the expansion of ADHD. That is, the widespread popular acceptance of behavioral disorders over time suggests a feedback loop among schools, professionals, organizational claims-makers, government agencies, the media, and the public in terms of the construction, expansion, and application of ADHD.

In sum, the historical institutional analyses herein demonstrate that the appearance of hyperactivity as a disease category owed much to the exercise of institutional power among interested actors. In this account, we see the historical and evolving political arrangements and interests of several actors – medical professions, lay persons, corporations – coincided with interests of state institutions, including schools and government agencies.

What began as a state effort to moralize/civilize the masses and construct a sense of citizenship set the stage for the emergence of child behavioral disorders. The state defined the arena – schools – in which ADHD would be identified. Further, incursions by medical professions also played a role. At different historical moments and socio-historical contexts, medical professionals, advocacy groups, pharmaceutical companies, academic researchers, and social movements have promoted the expansion of ADHD. Such agents (as groups as well as individuals) can be central in creating and legitimating specific diagnoses. Historical institutionalism also alerts us to unintended consequences, as in the case of the rise of managed care.

## **Cultural Institutionalism**

In state studies, the cultural institutionalist perspective calls for greater attention to the constitutive role of culture in state formation processes. Broadly, culture is conceived as a “system of meanings and the practices in which they are embedded” (Steinmetz 1999:7). It offers a basis for political and social identity and a framework for interpreting the world and beliefs about reality take on a cognitive as well as affective dimension. In distinguishing between groups and outsiders, moreover, culture defines and organizes action within and between groups. By delimiting the boundaries of “us” and “them,” furthermore, culture offers a source for conflict. Departing from other analytic approaches to institutions that treat culture as a product of the state, advocates of the cultural turn place culture at the center of state analyses (Steinmetz 1999, Ross 1997).

## **Social Categories and Medicalization**

Given the medicalization of ADHD surrounds issues of identity, the cultural approach is particularly useful, as the perspective is highly attentive to the role of identity in political action and struggles over symbolic – and not merely material – control. In what follows, we situate disease categories (and their attached identity) in a cultural context and in the process, speculate on the role of culture in medicalization and the process by which it affects the boundary expansion of ADHD.

As with any bureaucratized identification, the regulation of admission to a social category fundamentally necessitates a process of inclusion and exclusion. Definitions are conditioned by state interest to limit rights of access as designation along such identity criteria not only confers rights and privileges but symbolic meanings (understandings of selfhood) to populations. The benefits and interests are material as well as ideal (Brubaker 1992). That symbolic – and not merely material – benefits are critical to cultural analysis. It points our direction to the cultural context in which medicalization takes place.

As noted earlier, lay activists for ADHD are often parents/advocates and not the diagnosed children. Such an arrangement differs from other identity categories such as citizenship and advocating on their own behalf. What does it mean when one create identity on his/her own behalf? More

importantly here, what does it mean when one advocates on behalf of another? Does it operate more like other identity categories? While ADHD is often advanced by parents and other advocates, we only see a growing trend of sufferers becoming their own advocates with the rise of adult ADHD. This occurred in the 1990s when the diagnostic category expanded to include adult sufferers. Is one approach more effective than the other in expanding medical boundaries?

Identities that have to do with illness also raise issues surrounding both the creation of not only formal and informal identities that may be absent in other kinds of social categories. What particular identities change and for whom do identities change? In the case of hyperactivity, it is not just the sufferer who takes on a new identity but the caretaker (parents, and particularly mothers of ADHD children). Why do people elect to take on those identities if material benefits are modest or costs even great for these identifications in this medical group (taking some mothers out of the labor force to increase time to tend to children's needs)? What then becomes gained and who gains?

Taking such questions into account, we can attempt to speculate on the constitutive role of culture in medicalizing hyperactivity. A study on abortion activists may serve as a useful guide in how these cultural themes affect political outcomes. Luker's research (1984 in Berezin 1997) revealed that women's cultural conceptions of motherhood predicted their position on abortion as well as their degree of activism. Feelings and meanings toward the role of motherhood are cultural, latent, and independent of political exigencies. Certain political concerns (here, abortion), however, have the ability to draw those meanings out and they then potentially become the center of political mobilization.

Extending those findings to the case of ADHD, we see how a similar process might operate. Cultural meanings of motherhood that women hold may play a role in the acceptance and advancement of ADHD. The medical label of hyperactivity minimizes guilt by stressing the organic nature of the problem. In doing so, medicalization displaces responsibility and allows for the control of deviant behavior (Conrad 1975; Pozzi 2000). With medical identities, it is not merely who takes on or is accorded the identity. Not only children, but parents – particularly mothers – also benefit from the social control of hyperactive children. Unwanted behavior is controlled and guilt is reduced with the medical

model's dislocation of responsibility. Through medicaliation, parents can divest themselves of the 'bad parent' label.

The medicalization of ADHD, then, may serve as a response to norms regarding intensive motherhood. In addition, the attribution of human problems to a disease category enables affected parties to take on informal (good parent) as well as formal identity categories (ADHD sufferer). Here, we cannot understand the desire for inclusion in this category as simply rights of access to state resources. Symbolic benefits are also to be gained by a medical conceptualization of behavioral problems and they include less social stigma (Conrad 1975:18) for both the hyperactive child and the parent as well as reduced parental guilt. The biomedical model shifts moral responsibility to other arenas and displaces blame from the parents to an organic etiology. In this way, lay people are also contributors to their own medicalization, but along an individual rather than collective level.

## **Conclusion**

In the last four decades, ADHD was a medical category that did not exist previously. The analysis herein suggests that the rise in the medical designation of ADHD is more the product of effective social organization, alliances, political strategy, and power than the progress of medicine. The expansion of ADHD followed a distinct political path and was driven by a particular set of institutions – despite its medical conception. In the case of ADHD, the medical profession, when they did play a role, transferred their responsibility to other health and non-health related agencies to conduct the diagnoses such as schools. In addition, for adult ADHD, it is not uncommon for adults to self diagnose. Such displacement of diagnosis raises issues regarding medical jurisdiction. When left outside the hands of the medical profession, how much room is there for continued growth of disease categories? What does it mean to have non-medical personnel diagnose illness? In this way, there is an expansive character to medical practice's identity categorization. Further, medicine's jurisdictional boundaries have an interest in an expansive definition of disease, and hence have been inclusive rather than exclusive (Schneider and Conrad 1980).

The application of an historical institutional and cultural institutional perspectives to understanding of the emergence of ADHD as a disease category brings into relief the confluence of events and institutions, the convergence of interests, and cultural context that together create a climate receptive to the medicalization of everyday life. It also reveals a kind of elasticity characterizing medicalization and how these indeterminate boundaries are inscribed but are continually redrawn by interested parties.

The analyses herein show that together, the perspectives help us to find patterns in the ways in which the state and society interact, the institutional arrangements that influence and respond to structural and cultural forces that aim to shape political outcomes. Each approach also looks at the issue at different levels – from above and below – one complementing the other. Grounded in history and sensitized to the institutional context, historical institutionalism persuasively demonstrated its utility in comparative historical analyses. However, key insights could not have been gleaned without also taking into account the cultural institutionalist perspective that shed light on the cultural context potentially driving the rise in the medicalization of ADHD from below. In tandem, the two institutionalist perspectives offer a fuller understanding and analysis of the rise in the medicalization of ADHD.

While a historical institutional approach offered a more complex understanding of the relational configuration at various historical moments and demonstrated how the state plays an active role in promoting medicalization of behavioral problems, not only by its intervention in schools but its funding for research into psychostimulants. The approach also proved to be useful in directing attention to the actors involved in the contestation of medical control over populations, the capacities accorded to institutions to enact their preferences/interests, it is limited in its ability to explain why groups would seek medical labels when there are no real benefits. It suffers somewhat from phenomena surrounding identity formation. With the cultural institutionalist perspective, we see that medicalization preventing another personal identity label (bad parent). In this way, we also see that not all groups are resistant to the diagnosis – some contribute to their own rise. Social control is may be co-opted from below in this way. A focus on culture, moreover, may also draw our attention to the potential social problem in the system

and in that way contributes a different understanding of the way in which identity shapes and is used to propel the ADHD movement forward. The cultural institutional perspective also demonstrated how the role of exclusion plays out more at the individual level. In the end, achieving a fuller analysis relies on drawing on both analytic approaches in historical studies.

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