"Blurting out" to "Blending in":

An Inquiry into the Presence and Positioning of the Child's Voice within ADHD Assessments from an Actor-Network Perspective

by

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Declaration

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Abstract

Twenty five years ago, the 'voice' of the child emerged within a key piece of legislation (UNREC, 1999) alongside moves to re-position the child as social actor by the 'new' Sociology of Childhood. Adopting a methodological framework, Actor-Network Theory, that allows for the inclusion of non-human actants and can also capture the process of becoming an ADHD child, this thesis looks at how far the child's voice has been translated into the practice of the professionals who are mobilised in relation to the diagnosis of Childhood Attention Deficit Hyperactivity Disorder (ADHD), a condition which is claimed to be one of the most common mental disorders among children in Great Britain (Green et al, 2004).

Drawing on the analysis of qualitative interviews with twenty-two professionals working with childhood ADHD in one geographical area, as well as thirteen documents, I argue that the inclusion of ‘the child’s voice’ is not routine in professional practice in the case of ADHD diagnosis processes because what the child says and how they say it is highly entwined with that process of diagnosis and response. As the child becomes identified as problematic, the child's utterances are treated as vocalisations rather than voice. This is further compounded by the referral route to, and assessment by, CAMHS or Paediatrics, the child enters one of two different assemblages with different possibilities for status, actorship and voice. The diagnosis and interventions added further layers to the presence and positioning of the child's voice.

I argue that if, and how, the child's voice emerges in an assemblage depends upon a number of factors, including the positioning of the child, professional values, organisational practices, and the artefacts present. Artefacts, such as questionnaires or medication, extend opportunities for voice for some children, while muting others. Therefore, the findings also highlight a number of complexities of voice, particularly when the decisions are not of the child's making. The child's voice emerges as a controversial topic, part of the performance of the network appears to be to translate the vocalisations of the child into more adult controlled and legitimated speech or silences. I conclude that controversies and complexities need to be more openly discussed to create the conditions under which it is possible for the child's voice to be translated from policy into professional practice.
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Chapter One
Introduction

1.1. Overview
This introduction will provide a broad overview of the study with an explanation of why the research was undertaken. It will describe the reasoning for the focus upon the voice of the child within one area of professional practice, Attention Deficit Hyperactivity Disorder. It will show how the voice of the child has emerged within public policy and the academic context, further evidencing the pertinence of exploring the concept of the child's voice within professional practice. An explanation of why Attention Deficit Hyperactivity Disorder was chosen will then be presented, leading on to how Actor Network Theory as a guiding methodological framework was adopted. Both of these decisions influenced the shape of the study, but the other factors that also had an impact upon the research design will also be introduced as will the development of the research questions. An outline of each of the chapters including the key findings and arguments will also be presented.

1.2. Setting the Scene
As a social worker, who had worked in a variety of settings with children and their families, and having previously undertaken research within the realm of the Sociology of Childhood, I was keen to explore how the oft cited 'voice' of the child (within both academic literature and public policy) was being translated into localised professional practice. In particular, having a professional interest in children's mental health, I was curious about the presence and positioning of children within such services and whether their views were being sought.

Having worked with 'Looked After' children within a Local Authority, I had observed a growing inclusion of the views of children not living with their birth parents within 'Looked After Child' review meetings and related documentation. As such, I began to wonder if there had been similar moves for children who lived within their birth families and particularly those who came into contact with other professions.

A research report, much publicised in the media, had attracted my attention as it claimed that a national study had found ‘1 in 10’ children aged between five and sixteen had a clinical ‘mental disorder’ (Green et al, 2005). The three main ‘mental disorders’ were described as emotional (for example anxiety and depression), hyperkinetic (including ‘Attention Deficit Hyperactivity Disorder’, commonly referred to as ADHD).
Hyperactivity Disorder’) and conduct disorder (for example Oppositional Defiant Disorder). This piece of research suggested that a growing number of children were experiencing mental health issues and as such, would come into contact with mental health services. Therefore, if and how children were being included in decisions about their welfare within these services developed into a research interest.

At the same time, the National Services Framework for Children, Young People and Maternity Services (DfES and DoH, 2004) was published. In section nine, entitled ‘The Mental Health and Psychological Well-being of Children and Young People’, (DfES and DoH, 2004) a four tiered system was depicted that encompassed all professionals who worked with children. It outlined that all universal services, for example schools and health visiting, should be considered as Tier 1 of Children’s Mental Health Services, with specific mental health provision now referred to as ‘Specialist CAMHS’ providing services within Tiers 2, 3 and 4. Therefore, working with children deemed to have mental health issues would become the responsibility and touch the working lives of many professionals as they became formally encompassed within a mental health service. Therefore, I became curious about how these professionals 'knitted' together around the growing number of children managing a mental health condition and in particular, how the child's own views, or 'voice', were being incorporated.

1.3. Academic and Policy Context
Over the last twenty-five years there have been increasing calls for the voice of the child to be recognised, which has been reflected within UK public policy. For example, the United Nations Convention of the Rights of the Child (United Nations, 1990) is often claimed to be one of the first key documents to formally outline the children’s ‘right’ to participation, and it was ratified in the UK in December 1991. The document covered three wide areas – protection, provision and participation ‘rights’ (Franklin, 2002) and in particular, articles 12 and 13 recommended the inclusion of children’s views within discussions about their welfare (although maturity and age must be considered).

The 1989 Children Act (England and Wales) (DoH, 1991) is also cited as a key piece of legislation that first introduced a consideration of the views of the child. For example, Komulainen (2007) stated that "the Act required that important decisions to be made about the children concerned, for example by courts, would need to take into account ‘the
ascertainable wishes and feelings of the child concerned’, considered in the light of his/her age and understanding" (Komulainen, 2007:11). Within the arena of health, section nine of the National Services Framework for Children, Young People and Maternity Services (DfES and DoH, 2004) entitled ‘The Mental Health and Psychological Well-being of Children and Young People’, also advised professionals to “adopt a systematic approach which enables children and young people to contribute to discussions about their needs, care or treatment...and express their views” (DoH/DfES, 2004:91). Therefore, at a policy level there was a drive to recognise the views of the child in decisions about their welfare, but with certain factors to be considered, for example the child's age and understanding.

In parallel, the 1990's witnessed an emergence of the 'new' sociology of childhood (James and Prout, 1997). In summary, the approach re-positioned the child as a competent social actor with calls for their views to be respected and consulted. Ideas were developed which challenged the more traditional notions of the 'child' within developmental theories, with a change in emphasis to consider children as 'beings' rather than 'becomings' (Qvortrup, 1994). As a result, Graham and Fitzgerald (2010) concluded that "a substantial body of research has focused on the importance of affording children the rightful and legitimate claim to ‘have a say’ and for adults to ‘listen to the voices of children’ in relation to the decisions and activities that influence their lives" (2010:345).

More recently, the concept of 'voice' has attracted more critical sociological attention. Important questions have been raised, for example, about its relation to competence, reflection of diversity and translation into the everyday worlds of children's lives and professional practice (Spyrou, 2011; Komulainen, 2007). It has been suggested that the ways in which voice is played out, and the ambiguities that emerge, may be indicative of adult-child relations in general, particularly in adult institutions (Lee, 1999). Therefore, how the child's voice is being understood, managed and circulated has emerged as a pertinent sociological question.

1.4. Selecting ADHD

As I reviewed the literature on children's mental health, I realised that it would be beneficial to focus on one specific condition. Attention Deficit Hyperactivity Disorder was selected because, at the time, it was claimed to be one of the three most common 'mental disorders' in childhood (Green et al, 2005). I was also particularly interested in the middle childhood years
as there had been limited research on this age group. Attention Deficit Hyperactivity Disorder was claimed to emerge in the primary school years and on a personal note, I has also found that the condition was ever present in whichever service I had worked, for example within the Early Years Service, within the Fostering Service and within a Women's Refuge. I was intrigued to find out more about a mental health issue that appeared to touch the lives of so many children and professionals in such a variety of domains.

Attention Deficit Hyperactivity Disorder\(^1\) is associated with three key symptoms, hyperactivity, impulsivity and inattention, although "the particular behaviours that typify inattention, hyperactivity and impulsivity are very much influenced by the patient's age and developmental level" (First et al, 2007:380). The criteria for diagnosis are described within the American Diagnostics and Statistical Manual (American Psychiatric Association, 1994) and for the more severe Hyperkinetic Disorder, the International Statistical Classification of Diseases and Related Health Problems (World Health Organisation, 1990). To be diagnosed with the condition, the DSM-IV-TR (APA, 2000) stipulates that the symptoms must be evidenced for longer than six months, some should have begun before the child was seven years of age and the behaviours should be evident in at least two settings.

As well as personal motivations to study ADHD, there were also a number of other factors that suggested it would provide a useful and illuminating example of professional practice. Not only does it touch the working lives of professionals from many disciplines but professional health guidelines for its assessment, diagnosis and management have been established (see NICE, 2008). It is played out in a multitude of childhood spaces, including the home, classroom, media as well as health centres and as such, signifies a child and state encounter through which children are assessed and diagnosed. Yet, it is recognised as a contested condition, it "has been the subject of considerable controversy" (First et al, 2007:380). Indeed, there have been questions raised about its reality, its validity as a discrete mental health category, and around causation and treatment. It has been researched in a number of arena's including medicine, psychology, education and of course, sociology, with each developing their own theories and approaches to the condition.

\(^1\) For ease of presentation, ADHD will be used to refer to Attention Deficit Hyperactivity Disorder. It is acknowledged that there have been academic and professional discussions regarding whether ADHD and Attention Deficit Disorder (ADD) are the same or different conditions. An exploration of this aspect of the condition was deemed beyond the scope of the current study and as such, ADHD, as defined by the participants and documents within the study, shall be the term used.
In reviewing a selection of what had already been researched and written about 'ADHD', I concluded that within such controversy and contesting, the focus upon the child often becomes lost. A few studies had sought to explore the views of children themselves (see Singh, 2013), but whilst these often concluded with an assertion of the value of seeking the views of the child, they left a question of whether this was actually happening within professional practice. There appeared to be limited research upon professional perspectives in the UK, and certainly even fewer studies that had taken a multi-disciplinary approach.

Therefore, I began to consider the process of the assessment and diagnosis of ADHD as an example of both adult-child relations and mental health practice. I wondered what statuses were afforded to the child within this process, how children were being positioned, and more specifically whether there were possibilities for the child's voice to be included in discussions about their welfare.

1.5. Using Actor-Network Theory

In developing my ideas for the study, I became aware that much sociology of childhood research had focused on a Social Construction perspective. Yet, I needed an approach that in light of the medical theories proposed for ADHD as well as the use of medication as an intervention enabled me to embrace the biological as well as the social, childhood as a hybridity (Prout, 2005). A review of ADHD research across disciplines had indicated the broad range of factors that had previously been associated with ADHD, so I needed a perspective that could take these into account as well as allowing me to respect the multi-professional nature of assessment and diagnosis. A framework that enabled a conceptualisation of 'voice' as relational and fluid rather than as static and 'within child' was also important, similar to Middleton and Brown's study (2002) that found there was a process of scaling of the baby's agency on a Neonatal Care Unit.

As such, I explored the value of using principles and ideas from Actor-Network Theory to guide my research. The approach has been used not only to study organisational practices (Singleton and Michael, 1993), but also other health conditions (Mol and Berg, 1994). A few researchers had specifically applied the approach empirically to the field of childhood, for example exploring the use of an asthma inhaler (Prout et al, 1999) or studying the child in hospital (Place, 2000). In reviewing the literature on the approach, I felt that certain aspects
would be of particular value to the study, including a consideration of human and non-human actants, how the services (the network) were being performed, as well as a flattening of the terrain, so that the global (for example policies) could be explored in local professional practice. Certain notions within the approach also seemed to sit neatly with a study of both ADHD and ‘voice’, which would enable further exploration of the network, including identities, dichotomies and subjectivities. The literature on ADHD was indicating the presence and significance of certain artefacts, so I also became attuned to how certain objects may also contribute to the network and may have implications for the positioning and opportunities for the child’s ‘voice’.

1.6. Developing the Research Questions

My original research intention had been to gather the views of children on the mental health services they accessed, an evaluative study, to be guided by a social constructionist and grounded theory approach. As I developed the study, in both selecting ADHD as an example and exploring the child’s ‘voice’ within sociological literature, I began to consider what was actually meant by the ‘child’s voice’, both within policy and professional practice. I started to wonder if and how such policies concerning children's views were being understood and translated into services, particularly with the current emphasis on inter-agency working. Graham and Fitzgerald (2010) argued that "at the heart of this debate is whether the progress made in promoting the case for children’s participation has been matched by evidence of change for children in their everyday lives" (2010:345). As such, I wondered if there was evidence of children's participation within the work of the professionals who made up the mental health services.

As I developed my conceptual and theoretical positioning with Actor-Network Theory, ADHD and ‘voice’, research questions began to develop about how the organisation of the assessment and diagnosis of childhood ADHD was being enacted or performed; who or what were the ‘key players’ or actants? In particular, were children ‘key players’, and did the organisation of the network have an impact on the ways in which the child's voice emerged? I also wondered whether there were shared meanings of the ‘child’, ‘ADHD’ child and ‘voice’ among the professionals who contributed to the services and the implications upon the involvement of children with information sharing and decision making. Thus, a key research question was how was the ‘child’ present, absent or represented within the network?
Due to the multi-professional nature of the study, I had to apply for ethical agreement to conduct the study from a number of Ethics Committees. In order to get the study underway, I made the pragmatic decision to apply in two stages, so the first round of applications related the recruitment of professionals working in Health, Education and Social Care. I had decided that semi-structured interviews, using professional voices, would enable an exploration of the services, ADHD and the positioning of the child. At that time, my intention was to return to the Ethics Committees with an additional request to be able to involve children and their parents within my research, after I had built the relationships with the professionals I would rely upon to help me access children and their families.

However, the second application to gain ethical approval proved to be a similarly lengthy process as the first and a further hindrance was that one of the Trusts within the research had been re-organised following a tendering process. The new organisation had different staff, expectations and notably, procedures for seeking agreement to undertake research. Within the constraints of the time left available for data collection, a decision was made that to access, recruit, interview, transcribe and analyse the accounts of children and the parents in an effective and valuable way, rather than a tokenistic manner, had become beyond the scope of the study. In addition, at the same time, a large scale study was already being undertaken on the views of children diagnosed with ADHD in the UK and US (Singh, 2013). This research highlighted children's views, and experiences, of living with the condition, but what appeared less clear was whether their views were being heard or recognised in professional practice. There also appeared to be few multi-professional studies within the UK on ADHD practice and this contributed to my decision to focus on professional practice within the study.

In parallel, I had begun to explore and analyse the data from four pilot interviews and the first accounts of professionals within the main study. In 'tracing' the child I was struck by the different nuances of 'voice', and the positioning and statuses of the 'child' and 'child's voice', within professional descriptions of the performance of the network. At the same time academic debate within the sociology of childhood was emerging, as discussed, regarding the concept of the child's voice, and proposing it as a much more ambiguous, complex and multi-layered concept. I began to develop data driven research questions about what constituted the child's voice, and how was the child's 'voice' being understood and 'played out' within professional practice?
Mayall (1994) argued that “the level of powerlessness varies according to how the adults in specific social settings conceptualise children and childhood” (1994:116). I considered in what ways the adult institutions I was accessing positioned children, and the implications for opportunities for the child's voice. Adopting an Actor-Network Theory perspective to guide the study enabled consideration of who or what made up the network around childhood ADHD and within the performance of the network, where was the child and child's voice present, represented and absented. If the child and child's voice were present or represented, in what ways did this occur. In fact, Lee and Motzkau (2011) also recommended using the child's 'voice' as one of the multiplicities of childhood, as a 'navigational aid' to undertake research, which further supported the focus of the study.

In conclusion, a number of research questions were developed including what or who made up the ADHD professional network and how was the network performed; how did a child become an ADHD child? Within this process, in what ways was the child's 'voice' present, represented or absent and how was the child's voice, (and the child) being understood, circulated and managed by the professional network? What factors emerged as important to how the child's voice was positioned and translated within professional practice?

1.7. Outline of the Chapters

The next chapter provides an introduction to the literature and highlights that calls have been made for the views of children to be included within decisions about their welfare both within social policy, and the 'new' sociology of childhood. It will detail some of the research that has been undertaken on the seeking of children's views, and how children have been positioned in general. More recent sociological theorising of the voice of the child which has begun to raise questions about how voice conceptualised will be presented, proposing voice as a relational (Komulainen, 2007), multi-layered, contextualised, concept (Spyrou, 2011). It could be argued that if seeking children's views within professional practice is an easy and simple process, then after twenty five years we would expect research to find that children are routinely being asked their views on matters that affect them.

The second part of the chapter will present the sociological literature and key research findings with regard to Childhood ADHD. It will show how sociological research has illuminated a number of ways in which ADHD has been understood, including historically, neurologically, psychologically, culturally and as a social construction. It will also explore
claims regarding social causes and the potential social dimensions of ADHD. Empirical work on access to services and the use of medication will also be presented. It will outline a policy background, as well as studies that have sought to research children's own views. Of note, it will be shown that there have been few multi-disciplinary studies of professional views and practice within the UK. Similarly, recent studies have emerged that illuminate the child's perspectives on their experiences, but suggest that children's views may not be being sought or recognised within professional practice but to date, no study has gone on to examine the reasons why.

Chapter three describes how adopting an Actor-Network perspective added another layer to the research. The approach allowed a consideration of both human and non-human actants and their role in the presence and positioning of the child's voice. It also neatly fitted alongside an understanding of voice as relational, emerging differently, more fluidly, within different assemblages. The work of a small number of writers and researchers applying the ideas of Actor-Network Theory to ADHD will also be highlighted, but it will be shown that to date there appears to have been no empirical work with human actors, instead the focus has been on broad claims from policy and documentation. It will be argued that understanding ADHD childhood as a hybridity enabled the biological, social, psychological and technological to be considered and how these different aspects potentially interrelated and impacted upon the presence and positioning of the child's voice within the network.

The fourth chapter details how the study was undertaken, and some of the challenges that impacted upon the research design, including seeking ethical agreement. The final sample involved qualitative semi-structured interviews with twenty-two professionals from health, social care, education and the voluntary sector who were working with children aged four to eleven years within two locations in one town, as well as thirteen documents. It will show how findings from a pilot study were also used to develop a description of the network and understand how it was enacted. The chapter will move on to detail how the data was thematically analysed, and then how Callon's (1986) four moments of translation were used to develop an analytic framework; problematisation, interessement, enrolment and mobilisation layered with four processes of the performance of the network:- identification, referral, assessment and the diagnosis (including recommendations for intervention). Developing such a framework not only eased the management and presentation of the
analysis of what emerged as a complex and messy network, but also captured the 'movement' of the child through and around the network.

The first analysis chapter provides an introductory description of the network and actants as well as an identification of the aspects of the network that impacted upon the voices of all actants, for example the physical distance between the actors and settings, the fluidity of the positioning of actants and key dominant ideologies circulating within the network. The next analysis chapter explores how different parts of the child were positioned and made visible as the child became identified as problematic, including the brain, genes, body, mind as well as the child's vocalisations. The analysis of the organisational process of referral is also presented, unpicking how the child's pathway as Simple or Complex ADHD was negotiated (and by whom) and the implications for the child and the child's voice. This will be followed by the analysis of the assessment consultations within CAMHS and Paediatrics in the next chapter, identifying if and how the child's vocalisations and voice were present, represented or absented. The final analysis chapter examines the work of diagnosis and intervention, again considering the impact on the status of the child as well as the presence and positioning of the child's voice.

The Discussion chapter summarises the tracing of the child's voice through the identification, referral, assessment and diagnosis processes for ADHD within the geographical area studied. It evidences that one of the roles of the network was to translate the unapproved vocalisations of the child, in terms of frequency, timing and content, into more socially acceptable, adult approved voices. The findings will show that a number of different actants in the assemblage may interact to contribute to if and how a voice of the child emerges. Different assemblages may produce different voices of the child. These actants included the positioning of the child (which was multi-layered), professionals, parents, organisational practices, artefacts, the child and the context or type of decision or issue. The chapter will close by showing how the research raised a number of complexities and controversies regarding the child's voice in professional practice, which could indicate why it has not been a simple process to include the views of the child within decisions about their welfare in this arena.

The final chapter details some concluding thoughts and remarks about what the study can contribute in terms of sociological theorising (both in terms of childhood and methodology)
as well as professional practice. It will also discuss some of the limitations of the study and recommendations for future research. Whilst recognising the challenges of a small qualitative study, it will be argued that there is a value in the contribution to research on ADHD professional views and contextualised practices; to furthering the understanding of the complexities and layers of the voice of the child as well as to evidencing the use of Actor-Network Theory in researching childhood topics in applied, non-laboratory settings.

1.8. Summary

In summary, in 2015 it will be twenty-five years since the UN Convention of Children's Rights (UNICEF, 1991). The push from the new Sociology of Childhood which emerged in the 1990's too has called for a recognition of the 'voice' of the child and for the child as a competent social actor to be respected. But how successful has the translation been into professional practice, particularly within the field of mental health?

The key intention of the study was to inquire whether calls for the child's voice to be heard and to be included in decisions regarding their welfare were being translated into professional practice. Whilst researchers have focused upon the positioning and participation of the child within other institutions, for example those within schools or the Looked After system, none have specifically considered children who access mental health services. Similarly, within sociological studies of ADHD, few have researched professional practice and perspectives in the UK, with only a handful across multi-disciplines. Therefore, the current study examined and traced the child's voice within a Childhood ADHD professional network, to seek to understand the presence and positioning of the child's voice; where it was present, represented and/or absented. Using an Actor-Network Theory perspective, actants that impacted upon the presence and positioning of the child's voice within the assessment processes were investigated.

It will be argued that translating the voice of the ADHD child into professional practice is complex and multi-faceted. Understanding if and how the child's voice emerges requires contextualisation, recognising how different assemblages produce different possibilities for the child's voice. The role of artefacts and non-human objects within the assemblage must also be addressed. Even those children that share the ADHD assessment and diagnosis process may have differential access to voice, depending upon their age, gender, class, educational ability, as well as the perceived complexity of their condition; whether they are
referred to CAMHS or Paediatrics. Some will carry the association with 'chaotic' families or a mental health identity which may also add another layer to their status and the voice afforded.

Policy change is not enough, and without a more open acknowledgement of these complexities, calls for including the voice or the views of the child may not be realised. The challenge of recognising and hearing the voices of a group of children, particularly those under the age of eleven, whose vocalisations are problematised and used as an indicator of their condition is not denied; the ADHD child exemplifies the tensions in managing the child as speaker within adult-child relations. However, it is argued that this research evidences the need for further debate about the complexities and controversies as well as the possibilities for translating the child's voice into professional practice.
Chapter Two

The Literature Landscape

2.1. Introduction

This chapter provides a presentation of the literature that was reviewed in developing the conceptual framework for the study. In the first instance, it will locate a consideration of the child's voice within the UK policy context and field of sociology. It will show how calling for the views of children to be included within decisions regarding their welfare was first introduced within legislation twenty-five years ago and in parallel, at the same time, a 'new' sociology of childhood was emerging, which sought to re-position children as competent social actors. It will examine how children have been constructed within professional practice and the potential impact that these constructions may have on children speaking for themselves. It will also outline claims about how the voice of the child has been marginalised and detail social research that has explored in what ways children are afforded opportunities for participation. Finally, this section will turn to more recent sociological questioning of the child's voice as a concept and the re-positioning of it as much more relational, contextualised, multi-layered, and potentially ambiguous, thus informing the conceptual framework of the current study.

This will be followed by the justifications for the selection of ‘Attention Deficit Hyperactivity Disorder’ as a focus for the study. It will include a selective summary of previous relevant sociological and empirical studies, including the ways in which ADHD has been framed, for example historically, neurologically, psychologically, culturally and as a social construct. It will also present research that has been undertaken on ADHD services, for example in terms of access, medication and professional views. The policy context in terms of mental health and ADHD with regard to the voice of the child will be detailed, as will studies which have asked children themselves to give their views and experiences of living with ADHD. It will be highlighted that research on professional perspectives and practice, particularly across disciplines, has been limited, especially in the UK. Located within this previous theorising, the current research intends to offer another piece of the jigsaw in understanding ADHD in childhood, and in this case, the presence and positioning of the child’s voice within professional practice.

It will be highlighted that within the research, Childhood ADHD is interpreted as a social category that a large number of children share. These children will have lived the experience
of being assessed and diagnosed as ADHD. The 'ADHD Child' is thus a way of being. The current study will not seek to address the reality or causations of ADHD, instead the perspectives of those in the ADHD assessment assemblage will be presented. The chapter will close with, in light of the literature landscape, a reflection upon the development and synthesising of the research questions.

2.2. The Voice of the Child
Twenty-five years ago, two pieces of legislation emerged that have been credited with raising the profile in the UK of the views of children within decisions about their welfare. Despite criticisms, the United Nation's Convention on the Rights of the Child (UNICEF, 1991) and the 1989 Children Act (England and Wales) (DoH, 1991) evidenced a key political and theoretical shift in the way that children should be positioned within public institutions. At the same time, a 'new' sociology of childhood was being promoted that positioned the child as a competent social actor, placing the 'voice' of the child firmly on the agenda, and which has continued to be researched within a variety of contexts and settings.

It will be shown how the recognition of the child's voice emerged in UK social policy as well as the different ways in which the child's voice has been managed in the sociological arena. The ways in which the child has been re-positioned sociologically as well as constructions of the child will be discussed and then the ways in which children's voices have been managed and researched within the field. Finally, following a consideration of the more recent theorising about the voice of the child, the conceptualisation of the child's voice for the current study will be presented.

2.2.1. Policy and Voice
Daniel and Ivatts (1998) argued that legislation can provide a "subtle barometer of the status of children" (1998:196) and that as such, "children's lives are to a considerable extent shaped by public policy" (1998:1). Therefore, as noted in the introduction, the United Nations Convention on the Right's of the Child which was ratified in the UK in 1991 is often cited as a clear marker of the start of a change in the status of the child in UK social policy. Devine (2002) noted that it was Articles 12 and 13 in particular that promoted the rights of children "to be consulted on matters affecting them" (Devine, 2002:305). Lee and Motzkau (2011) suggested that "along with rights to provision and protection designed to foster children's flourishing, the UNCRC recognized a 'voice' for children, held independently of the states,
families and communities around them” (Lee and Motzkau, 2011:10). The rhetoric of the voice of the child began to emerge politically.

However, the Convention has not been accepted without criticism. It has been argued that it is ethnocentric (Pupavac, 2001) and ignores the ‘needs’ of specific groups of children. Freeman (2000) claimed that it does not prioritise the interests of children enough, that their interests should be the (rather than a) paramount consideration. In fact, Franklin (2002) has argued that instead the Human Rights Act (1998) may offer children an alternative avenue within English domestic law, for challenging public bodies who are believed not to be upholding their human rights. Wyness (2009:536) argued that "the very existence of a separate legal framework of human rights for children that sits alongside recent general human rights legislation, such as the 1998 Human Rights Act and the European Convention on Human Rights (ECHR), reinforces children’s homogeneity and separateness from others" (Wyness, 2009:536).

Lee (1999) too identified an ambiguity within the UN Convention, in particular within Article 12 which promotes children expressing their own views on issues that affect them, but only according to their age and maturity. He argued that legislation must account for both the general and the particular, children as a social group as well as the individual child within institutions, and therefore the idea of age and maturity retains an ambivalence about children's self-representation, left to be interpreted variably in different contexts. He suggested that the wording allowed for what he terms the 'burden' of ambiguity to be deferred or passed on, perhaps to those delivering services.

In 1989, the Children Act (England and Wales) (DoH, 1991) was introduced which defined the categories of a child in need and a child at risk. Moran-Ellis (2010) argued that the Act "introduced a more comprehensive legislative recognition of three things which can be associated with seeing the child as an individual agent: a right to be legally represented (separately from parents or the state) in proceedings affecting the child, a right to be consulted about decisions which directly affect the child and a complaints procedure" (Moran-Ellis, 2010: 191). However, Franklin (1999) has argued that although the 1989 Children Act (England and Wales) was hailed the 'children's charter', it was more about reassuring the media and the public of the role of the state within families than championing children's rights.
Further drives appeared within UK policy that claimed to be promoting children’s participation within the services that affected them. For example, within the field of Social Care in England, the Government introduced a ‘Quality Protects’ Programme in 1998, with the intention to improve social service delivery and management for children. As part of this programme, objective eight sought “to actively involve users and carers in planning services and in tailoring individual packages of care”. Therefore the emphasis was upon including children (as users), but notably also parents, in decisions about the child's welfare as well as in evaluating services in general.

In 2003, the New Labour Government introduced a Green Paper entitled ‘Every Child Matters’ (DfES, 2003a) following Lord Laming’s Inquiry into the death of Victoria Climbié (Laming, 2003) and the Government report ‘Keeping Children Safe: The Government’s response to the Victoria Climbié Inquiry Report and Joint Chief Inspector’s Report Safeguarding Children’ (DfES, 2003). This Green Paper outlined a set of five key outcomes for all children within the United Kingdom: being healthy, staying safe, enjoying and achieving, making a positive contribution and economic well-being. These outcomes were claimed to have been developed in consultation with children. However, again this piece of legislation has been critiqued. Williams (2004) argued that the Green Paper actually portrayed children as ‘future-citizen-workers’ which may actually enhance services for children but focuses on them as an investment rather than as citizens in the present and in their own right.

Following a period of consultation, ‘Every Child Matters-Next Steps’ (DfES, 2004) was published which coincided with the introduction of the Children Bill within Parliament. One of the key aspects of the Bill was to propose the introduction of the Children’s Commissioner, so children’s "views and interests are at the heart of policy making and national debate”, as stated by Margaret Hodge, the then Minister for Children, Young People and Families within the foreword of the updated Green Paper (DfES, 2004). The Bill was intended to build upon the recommendations of the 1989 Children Act which stated that the wishes of children perceived to be within the categories of ‘in need’ or ‘at risk’ should be ascertained in matters that concern them dependent upon their ‘age’ and ‘understanding’ and in turn, it became the 2004 Children Act (DfES, 2004). Despite great debate within parliament regarding the role of the Children’s Commissioner, the decision was made to
omit the word ‘rights’ from the legislation, as Moran-Ellis (2010) argued "this post has a focus on listening to children and young people, but does not have a focus on children’s rights" (Moran-Ellis, 2010:199). Despite criticisms and certain ambiguities (for example in terms of age, understanding and maturity), the legislative developments described, raised the profile of the voice of the child and introduced the seeking of children's views about issues that affect them to the political agenda

2.2.2. The Sociology of Childhood

"In the two decades following adoption of the most ratified international legal instrument, a wealth of literature has been produced on child participation" (Stoecklin, 2012:443). Moran-Ellis (2010) too, has provided a concise overview of the developments of the sociology of childhood which took place within the same time frames as developments and political debate within the UK.

Of note, since the early 1990's, contributors to what has been termed the ‘new’ sociology of childhood (James and Prout, 1997) have asserted that children should be considered competent social actors both within the field of research and in their everyday lives. For example, Hutchby and Moran-Ellis (1998) argued that the social competence and agency of the child in their own worlds should be recognised. These moves have led to calls for a change in the status or social position of children, from what is often perceived to be a marginalised group (Cockburn, 1998), and for children’s perspective to be given greater sociological attention.

Key assumptions that have been challenged are those within developmental models that present children as ‘human becomings’ rather than human beings (Qvortrup, 1994) and those that seek children’s views in tokenistic ways. Similarly, it has been argued that children should not be considered a homogenous group but that the diversity of childhoods should be reflected within research (Qvortrup, 1994). For example, Cocks (2000) in terms of her research with children with disabilities has identified "how the experience of childhood for disabled children differs from that of mainstream children" (Cocks, 2000: 509)

In the years that have followed, 'voice' has been approached in a number of ways by sociological researchers, including studies to understand children's worlds in their own words. Relevant to the current study, research has been undertaken to explore how the child
is currently constructed in society and the impact that this has on the opportunities for the child's 'voice' to be afforded. Others have undertaken empirical research to explore whether the voice of the child is being included within decisions about the child's welfare within specific adult institutions as shall be shown and as a result have proposed models or ways of understanding participation. It has been concluded that some children in certain contexts are more likely to be consulted and positioned as a social actors who can represent their own views, for example 'Looked After Children' or those over a certain age. More recently, the very concept of voice has been questioned, explored and critiqued.

2.2.3. Constructions of the Child

A number of studies have focused on how the ‘child’ has been constructed and the implications for voice in their everyday lives. It has been suggested that children are often constructed as villains or victims (Hendricks, 1994; Franklin, 2002; Dingwall et al, 1983) which will impact upon the ‘rights’ (including to voice) that are afforded them (Franklin, 2002). As ‘villains’, children are perceived not to deserve certain rights and as ‘victims’ they are perceived not to be able to manage them.

Stasiulis (2002) highlighted potential conflicts between a model of ‘active citizenry’ which is often associated with the UN Convention on the Rights of the Child and what are described as ‘western notions of childhood’ (Stasiulis, 2002:507) which may include ideas about innocence, vulnerability, passivity and incompetence. This has been highlighted by Aubrey and Dahl (2006) in a study of the views of children who had been defined as ‘vulnerable’ by service providers, which found that “there was not much evidence of vulnerable children having an influence on the decisions being made by external agencies about them” (Aubrey and Dahl, 2006:35). Similarly, constructions concerning children as an investment focused on their position as rights-holders of the future rather than in the present (Scott, 2002). Lister (2003) argued that representations of the ‘citizen-child’ are rare. This illustrated the idea that how the child is constructed within different spheres, for example policy documents or professional practice, may have an impact on the possibilities for voice.

Mayall (1994) has argued that “the level of powerlessness varies according to how the adults in specific social settings conceptualise children and childhood” (Mayall, 1994:116). Lee (1999) too claimed that dominant frameworks of childhood exist, particularly when adults are positioned as the experts within institutions, which may lead children to be viewed in
stereotypical ways. For instance, Moss et al (2000) explored the construction of the ‘child in need’ in nursery education and found that the category is “produced by a particular discourse of childhood” (Moss et al, 2000: 248) which led to children’s competencies being overlooked. In contrast, they provided an example of a town in Italy where children were constructed as powerful, competent, social beings who benefited from a number of social relationships and where children were constructed as ‘rich’ (for example in terms of potential or experience) rather than ‘in need’. Therefore, how children as a social group are positioned within mental health, and specifically ADHD, practices may have implications for if and how the child accessing those services is afforded voice.

Molloy and Vassil (2002) studied the social construction of Asperger Syndrome which they claimed was being interpreted as a disability and they highlighted that how the syndrome was defined and classified had consequences for how the children were interacted with and their behaviour managed. If a child’s obsession was interpreted in a positive way and their interest enabled to develop, the child may be perceived as an ‘expert’. However, for another child such an obsession could be interpreted as problematic. They argued that the reason that Asperger Syndrome has been classified in the way in which it has, is because of the value of the classification within ‘special education’ services which have a reliance upon a medical model. Therefore, the perceived ‘value’ of the child may have an impact upon their status and the significance or weight attributed to their views.

They suggested that the main approach has been to attempt to ‘normalise’ the behaviour of children classified with Asperger Syndrome to make them fit current interpretations of what it is to be a ‘normal child’, without any questioning of current constructions of ‘normal’ or the ‘child’ or re-framing such children or their behaviours more positively. They stated that for most children, formal identification of the ‘Syndrome’ occurs when they first enter the education system, when the issues are individualised, perceived to be within the child, rather than within any social structures or institutions, or current constructions of the ‘school child’. The findings of this study may provide some interesting parallels with the current research on the positioning of the child with ADHD.

White (2002) too, undertook an ethnographic study of children’s health settings including a child and adolescent mental health service to explore inter-professional discussions about how a ‘case’ was established. The study researched how cases were shared between
professionals, whether causes were attributed to biology or the environment and the implications for the child. It is suggested that during professional discussion and interaction, certain interpretations of the ‘case’ were closed down, so that a preferred interpretation was established. It was found that a number of dichotomies were in existence including good/bad parent and good/bad patient depending upon normative expectations of behaviour, although they could interrelate, for example a ‘bad parent’ could become a ‘good patient’ if willing to accept expert advice. Children were often exempt from the ‘bad patient’ category if their behaviour could be attributed to an ‘embodied’ illness (autism was offered as an example), or to their parents/carers behaviour or other ‘social’ factors within their life history.

2.2.4. Marginalising the child’s voice
Within the emergence of the new sociology of childhood, it was argued that children could be constructed as a marginalised social group (Cockburn, 1998; Qvortrup, 1994) and therefore, Mayall (2002) suggested that although children may have been re-framed as social actors with agency within particular sociological and policy arenas, the lived experience of childhood was still very different. In certain institutions, for example education or welfare systems, professionals such as teachers or doctors may continue to retain control and influence over children’s lives. For example, Kelly (2005) in a study of learning disabled children’s experiences and perceptions of their impairment and disability found that adults often did not take account of children’s views. Runeson et al (2002) in an observation of twenty-four children’s participation in decision making while they were hospitalized, evidenced that children were informed, but alternative interventions were rarely discussed with them and children’s own perspectives were not often sought.

Some studies have previously explored what has prevented the translation of calls for voice into specific areas of professional practices. For example, Roche (1999) in exploring the positioning of children studied the experiences of young carers to show how “children are often rendered silent and invisible by the attitudes and practices of adult society” (Roche, 1999:476). He argued that despite the role they play within their families and the responsibilities that they undertake, their views, needs and interests in their own words were often overlooked by professionals. He argued that “the combined effect of the problematising discourses surrounding children..., ‘adultism’, and the relative powerlessness of children is to marginalise their views and perspectives” ( Roche, 1999:479).
Buetow (2005) too provided an analysis of the individual and group decision making processes in seeking access to health care with or on behalf of children. It raised the issue of who are the important actors in seeking health care, for example parents/carers, siblings, professionals, friends, extended family members or the child themselves. He suggested that the amount of involvement of children depended upon perceived competence, permission from others (as well as whether children accept, negotiate or reject this) and the necessity of the situation. It was highlighted that children rarely have the opportunity to access health services independently but that their voices should be heard because their views “cannot be assumed to be the same as those brought to decision-making by other parties” (Buetow, 2005:114).

Within both of these examples, the complexities of adult-child relationships were accentuated, which may be particularly complex when children’s and adult’s opinions conflict (Frones, 1994). Another factor that could complicate children’s voices within services could be whether children are able to hold other actors, who often represent them, to account. Prout et al (2006) argued that “most opportunities for children to participate are created by adults or at best, alliances of children and sympathetic adults” (Prout et al, 2006:91). Pupavac (2001) has highlighted that children are rarely 'rights holders’, but instead ‘rights recipients’ requiring others, for example a parent or professional, to advocate for them but having no means for ensuring that they do so. Indeed, Prout et al (2006) ironically noted that “children’s rights may increase children’s dependency on adults since it is adults who have to take responsibility for respecting those protection, provision and participation rights” (Prout et al, 2006:211).

**2.2.5. Contexts and Conditions for Voice**

Some studies appear to have identified that opportunities for voice may vary depending upon the particular decisions to be made. These studies provide more positive indications that the views of some children within specific situations are being consulted. For example, Franklin and Sloper (2006) in a study of the involvement of disabled children within decision-making about their own care and about service development, found that children and young people were most likely to be included in reviews of their care, but less likely to be involved in Child Protection Conferences or in developing their own health care plans. Thomas and O’Kane (1999) too explored the involvement of 47 children aged between eight and twelve years who were ‘Looked After’ by Local Authorities and found evidence of the inclusion of children’s
perspectives in planning and review meetings. Therefore, previous research would indicate that the decision in question may have an influence on if and how children are afforded voice.

Ruddick (2007) argued that "the child cannot speak for him or herself without adult authorization" (Ruddick 2007:554) and that therefore, children are given voice but only in certain 'safe' contexts, for example "in designing their own leisure spaces, parks and playgrounds, spaces where their voice is not complicated by its relationship to 'others'" (Ruddick, 2007: 515). In studying the 'voice' of the foetus and the voice of the child in custody cases, she argued that the foetus is often positioned as having free will and being independent, achieved through technologies such as the ultrasound. In contrast, the voice of the child in court decisions about custody is frequently questioned, and even attributed to a disorder 'parental alienation syndrome', so that children are not positioned as knowing their own feelings and wishes. Thus adults must interpret their feelings and wishes for them. Ruddick argued that there is a "selective presencing and absencing of the child's voice" (Ruddick, 2007:523). It is interesting that in these examples, the technology in the assemblage contributed to the perceived agency and voice of the foetus, whereas a 'disorder' in the assemblage contributed to the discrediting of the voice of the child.

Alternatively, other sociological research regarding children’s voices within various children’s services (Health, Education and Social Services) has found an increase in children’s participation for particular groups of children (Mayall, 2006), usually older children and those deemed 'competent'. For example, Aubrey and Dahl (2006) argued that a key factor used by professionals when considering children’s involvement in decision making was the child’s chronological age, they suggested that older children were more likely to have their views sought about services that they receive. Franklin and Sloper (2006) too found that children over the age of eleven were also much more likely to be involved in decision-making processes. They argued “further research is needed to examine why disabled younger children are less likely to be taking part in decision-making” (Franklin and Sloper, 2006:736). However, Smith et al (2003) in a study of the involvement of children in decisions following their parents’ separation, argued that ‘age’ should not be considered as a ‘barrier’ to participation if adults create a supportive environment.

Alderson (1993) in a study of children’s consent to surgical treatment found that perceptions of children’s competence were associated with perceived experience and the context of the
decision as well as children’s chronological age. Thomas and O’Kane (1999) too found that some children were more likely to be involved than others, with discourses around ‘competency’ often prevalent. They suggested “adults’ perceptions of children’s competence seem to be of critical importance” (1999:375). Franklin (2002) has argued that in main, it is children’s ‘welfare rights’ that are focused upon rather than their participation or ‘liberty’ rights because of the reliance upon perceived ‘competency’ as a measure of the legitimacy to access ‘liberty’ rights.

Pupavac (2001) argued that groups who are constructed as less competent face many challenges in trying to ‘prove’ their competency to those who have the authority to decide which views or claims to focus upon. Fundudis (2003) has suggested that age, cognitive functioning, emotional maturity (including attachments, educational achievement, mood stability and mental state) and socio-cultural factors (including family, religious and cultural beliefs and values) have all been used to assess the ‘capacity’ of the child.

Others have explored how participation itself has been interpreted within professional practice which may impact upon children’s opportunities to be involved in decision making. Murray and Hallett (2000) argued that “the expectations of participation are often multiple, uncertain and variously defined by those in different roles” (Murray and Hallett, 2003:14). Kjorholt (2002) in a Norwegian study of children’s participation found that some of the reasons for involving children were to socialise or teach them, to ensure ‘healthy’ responsible citizens of the future, to ‘enrol’ them in particular ways of thinking (or example caring about the environment), to maintain a sense of ‘community’ and to use them as a resource. Kjorholt (2002) argued that there may be “different constructions of children embedded in these discourses on ‘children and participation’” (Kjorholt, 2002:64). Few of the respondents talked about ‘children’ within a ‘rights’ framework.

Thomas and O’Kane (1999) following their study of the participation of children who are ‘Looked After’ found that “there were several problems and dilemma’s associated with children’s participation” (Thomas and O’Kane, 1999:370). They developed a typology of adult approaches to children’s participation which included the ‘clinical’ (focusing on children’s vulnerability and capacity), the ‘bureaucratic’ (which could either be that the adults believed that organisational procedures or practices prevented the inclusion of children’s perspectives or alternatively, that new requirements emphasised the necessity of
including children’s views), the ‘value-based’ (adults who spoke favourably about children’s participation in itself) and the ‘cynical’ (adults who positioned children in more negative ways within decision-making).

Prout et al (2006) argued that there were four different factors that ensure children’s participation- their motivation to participate, resources, mobilisation (which includes opportunities to participate) and dynamics (for example organisational practices). They suggested that “lack of opportunity to participate is important for children as a group (despite all the differences between children as a group) as well as children as individuals” (Prout et al, 2006:91).

2.2.6. Problematising Participation and Voice

Some sociological research has sought to explore participation as a concept, and as such identified a number of layers. For example, there are those who have represented participation hierarchically from ‘consultation’ through to ‘full’ participation, for example Arnstein (1969) and Hart (1992). Alternatively, Kirby et al. (2003) presented a model that is non-hierarchical and more situation or circumstance specific, indicating that participation is a process rather than solely an outcome. Participation can be interpreted in terms of involvement in decision-making within children’s individual cases, but also as children sharing their views on service planning and provision, or their inclusion within community activities and more ‘public’ decision making.

Jans (2004) argued that discourses on participation are ‘adult-centric’ (2004:27) and equated with independence, individuality and responsibility. Cockburn (1998) argued that citizenship should be understood as a process and aligned with connectedness and association with others. Vandenbroeck and Bouverne-de bie (2006) too agreed that citizenship needs to be re-constructed, and that such constructions should be contextualised, “acknowledging that agency may take different forms in different contexts” (Vandenbroeck and Bouverne-de bie, 2006:139). For example, Devine (2002) identified some ways in which the typifications of children used by adults in schools, "may serve to constrain their capacity for independent action" (Devine, 2002:308) and thus opportunities for voice.

Indeed, Bordonaro (2012) in a study of Cape Verlean Street Children argued that children are only positioned as agentic when their actions are approved and legitimised by adults such
that "social intervention frequently consists of re-educative and disciplinary practices that aim precisely at mainstreaming of children's agency" (Bordonaro, 2012:423). He recommended asking 'what kind of agency is deemed appropriate for children?' (Bordonaro, 2012:423) and highlighted that if a child's actions are not approved or deemed morally acceptable by adults, for example violence, they would be positioned as "limited or constrained agency" (Bordonaro, 2012:423). Cocks (2006) too, in a study of children with disabilities proposed that ways needed to be found to overcome negative portrayals of incompetence, dependence and immaturity and instead argued for more relational and contextualised interpretations of agency, which "encourages exploration into a range of issues such as when and how it occurs, what facilitates its use, and whether it is influenced by macro-level factors such as economics, policies, culture, institutions and social structures" (Cocks, 2006:255).

More recently, there are those that have begun to specifically explore and critique the concept of voice within the sociology of childhood. Graham and Fitzgerald (2010:345) argued that "just at the time we are witnessing increasing numbers of government and non-government organizations (in education, family law, health, community services, research institutes and so on) laying claim to the value of participation, we are simultaneously querying whether 'listening to children's voices' guarantees any benefits for children, and whether public or private decision-making outcomes are shaped or impacted as a result of children’s participation" (Graham and Fitzgerald, 2010:345). In considering voice as a concept, they suggested that the "networks of power" (Graham and Fitzgerald, 2010:350) need to be considered and how these may influence what is defined or acknowledged as voice itself. They proposed that 'voice' should be understood as an evolving rather than a static concept, and as relational rather than absolute. They recommended a critical reflection on how the positioning of the child, for example in terms of competence or vulnerability are used as way to judge whether the child should have voice or not, to be included or precluded, when instead it should be used to identify and inform how children can most effectively share their views.

For example, in a study of early years documentation and parent-teacher meetings, Alasuutari (2014) found that there were "multifaceted relational processes in which the child’s voice and participation are embedded in adult-led institutional practices" (Alasuutari, 2014:243). Like the above claims about agency, children's views appeared to be accepted
when in line with the views of the organisation, but not so when they challenged it. Thus there was a presence of the 'competent child' discourse but alongside many other ideologies, such that "the findings point out how profoundly the notion of the competent child and child participation challenge childhood institutions, childhood professions and parenthood" (Alasuutari, 2014:255). Stoecklin (2012) has also argued that "paradoxically, the 'competent child' discourse falls into the trap it wanted to escape: because 'being competent' equates to being competent in the ways that are recognized as competence, maturity, rational thinking, etc." (Stoecklin, 2012:447). Therefore, ironically, in trying to re-position all children as competent, the ways in which competence is defined by adults, will in turn impact on whether a child is positioned as competent and eligible for voice. It has been argued that the voice of the child may threaten adult-child relations, but also the adult as a professional, and therefore professional status (Stoecklin, 2012).

It is also claimed that voice has become a rhetorical device (Komulainen, 2007). Voice has been simplified and dichotomised, children are perceived to have it or not, rather than the complexities of the child as speaker recognised and explored. It has been noted that there may be many different agendas motivating calls for children’s participation (Sinclair, 2004). Roche (1999) argued that “we need to think through the terms on which participation is being offered, to be aware of the context in which children are being ‘invited in’ and the risk of responsibility for making a decision being thrust upon children in circumstances not of their choosing” (Roche, 1999:489).

Komulainen (2007) too has advised "against too simplistic and/or sensationalized a usage of the term 'voice'" (Komulainen2007:21). She noted "that within the so-called ‘child-centred’ discourse in childhood sociology, children are often granted an individualistic status as subjects/agents and as intentional beings" (Komulainen, 2007:21). It is such individualisation that could make 'voice' problematic. For example, like agency, children are positioned as 'having' a voice, it is something within child. Instead, she recommended understanding voice in terms of ‘mutuality’ and ‘multi-voicedness’.

Another issue is that children cannot be treated as a homogenous group (Lansdown, 2001); children may have their own different views and ideas about how their views are included. Some may prefer to have adults around them decide upon courses of action while others may wish to decide for themselves. Thomas and O’Kane (1999) in their study of the decision-
making of children who were ‘Looked After’ by Local Authorities developed a typology of positions- ‘assertive’ (children who believed they should and do share their views), ‘dissatisfied’ (those who wished that their views were included), ‘submissive’ (children who were content for adults to make the decisions), ‘reasonable’ (children who suggested negotiation and compromise with adults making certain decisions) and ‘avoidant’ (children who stated less of an opinion on decision-making).

Wyness (2009) has argued that there has been limited research on the different voices of children, "in particular, those least likely to be heard, younger children, poorer children, marginalized groups of children" (Wyness, 2009:536). In studying the potential diversity of voice within pupil and youth forums, he concluded that representation of children's views varied, specifically for "young people who are disadvantaged in ways other than their subordinate status as children" (Wyness, 2009: 549). In addition, Horelli (1998) in her study of involving children’s views in three European countries concluded that “there are both individual, cultural and gender-specific differences in children’s participation” (Horelli, 1998:237). Devine (2002) found that certain groups of children responded differently to adult authority in schools, depending on age, class and gender which may impact on how their voices are legitimated, "boys and older children were more likely to query the control teachers exercised over them. Middle class children...in their classroom practices conformed in the main to teacher expectations" (Devine, 2002:312).

Armstrong and Galloway (1996) in their study of children’s participation within assessments for Statements of Educational Need argued that often not participating may be perceived by the child as the only way to show that they are not in agreement with the decisions being made. Therefore, it must be acknowledged that children may find alternative ways for trying to express their views. The concept of voice needs to be able to reflect the ways in which children express their views without vocalisations or speech (Komulainen, 2007). Lewis (2010) too recommended that children's silence in professional and research contexts also needs to be recognised, "listening better includes hearing silence and that silence is not neutral or empty." (Komulainen, 2010:20). Lee (1999) argued that "if children are silent, or if their voices are hard to hear, this can be read as a sign of their inability to represent themselves by virtue of their constitutional cognitive and/or social incompetence rather than as a result of a silencing process. This can legitimize the denial of opportunities for children to represent themselves" (Lee, 1999: 468), which he asserted could lead to a further
vulnerability. Therefore, consideration of silences and silencing processes appear to be crucial.

Lee (1999) explored three different situations to exemplify the ambiguity and complexity of children speaking for themselves within adult institutions. He argued that adult institutions required clear, definitive categories and therefore it was the perceived ambiguity of childhood itself that challenged child-adult relations. He used examples of the Article 12 of the UN Convention of Children's Rights, the 1980's Cleveland Crisis (in which 125 children were assessed by paediatricians to have been sexually abused) and children's testimonies in court trials. He suggested that "the key task is not to answer the question of children's status, but to examine how the question accompanies children in their passage through various social orders" (Lee, 1999: 465). So, for example what ambiguities regarding childhood are evident in institutions and how do these travel with children around the network. In this vein, it could be hypothesised that the voice of the child could be considered a childhood ambiguity and therefore embracing the ambiguity of voice, framing it as an object to explore and trace within the network, became a useful approach.

Lee (1999) claimed that "childhood ambiguity only arises when we set ourselves the task of forming an answer to the question of children's status that is generalizable over time, across different contexts and between different children" (Lee, 1999:465). So for example, when applied to policies for all children with ADHD to have a say in decisions about their welfare. Oswell (2009) explored "infancy and childhood organised speech" and identified a problem "regarding, in part, the distribution of communicative entitlements to children, the sites and conditions under which they may speak, and the authority with which such speech maybe endowed" (Oswell, 2009:149). As such there may be a number of questions when considering voice within a network: are children positioned as entitled to voice? Are there particular situations where speech is or is not legitimating? What credibility or authority is the child as speaker afforded? These considerations informed the development of the research questions of the study.

Spyrou (2011) has been critical of the idea of authenticity when associated with the voice of the child, which he proposed ignores contextualisation, for example how and in what ways voices are produced. Ruddick (2007) evidenced that the authenticity of children's views in custody cases appeared to be questioned because it was argued that the children did not know
their own 'real' wishes or feelings, but instead had been 'brainwashed' as part of their syndrome. The content of the child's voice was not what the adults were expecting, it was not approved or legitimated. Searching for authenticity may again position 'voice' as within child and perhaps even used to discredit their views. Stoecklin (2012) instead argued that "what is generally overlooked is that 'to have one's own views' is socially defined and also socially recognized" (Stoecklin, 2012:447).

Therefore, in light of recent developments in exploring the child's voice sociologically, 'voice' in the current study will be understood as a social process; a relational, contextualised, multi-layered concept. As such, in studying the child's voice in services that identify, assess and diagnose ADHD, it will be explored not only when the child's voice is present, absent and represented but also how the child's voice and the child as speaker are being positioned.

2.2.7. The Value of Voice

It is often claimed that it is the process of having their views included that is important for children, not necessarily the influence on the outcome. Yet, Sinclair (2004) has identified that there may be some negative outcomes if children do not feel that their views have been listened to or taken seriously and Katz (1995) highlighted that participation experiences may not automatically be positive or empowering. Therefore, a question has been raised regarding the value of including the child's voice within decisions regarding their welfare, particularly for children themselves and especially if these views do not have any influence on the outcomes. Franklin and Sloper (2006) argued that "there has been little published research examining the outcomes of children's participation" (Franklin and Sloper, 2006:734) and that much that has been written has been anecdotal.

However, it has been argued that "when we fail to create a social or political environment in which children can participate. Children miss out on the opportunity to talk about their views, experiences, fears, desires and uncertainties. There is less likelihood that informed, relevant decisions will be made" (Graham and Fitzgerald, 2010: 353) and as such, some researchers have provided evidence on the value of including the child's voice, particularly in the arena of children's mental health.

For example, Sinclair and Franklin (2000) have outlined what they perceived to be the benefits of children’s participation, including the promotion of children’s rights and their
protection, meeting legal responsibilities, developing service provision and decision-making. Dogra (2005) undertook a review of previous research regarding children’s views on mental health services and concluded that those that have been undertaken have shown that children and young people often have different perspectives to their carers and professionals which would be of value to decision-making.

For example, Evans et al (2004) in their study of young women’s experiences of anorexia nervosa highlighted how behaviours that may be perceived by adults as self-destructive may for children and young people be self-productive strategies, “a positive resource” or “a personal solution to broader social problems” (Evans et al, 2004:137). Haavind (2003) too undertook a study with a group of boys whose behaviour, it was argued, could have been diagnosed as an anti-social personality disorder. Instead, it was suggested that their behaviour was a collective way to manage the transition from middle childhood to the teenage years and construct ‘masculinity’ within this process.

Some research has emphasised issues that may arise when the voice of the child has not been realised or understood. Hutchby (2002) carried out a conversational analysis of children’s counselling sessions within a walk-in centre. He highlighted that what can often be classified as ‘oppositional’ by adults, may be children’s strategies for managing and resisting interactions in health settings, thus it is very important to understand the child’s perspective. He identified how if a child was not co-operating, it was the child’s behaviour and attitude that was questioned rather than for example the professional practice or the way in which the health service was structured. He presented an in-depth analysis of a session with a six year old child who responded to the counsellor with ‘I don’t know’ fifty-seven times. The counsellor interpreted the child’s behaviour as an unwillingness to engage in discussions concerning the separation of the child’s parents and yet by the end of the session, the counsellor appeared ‘enlightened’ about what the child was trying to communicate. The counsellor questioned why she should have expected him to have the ‘answers’ when no-one else did, including the parents who were separating and had arranged the counselling session.

Another study has also particularly highlighted why the seeking of the views of children may be particularly pertinent within welfare service provision. Window et al (2004) undertook an evaluation of a family support intervention, which was claimed to be ‘at the interface’ of social work and child mental health services. The research showed that children had their
own strategies for dealing with interventions and described how children resisted and rejected interventions, particularly if they had not been involved in their development. But one horrifying example illustrated the importance of listening to children. A child was given a behaviour chart to prevent her from shouting (a muting of voice) which did reduce this behaviour, however instead she began to self-harm. It came to light during the research that she was actually being sexually abused but did not want to ‘break’ the rules of her chart by displaying confrontational behaviour so channelled her anger and distress in other ways.

The above studies evidence and illuminate that despite the challenges of adopting voice as a sociological concept, there is still a great need to explore if, and how, the calls for the views of the child to be included in decisions about their welfare are being translated into children’s mental health practice.

2.3. Selecting Attention Deficit Hyperactivity Disorder

Following a review of the broad children’s mental health literature, it became clear that focusing upon one category of mental disorder (Green et al, 2005) would be more fruitful for the study. It was decided to use ‘Attention Deficit Hyperactivity Disorder’ (ADHD) as an example within the research for a number of reasons.

Firstly, as mentioned in the introduction, it has been claimed that ADHD is one of the three most common childhood ‘mental disorders’ (Green et al, 2005), therefore there was a likelihood that it would touch the lives of many children living in the UK, with or without the condition. Brady (2014) stated that "diagnosed cases of ADHD in the UK continue to rise, as does treatment with psychostimulant medication (prescriptions in England increasing by 50% from 2007 to 2012, Care Quality Commission, 2013)" (2014:227). It is argued that how the child with ADHD is positioned by the professionals working with them could influence the experiences of a large cohort of children.

Secondly, it is a ‘mental disorder’ that has attracted a great deal of controversy, academically and within the media. ADHD is usually identified in the middle childhood years and there have been a variety of competing discourses regarding causation. "ADHD has, for example, been associated with multiple factors, such as genetic, biochemical, neurological, cognitive, low birth weight, foetal hypoxia, brain injury, infectious diseases, exposure to toxins, diet, maternal smoking, maternal alcohol consumption, maternal depression and drug use during
pregnancy, paternal alcoholism, increased interpersonal conflict, divorce, severe early adversity, attachment and abuse”, (Kildea et al, 2011:2). There has also been much debate about how it should be categorised, and even whether it ‘exists’ at all. Unlike most other childhood mental disorders and despite such controversies, the main treatment that is officially recommended is medication (www.guidance.nice.org.uk), although within a multimodal framework of psychological, educational and behavioural interventions (NICE Clinical Guidance 72, 2008). Therefore, how the condition was being defined or interpreted, what controversies were being settled, could add further insight into the presence and positioning of the child's voice as Mitchell (2003) argued that the “views of young people as fully competent, rights-bearing citizens...is in direct contrast to the well-entrenched deficit labelling dominant in mental health” (Mitchell, 2003:291).

Thirdly, it is a condition that involves many professional groups and services and the guidance by the National Institute for Clinical Excellence recommends a multidisciplinary approach (www.guidance.nice.org.uk). Therefore, it could be used to illuminate the ways in which professionals ‘knit’ together around the child's voice as a children’s service and the positioning of the child in different settings. Fourthly, it will be shown, that there has been limited sociological attention on ADHD in the UK, particularly across professional groups or with a consideration of the voice of the child.

As mentioned in the introduction, ADHD is asserted as a fixed measurable category, defined by certain identifiable and observable behaviours namely inattention, hyperactivity and impulsivity. The focus of the current research was not to evaluate such perspectives but to highlight that being constructed or categorised as an ‘ADHD child’ using these discourses may have implications for how the ‘child’ is positioned and the possibilities for the child's voice within professional practice. As an ontological position it is accepted that children are assessed and diagnosed with ADHD, who then live with the diagnosis in their everyday worlds. Hacking (1999, 2006) proposed a 'looping effect' and the making of kinds, in this instance the making of the ADHD child.

Whilst it is acknowledged that ADHD has been researched widely in many arenas, including medical, psychological and educational spheres, the current study is located within the context of sociology and as such the literature review has focused solely on previous research and theorising within this domain. The majority of sociological studies have
focused in some way upon how ADHD has been framed. These findings have been included because the discourses described may be reflected by those that contribute to the study and impact upon how the child and child's voice are positioned.

### 2.3.1. Positioning ADHD: Neuro-biology

Some sociologists have provided historical overviews of how the condition, or its categorisation, have become established, particularly as a neurological condition. For example, Rafałovich (2001) claimed that the disorder was discovered by George Still in 1902 and that “the appearance of ADHD's essence” (Rafałovich, 2001:413) has changed over time, but that neurological interpretations have dominated. He described ADHD as “the collection of symptoms of childhood impulsivity and hyperactivity” (Rafałovich, 2001:397). He has argued that alternative interpretations have been marginalised so that there is now little “mainstream debate” (2001:410) in the United States. Conrad and Potter (2000) too highlighted that in America, the support group CHADD (Children and Adults with Attention Deficit Disorder) has been influential in the framing of ADHD, so has “positioned ADHD as a medical condition, a ‘neurobiological disorder’, rather than as a psychiatric or behavioural disorder” (Conrad and Potter, 2000:567).

Conrad and Potter (2000) noted a recent change in the framing of ADHD and in particular, they proposed that “genetics is the rising paradigm in medicine” (Conrad and Potter, 2000:972). They claimed that current genetic research links ADHD with a brain malfunction or disorder but as an inherited condition. For instance, one idea is that ADHD behaviours are due to an imbalance of dopamine in the brain, which is claimed to affect self-control. Barkley (1997) a prominent ‘voice’ in ADHD research, has also recently re-framed the issue in terms of ‘self-control’, which again may emphasise the role of the ‘brain’.

Rapp (2011) undertook a review of scientific research on children's neuro-diversity, including the condition of ADHD. She noted the rise of the brain as an object within scientific assemblages, and of interest to the current study, the positioning of the child as "necessary subject-objects to extend the fMRI research" (Rapp, 2011:674). In such studies, children could be understood as 'research tools' through which to access the brain.

Rapp (2011) explored the framings and understandings of brain research among neuroscientists in a laboratory and parents of children, including those whose children were
considered to be ADHD. She argued that there was what she termed an "existential gap" between "neuroscientists’ daily experimental processes and what many other publics – including many clinicians, parents of affected children, and young adults living under these diagnostic categories – anticipate" (Rapp, 2011:17). Rapp suggested the scientists were using research, for example brain imaging, to see what they could find out about the workings of brains, in contrast to parents who were seeking explanations for their individual child's behaviour or difficulties. The "hybrid usage" (Rapp, 2011:21) of the brain emerged within Rapp's study and she noted how "brains regularly float out of the laboratory" (Rapp, 2011:17). She hypothesised that locating children's difficulties or differences within the brain could enable parents and teachers to perceive the child with "less frustration and more compassion" (Rapp, 2011:12).

Blum (2007) has recorded, through research with mothers of children with a diagnosis of ADHD in the United States, what is termed as the rise of "brain blame" (Blum, 2007:205). She stated that ADHD is "the most common invisible disability" (Blum, 2007:203) of childhood and argued that "in the era of brain-blame, fewer mothers are blamed directly for their child's troubles, yet many experience stigma as secondary, contributing or proximate causes if they fail to act concertedly" (Blum, 2007:205).

Rapp (2011) too stated that "neurodiversity is under intense negotiation not only in labs but also in households across America" (Rapp, 2011:25), and as such, if and how 'the brain' of the child, featured in the assemblage to be studied was another layer to the research. Similarly, in another paper, Rapp (2011) claimed that "brains of children in all their neurodiversity are increasingly pictured in the media and flow through our daily lives" (Rapp, 2011:676). This was also highlighted by Wastell and White (2012) in their UK study of the image of one particular infant's brain and how it was used in policy reports and the media. They argued that rather than diversity, the brain shown was used to standardise interventions with particular families, with claims about the need to prevent damage to children's brains, medicalising rhetoric around policies and interventions (rather than consider more social approaches).

2.3.2. Positioning ADHD: Psychological
Rafalovich (2001) suggested that other influential frameworks for interpreting behaviours classified as ADHD have been those associated with psychological theories, in particular the
‘psychodynamic model’, although they have not had the same level of dominance. Such approaches framed ADHD as an anxiety or adaptive response to manage or survive certain stressful situations. Rafalovich (2001) argued that the psychological models have maintained a certain level of prominence because they are able to incorporate some themes from the neurological perspective, avoiding challenging their claims and yet also “psychologists carved out a territory of their own in which they treated the reaction to a physiological brain problem rather than the brain problem itself” (Rafalovich, 2001:404).

Two years prior to when Rafalovich (2001) was writing and in Britain rather than America, a Working Party for the British Psychological Society (Reason, 1999) suggested that ADHD should not be interpreted as a disorder but as an array of behaviours and queried the influence of societal expectations upon the interpretation and diagnosis of ‘ADHD’. Instead, they claimed, such behaviours may be due to individual differences rather than a ‘mental illness’.

Malacrida (2001) too suggested that in Britain, there was more of a “psychoanalytic tradition, shifting the focus for intervention from measuring and testing to understanding the traits, idiosyncrasies and fears and repressions of individuals” (Malacrida, 2001:144). As such, Malacrida noted, that at the time of her study, the initial intervention offered in the UK was usually ‘therapy’, in particular ‘family therapy’ to explore the child’s emotions. Malacrida (2001) argued that “the first assumption is that home life rather than classroom practice or the child’s capabilities, is at fault” (Malacrida, 2001:148) and that this “discourse devolves responsibility for risk and danger from public institutions and policies to the individual and the family, who are now held liable” (Malacrida, 2001:162).

2.3.3. Positioning ADHD: Social Construction
Yet others have framed ADHD as a socially created mental disorder, (Conrad, 1975; Conrad and Potter, 2000; Timimi 2005). The claimed motivations for constructing such a ‘disorder’ have included the needs of the changing education system (Barton, 1997) for example school funding and resources (Galloway, et al 1994; Slee 1995), the needs of parents-for example to avoid blame, achieve forgiveness for themselves and their child or for financial gain (Lloyd and Norris, 1999), the needs of the professionals- for instance to gain legitimacy, ‘ownership’ of a certain population or to develop their careers (Lloyd and Norris, 1999) and also, the needs of the pharmaceutical industry who produce the medication associated with the condition (Swanson et al, 1998; Lloyd and Norris, 1999; Conrad and Potter, 2000).
Breggin (1998) went so far as to suggest that ADHD does not exist and instead Ritalin is used to support ‘failing’ schools and parents, whilst promoting the interests of the pharmaceutical industry. Similarly, Conrad and Potter (2000) argued that “psychiatric and medical diagnoses are the product of socio-historical circumstances and the claims-making of particular interest groups” (Conrad and Potter, 2000:560). However, they also highlighted how those being categorised may conform or contribute to the medicalisation process as well, for example because it can offer a new public, possibly more acceptable, identity. They also suggested that a medical diagnosis of ADHD may provide an explanation for ‘under-performance’ which removes the responsibility from the individual.

2.3.4. Positioning ADHD: Cultural

Social models of disability have suggested that even if there is a biological component to ADHD, it could be a learning disorder rather than a mental illness (Conrad and Potter, 2000). Cooper (1999) too argued that children diagnosed with ADHD may be exhibiting differences in learning style rather than a disorder. He believed that such children display behaviours similar to those children perceived to be very creative. Timimi (2005) in what he claimed to be a cultural approach to children’s ‘mental disorder’ argued that social institutions may be less able to manage certain ‘temperaments’. He criticised the ways in which psychiatric diagnostic manuals have defined ADHD, which he argued may be reflecting the inheritance of certain personality traits or temperaments rather than a disorder.

For example, Cooper and Daniel (1999) argued that ADHD may be a reflection of the learning environment rather than a mental disorder. They undertook a small study of classroom management techniques by teachers within a UK school for children with learning and behavioural difficulties. Interestingly, they noted that different teachers experienced different levels of perceived behavioural problems from each child diagnosed with ADHD, children were not consistently hyperactive, inattentive or impulsive. The least number of behaviourally challenging situations occurred during music lessons and the researchers argued that lesson design, environment and content could be important variables in displays of ADHD symptoms as well as teacher-pupil dynamics. This research could imply that there may be certain spaces or social relations where ADHD is more likely to be present and encourages the contextualisation of symptoms. Lench et al (2013) too found that parents who valued their child's characteristics more positively, rather than solely perceiving their child
through the ADHD lens reported less frequent negative experiences with their child. Therefore, this would suggest that the behaviour and actions of others may impact on the lived experience of ADHD or how ADHD childhoods unfold. Coppock (2002) has noted research that has found an association between ADHD type behaviours and children who have experienced trauma.

Green et al’s (2005) national study claimed that ADHD was more predominant among white, boys within lower socio-economic groups and yet little research has addressed these social dimensions. Lloyd and Norris (1999) highlighted that there has been little research regarding, for example, the gender differences in the diagnosis and prevalence rates of ADHD, but that differences have been presumed to be either due to a referral bias or ‘real’ differences in externalising or internalising behaviour that are claimed to be due to biological factors or social expectations of behaviour. Brady (2014) too noted a concern about the number of children in the UK who were being diagnosed with ADHD from "more socioeconomically deprived communities" (Brady, 2014:220). It may be of interest within the current research, to consider social dimensions that influence the positioning of the child within professional practice, as these may provide an extra layer, or a scaffolding, to potential opportunities for the voice of the child.

Singh et al (2013) in a review of ADHD globally considered identified differences in diagnostic practices, including the potential role of structural factors. They highlighted again how much of the research has been undertaken in the United States. They recommended further study of what they call "first person accounts" of local models. Frazzetto et al (2007) in a study of the emergence of ADHD in Italy has also called for more research within different countries to explore the cultural variations of diagnosis and treatment of ADHD. The current study has been designed to include the first person accounts of professionals working in one geographical area, a local model, with ADHD.

2.3.5. ADHD Services

Some studies of childhood ADHD have explored how children access services. For example, Malacrida (2004) in a study of the experiences of British mothers, found that within the United Kingdom non-medical professionals who have contact with the child, for example teachers and special educational staff, were the ‘gate-keepers’ to the label ADHD and to medication administration.
Alternatively, Sayal et al (2002) in an investigation of children’s pathways to services argued that parents were the main gate keepers and that General Practitioners were the main referrers to CAMHS. General Practitioners tended to be responsive to requests for mental health service intervention by parents. They argued that “parents could be playing an increasingly active role in consultations and have greater confidence in asking for a referral’ (Sayal et al, 2002:46). However, they concluded that “a hierarchical model only involving primary care is likely to be an oversimplification...The multiple and parallel referral tracks to CAMHS that currently exists...need to be quantified and evaluated” (Sayal et al, 2002:47) The two studies highlighted that the current research across professional groups, to include health and social care, would be a beneficial addition to previous work.

It would appear from such research that children could be referred for an assessment through one of two pathways. Either they could be referred to a Paediatrician or to a Psychiatrist usually within a Specialist Child and Adolescent Mental Health Service which may have implications for the services that they are offered. For example, Parr et al (2003) in what they claimed to be “the first to report on the way ADHD is diagnosed and managed in the United Kingdom” (Parr et al, 2003:218) found that those children referred to a Paediatrician were less likely to be offered behavioural strategies than those seen by Child Psychiatrists. Those being treated by a Psychiatrist also had more regular professional contact. Yet, over ninety percent of all the children were offered methylphenidate. The ratio of boys to girls was 12:1. Just over half of the children had been assessed using parent and teacher questionnaires. Interestingly, they concluded that “the burden of diagnosis and follow-up of children with ADHD on Child Psychiatry and Community Paediatric services is significant in terms of both finance and personnel” (Parr et al, 2003:218), positioning children as a burden may have implications for the voice of the child within professional practice.

Salmon and Kemp (2002) too found differences in the working practices of Child and Adolescent Mental Health Teams and Paediatricians in Wales. They suggested that both use a clinical interview, observations and information from parents and other professionals, often through questionnaires. They noted that Paediatricians used significantly more medical assessments to explore the possibilities of physical problems contributing to ADHD but that Child Psychiatrists were more likely to offer behaviour strategies, parenting groups and social skills interventions. Again there was not any difference between the two professional groups...
in the likelihood of medication being offered. They argued that alternatives in treatment were less likely “in a climate where social work and educational resources have increasingly been drawn away from CAMHS” (Salmon and Kemp, 2002:77), perhaps indicating how the structuring of children’s mental health services, who or what is assembled, may have impacted upon options offered. Like the previous study, they again referred to the “huge financial cost” (Salmon and Kemp, 2002:77) of ADHD which may have implications for the constructions and experiences of children associated with this category.

2.3.6. ADHD and Artefacts

It is worthy of note, that much of the literature written on ADHD has also referred to the significant role of medication. For example, all of the above studies on professional practice implied that it is one of the main forms of intervention and Rafalovich (2001) argued that medication was promoted as the best form of treatment within dominant neurological interpretations.

Yet, there may be important complexities between ADHD, medication and the positioning of the child within professional practice. Indeed, in a study of the perspectives of children diagnosed with ADHD, Cooper and Shea (1999) found that all of the children associated diagnosis with medication and this was the main intervention discussed. They believed it increased their concentration and led to greater success academically and yet there were some perceived costs to their own personality, for example they felt less spontaneous or quieter, sometimes not having as much ‘fun’. Cooper and Shea (1999) suggested that the young people’s accounts implied the use of medication as a form of social control, which the young people accepted, for the benefit of others rather than themselves. The young people also voiced a desire to behave in ways that were socially acceptable, which would lead to school success. Taking medication was perceived as key way to achieve such goals. Singh (2013) too found that while children could describe threats to their authenticity by medication, they were not unsettled by them and these were more likely to be framed as side effects of the medication (rather than caused by the medication itself). However, it was argued that medication could offer possibilities to enable them to be their true self or the self that they would like to be.

Some have judged medication more critically. They argued that medication has been used to encourage children to conform to specific stereotypes, for example in terms of achievement
(Timimi 2005). In fact, ADHD medication has been framed as a ‘performance enhancing’ drug (Diller, 1998) which may “have potentially serious implications for notions of children’s free will and personal responsibility” (Singh, 2002:365). Coppock (2002) "raised ethical concerns about the use of a "chemical cosh" to control non-compliant children and young people" (Coppock, 2002:146). Therefore, it may be important to consider medication and its potential impact upon the positioning of the child and possibilities for child's voice.

A number of researchers have provided an historical overview of the category ADHD in terms of its development within the artefacts of psychiatric manuals (Conrad and Potter, 2000; Singh, 2002). Conrad and Potter (2000) argued that that the behaviours were first interpreted together as a diagnostic category in the 1950’s, since when there have been many ‘labels’ including ‘Minimal Brain Dysfunction’, ‘Hyperactive Syndrome’, ‘Hyper kinesis’, and ‘Hyperkinetic Disorder of childhood’. They noted that the DSM IIIR in 1987 re-categorised the condition as ‘Attention Deficit Hyperactivity Disorder’ which enabled the threshold to be extended to also include those children perceived to be hyperactive or impulsive but not necessarily inattentive. They stated that the DSM IV advised that the symptoms must be evident in at least two settings, and that such symptoms must affect social or academic development, although the levels of dysfunction may be perceived to vary across settings. In contrast, Malacrida (2001) from a study of ADHD in the UK and Canada argued that the criteria set out by the World Health Organisation (ICD-10) were more influential in the UK, placing a greater emphasis upon levels of hyperactivity.

2.3.7. ADHD and Adult Voices

One group of adults whose voices have been explored in relation to ADHD are mothers. Research (for example Blum, 2007; Malacrida, 2001; Singh, 2002) has explored mother's perspectives on their child's condition and their experiences of interacting with professionals. For example, Malacrida (2001) following interviews with 34 mothers living in England and Canada, suggested that the women believed their children’s behaviour to be perceived by others, including professionals, as a reflection of their mothering and so the women worked hard to present their families as ‘worthy’ or ‘deserving’, which framing their children through a medical ‘model’ enabled.

Few studies have specifically included the voice of fathers. One study undertaken by Singh et al (2005) found that fathers identified the behaviours of their sons through the lens of their
own childhood, and therefore perceived them to be 'typical' behaviours of an authentic boyhood. It was only when performances in sport were affected that fathers perceived the behaviours to be more problematic, when boyhood associated behaviours affected boyhood associated activities.

Lloyd and Norris (1999) in their analysis of 98 newspaper articles, claimed that it was the views of the parents and the experts, in particular those within the fields of medicine and psychology, that have, in the main, been represented in the media. They argued from their research that a number of parents have called for ADHD to be treated as a medical issue and framed the debate as the child’s ‘right’ to appropriate treatment which is equated with medication. This again highlighted the complexities of discussions around rights, for example who is positioned as having the right to voice or influence within the network.

A minority of sociological studies have explored professional perspectives of ADHD and the voices of those working with the condition. Rafalovich (2005) in a study of 26 clinicians practising in America argued that there were two main areas of ambivalence within professional practice around childhood ADHD. One concerned the validity of the category of ADHD while the other was about the appropriateness of medication. However, Pentecost and Wood (2002) in a study of 440 Child-Care Social Workers based in the United Kingdom found overall consensus upon perceived symptoms of ADHD and support for parenting training as an intervention. The researchers claimed that those with longer service were more likely to have greater familiarity with the medical and developmental psychological models.

Only a very few previous studies have explored ADHD across professional groups within the United Kingdom. Hughes (1999) undertook interviews with nine professionals working with children who had been diagnosed with ADHD, those working within psychiatry, educational psychology and paediatrics. She found some level of consensus on aetiology, (with a preference for biological interpretations) and most also believed that the family or home environment was a contributing factor; four felt that the school might also play a role. The findings did highlight that the professionals were using different diagnostic criteria and methods of assessment. Dependent upon the professionals perspectives on the influence of the home or school environment, meant that they gave different emphasis to information received from teachers or parents, with little liaison with any other professionals. Significant
for the current study, no reference was made by professionals to consulting or involving the child.

Kildea et al (2011) have also undertaken a qualitative study of ADHD 'stakeholders', a term they used to describe professionals, parents and children, which they argued had received very little research attention. They claimed that there were "no studies that have systematically explored comprehensive stakeholder views in the context of child and adolescent mental health service (CAMHS) delivery" (Kildea et al, 2011:4). As such, they interviewed ten professionals (teachers and CAMHS staff), seven parents and twelve children. In terms of the professional interviews, they argued that the professionals used the categorisation of 'pure/true' ADHD (associated with biology) and 'pseudo ADHD' (attributed to chaotic parenting) to achieve order and certainty to the messiness of ADHD in practice. They claimed that children's identities became influenced by the professionals sense-making through such categorisations. The researchers also noted inter-professional allegiances as well as conflicts, "where the most powerful group was felt to dominate the labelling and treatment process at any one time" (Kildea et al, 2011:9). The researchers claimed that "an important intervention identified for the children with ADHD is helping them to take responsibility and develop a positive sense of self and agency" (Kildea et al, 2011:16), highlighting the value for the child within the network to have opportunities to experience 'voice'.

Frigerio et al (2013) have explored what they termed the 'chorus of voices' around ADHD and they found that 'mutual blame' was "a significant factor in relations between adults" (Frigerio et al, 2013:586). They also noted the challenge of controversy about causation and treatment which surround children with ADHD. They asserted "that people who are personally and professionally engaged with ADHD negotiate the reality of the child’s condition, the necessary interventions and their subjectivities in a vicious circle of mutual blame" (Frigerio et al, 2013: 594). They also found that those considered experts devalued the perspectives of parents and teachers. Bendelow and Brady (2002) too noted the potential hierarchical nature of the organisation and ordering of the CAMHS clinic, in terms of the assessment and diagnosis of ADHD, where professionals act as gatekeepers to resources. Parents and children were described as being aware that their opinions were not given the same weight as those of the professionals, leading to "negotiation of these hierarchical relationships" (Bendelow and Brady, 2002:177).
2.3.8. ADHD and Children’s Voices

"Children with ADHD are rarely asked what they feel and when they are they are often not considered to be competent enough to make decisions about their own health and well-being" (Brady 2014:226). Yet, one area that has seen an increasing acknowledgement of children's views is medical research into the quality of life of those diagnosed with ‘ADHD’. Although earlier research focused upon parent views, a growing number of tools have been developed to evaluate children’s own perspectives on their quality of life. For example Varni and Burwinkle (2006) used self-report measures with seventy-two children diagnosed with ‘ADHD’ and found that they rated themselves significantly lower in terms of psychosocial health than other groups of children. They also found differences between parent and children’s perspectives, arguing therefore, that children too should be offered self-report measures, which Klassen et al (2006) also concluded.

Similarly, Sciberras et al (2011) found that parents reported lower scores for quality of life than their children in most domains, leading to the conclusion that the child's perspective should also be sought. Alternatively, Traywicks et al (2006) found a significant correlation between parent and child perspectives, except for one outcome, the use of medication. As such, they recommended that the child's views on the medication regimen should be included in professional practice. Thorell and Dahlstrom (2009) found a small number of children reported negative effects of medication, even if they wished to continue. They also found that there were two strong indicators to whether children were likely to agree to medication, their parents view but also the child's own knowledge about the reason for medication, which would indicate the importance of sharing information with children themselves. These studies would suggest that even within a medical model there is a potential for using quality of life tools to enable children to share their views on assessment, diagnosis and intervention, and so whether such artefacts are used in the network studied will be explored. Brady (2014) argued from her research with children that "the way in which diagnosis plays out in an everyday context, quality of life is important to children" (2014:224).

A small number of other studies regarding ADHD have also included the perspectives and experiences of children themselves. Cooper and Shea (1999) explored children’s experiences of ADHD by interviewing 16 young people who had been diagnosed with the condition and were attending a school for pupils with learning and behavioural issues. They claimed that
their study was “the first published empirical study of the perceptions and attitudes of children with ADHD to their condition, its effects and their ‘treatment’” (Cooper and Shea, 1999:225).

Within their research, they found that all participants claimed to have experienced social or educational difficulties. The young people were all able to offer accounts of when their behaviour had been perceived to be disruptive, which the researchers argued that for one reason or another, had come to dominate their ideas about their identities. They argued that the young people’s recollections may be influenced by the reminders and often voiced perceptions of significant adults in their lives. Fourteen of the sixteen children interviewed supported the diagnosis, perceiving ADHD to be a “physical and social reality” (Cooper and Shea, 1999:242) and the young people had different opinions about the importance of diagnosis, for some it lifted the blame or provided an understanding but others were worried about being stigmatised or seen as different. Singh et al (2011) undertook focus groups and interviewed young people about ADHD and found that young people perceived the stigma to be associated with their ADHD behaviours, rather than the medication prescribed. They concluded that "adults understanding and sharing information with children about the experience, personal benefits and disadvantages of methylphenidate may well prove to be a promising approach to enhance clinical progress for the child with ADHD" (Singh et al, 2011:7).

Singh and Baker (2013) as part of a large scale study of children's voices in the UK and America, identified two ADHD 'niches', the performance (educational) and the conduct (associated with social behaviours such as aggression). They suggested that those from the performance niche, most evident in the United States, were more likely to keep their ADHD diagnosis a secret due to anticipated stigma. They argued that silencing the ADHD diagnosis may lead to limiting the child's access to resources or knowledge about their condition. Malacrida (2001) too found that for some mothers in her study, it was the educational establishment and reactions of others that were perceived to be a psychological threat to their children rather than ADHD itself. Therefore, how professionals interpret ADHD and explain it to the children with whom they work, if at all, would be another facet of the study.

Of particular interest for the current study, children from both groups within the project described above stated that they had "little meaningful contact with medical professionals"
Hughes (1999) too, in the study of nine professionals working with ADHD, found that “it was clear that respondents avoided asking children their perspective about their behaviour” (Hughes, 1999:199) and noted that “it seems that the dialogue between the professions and the child was poor” (Hughes, 1999:195). Hughes (1999) claimed that although there has been increasing promotion of involving ‘users’ in the development and planning of services and policy documents, the ‘user’ is often translated as the ‘parent’ within medical decisions regarding the child. Brady (2014) in researching the views of children also found that there was "still minimal attention paid to the child's perspective and the meanings that they give" (Brady, 2014:219). Whether this was the case for the assessment and diagnosis ADHD network studied was an important aspect in the current research.

Travell and Visser (2006) in a study of seventeen young people aged 11 to 16 years and their parents explored five aspects of experiences, one of which was voice and participation. They found that the majority were prescribed Ritalin (a methylphenidate medication used to treat ADHD) after assessment and diagnosis, and that there did not seem to be an opportunity for the side effects of the medication to be explored. In terms of involvement, the young people recalled that this was usually in conjunction with discussions about medication, trying to achieve their consent, when they were being convinced that medication would calm them down. The decision appeared to be presented as an ultimatum that without medication they would still be seen as misbehaving and causing stress for their parents. Bendelow and Brady (2002) claimed children who do not give their consent are often framed as lacking knowledge or irrational.

2.3.9. ADHD, Voice and Policy

There have been a number of policies and guidance, specific to the field of Children’s Mental Health and ADHD that have referred to the inclusion of the views of the child. Kildea et al (2010) argued that "in particular, eliciting views from children and young people about CAMHS is central to the thinking of Every Child Matters and to the modernization of CAMHS (Aynsley-Green, 2005; Department for Education and Skills, 2004; Department of Health, 2004)" (Kildea et al, 2010:5). For example, the Department of Health’s National Service Framework for Children, Young People and Maternity Services 'The Mental Health and Psychological Well-being of Children and Young People' (2004) stated,
"As a minimum, all services evaluate outcome from the perspective of users (including where possible the referred child or young person themselves as well as key family members or carers)" (2004:37).

Under the 1989 Children Act, children may refuse a psychiatric assessment, although again their ‘age’ and ‘understanding’ must be given due consideration, and parents may override the child's decision if it is deemed in their 'best interests'. Children’s consent to treatment is also often referred to in terms of the ‘Gillick principle’ (Gillick vs Wisbeck and W Norfolk AHS 1985) where it was "established in English and Welsh common law that children under the age of 16 should be able to make a decision about such matters as medical treatment or contraception, without parents needing to know, once they are judged to have 'sufficient understanding" (Hill and Tisdall, 1997:154) . However, Cocks (2006) argued that in this case competence is not only assessed using chronological age but also how such aspects as 'maturity', 'intelligence' and 'understanding' are being interpreted (2006:253). It must be noted that in terms of giving informed consent, adults are assumed to be 'competent' unless proved otherwise, but for children it is the other way round, they must evidence their understanding and maturity before they are perceived to be competent in this sense. How these terms are interpreted in professional practice, for example 'understanding' may vary and it may also depend upon what information has been shared with the child.

Coppock (2002) has shown how children's refusal to consent to treatment has been used to indicate a child's "Gillick incompetence" and that their decisions have often been overridden by parents, considered to be in the child's best interests in later judgements. James and James (2004) have argued that children may have to show a greater competency than adults would in order for their views to be heard "the setting of a higher standard of 'competence' for children has also worked against the exercising of their rights when set against the 'best interests', which adults have decided for them" (James and James, 2004:158).

During the time of the study the National Institute of Clinical Excellence was in the process of consulting upon and producing a professional guidance for ADHD that was published in 2008. The Guidance stated that children should “have an opportunity to be involved in decisions about their care in partnership with health care professionals” (NICE, 2008: 8) and their parent should also have input.

In particular, it goes on to state,
"When assessing a child or young person with ADHD, and throughout their care, healthcare professionals should:
allow the child or young person to give their own account of how they feel and record this in the notes
involve the child or young person and the family or carer in treatment decisions
take into account expectations of treatment, so that informed consent can be obtained from the child's parent or carer or the young person before treatment"
(NICE, 2008: 14).

It could be perceived that the guidance formalised certain practices in terms of the child's involvement in decisions about their care and potentially mobilised the inclusion of the child's voice within professional practice.

To conclude, in a national investigation of children’s mental health service provision, the Audit Commission (1999) found that only 35% of Health Authorities were consulting children, despite the recommendations of an earlier report by the Health Advisory Service in 1995 (Claveirole, 2003). The current qualitative study will provide an insight into whether the situation is changing in terms of hearing the child’s voice in mental health services.

2.4. Discussion
This chapter has reviewed sociological literature regarding both the child's voice and ADHD, as well as the reasons for the condition being selected. It has been highlighted that within general social policy, as well as legislation or guidance specific to children's mental health or ADHD, there has been an increase in the recognition of seeking the views of children in decisions about their welfare. However, it has been also noted that a certain level of ambiguity (Lee, 1999) remains which may be played out and settled in professional practice.

The literature review illuminated that whilst 'new' sociology of childhood has re-positioned children as competent social actors, the constructions of the child within adult institutions, for example as vulnerable or as a threat, may continue to vary and it has been suggested that how a child is positioned, may impact on the opportunities or possibilities for voice. The ADHD literature has recognised that the condition may be framed in a number of ways, for example neuro-biologically or psychologically, which may add a further layer to the positioning of the
child. Children have been understood as a marginalised group, whose access to voice is often decided by the adults around them. Within the general sociology of childhood literature, chronological age and competence have often been explored in terms of claims about which children can access voice. Other social dimensions that may scaffold the positioning of the child have also been explored such as gender and class. The type of decision in question may also be a contributing factor.

It has been highlighted that there are few studies that have specifically explored ADHD professional practice and the perspectives of practitioners across multi-disciplinary groups in the UK. Yet, studies in both fields have continued to highlight the benefits and value of the child's voice to both themselves and the services that they access, thus evidencing the need for a study to understand how the child's voice is being translated within multi-disciplinary ADHD practice.

It has been found that both ADHD and voice as concepts have been critiqued, and that they emerge differently within different contexts has been proposed. As a result of recent 'voice' theorising, the current research will position the voice of the child as a relational, multi-layered, contextualised concept and as such, the scope of the study will be to explore if and how the voice of the child emerged. It will also identify which factors or entities contribute to the possibilities or opportunities for the child's voice. Voice will be understood as an experience or dynamic, a social process, rather than a within child, fixed and static concept. ADHD childhood is conceptualised as a social category and it is argued that many children share the lived experience of the assessment, diagnosis and treatment of the condition. The presence and positioning of the child's voice within these processes will be focus of the current study.

Previous ADHD research indicated the presence of certain artefacts or objects which may have an impact on the positioning and presence of the child's voice in the network and these will be considered in the analysis, for example, medication or the brain. Sociological studies on children's voices have highlighted that children may share their views or have influence without actually speaking, for example through absence and that there may be silencing processes being enacted. Therefore, it will also be important to explore if and how children's views are represented, silenced or absent within the research.
2.5. Summary

This chapter has provided a focused overview of the relevant policy and literature on the child's voice and ADHD. It has shown the different approaches to both concepts within the sociological arena as well as previous research both on the views of professionals and children themselves. It was decided to focus on one condition, ‘Attention Deficit Hyperactivity Disorder’, and this chapter has described how the condition has been framed. It is hypothesised that such constructions may have implications for how the child is positioned as well as whether there are opportunities for children to be involved in decisions that affect their welfare and perhaps, on services in general. The literature indicated that a variety of factors may need to be taken into account in developing further a sociological study of ADHD, for example the numerous professionals working with the condition, medication, and certain organisational practices. In concluding the chapter, the conceptual framework for the child’s voice (and ADHD) which guided the study was outlined.

As a result, a methodological approach was needed that allowed for 'things' as well as people, and captured the multi-disciplinary nature of ADHD professional practice. The approach had to be sympathetic to an understanding of voice as a relational, fluid social process. It was hypothesised that depending on who or what made up the ADHD assessment, would in turn affect if and how a child experiences opportunities to share their views and contribute to decisions about their welfare. If, and how, the child as speaker is afforded credibility or legitimacy could also vary, for example depending up the social statuses of the child. Therefore, an approach that allowed for researching how the ambiguities of the child's voice became settled within professional practice was essential and it is the methodological framework selected, Actor Network Theory, to which the discussion will now turn.
Chapter Three

Methodological Framework: Actor-Network Theory

3.1. Introduction

This chapter provides an overview of the methodological framework used to guide the study, including reasons for its selection and the implications for the research design. Actor-Network Theory has previously been applied to many areas of health related organisational practices including the UK Cervical Screening Programme (Singleton, 1996), a Neonatal Care unit (Middleton and Brown, 2002), a Paediatric Intensive Care Unit (Place, 2000) as well as to health issues such as anaemia (Mol and Law, 1994), cholesterol (Garrety, 1997), and medical devices (Prout, 1996). In brief, the approach recommends ‘tracing associations’ (Latour, 2005) between entities in order to understand if and how they connect as a ‘network’ around certain objects, representing, constructing, re-construction and translating those ‘objects’ in particular ways so that certain interpretations dominate while others are marginalised or oppressed. The approach focuses on relational aspects of the ‘social’, rather than individuals.

It will be highlighted that the small number of theoretical reflections regarding the potential application of Actor-Network Theory to a study of ADHD have focused on historical or documentary analysis and, as yet, have not been translated into empirical research involving those working with the condition, a gap that the current study was intended to go some way to fill. It will be argued that key ideas adopted from this perspective, for example the use of dichotomies and the notion of hybridity, can provide new insights for sociological accounts of children’s voices within mental health practice. However, it will be highlighted that using Actor-Network Theory has some methodological limitations of its own which have impacted upon choices made during the design of the study, as will be described.

3.2. Selecting Actor-Network Theory to study ADHD

Contributors to the development of Actor-Network Theory have highlighted how it should not be considered a ‘theory’ as such but as a methodological framework that enables the exploration of ‘messy subjects’ (Law, 2004), which could be an apt description of children’s ADHD in light of the multitude of interpretations, causations and professionals involved, as discussed in the last chapter.
After reviewing previous sociological literature on Childhood ADHD, it was felt that ideas from Actor-Network Theory could offer a way to develop some of the previous findings, extend sociological discussions on the voice of the child and contribute new insights into the provision of children’s services. Previous ANT studies have focused on organisational practices (of which an ADHD assessment assemblage could be considered) and other health conditions hidden within the body. One of the key claims regarding ANT is that it allows the researcher to make the invisible, visible.

As noted, medication is claimed to be the main treatment that is officially recommended (www.guidance.nice.org.uk), and ANT approaches illuminate the non-human as well as human actors. The role and significance of artefacts have been mentioned within previous sociological research on ADHD. For example, Malacrida (2001) found that for the mothers of children who had been diagnosed with ADHD, record keeping was an important activity with the women bringing “stacks or boxes of files, report cards, papers, assessments, information sheets, letters” (Malacrida, 2001:150/151) to the interviews. Rafalovich (2001) also implied certain roles for ‘technologies’ and particularly that their translation within ‘scientific reports’ has contributed to the dominance of the neurological perspective. Lakoff (2000) in an anthropological overview of ADHD in America concluded that “behavioural checklists and cognitive tests helped to stabilize the disorder and make it reproducible. In doing so, they bound together various actors-patient and family support groups, physician, school administrators, managed-care administrators and pharmaceutical company representatives” (Lakoff, 2000:166). However, such actor-network ideas of ADHD were not developed any further.

Previous research and policy documents have indicated the array of professional groups that may work with the ADHD child, and as such ANT has a potential to explore the ways in which these actants ‘knit’ together around the child, in a way few previous studies have done. As mentioned in the literature review, recent developments within the sociology of childhood, have suggested that ‘interconnectedness’ and ‘interdependence’ should be considered and explored for both adults and children, rather than always framing ‘personhood’ in terms of separateness, individualisation and independence. Therefore, a methodological framework which at its core emphasises the connections and associations between actors would appear to be an apt guide for a study of the child's voice within ADHD services.
During the time period of the study, there had been a marked increase in sociological interest in ADHD, though Singh (2011) remarked "in sociology and bioethics, ADHD is still surrounded by a discourse of suspicion fuelled by worries about social construction and medicalization" (Singh, 2011:289). Another recent development was also that some argued for ADHD to be understood in terms of a ‘bio-psycho-social’ model (Singh, 2002) reflecting the interaction of many entities in a child’s life which may contribute to their behaviour. Previous Actor Network studies have embraced the interaction between the biological and the social, so this seemed an approach that could offer greater scope for researching childhood, voice and ADHD.

Some writers have also previously suggested the potential application of ANT theorising to ADHD, but none have undertaken an empirical study using the approach in the UK. For example, Wróblewski and Afeltowicz (2013) applied an ANT perspective to what they considered to be the "controversies" of ADHD in the United States. They questioned how, in light of what appears to be a lack of agreement around many aspects of the condition in the United States, for example in terms of aetiology or medication, so many children continue to be diagnosed and medicated. Thus, their aim was to "analyse the controversies surrounding ADHD and the process whereby this psychiatric unit was formed and constituted as a social and scientific fact" (Wróblewski and Afeltowicz, 2013:241). In considering ADHD as a black box, they traced the condition through a psychiatric manual (the American Diagnostic and Statistical Manual of Mental Disorders), scientific research studies on the causes of ADHD (and newer claims regarding its longevity into adulthood), policy and legal developments, particularly in terms of medication, and how ADHD has been presented to and stabilised among the US public, for example in media accounts, the internet, pharmaceutical companies and support groups. They used their ANT analysis to demonstrate how ADHD has become successfully established as a "neuro-biological mental disorder" (Wróblewski and Afeltowicz, 2013: 357), in the United States, despite alternative claims (for example by Diller, 1998) or the research by Rafolovich (2005) on the uncertainty among doctors. They illuminated how the criticisms and questioning of the mainstream claims around ADHD have, ironically, maintained the condition in the public eye. They concluded that in some sense science may have "lost control" of ADHD and that ADHD itself could be interpreted as an actor, "ADHD has gained a life of its own" (Wróblewski and Afeltowicz, 2013:372).
Prout (2005) also asserted the potential use of ANT to study ADHD and how the condition could be understood as a nature-culture-technological network of heterogeneous entities. He claimed that certain sets of connections lead to particular childhoods, using the example of the connection between technologies (medication) and the child within an ADHD childhood. So, who or what is part of the network will impact upon how a childhood emerges. Therefore, this could provide a good starting point for the analysis within the current empirical study.

Oswell (2013) too reviewed ADHD as a biomedicalisation of childhood, identifying links between genes, the brain, dopamine, methylphenidate, experts in support teams, schooling and the role of pharmaceutical companies. Citing research by Phillips (2006), he argued "the referral can become a device for managing disruptive conduct in the classroom" (Oswell, 2013:185), indicating again a potential role for artefacts within the network.

Yet, to date, such ANT theorising about Childhood ADHD has occurred at an over-arching level but has not been translated into a specific empirical research design, and certainly has not included professional groups working with the condition in the UK. Those who have used the lens of Actor-Network to explore different aspects of ADHD have not undertaken a study of the local performance of an ADHD network empirically, or translated their hypothesising into research of the everyday practice of professionals.

3.3. Actor-Network Theory: An Overview

Actor-Network Theory emerged as an approach in the late 1980’s, following developments within the Sociology of Scientific Knowledge, “to capture the dynamics by which scientists and technologists maintain a central role in the ‘understanding’ of the natural and social world” (Singleton and Michael, 1993:227). Since the emergence of the approach, there have been a number of developments and interpretations, although some core ideas remain among those claiming to support this perspective which will be discussed.

It is promoted as an approach that can be used to explore the ‘ordering’ of the social (Latour, 2005), as “different modes of ordering produce certain forms of organisation. They produce certain material arrangements. They produce certain subject positions. And they produce certain forms of knowledge” (Law, 2001:3). The focus is on making the ‘invisible’ or taken-for-granted, visible and describing how the ‘social’ is performed (Law, 1994). As such, the broad aims of research underpinned by Actor-Network Theory are to trace the associations or
connections (Latour, 2005) between various heterogeneous entities and define ‘actions’ that are taking place (Law, 1994).

3.3.1. The ‘Actors’ in Actor-Network Theory

Actor-Network Theorists argue that an actor or ‘actant’ can refer to a single person, group of people, institution or non-humans. Therefore one of the key ideas within Actor-Network Theory, is the suggestion that both human and non-human ‘actants’ should be considered. Prout argued that “Actor-network theory can help in understanding the intricate and mutually constitutive character of the human and the technological in the processes and relationships of sickness and healing” (Prout, 1996: 214). For example, Latour (2005) highlighted the role of ‘intellectual technologies’ such as documents, charts, files, paper-clips within social life. Latour (1992) argued that technologies may define particular ways of interacting and contribute to the construction of identities of other actors as well as social ordering. Such technologies could allow or prohibit opportunities, ways of thinking or actions.

Increasing the attention paid to the role of non-human actants may be particularly relevant to study of children’s mental health and illness, and ADHD in particular. In fact, previous sociological theorising has implied certain ‘activity’ by non-human actors. For example, Kutchins and Kirk (1997) in reviewing the history of the American Diagnostics and Statistical Manual suggested that it can be considered as a “scientific classification system” (1997:15) but also as “a guidebook that tells us how we should think about manifestations of sadness and anxiety, sexual activities, alcohol and substance abuse and many other behaviours. Consequently the categories created for DSM reorient our thinking about important social matters and affect social institutions” (Kutchins and Kirk, 1997:11). They described the influential nature of such diagnostic texts within society, for example within the education system, the court process or research practices, which led to certain social issues being re-constructed, some groups being treated very differently from others and defined who or what would be interpreted in terms of ‘mental disorder’.

The role of pharmaceutical companies has also been explored (Kutchins and Kirk, 1997; Pilgrims and Rogers, 2005). For example, their role “in expanding the number of people who can be defined as having a mental disorder and who then might be treated with their chemical products” (Kutchins and Kirk, 1997:13) or how the work of certain professional groups are structured (Pilgrims and Rogers, 2005). Identifying the significance of
interpreting the ‘mental illness’ as an actor itself has also been undertaken. For example, Weinberg (1997) illustrated how the ‘non-human’ agency of mental illness was interpreted by professionals and those experiencing the illness, and in particular when it was perceived to be ‘controllable’ or held accountable.

The ‘agency’ of mental health ‘labels’ has also been implied within previous research (Rosenhan, 1974). In fact, Reid (1996) has written about the ‘power’ of the label ‘ADHD’, “it carries credibility and weight of a medical diagnosis and is able to command attention and respect…the ADHD label literally transforms a child from transgressor to victim” (Reid, 1996:254). He argued that the ‘ADHD’ becomes externalised and separate from the child themselves. Rafalovich (2001) also argued that within the neurological model of ADHD “the blame for deviant behaviour was attributable to a non-human agent” (Rafalovich, 2001:404).

Malacrida’s (2001) study found a mother who was trying to save the ‘good part’ of her child from ADHD and she suggested that “the discussion of “nipping the mental illness in the bud” is a prevalent part of ADHD clinical narrative”, so that “ADHD symptoms must be addressed before the condition solidifies and becomes “too late” for the child” (Malacrida, 2001:400). Singh (2011) claimed that for children in the 'Voices' study, the ADHD diagnosis was mobilised to manage certain situations or to excuse children's behaviour, it was adopted as a social resource by the child. However, she identified that "the more ADHD is socially available as an excuse for behaviours, the less control a child with ADHD has over how he is seen, and indeed, how he sees himself" (Singh, 2011:894).

Yet, Actor-Network Theory has been criticised for a tendency to imply technological determinism. Whilst Moreira (2004) argued that “medical knowledge and technologies…play a pivotal role in shaping the patients identity” (Moreira, 2004:46), Berg and Bowker (1997) highlighted, from their exploration of ‘medical records’, that artefacts could be perceived as ‘mediating’ rather than determining interactions. An important tenet of the ANT approach appears to be that nothing should be assumed, there may be many different roles for the various actors (including humans, ‘things’, institutions, or practices) within a network.

Likewise, the activity of non-human actants should not be assumed to always be negative. For example, Prout (1996) commented on the ways in which asthma sufferers and their families interacted with the inhaler to make their lives more ‘ordinary’. In terms of the
present study, it could be argued that technological artefacts may enable children’s participation rather than inhibit it. For example, Gringras et al (2006) reported on a new internet programme that “children as young as 5 years have successfully accessed” (Gringras et al, 2006:593) so that children can contribute to the ongoing evaluation of their cases and quality of life.

One of the main critiques of Actor-Network Theory has been that non-human entities do not ‘act’ in their own right, but instead it is argued, they are given agency and meaning by human actors (Collins and Yearley, 1992; Vandenberghe, 2002) and that these human actors should instead be the focus of sociological studies. However, Callon and Latour (1992) replied that such non-human entities themselves represent and reflect a variety of social relations, and yet the processes and procedures that have made such social relations and meanings and how they somehow disappear, was sociologically interesting to study.

Yet, within the current study, the issue of ‘intentionality’ has led to a great deal of apprehension. For example, Vandenberghe (2002) rather convincingly illustrated that non-human ‘things’ cannot express themselves, control their own movements and appear ‘indifferent’ to themselves and others. However, this may reflect a rather narrow interpretation of intentionality, action and effect. I began to think of instances where humans ‘act’ without ‘intentionality’ but may still have an ‘effect’ on interactions. Therefore, does it matter whether the action was ‘intentional’, if it has had an effect on other actants? This approach may concentrate the researcher on ‘how’, ‘what’ and ‘when’ questions rather than the ‘why’?

3.3.2. The ‘Network’ in Actor-Network Theory

The ‘network’ can be understood as a description of the relations or connections between actors, including the continuities and discontinuities. Actor-Network Theory explores what are the controversies within associations, how are they settled and how such stabilities and social orders are maintained, if only provisionally or momentarily. The approach also allows the possibility for the consideration of how it could be otherwise.

Latour (2005) argued that ‘work net’ may have been a more appropriate term than ‘actor-network’ because it can be more reflective of the flow, changes and movement of the associations and connections. He highlighted how it is also important to consider actants that
may appear silent but that have had an effect within the ‘work net’, where there is ‘proof of presence’, which for example may include the embodied child. Latour (2005) also suggested the importance of considering who defines groups or categories and how this is done, and also the ‘anti-groups’, that which the group or category is not.

Some Actor-Network Theorists have concentrated on how ‘networks’ emerged and strategies that are used by certain ‘actants’ to establish ‘networks’. Singleton and Michael (1993) suggested that the approach could be used to understand the processes by which entities enrol other actants and encourage their alliance. Callon (1986) described what he referred to as four ‘moments’ of translation. ‘Problematisation’ referred to the identification of a social or technical issue as a ‘problem’ that needs to be overcome by activities of a ‘network’. The next stage described was “interessement”, “actions by which an entity attempts to impose and stabilize the identity of other actors it defines through its problematisation” (Callon, 1986:207-208), what and whom are allowed to be included and what is excluded, both within the ‘network’ and within certain interpretations or understandings of the ‘object’. The process can be perceived as a way of ‘gate-keeping’ and developing barriers. Singleton and Michael (1993) argued that this is a multi-lateral rather than unilateral process, as other actors have to agree to or be willing to conform. However, it could be questioned whether all actors know that they have the option not to ‘conform’, resist certain interpretations or not be enrolled, for example children, particularly if information or consequences are presented in specific ways.

It is claimed that the third ‘moment’ of translation is ‘enrolment’ (Callon, 1986). Prout (1996) described the ways in which entities or ‘actants’ gave other entities particular roles and identities to ensure their enrolment. There were also what are termed ‘obligatory points of passage’, particular entities that other actants and entities must associate with or go through in order to access other parts of the network. Finally, Callon (1986) proposed ‘mobilisation’, “the practices through which enrolled networks are stabilised, however temporarily, and made manageable and mobile” (Usher and Edwards, 2005:406). For example, Singleton and Michael (1993) referred to “displacement” which they define as “the ways in which entities organise and structure the movement of materials, resources and information” (Singleton and Michael, 1993:230), for instance arranging meetings, experiments, or keeping certain contacts which will enhance the durability of the actor-network. In terms of the current study, certain organisational practices could construct the ‘ADHD child’ in certain ways which may offer possibilities for (or silence) the voice of the child.
Latour (1990) also suggested ‘inscription’ as another way in which the ‘network’ is mobilised. ‘Inscription devices’ collapse and transpose the ‘network’ across space and time, for example a textbook or medical check-list. Prout (1996) referred to the delegation of the network so that a ‘device’ in his own study an asthma inhaler, ‘packages a network’ and moves it across time and space. Such devices are also ‘actors’ within the ‘network’. Latour (2005) identified that there may be different roles within the process of translation. He suggested that there are, what he terms ‘intermediaries’, those entities which do not transform the knowledge or information that they receive, so the ‘input’ is the same as the ‘output’. However, there are also ‘mediators’, which do transform or modify the meaning. An ‘actant’ can at different time points be both an ‘intermediary’ and a ‘mediator’. Singleton and Michael (1993) suggested that due to the “heterogeneity of the network...any entity can begin to step out of semiotic character within the network.” (Singleton and Michael, 1993:230) and similarly, those that once were the enrolling entities, can themselves become enrolled by others. Therefore, translations may not be stable but instead challenged and contested.

A successful translation is when networks enable that which was problematised to become ‘blackboxed’ (Latour, 1987) so that any controversies become ‘hidden’. For example, Garrety (1997) explored how research has been used to establish the facts within the controversy of a link between cholesterol and heart disease. The study enabled a consideration of all the actants over a number of years and how different representations and interpretations of the research were preferred by certain actants for particular reasons to make the issue become ‘uncontroversial’. As Latour (2005) argued domination is ‘produced’ and then collapsed so that it is less ‘visible’, the state of affairs becomes taken for granted rather than challenged or questioned. Latour (2005) suggested that one possible role for the Actor-Network researcher is to re-open the ‘black boxes’ and to describe how such controversies were settled and certain networks sustained.

3.4. Actor-Network Theory: Core Concepts

As mentioned, Actor-network Theory has been revised and developed but a number of core concepts have remained central to discussions of the approach. In particular, debates have focused on ‘objects’, ‘identities’, ‘subjectivities’, ‘dichotomies’ and ‘ambiguities’ and it is consideration of these particular ideas within ANT that have guided the study.
3.4.1. ‘Objects’ and Identities

The approach is used to study ‘objects’, defined by Law (2000) as “an effect of an array of relations, the effect in short, of a network” (Law, 2000:1). Actor-Network has been applied in the past to researching conditions that cannot be ‘seen’, for example anaemia, cholesterol or hypoglycaemia. Previous researchers have used the approach to study how such objects are made ‘visible’ within the ‘network’. For example, Place (2000) considered the vital signs observation chart in representing the inside of a child’s body in an intensive care unit and the ‘theories’ behind these observations. In particular, Place (2000) looked at how the child’s heart is ‘extracted’, ‘abstracted’ and simplified through the monitoring of the heart rate. Place (2000) argued that devices are constructed using certain theories and then used as ‘objective’ evidence to support such ideas about the child’s body.

It has been argued that different actants may have shared meanings and interpretations of the ‘object’ which are passed around and translated within the ‘network’. Latour (1990) introduced the term ‘immutable mobiles’, for those ‘objects’ whose interpretations remain stable and can be passed across time and place, representing the network. However, other Actor-network Theorists have described how different interpretations of the ‘object’ may evolve within different practices. For example, Star and Griesemar (1989) in their study of a Zoological Museum, developed the term ‘boundary objects’ which “have different meanings in different social worlds but their structure is common enough to more than one world to make them recognizable” (Star and Griesemar, 1989:393). Therefore, one consideration within the study could be to explore whether any objects act as ‘immutable mobiles’ or ‘boundary objects’.

Alternatively, Law and Singleton (2005) recommended more fluid notions of the object. They argued that earlier Actor-Network Theorists described the ideas and interpretations of ‘objects’ by the actants in very fixed and static ways. Instead, they suggested that ideas and ‘objects’ change, and often need to, if ‘networks’ are to be maintained. For example, Law and Singleton (2005) in their study of alcoholic liver disease, described it as a ‘fire object’ to highlight the ‘elusive’ nature of the condition and the continuities and discontinuities in the ‘object’s presence and absence within the accounts of the actors. They highlighted how the different identities of the ‘object’ within different practices or realities were in some sense partially connected. Similarly, Mol and Law (1994) used Actor-Network Theory to explore anaemia and how the medical profession have tried to represent anaemia in order to make it
somehow visible to measure and treat it. However, from studying medical texts and doctors accounts across two countries they suggested that ‘anaemia unsettles spatial securities’ (Mol and Law, 1994:642) and they recommended incorporating ‘fluidity’ into understandings of ‘anaemia’ rather than previous interpretations of a ‘static’ network which would imply discontinuity.

Therefore Actor-Network Theory has been used to explore how different meanings or identities of the ‘object’ are managed and connect within the ‘network’, as Mol (1998) did in her study of atherosclerosis. Mol and Berg (1994) too in their study of anaemia found that by using a rhetoric of ‘principles-and-practice’ within medical textbooks it enabled different ideas of the ‘object’, anaemia, to co-exist and the issues to be presented as uncontroversial, even though they appeared to be explaining or defining different identities of ‘anaemia’ altogether.

Middleton and Brown (2002) also identified that the object, in their research the baby in neonatal care, had numerous ‘identities’ and that “the negotiations about mundane practices like providing vitamin K settle the identity of the baby in one particular way” (Middleton and Brown, 2002:8). Therefore it will be investigated how stabilities are achieved with the ADHD network around the object of care, namely the child, and if and how practices are used to enable the stabilisation of the identities of child's voice. An exploration of the management of certain identities rather than an exhaustive description of them all will be within the scope of this study.

Latour (1993) has referred to the term ‘hybrids’, objects that are created during interactions between culture, nature, society and technology. These ‘hybrids’ may connect many human and non-human entities which were previously perceived as ‘heterogeneous’. Prout (1996) suggested that the asthma inhaler could be an example of a ‘hybrid’. He argued that it has been created and constructed to appeal to both practitioners and families, enrolling them in particular ways with certain understandings of the ‘child with asthma’. Yet as Prout et al (1999) argued, it cannot always be assumed that those using or accessing certain devices will use or interpret them in the way that they were originally intended. In reviewing the literature on ADHD, which encompassed biological interpretations, social factors cultural aspects and a connection with technologies (for example, medication), in the ANT vein, an ADHD Childhood could be proposed as a hybrid (Prout, 2005).
Lee and Motzkau (2011) too recognised the value of exploring hybrid childhoods rather than resorting to bio-social dualisms. They considered the value of using hybridity as, what they term, a 'navigational aid', but in doing so, were concerned that this approach may lead to claims that "everything is hybrid" (Lee and Motzkau, 2011: 15) and they argued that due to its all encompassing nature, it could present challenges when translated into an empirical research design. Instead, they recommended finding ways to complement the concept to allow, in addition, for some points of reference and contrast across childhood studies and suggested using 'life', 'resource' and 'voice' as what they term 'multiplicities'. They applied the three 'multiplicities' to the study of one device, the Mosquito Teen Deterrent, evidencing how this approach could be developed to enable "'path finding' and 'orientation'" (Lee and Motzkau, 2011:9) within empirical research. They asserted that exploring the 'multiplicity' of voice, for example, would allow for the "complex interplay this has with the many circumstances in which children can and cannot find voice, along with the range of institutional and technological conditions in which their voices are interpreted, mediated and amplified" (Lee and Motzkau, 2011:11). They claimed that three key questions could be applied across, and in comparison to, studies within other bio-political situations, namely "how are children's voices being composed, transferred and circulated? How are children figured as resource and users of resource? How are children's life processes engaged with in these circumstances?" (2011:18). The first of these questions held most relevance in developing the current research.

3.4.2. Subjectivities and Agency

Actor-Network Theory has also been used to explore different possibilities for agency which again, related to the present study and the childhood literature. For example, Moreira (2004) investigated experiences of surgery and how patients pass control to the medical staff but then re-gain it again post-operatively. A ‘period of detaching’ was described, where in a variety of ways the connection between the surgeon and patient was undone, and the patient’s sense of ‘agency’ resumed.

Oswell (2013) has also proposed the value of ANT to understanding agency within childhood as not a within the child phenomena, "but as itself distributed across a network of agents or actors, both human and non-human “ (Oswell, 2013:69). Of particular relevance to the current research, Middleton and Brown (2002) in their study of a neonatal unit, argued that
the baby was attributed with varying degrees of agency, which they term ‘scaling’, depending upon situational demands. So within certain circumstances the baby’s agency was ‘worked up’ (2002:19) while in other professional discussions it was downplayed, both of which had implications for the ordering of medical practices, for example in terms of accountability for the baby’s care. They too argued that ‘agency’ was relational, “an effect arrived at by moves that implicate both the social and the nature, the technological and the human, expertise and emotion” (Middleton and Brown, 2002:16).

Latour (1999) too has described ‘agency’ as a social practice rather than intrinsically within an individual. Therefore Bruni (2005) argued that the researcher should “focus not on individuals but on the relations that enable them to accomplish the position of ‘subject’” (Bruni, 2005:362). Lee (1999) illustrated how agency could be re-positioned as dependency and interconnectedness by showing from research on child witnesses in court how they were positioned as more agentic and able to self-represent as more actants, human and non-human were added to the assemblage, for example video-camera's, television screens, social workers, and police, "the addition of extensions" (Lee, 1999:130). So, "we can ask what a given person, adult or child, depends upon for their agency?" (Lee, 1999:131). Therefore, different artefacts or 'extensions' may play different roles in the positioning of the child as agentic in the ADHD assessment assemblage.

For example, Tait (2010) has specifically raised the issue of free will and moral responsibility in the context of ADHD. He noted a risk that all of the child's behaviour would be attributed to ADHD and whilst on the one hand it could devolve a child of responsibility, when in the assemblage it may also reduce opportunities for a child to be positioned as agentic. Brady (2014) too questioned the potential agentic position of children "within a framework of understanding that regards them as having a neurological condition that renders their choices and decisions as impulsive or lacking attention and focus" (Brady, 2014:223).

However, Singh (2013) used data analysis from over one hundred and fifty interviews with children from the UK and US, to highlight that another artefact, medication, could increase a child’s potential for moral agency, because with it, children were more likely to perceive themselves to be able to meet normative expectations. Singh (2013) also explored another actant, the brain, in what she referred to as the 'self-brain-behaviour'. Singh and her colleagues asked children about the role of their brains in their behaviour, and analysis was
undertaken to ascertain the status children attributed to their brain, and its potential power. They found that the power dynamic between the 'I' and the brain changed, at times the brain was framed as powerful, at others vulnerable or unreliable so the relation between the brain and the 'I' was, in the main, perceived to be negotiable rather than pre-determined. Medication again offered a way for the child to re-connect the brain and the 'I' so that the children felt that they had a greater control in decisions. However, children also stated other ways for the brain and the 'I' to have a better connection that did not involve medication, for example through physical activity, good teachers and friendships. Therefore, the significance of the brain as an actant and its connection with agency and voice within the network may require consideration within the current study.

Middleton and Brown (2002) used the term ‘virtuality’ to describe “the potential forms of identity and attributes that a thing might come to be accorded” (Middleton and Brown, 2002:3); therefore a child could potentially be accorded agency or passivity, or certain rights or limitations. They contrasted this to the ‘actual’, “the given identity and attributes that are identified when a thing is grasped and recognised as such and such an entity” (Middleton and Brown, 2002:3), for example the ‘actual’ opportunity to participate within decision-making when a ‘child’ is framed as an active social agent within the network. They argued that studying organisational structures and relationships, particularly in terms of the role of specific technologies, enables the way in which certain perceptions and connections are repeated or routinised to be explored. They suggested that certain research questions can be asked, such as “what possibilities for action are structured by the current networked relationships and what possibilities are foreclosed?” (Middleton and Brown, 2002:3). Therefore, what possibilities for children’s action are structured and routinised within the children’s mental health network and what possibilities have been closed down?

Another aspect that actor-network researchers have investigated is how ‘subjectivities’ are created within social relations or practices involving technologies. For example, Cussins (1998) looked at the possibilities for women attending an infertility clinic. She reported that there were two dominant constructions of women, as ‘helpless’ (‘cured’ by the technologies) or as the ‘victims’ (of invasive technologies), neither positioned them as active social agents or with their own ‘voice’. Therefore Cussins (1998) explored the ways that the women were ‘objectified’, ‘naturalised’ and ‘bureaucratised’ but also reflected upon women’s participation within these practices. She suggested that there were possibilities for objectification and
agency to co-exist; they should not always be framed as dichotomous. For example, the patient may actively promote their ‘objectification’ in order to access particular services which may lead to the women constructing themselves as autonomous, making certain informed choices.

There has been much discussion of objectivity and subjectivity within sociological theorising. However, from an Actor-Network approach it is argued that the object/subject dichotomy is artificial. Through actor-networks both objects and subjectivities are created. For example, Mol and Law (2004) in their study of Hypoglycaemia suggested that the body can be both an object and a subject. They argued that the body can be an object of medical knowledge (the public body) but also can be a subject, the embodied or private body. They also suggested that bodies can be ‘done’, enacted or performed.

ANT insights into the connections between technologies and various identities may also be particularly beneficial to a study of childhood ADHD because previous research within the field has already implied a relationship between medication and children’s subjectivities and identities. For example, Rafalovich (2001) referred to how certain medications have been framed as “providing a window into the true “soul” of the ADHD child-a neurologically-challenged soul” (Rafalovich, 2001:404) and Cooper and Shea (1999) too, in their study of sixteen young people, found that they were “often casting their non-Ritalin selves as their authentic selves and that the self created by the application of Ritalin as a new and different self” (Cooper and Shea, 1999:239). Alternatively, within the ‘Voice’ interviews, Singh (2013) reported that few children stated that medication made them a different child, even if it changed their behaviour. She stated that even when a child felt that their 'real' self was non-medicated, this was not given as a reason to not take medication. She asserted that "stimulant drugs put them in the position of being able to choose between versions of themselves depending on what the situation calls for" (Singh, 2013:362).

3.4.3. Dichotomies
A number of other dichotomies have emerged within previous sociological research on mental health and illness. For example, there has been much discussion about whether certain social groups, such as women, ‘really’ experience greater mental distress, perhaps because of the ways in which their lives are structured (Brown and Harris, 1978) or whether they are just more likely to be labelled as suffering from a mental illness (Becker,1963; Scheff,1999).
Within Social Constructionism, one of the main challenges has been how to incorporate a physical reality within the approach in order not to deny the ‘lived experience’ (Hacking, 1999).

However, from an Actor-Network Theory perspective such dichotomies between ‘real’ and ‘constructed’ are artificial. Latour (2005) argued that numerous interactions are much more likely. Latour (2005) also recommended avoiding the natural/social debate arguing again that there may be complex interactions rather than simplistic dichotomies. In terms of dichotomies and ADHD, Reid (1996) has shown that ADHD has often been presented in terms of “false and simplistic dichotomies” (Reid, 1996:260) which it is argued polarise particular standpoints such as the medical versus social interpretations. Therefore the study will move on from certain debates for instance about whether ADHD is real or constructed, and instead focus on the actants and how certain interpretations are maintained within the network.

Using the approach can highlight how certain artificial dichotomies are used within networks to maintain certain understandings or social orders. For example, McLaughlin (2003) in her study of antenatal screening highlighted how networks can set ‘boundaries’ for what is ‘normal’ and ‘abnormal’, “marginalising those deemed unable to be accommodated within its cultural and political values” (McLaughlin, 2003:307). This may be particularly relevant to a study of the positioning and participation of the child within a mental health service because previous health research has highlighted a number of dichotomies that have been associated with these topics. For example, Cockburn (2005) highlighted that competency is often dichotomised and it is argued that tensions between competency and incompetency contribute to uncertainties around children’s participation.

3.4.4. The Global and Local

Another dichotomy that has received much attention has been termed the ‘macro/micro’, the ‘structure/agency’ or the ‘global/local’ debate (Latour, 2005). For example, in trying to incorporate a sense of agency within Labelling Theories of mental health and illness, some have argued that the success of the labelling process may depend upon how far the person being labelled accepts the label (Horwitz, 2002) although whether a person feels in position to reject the label or possible negative consequences may be issues. Those supporting a Social Constructionist perspective have also tried to include human agency. For instance,
Hacking (1999) suggested the ‘looping effects of human kinds’ such that, he argued, people actively respond to the way that they are classified which in turn modifies the construction and the way in which they are constructed.

Actor-Network has not avoided having to deal with similar issues. Actor-Network theorists have been criticised for depicting networks in powerful or dominant ways (Star, 1991). To this end, Latour (2005) acknowledged that there may be ‘structuring templates’ but individual action is also respected. Within Actor-Network Theory, Latour (2005) argued that any descriptions of traces of associations must move between the global and the local and thus again a distinction between the two is artificial, “no place dominates enough to be global and no place is self-contained enough to be local” (Latour, 2005:204). He recommended a researcher should ‘relocate the global’ (Latour, 2005) to explore how the ‘global’ is being generated within the ‘local’ (for example by an actant or a set of practices) as well as trying to ‘redistribute the local’, (Latour, 2005). However, he accentuated that the ‘global’ should not be perceived as above the ‘local’, thus recommending a flattening of the landscape of the social.

3.4.5. Uncertainty and Ambiguity

One criticism of Actor-Network Theory is that it has only focused on ‘successful’ networks (Manning, 2002); although it could be argued that it is much harder to study those attempts to establish a network that have failed. Yet, even among supporters of Actor-Network Theory, it has been suggested that there may be much more uncertainty and ambiguity within networks than reflected within earlier descriptions of the processes of translation and the establishment of a network. This was illuminated by Manning (2002) in his study of Personality Disorder, a rare application of Actor-Network Theory to the field of mental health and illness.

For example, Mol and Berg (1994) too in their study of Anaemia suggested that “social studies of science haven’t given diversity in medicine the attention it deserves” (Mol and Berg, 1994:249). They recommended that research should explore what appear to be incompatibilities or diversities that exist within the network and what strategies are used to enable them to co-exist without controversy, to be separate but also linked and thus for the network to be maintained. Middleton and Brown (2002) in their study of a Neonatal Care Unit also argued that “the boundaries of what counts as the unit are always shifting” and therefore “much effort must be expended to hold the unit together as a functional entity”
Singleton and Michael (1993) too suggested that although the Cervical Screening Programme appeared to be “a durable actor-network” (Singleton and Michael, 1993:228) including “the British Government, General Practitioners, medical researchers and technicians, health promotions officers, feminist commentators, lay women and cervical cells” (Singleton and Michael, 1993:228) supporting the acceptability of the CSP programme, ‘black-boxed’ and de-problematised, they actually found much more ambiguity and ambivalence and “less than clear relation between these various actants despite apparently successful enrolment” (Singleton and Michael, 1993:228). For example, they claimed that General Practitioner’s were both ‘pivotal actors’ in terms of enrolling other entities into the network but at the same time, a “major detractor, problematising the CSP network” (Singleton and Michael, 1993:234). The network was sustained because of, as well as despite, the controversy, ambiguity and ambivalence. Therefore, it is important to consider as much how ambiguity, ambivalence and marginalisation may sustain the actor-network around the child and the child’s voice as well as constrain it.

3.5. Actor-Network Theory and Reflexive Researching

3.5.1. Actor-Network Theory : Principles of Research

Callon (1986) argued that there should be three underlying principles when undertaking research guided by Actor-Network Theory. The first is ‘Agnosticism’ implying impartiality rather than the researcher privileging any of the accounts. Latour (2005) also recommended that any assumptions regarding associations are also suspended. The second is ‘Generalised Symmetry’, which involves using neutral terms within the study to describe different perspectives. Lastly, ‘Free association’ requires previous assumptions about dichotomies or distinctions between the natural or technological and the social also to be put aside when undertaking the study.

At this point, it is also important to draw attention to the issue of terminology. There have been a variety of terms used to refer to the topic under study, including ‘mental illness’, ‘psychiatric illness’, ‘mental disorder’, ‘psychiatric disorder’, ‘mental distress’ and ‘mental
ill-health’. However, within this study, these terms will be treated and often written interchangeably, no one term privileged or deemed to reflect a particular researcher position.

3.5.2. Actor-Network Theory: Researcher Value Positions

Therefore, in using Actor-Network Theory all of the different ideas and theories concerning ADHD should be treated as different ‘lens’. Even interpretations within the ‘new’ Sociology of Childhood around the child’s voice should be viewed as one perspective and not necessarily privileged within the research, particularly as notions of empowerment and participation may be complex and not necessarily unproblematic. For example, Usher and Edwards (2005) using Actor-Network Theory to explore educational guidance services, argued that ‘empowerment’ may not mean less regulation or repression but a different form of regulation, such that people are “more effectively regulated through regulating themselves” (Usher and Edwards, 2005:399). The ‘new’ subject positions offered by ‘empowerment’ rhetoric, may have many consequences such as encouraging students to make themselves ‘objects of knowledge’ and “a site of intervention by the expert” (2005:400) who then has “an active and power-full role” (Usher and Edwards, 2005:400).

Therefore, in adopting Actor-network Theory as a guiding framework, it led to a reflection upon value positions. Actor-Network Theory has been presented as a descriptive approach, Latour (2005) argued that the role of the theorist is not to solve or settle controversies but to trace and describe the connections. In describing the network it could be understood that there is not an avenue for challenging the network or to question why the ‘voices’ of certain actants are overlooked, why others have dominated. Hall (2005) in a study of the ‘geneticisation’ of heart disease, reported that although an excellent descriptive tool, Actor-network Theory needed to be developed to more critically illuminate inequalities within interactions, or “the social unevenness of the network” (Hall, 2005:2681). Therefore, a consideration of aspects of social unevenness could be incorporated into the analysis of the network, and if and how these are maintained or stabilised.

Indeed, one of the main criticisms of Actor-Network Theory has been its ‘managerialism’, the concentration upon the more dominant actants within a ‘network’, rather than those who may have been marginalized or excluded (Star and Griesmar, 1989; Vandenberghe, 2002). Thus, Vandeberghe (2002) recommended rather than exploring the ‘closure’ of the ‘black boxes’ the researcher should instead aim to re-open them, to realise the ‘hopes of the
excluded’ (Vandeberghe, 2002:63). He argued that researchers have often focused on the ‘managers’ because it is these actors who may be perceived to be sustaining a particular network. However, this should not be presumed, as Middleton and Brown (2002) argued that “unlike traditional actor-network stories, which revolve around powerful figures like Pasteur or impressive achievements like the maintenance of great sea trading routes, our account turns around the fragile and powerless neonate. It is the weakest, the least well defined entity which turns out to be the thing which holds the network together” (Middleton and Brown, 2002:20).

Martel (2004) too argued that Actor-Network can be at risk of perpetuating the ‘blind spot’, so she suggested that the approach can enable the researcher to recognise previously excluded groups as ‘valid claims makers’ (Martel, 2004:172). She suggested that a researcher needs to consider the impact for such groups when knowledge claims are presented as ‘scientific facts’ and also when the ideas of such groups have been discredited. In terms of the current study, this would justify the child’s voice being the focus and traced through the performance of the network rather than the parent or professional.

Star (1990) too, suggested that those who have been marginalised should not be ignored and simply referred to as ‘outside’ the network, they may still have had, in some way, an influence or impact upon the network. Star (1990) argued that concentrating on those who have been excluded may illuminate what operationalises the network. Or it could be that the continued marginalisation of certain actors maintains the durability of the network. Star and Griesmar (1989) highlighted that “only with tracings from multiple starting points can we begin to test the robustness of the network” (Star and Griesmar, 1989:396). Therefore, in the current study, this has been translated into the inclusion of professionals from a number of disciplines.

Yet, Actor-Network Theory has also been presented as an approach which enables the consideration of how it could be otherwise and perhaps one way it may have been otherwise would be if certain entities were not marginalized or particular interpretations excluded. In fact, Law (1992) argued that “Actor-Network theory is all about power- power as a concealed or misrepresented effect, rather than power as a set of causes” (Law, 1992:5).
Feminist researchers who have used Actor-Network Theory have provided some insights into if, and how, their own value positions can been incorporated into their research. McLaughlin (2003) highlighted how a feminist approach could be combined with Actor-Network Theory when she explored antenatal screening. She argued that in exploring how a socio-technical network was established, she could study how social positioning was transmitted and that feminist developments of the approach could enable the consideration of oppression within such processes. However, she also warned that the ‘language of rights’ could also be perceived as a ‘rhetorical device’ used to enrol others for a variety of means, therefore a researcher must “allow for greater recognition of the political significance of particular forms of network relations” (McLaughlin, 2003:306) and consider such dynamics as class and gender within the network.

In this vein, Silva (2002) used Actor-Network Theory and post-structural feminism to study cooking technologies which she suggested showed that “the construction of gender identities” is a “dynamic social and relational process achieved in daily social interactions” (Silva, 2002:612). Therefore, it is argued that the current study could use Actor-Network Theory to focus on how the voice of the child is positioned within the relational processes of the assessment and diagnosis of ADHD. Whilst my own researcher positioning, influenced by the 'new' sociology of childhood, should be acknowledged and would not necessarily be incompatible with a study guided by ANT, I had to remain open to the various ways in which voice may be played out or enacted within the network, including as a rhetorical device.

In summary, ‘agnosticism’ (Callon, 1986) could imply that all accounts should be given equal attention and worth, no one interpretation should be privileged. However, by seeking to include the experiences of those who may have previously be marginalized or overlooked, it is not necessarily to privilege them but to offer them the equal attention and value that has been given to more dominant actants or entities within the network in the past. Therefore, it is argued that Actor-Network Theory can be used within this study to focus on the child's voice within ADHD services, exploring ‘evidence’ of presence and positioning within the network.

3.5.3. Actor-Network Theory: Managing Multiplicity

It has been illustrated that one entity can have many roles or be part of many networks (Star, 1986). Therefore how far to take the traces and what limits, if any, to place on the network remain a challenge for any Actor-Network study. Singleton and Michael (1993) argued that
being part of numerous networks, “actants have many resources to draw upon which, while problematizing certain components of the original network, can ultimately contribute to its durability” (Singleton and Michael, 1983:232). Thus within this study a professional, could be part of numerous networks, for example the teaching profession, the school, or a family with multiple identities as perhaps a teacher, friend, sibling or parent, which may impact upon their identities and interpretations within the network under study.

Law (1992) reported that actors themselves can also be considered as networks. Prout (1996) has used the term ‘Punctualisation’ to understand how when describing the network, an entity can be replaced with a point or node to enable an easier discussion, but with the understanding that these entities have their own networks which may seem ‘hidden’. Therefore, although it would be impossible to describe all of the networks within the study, it must be remembered and reflected upon, that entities are both points in many networks as well as having networks of their own. Singleton and Michael (1993) too identified that even within one network actants may have numerous roles and identities. For example, as discussed, they identified General Practitioners as both significant actors in maintaining the network but also as ‘detractors’, problematising the network. Therefore, ways in which the study was made more manageable, and even possible, will be detailed in the next chapter.

3.6. Summary

One way in which ANT is particularly useful to the study of Childhood ADHD, is that it moves on the debate from the 'reality' of the condition. Within this study, it will be argued that ADHD is ‘lived experience’ (Hacking, 1999) for the many children who experience the assessment process and becoming an 'ADHD' child. They live with a diagnosis of ADHD. This study will understand the ADHD child as a networked position, as a social category, and as a state of being.

Other notions from the perspective were also helpful to make sense of the network, including dichotomies, obligatory points of passage, the nature of objects, identities and agency as well as making visible the role of non-human actants. Using the perspective, ADHD Childhoods can be understood as hybrids, an assemblage of social, biological, cultural and technological actors. Lee and Motzkau's (2011) question of "how are children's voices being composed, transferred and circulated?" (Lee and Motzkau, 2011:18) proved to be a pertinent consideration for the analysis. Similarly, Prout's (2005) recommendation to consider what
entities or actants make-up an assemblage that produces a certain type of childhood, in this case the ADHD childhood, also provided a good starting point for the research.

There has been much academic and media debate around the framing of Childhood ADHD. The aim of the study was not to establish a truth about the condition or privilege any one interpretation, but instead the focus of the research was to explore what constituted voice within the network, and how was the voice of the child managed, translated and circulated during the assessment and diagnosis of ADHD; when was the child's voice present, represented or absent. Therefore, in tracing the presence and positioning of the child's voice, the key research questions that evolved included how was the network being performed, what actants were assembled, and what impacted upon if and how the voice of the child emerged.
Chapter Four
Translating Actor-Network Theory into a Research Design

4.1. Introduction
Latour (2005) defined an Actor-Network Theory study as an ‘inquiry’; as such the current research could be framed as an ‘inquiry’ into the assessment of ADHD, as an example of a children’s mental health service. He also recommended focusing on a case study, an ‘instance’ which can be used to research and describe in detail a certain ‘state of affairs’. Law (2004) too argued that an Actor-Network Theory study should seek to provide a ‘snapshot’ of a situation or set of circumstances. Therefore, decisions were made, like many other previous Actor-Network studies have done, about how to make the network stand still temporarily, in this case by focusing upon one geographical area, specific professional groups and documents, as well as those working with children aged four to eleven years of age. As such, the methods that were adopted in order to enable a study of the presence and positioning of the child’s voice within an ADHD assessment assemblage will now be presented.

4.2. Researching a Childhood ADHD Network
As noted, “ANT presents a way of thinking and seeing that is relational rather than individualistic and that gives equal importance to the non-human as well as human in social practices” (Usher and Edwards, 2005:407). It enables the exploration of ‘artificial’ dichotomies and both the ‘global’ and the ‘local’ to be incorporated. It has been particularly applied to ‘objects’ that cannot be seen and the construction of ‘subjectivities’ and agency within connections and associations.

Therefore, it is argued that Actor-Network Theory was an appropriate methodological approach to explore children’s mental health services, and in particular ‘ADHD’, and the positioning of the child’s voice. It offered a way to investigate who or what ‘made up’ children’s ADHD services and how children were involved, in what sense they were ‘actors’ within the network. It enabled an illumination of what was made ‘visible’ within the network and an identification of the entities and artefacts that were passed between the actors who contributed to ADHD assessments. It offered a way to understand how identities associated with the ‘child with ADHD’ and the child’s voice were created, managed and stabilised, and circulated within the network, considering the implications for children as speakers in their
own right. Therefore is was possible to consider, was the child's voice present, absented and represented, and in what ways? How did professional practices offer possibilities for certain understandings of the ‘child’ or ‘child’s voice’ and what others were closed down? It also enabled a description of how the network was performed and an analysis of the ‘complexity’ and ‘messiness’ of the assemblage, including the voice of the child within it.

4.2.1. Capturing the ‘Network’

Although Prout (1996) suggested that in using Actor-Network Theory social life is perceived to be shifting and moving, he also argued that for the purposes of research, ‘networks’ have to be treated as if they are stable and durable to enable their exploration. Place (2000) recommended that the establishment of ‘reality’ is a process and so the network should be understood as a reflection of a process, rather than an end-point. Therefore, it was necessary to try to analyse and represent the network in two ways, to make it ’stand still’ so that the actants and assemblages could be ‘captured’ to study, but also to reflect the ‘movement’ of the network, how it was performed and enacted.

Early ANT studies were physically located in one setting, for example a Scientific Laboratory and as such it was necessary to give the research a physical location, which would still enable the different professionals to be included. Therefore, it was decided to physically locate the study within one British Town. The town was selected because it was part of a Local Authority that at the time of the study had achieved ‘Beacon Status’ for its children’s mental health services, indicating Government approval for current practices. Evans et al (2004) argued that due to assumptions regarding the link between socio-economic status and mental illness, social research often focuses on the experiences of lower socio-economic groups and the experiences of mental illness among those termed ‘middle class’ are often overlooked. Therefore the inclusion of two areas of a town with very different scores on an index of social deprivation (Office of the Deputy Prime Minister, 2000) sought to address this issue, but to provide diversity rather than comparison. The town was also selected because it was served by the same Hospital Children’s Unit and Specialist ‘Child and Adolescent Mental Health Practice’.

2 Forthwith referred to as CAMHS
To gain an idea of the professionals who could be involved with Childhood ADHD, the National Services Framework: Psychological Well-being of Children and Young People (DfES and DoH, 2004) was consulted. This document defined the Children’s Mental Health Service in terms of a range of professional groups from school teachers, health visitors, General Practitioners and school nurses, through to those providing a more ‘Specialist Children’s and Adolescent Mental Health Service’ within the community through to those providing in-patient care.

It is acknowledged that this representation of the Children’s Mental Health Service could be specific to time and place, however it was also the framework that was currently being presented as ‘best practice’ and so it was a structure that children who were identified as experiencing some form of mental health issue were likely to encounter in England at the time of the study. It was maintained that the value of using a pre-defined professional network as a starting point was that it offered a direction in the selection of the professional groups to be included, somewhere to begin the study, particularly for the pilot work. As has been described, other Actor-network Theory studies have successfully focused on particular services and within specific locations. Therefore, secondly, using the framework enabled the study to begin within particular research sites, for example a school or a CAMHS practice.

In considering the study of a Childhood ADHD network and the decision to locate it within one town as an instance, literature on the case study approach to research methods was also explored. Hamel et al (1993) argued "it is the type of study best suited to understanding the way in which the subject under investigation by the researcher (sociologist or anthropologist) is defined or established within the meanings of the social actors, by the description of the object as the study develops" (Hamel et al, 1993:33). The current research seeks to understand how the social actors (professionals and professional documents/artefacts) understand or give meaning to the subject or object of study, the voice of the ADHD (or potential ADHD) child. As noted it was important to gain an understanding of the network from many different perspectives, hence the inclusion of representatives from a number of professional groups who may come into contact with children being identified, referred, assessed and diagnosed as ADHD. It was also important to include those non-human actants that appeared in a number of sites of association across the network, for example questionnaires.
One aspect to note is that Yin (2003) recommended that research ideally would be reviewed by those involved, to ensure factual correctness (construct validity). In developing the current study, a mapping exercise was undertaken for the Local Authority and was presented as a report to a CAMHS Strategy group outlining the key actors and documents as well as describing the identification, referral, assessment and diagnosis processes being performed within the ADHD network. The feedback from those professionals who attended the meeting was an agreement with the representation of the actants (human and non-human) and assemblages. The pilot study, which included evaluating the interview schedule with those who took part, also contributed to the construct validity, as did involving professionals from different services.

The study of a network charged with identifying, assessing, diagnosing and treating Childhood ADHD in a specific geographical area (the unit of analysis), was intended as an example of the performance of children's mental health services, using a single case (embedded) design. Yin (2003) recommended five different possible rationales for a single case design, one of which was that the case could represent a 'critical case' in testing a theory. It could be argued that as the children's mental health service studied had achieved 'Beacon Status' from the Government at the time, it was promoted as an example of good practice. How far the participation of the child being assessed for ADHD had transferred into the practice of a Local Authority with Beacon Status was deemed to be a worthy theoretical question.

The design was considered to be a single case embedded design because a number of sub-units or organisations were analysed, including the different processes (for example identification or referral), different professional groups as well as different sites of association (such as the consultation or the school). Locating the study within past literature and research as well as considering the potential comparisons for the unit of analysis, including the transferability of the findings to other UK ADHD services or to the circulation of the child's voice in other bio-social networks (Lee and Motzkau, 2011), contributed to the external validity of the study. Kildea et al (2011) also used accounts from a variety of stakeholders to explore ADHD, including teachers and CAMHS workers, and argued "exploring multiple perspectives also triangulates the data and arguably provides stronger validity to the conclusions" (Kildea et al, 2011:3).
Whilst the human network was used as a starting point, it was approached with an open mind, such that an inquiry could still be made into what other actants made up the network. It was acknowledged that during the course of the inquiry, it was likely that the nature of the network may be something very different and as with any piece of qualitative research it was necessary to allow for the exploration of the ‘unexpected’ (Cooper, 2001). Yin (2003) argued that one of the challenges of the single case design is that "a case may later on turn out not to be the case it was thought to be at the outset" (Yin, 2003:42) and yet, from an ANT perspective, as will be shown in the analysis, this may actually contribute to more interesting findings and reflect the complexities of the network studied.

4.2.2. Containing the ‘Network’

As discussed, many of the previous Actor-Network Theory studies have focused on ‘networks’ within certain physical settings, for example a Neonatal Unit (Middleton and Brown, 2002), a Paediatric Intensive Care Unit (Place, 2000), a Museum (Star and Griesemar, 1989), or a surgical ward (Moriera, 2004). As Moreira (2004) highlighted, that by focusing on a particular physical location, multiple heterogeneous components, both human and non-human “are brought together...in one single place” (Moriera, 2004:36).

However, as described, at its widest interpretation, children’s mental health services were structured to take place in a number of locations, ‘sites of association’ (Latour, 2005). As such, a way to place some boundaries around the research was required. Strathem (1996) has argued that the possibilities for following connections within Actor-Network are boundless, everything could be included and thus, in order to use the approach effectively possibilities had to be found to ‘cut’ the ‘network’.

It was decided to focus on the network of actants working with children aged four to eleven within the geographical area. It was decided to focus on children within what are often referred to as the middle childhood years for two reasons. One, ADHD was most likely to be identified in the early years of formal schooling and two, at the time of the study, this age group of children had received limited sociological research attention.

Therefore criteria used for the sampling frame to contain the network to be studied was threefold; that the professional had worked with Childhood ADHD in some way, that s/he had worked with children receiving services within the specific geographical area and that
s/he had worked with children up to and including those aged eleven years of age. A strategic sampling (Mason, 2002) approach was also adopted so that the National Services Framework (2004) was used to include professionals from each of the range of services that could potentially work with Childhood ADHD, including four schools, two General Practitioner3 Practices, a Locality Team (for example Educational Psychologists), two children's social work teams, a Hospital, a Community Health Centre and a CAMHS service.

4.2.3. Pilot work
It was decided to carry out a pilot study for three main reasons. The first was to evaluate and modify the research tool, the interview schedule (see Appendix I). The second was to gain a preliminary insight into the network, to ensure all of the relevant professionals working with ADHD had been included and provide a draft mapping of the ‘network’. The participants also suggested contact names and details for professionals working within the identified area who could be recruited to participate. Thirdly, the pilot was used to identify key ‘non-human actants’ which appeared to play a role within the network.

The interview schedule was piloted with four professionals between December 2006 and March 2007; a Social Worker, a Teacher, an Educational Psychologist and a Primary Mental Health Worker from a CAMHS team who had all worked directly with children diagnosed with ADHD. Two of the pilot participants were male and two were female. Three interviews took place in the homes of the professional and one in a work context. As noted, these professionals were identified for the pilot because they had been defined as part of the children's mental health network within the National Services Framework (DfES and DoH, 2004). They were also all known either due to previous professional working relationships or through a shared colleague. The qualitative interviews lasted about two hours and participants were asked to reflect upon the questions and interview process.

The interviews were transcribed and analysed manually, to explore common themes, a provisional description of the network and how it appeared to be performed. The pilot raised some issues that needed to be considered within the main study. Firstly, it had been intended to include six professionals within the pilot, two cancelled on a number of occasions and found it difficult to find the time to re-schedule. Contacting professionals was difficult as

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3 Forthwith referred to as G.P.s
they often worked out in the community rather than being office based during their working day. These difficulties with access continued to be reflected in the setting up of the interviews for the main study and although the original intention was to use the telephone as the initial form of contact, a letter with a follow-up e-mail proved to be more effective.

Secondly, as hoped, the pilot highlighted the role of certain non-human agents, for example the ‘statement of special educational needs’ and questionnaires relating to children’s behaviour. These tools appeared to connect some of the actants at particular times. The pilot work also indicated the significance of other objects within the network, for example medication and chairs, as will be discussed in the analysis chapters. It emerged that tracing the inter-relationship of the child's voice with such objects through the accounts of the performance of the network would become worthy of analysis.

Finally, the participants suggested a number of different organisational practices within the assemblage that could have had a potential impact upon how the child's voice was positioned and it was identified that the consideration of these would also be beneficial to the study. The analysis of professional accounts of two such practices, the referral process and the assessment consultation, will be presented.

During the early stages of the research, I was also employed to complete a mapping exercise for the Local Authority on ADHD pathways to services and any unmet needs. This involved telephone (twelve), email (two) and face to face interviews (five) with nineteen professionals, including CAMHS workers, Paediatricians, teachers, a health visitor, a youth justice worker and a voluntary sector representative. Six focus group discussions at team meetings and two group consultations with local mental health strategy groups were also undertaken, including three in the geographical area studied, of which one was with a Locality Team (Educational Psychologists, Behaviour Support, Education Welfare) and another with the CAMHS team. I also attended a Strategy Group meeting that covered the area, at which Paediatricians were present. These meetings provided an opportunity to build links with professionals, enabling recruitment and promotion of the current study. The work also provided a confirmation of the actants in the ADHD network in the geographical area to be studied.
The pilot work and mapping study identified a significant key group of professionals that required inclusion within the research, Paediatricians. This early work identified that during the referral stage of Childhood ADHD, there were two pathways to assessment rather than one, and that how this was played out in the geographical area studied and what this meant for the child and child's voice would become salient within the research. Also, the complexities around how ADHD was being framed globally at the start of the study (for example as one of five main childhood mental disorders) and how it was being interpreted, translated and worked with locally, (the global in the local), as well as the impact upon the positioning of the child and child's voice, proved to be another interesting, and yet challenging, aspect of the analysis.

4.2.4. Translating the Study to Ethics Committees

A major hurdle for the research was the translation of the study to the Ethics Committees. As the research involved what would be considered by an Ethics Committee to be a ‘vulnerable group’ (children) and those interviewed were employees of health and social care organisations, agreement to the study had to be sought from Medical Research Ethics Committees, the Local Authority, and the University Ethics Committee prior to data collection. Despite the health professionals being located in the same geographical area they were employed by two different Trusts which each had their own Research and Governance Committees to whom applications also had to be sent in order to gain their agreement to the study.

Rapp (2011) has highlighted the challenges of trying to undertake research with children in a health setting and Coyne et al (2009) pointed out that "gaining access to children for the purposes of research often requires dealing with multiple gate keepers which can cause problems and delays" (Coyne et al, 2009:420), even preventing research itself, they argued. In their own study of hospitalised sick children aged seven to eighteen years, they highlighted that several factors linked to access and gate keeping affected the shape of the study and the type of data collected. Interestingly, the researchers felt that their access to three children with mental health issues was being prevented and in the end, these children, who were deemed by gate keepers as much more vulnerable, were not included within the study.

Due to the time it was known to take to receive a favourable ethical opinion, applications to the Committees were made quite early on in the study. However, within an exploratory
qualitative study, knowledge and perspectives changed and in using Actor-Network Theory, the research ideally required flexibility to follow certain connections or associations, to include actors as their presence became evident. But this did not ‘fit’ with the rather ‘static’ framework of Ethics Committee's application forms. An application document had to detail exactly who would be involved, in what ways and for how long prior to entering the field (attaching copies of the recruitment and consent documents) and the favourable opinion related only to this document, any major changes to the research had to be sent back to the Committee for further approval. The Committee required a defined interview schedule so that they were informed about what exactly what would be asked. This is not to deny the essential importance of ensuring that research is undertaken in an ethically appropriate manner but it did highlight the impact that this had on the way in which the study was produced and methods developed.

Therefore, in the first instance, it was decided to apply to the Committees for their agreement to the interviewing of professionals regarding their views and experiences of working with childhood ADHD, particularly so that that pilot work could get started. The original intention had been to use the relationships established within the CAMHS and Paediatrics teams to recruit children and their families, to engage reliable 'gate-keepers'. Once access was assured, the plan was to re-apply to the Ethics Committees with an addition or modification to the study (adding children and parents). Unfortunately, when the time came to re-apply, one of the Trusts that covered the CAMHS team had been re-organised and I was told that my application would have to start again, by the new Trust's Research and Governance Department and there had also been some organisational restructuring of staff.

Within the scope of the current study, starting the process again was not an option. However, in parallel, the findings from a large scale study of children's voices with ADHD was being published (see Singh et al, 2013). Similarly, developments within sociological theorising on the voice of the child indicated that the analysis of the data already collected from professionals and documents could alone provide interesting and useful contributions to the debate around the emergence of the child's voice within different assemblages. Research was suggesting that there were limited opportunities for children's views to be included in the field of ADHD assessments and yet still, there were few studies that focused specifically on professional practice (in its widest sense), particularly in the UK, and across multi-
disciplines. Therefore, the decision was taken, that for the present study, another Ethics application would not be made and the study would retain a focus upon professional practice.

4.3. Methods: Data collection and Management

This section will outline the methods and decisions made in order to enable the exploration of the child's voice within Childhood ADHD assessment processes. The over-arching research inquiry was into the presence and positioning of the child's voice within the assessment processes of Childhood ADHD. But it was also necessary to understand how the network was being performed, who or what was involved, how did they connect and what dominant discourses were stabilised and circulated. Thus the steps that were taken to enable the collection and analysis of data, in order to address the research questions guided by an ANT framework, will be described. The recruitment and sampling process will be explained, as well as outlining the final sample included within the study and the data collection methods. It will conclude with some reflections on the positioning of the researcher and a description of how the data was managed and analysed.

4.3.1. Data Collection- Recruitment, Access and Sampling

As noted, the identification of the professional groups was based upon a national and 'objective' definition of the children's mental health service (NSF, 2004), objective in the sense that it was not determined by the researcher's own ideas and decisions about who to include within the study

Professionals were recruited for the study in different ways. As mentioned in the previous section, the profile of the study had been raised at the CAMHS, Social Care and Locality team meetings used for the mapping study, and this provided one way to recruit participants. Schools and General Practitioner practices within the two locations of the Town being researched were identified and recruitment letters (see Appendix II) were sent via the Head teacher's (Schools) or Practice Managers (G.P's), with follow up emails.

As participants were interviewed, they suggested the names of other professionals within the geographical area that should be contacted and included, which was particularly important and useful for recruiting the voluntary sector professionals, Paediatricians, and those working in non-mainstream schools. They also showed me artefacts, for example a leaflet, questionnaire, or model. As Yin (2003) argued, these participants could be considered more
as 'informants', as "key informants are often critical to the success of a case study" (Yin, 2003:90).

As a result of this snowball sampling approach, recruitment letters were then sent to these professionals, again with follow up emails. This enabled a more flexible tracing of the network, as described by those within it. The form used to log contact with professionals is presented in Appendix III. Despite having been 'visible' within in the network during the mapping study, access to some participants continued to prove to be very difficult and trying to engage participants from so many different settings took a great of time, longer than anticipated. One of the key recruitment issues was that it was often necessary to go through another person to gain access to a participant, for example a Head Teacher within a school or a Practice Manager for a G.P. Another issue was the availability of participants and the time that they had free to be interviewed. Participants were often working in different community locations to their main offices so it was harder to contact them.

The original sampling quota had been to recruit fifty-two participants, but due to access issues, the final sample was a third of this number. Flick (2006) too identified some of the issues in gaining access to institutions, which included that "different levels are involved in the regulation of access" (Flick, 2006:115), as well as the time professionals have available to take part and the priority of the research in their workload. Yet, Flick argued that "the analysis of failures in this process allow the researcher to reveal central processes of negotiation and routinization in the field" (Flick, 2006:115), which will be reflected upon further in the discussion. Flick (2006) noted that research may be perceived as an intrusion, without payoff, where there is a risk that the activities of the organisation, or some limitations, could be exposed. It has already been highlighted that ADHD could be considered a controversial topic.

The most challenging groups to recruit were teachers and G.P.s. Whilst four mainstream schools were included, only teachers from two schools agreed to participate (one of which was in the pilot). However, additionally two teachers from two non-mainstream provisions were contacted as suggested by other participants in the network (from a school for children with Emotional and Behavioural Issues and a Pupil Referral Unit). The one professional group that could not be engaged at all was General Practitioners. Only one G.P. agreed to be part of the study and after numerous attempts to set up an interview to fit the work days and
clinic schedule of the practitioner, on the day of the interview it was cancelled by the Practice Manager and then again on a second occasion, after which the G.P. withdrew from the study.

4.3.2. Data Collection- The Sample
The sample finally recruited for the main study involved eighteen participants from at least seven different professional groups working with Childhood ADHD. Apart from the G.P.s, all of the professional groups identified in the National Services Framework (2004) were represented. The response rate from those involved specifically with assessing ADHD within the Town was very good, those from the CAMHS and Paediatric services made up half of this sample (n=9). The data was collected between June 2007 and December 2008.

Of the eighteen professionals, five participants worked in CAMHS (a therapist, a nurse, two psychologists and a psychiatrist), four worked in paediatrics (three in the Community and one in an Acute setting), four worked in social care, the Local Authority or the voluntary sector and five worked in the field of education, either in mainstream and specialist schools or education related support services including psychology and health (three teachers, an educational psychologist and a school nurse). Fifteen of the participants were female and three of the participants were male. Participant’s professional backgrounds ranged from recently appointed to post through to about to retire.

A decision was made to include the data from the interviews from the four pilot participants in the main analysis as well, as the data related to the geographical area studied and had contributed to an understanding of the network, including how it was being performed. As such, the analysis presented in the following chapters was based upon twenty-two interviews as shown overleaf,
<table>
<thead>
<tr>
<th>Professional Group</th>
<th>Number of Interviews</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMHS</td>
<td>6</td>
<td>5 female, 1 male</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4</td>
<td>3 female, 1 male</td>
</tr>
<tr>
<td>Schools</td>
<td>4</td>
<td>3 female, 1 male</td>
</tr>
<tr>
<td>Locality Team</td>
<td>2</td>
<td>1 female, 1 male</td>
</tr>
<tr>
<td>School Nursing</td>
<td>1</td>
<td>1 female</td>
</tr>
<tr>
<td>Social Care/Local Authority</td>
<td>3</td>
<td>1 female, 1 male</td>
</tr>
<tr>
<td>Voluntary Sector</td>
<td>2</td>
<td>3 female</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>22</strong></td>
<td><strong>17 female, 5 male</strong></td>
</tr>
</tbody>
</table>

**Figure 4.1.: A table depicting the number of participants recruited across the seven professional groups**

In trying to understand and analyse the network, and how it was performed as well as the positioning of the child's voice, certain documents were also included in the study. Therefore, the human actants sampled above were the starting point, but objects that also appeared evident in influencing the structuring and positioning of the child's voice within the ADHD network were included within the study. Perakyla (2008) claimed "much of social life in modern society is mediated by written texts of different kinds" (Perakyla, 2008:352). Flick (2006) too stated "documents can be very instructive addition to interviews and observations" (Flick, 2006:252). Using ANT as a methodological framework, documents were considered as non-human actants and their role within the network, was not just an addition to the study, but in fact an essence of it.

A full list of the documents included within the research are listed and referenced in Appendix IV. These included documents that would be used nationally including the Strengths and Difficulties Questionnaire, the Connors Checklist, the Behaviour Checklist, the ADHD criteria of the Diagnostic and Statistical Manual of Mental Disorders4, 4th edition, Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000), the ADHD (Hyperkinetic) criteria of the International Statistical Classification of Diseases and Related

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4 Forthwith referred to as the DSM-IV-TR
Health Problems\textsuperscript{5}, ICD-10 (World Health Organisation, 1990) and the National Services Framework (DfES & DoH, 2004). As an example of the documents also being shared with children, a book for children circulating within the local network at the time (Everything a Child Needs to Know about ADHD for children aged 6-12 years by Dr CR Yemula, 2006) and the CAMHS information leaflet were also included. Other local documents were also included, the Local Authority's CAMH Partnership Business Plan (2005-2008) and the CAMHS Health Needs Assessment (October 2004). As mentioned, the mapping report for the Local Authority also provided information on the breadth of the network, pathways and actants within it. Finally, the report, The Mental Health of Children and Young People in Great Britain (Green et al, 2005) was also included, because when examined further it implied a settling of eligibility to 'voice' using chronological age which, as will be shown, was traced through the network. The inclusion of these artefacts provided evidence of the global within the local, and in total, the child's voice was traced through thirteen documents.

Finally, in researching the network, I was invited to a one day workshop for professionals working with ADHD within the Local Authority, to attend a one day ADHD parent training facilitator's course and shared a meeting with a University Lecturer who had undertaken research with ADHD young people and University students, as cited by a voluntary sector practitioner. The notes and reflections made at these events also contributed to the analysis of the network.

\textbf{4.3.3. Data Collection: Qualitative Interviewing}

As discussed, the challenge was to translate the study of the 'laboratory' into a community study, finding a way to capture the organisational practices, particularly those that could not been seen, for example the movement of a document between two locations. Yin (2003) argued that "\textit{one of the most important sources of case study information is the interview}" (Yin, 2003:89). As such, it was decided to access the network through professional accounts through their 'voices', and so qualitative interviewing was used to understand the performance of the network, in all its visible and invisible guises, and the positioning of the child's voice within it.

\textsuperscript{5} Forthwith referred to as ICD-10.
Latour (2005) accentuated that the role of the researcher should be to describe and record. He recommended that “the task of defining and ordering the social should be left to the actors themselves, not taken up by the analyst” (Latour, 2005:23). He also suggested that the language of the actors should be used within descriptions rather than research ‘meta-language’. Demant (2009) in an ANT study of young people and alcohol argued that "the way things (topics of discussion) are translated in the interview is a precise description of how it is a matter of concern for the particular interview participant" (Demant, 2009:32), the actants (human and non-human) to which the interviewee refers illuminate the connections and associations between them. Such translations, Demant suggested, provide 'traces of association'. As such, the professional narratives of the network were considered an apt form of data to analyse the performance of the network, and the spaces for the child's voice within it.

The semi-structured interview guide (see Appendix I) was developed following discussions with those working in the field (the mapping study) and the pilot work. The interview schedule was arranged to start with the introduction of questions about key focused topic areas including who made up the network and how ADHD was assessed, and then moving on to questions about the child's participation in practice. Questions were designed to be 'open' to enable the 'traces of association' as described in the own words of the participants to emerge.

At the beginning of the interview it was established that all professionals had something to offer, not just those professionals ascribed the role of assessor or diagnoser. Flick (2006) argued that in interviewing 'experts', "the interviewees are of less interest as a (whole) person than their capacities of being an expert for a certain field of study" (Flick, 2006:165). Yet, the questions were phrased to not only access the 'expert' knowledge of participants, in terms of the processes of the network, but also to understand their experiences of Childhood ADHD, which for many allowed the inclusion of their personal as well as public encounters with the condition. Whilst some previous researchers have attempted to keep participants 'on task' (as noted by Flick, 2006), with a strong focus on the expert knowledge, the inclusion of both the private and the public, in the end actually raised some very interesting themes that emerged within the analysis.
The length of the face to face interviews usually lasted between one and two hours. The length of the interview was originally intended to be about forty-five minutes in order to fit in with the work demands of the professionals involved, but the final length was determined by the availability of the practitioner on the day of the interview. For example, the shortest interview (just under one hour) was with a Paediatrician slotted in at the beginning of a clinic. All of the eighteen interviews of the main study occurred at the practitioner's place of work. This offered many positives, for example an opportunity to see a room where a child would be assessed or the artefacts at hand for the professional to show, such as a model of brain, a leaflet or questionnaire. However, there were two main issues. The first was interruptions, for example when interviewing a Paediatrician the interview was interrupted three times, once by a person and twice by a telephone, which may have influenced the 'flow' of the conversation. Secondly, a few participants appeared to be wary of sharing their views in a work space, for example one participant did not want to be recorded and as such interview notes were made.

As interviewer, I had decided to take a stance of 'learner', adopting a position of agnosticism, inviting those being researched to tell me about the network and describe in their own words how it was being performed. Yin (2003) recommended in using a focused interview to check out the 'facts' of the topic under study, "the specific questions must be carefully worded, so that you appear genuinely naive about the topic and allow the respondent to provide a fresh commentary about it" (Yin, 2003:90). Yet, due to earlier contact, some professionals knew that I had been involved with mapping ADHD services so had a prior knowledge, therefore they were at times puzzled to be asked about certain aspects of the network. However, by gaining commentaries from different stand-points, it enabled an exploration of differences and similarities in experiences of the performance of the network.

On reflecting after the interview, some flowed more easily than others. Whilst the majority of the interviews were very relaxed, two were more strained. The two professionals being interviewed were very experienced in their field and from accounts of other participants, were highly respected in the area. Their time commitments had also been emphasised to me. It was acknowledged that this led to feelings of inferiority and a heightened awareness of professional hierarchies within these interviews. Denzin and Lincoln (2008) stated "the interview is a negotiated text- a site where power, gender, race, and class intersect" (Denzin and Lincoln, 2008: 47). I would add occupation or professional status to this list. Yet, the two
interviews where my position felt less respected, perhaps provided me with the first hand experience of how a child or parent could feel when being questioned during an ADHD assessment.

A great deal has been written about the influence of the researcher on the interviewee, how the interview process can be "influenced by the personal characteristics of the interviewer" (Denzin and Lincoln, 2008:47). I reflected upon how much of my own background to share at the beginning of the interview, and I did decide to disclose that I had a professional background as a Social Worker, perhaps to build a professional trust. There were a small minority of participants who were less sympathetic to the sociological endeavour and one in particular queried why I was asking questions about aspects of the process that they felt I should already know (as a Social Worker), when they were expecting much "harder" questioning. On the other hand, some participants did engage in the interview process as a way to reflect, discuss and develop their practice, for example they suggested the ways that they could or would consider the participation of children in their work in the future. On reflection, the interview itself could inadvertently have been enrolling some participants in alternative discourses on the voice of the child.

It is recognised that the information and knowledge shared by participants was situated, their perceptions of the social world. However, it is argued that the performance of the network will be influenced by the values and perceptions of those very professionals interviewed. Also, by interviewing participants from a number of professional backgrounds any consistencies and commonalities across the data could offer insights about a shared social reality.

To note, the inclusion of non-participant observation of those professionals practising within the settings was discounted due to the potential researcher bias in impacting upon the behaviour of those being observed, (for example children may be treated very differently than they would usually do) and the sensitive nature of the research. Access would also have been much more difficult both in terms of gaining ethical approval and agreement from professionals, there was already a perceived ‘threat’ of the study to some of the participants, as detailed in the next section. Qualitative interviewing was deemed more likely to increase consent to participation and enable some sense of control of the data for professionals, for example whether the interview was recorded, which appeared to be important to them.
However, the settings or sites of association were indirectly observed and accessed through interviewing at places of work, in the field, (thus experiencing classrooms, consultation rooms, office spaces and the waiting rooms) which also complemented the narratives of the professionals.

4.3.4. Interviewing: Anonymity, Confidentiality and Informed Consent

Some of the participants were very concerned about how their anonymity would be preserved during the presentation of the study. Many of the participants knew each other in a professional capacity so were worried about the impact on working relationships between services (as identified by Flick, 2006) but also due to personal threat, if they shared a perspective that they felt was not in keeping with their professional role. Yin (2003) argued that ensuring anonymity is important in at least two circumstances- when the topic under study is considered to be controversial and if the study or its findings may impact on the actions of those studied. It was decided that the research met both of these criteria, ADHD (including its diagnosis and treatment) appeared to be controversial globally and locally, and there was a potential that the findings could impact upon partnership working or the professional identities of some of those involved.

During the interviews, some participants shared a perceived high level of 'risk', in sharing their thoughts around Childhood ADHD. This was particularly the case if they wished to share any ambivalence regarding dominant discourses within the network. For example, one participant within the study requested not to be recorded, whilst another asked about confidentiality before sharing a view in attempt to offer 'off the record' information (King and Horrocks, 2010:116). Both participants required confirmation that the sample would be anonymised so that they could not be identified. Others highlighted the fragility of connections between certain professional groups, that required protection from further damage. One participant referred to the performance of the network as a "delicate issue" (009, Teacher), whilst another chose not to give a view to a particular question about Childhood ADHD,

"I don't want to say too much as I don't really have the facts"

(019, Educational Psychologist)
Therefore, it was decided that the details that could be used to identify the participants would be kept to a minimum, particularly in specialist areas or small teams. So for example, specific job roles for CAMHS workers were not stated, neither were the Paediatric settings (Acute or Community) or the names of schools for teachers, only professional groups. The town and Local Authority have also not been identified in the presentation of the research.

Another decision was how to manage 'confidential' information. In line with good practice, the interview transcripts were only been shared with my supervisor. Individual transcripts did not contain the name of the professional, only an assigned number and job role. Yet, one participant specifically asked if certain information they wanted to share would remain confidential and were reminded of the consent form signed about where the work would be published. The discomfort of the participant in itself was evidence of the controversial nature of the topic and how professionals silenced or muted certain views of their own within the network, which was important to capture. Some participants also shared their own personal stories of children with ADHD, both of children within their own family, those of friends and those they had worked with in a professional capacity. As such, participants were asked not to name the child during the interview or provide any identifying or highly confidential information.

All of those interviewed were given an information sheet regarding the broad aims of the study, prior to agreeing to take part (see Appendix V). Flick (2006) has recognised the importance of providing such details to participants so that they feel informed and a level of trust can develop between researcher and participant, particularly those working within institutions. I also asked those taking part to sign a consent form (see Appendix VI). It was explained that consent was given on a voluntary basis and that participants could withdraw at any point. None of the participants were familiar with Actor-Network Theory, although two of the respondents wanted to learn more as they were already sympathetic to a systems approach in their work, and so as such the study was presented very generally, as a way of acquiring professional views and experiences of Childhood ADHD.

4.3.5. Data Collection: The Positioning of the Researcher

One on-going consideration within Actor-Network Theory is “in the recounting of an ANT story, where does the analyst situate him/herself” (Singleton and Michael, 1993:231) in relation to the network being studied? Although it could be perceived that the researcher is
outside of the ‘network’, observing the relations between entities, the researcher must also be aware that through the research itself they may be creating or developing new networks or connections. For example, two of those interviewed commented that it had made them consider how children's views were sought and they shared how they would be trying to change practice in the future.

The researcher could also become an actant within the network. This was highlighted within the current study when on two occasions I was encouraged to become involved within the ‘ADHD’ network by presenting at a local ADHD Conference and by becoming a children’s advocate. As the study developed, I became known in the Local Authority for my interest in Childhood ADHD. Although I did not work in the geographical area, I was approached by a professional working there to co-facilitate a parenting group for parents with children with ADHD, which in the end led to me attending a facilitator training day. I was also approached by a voluntary agency to enable them to offer an ADHD parents support group at my place of work, which I also became involved in supporting for a time period.

Researchers may also have to establish a network around their own study. Martel (2004), after having her own research marginalised, admitted to writing about her experiences ‘strategically’ (2004:158), so that her work would be more readily accepted within scientific and research worlds. For my own research it is acknowledged that it was important to create a “supportive network of key players” (Martel, 2004:168). For example, the mapping study for the Local Authority provided an ideal opportunity to build a supportive network to secure access. In order for the study to go ahead it was also necessary to gain ethical approval from certain committees and engage professionals within recruitment processes.

As detailed in an earlier chapter, in analysing the data, I also needed to reflect upon my own political, sociological and personal values. My previous research interests had focused upon critical perspectives (Travers, 2001) such as feminist approaches and the work of theorists within the 'new' sociology of childhood, with claims about giving 'voice' to potentially oppressed social groups, such as women and children. I had also firmly placed myself within sociological understandings of the world, so to entertain, explore and attend to biological and medical explanations and claims within the study was a larger undertaking for me than I had first imagined. Yet, in attempting to adopt an 'agnostic' approach, findings emerged that led
me to reflect upon my previous values and approaches, including, for example the role of medication, and the complexities of voice.

4.4. Methods: Data Analysis
4.4.1. Transcription and Coding

The interviews were recorded and then transcribed verbatim. In the first instance a detailed diagram of all the human and non-human actants mentioned or referred to within the data was constructed, a visual representation of the network. The transcripts were coded (Mason, 2002) and the original intention was to use a computer package (Atlas.ti 5), to code (Urquhart, 2013) and categorise the data which was started with the first few transcripts from the pilot study (see Appendix VII). However, the codes felt distanced from the raw data and as such, the categorisation was then undertaken manually.

The analysis was originally guided broadly by ideas within a ‘Grounded Theory’ (Strauss and Corbin, 1990) approach to enable thematic strands to emerge from the data and literature review. Themes were identified and developed, for example on dominant discourses circulating in the network such as the positioning of ADHD (see Appendix VIII). Moriera (2004) argued that such an approach can sit comfortably with Actor-Network Theory and reflected how themes may be interrelated. However, there was a concern that such categorising, ordering and structuring of the data was masking uncertainties (Latour, 2005) and did not reflect the ‘ANTness’ of the study, instead the presentation of the data was veering to a social construction analysis. As such the data was analysed again with greater focus on the performance of the network in terms of factors that had been significant in previous ANT studies, for example the use of dichotomies, the role of non-human actants, obligatory points of passage, how issues of uncertainty or controversy were evidenced and settled, and the presence of boundary or fire objects, with consideration to how these related to the themes identified.

Yet, it still felt as though something of substance was missing from the analysis of the data. There was a risk that the data had become de-contextualised from the social processes within the network, in a study where contextualisation was key. The research questions posed for the current study could be defined as a "mechanical puzzle" (Mason, 2002:18), how the ADHD network worked, and specifically tracing the child's voice. Mason (2002) recognised that analysis of social processes may be too complex for simply an indexing of categories and
instead a more holistic, contextual analysis may be required, perhaps supported by diagrams and charts (Miles and Huberman, 1994).

There was a concern that in making the network stand still for analysis, the 'movement' of the child and child's voice through and around the network had been lost and the performance of the network was not being captured. Therefore, after becoming familiar with the data, an analytic structure was developed which could also be layered with the themes and ANT concepts that had already been identified, to better aid an explanation of the network and findings (Layder, 1998).

4.4.2. Developing an ANT Informed Analytic Framework

In developing an analytic structure that could reflect the movement and performance of the network, previous ANT studies were re-considered. An approach was required that could allow for complexities but that ultimately enabled the findings to be presented and discussed. King and Horrocks (2010) recommended providing an 'audit trail' of analysis, "which documents the development of a researcher's thinking as their analysis progressed" (King and Horrocks, 2010:165) and as such, the analytic framework that was developed will be described.

It was recognised that any framework used may risk simplifying the network, however it was decided to explore the data again using four previously suggested "moments of translation" (Callon, 1986: 207-208); Problematisation, Interessement, Enrolment and Mobilisation. These were proposed as four overarching enactments of the network and provided an alternative way to 'slice' the data. ‘Problematisation’ was used to analyse in what ways the child and the child's voice were being defined and understood within the network. 'Interessement' was used to analyse the processes that established or stabilised certain identities for the child and the child's voice within the ADHD network. The 'enrolment' of the child within the performance of the network was examined and then an analysis of how the child and the child's voice were being "mobilised" around the network, so what was being moved around the network and with what implications.

The four moments of translation could be understood as occurring simultaneously within the network and yet, for individual children joining the network, the moments could happen chronologically, for example their behaviour is problematised, actions within the network
occur which assign them certain 'ADHD' identities, the child themselves becomes enrolled in the assemblage and then certain aspects of their identity and their positioning within the network are mobilised. In using the four "moments of translation" (Callon, 1986) as an analytic tool, it enabled an opportunity to follow a hypothetical child's journey through the process from first being identified as 'problematic' through to diagnosis and intervention.

Four time-points in the ADHD network process were also cross-sectioned with the "moments of translation" which further captured the performance of the network and the journey or movement of the 'child' and 'child's voice' within it. These four time-points were explored as specific assemblages- the identification (whether the child was the right sort of child for the network), the referral (where the child should be assessed), the assessment consultation (potentially engaging and enrolling the actual child) and the diagnosis, including decisions about treatment (producing certain kinds of diagnosed child and interventions) as well as the connections between each of these stages.

![Figure 4.2. A table outlining the framework developed to guide analysis.](image)

In analysing the processes and practices of the network, and the movement of the child and the child's voice within it, diagrams were created to depict the performance of the network, an example of which is presented in Chapter Six. This enabled a better understanding of when the physical child was present, absent and represented, as well as the child's 'voice'. Yin (2003) showed how a diagram, a logic model, could be used to understand how a hypothetical young person "might have encountered and dealt with" (Yin, 2003:130) different time-points in becoming part of a gang (or not) and as such, a diagram approach seemed an appropriate tool for exploring how a child in the geographical area studied may
encounter being assessed and diagnosed, becoming an ADHD child, at four different time-points within the performance of the network, as well potential possibilities for voice. However, in analysing the data, it was also important to consider negative cases, as Mason (2002) recommended "cases or instances which do not fit with your ideas" (Mason, 2002:136).

4.4.3. Presentation of the Analysis

Intentionally, as the study is located within childhood studies, the 'child' has remained central to the presentation of the analysis of the data. Therefore connections between human and non-human actants are mainly presented within the analysis chapters in terms of how they are linked in some way to the positioning of the child and the child's voice.

The analysis will be presented in four chapters. The first chapter provides an overview of and introduction to the network, including the key actants. The chapter will go on to illuminate some of the general characteristics of the network, for example its size and the physical distancing of some of the actants. The chapter will also explore in further depth, the potential fluidities of the network, in particular how the positioning of actants changed and their presence of their voices was scaled up or down (Middleton and Brown, 2002).

The next three chapters will provide an analysis of the child's voice and the child within the network, guided by an Actor Network perspective. In the first of these chapters, the focus of the analysis will be problematisation and interessement, so within the identification phase of the network what about the child was defined as problematic, (including how, where and by whom), and how did the child's voice figure as part of this process. The action of the 'referral' including the dichotomies and decisions that were being played out, as well as the identities for the child that ensued will also be explored.

The chapter that follows, will present the ways in which the child was enrolled and assessed within two specific sites of association, the Paediatric or CAMHS clinic consultation, again with an emphasis upon the presence, and positioning of the child's voice. It will be evidenced that different assemblages allow for different presences and positionings of the child's voice. Finally, the last analysis chapter will conclude with a discussion of 'mobilisation', linking it to diagnosis and intervention, considering how the identities and positioning of the ADHD child's voice were settled, circulated and mobilised around the network in different ways.
4.4.4. Research Questions Re-visited

To re-iterate, the over-arching research inquiry was into the presence and positioning of the child's voice within ADHD assessment processes. If, and in what ways, the voice of the child was present, represented and absent and what constituted the child's voice within the network. So, "how are children's voices being composed, transferred and circulated?" (Lee and Motzkau, 2011: 18).

However, it was also important to consider when the child was also present, absent and represented as well as the identities of the child that were being settled, as these may have had implications for the child's voice. It was necessary to ask what constituted the ADHD professional network studied and how this network was being performed- how did a child become an ADHD child? This was important to analyse to understand what other factors or entities impacted upon if, and how the child's voice emerged within the network.

4.5. Summary

This chapter has outlined the methods used to enable an inquiry into the presence and positioning of the child's voice within ADHD assessments, guided by an Actor Network perspective. It has described the pilot study and work that was undertaken to develop, and prepare for, the research. It has defined the sampling frame and criteria used, as well as how participants were recruited. Issues with access were also discussed, as well as the applications to Ethics Committees and the implications for the research design. Details of the final sample were provided, including professionals and documents.

The chapter moved on to describe how data was collected through twenty-two qualitative semi-structured interviews with professionals working in one town, and thirteen documents, including some of the challenges that arose during this process. The reasoning for the selection of the methods was also discussed. Ethical issues, including anonymity and confidentiality were explored as well as the positioning of the researcher. The chapter concluded with a description of how the data was managed and analysed, including an analytic framework that was developed guided by an ANT perspective, to help explain the data. The research questions that guided the study were also re-visited.
Chapter Five
Ordering Disorder -
An Introduction to the Network

5.1. Introduction
This chapter will provide an introduction to, and description of, the performance of the network. In order to be able to begin to describe the network, it is acknowledged that such a description will necessarily simplify the network and make it ‘stand still’, but somehow the ‘messiness’ must not be ignored. It should also be noted that the key actants detailed will be illustrative, for the purposes of focus of the study on the child's voice, rather than an exhaustive list.

An overall descriptive introduction to ways in which the network was performed and enacted was imperative to underpin the further analysis and greater focus on the child and child's voice. In brief, it will be shown that, within the geographical area studied, when a child's perceived behaviours of over-activity, impulsivity and inattention were identified as concerning by the Parent or School Staff, the child was referred by the School or G.P. for an assessment by CAMHS (including a Psychiatrist), or Paediatrician. Other actants were also involved and influential within the process, as will be discussed, including questionnaires, diagnostic manuals, reports, medication and other professional groups.

The chapter will move on to present three aspects of the performance of the network which were identified as impacting upon the way in which 'voice' was managed in the network in general. It will be shown that due to the size of the network and the physical distance between the human actants, who rarely met in person, the prominence of certain artefacts was raised, representing the views of professionals. It will be argued that the ordering of certain actants, human and non-human, within the network appeared to be fluid. There were some actants who were always positioned as obligatory points of passage, but for others, their influence and importance was scaled up or down (Middleton and Brown, 2002). There appeared to be certain mechanisms used to settle ambiguities about the value of certain voices, for example perceived experience or understanding as well as their necessity to the effective performance of the network.

6 G.P. to be used to denote General Practitioner
7 CAMHS to be used to denote Specialist Child and Adolescent Mental Health Service
Finally, it will be evidenced that some of those who participated in the study differentiated their professional and private views about ADHD; those that were shared within the actor-network, and those that were intentionally kept hidden. It was important to consider the importance of the perceived value of self-regulation of 'voice' in general within the network, which also emerged as significant to the positioning of the voice of the child.

5.2. Actants and Assemblages

In summary, it would appear that parents and teachers were most likely to first identify the child's behaviours as problematic. Schools had their own systems to monitor the child's progress, for example a Code of Practice, which may involve an Individual Education Plan or as concern rose, applying for a Statement for Special Educational Needs, after consulting such professionals as the assigned Educational Psychologist or a Behaviour Support Worker (the Locality Team). Schools may also consult their School Nurse or the School Medical Officer, who may also be the Community Paediatrician.

As concern arose, school staff could seek the permission of parents to refer to CAMHS or Paediatrics or a member of school staff may advise a parent to visit their doctor (G.P.). Parents may have already been to see their G.P. to share their own worries about their child. Therefore G.P.s and Schools were the main referrers to CAMHS and Paediatrics, though Social Workers were also a possible referrer to CAMHS. The CAMHS team or Paediatricians may refer a child to each other's service if they feel the referral that they have received for a child was more appropriate for the other service. The referral pathways are depicted below,

![Diagram of referral pathways]

Figure 5.1.: A diagram providing an overview of referral pathways.
In terms of choosing a referral pathway, a referrer would make a decision about whether the child's ADHD was simple, or straightforward, in which case the child would be referred to Paediatrics. Alternatively, children deemed to have more complex ADHD would be referred to CAMHS, where decisions would then be made about whether the child would be seen in the generic clinic (assessed by one practitioner) or the neuro-developmental clinic (assessed by a team of practitioners). The organisation of the referral will be explored in greater depth in the next chapter.

Prior to the child attending an assessment appointment, teachers would be asked to complete a school report and questionnaire. Parents would also be asked to complete a questionnaire. There was some discrepancy over which questionnaires were used, particularly as the Connors checklist was perceived to be very expensive to purchase and as such some suggested this made it less popular, particularly with one of the Health Trusts. The other main questionnaires cited were the Strengths and Difficulties questionnaire, and the Behaviour Checklist.

A more detailed description of the assessment consultation will be provided in chapter seven, but here it is necessary to note that only Paediatricians and CAMHS Psychiatrists were positioned as being able to formally diagnose ADHD. Assessment appointments varied in length and content between the two services and there was also variation in when a diagnosis would be made. Both services used the criteria from the DSM-IV-TR.

Even prior to diagnosis, medication could be trialled as an intervention. Following diagnosis, if a child was not given medication for any reason within Paediatrics, the child would not be seen again by them. Within CAMHS, other interventions as well as medication could be offered, for example parenting groups or behaviour management advice. Following the diagnosis a letter would be sent to the parent, the G.P., and the School if they had been the referrer. Parents were often sent two letters so they could decide whether to share the information with the school.

5.3. Size and Physical Distancing
The findings illuminated the wide range of human and non-human actants that could become connected within the network across health, education and social care. There were a number of 'sites' where different assemblages could be enacted or performed which were physically
separate and distant from each other. For example, in the main, identification occurred within the home and/or school setting. Referrals were completed either within the school setting or G.P. practice. Assessments were undertaken within a Paediatric clinic in a community setting or at a hospital, or in a local CAMHS building, as did diagnosis and intervention recommendations. Interventions could occur in these clinics, but also the school, home and even community settings.

It was highlighted that there were not dedicated services for ADHD, but that children were assessed and diagnosed alongside children with other physical or mental health conditions. Neither was one professional assigned to co-ordinate the services involved. As such, it would appear that the network felt large, complex and messy to those within it,

"I think families can end up with lots and lots of people involved and it all feels a bit out of control and people are doing things all over the place"

(005, CAMHS)

"ours [the service] is all muddled up together".

(010, Paediatrician)

It was not routine practice for those who referred the child to meet those who would diagnose the child in person. A few rare occasions were mentioned,

"But we may, to complete the diagnostic process if we haven’t finished it we might actually visit the school and do an observation so somebody else from our team would do that".

(016, CAMHS)

Interestingly, the reason given for visiting the school was to do an observation of the child in the school setting. The information to be gained was through the child as an observable object, not to meet with the child to gain their views.

At the Paediatric or CAMHS assessment consultation, only the child and their family would be invited. The referring professional (for example teacher or G.P.) was unlikely to be present,
"As a class teacher, um, no, I've never had to visit or had to go to a consultation... It's to do with the parents and the paediatrician"

(002, Teacher)

“I think that you'd infrequently get all people involved together physically”.

(010, Paediatrician)

It was noted in the above description of the consultation that the consultation was perceived to be about the professional and the parent, there was no mention of the child. Multi-professional meetings would usually only be arranged if the child was also part of another professional network, for example the child was 'Looked After' by the Local Authority or if the child had a Statement of Educational Needs, in which case planned reviews occurred on a regular organised basis. Many of those that were being assessed for an ADHD diagnosis would not be part of these networks. Even in these circumstances, not all professionals involved attended the meetings, as participants stated,

"One Paediatrician is very good at taking part in meetings, however another Paediatrician, there aren't the same opportunities"

(003, Educational Psychologist)

"it varies from Specialist to Specialist. Some of them are very open to coming into school. Some of them won't come in".

(021, Teacher)

There were some very specific circumstances described where professionals from different physical settings would meet. For example, within both the school for children with Emotional and Behavioural needs and the Pupil Referral Unit, the teachers explained that there were CAMHS professionals who worked within the settings for a specific period of time on a weekly basis,

"we've got a CAMHS worker which is very useful".

(009, Teacher)
Not meeting in person appeared to lead some professionals to feel that they were not working as part of a team with their health colleagues, and that it impacted upon communication, despite the artefacts that were transferred between them, as will be discussed,

"we sort of have communication, I'm not sure that we work together"

(019, Educational Psychologist)

"generally between health and education there's a bit of a gap in communication anyway".

(022, Voluntary Sector)

Paediatricians and the CAMHS team also seemed to rarely meet in person despite working with the same condition. This physical distance may have contributed to the maintenance of two different assessment assemblages, as will be discussed in the next chapter. Sometimes, referral documents were passed between the two services. There was a perception that this led to some children falling into in a network 'gap', where they did not 'fit' either service,

“there have been occasions when we have seen children and we want CAMHS to see and we’ve made the referral, that referral’s not taken on board saying that this is not appropriate for their services...so these children, I think we do what we can, but there’s this sort of gap there”.

(014, Paediatrician)

It is interesting in the above statement that it is the 'referral' that is not taken on board, that 'it' is not suitable for the service, rather than any reference to an actual child. The child somehow disappears in this process, the referral as an actant replaces the child. So, the network was believed to have 'gaps', for example in communication or between services, which again emphasised the perceived physical size of the network and distancing between sites where the network was being enacted.

5.4. Artefacts and the Network
Due to the size of the network, the distance between the sites of enactment and with few opportunities for professionals to meet in person, the role of the non-human actants or
artefacts appeared to be prominent to link the actants together and to represent certain views or voices.

Some of those interviewed spoke about how they tried to talk to each other in person by telephone, but this often proved to be problematic, as professionals left messages for each other. Others commented on the use of email, but an issue of 'confidentiality' was mentioned, as personal details were not meant to be shared in emails which travelled across organisations.

Therefore the role of questionnaires, reports, and letters that were circulated or moved around the network was emphasised. These artefacts appeared to fulfil five main functions: to represent the voices of certain human actants, to enrol actants in the network, to circulate certain ideas and identities of the child, to connect actants as a network and to circulate a representation of the network. Firstly, reports, and questionnaires could represent the views of those who were not invited to attend the assessment consultation, for example educational professionals,

"I haven't actually spoken to the Paediatrician, but they'd be a kind of report correspondence".

(019, Educational Psychologist)

Additionally these objects served to formally enrol specific actants with the assessment. For example, by returning questionnaires parents were positioned as enrolling themselves and their child into the CAMHS assessment process,

“so the questionnaires kind of act as an opt in”.

(005, CAMHS)

These artefacts could also enrol actants with certain dominant understandings and interpretations of ADHD and the child. For example, the content of the questionnaires appeared to assert certain constructions and expectations of the 'normal' (and abnormal) child, for example in terms of listening, as will be discussed in greater detail in the next chapter,
"a lot of does the child do this, that and the other, and you go through the tick boxes"

(002, Teacher)

"Something like 24 questions where a respondent rates a particular situation, for example a question may concern a child's listening skills".

(003, Educational Psychologist)

As will be discussed further in chapter seven, the questionnaires also positioned the child as object, to be observed and reported on by the teacher and parent, rather than as a subject or social actor who could also contribute a view to the process.

Certain artefacts had some contribution in 'holding' the network together, connecting actants across time and space. For example, those interviewed described the referral document as linking the G.P. or teacher to the Paediatrician or the CAMHS team. Similarly, the questionnaires connected the Paediatrician or CAMHS Psychiatrist and the DSM-IV-TR to the school and family home. The reports and letters produced post assessment connected the Psychiatrist or Paediatrician with the referrer, the parent and other professionals,

"Contact with Health Professionals generally might be a phone call, but often it's just through reports and letters".

(019, Educational Psychologist)

Some artefacts also appeared to translate and represent parts of the network, acting as inscription devices. For example, a school report sent to the Paediatrician or CAMHS Team would state which other professionals had been involved to date or letters sent to the parent following assessment would outline the care plan, which could include the work of other professionals to be involved. Such letters could also prompt human action, for instance a letter from a Paediatrician requesting a report from a teacher.

Some artefacts could also be attributed with re-ordering the network. For example, as will be seen later in the chapter, some parents were positioned as 'chaotic' within the assessment processes, their parenting style portrayed as a contributor to, or maintainer of, their child's condition. This appeared to de-value their positioning and their credibility within the
network. However, after assessment, a letter was sent to parents, and it was often up to them to choose what information to share with the school, so the parent then became a credible knowledge holder and an obligatory point of passage for the teacher to gain information from the Paediatrician or CAMHS team. The artefact, the letter, served to re-order the position of the parent within the network.

However, the work of the artefacts themselves did not appear to always be valued, or recognised by the professionals within the network. For example, the professional below was aware that questionnaires were completed (an action triggered by the artefact), but did not know what happened to them afterwards. Therefore the questionnaire linked the teacher with another actant, the Paediatrician or the CAMHS Team, but the teacher was not aware of who this would be. Instead, it was perceived to go into a 'black hole', again perhaps an indication of the perceived hugeness of the network, or that some professionals did not perceive themselves to be part of a network, as they were not physically located together,

"Sent to? Um it is a bit of a black hole really, I think it [the questionnaire] might sometimes go to the Doctor".

(002, Teacher)

Similarly, the Statement of Special Educational Needs used for some children with ADHD, was positioned as just a "piece of paper", yet it would appear that the process it triggered, the information sharing, was considered valuable and may not have happened without the artefact itself. This again could be understood as the unseen work of the artefact, that may not be visible or acknowledged by the human actants,

"the Statement is just, you know, a piece of paper really. It's the bits that you get ready between the lines, you know, the information you pick up".

(021, Teacher)

A few participants believed that artefacts had a greater influence when their circulation around the network was also accompanied by a human actant, perhaps evidencing the valuing or privileging of the human, or adult voice, within the network. For example, the teacher from the Pupil Referral Unit emphasised that a referral for a child to be assessed was likely to be responded to much more quickly if taken in person to a meeting at CAMHS by the worker,
"so she can sort of assess them here and then take them back to CAMHS, and accelerate, you know she attends the CAMHS meetings, so she can actually advocate for us".

(009, Teacher)

Having a human actant, the CAMHS worker, to travel alongside the non-human actant (the referral) and advocate for, or represent, the 'voice' of the teacher, was perceived to have greater impact and weight within the network, to "accelerate" the process. In this circumstance, the actant with a human voice, appeared to hold a position of privilege within the network. What is also of interest in this statement is that the practitioner described assessing 'them’ in reference to children, and then stated that the CAMHS worker takes 'them' back to a meeting, but this time the 'them' means the referral rather than the actual children, the referral again replaces the child. Similarly, it is the professional who is positioned as having their views advocated, not the actual child.

5.5. Ordering the Network

The next section of the chapter will present some of the ways in which the network appeared to be ordered. Certain actants were identified as being positioned as obligatory points of passage. Paediatricians and CAMHS Psychiatrists appeared to have a stable and settled position within the network, but for other actants their position was much more fluid. Some of the mechanisms used to scale up and down the voice of actants in general within the network will be detailed. Managing the public and private, in terms of voice, appeared to emerge as a theme within the analysis and this will be further explored at the end of this chapter.

5.5.1. Obligatory points of passage

Studying the performance of the network, from identification through to diagnosis and intervention, highlighted that there were a number of obligatory points of passage, actants through which other actors had to go in order to access parts of the network.

So, for example, the school and G.P. acted as obligatory points of passage for a child and their parent to gain an assessment with CAMHS or a Paediatrician. The child or parent could not access these services directly. Similarly, the Paediatrician and CAMHS Psychiatrist were
obligatory points of passage for a child to a diagnosis of ADHD. The DSM-IV-TR was also established in theory as an obligatory point of passage, the child's presenting symptoms had to meet the manual's criteria for an ADHD diagnosis to be afforded, although there was some suggestion that in practice there may have been circumstances where a child was diagnosed without the criteria being met, for example when behaviours were not displayed in at least two settings.

The Paediatrician and CAMHS Psychiatrist, were also established as obligatory point of passages to medication within the network. Whilst the ADHD diagnosis itself appeared to also act in this way, respondents noted that sometimes medication was 'trialled' before an ADHD diagnosis had been formally given. Medication was also the obligatory point of passage for a child to continue to be supported and monitored by a Paediatrician,

"if the family really doesn’t want medication and that’s very clear, then I would usually say well I think that this is the diagnosis but medication isn’t the only way and give them information then I wouldn’t usually see them again".

(007, Paediatrician)

As noted earlier, no one professional was attributed with co-ordinating the services and instead, parents were often perceived to be the human actant 'holding' the network together on behalf of the child, positioned in a 'keyworker' role,

"we kind of leave the parents then to be sort of key worker for that child."

(007, Paediatrician)

The parent or carer, rather than the child, was positioned as the human actant common to most of the nodes and assemblages, for example school meetings, the CAMHS or Paediatric consultation and the home. A child could not access a referral if the parent did not take the child to a G.P. or provide agreement for the school to refer the child to a Paediatrician or the CAMHS team, so the parent was an obligatory point of passage for the referral, and for the child to access an assessment. The parent/carer was expected to arrange the assessment appointment, complete the questionnaires and take the child along to the first consultation.
However, participants did note that a child should be present at the clinic for a diagnosis to be possible and they highlighted the challenges to the process if a child refused to attend. In this sense, the presence of the actual child's body at the assessment was an obligatory point of passage to an ADHD diagnosis.

Following the appointment, the letters and/or reports were sent directly to the parent who would decide whether to share with other actants, such as the child's teacher or, as will be discussed, even the child. Therefore, the parent was again positioned as an obligatory point of passage to information for the child and school,

"we send everything out to the parents and the parents would have to take them into schools because of confidentiality issues, we don’t tend to contact schools directly without parent’s permission”.

(005, CAMHS)

As will be discussed further 'confidentiality' was used as a mechanism to manage who had access to information, but it was also scaled up and down to enable connection between actants, but also to disconnect them, for example CAMHS and the teacher above.

5.5.2. Positioning Actants in the Network

Whilst parents in general were positioned as obligatory points of passage, so actants with influence within the network, on the other hand, as has been noted, some parents were at times devalued within the network. Comments were made about the abilities of some parents to reply to letters, book appointments or organise groups. These parents were often associated with ADHD themselves and described as 'chaotic',

"lots of the families that have got children with ADHD, they have got a bit of it too and find managing things consistently quite tricky ".

(007, Paediatrician)

As well as being devalued for being disorganised, the parenting abilities of these parents was criticised, which would indicate underlying expectations about what constituted 'good' parenting,
“a child that runs rampant in my clinic...would probably not do so under different parenting”.

(008, Paediatrician)

To note, the 'chaotic parent' became a lens through which to view all behaviours by certain parents. Therefore any signs of non-compliance by these parents was portrayed as another example of their 'chaos', rather than interpreted as resistance or an informed decision not to attend the appointment, requiring extra work to achieve enrolment,

“We have to chase up, because some of the parents can be quite chaotic”.

(016, CAMHS)

Some parents were also positioned as 'not believed' in terms of their child's ADHD symptoms, which appeared to impact upon the perceived credibility of their 'voice',

“They [schools] see the parents as trying to get one over on them”

(013, CAMHS)

“Parents sometimes think their child has got ADHD and they want to get medication so they try to fill in a questionnaire deliberately blankly if you like, and that questionnaire doesn’t fall for that one”.

(006, CAMHS)

These parents were positioned as trying to use their 'voice', or representations of it through the questionnaire, in unapproved ways. The questionnaire and teachers were described as not being seduced by the claims of the parents. The views of these parents were questioned but also tensions between actants were evidenced. Interestingly, in this case the questionnaire was afforded its own agency, not to believe the parent.

In contrast the position of the CAMHS Psychiatrist and Paediatrician appeared much more stable within the network, not only as they were obligatory points of passage to both the ADHD diagnosis and medication, but there also appeared to be a perceived association between medical knowledge and influence within the network. Those with medical
knowledge were afforded the position of most authority within the network, which could silence views of others,

"sometimes my, sort of opinion may be different to my medical colleagues, but I have to respect their authority and their diagnosis".

(015, CAMHS)

One Social Worker described how the view of the Psychiatrist had been directly challenged regarding the use of the ADHD diagnosis as an explanation for a child's behaviour. The Social Worker suggested how their alternative opinion, or voice, providing a different explanation for the child's behaviour was silenced,

"But he said no, it's not. It's just solely to do with ADHD".

(012, Social Worker)

The same Social Worker stated that he had never been asked to contribute his knowledge, to offer his opinion in the assessment process, despite having a background in working with young people diagnosed with ADHD,

"I've never actually been, you know, asked to contribute about ADHD, even though I have got a relative knowledge".

(012, Social Worker)

The views of some professionals, particularly if they expressed alternative opinions to Paediatricians or CAMHS professionals, appeared to be discredited using the mechanism of 'understanding' which was also related to experience, as well as their professional role,

“I mean there’s different levels of understanding. We’ve had a whole influx of very junior social workers for instance some of whom seem to really struggle with understanding”

(016, CAMHS)

"Then sometimes there's a lack of understanding between, you know the schools ”.

(015, CAMHS)
Therefore, Social Workers or Teachers who did not agree with Paediatricians or CAMHS Workers were perceived to lack 'understanding' rather than disagreeing because they held a different opinion which could be equally valued in the network. This may also raise the question of how far such professionals would be valued in terms of advocating or speaking on behalf of the child.

Both CAMHS workers and Paediatricians described the work that was undertaken to try to ensure that these differences of opinion did not arise, that other professionals were enrolled with certain discourses on ADHD and medication as an intervention,

“we have to do lots of work with school, educating in schools, helping repair branches that have broken down, opened up because of differences in opinion”.

(016, CAMHS)

Differences of opinion appeared to be a threat to the successful performance of the network. It was the professionals that saw the child on an everyday basis who would have to put certain recommendations into practice and for the network to be effectively enacted, therefore, the enrolment of the teacher seemed a necessity. Their influence, in these circumstances, was scaled up,

“unless the teachers in school are completely bought into the diagnosis and the sort of plan that the child and we have come up with to help him to manage it, it evaporates when they get to school”.

(013, CAMHS)

The Paediatrician below explained how scaling up the value of the teacher's views to the teachers themselves was a mechanism for encouraging their enrolment and in turn, compliance with the assessment process, for example ensuring the completion of questionnaires,

"it's taken I think 5, 10 years for people to start to realise that actually the information that they have, because they feel very inexpert, that the information they have is actually important. I think that’s changed a little bit for the better. So they are more likely to fill in a questionnaire and put comments on it”.

(010, Paediatrician)
This would again indicate that the voice of the actant is scaled up (or down) depending on the necessity of their voice and/or compliance to the successful performance of the network. Therefore, the valuing of certain actant's voices may vary depending upon the task or decision in hand.

Analysis of the data seemed to suggest that within the network, actants could be positioned in relation to whether they were perceived to have information or a role that was necessary to the how the assemblage worked. For example, during the referral stage teachers were positioned within the assemblage as having information necessary to the performance of the network. They were positioned as obligatory point of passage for parents and children to a referral to CAMHS or Paediatrics, as well as providing an insight to the child through a report and questionnaire, thus at this point in the process, their value to the network was high, it could not function without their 'voice'. However, following the assessment, they were not positioned as information receivers in their own right or being able to access the information from the assessment directly, only in some circumstances (if they had been the original referrers), or if shared by parents. Teachers were expected to be enrolled enough to pass on or give information to contribute to the assessment, but paradoxically it was not perceived necessary for them to receive it, after the assessment, in their own right. Yet teachers too were expected to support the interventions recommended.

Another factor within the network which appeared to impact upon the position of an actant and connections between actants, was 'confidentiality'; who had access to certain information about the child and their family. Therefore, the content of the information was important as was the perceived ability to be able to 'hold' personal information about the family. For example, G.P.s were a group of actants whose value and importance was emphasised and in the main, appeared to remain steady within the network. There appeared to be a greater level of professional trust and connection between CAMHS or Paediatricians and the G.P., they were perceived to know and 'hold' information, so information was shared with them,

"G.P.s are much easier because rightly or wrongly we just sort of accept that the G.P.s kind of get to know everything and will hold that".

(013, CAMHS)
Professionals were positioned differently in relation to the family's personal information. For example, teachers cited the role of 'confidentiality' in limiting their access to information, which was perceived to impact upon professional relationships and connections,

"the frustration with working with any of these outside agencies is always the confidentiality"

(021, Teacher)

"this is a delicate area because they [Paediatricians] can't disclose medical information, so we don't hold close relationships with them".

(009, Teacher)

The position, and influence, of non-human actants within the ordering of the network also changed, again depending on the perceived importance to the performance of the network. The DSM-IV-TR (the American Diagnostics and Statistics Manual, fourth edition) was described as a valued and influential actant in the assessment of ADHD, holding important information too- the criteria to be met for a diagnosis. Yet, as noted, examples were given when the clinical judgement or "personal experience" of the Psychiatrist or Paediatrician overrode the DSM-IV-TR criteria, so that a diagnosis could be made. For example, the DSM-IV-TR stated that symptoms should be evident in at least two settings and yet, participants gave examples of when a child would be diagnosed with symptoms in just one setting,

“this is where personal experience comes in, I think that we have to really pick that apart when we are assessing because some parents manage their child’s behaviours extremely well so that they are not actually going to be able to tick the boxes on the Connors questionnaires”.

(013, CAMHS)

Others highlighted that there may be variation even in one behaviour for the same child. For example it was highlighted that a child may vary in attention across settings,
“we usually expect a child to have certainly problems with concentration and attention but it may be in only certain situations, so it maybe that they can concentrate for ages on their computer game or on the internet or something because it is really stimulating and really interesting and motivating to them, but in other situations like school work it’s impossible”.

(005, CAMHS)

This would suggest that how ADHD symptoms or behaviours are exhibited may vary depending upon what else is in the assemblage.

Similarly, it was noted that some actants were no longer deemed necessary to the assessment process and had become absented. In the past, it was claimed that the ICD-10 (International Classification of Disease, World Health Organisation) had been used to assess and diagnose children but this actant had been replaced locally by the American Diagnostics and Statistics Manual (DSM-IV-TR). The over stringent criteria of the ICD-10 was cited as a reason as to why it was no longer used within the network, if still used many children would be excluded from the diagnosis and it also did not allow for a dual or co-morbidity diagnosis, so was positioned again as preventing the successful performance of the network. The rhetoric of ‘inclusion’ of children was used to justify the exclusion of the ICD-10,

“the strict criteria of HKD we’ve actually disadvantaged some kids...so that’s why it became, we became much more inclusive in our diagnostic approach”.

(016, CAMHS)

It was also highlighted that Educational Psychologists were no longer deemed an obligatory point of passage within the network to medication,

“when we first started looking at ADHD maybe, I don’t know, 12 years ago or maybe more, we wouldn’t start anybody on medication until they had an educational psychologist involved...it just doesn’t happen, it doesn’t happen”.

(010, Paediatrician)
Which was re-iterated by an Educational Psychologist,

"I'm not as a matter of course asked for my opinion by medical professionals".

(019, Educational Psychologist)

Therefore, this highlighted the fluidity and changing nature of the network. The prominence or importance of certain actants could increase or decrease. Analysis of the data indicated that the introduction of artefacts or technologies within the assemblage could change the positioning of actants, but it could also offer actants opportunities to move out of semiotic character, to behave in ways not expected by the network. For example, when medication was an actor in the assemblage, it was noted that certain G.P.s within the network were more resistant to prescribing and therefore did not fulfil the role that they had been assigned within the network,

“some would be more willing to prescribe and some would be less willing to prescribe so you've got extremes at both ends”.

(006, CAMHS)

This highlighted how actants themselves could resist and change their position, but it could lead to them to being devalued by other actants, such as Paediatricians. Artefacts in the assemblage may change allegiances and connections between actants. Interestingly, it was described how G.P.s used 'lack of knowledge' to minimise their own role in relation to medication in the network, but this was understood as masking the 'real' reason, which was perceived to be less acceptable,

“Their excuse is that they lack the knowledge to prescribe it… the real reason is that they don’t want to pay for it but they are not allowed to say that”.

(008, Paediatrician)

Some views were deemed to be acceptable within the network and others were not, for example G.P.’s opinions on paying for medication. This suggested that as well as being muted by others, actants also made decisions about what views or voice to share in the public network, and what to keep hidden.
5.5.3. Managing Public and Private Voices

Despite evidence of dominant discourses regarding causation (as a neurobiological disorder), the reality of the condition and recommended treatment (medication), some professionals shared ambiguities around Childhood ADHD,

"Some professionals don't believe it, some professionals do, some professionals do believe it but don't believe in medication, some professionals believe in medication."

(012, Social Worker)

For example, within the professional interviews, a few participants shared their ambivalence about the 'reality' of ADHD now or in the past, as well as the extent to which it is diagnosed,

"when I was a registrar I didn't use to believe in ADHD"

(007, Paediatrician)

"even some of the CAMHS workers I've spoken to have suggested that they're not necessarily in agreement with the whole ADHD thing".

(012, Social Worker)

It was suggested that others expressed their views about the reality of 'ADHD' when they were no longer in a professional role or were outside of the network,

“There are some child psychiatrists, interestingly, who say it doesn’t exist. Interestingly, a lot of them retire and then they’re outside of the mainstream”.

(015, CAMHS)

Yet, the worker above instead spoke about performing a professional role with a particular public voice in the network,

"but I’m in a context that is in an NHS health context that has a reality that ADHD exists as a thing”.

(015, CAMHS)
Therefore there appeared to be a reticence in publicly voicing alternative viewpoints to the dominant discourses and instead these were often kept out of the network. It seemed that regulating 'voice', exampled through keeping certain views or information out of the network, separating the personal or private from the views expressed in public, as part of the professional role, was an accepted practice. This may raise interesting questions about the acceptability to have different voices in different spaces. These views, which could be indicators of partial enrolment, were intentionally hidden and as such the stability and durability of the network was not threatened.

Despite querying the 'reality' of ADHD for all children, there was a paradox that some of these same professionals described children within their private nodes who they believed had the condition, children of professionals. For example two participants explained how they had children who had been diagnosed with ‘ADHD’, another had a brother with the diagnosis, whilst another referred to the best friend of their child who had received an ADHD diagnosis. One educational professional questioned whether her son should have been diagnosed with ADHD as a child. It could be argued that being diagnosed as ADHD among the children of working professionals could be 'more believed' than the diagnosis of children from 'chaotic' backgrounds. However, as a result of the silencing of personal views, or keeping them hidden in the public performance of the network, there was not a space for the open discussion of moral judgements which could be influencing decisions about children's care.

5.6. Summary
To conclude, this chapter has provided an introduction to, and description of, the network studied, in terms of actants, assemblages and performance. The magnitude of the network has been shown, as well as the physical distance between sites of enactment and actants. It was argued that this raised the profile and importance of artefacts that connect the actants. Other roles of the artefacts were considered, including representing the voices of the professionals, positioning the child in certain ways, enrolling other actants, depicting the network itself and even, at times, re-ordering it.

Singleton and Michael (1993) referred to 'displacement', for example the meetings that are arranged or certain contacts between actants that are established to organise the movement of information. Yet, the not meeting, the lack of face to face opportunities or physical contact between the human actants, and thus information not being shared, could perhaps also
contribute to the durability of the network. For example, by absenting those who may hold different opinions from the assessment consultation or enabling the stability of two different assessment assemblages, as will be explored in the next chapter.

As the network was performed, increasing or reducing the value and voice of actants within the network was an accepted practice for adults and artefacts. For certain actants, such as the teacher, their positioning was more fluid, whereas for other actors, such as the Paediatrician, their position was more fixed and static. The general social ordering of the network was important to explore because, in relation to the positioning of the child and child's voice, it indicated not only the hierarchical aspects of the network but also the potential fluidity of the positioning of a number of actants. Mechanisms used to re-position or discredit voices in general within the network were also evidenced, for example associations with performing organisation (chaotic parents), or understanding (social workers and teachers). The impact of the introduction of certain artefacts on the position of other actants was also discussed, for example medication or 'confidential' information as well as the potentials for certain actants to act out of character or role, for example the G.P.s. It also emerged that managing the public and private, for example keeping personal thoughts hidden from the professional network was an important theme, perhaps avoiding unsettling the network.

It was important to explore how voice and status or positioning were managed within the network in general, to understand how the child's voice, and even the child, would experience the network as simply an actant, never mind as a child or as a child with ADHD. This could provide another layer to the voice of the child within the network. It is important to note that other actants were potentially silenced or muted and their voices discredited or their legitimacy questioned. Often, childhood research focuses quite rightly on the child but in doing so may continue to perpetuate the idea of adults and children as always different (Spyrou, 2011), and yet through voice it could be argued that the management and circulation of some adult voices may hold similarities with the way in which the voices of some children were positioned. Similarly, when these actants attempt to represent, advocate or communicate the views or meanings of such children, this may be less successful for some of the reasons described here.
Chapter Six
Differences, Decisions and Dichotomies

6.1. Introduction
This chapter will focus on the analysis guided by the "moments of translation" referred to as Problematisation and Interessement (Callon, 1986), and in particular the identification and referral processes within the performance of the network. It will start with showing how the child could be traced through the network, in order to understand when the actual child was present (so there could be possibilities for voice) and when the child was abstracted and circulated around the network (for example through artefacts), so when the child's voice was represented or absented.

This chapter will show, in the identification and referral processes, how when the child's voice was abstracted, it was often problematised, as vocalisation, through questionnaires, diagnostic manuals and the narratives of the professionals. The vocalisations were observed by others as indicators of ADHD symptoms, and for children under eleven in particular, there was not a way for them to share their views within the referral process, this was guided by the voices of others.

It will also be highlighted that other aspects or parts of the child were also being extracted and abstracted, including the child's body, mind, brain and genes. The first three of which, at least, were interconnected with the child's vocalisations. The findings will show that a dominant discourse existed within the network that all children were 'different', yet encompassed within a spectrum.

The analysis chapter will conclude with showing how these different children had to be standardised to fit one of the two pathways of the referral process, which in turn defined and stabilised certain identities for the children involved. This involved a decision about whether the child's perceived ADHD was judged to be simple or complex, presented as being determined by the child's symptoms or behaviours. Yet, it will be argued that further investigation suggested that a number of negotiations took place, separate and outside of the child, that were black-boxed within the decision making processes. The significance of this decision was that the child then entered one of two assessment assemblages, which the next
chapter will show, had different possibilities for the presence and positioning of the voice of the child.

6.2. Tracing the Child

Previous ANT studies have focused on one object or actant for example, a health condition, a baby, shellfish or a microbe. In this vein, the actant that was traced through the accounts of the network was the child, in order to understand and examine the presence and positioning of the child's voice. It is argued that both the child and the child's voice had to be traced in order to understand when the child was present but their speech may be silenced or not constituted as voice. Similarly, there could have been times when the actual child was not present, but their views were represented or had an effect.

Therefore, in exploring the performance of the network and tracing the child within it, the actual child was present in the school, home and G.P. appointments where the child was first identified as problematic. The child then became abstracted and represented in the referral document as it travelled from the G.P. or school to the CAMHS or Paediatric clinic. The children's views were not included but their vocalisations may have been evidenced as indicators of the problem, as will be discussed.

During the 'sifting' (or screening) process within CAMHS and the Paediatrician's consideration of the referral, the actual child was absent but the abstracted child was present within the referral form or letter. A request was then made for questionnaires to be completed in certain settings, the classroom and the home, where the actual child was again present. The abstracted child was then transported back to the CAMHS Clinic or Paediatrician through the completed questionnaires and school reports. As will be discussed, the research highlighted that such questionnaires often referred to the child's speech, but again as vocalisations, as a problem. It will be shown that children under eleven years of age were not able to complete their own questionnaires about their symptoms.

Both the physical and the abstracted child were present together at the CAMHS or Paediatric assessment appointment when reports and questionnaire results were shared with the children and their families. The analysis relating to the assessment consultation, and the possibilities for the presence and positioning of the child's voice, will be presented in the next chapter. Documents such as case notes and "paper records" (007, Paediatrician) were also non-human
actants within the assessment which also represented and translated the child, but the child's own views were not routinely recorded. Then the abstracted child was again circulated around the network within letters to parents and the referrers. It will be shown in the next chapter, that children were not routinely included in this information sharing.

Figure 6.1.: A diagram depicting the circulation of the actual child and the abstracted child around the Childhood ADHD network studied.

The diagram, Figure 6.1., provides a visual description of the presence and representation (and absence) of the actual child. It also details when the child was abstracted and represented within artefacts, such as letters, questionnaires and reports. So, in tracing and exploring the 'voice' of the child further in the identification and referral processes, it emerged that the speech or utterances of the child were being circulated as a problematic entity, as vocalisation rather than voice. In addition, other different parts or aspects of the child were also being extracted, abstracted and circulated as problematic entities, which appeared to have implications for the presence and positioning of the child's voice. Each of these five entities (vocalisation, body, mind, brain and genes) will be detailed in turn.
6.2.1. The Child's Vocalisations

"When they're 8 or 9 they're usually funny and witty and slightly off the wall and can talk for England, and talk out of context"

(011, Voluntary Sector)

"a younger child probably around 5 or 7 or 8 will generally be very chatty".

(013, CAMHS)

Participants within the study described the vocalness of the child, children whose speech was often heard in the classroom, playground and home. However, it emerged that the vocalness of the child was often problematised and actually used as an indicator or symptom of the condition, ADHD. During the identification and referral processes, the child was positioned as a problematic speaker, as vocal but not voiced.

Those interviewed referred to the DSM-IV-TR that listed talking excessively (used as an indicator of hyperactivity) as well as blurring out and interrupting (used as an indicator of impulsivity) as key criteria for diagnosing Childhood ADHD, as well as difficulties with playing or undertaking activities quietly. Speech was referred to in terms of inattention, but this was in reference to the speech of adults, when children were perceived to not be listening to the voices of others. Therefore not being silent was also problematised.

These criteria were reflected within some of the questionnaires sent to parents and teachers for completion prior to the assessment appointment. For example, the Behaviour Checklist asked about how much a child talks, interrupts and blurts out. This appeared to indicate that there were certain social rules around children as speakers in the ordering of adult-child relations. The child was expected to follow the 'timing' of vocalisations, knowing when to speak, as well as know how to speak and when to be silent. These ideas were also evident within the accounts of professionals,

“blurting out with things, or saying what might be inappropriate things while I am still chatting to their parents”

(007, Paediatrician)
"Impulsivity, blurt out answers".

(017, School Nurse)

The child as a problematic speaker was also circulated within other artefacts, including those shared with children themselves. For example, within the book circulated for children (Everything a Child Needs to Know about ADHD for children aged 6-12 years by Dr CR Yemula, 2006), the boy is described as noisy in the classroom, talking a great deal and interrupting others. He also calls out loudly and interrupts the teacher, which results in him being excluded from the class. At home, he is described as loud, disturbing his mother's telephone calls. Therefore his vocalisations would appear to be a threat to the voice of the mother and teacher.

The child's vocalisation was used as evidence of ADHD symptoms, vocalisation enabled impulsivity to be heard and these interior processes of the child to be 'seen' in the public domain. The vocalisations were not approved or legitimated by adults, therefore not positioned as voice or agentic. The vocalisations instead were positioned as out of the child's control and attributed to their ADHD,

"the nature of the child having ADHD in a way, they blurt everything out".

(013, CAMHS)

The little girl in the book described above has ADD (without the hyperactivity), she is described as much quieter and her vocalisations only become problematic when she attention-seeks, is stubborn (opposing adult voices) or screams when angry. Therefore, her speech only becomes problematised when it challenges adult authority.

However, there was a sense that the child had a certain power or influence through their vocalisations, but this was not deemed appropriate or valued by the professionals working with them,

"they're very used to being very vocal about what they want"

(009, Teacher)

"they are shouting out".

(019, Educational Psychologist)
The child as speaker was positioned as demanding and even intentionally using their 'vocalness' to gain something, but in non-legitimated ways. Therefore, there were two positions available. Vocalisations as 'out of the control' of the child or 'intentionally used' by the child, to try to influence others, but in what were deemed unacceptable ways. In neither case was the child's speech positioned as 'voice' to be listened to by others. Vocalisations were positioned as problematic in terms of frequency and volume.

There also appeared to be an underlying theme within the professional interviews, that one of the key challenges to the effective performance of network was actually the child as speaker. For example, as will be explored further in next chapter, the child was described as less likely to follow the communication 'rules' and the use of the professional's time, for example in the classroom or the clinic. Their vocalisations were not positioned as valued information sharing. As well as the frequency and the volume of the child's vocalisation, the content of their speech was also problematised. The child was often perceived to share "inappropriate things" (007, Paediatrician) and make their personal thoughts public,

"I am not trying to say all children with ADHD are like that or that they never have secrets, but they do find it really hard to keep themselves private more than the average, more than the same age child might, and it gets them into a huge amount of trouble".

(013,CAMHS)

As described in the last chapter, professionals appeared to practice a regulation of 'voice' within the network, sharing public views in line with their professional role while keeping certain thoughts about ADHD, private. In contrast, the child was problematised for having an unregulated 'voice', not separating the public and the private. The child was positioned as vocal, but not afforded a position of 'voice'.

As noted, as part of the referral process, and usually prior to the first assessment appointment, teachers and parent/carers were asked to complete questionnaires about the child. These questionnaires as described above, positioned and circulated the child's utterances or speech as problematic. However, it also emerged that specific questionnaires for young people were also sent to families, to be completed by those young people over eleven
years of age. Therefore, the inclusion of the questionnaire within the assemblage could, for older children, enable a possibility for their views to be included as voice,

“When they are over eleven we ask them to fill in the forms so they do their own questionnaire, saying how they feel”

(006, CAMHS)

“a Connors questionnaire which can be used by the teacher, the parent and if the child is old enough or wise enough”.

(003, Educational Psychologist)

It appeared that children had to be perceived to be “old enough” to contribute their views via the questionnaire. Eleven years of age was deemed to be the earliest chronological age at which children could formally contribute to this process by completing questionnaires in the same way that others did, for example parents and teachers. This idea was circulated in other global documents. In a major research report, published in 2005, a national study that claimed that ‘1 in 10’ children aged between five and sixteen had a clinical ‘mental disorder’ (Green et al, 2005), those over eleven years of age were asked to complete a Strength and Difficulties Questionnaire as well as teachers and parents/carers, but the views and experiences of children under eleven years of age were not included in the report at all. Therefore age had been used to settle which children would and would not contribute their own written or recorded views on their symptoms and this was dichotomised into those children over eleven and those under eleven years of age.

Whilst affording children over the age of eleven a ‘voice’, the questionnaire also perpetuated a closing down of the formal inclusion of the views and opinions of the child under the age of eleven at this stage. It standardised and made durable the idea that chronological age denoted eligibility for 'voice' in the assemblage, rather other individual factors such as previous experiences. It stabilised and supported perspectives around the devaluing of the younger child’s voice and that their speech could only be positioned as a problem, as vocalisations.

As mentioned by the professional above, the Connor's questionnaire had a version for completion by young people over the age of eleven. However, within the local network
studied, this version was not used frequently and the reason given appeared to be financial. Those decision makers within the 'Trust' were other actants that indirectly could impact on the possibilities for even young people to share their views,

"The Connors Questionnaire for teachers and parents, sadly we haven’t got an adolescent one, I gather there is one but it’s very difficult to get the Trust to fork out for anything".

(016, CAMHS)

Whether organisations were willing to "fork out" for such questionnaires, could also be an indication of the value of the information, and 'voice', a child could potentially provide. Interestingly, some professionals, particularly those in the CAMHS team, viewed the Connors Questionnaire as a much more thorough tool to assess a wider range of symptoms and issues and thus preferred to use it. However, if for this reason, to aid a more thorough assessment, the Connors Questionnaire was circulated, ironically it was likely to lead to the absence of even the views of the young person over eleven years of age.

6.2.2. The Child's Body

"Very physical, very restless".

(011, Voluntary Sector)

The majority of participants stated that the behaviours that they associated with childhood ADHD emphasised a physical impulsivity and hyperactivity. Examples were given of when children jumped out of their seats during lessons at school or ran into a road without looking. They were described as children whose bodies moved very quickly, out of time or sync with other children and adults.

Reference was made by Participants to the behaviours described within the DSM-IV-TR. Some examples of specific behaviours described within this diagnostic document included the child's failure to finish tasks; difficulties with being organised; fidgeting, and leaving their seats. It could be argued that these documents contributed or sustained ideas about the 'normal' child, one who is able to sit still, complete adult directed tasks and is organised.
There appeared to be a physical regulation of the child's body, children were expected to move only in certain ways and at specific times.

Participants within the study also made reference to the questionnaires that were circulated within the network and used to report symptoms. For example, the Strengths and Difficulties Questionnaire, used to assess and diagnose an array of childhood disorders, asked whether children were obedient, offer to help and stay still. What is interesting about some of these behaviour descriptors is that they are relational, for example how a child interacted with adults who are making requests or in need of help, and yet the context of such interactions was hidden and only the child's behaviour is reported.

The child was positioned as having a lack control over their own bodies which moved or acted in impulsive rather than intentioned ways. Their bodies were also positioned as being out of the control of the adults around them. They were children who would be known by the visibility of their bodies within a social situation or interaction and their bodies were noticed by adults. The child was described as very physically active, comments about "running around" were used by a number of those within the study. They were often defined in untamed, non-human ways, being "wild",

"They will run around literally like a wild thing"

(021, Teacher)

"you can't break the spirit of wild stallions".

(011, Voluntary Sector)

The child's body was described as 'over filling' the social spaces they inhabited, such as the classroom, consulting room or home. As such, there appeared to be social rules about how much physical space a child should fill, the ordering of childhood space, which the children in question did not follow or respect. Instead, they "invade other's space" (020, Teacher). Touching the belongings of others appeared to be particularly problematic for professionals, perhaps again indicating a sense that such children are positioned as not respecting the public and the private divide. For example:
“If a definitive ADHD child came in here now, they'd be straight away, you know, there’d be flying over and they'd turn on the computer and they'd touch this, you know”

(015, CAMHS)

"going and looking out of the window, flicking the radiator, going through all my drawers ".

(007, Paediatrician)

The child's body was also positioned as being out of sync with the pacing of the lives of other children and adults,

"they lead lives that are really fast pace, they very rarely slow down".

(011, Voluntary Sector)

Yet, also out of sync in terms of the development of their bodies compared to peers, positioned as delayed,

“ I would like to think of it as a developmental disorder”.

( 016 CAMHS)

The child's body was also positioned as overly demanding of adult's time and attention, requiring greater monitoring and supervision than other children's bodies. This would indicate that there are norms about how much of an adult's time, for example a teacher or a parent, a child is expected or permitted to demand,

"It was suggested that he was attention seeking"

(012, Social Worker)

"they are quite demanding of the teacher".

(002, Teacher, Pilot)

As mentioned, sitting still emerged as an indicator of when a child was deemed to be controlling and regulating their bodies. Using an ANT informed approach, the significance of
one artefact, the chair, emerged not only as a way in which the symptoms were materialised but also how, when it was included within the assemblage, it impacted upon the positioning of the child's body and could potentially re-position the vocalisations of the child as voice.

The child was described as being unable to sit in a chair for an expected period of time,

"literally cannot sit in their chair for two or three minutes".

(009, Teacher)

Therefore, the presence and use of chairs in the assemblage, other than to sit on, materialised the ADHD and positioned the child's body as problematic,

“we certainly have our children who have been jumping off chairs”

(005, CAMHS)

"doing handstands and climbing around chairs".

(022, Voluntary Sector)

Seated children appeared to signify that the child was following and respecting the norms and rules for social interactions. This could be linked to evidencing that the adult too was 'in control' of the situation and that the accepted order of adult-child relations was being maintained. For example, it was noted that in the classroom, the chair was often used to regain adult control over the child's body,

"you have to get him back to his seat"

(002, Teacher)

"I found ADHD children being asked to sit for 10 minutes. Right, you owe ten minutes. You sit there".

(021, Teacher)

A child whose body could sit for a period of time seemed to be positioned as cooperative and compliant, therefore more likely to have their vocalisations interpreted as voice. It will be
discussed further in chapter seven, how being seated in a chair potentially afforded the child a position of 'voice' within the assessment consultation, the potential to be re-positioned as a subject. But, as argued above, the chair also appeared to be used within interventions, to control the child's body and mute vocalisations. Therefore, the effect of the chair on the voice of the child in the assemblage may vary, depending upon how it connects with the child's body.

6.2.3. The Child's Mind
The mental processes of the child were also problematised, as the 'mind' of the child. These mental processes, or the distortion or absence of them, were seen to be evidenced and externalised through the child's body and vocalisations. The interior of the child was judged by the exterior. These mental processes included management of emotions, thoughts, concentration and self awareness. The child was perceived to need to,

"learn to be calm and learn to think".

(011, Voluntary Sector)

In terms of learning, the child's 'mind' was perceived to be inattentive, distractible and unable to sustain concentration for the necessary period of time, which was reflected within the DSM-IV-TR, questionnaires and the accounts of professionals,

“I mean ADHD really is around, the problems are, that they won't be able to learn, their concentration is all over the shop”

(016, CAMHS)

"children find it very difficult to attend and concentrate".

(003, Educational Psychologist)

As such, the child was often considered not to be listening to the voice of the adult. So another of the key ideas to emerge within the data, was how children were perceived to 'perform' listening, to hear other's voices in adult defined ways. If a child's body was still or seated, this was interpreted that a child was listening. If a child's body was moving, the child was positioned as not listening. Children were positioned as showing through their still, usually seated, bodies and muted voices that they were attending and listening. Therefore, it
was possible that the child's vocal responses within interactions could be devalued, when accompanied by a moving body, as the child would not be perceived to have listened. There did not appear to be a space in the network for a child to be moving and listening, and therefore responding in an active way with 'voice'.

Similarly, when the child was not perceived to be listening to or concentrating upon the adult talking, whether parent, teacher or other professional, this appeared to be generally understood through the ADHD lens and attributed to their condition rather than any other explanation. The not attending or listening, for example was not positioned as an intentional resistance, for a reason, as a way of expressing a 'voice'. For example,

"because they have got ADHD they may well not be listening"

(013, CAMHS)

"not listening to the teachers in school, generally being defiant, oppositional".

(012, Social Worker)

Children were described as having very quick thoughts, or even not 'thinking'; their ability to think intentionally or rationally was questioned. Children were positioned as being unable to disconnect what they thought in their mind with what they spoke. They could not regulate their thoughts or prevent them from being expressed as vocalisations. These children 'blurted out' what were deemed to be private thoughts which were perceived to be problematic in their interactions with others, for example,

"loads of problems interacting socially with other children because he's very verbal and didn't stop and think".

(011, Voluntary Sector)

The child's thoughts were also understood as being at a much faster pace than their peers. Their thought processes were likened to a butterfly, flitting from task to task,

“*Their thought processes move very quickly, people talk about butterfly attention*”.

(006, CAMHS)
This was described as particularly problematic in the classroom, where children's thought processes were required to work in standardised and structured ways to fit the timings of the lesson and school day. There was little discussion of the potential value of being a quick thinker.

The child was also positioned as problematic because the child was perceived to be unable to perform 'self-awareness',

"they are not aware of themselves"
(002, Teacher)

"when they are younger they are not particularly self aware".
(016, CAMHS)

Within the network professionals spoke about children not knowing they were 'different' and not perceiving that their behaviour needed to change. Rather than question difference or for whom the child's behaviour was a problem, one of the shared roles of those in the network appeared to be to enable children to develop a view or an awareness of themselves as different and problematic, as will be discussed in the next chapter. The lack of self-awareness was perceived to be exhibited through the content of the child's speech, again retaining the notion of the child as a problematic speaker.

Participants hinted that the child enacted their emotions very quickly, they could become frustrated or angry easily, evidenced again through their bodies and vocalisations. Interestingly, this was attributed to their condition rather than considering the challenge for a child of living a childhood where most adults around them consistently and continually express that their actions, speech and thoughts are problematic. It is also worth noting that easily displaying emotions, such as anger, was not a formal criteria listed in the DSM-IV-TR as an indicator of the condition and yet it was strongly circulated within the verbal accounts of the professionals. The child was perceived to be volatile, overly-sensitive and unable to regulate emotions,

"being very volatile, being very emotional, being highly sensitive".
(011, Voluntary Sector)
"they are still having their two year old tantrums at the age of fourteen".

(021, Teacher)

The most challenging aspect of the child's exhibited emotions appeared to be lack of 'calmness'. Being calm appeared to be a valued and privileged attribute within the network. One of the roles of the professionals appeared to be helping children to keep calm,

"you have to try and find a way of pulling them in and calming them down"

(002, Teacher)

"to put in support for children to keep them calm".

(021, Teacher)

Uncalm children appeared to be problematic and a threat to adult-child relations. Uncalm children were considered to be over-displaying their personal emotions, making their private minds or thoughts visible through their public bodies and vocalisations. These children, it would seem, needed to be able to control their emotions, to keep their feelings and thoughts within their own minds and bodies, rather than display or vocalise them in public domains.

6.2.4. The Brain
During the time of the study there was a significant rise in the influence of neuroscience and this emerged as a strong dominant discourse within the network, affording the condition a biological identity. Therefore, the 'brain' of the child emerged as a separate entity within the network. It was claimed that Childhood ADHD was a result of the malfunction of the brain, but there was not a clear agreement on the specific reason. There were claims that it was due to a developmental delay in the brain, or problems in certain areas or chemical imbalances and/or issues with certain connections (or 'wirings'),

"I can only go along with current thinking that it is some sort of chemical imbalance"

(002, Teacher)
"the pre-functional cortex where executive function takes place and helps us to attend to task...that area is relatively underdeveloped and connections with other areas are less well developed".

(016, CAMHS)

However, the differences in understandings about what within the brain led to ADHD, did not unsettle the dominance of the discourse. The brain as an entity had certain overarching identities that were shared and circulated around the network. For example, the child's brain was dominantly positioned as a physical object, a body part, and therefore ADHD had become positioned as a biological rather than a mental condition,

"we’re always told that it’s a physical something in the brain”

(009, Teacher)

"its neurological but I’m not sure that its mental".

(021, Teacher)

The child's brain had been re-framed from a static object to become positioned as a more fluid, evolving object,

“it’s to do with the way your brains developing”.

(005, CAMHS)

The brain as fluid object also allowed the potential for the brain to change and develop over time, offering the possibility that symptoms could improve as the child got older. Therefore, the brain was presented as unfinished, as becoming, children were positioned as ‘immature’ because of their brain development. The brain could be used to uphold ideas about the separation of childhood and adulthood, children’s brains were different and not yet able to perform like adult brains for biological reasons,

“The pathway might develop, the pathway hopefully will continue to develop so that their ability to attend, concentrate and be impulsive might all improve over time as they mature, as the brain matures”.

(013, CAMHS)
Certain other aspects of the child, for example the ability to become self-aware or have intentioned thought or 'voice' could therefore be associated with the 'natural' maturity of the brain, rather than, for example, considering the social experiences being offered to the child. The brain as fluid object could also justify the need for early intervention, usually involving medication, to aid brain development. Professionals interviewed spoke about the success of medication as an intervention with the brain, as the following CAMHS worker exemplified,

"medication can help in the meantime with those neurological delays".

(013, CAMHS)

The child's brain could enrol and afford a number of linkages and connections between ideas and actants that appeared to have previously been very separate. For example, some suggested that the child's brain could be damaged or be affected in response to how a child was cared for or parented, (thus also linking to psychological theories of attachment),

"where they may have lived with a lot of either chaos or trauma, it has the same effect on brain development",

(004, CAMHS)

or because of their brains, certain children would find it difficult to manage the current structuring of childhoods such as the education system. Therefore, the brain potentially connected social, biological and cultural factors,

“the brain chemistry isn’t quite right, but it’s how that different wiring affects them in school, in their relationship with their families”.

(015, CAMHS)

There was also a strong discourse around the 'complexity' of the brain which served to retain an ambiguity around the 'cause' of a specific child's ADHD and the differences between each child could be emphasised. The brain carved a space within the network for ambiguity and negotiation which could hold the network together rather than de-stabilise it. For example, necessitating the involvement of others from the wider network to help 'unpack' the
complexity of the brain, including teachers and parents. As one CAMHS professional highlighted,

"So you are always working, this sort of combination and trying to see how much is partly to do with the wiring that the kid has got and how much is to do with the environment in which they are in".

(016, CAMHS)

The child's brain was also positioned as different from other children's, which in turn made them different from other children, but also different from each other,

“*A different brain but not a poorly brain*”

(005, CAMHS)

"*they are different because their brains work differently*"

(011, Voluntary Sector)

"*whether it [the ADHD brain] was caused because of factors in the environment at the beginning of the child's birth or birth defects is different for each child*."

(004, CAMHS)

However, the brain as an object could also link the problematised child to other children, so in fact all children could be viewed through the 'lens' of the brain,

"*it's a condition which is thought to have a biological basis related to neurotransmitters in the brain probably but, and it's kind of an extension to the normal population as well, is my view on it*."

(007, Paediatrician)

The brain had a strong visual identity within the network. There were a number of examples of the visual image of the brain being circulated, which were also used to try to enrol the child, as will be shown in the next chapter. The 'wiring' of the brain was often referenced which contributed to the visual imagery and positioned the brain as similar to an electrical
object, a thing; a piece of equipment. The child's brain was described as almost visible itself, as one professional noted,

"you could almost see his brain ticking over behind his eyes".

(011, Voluntary Sector)

This would suggest that when interacting with a child in the network, the child's brain had become the focus and what was 'seen' or made visible about the child, rather than for example, their views or 'voice'. What the child said may also become viewed through the lens of the brain as vocalisation connected to an immature or malfunctioning brain, rather than afforded a position of voice.

There were no specific 'tests' within the network to specifically enable an assessment of the functioning of the individual child's brain. The working of individual child's brain was instead observed through the child's body and vocalisations, documented within the questionnaires completed about behaviour by parents and teachers. Within the Paediatric Clinic, some neurological tests were used as part of the assessment to indicate the general functioning of the brain,

“but we would do a general neurological one where coordination, those sort of things come together and there are some tests that you do, we look at the way that they walk and whether they have any subtle neurological signs, so those things will be done and then reflexes and looking at their muscle tone to see whether they're floppy or if they're toned or things like that”.

(014, Paediatrician)

But again the reactions of the child's body, the exterior, was used to assess the interior of the child, the brain. However, participants did not appear concerned about the lack of tests of the brain for individual children with suspected ADHD. Only one participant noted that these questions were sometimes raised by other professionals,
"I do run a course on ADHD and people always say, well,...if that's the case, why don't they just do the brain scan of everybody and then they would know whether or not they had it, which is quite an interesting point".

(019, Educational Psychologist)

There also appeared to be some acceptance within the network about the limited amount of scientific research to support the claims about the brain and this did not unsettle or destabilise the dominant discourse,

"I think that research into how this works in the brain has come a long, long way in the previous decade, in the 90’s but there is a lot further to go, there is an awful lot more that we need to know to fully understand it"

(013, CAMHS)

"there's a lot in our brains we don't understand, we don't understand where the connections have gone wrong ".

(007, Paediatrician)

Uncertainty about brain research or brain tests did not undermine the claims or prevent the privileging of the brain within the network. Despite the ambiguity about scientific 'facts', the general claims about 'brain research’ were strong enough for the brain to continue to be circulated as an ADHD related entity and as will be shown in the next chapter, the brain (and images of it) were used to enrol the child in particular understandings of themselves during assessments,

"the research does now indicate there are brain chemical imbalances within the brain to do with the neurons and the pathways in the brain where the messages don't get through in the same way and that causes the impulsivity".

(004, CAMHS)

It could be argued that the child's brain emerged as a 'boundary object’ (Star and Griesmar, 1989) within the network. It inhabited different sites of association, such as the individual child's clinic appointment, the media or a classroom with perhaps different understandings but with some core common identities that could hold the network together, for example as
a complex, fluid, physical object. As noted, the brain could become linked to not just biological theories, but also social, psychological and cultural factors too, for example,

“I think we know more now about early attachment disorders in children, and how they may be associated with significant ADHD type problems later on”

(010, Paediatrician)

"but how do you get that chemical imbalance? I believe that it's down to family factors and the environment".

(012, Social Worker)

By establishing the brain as a physical entity, within the network and a dominant lens through which to view the child it could be argued that there was a risk that childhood could be 'naturalised' (Cussins, 1998), the social and cultural could become subsumed within the biological. Wider structural issues such as class, gender, poverty, deprivation or access to resources could be ignored, or 'blackboxed'; the responsibility of social institutions silenced and the 'problem' of ADHD medicalised, individualised and framed as a result of the child's brain. Although social factors may be connected, these too could be individualised, for example as the result of damage to the brain by particularly poor parenting. The brain of the child could be extracted and made visible; circulated within the network as an individualised problem that required a shared public response. In practice, the hybridity of the ADHD childhood could be masked and the brain could become an overriding way to see or view the child which could de-emphasise the child's voice, body and mind.

6.2.5. The Child's Genes

Another key actant emerged within the biological discourse, that of the child's genes. ADHD was often described as an inherited condition, which in turn made the genes of the child more visible within the network,

“I think there is a major genetic element there”

(014, Paediatrician)

“It is a genetic disorder so often the parents have it as well”.

(006, CAMHS)
In emphasising 'genes', it also illuminated or made visible the parents of some children who were also positioned as having ADHD. Most of those interviewed spoke of parents who also had the condition,

"a lot of our parents are sort of ADHD-type people"

(021, Teacher)

"I would say probably at least 40% of the parents that come along here with their children have obvious ADHD traits".

(011, Voluntary Sector)

Genetics appeared to be an acceptable way for linking ADHD to parenting, and different cultural experiences of parenting, for example in terms of class, or access to social resources were perhaps minimised. ADHD was at times presented as a 'cycle', children acquired ADHD because of their genes but they were also being parented by more 'chaotic carers', thus an interrelationship between the biological and social. Whilst children's ADHD behaviours were seen to be amplified by living with chaotic parents, this was not necessarily positioned as the parent's fault as they too had ADHD, diminishing further blame and responsibility,

"And I think probably the generation of adults who had severe ADHD are a lost generation because you have lost the ability to really help them to manage the situation themselves and if they have children they are not going to have the ability to cope with the problems that their children have”.

(008, Paediatrician)

Therefore ADHD was not just positioned as a category for children but as a category of the population as a whole. ADHD was attributed as determining the behaviour of adults as well as children.
6.3. Referring the child
6.3.1. Being Different

The children were positioned as being very different from adults, but also different from other children, often using a developmental approach,

"a hyperactive behaviour which is beyond normal limits for a child of that age and that developmental stage".

(016, CAMHS)

One participant claimed that expectations had changed in terms of health and illness, so that there was perceived to be less margin for difference within society in general, as well as childhood,

"So there’s a sort of societal expectation, just like that with mental health, that we should be a hundred percent happy, calm, relaxed, hundred percent well behaved".

(016, CAMHS)

However, the children were also positioned as being very different from each other,

"They're all very, very different"

(012, Social Worker)

"Well they are very different I guess but generally, there isn’t just one presentation of a child with ADHD".

(013, CAMHS)

Therefore, being different was used to explain why children may display the symptoms of over-activity, impulsivity and inattention in different ways and with varying levels of severity. Rather than just having the condition or not, there were possibilities for the condition or even each of the symptoms to be considered mild, moderate or severe. This interpretation appeared to allow for a multiplicity of identities of the child to co-exist within the network, for example the very hyperactive child; the inattentive child; the child who lacks concentration in some areas but can focus on others,
“I think it still tends to vary across the spectrum, so you can get children who have all three of core symptoms in very severe ways and its really, really affecting them, or you can get children who just have sort of two of them, they have hyperactivity and then children may have all three but actually its much less severe so they are much more on the border”.

(005, CAMHS)

It also allowed for the claim that the same child may behave differently in different contexts,

“Typically a child with ADHD will be less able to focus on anything for any length of time. but of course again, even that’s a grey area because children with ADHD can watch tele for long periods sometimes, but not, but have much more difficulty with say classroom work, so it’s not clear cut”.

(010, Paediatrician)

Therefore, the data showed Childhood ADHD being portrayed as a spectrum condition in terms of types of behaviour and severity,

"you don’t see ADHD as an all or nothing condition, it is a spectrum”.

(006, CAMHS)

Children were understood to have all three of the symptoms in varying degrees which enabled them to share a category 'ADHD' but for them also to be positioned as 'all different'. Not only could the 'ADHD as a Spectrum' discourse lead to more children being enrolled in the network, being encompassed within the category, it could also be adopted to mute challenges as to why children with ADHD did not all behave in the same way. Some professionals interviewed noted the challenge of deciding where the spectrum started and finished,

“I think most people now agree that there is a discreet entity, what we don’t know I think is more where it finishes, how much should be included in it”.

(010, Paediatrician)
Despite all of the children being positioned as different and on a spectrum, somehow it had to be decided which referral pathway to follow, difference had to be standardised and a dichotomy was identified.

The suggestion appeared to be that for school-aged children it was easier to differentiate between 'normal' and 'abnormal' behaviours and that developmental maturation became more consistent by the time children attended school,

"so we don’t tend to look at pre schoolers because it's very difficult to know what's normal and what's not, and then obviously it would be the older children, its working out is this more than what would be expected in the other sort of children of the same age"

(005, CAMHS)

However, others highlighted that it could be difficult to ascertain when a child's behaviour moved from normal to problematic,

"When does it cross the threshold into being a disorder or pathological, and when is it a range of normal? ".

(010, Paediatrician)

6.3.2. Dichotomising Disorder: Simple or Complex?

As described above, the children being referred for an ADHD assessment were positioned as being very different from each other in terms of symptoms and behaviour. Yet, somehow, these different children had to be standardised to fit one of the two pathways for the assessment of ADHD, CAMHS or Paediatrics. It will be shown that depending upon which service the child was referred to, would lead to different assemblages and in turn, different possibilities for the presence and positioning of voice as will be discussed in the next chapter.

From the accounts of the professionals, referrers had to make a judgement about whether the child’s potential ‘ADHD’ was considered to be ‘simple’ or ‘complex’, a dichotomised decision. Within the geographical area studied, a process had been established whereby ‘simple’ ADHD was referred to, assessed, diagnosed and managed by Paediatricians and
‘complex’ ADHD was referred to, assessed diagnosed and managed within the CAMHS team (with a diagnosis by the CAMHS Psychiatrist),

“the run of the mill ADHD is assessed by the paediatricians in this area”. (006, CAMHS)

The referral decision regarding CAMHS or Paediatrics was presented as determined by the child, if their ADHD was deemed simple or complex. Within the current study, ‘simple’ ADHD appeared to be applied when there were not perceived to be any other factors influencing the child’s behaviour apart from the ‘ADHD’ alone. On the other hand, ‘complex’ ADHD would be applied if it was perceived that the child had other factors in addition to the ADHD symptoms, such as family dynamics and/or co-morbid conditions. These factors were assumed to be contributing to or somehow be connected to the child’s ADHD, and therefore ADHD could still be positioned as a biological condition, within the brain, but other entities became amplified such as the child's mental health or the child's family or parenting (social factors),

"there are additional mental health problems or additional family or social problems or additional developmental problems or its very kind of complex ADHD". (005, CAMHS)

In the area studied, CAMHS did not work with the 'ordinary' or straightforward ADHD, this was referred to Paediatricians. 'Simple' ADHD appeared to be positioned as a naturalised condition, the brain as biological (possibly with social and cultural factors subsumed within it, for example the teacher or parent's responses to the child's different brain), whereas 'complex' ADHD, was positioned as biological plus other factors, whether these were biological, social or psychological.

Another layer in the decision making process around 'simple' or 'complex' appeared to be whether the Childhood ADHD was deemed to be related to 'educational' or 'behavioural' difficulties. 'ADHD' which linked to a child's poor educational attainment or learning ability was considered to be within the boundaries of 'simple' ADHD, thus within the domain of Paediatrics,
“and they would be thinking about it more generally within the context of learning, and we deliberately shut it out of mental health field”.

(013, CAMHS)

Interesting to note within the quote above is the action of "shutting out" ADHD from CAMHS, which links to the discussion in chapter eight regarding the need to protect services from the 'threat' of ADHD. Alternatively, 'ADHD' associated with a child whose behaviour was considered to be disruptive or a challenge to parents or teachers and associated with "emotions", was perceived to be the realm of CAMHS,

“So the children who have more obvious emotional behaviour problems may well go the child mental health service in the first place, and the children would be more obvious educational, less behavioural problems may well come through to us, so there may be a natural selection if you like, for which goes which way”.

(010, Paediatrician)

Therefore the referral to CAMHS or Paediatrics appeared to be influenced by whether the ADHD was perceived to impact on the child's learning or whether there was an impact on the child's emotions. This is interesting in light of the number of participants who mentioned the over-displaying of emotions as a general characteristic of the child. Yet, the process was presented as a 'natural selection', as if it was clear cut, obvious and pre-determined by the 'problems' of the child. There appeared to be an organisational distinction between the two types of ADHD identity, even if there was much more of a blurring in practice.

The professionals description of the referral process in this way, as a dichotomous decision between 'simple' and 'complex' would indicate that the network had undertaken a type of work similar to purification (Latour, 1993). This resulted in 'simple' and 'complex' Childhood ADHD being settled and stabilised as two distinct, separate categories or identities of the condition which in turn led to two different assemblages which, as will be discussed, sustained children within two main identities for the ADHD child, and potentially offered two different experiences of voice.
6.3.3. Dichotomising Disorder: CAMHS and Paediatrics

By having two different assessment assemblages, including different artefacts or tools, some aspects of the child were accentuated, while other factors could remain hidden or less visible. It could be argued that the CAMHS assessment was more in-depth because the children that they were referred were much more 'complex', but this approach to assessment would also draw greater attention and assimilate more information about many more aspects of the child's life than the assessment by a Paediatrician. Yet, within the CAMHS assessment, any medical basis to the child's behaviour could receive less attention, for example fewer physical checks of the body, and therefore these aspects could remain 'hidden' or less visible.

The two assessment assemblages were separate, not only in terms of the actants, but as described in the last chapter, they were also located in different geographical sites, physically distanced from each other. Any connection between the two services about a child was often only via referrals passed between the two rather than a meeting in person of the human actants. There were few opportunities for the two assemblages to connect or merge to see the whole child.

So for example, from the data it would appear that within the 'simple' Childhood ADHD assessment assemblage in Paediatrics, the assessment was described as much more medically based with a focus on the child alone. The ADHD was more likely to be located as 'within' child; there was presumed to be something 'wrong' with the child usually the workings of their brain that required treatment. How a parent had managed the neurological condition may be considered but subsumed under the naturalisation of the brain as biological. The dominant discourse was that the ADHD should be managed through medication.

Within the Paediatrician's much shorter, medically focused assessment, details of family history and dynamics or mental health could remain less visible. One Paediatrician highlighted how within their assessment there was not time to explore social or mental health factors, and that to do so would require a greater amount of time than the organisation of the service allowed,

"we will need to spend a lot of time with the family, which our consultations don’t allow really, that amount of sort of time for mental health issues".

(014, Paediatrician)
Formal observations of family interactions were not included. Instead, observations were made of how the child walked, their blood pressure or head shape,

“physical examination, height, weight, blood pressure if you’re going to start medication”.

(010, Paediatrician)

Medical histories were taken,

“in which we ask all the questions relevant to the medical side of life, from pregnancy to birth, previous medical history, ...and in the medical history, ask questions relevant to differential diagnosis, whether there’s a chance of epilepsy, that kind of thing, other than the developmental problems, coordination problems, those sort of things”.

(014, Paediatricians)

Therefore the idea that the child's ADHD was a solely a physical or medical condition within this assemblage would be upheld and maintained, other factors could be masked or kept out of the assemblage.

Within the ‘complex' Childhood ADHD assessment assemblage, from the data it would appear that the CAMHS assessment explored more family factors, perhaps including an account of previous family experiences, histories and dynamics as well as parent-child observations, possibly through a one way mirror. Within CAMHS, for example, practitioners spoke of using genograms, a pictorial representation of the family tree,

“we want a full family history, we want to know all about from the time of their birth, we do a genogram and there might be previous generations we are interested in and want to know more about, Uncle Johnnie if there is something about that that seems relevant or that Granny has always looked after the children after school”.

(013, CAMHS)

A general medical history and developmental background for the child would also be recorded,
"a much more in depth interview about developmental history and what triggers the responses and the behaviours and so on".

(013, CAMHS)

The assessment would be much longer than that within a Paediatric clinic, typically an hour and a half and was less likely to include physical or medical tests. The 'ADHD' was more likely to be located within the child's brain and the child's environment, so although ideas around ADHD as a brain disorder were still upheld, the way in which the child and family interacted or how the child's behaviours were managed by the parents or by the school were framed as much more contributory. Similarly, the assessment would explore whether the 'ADHD' was associated with other mental health issues,

"But if it’s a youngster who’s got diagnostic issues, probably because of attachment difficulties in the family or there’s other co-morbidities like maybe autistic spectrum disorders or learning difficulties, depression, anger, conduct difficulties, all of that sort of, will be the ones we come to see for assessment".

(016, CAMHS)

Therefore, those that were referred to CAMHS, who were perceived as having an ADHD that was 'complex', were described as having "diagnostic issues". The 'complex' category was used to describe a group of children whose behaviours or presentations perhaps did not 'sit' neatly with a 'straightforward' ADHD diagnosis. Within CAMHS, intervention might still include medication, but could also potentially involve some type of therapy or parenting work, widening the assemblage and management options for the child. A few within the study suggested that for some children, their ADHD could be managed without medication if the appropriate support for families was available and changes were made in the child's life. However, ironically, in the organisational system studied the parent would have to accept the child's referral as 'Complex' ADHD and to CAMHS, in order to access any alternatives to medication. The 'complex' ADHD label was an obligatory point of passage to these alternative interventions,
“I think there are many family situations where if a child is inclined, the child could be managed without medications which is I think where CAMHS come in because if they can get in early enough to help the family deal with that individual child they will probably get away without a lot of other support”.

(008, Paediatrician)

Therefore the 'simple' and 'complex' referral route, as well as leading to different assessments also led to different options and possibilities in terms of intervention.

The very act or process of defining a child in terms of 'simple' or 'complex' ADHD could settle certain identities for the child which would be circulated within the network. For example, depending on whether a child was deemed as simple or complex ADHD may lead to assumptions about the child and their background. Children assigned a 'complex' identity and thus referred to CAMHS, would be more likely to have their social factors and mental health accentuated, framed as 'mental'. For those referred to Paediatrics, where medical tests were part of the assemblage, a more dominant medicalised biological ADHD identity could be circulated and maintained. This could have implications for how the child is positioned and the status afforded.

It is interesting to note that within the interviews, connections were made between ADHD and a variety of factors, for example the brain, genes, the family, schooling, television and computers, foods, sleep, peers which would support the idea of positioning the ADHD childhood as a hybridity. Yet neither of the assessment assemblages embraced all of these aspects, so whilst the CAMHS assessment was described as much broader, for example in terms of the inclusion of psychological and social aspects of the child's life, it did not involve the medical tests or histories that would be gained within a Paediatric assessment. Instead it continued to be maintained that different assessments were required for the two different 'types' of ADHD, simple and complex.

6.3.4. 'Simple' and 'Complex'- An Artificial Dichotomy?

Whether ADHD could be distinguished as 'straight forward’ or otherwise at the point of referral could be questioned, but this referral process continued to be stabilised and maintained. Some participants did question the assumed ease of separating Childhood ADHD into two such distinct categories,
“simple ADHD, if there is such a thing”

(005, CAMHS)

“So ADHD isn’t a nice neat package...it is very complicated in terms of service delivery“.

(016, CAMHS)

There was a view that all ADHD was in fact complex and complicated and whether any child's ADHD could be considered simple or straightforward was queried. Even those practising within Paediatrics and thus managing 'simple’ or straightforward ADHD, commented upon social factors, such as parenting which may impact upon how the condition was experienced by the child or how ADHD was played out.

Some highlighted that children living with ADHD had a greater likelihood of developing additional mental health issues (for example, depression), due to the impact of living with the condition and the responses from others to them. For example,

“lots of secondary problems in children who might get low self esteem because they are not achieving in school and people are having a go at them”

(005, CAMHS)

“often being in trouble, that has an effect on your self esteem and friendships are not easy maintain, so that has an effect on their self esteem, so they can become quite depressed”.

(013, CAMHS)

Fitting children into a simple or complex organisational system, could lead to some children’s mental health being accentuated and other's needs not being addressed.

It emerged from the data that a clear cut dichotomy was on reflection much more ambiguous and uncertain. Others noted the confusion about when the child’s behaviour could be
attributed to a purely biological or simple condition, and when for example, the ADHD was associated with another condition or other factors,

"I'm sure it's the case with a lot of children with ADHD, there is an awful lot else going on in there as well, and it's actually quite tricky to work out"

(012, Social Worker)

"sometimes you can't unpick it....even our mental health worker is not terribly sure".

(021, Teacher)

The role of medication was illuminated as an important actant within the decision making process, with the perceived 'need' for it possibly determining the referral pathway rather than the child. Paediatricians were positioned as the key obligatory points of passage to medication within the network. Therefore even those children with additional factors or mental health issues may be referred to Paediatrics if the child was "in need of medication",

“If there are, kind of, morbid issues, the child’s depressed or anxious, in need of medication, if it’s kind of morbid and that’s the, kind of, where we think on the pathway that it’s still the responsibility of the paediatricians initially, you know, but if it’s complex family matters, family complex situations that’s facing him or the child is depressed, then it would be a CAMHS, a mental health issue”.

(015, CAMHS)

Due to the challenge, and perhaps greater ambiguity, of distinguishing 'simple' or 'complex' ADHD at the point of referral, it emerged in the data that the referrals for some children are passed back and forth between CAMHS and Paediatrics. This highlighted again that although the referral process was presented as stable and clear cut, there may be greater uncertainty,

"we will send on the referrals that look simple and straightforward ADHD to paediatricians and then we will always say when we pass them on if this turns out to be much more complex than the referral suggests, you pass it back and we will take them back ".

(005, CAMHS)
What is again interesting in the above quote, is that not once is the term 'child' used, the referral replaces the child. The represented child is passed between the referrer, the Paediatricians and CAMHS positioned as object; a thing rather than a subject. The actual child and child's voice are absented.

6.3.5. 'Simple' and 'Complex' - Negotiating the process

Although this decision making as part of the referral process was presented as stabilised and determined by the presenting circumstances or needs of the child, it may have masked or 'black boxed' certain processes of negotiation.

From professional accounts, it became clear that what at first appeared to be an organisational simplicity and certainty, as if ‘simple' ADHD and ‘complex' ADHD were intrinsically different objects which could be transparently identified and referred through particular pathways, was in practice much more ambiguous. The seen and heard exterior of the child, the vocalisations and the body, were presented as informing the judgements about the interior of the child; the brain, the 'mind' or the genes (in terms of the impact of a chaotic family).

Yet, there appeared to be other factors at play which could influence how the referral process was enacted for children within the network. The decision about which service to refer a child to may have been less about the needs or behaviours of individual children and more about how the referral pathway was being negotiated,

"it's always a matter of negotiation, level of concern influences, level of urgency might influence it, parental views influence it very strongly”.

(010, Paediatrician)

Therefore, how and why a child came to be referred as 'complex' or 'simple' may have been due to a number of other negotiations rather than solely the referrers perception of the child's behaviour or presenting symptoms. For example one such factor appeared to be perceived availability of resources and how quickly services could respond. The G.P. to Paediatrician route was perceived to work most quickly rather than referrals to CAMHS and this was presented as a reason why families were encouraged to go to their G.P. and negotiate a referral to a Paediatric clinic. The long waiting time for a CAMHS first appointment was
highlighted within the research. A number of participants also cited the small size of the CAMHS team which limited availability and extended waiting times,

"Sometimes the parent goes to the GP because the school has told them to go, so really they are a school initiated referral but there’s a belief in the school that they get there quicker if the GP refers them".

(016, CAMHS)

Professional allegiances, and tensions between services could also impact upon the process. As noted earlier, some participants also emphasised the perceived association between Paediatricians and easier access to medication. As stated, one of the key roles for Paediatricians was to prescribe and monitor medication. Therefore, if there was a motivation to medicate the child more quickly, for example by the parent or the school, or for the child's ADHD to be solely managed by medication then the child would be more likely to be referred to Paediatrics rather than CAMHS. One paediatrician illuminated that they

“tend to see them with a view to whether or not they are a candidate for medication because my role is to monitor and supervise that really”.

(008, Paediatrician)

A few professionals also highlighted a resistance by parents to a referral to CAMHS. CAMHS had a mental illness identity within the network 'mental' was included within the name,

“we are actually a Mental Illness Service, quite honestly”.

(015, CAMHS)

So parents were perceived to resist themselves and their child being associated with mental disorder,

"If I refer to CAMHS and I tell them [the parents] what it stands for, they say "no thank you very much""

(020, Teacher)
"I think the parent’s probably wouldn’t be very happy if they were going into that and saying, okay it’s a mental health problem".

(014, Paediatrician)

The professionals interviewed shared their own resistance to defining ADHD as a mental health issue. The CAMHS information leaflet for families under the heading 'Understanding Mental Health Difficulties' included 'Attention Deficit Hyperactivity Disorder' and one of the 'Service Development Priorities' for the CAMH Partnership Business Plan and Strategy (2005-2008) was "ADHD-implementing gold standard guidance/NICE Guidelines" (2005:28). ADHD was circulated globally as a Mental Disorder, and some defined ADHD by the criteria in the Diagnostics and Statistics Manual,

"it's under the DMS4 criteria isn’t it".

(014, Paediatrician)

However, a number of participants struggled with defining ADHD as a mental disorder,

"a horrible label for a child".

(001, Social Worker)

Participants shared their ideas about how they would perceive someone with a mental health condition to be, and this did not seem to fit their framing of the ADHD child,

“I suppose I come from a generation where mental illness was where they locked you up and threw away the key "

(021, Teacher)

"when I was younger, you’d think it was someone that was, you know a psychopath, or someone who wasn't right in the head, who was saying wrong things all the time".

(012, Social Worker)
A key issue appeared to be the association between children and the term 'mental disorder'. The term was instead associated with adulthood, not childhood. Mental Disorder appeared to be something that happened later in life, not during childhood. As such, there may also have been a professional and parent reticence in referring a child to CAMHS, which emerged as rather a stigmatised service.

In attempting to define mental health and illness, there appeared to be a great deal of ambiguity and confusion. One participant summarised that,

"medical things are things that ...we can fix or not necessarily fix but understand and mental health problems are things that we don’t understand".

(007, Paediatrician)

With the rise in theorising of ADHD as a neurological condition within the network and associating it with the brain, this perhaps provided a growing certainty or 'understanding' about ADHD. Therefore, differences in views on ADHD as a mental health issue may have been indicative of how the network was evolving and changing, with a rise in neurological perspectives that were stabilising the network in a different way. ADHD was now being presented as an 'understood' condition, thus perhaps moving it from the mental health to the medical arena. Again, this could lead to a greater number of children being referred to Paediatrics rather than CAMHS. One participant did note the challenge in moving ADHD from a mental disorder to a physical condition. Re-categorisation it was claimed, could only occur if global texts were re-written and other disorders were re-classified,

“but it could also just as easily be called a physical disorder in that you know, well it couldn’t be I suppose without re-writing a whole lot of other mental disorders, switching them across”.

(013, CAMHS)

Interestingly, the book circulated for children within the network (and produced in conjunction with a national Support and Information group for parents and children) positioned ADHD as a medical condition and of the two children cited within it, Tom went to see a Doctor and Laura went to a Clinic, but in neither case was CAMHS mentioned.
The perceived intrusiveness of the CAMHS assessment compared to that of the Paediatric clinic, was also framed as a reason why parents may try to negotiate a referral to Paediatrics or resist a referral to CAMHS,

"They're [CAMHS] looking at everything and sometimes, I guess, it opens cans of worms that parents, in order to make a full assessment, I think people do shy away, "just sort it out, I don't want to talk about it"."

(009, Teacher)

It is ironic perhaps, that the CAMHS assessment was presented as providing a much greater depth but then this was understood to be more threatening to parents. The CAMHS assessment was also seen to be missing the 'medical' emphasis whereas the Paediatrics assessment would perhaps spend less time on social and psychological issues. As will be shown in the next chapter, the CAMHS assessment could offer more scope for the child to provide their views and speak for themselves but these opportunities may be less available if a referral to Paediatrics is negotiated. On the other hand, a referral to CAMHS would associate the child with a 'mental label', which has been shown by professionals to have negative connotations circulating within the network and therefore may impact upon the child's status or identity.

In light of the accentuated social or family aspects of the CAMHS assessment, a referral to CAMHS could have also been perceived to indicate that the child's parents were in some way being held accountable or responsible, which parents may also seek to resist,

“I think that largely they feel that it [a referral to CAMHS] is an affront to their family unit because they don’t like to feel like there is anything wrong with the way they are bringing up their children”.

(008, Paediatrician)

Instead, parents may be motivated to gain an assessment by a Paediatrician, where the child would be the focus, medical tests would be carried out and the child alone would be treated. Within CAMHS both the child and their family could have to participate in alternative interventions such as parenting work or family therapy. The resources that the parent had to
accentuate the biological aspects of their child's condition or perhaps keep less visible 'social' or psychological factors may also have impacted on the referral process. As noted in the last chapter, parents could hold different positions of power or influence within the network, and some could be more successful at resisting or negotiating the pathways thus ensuring that their child is referred to a particular service. It could be suggested that parents who were viewed through the 'chaotic parent' lens would be less able to assert their influence within the network or even position their child's ADHD as 'simple'.

Parents and Professionals were the child's obligatory points of passage into the assessments, the child could not access these assemblages except via the parent and the referrer. Depending on the success of the negotiations, a child would potentially enter into either one of the two assessment assemblages and their identities in terms of Childhood ADHD would be stabilised as simple or complex. Despite a referral process that is presented as based upon the 'child', it would appear that whether a child was referred to a Paediatrician or CAMHS would depend more upon negotiation processes. The voice of the child in the referral process was absented and vocalisations of the child were used as indicators of the ADHD condition.

6.4. Summary

In tracing the child's voice within the network, this chapter has outlined that whilst the child was considered to be very vocal within the network, their position as speaker was often problematised rather than regarded as a valued 'voice'. It was also shown that other parts of the child were also made visible and circulated as problematic within the network, including their bodies, minds, brains and genes. The problematisation of these other aspects of the child may have implications for the positioning of the child's voice, with perhaps a greater focus emerging on the child's brain rather than a concern for seeking children's views.

It was shown how the views of the child under eleven were not formally recorded within the referral process, those over eleven were more likely to have the opportunity to complete questionnaires, but perhaps enrolling them in an understanding of themselves as problematic. The findings showed that the referral process was organisationally dichotomised, into 'simple' and 'complex' ADHD pathways. This decision was presented as straight forward and clear cut, and yet there were indicators from the professional accounts that in practice, the decision was much more difficult and 'messy'. It also emerged in the data that which service the child was referred to may instead be based on a number of different factors and negotiations
separate from the child. Within Paediatrics and CAMHS it was shown that different actants made up the assemblages and different aspects of the child were amplified. As such, these different assemblages could have implications for the presence and positioning of the child's voice as will be explored in the next chapter.
Chapter Seven
Assessments, Artefacts and Assemblages

7.1. Introduction

This chapter will discuss and explore the enrolment of the child within the network, specifically the point at which the actual child first came into contact with the Paediatrician or CAMHS team. It will seek to describe how the child was positioned during these enrolment processes and the opportunities for voice that were afforded within the two assemblages. It will be shown that different assemblages contributed to different subject positions and possibilities for if and how, the voice of the child emerged.

7.2. Enrolment of the child

As noted in the previous chapter, in exploring the processes of the performance of the network (identification, referral, assessment and diagnosis/intervention), and tracing the child, and the child's voice within them, it could be highlighted when the actual child was present and when they were abstracted or represented and circulated around the network. The last chapter showed how different parts or aspects of the child were abstracted and translated within the network, including the vocalisations of the child. It was evidenced that despite the referral process being described or presented as based upon the child, for example the complexity of the child's symptoms or behaviours, there were many other factors and negotiations being played out that actually impacted upon the decision making processes, additional to the child's body and vocalisations. The child was not positioned as a decision maker within this process, but as the object about whom the decision was made.

Whilst the speech of the child was present and represented as part of these processes, it was as problematic vocalisations rather than 'voice', as an object to be reported upon and observed by others. Similarly, the views of children under eleven about their own symptoms or behaviours were not included within the documents being circulated, for example the questionnaires, but these documents could also contribute to settling the position of the child, and child's vocalisations, as object. Only the perspectives of adults and at times, young people were represented in these documents.

Following a referral, an assessment appointment would be offered for those children successfully referred, either within the CAMHS team or Paediatric Clinic. Parents were
framed as the decision makers about whether a child would 'opt in' to the clinic appointment. It would appear that it was at this point of the process, the assessment appointment at the clinic, that the actual child would have a possibility to be involved as a social actor, to be enrolled in their own right and to potentially share their views in person.

7.2.1. Object and Subject
According to those interviewed, both the child and the parent\(^8\) were seen together at the first assessment appointment. Despite including the child in this first consultation within both settings, it emerged from the data that the presence and positioning of the child's voice emerged differently within the different assemblages.

Within the Paediatric accounts of the assessment appointment there was less reference to seeking the child's views from the beginning of the consultation and instead there was a greater focus on the parent as speaker. So, for example in gaining a child's background information,

“it's more from the parents that we get the history”.  
(014, Paediatrician)

Within the Paediatric assessment, the child was positioned as either present but to be ignored or present and to be observed. Ignoring the child and focusing on the parent was established as usual practice. As Paediatricians illuminated,

“talking to the parents and ignoring the child for the first half of it and then turning your attention to the child”

(007, Paediatrician)

"With the younger ones we generally talk to the parent only, so I wouldn’t say anybody under six, five years, I wouldn’t be sort of saying a lot to the child”.

(014, Paediatrician)

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\(^8\) The term parent used to refer to parents, carers, adult family members
Therefore, although the child was present, their 'voice' was not. The child was expected to be silent, and instead it was the voice of the parent that was the focus of the assessment. One Paediatrician did note some more creative ways to involve children, but this approach did not appear to be a routinised practice by the same professional or across paediatric assessments as a whole. Also, the responsibility for the interaction appeared to be placed with the child, it depended on how the child interacted with the professional, rather than considering ways in which the child could be engaged differently or the organisational practices modified,

“to get the child into a sort of discussion or sort of conversation, get the child talking we might sort of get to something like doing a puzzle, or getting them to draw something and then talk about it, that kind of thing. So it’s generally, I wouldn’t say that, it is fairly, it’s not always the same way, in fact we’re guided by the history of what you find and how the child also interacts with you”.

(014, Paediatrician)

It would appear that some children continued to try to make themselves heard in the consultation. However, their vocalisations were interpreted as further evidence, or indications of, impulsivity and a lack of concentration rather than positioning the child as a legitimate speaker. It was expected that children would sit for an adult defined period of time playing with the toys, without "interrupting" or interacting with the other human actants in the room,

“The child would have been in a room, you see them for at least an hour and you watch them playing whilst you are chatting to mum and often because they come in and they interrupt their mum and they can’t sit still and they can’t concentrate on the things they are playing with”.

(007, Paediatrician)

The child was perceived as not respecting the rules for children's speech within the consultation. The child's vocalisation was positioned as problematic rather than a valued 'voice', in this instance vocalisations did not constitute voice. Instead the child would be watched, observed, positioned as object rather than subject. The child's body and vocalisations were used as tools to assess the child.
Within the CAMHS assessment, the practitioners described how the views of the child were more likely to be involved from the very beginning of the meeting, for example asking the child to talk about their education or to share their understanding about why they were at the appointment. The CAMHS professionals described how they sought the perspectives of the child,

"I mean we always ask the children directly why they think they are here and why they think they have come to see us today".

(005, CAMHS)

Practitioners noted the vocalness of the child, and that the child's voice was much easier to hear than it was for some other groups of children,

“I don’t think I have ever particularly found it difficult to hear the child’s voice in any assessment here with ADHD, it is very difficult in some other cases, but not with ADHD”.

(013, CAMHS)

However, as will be shown later in the chapter, ‘hearing’ the child’s voice does not automatically equate to listening to what the child has to say or for the child's views to have influence or weight in decisions being made. It may depend how the child's voice is positioned, for example as a way to achieve enrolment of the child, to meet adult defined goals, rather than to gain an insight into the views or meanings of the child.

However, the child's voice was positioned as providing information for the assessment, for example about school or living with ADHD symptoms. Therefore there were possibilities for 'voice' in these assessments,

“we ask the child what they like doing and what they don’t like doing at school”

(013, CAMHS)
“I work in getting the kid’s definition of ADHD and their story about it and what it means to them”.

(015, CAMHS)

The CAMHS practitioner below emphasised how the child was made aware that the appointment was focused upon them, what could be framed as 'child-centred' practice. Whilst this could be understood as valuing the child, being told that they were the most important person could also carry a great weight. It could also again indicate to the child that they were the 'problem', the reason why the family have come for an assessment,

"If they are under 11 then their appointment is often focussed on them, they are the most important person in that room and they are told that when they first arrive. Although there are lots of adults around, the appointment is for them and everybody else is trying to help them, so they are set up as the most important person”.

(006, CAMHS)

Engaging the child in their own right as a social actor with 'voice' could be interpreted as a positive action within the network. But it also became apparent that it could be a mechanism to enrol the child with dominant discourses around Childhood ADHD to ensure the child realised that they had a problem which required an intervention, as will be discussed.

Some CAMHS practitioners described recording the 'family dynamics' that were observed during the assessment consultation. It was also reported that within CAMHS, a one way screen could be used to observe the child interacting with parents during the consultation at the neuro-developmental clinic. As such, in this sense, the child's voice or interaction with their parents was also treated as object, something to be observed from another room to inform the assessment,

“we see them with a screen, a one way mirror, a team that can note interactions, look at them while we are taking a history“.

(016, CAMHS)

Therefore during the CAMHS consultation there was scope for the child to be positioned as both subject and object, attention was paid to both their vocalisations and their voice.
As discussed in the last chapter, children were referred to Paediatrics and CAMHS using a simple and complex dichotomy. Children referred as 'simple' ADHD to Paediatrasics were more likely to be primarily positioned as objects within the consultation but perhaps with a greater likelihood that their condition would be framed as a medical condition, perhaps with less impact upon status. A child deemed to have 'complex' ADHD, where other factors apart from the child were associated with the condition, for example the dynamics of the family or a mental health issue, would be assessed in CAMHS. Such children had a greater likelihood of being offered an opportunity to share their views and be positioned as subject as well as object, but could be perceived to experience more moral judgements about their family or about their link to 'mental health services', perhaps impacting upon their status. Therefore, there were different possibilities for positioning, status and voice depending on the assemblage to which they had been referred.

7.2.2. Parent Presence

From the interview data, it appeared that CAMHS had greater flexibility to see the child alone, although usual practice for both services was to see both parent and child together. It was argued within CAMHS, that a child may be seen alone if there was a tension between the parent and the child, and this was deemed to not be 'helpful' to the 'work' of the practitioner.

"Sometimes we might see the child on their own if we think it feels like a very difficult dynamic between the parent and child and they are kind of disagreeing and or it just feels there is a big conflict and we are not, it's not very helpful".

(005, CAMHS)

Therefore, the motivation to see the child alone was not to gain the child's views separately, but to protect the child (and perhaps the assessment) from conflict. In this instance, protection of the child could lead to the child being seen separately and having their views heard in their own right, rather than with and through the parent. The child was seen alone as a 'protection' right, rather than a liberty right.
Seeing the child alone was considered 'out of the ordinary' within Paediatrics, even framed as an 'exclusionary' practice as highlighted by the respondent below. Meeting both parent and child together was framed as being more 'inclusive',

"so you sometimes have to engineer it to see the child on their own, and I find that quite difficult because it's not your ordinary pattern of practice and it's not their ordinary pattern of practice in coming to you in a paediatric clinic. It feels like somebody's being excluded rather than the normal practice".

(010, Paediatrician)

The 'somebody' being excluded would be the parent and this appeared to make the paediatrician uncomfortable as it was not the 'norm' of their practice. However, the Paediatrician also highlighted that it could also feel strange to the child so some children might prefer parents to stay present.

Professionals did identify the challenges of routinely seeing both parent and child together, rather than the child alone. The child would often hear themselves being represented and described by the parent's voice in negative ways. Therefore presence or inclusion of the child might not always be a positive experience for the child,

"Sometimes you find the parents being very negative in the child’s presence and upsetting them"

(006, CAMHS)

"So when they eventually go to consultants, one of the difficulties is that the parent, usually the mother, has to list a huge, has to provide a huge great list of negatives, usually in front of the children, as to why they're not just a normal naughty boy or girl".

(011, Voluntary Sector)

Whilst on the one hand the child was perceived to require protecting from hearing the negative views about them, the organisation of the consultation in terms of seeing both parent and child together, could also serve the purpose of helping to enrol the child into the idea that they were the problem and 'different'. The 'risk' to the child was not considered great
enough that this practice was stopped. In light of the discussion of professional expectations and ideas regarding 'normalcy', it is interesting to note the reference to a "normal naughty boy or girl". This would suggest that there are "normal" children, "normal naughty children" and "abnormal naughty children" and parents undertake work to present their child as the latter in an assessment consultation. It may also indicate again the hierarchical nature of the network that becomes translated into the assessment consultation. The Paediatrician or Psychiatrist hold the access to a diagnosis (and possibly medication), so the parent must also undertake work to enrol them into a view of the child as "not just a normal naughty boy or girl". Therefore, there may be a number of layers to the enrolment process being enacted.

One of the observations of the child was that they needed to learn how to keep private thoughts and information to themselves, out of the public arena. Also, as noted in chapter five, professionals used 'confidentiality' as a justification for with whom information was shared in the network. It was scaled up to enhance or diminish certain connections, perhaps contributing to the retention of the ordering of the network, and the positioning of some of the actants within it. It was suggested that there was private or personal knowledge about the child and family circulating within the network that could not be publicly shared with everyone. Yet, within the consultation 'confidentiality' of any information that the child would share was scaled down, and this appeared to enable a justification for why the parent could be included and stay in the room,

"we are not looking for, you know, things that are confidential".

(016, CAMHS)

It was stated that it was assumed that any information the child shared the parent would have already heard, because these were children who were positioned as usually expressing their private thoughts, publicly.

7.2.3. A Common Understanding

As noted in chapter five, participants within the study spoke about the engagement of other actors, including the child, with a "common understanding".
"once you’ve got to that consensus, that’s what I mean a common understanding, then we can go onto the next step".

(016, CAMHS)

Children over the age of eleven completing the questionnaire could be positioned as enabling 'voice' or the sharing of their views as discussed in the last chapter, on the other hand it could be understood as a way of enrolling the child into certain understandings of themselves. As noted, the questionnaires asked specific questions about the child's inattention, impulsivity and hyperactivity and situated the condition solely 'within child', problematising the child's body and vocalisations.

The emphasis on the process of 'engagement' or enrolment of children with an 'understanding' of themselves as problematic was translated throughout the network. For example, the Department of Health's National Service Framework for Children, Young People and Maternity Services 'The Mental Health and Psychological Well-being of Children and Young People' (2004) stated,

"the process of 'engagement' and establishing a trusting therapeutic relationship can be a necessary prelude to a treatment intervention and may take some time. Successful outcomes...rely to great extent on them [the child] being able to understand and 'own' their problems" (2004:16).

Therefore, it was proposed that children needed to understand their symptoms and condition, to 'own' the problem, and this was perceived to enhance the likelihood that children would adhere to interventions; to cooperate and comply. This discourse of 'engagement' was translated within the network, interestingly again linked to the child's chronological age,

“what you’ve got with ADHD kids depending on their age is an engagement process”

( 016, CAMHS)

"But I think we would all, and certainly I would try very hard to make sure that the child understands to the level of their capability what we’re talking about and the end point of our discussions, which is, which might be for a younger child that you keep getting into trouble with your teacher because you’re not concentrating”.

(010, Paediatrician)
Even for younger children, the above quote highlighted that the child could be talked to, in an attempt to ensure the child understood that their behaviour was problematic and troublesome. Voice, then, could provide a tool with which to enrol the child in particular discourses, for example understanding their behaviours or vocalisations as problematic. Opportunities for the child's voice could emerge, but as a way to enrol the child into particular discourses and even to achieve compliance.

Involving children by seeking their views also appeared to be used as a way to help to re-socialise the child, to ensure that they had an understanding of social or educational norms and expectations for their behaviour,

"We try to help them understand we are going to help them..even 6 year olds need to know that if it is story time they need to be able to sit on the floor and listen to it and not be running around, and that we know that is difficult for them, but we are going to help them learn how to do that".

(013, CAMHS)

The above child was being enrolled in an understanding of their need to change and what needs to change. Interestingly, when children were involved in this way, "even six year olds" were positioned as competent enough to be enrolled in the network, in their own right, and to be able to change their behaviour. But the issue or problem (the not sitting child's body) was adult defined and the decision or outcome was presented as adult controlled, that the child's body will sit on the floor for a story and the child will listen (be silenced). The child was not being asked why s/he did not sit on the floor or what they thought could be done differently. However, the child's co-operation and enrolment is crucial to the outcome of this behavioural goal. Yet, as will be shown, when decisions or issues are positioned as more 'risky', for example understanding and consenting to starting medication, children of this age were not positioned as 'competent' and actually, their cooperation was not even positioned as important or crucial to the outcome. It was parents who would need to be enrolled and parents who would decide to start the medication, supposedly with or without the child's consent.
It also emerged within the data that involving children could be used as a mechanism to encourage the child's cooperation and compliance with adult decisions. The child's voice was not valued its own right, for what it could offer the assessment, but as a means to achieve other goals, for example ensuring children physically take their medication,

“then they are more likely to carry on with it, rather than spitting it out I am afraid”.

(007, Paediatrician)

A few of those who took part in the study stated that they used well-known celebrities, in particular Richard Branson and Robbie Williams, who were perceived to be successful in society, to promote a more positive image of ADHD and to enrol the child in the network. Thus, the underlying message appeared to be that accepting the condition of ADHD was not necessarily negative, positive outcomes were possible,

"Richard Branson's ADHD, you know, and I always tell them of, sort of, famous people with ADHD and you know, look where he is, I know that he's got, you know, a multi-billionaire".

(015, CAMHS)

It is interesting to note that the two celebrities used most often to enrol the child within the network were those considered at times to have been very vocal within the media and valued for their 'voices', as a singer or a persuasive entrepreneur.

7.2.4. Absence and assessment

In exploring the accounts of professionals, it became clear that the absence of the child should not always be viewed as negative. Some children may resist enrolment, for example, it was described how older children and young people had refused to attend the appointment, thus absenting themselves from the assessment process,

“They vote with their feet though if they really don’t want to come to something, if they don’t like it they say they won’t come, and that is respected”.

(006,CAMHS)
One aspect that arose from the study was that the network and the decisions made were not necessarily of the child's own making, raising implications about calling for the voice of the child in decisions that a child may not choose to make. The child as object, for example the perceived actions of their body and vocalisations by the adults around them, may trigger a referral and assessment and have an effect, but the child as subject or social actor may not wish for this to happen. For example, some of the professionals highlighted that children may not perceive themselves to have a problem,

"they are so lively and you know, driven, actually the parents are more hard work because the kid's quite happy with tearing around and very energetic and the parents often have more of a problem with it".

(014, CAMHS)

So, children may not want an assessment or to be enrolled in the network in the first place. Asking for their views to be heard may place greater pressure on them to become enrolled in an understanding of their bodies and vocalisations as problematic.

Similarly, the absence of a child's voice within an assessment may not always be interpreted as negative. Some parents may speak on behalf of their child because they are trying to advocate for their child, however this may in turn mute or silence the child,

"the families with the very supportive parents and things, and it's understandable for them to think that they know what's best for their children".

(022, Voluntary Sector)

The interdependency of the child's voice with that of the parent cannot always be assumed to be negative.

Being voiceless could be a strategy used by the child to influence the actions of others, for example to stop a professional talking,

"they maybe nodding their heads but it maybe you know, they know if they nod their heads we will stop talking [laugh] stop asking them questions".

(015, CAMHS)
Professionals in the wider network though, held the opinion that the child's voice was absented within the assessment meetings,

"I don't know any young person personally, through my experience, that has been involved with their diagnosis"

(012, Social Worker)

"I think sort of the 8 to 10 year olds certainly in my opinion aren't asked enough about their individual cases and things, because I think a lot of people think that they don't know enough about it or that they're a bit young to understand so we won't bother asking them their opinions".

(022, Voluntary Sector)

Alternatively, it was claimed that children were 'over' asked the same questions, for example about a behaviour or actions deemed to be problematic, rather than perhaps involving the child's views in way that the child would find helpful or positive,

"Lots of them when they first come here are really resistant to any sort of, resistant to seeing yet another person who is going to ask them how I feel or what I do about my temper, and again one of the key things is that they don't really have to say things, they can draw things"

(011, Voluntary Sector)

"there will always be adults who know the children and talk to the child, but sometimes they are just not asking the right questions".

(019, Educational Psychologist)

So, it could be argued that children's views were absent because they were not being asked the 'right' questions or in the 'right' ways. It was suggested that children may prefer to give their perspective in other ways, for example through drawing, rather than the 'talking' of the assessment. Finding different ways for children to be 'voiced', for example the methods used and the types of questions asked, as well as the way in which they were asked, seemed to be important for all children to have the potential to participate.
7.3. Artefacts and Assessment

7.3.1. Artefacts and Enrolment

Professionals shared a number of artefacts in the assemblage that could also be used to enrol the child in the network and an understanding of themselves in certain ways. For example, one clinician described how the scores from questionnaires were presented in a graph,

“you plot them on a graph so you can see which areas the child’s struggling in most and it focuses on all the ADHD dimensions according to the DSM criteria, but it also adds in emotional problems and behavioural problems”.

(005, CAMHS)

The graphs or charts were shown to, and explained to, the child and these visual tools were used to illuminate the ‘problem’. Again, for some, particularly those in Paediatrics, age was a deciding factor for whether the child would be enrolled in their own right using the artefact and whether the child was judged to be of an age where they could ‘understand’,

"Again depends on the age, we do actually show the charts and the scores and things like that saying if they are sort of that age that they can understand".

(014, Paediatrician)

In CAMHS, it was claimed that the questionnaire results were shared with the child on a more routine basis, regardless of age,

“when we do our feedback at the end we always show the results of the questionnaires to the families. We will always make sure we show the child as well because obviously it's about them and just let them know what it means ".

(005, CAMHS)

While this would indicate again that the child was being positioned as a social actor in their own right, as discussed, the purpose would seem to have been to enrol the child in perceptions of themselves as problematic, so that the child was made aware of what the information 'means'. In this subject position, the child would be expected to show awareness that they are different and that they were the problem.
Another artefact that was used to enrol the child during the assessment was the 'brain'. As mentioned, the consultation appeared to be an arena to accentuate and enrol children in the idea that they were different from other children, and this included having a 'different' brain or a brain that worked differently to other children. For example, one Paediatrician spoke about how a plastic model of a brain was used (which was shown during the interview) to highlight to children what part of their brain was not working as it should,

"[I] get my brain out and show the bit of the brain that we thinks gone wrong, and explain, try to explain that they can't help it and it's you know, it's how their brain's wired up"

(007, Paediatrician)

The last chapter described how participants acknowledged the lack of scientific evidence or explanation in terms of how exactly ADHD and the brain are connected. There was a common discourse that they were, but differences in opinion about how, for example whether it was a chemical imbalance, a issue of 'wiring' or an area of the brain that was not functioning as expected. Yet, information regarding the brain appeared to be presented to children as 'fact' and with certainty.

Similarly, a book promoted for children, 'Everything a Child needs to know about ADHD' (2006), by Dr Yemula (produced in conjunction with The National Attention Deficit Disorder Information and Support Service, ADDISS) also made claims about linking an imbalance of chemicals in the brain with ADHD. Next to the explanation is an image of a head with a pink brain. Examples were given by those interviewed of how images of the brain were also used to support and supplement the enrolment of children within other sites of the network. A worker within the voluntary sector described how visual imagery of the brain was used to accentuate its connection to ADHD to the children in their service, evidencing the wider mobilisation and translation of the brain outside of the Paediatric or CAMHS clinics,

"we do it by visual wall charts...the first one explaining how the brain works and we show the right and the left hand side of the brain...by actually showing the flip chart and drawings it clarifies things in a way that they actually understand in non clinical terms”.

(011, Voluntary Sector)
The above quote again highlighted enrolling children with certain understandings of the brain, and finding an alternative, perhaps what was perceived to be a more child-friendly, way to engage them. 'Clinical terms' were positioned as a barrier that may prevent children's understanding.

Those interviewed mentioned other artefacts which contributed to the engagement and enrolment of the child within the assessment consultation. A number of professionals mentioned the literature produced by the pharmaceutical companies that were given to children. These leaflets were perceived to be a valued service for the child without agenda,

"there’s a pack that I use which Concerta XL, that company has produced and there’s another pack from Equisym XL, so those are good and it’s not promoting the drug companies or the drugs, they do it as a service to the, for ADHD children"

(014, Paediatrician)

"they are produced by one of the drug companies but they are not particularly drug focused so they are not kind of pushing their medication"

(005, CAMHS)

The written information was not perceived to promote a particular type of medication, however it could be argued that such leaflets performed unseen work in normalising medication as a routine or usual intervention for ADHD, with particular interpretations of the condition. Such leaflets were again framed as enabling 'understanding' for the child, in their best interests. It was noted that within the narratives of both CAMHS and Paediatricians, critical reflection on the role of pharmaceutical companies was absent. Yet within both of these two settings (Paediatrics and CAMHS), pharmaceutical companies appeared to have a subtle but continuous physical visibility, a background presence, which could ensure that their influence as actants within the network was maintained, in addition to the medication being used and prescribed. For example, as well as the leaflets described above, that were shared during the interview process and visibly present within the clinics, when the interviews were undertaken there were also pharmaceutical company names and logos on behaviour charts, across pens on desks and on the cups of those being interviewed. At an ADHD study day within the network lunch had been funded by one such pharmaceutical company.
7.3.2. Artefacts and Voice

It was also illuminated that the organisation of the consultation itself could result in the child being positioned as object and/or subject. From the accounts of the professionals it would appear that certain artefacts within the consultation room could increase or decrease the likelihood that the voice of the child would emerge. For example, one participant noted how in the clinical setting, where there may be medical tools and machinery, which could be of interest to the child, the child's interaction with such objects could be materialised as ADHD,

"and interestingly, in certain settings, because I work in a health centre a bit like this actually, with white walls, there’s a few medical things, like scales and a weighing machine and they start playing with that, you know and the parents start getting annoyed with them".

(015, CAMHS)

The chair also emerged as a significant artefact within the ordering of the consultation whether in CAMHS or Paediatrics, as well as the positioning of the child within the assemblage. Children who did not sit on the chair during the consultation were framed as difficult and problematic. Their bodies were perceived to be out of their control and those of the adults, actions were interpreted as unintentional, their speech was framed as 'vocal' interruptions. The chair too appeared to be used to illuminate and materialise behaviours associated with ADHD, to 'evidence' the need for assessment and diagnosis,

"a younger child probably around 5 or 7 or 8 will generally be very chatty, not able to sit still on the chair in the room...so if being forced to be still then I would be expecting to notice that the child wasn’t managing that very well, that they would be finding ways of fidgeting, fiddling with clothing or swinging legs, tapping or trying to jump up and down, or talking a lot."

(013, CAMHS)

Therefore by expecting the child to use a chair in the assessment clinic, in a particular way, 'problematic' behaviours would be accentuated and so the chair also became an assessment or diagnostic tool.
Yet, by sitting in the chair children could be re-positioned as 'in control', therefore leading them to be seen as a social actor or even 'agentic', and thus their voices would be positioned as legitimate and approved. The child would be invited to be involved in the information sharing and discussion as well as potentially asked their opinions, even in Paediatrics,

“If the child is also seated there we work together and we are consulting both and we share the school reports with the child saying oh you’ve done well in this subject, you have had some trouble, can you explain what happened there and some children are quite open”

(014, Paediatrician)

“If being made to sit down in the chair by the parent which is the way around it would happen, we would generally ask the child to sit but the mother might say ‘Come on, sit down, the lady is trying to talk to you, come on we are here for you, you must tell her, sit down’.

(013, CAMHS)

During the consultation with either the Paediatrician or CAMHS, it appeared that if a child sat on the chair there appeared to be a greater opportunity to them to participate in discussions about their welfare, though again it may be to talk about the “trouble” that the child has had. Yet in sitting on the chair, the child's body and vocalisations became translated from problematic to participating. The child's 'voice' became legitimated, however paradoxically it also indicated the child's compliance. Again, what was being asked of the child was why they had been in trouble, as such the discussion was adult led and problem orientated.

Organisational practices were also cited as impacting upon the possibilities for voice afforded the child, particularly in the Paediatric clinic. Participants identified that because of shortage of time, and the priority being to concentrate upon parents, this impacted on how much time was left for the child to have an opportunity to share their views,

“The involvement is, again, very variable I would say with some children. It may be because of lack of time, when you’re mainly talking to the parents”

(014, Paediatrician)
"one of the barriers is unless you've got a lot of time...you end up being quite led by the parents as to what they think and what they think the child has said or what they've persuaded the child".

(010, Paediatrician)

The findings also showed that there was not a routine way of recording the views of the child as part of the assessment. For example, those who contributed to the assessments within CAMHS and Paediatrics noted, when asked about ways to record children's views, that the assessment forms used did not automatically require the child's opinions to be logged,

“*There's not a formal way of doing that*”

(015, CAMHS)

"*would I always record it? I don’t know*".

(010, Paediatrician)

Formally recording children's views was framed as an extra administrative task rather than a routine practice and administrative tasks were completed when time allowed, rather than specifically allowing time for them,

"*I think you know, most of us have very heavy clinical workloads and have huge numbers of cases that we are working with that take up most of our time and they tend to be the priority, so the other sort of more admin tasks that aren’t so pressing tend to just happen to slip down the list a little bit*".

(005, CAMHS)

Some professionals in CAMHS did note that ideally children would sign their agreement to the care plan,

“*we would always want the child to be agreeing and signing the care plan*”.

(005, CAMHS)
Although others emphasised the practical implications of recording children's views separately to their parent's during an assessment, especially when they had both been seen together,

"so quite difficult to separate out parent's from children's views sometimes".

(010, Paediatrician)

It was also noted that following the consultation appointment with CAMHS or the Paediatrician, letters were sent to the parents. The parents were then positioned as the decision makers about who to share the letter with, for example the school or the child. The parents became the obligatory points of passage to the information contained in the letter, so if the child wished to know what had been recorded they must go through the parent. Participants within the study stated that letters were not sent directly to children which it could be argued, continued to perpetuate the ordering of the network and the positioning of the child within it. The child was not positioned as a key receiver of the recorded information regarding the ADHD assessment. The child was excluded from this information sharing process in their own right,

“there's not a separate communication to the young people, the parents get theirs, but we don’t communicate directly with the child, you know”

(015, CAMHS)

"we don’t tend to send stuff to children directly".

(010, Paediatrician)

So, despite assertions by the professionals earlier in the chapter, that the child for some was "the most important person in the room" during the assessment consultation, the child (and especially the pre-adolescent child) was excluded from written or recorded information about the consultation. The child was moved back into the position of 'object', something about whom the letters were written and their social actorship was scaled down. The actual child became represented through the letters and therefore the abstracted child was translated and circulated around the network.
7.3.3. Informed Consent to Medication

Further analysis of the NICE guidance (2008) on ADHD explored how the seeking of children's involvement in decisions about their welfare was being defined, and considered what was, and what was not being stated in the good practice recommendations. For example, it was stated that children should be 'allowed' to share their feelings and that these should be recorded within case notes. Using the term 'allow' rather than for example 'enable' retained the ordering of the consultation as children required permission from the professional to contribute. Similarly, it was stated that the child and parent should be involved in treatment decisions, however there was no indication of how much involvement for the child was recommended, or level of influence. 'Involved' may mean that they were simply told what the decision would be. So, professionals should,

"involve the child or young person and the family or carer in treatment decisions, take into account expectations of treatment, so that informed consent can be obtained from the child's parent or carer or the young person before treatment"


In terms of informed consent, it was recommended that this should be sought from the child's parent 'or' the young person, rather than 'and' the young person. So, perhaps if a parent gave informed consent, it would not routinely need to be sought from the young person as well. What is also significant, from the second part of this clause, is that the reference to the 'child' (rather than young person) has been completely absented. The 'child' is not included in recommendations for informed consent and in doing so, there is an implicit message about eligibility to self-representation within certain decisions which were linked to age.

The professionals too noted that in terms of informed consent to medication, agreement was sought from the parent rather than the child under eleven years of age,

"So it's not a case of we ask directly from the child, will you take this medication, and we generally get the involvement with the parent"

(014, Paediatrician)

"if they are ADHD and they are going to go on to Ritalin then that will be the parent's decision".

(002, School Teacher)
Those interviewed also highlighted that parents were used to encourage the child to accept medication as an intervention and as a way to persuade the child to agree,

"mummy thinks it might help if you are given some tablets"

(010, Paediatrician)

“I mean, obviously medication is always done in collaboration with explanation, and it’s using the parents more, you know, little ones particularly, more go along with it”.

(015, CAMHS)

Younger children were positioned as 'going along with' their parents' decision. The age of eleven, the age from which questionnaires could also be given to the child, was translated again as the earliest age at which children would be asked to provide consent to treatment in their own right. Up until that age, at least, parents were positioned as those that needed to be informed and provide consent to diagnosis or treatment,

“the under 11s don’t and they are just talked to a lot”.

(013, CAMHS)

The under eleven child was positioned as being "talked to a lot", there was not an emphasis on gaining their consent. Parents, rather than the child, were positioned as the decisions makers. Yet, few of the Paediatricians or CAMHS workers felt that children were expected to take medication against their 'will',

"To be honest, in all my time in CAMHS, I've never had a time when we had to take a position on it and actually give the child medication against their will”.

(015, CAMHS)

So, a great deal of work appeared to have been undertaken to ensure that younger children were enrolled in a particular understanding of the condition, and the perceived need for medication to help them. As the participant noted below, the adults worked with the child to ensure that they were "motivated" to agree to take the medication,
“I can’t think of an example where the mother wanted to force tablets into a child that was refusing to take them. So it is working with them to help them to be motivated enough to decide that the medication is beneficial”.

(013, CAMHS)

However, it did appear to be more acceptable to administer a procedure or intervention for younger children even if they did not agree, perhaps using a ‘best interests’ model,

“Well in a sense that the 7 year old, it’s about capacity isn’t it, what does the child understand about what they are consenting or refusing to. A 7 year old may consent to a little thing, I am going to give you a little scratch here, that means I am going to, is that alright? Yes, but if that child said no, you know you’d needed it, you would carry on and do it and you just try and make it as comfortable as possible. So you are looking always at capacity and obviously that becomes more and more important with adolescence“.

(016, CAMHS)

This raises an interesting question about why the child is asked their opinion or to give consent, if the practitioner knew that their view would be ignored anyway. Children may be asked to share views but these will not necessarily have any influence. It could be argued that the child's agreement or voice was not positioned as necessary to the effective performance of the network.

'Capacity' was used as a mechanism to decide whether a child's view should be taken into account or ignored, but it was considered more important for a young person (aged over eleven) than a seven year old child. In the quote above, younger children were assumed not to have the capacity to make such decisions, so capacity was not an issue that had to be considered for them. It would seem that doing something in a child's 'best interests', without their consent or even against their wishes, was acceptable when the human body was small, however the above statement appeared to indicate that it is less so when the child was an adolescent. The point at which doing something to a child's body without their consent or against their wishes moves from acceptable to unacceptable appeared to be established at over eleven years of age within the network,
"Because you’ve got to have that parental buy in and if it's an older child, I mean when I am talking about 13, 14, 15, you can’t, even if the parents are saying I want him to take medication and the kid is adamant they won’t, you can’t just ignore that".

(016, CAMHS)

For children of an older age, having medication within the assemblage may actually offer an opportunity for the child to be re-positioned as social actor with voice and involved in discussions around their care, for their views not just to be included in the decision making but to hold some weight and influence.

Instead resistance to medication was framed as illogical for a younger child. The child was perceived not to be able to consent because they did not have the ‘capacity’ and perhaps their reasoning was not understood. For example, the following account suggested that the child did not want to take medication because of the child's experience that an elderly relative had taken tablets and then died. Using previous experience to inform a current decision could actually be framed as a rational action, an indication of reflection and intended thought, but for this younger child, it was not,

"sometimes they really don’t want to have medicine but you find out it’s for some bizarre reason like I don’t know, granny had pills and she died, something, you know there’s some peculiar reason why they didn’t want it ".

(007, Paediatrician)

Interestingly, the child's reasoning was framed as bizarre or peculiar, because s/he linked medication with death. Yet, in the NICE Guidance (2008) it stated that,

"When starting drug treatment children and young people should be monitored for side effects...parents and/or carers should be warned about the potential for suicidal thinking and self harming behaviour with atomoxetine"

(NICE, 2008:33).
Therefore, there was a slight chance that for some children the side effects of taking certain medication could actually lead to death or thoughts of death. The child's theorising from this different perspective may not have been considered quite so irrational or illogical. It would also have been interesting to consider how the situation may have been different if the speaker was thirteen or thirty. Age was used within the network to settle ambiguities about 'voice' and to perhaps manage the risk of deciding what weight was to be given to the 'voice' of the child. Age appeared to be dichotomised into two groups, those under eleven years of age and those over it, the latter group being more likely to be positioned as voiced. Using past experiences, in the above example, was not positioned as positive, and yet if the child had been older, the same action might have been.

One professional outside of the assessment assemblage did query the idea that younger children were more likely to change their mind than older children or adults, which was often provided as a reason why their views should not be taken into account,

"some professionals and things have said to me in the past, oh but you know they're so young, they change their mind all the time, and it's like well that's fine, if they change their mind 10 times in a week,...you know adults change their mind all the time as well, they're no different really".

(022, Voluntary Sector)

Interestingly, this professional minimised the difference between children and adults, which elsewhere in the network had been accentuated.

7.3.4. Enrolling the child: medication

A number of the participants in the education, social care and voluntary sector suggested that children were more resistant to taking tablets than was acknowledged by those prescribing, but that younger children do comply, for example

"I've only met, I don't know 5 or 6 kids that actually didn't mind taking the tablets, all the rest of them really don't want to take them, primarily the majority of them do [take the tablets], particularly if they are younger".

(011, Voluntary Sector)
It has already been noted that the younger child might not have perceived themselves to have a choice, parents are positioned as the decision makers. Some participants suggested that children may comply because of the way in which younger children had been enrolled into the idea of medication. They way in which information was shared about medication could have been important. For example, if a child had experienced being positioned as different and problematic and usually received negative responses from adults, being offered a way to please their teachers and parents could be very attractive. One participant described the persuasiveness of a tablet that can "make you good",

"they've always been told they've got some dreadful disorder and if you take a tablet it's going to make you concentrate or make you good".

(011, Voluntary Sector)

Alternatively, medication could be interpreted as a resource for children, it could offer the ADHD child a way to be re-positioned as valued or to have their views listened to, when there were few other alternatives available,

"it improves the relationship between the child and the parents because they are now a joy to be with as far as the parents are concerned"

(006, CAMHS)

"an opportunity to feel good about themselves".

(020, Teacher)

Therefore, there may be certain 'pay offs' to taking medication. Medication could offer a child the chance to practice having a 'normal childhood', with all of the experiences that this could be perceived to bring. Being positioned as a child who was 'included' may offer increased opportunities to participate in other areas of their lives for example at school or with friends. Medication was perceived to offer children a 'window of opportunity' to have a 'normal', perhaps standardised, childhood rather than an ADHD childhood,

"some children get that window of opportunity...we would medicate between say 7 and 13...and they have had a good whack of being able to attend at school and get their friends and go to clubs, and they can contain and manage their problem without the drugs after having had a period on drugs they are now practiced on how to do it, how to cope".

(006, CAMHS)
7.4. Child as Service User

Once children have attended their assessment, they could be positioned as a 'user' of that service which could lead to accessing other services or activities, including providing feedback or evaluation on the CAMHS or Paediatric service. Yet, it will be shown that if and how the child was positioned as 'user' varied between the two services. Even within CAMHS, where a child could be positioned as a 'user' of the service (in terms of providing feedback or accessing advocacy), it will be shown that age and competency were used as criteria. It was also argued that the subject position of 'user' could enrol the child with services longer than was necessary which may impact upon their status.

7.4.1. Paediatrics

Parents were more likely to be positioned as the 'rights holder' within the Paediatric assessment, rather than the child,

"Obviously if the child's not seen as normal, you want to find out what the reasons are, so every parent, I think that's their right".

(014, Paediatrician)

The Paediatrician positioned the parent as having the right to know why the child was 'not normal' rather than the child themselves. The parent was positioned as the service receiver to have their child assessed and treated, rather than the child themselves.

Within Paediatrics, in terms of providing feedback and evaluating the service, children's views were not sought and the parent again was positioned as the service user rather than the child. For example, the Paediatrician below referred to the National Service Framework (2004) Standard Eight but interpreted 'user' as seeking the views of the parents rather than children,

"the National Service Framework for the Standard 8 is about children with disabilities and complex needs,...under some sections one would be actually looking at what the user participation is, and with parental views".

(014, Paediatrician)
It is also interesting that the practitioner referred to the National Services Framework, but not the standard that covered mental health and instead incorporated the parents of children with ADHD within the standard that covered disabilities and complex needs.

Another Paediatrician noted how decisions had been made about the local service development for children with ADHD, but without actually consulting and involving the children. For example, when deciding whether to offer a clinic specifically for children with ADHD, their views were clearly absent,

"we didn't ask them that when we were looking at it, we just looked at numbers and the spread, but we should have done".

(010, Paediatrician)

The child was treated instead as object rather than subject; as a number to be counted in reviewing the service provision. It could be argued that as objects, the children counted may still have influenced or had an effect on the decision that was made.

7.4.2. CAMHS

Within CAMHS, the CAMH Partnership Business Plan and Strategy for the Local Authority (2005-08) stated that the

"views of service users are actively sought via consultation and participation...User views have been included in clinical audits,...service development. clinic environments; service access, and interview panels" (2005:31),

but it did not specify to whom the term 'user' referred. The information leaflet for families about CAMHS also stated that

" we will involve children and young people in the development of services. We will work with children, young people and their families and make sure services are assessed from their point of view".
Within this document children and young people were positioned as 'users' and it was claimed that their views would be taken into account in shaping services. It could be argued that decisions about service development were a less threatening way for younger children to be involved without significant implications for individual children. Therefore it could be argued that general 'voice' from children as a social group was easier to translate into professional practice than individual voice within specific decisions about a child's welfare, particularly if those decisions were presented as 'risky', for example in terms of medication.

Those working in CAMHS were able to describe how children using their service had been able to contribute to its evaluation, for example through feedback forms,

"we do respond to what they put and they put funny things on these forms that you wouldn’t have thought about, like we had a complaint, there were no comics in the waiting room and there was all, sort of, adult magazines and things people bring in from home, they want throwing out and so in response to that, we’ve got, kind of, teenage magazines for girls and comics for boys, Beano and Dandy”.

(015, CAMHS)

This highlighted that factors that adults may not have considered, or even perceived to be unusual, but which were important to children using the service could be captured through written feedback from children themselves and change aspects of the service.

At the time of the study, there was a voluntary agency within the area which had been commissioned to represent children's views and advocate on their behalf within CAMHS, as well as find ways for children to contribute to the evaluation and development of the service. Some CAMHS workers identified how children and young people had been involved in the service development through this organisation, for example interviewing professionals and training days. However, this seemed to refer to older young people and age appeared to be a significant factor in influencing these possibilities for participation,

“we do involve children in staff interviews, older adolescents and it has been a very positive experience and they are so good, they are so straight and they’re so clear who would be good, who wouldn’t be so good and why and interestingly, we’ve involved children in interview panels”.

(015, CAMHS)
One challenge was that to access children to participate in service development and evaluation activities, the voluntary body had to rely on professionals or parents telling children about what was available,

"so I kind of have to rely on the professionals to pass young people that are interested on to me".

(022, Voluntary Sector)

One professional thought that it was harder to involve children living with birth parents than it was with children who were living in residential or foster care, however apparently even for Looked After children, access had not always been easy,

"I think access to young people who are looked after seems quite easy now but it was quite difficult six, seven years ago when I started here, when foster carers and that were quite reluctant to get young people involved and workers were quite suspicious and anxious about it".

(018, Local Authority)

This participant indicated that the 'voice' of the child, for example in evaluating services could be positioned as a threat within the network, raising professional anxiety,

"I think that there is a lot of reassurance involved because complaint, sometimes concerns, sometimes come out of participation and so I think probably the service has to be open to that as well really".

(018, Local Authority)

Access to the advocacy provided by the voluntary agency also seemed to be based on an age and competency model, which could be influenced by the professional working with the child,

"there's no set younger age limit, it's basically as long as the child is old enough and competent enough to need the process and instruct the process".

(022, Voluntary Sector)
The child had to be deemed old enough and 'competent' enough to need advocacy, to have their views represented. The child also had to rely on the parent and professional connecting them with the organisation. It could also be argued that even within these projects, the voice or participation afforded to the child was in very adult determined, organised, and controlled ways. In terms of advocacy, the adult would be representing the voice of the child, rather than the child themselves, however having the advocate in the assemblage may also increase the likelihood that their views would be heard or included.

One of the complexities raised by a professional, was that in continuing to involve a child or young person in service development, it maintained their subject position as a 'service user' for a longer length of time and perhaps sustained their difference from other young people and children. It continued to involve them in the certain services or assemblages, when they could have moved out of them. Thus enabling 'voice' within services may contribute to the child being framed in certain way by those outside the network, and keep them enrolled for longer than necessary.

“I've seen a couple of examples of seeing young people, you go to a conference and there they are again, they’re the CAMHS person, talking about and they’re there again six months later and what’s this young person, why aren’t they getting on with their life, why are they getting, you know, that their life isn’t as a CAMHS ex-service user, their life is as a young person who’s got, you know, dreams, hopes, a future and we have a moral responsibility not to make people into, sort of, professional CAMHS users”.

(015, CAMHS)

This highlighted that 'voice' may not always be positively valued or have positive outcomes for children. It may enrol them into certain subject positions that it may be harder to move on from. Though through CAMHS children could be offered access to advocacy and participation projects, it could be argued that this 'voice' was positioned in a very formalised adult directed way, and therefore perhaps, another mechanism for ordering the child's voice within a network.
7.5. Summary

This chapter has explored the assessment assemblages more closely. The findings showed that different assemblages produced different subject positions and different possibilities for voice for the child. Whilst within CAMHS, children were positioned as object and subject, and increased opportunities for voice emerged, it could be argued that voice could also lead to greater enrolment in certain understandings (of their bodies and vocalisations as problematic), or be used to socialise the child in expectations of their behaviour. Alternatively, when children were positioned as 'object', they could also have an effect on the network, for example triggering a diagnosis, but this may not be intentioned or reflect the child's wishes. The chapter also highlighted how absence should not always be perceived to be negative, for example it may be indicative of a child's resistance. The positioning of the child's voice may also be linked to the type of decision to be made, and this was evidenced through informed consent to medication and the evaluation of services.

The chapter also presented an analysis of the significance of the artefacts in the assessment assemblages. Artefacts could be used to enrol the child, but they may also re-position the child into different subject positions and contribute to or close down opportunities for the child's voice to emerge. It was highlighted that the same artefact may have different effects for different children. As one participant concluded, when describing a "cultural shift" that was required to include the child views of the child in the assessment process,

"the will is there in some quarters but we have a long, long, long way to go, a long way".

(017, School Nurse)
8.1. Introduction

This chapter will focus on the analysis of some of the ways in which the positioning of the ADHD child and the child's voice were mobilised and translated around the network through diagnosis and intervention. It will explore how becoming an ADHD child may have implications for how the child was positioned, for example, the typifications of the child in terms of age, gender or class or the value of the present or future child, which may scaffold possibilities for voice.

The chapter will continue with how interventions may impact upon if and how the voice of the child emerged. Medication will be used to examine the complexities of voice, how an artefact can both afford a child a position of 'performing' voice, but also contribute, at times, to the closing down of opportunities for the voice of the ADHD child, as well as other interventions. It will be highlighted how medication can contribute to certain interpretations of the child as speaker which were linked to ideologies around self-control and competence. Accepting medication may lead to greater inclusion, within such social spaces as the classroom, which in turn could position them within the network as a child who was afforded participation. It will also be highlighted that whether an artefact such as medication extends opportunities for voice, or silences them, may vary for children and age may be an influencing factor.

It will also be shown how social interventions could also silence the child, or voice could be used as a mechanism to control the child. Within both types of intervention the vocal child could be translated into the adult approved voiced child, where voice was interpreted or used in different ways. This will evidence the very complex nature of voice and that as sociologists, it is essential that a move is made away from simplistic notions of calling for children's 'voice', and that the controversies of translating the child's voice from policy to practice are recognised and addressed.

8.2. Becoming an ADHD Child

As noted within chapter six, the dominant discourse within the network was that ADHD was a medical (rather than mental) condition, often linked to the child's brain and genes,
"obviously it's a medical diagnosis"

(019, Educational Psychologist)

8.2.1. Diagnosing ADHD

Children who displayed 'moderate' impairment (social, psychological or educational), as the NICE guidance entitled 'Attention Deficit Hyperactivity Disorder: Diagnosis and Management of ADHD in Children, Young People and Adults' (2008) could be diagnosed with ADHD.

"for a person to be diagnosed with ADHD, their symptoms should be associated with at least a moderate degree of psychological, social and/or educational or occupational impairment" (2008:5).

The DSM-IV-TR recommended that the symptoms should have started before the child was seven, have been evident for at least six months and have been displayed in at least two settings. Following assessment, a diagnosis of ADHD could be made by either the CAMHS Psychiatrist or the Paediatrician within the network studied.

It emerged from the data that the child's perceived level of impairment could be related to aspects or factors outside of the child. For example, in terms of educational impairment the professionals' perceptions of the child's behaviour could depend upon the previous experiences of the professional themselves. As an example, an educational professional highlighted,

"the teacher, who's very young, probably an NQT, said to me, do you know, if I tell you what he did and I'm thinking, what? And she went he threw a pot of pencils at me and I was like, ooh? Only a pot of pencils?...In the school that I came from...if you've got tables, chairs, the gerbil and the wardrobe thrown at you then you might begin to worry".

(021, Teacher)

There may also have been a variation in what was considered problematic, depending on the professional's approach to adult-child relations, and what they would consider as 'normal'
behaviour for a child. For example, the statements by the professionals below would indicate that it was thought that children should be controlled by their parents and be compliant,

“for one reason or another parents have either given up or never had the ability to be able to make the child obey instructions”

(008, Paediatrician)

"so that for us would be normal here. The child who's compliant, happy to learn, goes along, follows boundaries".

(021, Teacher)

Others noted that environmental factors, outside of the child, could also accentuate the child's level of impairment. For example, how a school was structured such as the class size could amplify the child's behaviour in a classroom,

"I think in a class of 30, I can't imagine what it is like".

(009, Teacher)

Other professionals noted family dynamics,

“the family's interaction with the child was complicating things and making it worse, so you know, we studied them and their interaction with any child would have probably made them a bit hyper”.

(015, CAMHS)

The same CAMHS worker also gave an example of a parent from a more privileged background who had the resources to structure the child's free time, channelling the child's energy and therefore, behaviours were less accentuated as 'impairment',

“his mother, they had a very big house and it was quite an interesting example of how the energy is possibly channelled, because apparently in the summer time, he used to love cutting the grass and he spent hours cutting the grass apparently, with a sort of proper mower".

(015, CAMHS)
Another factor which was suggested that could impact upon the child's perceived level of impairment was how the adults made sense of the child's behaviour,

"I feel that decisions are made to diagnose because people aren't really sure why a child is behaving in a particular way"

(019, Educational Psychologist)

"I found that a lot of the young people were diagnosed as a way of finding a reason for their behaviour".

(012, Social Worker)

Some participants within the study, provided examples of how children's behaviour had been understood differently by different adults. For example, one CAMHS professional showed how he interpreted a child consuming food without permission from his parents differently to the child's parents,

“the kid was then starving hungry and that he's stealing food, you know, taking biscuits and he's stealing food and they're more against him and I said, that's not stealing. What I would call taking food from the cupboard, they'd call stealing, you know, but then the kid needed to eat, he was really hungry".

(015, CAMHS)

Similarly, another professional provided a different understanding of why such children may be perceived as resistant or unable to manage the pace of the school day,

“Certainly children who when they start succeeding at something don’t want to stop, they don’t like to change from one lesson to the next lesson if they are in the middle of something that there is really joy and they are getting success out of it, they don’t take kindly to ‘come on, pack away, we are going to do something else now’, that goes down like a lead balloon”.

(002, Teacher)

These examples evidenced that adults may have had different interpretations of the child's behaviour in making sense of the child's actions. Differences in the adults' sense making of
the child's behaviour could lead to variations in the perceived severity of impairment. Some professionals indicated that the social distances between the adult and child, for example in terms of generation, class, or gender could also be important in trying to make sense of the child's behaviour. Some professionals were believed to be better able to 'understand' the child, or better able to be child-focused,

"I suppose there's paediatricians who tend to be quite child orientated but not everybody's the same really".  

(007, Paediatrician)

In terms of gender, there was a question that there may be a difference in the sense making or dynamic between the female professional and the male child,

"for all the children with ADHD, they have come to me only having had female teachers, I don't know if that has an impact".  

(002, Teacher)

Similarly, it was suggested social backgrounds could be an important factor,

"If a young person from an estate, generally speaking, you have a, your access to amenities, your access to services, your access to the better side of life doesn't really exist, so you're fighting many other ways of trying to get those services or trying to get that material wealth. Now if you're not from that kind of a background sometimes you don't understand".  

(012, Social Worker)

Therefore despite the decision about diagnosing a ADHD claimed to be centred upon the child, dependent upon the severity of impairment to their lives, as has been shown, this may instead have been linked to many other different factors, aside from the child's symptoms alone.

8.2.2. ADHD as a Diagnosis

From the accounts of the professionals, it appeared that the ADHD diagnosis was circulated as an 'object' within the network, as an 'it' or thing,
"in a context that is in an NHS health context that has a reality that ADHD exists as a thing"

(015, CAMHS)

“it’s not so welcome when they go to scouts, not so welcome in the shops and not so welcome at school “.

(006, CAMHS)

There was a concern by some that in diagnosing ADHD, other factors within the child's life could be hidden or ignored, everything would become attributed to the ADHD. It had a strength within the network that closed down other explanations or interpretations of the child or the child's behaviour,

"I think the biggest concern I have of diagnosing ADHD is that it sometimes allows you to not recognise other underlying problems"

(010, Paediatrician)

"I think ADHD is a kind of label that is used and actually, there's more complex reasons behind it".

(019, Educational Psychologist)

ADHD was often positioned as taking over the whole child, rather than a condition that the child was experiencing or an addition to the child. For example, one teacher explained how a child was being given a consequence for fidgeting when they had been asked to sit still for a period of time, and she argued,

"Well, I said excuse me, they can't stop twitching. That's what they are".

(021, Teacher)

Another participant highlighted that children may also define themselves by their diagnosis,

“T'm hyper. Hyper is used quite a lot”.

(014 CAMHS)
Therefore, it could be argued that ADHD became a 'lens' through which the child was positioned by others, but also could be used by them to position themselves. ADHD became a way of being. Some argued that it may be difficult for the child to be positioned as simply a child rather than an ADHD child, as it was stated:

"at the end of the day, they're not ADHD as a person, they're a person first and foremost".

(012, Social Worker)

Therefore, in being diagnosed, or becoming an ADHD child, it was argued that the child could be positioned as being controlled by the ADHD, so a risk was expressed that all of the child's behaviours and actions would be perceived through the ADHD. ADHD was positioned as determining the child's behaviour, experiences and outcomes,

"it causes kids to be less successful in school".

(016, CAMHS)

In terms of affording the child a voice or a position of agency, this would suggest that it would be much harder for any actions or vocalisations of the child to be understood as intentioned or planned rather than impulsive, as determined by the child rather than the ADHD.

Some within the study felt that for the child, in becoming an 'ADHD child' it would raise their visibility, for instance at school and the child would attract negative attention,

“So when they're at school the teachers are all seeing this kid, this difficult kid because he’s been labelled with ADHD.”

(012 Social Worker)

Alternatively, others argued that the ADHD diagnosis could potentially reduce stigma and negative treatment. It was suggested that the ADHD diagnosis could provide the child with a more socially acceptable explanation for why they were often perceived to be different or difficult to parent or teach. It was argued that these children were already identified as
problematic as their bodies and vocalisations made them stand out, more visible, compared to other children. Up until the point of diagnosis, such children were likely to have been treated as naughty or troublesome, but the ADHD diagnosis would provide a more validated reason for their behaviours,

"a lot of people question labels but these children have been labelled negatively all their lives".

(011, Voluntary Sector)

Therefore, the ADHD diagnosis could actually be a way for the child to be re-positioned not as a naughty or badly behaved child, but as a child with a medical condition. Others suggested that some parents could also take steps to have their child diagnosed with ADHD in order to avoid negative judgements about their parenting, or their child,

"some parents do want that diagnosis, I think the reason being they are seen as naughty children or they are seen as bad parents"

(014, Paediatrician)

"ADHD is one that the parents are always very keen to tell the school about, because they see it as a kind of defence for their child".

(013, CAMHS)

In fact, it was claimed that ADHD had become a much more common place term with an acceptability within society at large, so carried less stigma than being a poor parent or a naughty child,

"I think it's one of those things that's become a bit more sort of mainstream through things so there's not as much stigma around".

(022, Voluntary Sector)

However, due to its widened mainstream use and ownership, one participant shared a view from a young person who felt that now everyone had a claim on 'understanding' ADHD, it had in some ways diminished the voice of those diagnosed with the condition,
"she was like, oh you know, everyone including school and parents as well, she was like, you know they think they know what it is, they hear about it all the time and everyone says 'oh ADHD I know about that' and she kind of said they don’t know, they don't know what it's like...it kind of belittled her feelings about it a little bit".

(022, Voluntary Sector)

This seemed to suggest that children's own descriptions of their experiences were being crowded out by other voices, for example teachers and parents who claimed to 'know' what it was like to live with ADHD. This could lead to children's voices becoming silenced or ignored when everyone was having their say or children's views could be assumed by others, losing the child's own meanings.

In summary, the diagnosis 'ADHD' appeared to have a strong overall identity in terms of indicating a child with certain agreed symptoms and behaviours, namely hyperactivity, impulsivity and inattention. Therefore, even if professionals shared their private concerns about its reality or over-use, or there were differences in opinion to the dominant biological discourses on causation (for example, social or cultural explanations offered), the strong overall identity held the network together. The diagnosis of ADHD indicated that there was a child whose brain, body and vocalisations were 'out of sync' with other children, they were different, and this made life difficult for themselves and others at home and in the classroom. There was also an assertion that a child's perceived behaviours, for whatever reason, were not just problematic to childhood spaces but, as will be shown, to society as a whole, therefore requiring intervention.

8.2.3. Typifying ADHD

"Most of these kids, particularly the hyperactive ones, are never going to be standard boring children".

(011, Voluntary Sector)

In exploring the positioning of the child within the network, those within the study described them as 'all different', in terms of symptoms and severity, from each other and from other
children. Yet, participants also described many ways in which the ADHD child was typified, which could indicate certain social statuses. These were important to explore as they may provide a further layer to the positioning of the child, and the child's voice, within the network.

Participants described a profile of the typical ADHD child who would be male and aged between seven and ten,

"a typical case which I guess would be a boy, in Junior school, aged say 7 or 8".

(003, Educational Psychologist)

Yet, many of the practitioners emphasised that 'ADHD' was not a condition that developed overnight, and that in fact, there may have been indications that the child had displayed symptoms associated with the condition from a young age, but that these were not recognised within the network as indicative of ADHD,

“So if I do a developmental history I would find that there were real sleeping problems, that this toddler was a nightmare, was on the go in a way that other kids weren't".

(016, CAMHS)

It was noted that the majority of medications were not meant to be prescribed until a child had reached six years of age. Therefore including the artefact, medication, as a key actant within the network, could have influenced the age at which the child was assessed or diagnosed. Indeed, the NICE (2008) guidelines stated,

"At the time of publication, methylphenidate and atomoxetine did not have UK marketing authorisation for use in children younger than 6 years. Prescribers should advise people with ADHD and their parents or carers of the implications of prescribing unlicensed or 'off-label' drugs" (2008:6).

It is interesting to note that within the book for children circulated in the network, the boy is six years old when he first visits the Doctor and the girl is seven years of age. Some within the sample did claim, that on occasion children did enter the network at a younger age but this was not the 'norm' for the network,
“generally between three and four, the most severe ones can actually be raised as suspicious and diagnosed sometimes by the age of four”.

(014, Paediatrician)

As noted, the ADHD child typified within the network was also male,

"I think sometimes people sort of explain ADHD as very much a boy, or a real boy, associated with boy type behaviours"

(017, School Nurse)

"naughty boy behaviour".

(001, Social Worker)

ADHD appeared to be aligned with "naughty boys" and indicated a gendering of "naughtiness". ADHD was rarely associated with girls

"I haven't had any ADHD girls in the ten years I have been teaching".

(002, Teacher)

Interestingly, in the book aimed at 6-12 year olds circulating in the network, the boy was diagnosed with ADHD and the girl was diagnosed with ADD, without the hyperactivity. The ONS survey on the Mental Health of children and young people in Great Britain, (Green al, 2005) also stated that the majority of those with 'hyperkinetic disorder' were boys. In terms of why ADHD was usually associated with boys, few within the study questioned the 'fact'. One participant did note a possibility that boys and girls could display ADHD symptoms differently perhaps due to biological factors, or that there was a greater 'visibility' of the behaviour of boys,

“boys and girls are affected in different ways, aren’t they, perhaps reflecting a different genetic background. That is girls tend to be suffering from ADHD where the emphasis is upon inattention...Whereas boys suffer from all respects and are very easily noticed because of the hyperactivity element“.

(003, Educational Psychologist)
There were some indicators with the professional interviews that that the typified ADHD child would also come from a lower socio-economic background. The ONS survey on the Mental Health of Children and Young People in Great Britain, (Green et al., 2005) stated that children with hyperkinetic disorder had a greater likelihood of coming from households on a low income. Among participants it was noted that in terms of ADHD,

"we have very few uncomplicated, nice middle class children".

(021, Teacher)

The assumption appeared to be that middle class children were less complicated in terms of emotions and behaviour, compared to children from a lower social strata. Another participant expressed surprise at a 'middle class' child with an ADHD diagnosis, suggesting a difference to the typified ADHD child,

"They were quite well off, you know, they weren't poor or anything like that".

(012 Social Worker)

However, class or socio-economic group appeared to be a more hidden way in which the child was typified within the network, compared to gender and age, which was much more explicit. One participant appeared uncomfortable when referring to social strata and suggested that the view was 'prejudice', which was less likely to be shared publicly within the network,

"being very prejudice about it, it conjures up for me children whose social life chances are less than the average child of that age".

(001, Social Worker)

There also appeared to be some acceptance of a poorer health status for children with less wealth. For example, one participant stated that those from lower class backgrounds would historically not expect to be in full health, whether physical or mental, whereas it was argued that 'everyone' now expects to be happy and healthy,
"I mean if you’d have lived a hundred years ago...if you were just a working class person, you might have had rickets, you might have had skin lesions from having had smallpox, you know...now we expect a hundred percent physical healthy don’t we”.

(016, CAMHS)

As noted in chapter six, ADHD children were associated with ADHD families,

"ADHD means you may come from a family where there are other people with histories of ADHD".

(016, CAMHS)

When this typification is placed in the same pool as assumptions made about class and the ideas circulating within the network about genetics, it could lead to questions about whether ADHD has a much wider role to play in ordering, and through interventions, standardising whole sections of society.

Interestingly, there appeared to be a paradox at play as children diagnosed with ADHD were presented as unable to 'fit' the structured life of school and leisure activities, requiring adult control and supervision. Yet on the other hand, a large number of such children were claimed to come from families where there was perceived to be less 'structure' and more disorganisation, parented by 'chaotic carers' believed to display traits of the condition themselves, which proved problematic for the child when they entered the school environment, when the private met the public. The ADHD child could signify not only a meeting of, but a visible 'clash' between, the private home and the public institution.

There were suggestions that parents from higher social economic groups would have greater access to certain resources with which to manage their child's behaviour. For example, some of those interviewed spoke about children going to physically active clubs that channelled their energy, but families would have to be in a position to pay for such clubs. Parents from more privileged backgrounds were also perceived to have more resources to keep their child's ADHD diagnosis (or association with CAMHS) hidden. For example, some participants noted that parents from lower socio economic backgrounds accentuated the ADHD diagnosis for their child at school, whereas more wealthy parents tried to keep the child's diagnosis and enrolment with CAMHS hidden,
“The only families who do that are the private sector kids who for some reason feel that they might jeopardise their place at school if they know they are coming here for ADHD”.

(013, CAMHS)

This could suggest that despite the participants claims around the 'mainstreaming' or acceptability of ADHD as a diagnosis, for some social circles it was still viewed as a stigma. There may be class differences to how ADHD and CAMHS are experienced and played out, so that some children (and parents) become more visible than others and associated with the condition and certain services.

The ADHD child was typified as struggling in the education system, not considered a 'schooled' child,

“but he doesn’t fit the British Educational system that’s the problem, that’s designed for children who can be organised, focussed and diligent”

(013, CAMHS)

"these kids are always going to struggle at school” .

(011, Voluntary Sector)

The ADHD child was typified as better suited to working than being in the classroom setting,

“I have a strong belief that if we lived 100 years ago and kids didn’t go to school and they had to be out and active that we wouldn’t have seen ADHD”.

(005, CAMHS)

Professionals within the study did note that those who were more academically able may well have ADHD symptoms, but were likely to find ways to manage their condition within the education system, they were less visible,

“I am absolutely certain that we have quite a lot of ADHD in the top academic levels but they get away with it, they don’t turn up in clinic because they are very able and they manage it”

(006, CAMHS)
"Some of them will do very well because they're able".

(021, Teacher)

Interestingly, academic ability appeared to be framed and accepted as 'within child', an innate, natural facet. Yet, this could mask and hide the potential complex interplay between biology and social factors which could influence a child's academic ability and attainment, including class and access to certain resources, as one participant identified,

"it's one of those self perpetuating things so parents didn't achieve in school, a lot of them don't have a high priority on school".

(021, Teacher)

The ADHD child was often positioned as isolated and excluded. It was suggested that they spent less time with other children, for example they were less likely to go to after-school clubs or leisure activities, and were portrayed as having more difficulties with friendships in the playground and classroom. It was also described how these children spent a great deal of time in adult company, being supervised by parents or teachers compared to their peers.

Therefore, it could be argued that the child's status within the network may not only be affected by being a child, by being a child with ADHD, by being associated with CAMHS (or Paediatrics) but also due to a number of other typifications including age, gender, class and academic ability. These social dimensions may scaffold the child's experiences and the way that they are positioned within the network, which previous research has highlighted may also further impact upon if and how their 'voice' emerges in the assemblage.

8.2.4. Valuing ADHD?

There was a belief circulating within the network that at other cultural or historical time points the ADHD behaviours would have been understood as a difference, rather than problematised or medicalised. These claims appeared to focus on how child behaviours associated with ADHD were managed and valued within a society. Therefore, it was suggested that the ADHD child was 'out of sync' with the current ways in which childhood was structured,
“The expectations we have now just don’t fit with those sorts of children, they have all sorts of problems now. So there is a bit about society and our culture, I think compared to other cultures there will still be people with ADHD but they just wouldn’t be recognised as having a problem or maybe seen in a slightly more sort of positive way with different skills”.

(005, CAMHS)

It was argued that the current education system devalued their skills but at other time points, the ADHD child would hold greater value or use to society,

"In fact those kids would probably have been very useful, they’d have been active, on the go, energetic, but now we expect kids to sit in classrooms”.

(006, CAMHS)

This would suggest that the ADHD child could potentially have higher social status or be more valued within other societies, where their different skills were respected rather than standardised. Many of the participants referred to the poor self-esteem of children with ADHD and the impact of constantly being in trouble with parents and teachers. Therefore, the ADHD child was also, at times, circulated as vulnerable and in need of protection, from themselves and others,

“they are more vulnerable and all the added issues about being bullied, being picked on, you know, because of the disorder”

(015, CAMHS)

“we know he has got that bit of extra vulnerability about him”.

(013, CAMHS)

This need for protection by adults, required a greater amount of supervision and monitoring, which was portrayed as a drain on adults’ time. Examples given included parents being unable to work or go out due to the need to supervise their child, or teachers having to provide extra monitoring and support at school. A few others noted that the ADHD child was
more easily influenced by the 'wrong crowd', which at times also appeared to be related to class,

"For young kids, if its nearer the wrong crowd, that can be an issue and you know, similarly with a middle class kid who's not in those circles, they can be sheltered from those"

(012, Social Worker)

"If they get in with a bad crowd...they can spiral downhill quite rapidly".

(011, Voluntary Sector)

The Social Worker referred to a child who got in with the 'wrong crowd' whilst playing out in the housing estate compared to the middle class child who was often supervised in the home, or encouraged to take part in structured, out of school activities. Again, some commented that because the child may not feel valued or had low 'self esteem', they may make certain decisions to keep friendships, that other children may not do,

"these children are often desperate to have friends and fit in, so are quite easily led into doing things that aren't appropriate".

(005, CAMHS)

Participants within the study noted that there had been a rise in the number of children who were being diagnosed with ADHD,

“"I've worked in CAMHS for 15 years and in that time I've seen a huge increase in kids diagnosed with ADHD”

(015, CAMHS)

"I think in every class I could identify one child at least who is ADHD”.

(002, Teacher)
A number of reasons were given for this rise. For example, the most popular assessment tool had changed from the ICD-10 to the DSM IV-TR, which was considered to have a criteria that was less stringent and so could include a wider number of children, including those considered to have a dual diagnosis who would not have been included before. Others commented on the rise of everyone's awareness of the condition, professionals were much more likely to identify the symptoms and refer for assessment.

Yet the rise in ADHD was presented as a threat to services. Professionals were concerned about how they would cope with the number of children requiring services and that such children could 'overwhelm' what was available,

"if we get a floodgate opening and a hundred ADHD referrals what on earth would we do with them?"

(001, Social Worker)

"ADHD is a big topic nowadays and my thought is that it is almost growing too big and too fast for us to be able to cope with".

(004, CAMHS)

There appeared to be a paradox between the work that was being undertaken to problematise the behaviours of a higher number of children, for example by using the DSM-IV-TR rather than the ICD-10, but also the work that then went into limiting access for children to assessments and services, to manage the 'demand' of this group of children.

The financial cost of the ADHD child to certain sites of the network was also mentioned by a few participants. References were made to the cost of certain assessment tools, such as the Connors questionnaire, which Health Trusts could not afford to provide. Paediatricians too indicated that G.P.s may be reticent to prescribe medication due to the financial cost. Yet the ADHD child, in certain circumstances, could also be positioned as financially valuable for certain other actants. A small number of the participants noted that schools may gain extra funding if the ADHD child had a Statement of Educational Needs. Therefore, another artefact, the Statement, could increase the economic value of the ADHD child.
"a child is going with a statement, they are a commodity within the education market".

(020, Teacher)

The value of the medicated ADHD child to the pharmaceutical companies was also identified. So medication in the assemblage made the ADHD child costly to some in the network (G.P.s), but also increased the financial value of the child to others.

During the professional interviews, it emerged that ADHD behaviours, and thus the child's body, brain and voice, were in the main valued negatively. They were nearly always discussed as problematic rather than in positive ways. Within the study, there was only a small minority of participants who framed the child as non-problematic. The voluntary sector professional that supported children's rights and advocacy within CAMHS, spoke of the energy that such children and young people brought to projects. Similarly, another professional who set up an organisation that offered days out and groups specifically for ADHD children and young people, described the value of children who could be quick thinking, and energetic, particularly to team work. This worker also cited research by a local University comparing the entrepreneurship of ADHD young people with a sample of non-ADHD University students which found that ADHD young people scored much more highly on indicators of innovation, which was later confirmed in a meeting with the researcher. However, this research was not cited by any other participants and did not appear to be circulating within network. One participant did comment on the enjoyment of working with ADHD children,

“I always actually find it quite fun because these children are not usually miserable and they are normally, usually quite upbeat and I am sort of grateful for that in a job where there is often a lot of miserableness”.

(013, CAMHS)

While another spoke of a mother's valuing of her child (which was rare),

"But she [the mother] said if it came to the crunch and I was marooned on a desert island it would be him that I would want because he can talk, and laugh and he makes me laugh".

(011, Voluntary Sector)

Interestingly, it is the child's voice, his talking and laughing, that was most valued in this account.
8.2.5. The Future of ADHD

The future ADHD child was also typified, and often associated with lack of educational attainment, substance use and even criminality.

"Their future is pretty grim indeed, you know, they'll be lucky if they're not in a secure unit by the time they're 15,16"

(021, Teacher)

"I know the progress isn't very good from what I've read, 25% of the prison population or something are children with ADHD".

(002, Teacher)

Therefore, unless treated, the future child would be a threat to themselves and society as a whole. The typified ADHD child was depicted as a potential demand upon adults, services and society, rather than valued as a future investment. This could also impact upon their status or social position. Similarly, it may also impact upon the motivation for others, or society as a whole, to hear, or care about hearing, the views or 'voices' of this group of children. This future threat also appeared to be used to add weight to the importance of diagnosis and treatment, for example, the prescribing of medication. This could mean less opportunities for children to contribute to decisions within these areas as the adults were positioned as needing to make decisions to protect the child (and society at large) from the future child.

A small number of participants did identify factors that may lead to more positive outcomes for the ADHD child. For example, a few participants reflected that ADHD children who were deemed to be more 'academically able' were perceived to be more likely to have positive outcomes. There was a suggestion that those who were academically able would, in the future, be 'mad' or quirky, rather than 'bad', but in a socially acceptable way,

"I think some of our more able pupils who've got elements of ADHD are probably going to go on and be mad professors".

(021, Teacher)
There appeared to be a dichotomising of the future identities of the ADHD child into two extremes, for example, Professor or a Prisoner,

"One of our sayings is that they're likely either to be workaholics or alcoholics".

(011, Voluntary Sector)

"I've known young people that have done really well with diagnosis of ADHD, but I also know young people that have gone to prison".

(012, Social Worker)

These differences in outcome tended to be portrayed as completely within child and/or intervention related. Factors such as academic prowess were mentioned, as above, but not reflected upon in terms of the impact of social status, for example as in relation to class or access to resources. In the main, it was claimed that the child's outcomes were dependant on how quickly the child was diagnosed, and 'treated', usually through medication. As noted, it justified a need for early intervention from services,

"Some will have quite marked symptoms throughout their lives, others will have mild symptoms, and it depends on how quickly one can intervene ".

(003, Education Psychologist)

8.3. ADHD, Management and Medication

8.3.1. ADHD and Medication- A Binary Relationship

There was one significant technology with which the ADHD child was linked, and that was medication, the majority within the study referring to Ritalin. The typified ADHD child was a medicated child,

"the word that always comes to mind when I think of ADHD is Ritalin".

(001, Social Worker)
Those interviewed identified medication as another motivation as to why the parent or child may wish for the child to be diagnosed with ADHD. The ADHD assessment was positioned within the network as an obligatory point of passage to medication and as such, it was argued that some parents sought a diagnosis for their child in order to access medication,

"a lot of people think it's a label to get medication for these kids".

(012, Social Worker)

So, there was a strong association between ADHD and medication and the two seemed to move around the network together in a binary relationship. Medication was described as the main, if not the sole intervention,

"the only treatment to it, really, is medication".

(012, Social Worker)

Some participants did identify that although the positive outcomes for medication were often cited as 'fact' within the network, there was also an ambiguity to the research, for example due to the small number of studies or the circumstances in which they had been undertaken,

“ It’s a difficult one to judge really because evidence is there that those who are treated do better than those that aren’t, but that’s in research programmes where they will have used fairly strict criteria for diagnosis”

(010, Paediatrician)

"Long term it is really difficult because there haven’t been very many long term outcomes and that was what that Panorama programme was hooking onto".

(016, CAMHS)

Interestingly, the differences of each child's presenting symptoms or differences to adults that were emphasised at other times in the network were paradoxically downplayed when considering medication as an intervention. The value of scientific research or 'evidence' was also scaled down. For example, the Department of Health's National Service Framework for
"A large proportion of the available evidence does not reflect the co-morbidity issues...services frequently have to rely on either extrapolating research findings from abroad or from adult literature...lack of evidence of effectiveness does not equate to an intervention being ineffective" (2004:35).

Instead, a trial of medication was presented as an acceptable first approach, without needing scientific research evidence about how or why it would work for a specific child. It was an established working practice within the network for children to try a medication and then monitor side effects and review dosage to see if it had worked. In an era of the rhetoric of 'evidenced based practice'. and a growing emphasis in health, education and social care to measure impact and outcomes, the lack of evidence or outcome studies was not problematised within the Childhood ADHD network.

It could be argued that medication packaged the network and represented certain understandings of childhood ADHD as it moved around the assemblage. It linked a range of actants from those who produced it (the pharmaceutical companies and scientists) to those who prescribed it (Paediatricians, CAMHS Psychiatrists, G.P's) to those who administered it (Parents/carers, School staff) to those who physically took it (children and young people). At both a global and local level it also connected many other actants such as those who recommended how it should be used (Government or medical guidelines such as NICE) through to those who wrote or spoke about it (for example within the media and academia). Professionals also gave cultural examples of when it was used by those children and young people for whom it was not intended, for example its 'street value' as a part of youth culture or to enhance some children's academic performance, so it could also enrol children and young people within the network who did not have an ADHD diagnosis.

Despite different discourses on medication within the ADHD network, at a simplistic level when a child is intentionally prescribed the medication it denoted that they had been through the assessment process and received (or medication was being used to test) an ADHD diagnosis. The medication collapsed the network, and all of the related actants (such as the professionals, questionnaires, the Diagnostics and Statistics Manual) within it. It carried and
extended the network to public places such as the classroom as well as into the private world of the home. It confirmed that the child had been positioned as problematic and out of sync with developmental norms, that they were somehow 'different' to other children. It signified that the individual child needed to be changed and that in particular perhaps, that it was the child's brain which was not working as it should. It could be argued that it again confirmed that the child as the 'problem' and positioned ADHD as a 'within child' phenomena.

However, on closer analysis of the accounts by professionals, a more complex interaction of the role of medication with the positioning of, and 'voice' of the child within the network emerged. Medication appeared to afford some children greater social actorship and opportunities to access 'voice'. For others, alternatively, such affordances and opportunities were closed down.

8.3.2. Becoming A Medicated Child

Participants identified the ways in which the ADHD child became a medicated child, and some of the implications for this new way of being. There were indicators within the network that medication potentially changed the timing, pace and organisation of ADHD childhoods. As remarked by participants in chapter five, the ADHD child was often framed as disorganised and out of sync in terms of the timing and pacing of childhood, compared to other children. Some ADHD parents were also described as 'chaotic', lacking the 'organisation' and timing of 'good' parenting. Yet, the very act of taking the medication could be perceived as prompting a structure and routine to the child's life. For example, the NICE (2008) guidelines recommended professionals,

"advise children and young people and their parents or carers that taking medication should be incorporated into daily routines (for example before meals or after brushing teeth" (2008:47).

The very act of taking medication could become a marker within the child's life, a timed routine to order the child's day. Medication promoted and circulated an ideal of the 'routinised' childhood. As one professional identified,

"they have got to have a regimented lifestyle as far as I understand it with Ritalin"

(002, Teacher)
It could be argued that the pattern of medication also routinised and organised the life of parents, so extending a structure from the public into the private lives of whole families.

The NICE (2008) guidelines also recommended,

"Healthcare professionals should advise parents or carers to provide the child or young person with visual reminders to take medication regularly (for example, alarms, clocks, pill boxes or notes on calendars and fridges" (2008:47).

Therefore medication may also lead to other artefacts being included in the assemblage and link the child with additional objects used to structure and organise a child's day. This again could be linked to a class analysis and how 'organisation' is performed through objects such as diaries, clocks and calendars. Therefore, medication enabled an opportunity to perform organisation and a certain ordering of time, as well as pacing, of the child's day. It re-asserted the value of order and structure over alternative lifestyles that were framed as 'chaotic'.

Some of those interviewed commented on how taking medication could make the child even more visible to other adults and children within the network, perhaps accentuating difference. For example, if a child was prescribed a medication that required them to take it a lunchtime, then they would have to visit the school office or school nurse. Thus, the ADHD medicated child was more likely to attract greater adult supervision compared to other children.

"There's another boy in the year below and he is constantly having to be checked up on- has he had his Ritalin?"

(021, Teacher)

"the school nurse has to distribute the medication during the day so these kids are seen as different" .

(012, Social Worker)

Others noted that taking medication at school would make the ADHD child more visible to peers,
“when he wanted to take his medication, it’s very kind of obvious, at school it was obvious where he was going and they used to take the mickey out of him for taking his medication”.

(014, Paediatrician)

Some professionals spoke about the newer types of pharmaceutical drugs that had been developed which were slower release and therefore lasted all day, avoiding children having to take them within school,

“the stigma of taking tablets. Much improved though since we’ve had the once a day preparations, it was a nightmare when they used to have to go to the school office and get their tablets and they’d be teased and all sorts of stuff”.

(016, CAMHS)

Therefore, for those who did not have to take it at school, medication, it was argued, could help a child to become less visible, their physical bodies would blend in, their ADHD symptoms could become hidden,

"I've kind of had the experience of working with young people with ADHD who you'd never know because they were on Ritalin or things like that"

(022, Voluntary Sector)

“I think that is the key thing really, to help them blend in and achieve their potential”.

(006, CAMHS)

Some of the participants argued that medication indicated to a child, and others, that the child was the problem, it carried certain meanings associated with ADHD around the network that the child could also absorb,

"they think taking a tablet is another sign that they are crap".

(016, CAMHS)
Similarly, medication also contributed to, sustained and circulated the 'within child' medical portrayal of ADHD within the network, despite the often complex interaction of biological, cultural, psychological and social factors that many of the professionals identified,

"Very difficult to know how to put it, because you don’t want to medicalise it too much in a child's mind, but inevitably if you're giving them a tablet that calms them down it does affect the way they look on it".

(010, Paediatrician)

Medication may also contribute to the enrolment of the child in certain discourses of ADHD, as noted above.

But for some professionals, the medicated self was not considered to be the child's 'normal' self. The medicated child was positioned as different to the usual ADHD child,

“unless they are on medication in which case they are different children then”

(006, CAMHS)

"One particular young person I worked with, it was really, really noticeable whether or not they'd taken their Ritalin in the morning".

(022, Voluntary Sector)

It was argued that the child may lose a sense of who they are without medication. Medication was understood as changing a child's essence or whole self, again using a developmental lens through which to view the child,

"But when you've been on medication for so long, it's like cleaning addicts almost. You don't know what you're going to be like. You don't know, but it's even worse because they are 6,7, they haven't necessarily got their own, they're not fully developed so they don't know what they would have been like minus the medication".

(012, Social Worker)

Therefore, medication also led to some negative portrayals of the ADHD child, including associations with 'addicts'.
8.3.3. Medication and Voice

There appeared to be an on-going theme within the data around the separation of the private and public. Medication in the assemblage appeared to offer an opportunity for the child to perform the separation of the public and private. The public medicated self could be present in the classroom or after-school activity, as 'in control', whilst the unmedicated private self could be kept for home, for example at the weekend or school holidays, during a medication 'holiday',

"The advantage of things like Ritalin was that you can have holidays from it so they wouldn’t give it at the weekend, they would just have their normal child back at weekends".

(006, CAMHS)

Therefore, for some children, medication in the network allowed them to make choices; it offered greater possibilities for the child to experience voice,

"you would never get a pill into him at the weekend or during holidays when he wants to be himself...he knows that he can’t work very well at school without it, but he doesn’t like how he feels on it but...he is prepared to sacrifice those bits that he enjoys about himself during those hours".

(013, CAMHS)

The above quotes suggested that the child used medication in the school week so that he could be the schooled child but at the weekends he did not take medication. Medication enabled the child to voice a choice about how to be present in different situations. Taking the medication when 'needed', the child also could show that they were aware that they required 'support' to manage certain behaviours or thoughts in particular contexts, thus also performing 'self awareness', often associated with 'competency',

“the mum had started breaking up the Concerta, it was a slow release and she couldn’t concentrate at school and she [the child] made a connection that okay, I wasn't taking the medication properly "

(015, CAMHS)
"he's 10 coming on 11 and he's got to the stage where if he goes out somewhere and he feels he's not coping he asks if he can have a tablet...you know, they're taking responsibility and they're recognising what it is that's irking them and then when they need extra support they can actually take it”.

(021, Teacher)

Ritalin, in particular, was portrayed as a drug that could be taken as 'needed' and thus also enabling the child to access a position of agency,

"Ritalin is one of those that you can use it when you need it”

(006, CAMHS)

“he refuses on Tuesdays and Wednesdays because he wants to be creative, but he will take it on Mondays, Thursdays and Fridays when he has more academic subjects”.

(013, CAMHS)

On the other hand, it could lead to the child being held responsible, for their medication and behaviour. For example, the NICE Guidelines stated (2008), that children should take responsibility for their medication,

"Health care professionals should encourage children and young people with ADHD to be responsible for their own health, including taking their medication as required, and support parents and carers in this endeavour” (2008: 47).

Therefore, medication could also lead to children experiencing and being re-positioned as 'responsible', perhaps moving into the role of 'expert' (or good) patient. However, some respondents identified that children could develop an over-reliance on their medication, so that it was afforded a high position of influence and control in their lives, without which there was a sense of panic. So, for example forgetting to take their medication, could lead to a fear of being held responsible, or a worry about what might happen,

"it's almost the expectation, the first time something goes wrong, it's oh my god, I'm not on medication”.

(021, Teacher)
Although for some, medication within the network had the potential to place the child in the position of decision maker, for example to determine on which days to take it, this was again less so for younger children. 'Age' again seemed to be a way in which ambiguities about the child's voice within medication decisions were settled. For example, a thirteen year old was deemed 'old enough' or had the 'right' to make his own decisions,

"there was a boy, a thirteen year old who said 'It is working far too well, I can't stand how calm I am...and I spend two hours on a piece of homework that takes half an hour and he thought it was just too bizarre and too odd and therefore wouldn’t take it, the mum was very disappointed, but he was 13 and he had the right to make the choice"

(013, CAMHS)

"I had one young man who said quite legitimately he didn’t like treatment because life was less fun, and you think well it's perfectly legitimate really. So he has to weigh up whether he wants to do better at school or have more fun".

(010, Paediatrician)

Younger children appeared to be positioned with less opportunities for voice in terms of views on when and whether they took their medication,

"for a younger child the parents give it in the morning and to a large extent the child can’t argue".

(013, CAMHS)

As such, for the younger child, medication may enhance adult control over the child and child's life; parents are positioned as the decision makers. For example, it may be the adult who decided when the medication was taken,

"so if they have got an important piece of homework or have to be at cubs that evening they [parents] would give the medication”.

(006, CAMHS)
Yet, some within the network noted how medication could physically silence the children who took it. The child's actual body was no longer vocal,

"I've had more experience of children saying I don't want to take Ritalin, it makes me feel odd, it makes me feel like a Zombie"

(009, Teacher)

"this young person was sort of very, I don't know, they changed quite a lot when they started being medicated for it and became quite kind of withdrawn and kind of would sit a bit hunched up, and very, very, very quiet".

(022, Voluntary Sector)

The young person described above was first encountered as "bubbly and bouncy" as "you know eleven year olds are", according to the worker interviewed. They attributed the quietening of the child's vocalisations to the commencement of medicaton. Therefore, not only was medication positioned as making child's bodies 'blend in', but their vocalisations were also muted.

A number of those interviewed were able to share what they perceived to be the views of children that they worked with on a daily basis, (for example the education and social care staff) on the children's experiences of medication. Such views included opinions on side effects, which could potentially have been very useful to the on-going monitoring of interventions by CAMHS and Paediatricians,

"they feel that they can't sleep"

(009, Educational Psychologist)

"they don't feel hungry and so don't want to eat because of the Ritalin".

(002, Teacher)

Yet, as the last chapter highlighted, there appeared to be less opportunities for, particularly children under eleven, to share their views and this information could be lost. It was
highlighted in chapter five that the feedback from certain professionals, for example social
workers or educational professionals, may also not be recognised so the possibilities for these
professionals to advocate on behalf of the child or to pass on their experiences could be
limited. However, as noted in the last chapter the side effects could also be pay-offs that the
child accepts in order to be repositioned as valued or included.

8.3.4. Medication and other interventions
At times, it was also claimed that medication was perceived to be the ‘answer’ to ADHD
and therefore the only and sole intervention to be used, so alternatives were not explored.
This may exclude children and their families from trying other forms of intervention. Those
in the study felt the children, parents and professionals may focus solely on the medication,
without considering other options.

“sometimes if the child’s on medication they kind of then don’t see the point of
doing additional sort of work or sometimes parents don’t see the importance of doing
additional work, they think medication is sort of the solution”
(005, CAMHS)

" I think people do move to medication quickly in the hope that it will get things off to
a good start...And that risks meaning that the environmental modifications often not
done very carefully I think”.
(010, Paediatrician)

There could have been a number of reasons why the local network may be more easily
persuaded that medication was the most appropriate option. For children, whilst it places the
condition firmly 'within child' it also offered an explanation for their behaviour and why they
were 'different' from their peers, perhaps with less responsibility. If successful, the
medication could make their behaviour appear less different and 'problematic' and more
favourably accepted by peers, parents and teachers. Particularly with the slow-release
varieties, they would be able to take the medication at home and then they would be able to
'blend in' at school. For parents, medication could signify that the 'cause' of the ADHD is
within their child rather than their family. It might mean that there is less likelihood of them
being perceived as 'chaotic' or poor parents. It could mean that they do not need to attend
regular appointments, for example at CAMHS, which they could perceive to be an intrusion as has been identified in chapter six.

For those professionals assessing and diagnosing ADHD, who appeared to be time and resource limited, it offered a quicker way to see and treat a vast number of children. Other options, such as groups with children or parents were framed as more difficult and labour intensive, even within CAMHS,

“one of our big sadness is that we haven’t got the resources I think to really deal with some of the kids”.

(016, CAMHS)

As already discussed, medication was the only intervention available within Paediatrics.

8.4. Social Management

8.4.1. Social Management and positioning the child

Some children within CAMHS did appear to be offered interventions in addition to or as alternative to medication, such as individual work or family work.

“we then offer follow up intervention and that may include work with our Tier 2 colleagues in groups, individual work, behavioural work, medication, family work, education”.

(016, CAMHS)

A small minority within the study mentioned the management strategies that children could be offered to learn to cope with ADHD. For example, the CAMHS worker below explained that some people learn to be ‘organised’ by using a diary or calendar to manage their ADHD,

"so they learn they need to write everything in their diary or write things on the calendar otherwise there is no way they will know where they are meant to be or what to remember”.

(005, CAMHS)
But using such artefacts could again depend upon the child's life experiences. Whether such objects as diaries and calendars were used or important in the everyday world of the child may depend on many factors such as class, gender, or parenting style. The inclusion of such non-human actants within the assemblage may again change the way the young person or adult is positioned, in terms of being seen as self-regulated or 'organised'. Just like medication, introducing these artefacts could be way of ordering or standardising childhoods, children and families.

Interventions within schools to manage 'ADHD' could also accentuate the child in a setting, making them more visible and different from their peers. Recommended classroom strategies could serve to draw attention to children, which children could dislike, as well as focusing on silencing the child, for example in a quiet area or by seating them near a teacher,

"it might be a quiet corner or whatever. The difficulty with that of course is kids often don't like to be singled out and be different"

(010, Paediatrician)

"one was made to sit in front of the teacher's desk, you know, right at the front to make them concentrate more and stuff, and he was like that wasn't fair because I didn't get to mix with my friends in lessons".

(022, Voluntary Sector)

So, the practices associated with managing Childhood ADHD through interventions in the classroom, may also actually perpetuate and contribute to the positioning child as 'different'. Therefore, medication that did not need to be taken within school could actually provide an preferable alternative for the child to avoid being singled out.

Some continued to overtly position adults as the sole decision makers, as one participant explicitly claimed,

"I don't like it when adults say "I'll see what he thinks". It is not right. Children shouldn't make decisions- adults should make decisions for them".

(020, Teacher)
Others identified that there may be resistance by parents to the child having a 'voice',

"I think some parents may decide that young people shouldn't be involved because they don't feel that, well, they're the ones getting the raw end of the deal because the parents are the one that are suffering for their [the child's] behaviour".

(012, Social Worker)

8.4.2. Social Management and Voice

Some of the participants described ways that ADHD could be managed, for example helping a child diagnosed with ADHD to manage the classroom, which would impact upon possibilities for voice. An underlying theme within medication as an intervention, was helping the child to be able to 'blend in' at school, to reduce visibility, and attention from the teacher, and this did not appear to differ for social interventions. 'Blending in' was hypothesised to lead to a greater inclusion, for example being able to stay in the classroom. One participant used the metaphor of a soldier in the trenches,

“his key metaphor for not getting into trouble was not to put his head up over the trench and to keep down and low which he got, so it was fun to be able to say he had done pretty well though there were some times when he really got into trouble and we would usually come back to him and say ‘What was it you have forgotten to do?’ and he would say ‘I forgot to keep my head down' because by being noisy in the class, because whatever it was, the teacher spotted him and then he got into trouble, whereas if he had remembered his soldier in the trenches picture he would have thought no, I better sit quietly at this point’.

(013, CAMHS)

Whereas medication was positioned as physically muting the child, or helping them to be quiet in certain situations, the intervention above also aimed to help the child be "less noisy" and "sit quietly", to silence the child's vocalisations. This highlighted again, as described in chapter six, that children were expected to 'sit still', as a way for the child to perform and evidence 'self control' and that they were within the control of the adult. Vocalisations were positioned again as problematic. However, by silencing the child, the child was more likely to be allowed to stay in the classroom which may lead to greater opportunities for voice or the child as speaker, but in adult defined and controlled ways.
The chair too emerged again as a way to silence the child and to teach the child to sit still. It was used as a tool to manage children's disruptive behaviour in a school,

"We do a system of what we call time, which is literally sitting quietly, composing yourself, fold your arms".

(021, Teacher)

Adults were asserting their control over the child's voice and body, and here, muting or silencing the child was used as a consequence for misbehaviour. It would appear that such children must be able to perform compliance and silence to enable them to be afforded a position of approved participation in the classroom again.

Voice could also be used as a rhetoric to meet adult controlled and defined goals for children's behaviour and education. Vocalisations were translated into adult approved or legitimated voice. For example, in terms of educational targets,

"Children are involved as much as their targets are discussed with them".

(021, Teacher)

Seeking the child's views and experiences appeared to be to associated with the management of the child's behaviour, again showing the child 'understanding' or giving them 'responsibility' for their behaviour were considered as ways to achieve their compliance,

"If you are working with a child with ADHD and have the opportunity to find out about them, then that is a really informed and helpful way to work in trying to manage their behaviour because they would know that you show an understanding"

(001, Social Worker)

" if you give a child ownership and control from a young age, ... then that young person would work better with services".

(012, Social Worker)
Participants used terminology such as 'empower' and 'involvement' rhetorically too. These terms again used voice as a mechanism to gain control over the child's behaviour, by the adult and the child themselves and to encourage self-regulation,

"Empowering children to see that they can deal with the control of their own behaviour"

(009, Teacher)

"the principle is to involve the child in monitoring and evaluation of his or her behaviour"

(003, Educational Psychologist)

"I do try and involve them...like I'm really having difficulty when you come into the classroom....I will ask them how can we change this?".

(002, Teacher)

Others used the rhetoric of choices in order to encourage children to make the 'right', (adult preferred) decisions,

"It's making them feel they have got a choice, but whatever choice they've got, there'll be consequences".

(021, Teacher)

Therefore, such terms as choice and empowerment had been translated into practice as ways to ensure compliance and conformity from ADHD children. Both medication and social interventions could increase inclusion, through 'blending in' children, but which would lead to greater control of the child's behaviour and vocalisations (by the adults, medication, or through self-regulation) to meet the adult approved norms and goals. Perhaps the role of 'participating child' was not one where the child was valued as a social actor in their own right, but rather interpreted as a conforming child. The vocalised child could become the voiced child, but voice was positioned and translated in many ways.

Even within the social interventions, the child's voice could be muted or silenced as well. Those interviewed cited some reasons for why a child's views may not be taken into account
within such settings. As within the assessment, one reason given was that the child did not have enough self-awareness. So, for example, the child would not have the knowledge or ability to be able to offer an opinion on future academic goals,

"I don't think children are that aware of what could be their next steps in education".

(002, Teacher)

The annual reviews for children with a Statement of Special Educational Needs process were often heralded within the network as a more opportune and routinised way for even younger children to experience contributing their views, prompted by the annual review form,

"For schools, if they are requesting a Statement they have to include the child's views and annual reviews of statements, you know the child's view is meant to be included in that as well"

(019, Educational Psychologist)

"so you can say, well what do you think about school, there's a standard form".

(009, Teacher)

However, when discussed in practice, the participation of the child was not always enacted. Children, it seemed, were more likely to be included if they could demonstrate calmness, perhaps another attribute associated with the voiced or participating child,

"children if they are calm or if it's appropriate we will invite them to an annual review or talk to them about it".

(021, Teacher)

If the child was not calm, they were not included and their views may not have been expressed or may have been represented by others. Some practitioners felt that it was inappropriate for younger children to attend the annual review meetings as they thought the child would not be able to understand or manage the meeting, again because of their age,
"you are talking at a level that is not in the child's consciousness, may be an eight year old, they are interested in DVD's and playstation 2's...it's not a meeting of minds in a conversation".

(002, Teacher)

Eight year olds were again positioned as different from adults. Therefore, as the clinicians highlighted within the assessment process, generation was circulated around the network as a criteria for if and when the child's views were sought,

"some colleagues feel that, you know, some young people may be too young to make a decision for themselves".

(012, Social Worker)

There was also a sense that involving the child with decisions about their welfare may 'over-burden' them, if too much information was given, and that instead children required protection,

"if they are not aware that there might be a change, then do you let them know about it because they might worry".

(019, Educational Psychologist)

A small minority of participants queried the ethics of consulting children if their views would have no impact upon the decision or issue,

"are you actually going to be able to do anything differently with it?"

(019, Educational Psychologist)

"Young people are encouraged to take part and in reality, even if they do and they put across they still won't be listened to. Well they are listened to but you can't carry out their wishes, necessarily".

(012, Social Worker)
However, another argued that although it was unlikely that anything would change, the process itself for involving the child's voice was important for the child. It was having the experience of sharing their views,

"we work with a lot of young people who are never going to get what they want and they are never going to get the things that they ask for, but a lot of the time the process is more important than the outcome".

(022, Voluntary Sector)

However it could be questioned whether children would agree that the process is more important than the outcome, including the child's voice with no intention of it having an influence in the decisions making or unsettling adult-child relations. As with the assessment consultation, there was an underlying complexity of the interplay between participation and protection. Professionals may avoid involving children in decisions and seeking their views as a way to protect them, again emphasising a discourse of the ADHD child as vulnerable.

Only one participant reflected upon changing the way professional meetings around ADHD children were performed, so that they could be structured and organised in other ways. It was suggested that this could enable greater participation and inclusion of the child's views,

"you may need a different setting, you know it's a culture thing, rather than adult tables and chairs, meeting rooms".

(001, Social Worker)

Yet again, it would appear that the artefacts, the non-human actants, in this case objects such as chairs and tables, potentially play an important role in creating or closing down possibilities for the presence and positioning of the voice of the ADHD child.

8.5. Summary

This chapter has explored the diagnosis and intervention stages of the performance of the network. In particular, it has focused upon how becoming a diagnosed ADHD could impact on the positioning of the child, in terms of typifications and valuing of the child, as well as the future child, which may in turn impact upon or scaffold the possibilities for voice for the
diagnosed child. It could be argued that there may be less motivation to recognise the voices of children who are seen as a threat or demand on adults and society, now or in the future, and if the typical ADHD child is problematised in other ways, for example in terms of gender or socio-economic group, this may interweave additional layers to marginalisation.

The chapter moved on to consider the impact of medication on the presence and positioning of the child's voice. It was shown that such impact cannot be assumed and may vary, for example, upon the age of the child. For older children, it may offer an opportunity to make choices or be re-positioned as self-aware, leading to more possibilities for voice, but for younger children it may enable continued adult control. Therefore artefacts may supplement or extend voice for some children, but close it down for others.

Finally the same question was considered for social interventions. Traditionally, Sociologists would have been critical of the medicalisation of children, proposing the value of more social interventions, particularly due to the emphasise on 'talking' to children within these approaches. However, the findings have shown that social interventions may also contribute to greater adult control, leading to a rhetoric of 'voice' but only when the child as speaker conformed in particular adult legitimated or approved ways. Alternatively, such interventions may mute the voices of younger children, when adults were positioned as the decision makers or children were not positioned as calm or self aware. Through social interventions the vocal child may be translated into the voiced child, (but with particular positionings of voice), or silenced.

The research highlighted that the voice of the child emerged as a controversial concept and that the ambiguities of policy, for example in terms of age and understanding, were settled in particular ways, often dichotomised between those over and under eleven, observed through the referral, assessment and intervention processes. In turn, this ignored the individual experiences and abilities of younger children and led to a muting or controlling of the views of younger children, ironically often using the 'rhetoric' of voice. Broadly, the vocal child was translated into the adult approved voiced child through the performance of the network, from a speaker who blurted out to a speaker who blended in.
Chapter Nine
Discussion

9.1. Introduction
Voice, for the purpose of the study, was understood as a relational, situated and contextualised concept, and the research highlighted that if and how the child's voice emerged depended upon the assemblage of certain actants. From an ANT perspective, the child's voice was considered to be a social practice or process. This chapter will begin with a summary of the tracing of the child's voice through the identification, referral, assessment and diagnosis/intervention processes to evidence how the child's voice (or vocalisation) was translated and circulated during the performance of the network.

By following the child's voice through these processes a number of actants, human and non-human, were identified that impacted upon the presence and positioning of the voice of the child. The literature review highlighted different factors which could impact upon if and how children are afforded opportunities of voice. Some sociological studies focused on how the child was positioned, whilst others looked at the organisational practices that created or closed down spaces for children's participation. Prout et al (2006) claimed that four main factors affected the child's participation—the child's motives to participate; resources; mobilisation (opportunities to participate); dynamics (organisational practices) and the latter three were considered and developed within the analysis of the current study. It will be argued that the actants which impacted upon if and how the voice of the child emerged, included artefacts, organisational practices, parents, professionals, positioning of the child, the child themselves but also the context, the decision or issue of the child's welfare under discussion. The chapter will conclude with an identification of some of the complexities regarding the child's voice that emerged from the findings, for example when decisions are not of the child's making, the authenticity of views, adult approved agency, the object-subject dualism and the multiplicities of voice.

9.2. The child's voice and the assemblages of actants
9.2.1. Tracing the child's voice through the assessment processes
As highlighted within the analysis, the 'voice' of the child was traced through accounts of how children were first identified as problematic through to the assessment and diagnosis, including professional narratives on recommended interventions. In considering the
performance of the network, Lee and Motzkau's (2011) question was considered "how are children's voices being composed, transferred and circulated" (2011:18).

What was evident was that the speech of the child within the identification phase was positioned as part of the problem of ADHD. Vocalisations were deemed problematic due to their timing, frequency and their content. Children were described as 'blurting out' into adult conversations or the classroom, rather than respecting social rules and norms around communication. Similarly, these children also appeared to express their thoughts directly, rather than self-regulate and respect conventions around content of speech. Inappropriate and ill timed vocalisations were used as indicators of impulsivity and lack of self control. They were viewed as negative, and not positioned as 'voice'. Similarly, children were framed as not listening to the voices of others, particularly adults, as they were rarely sitting still and deemed to be concentrating or attending. On other occasions children were described as using their vocalisations to gain certain outcomes, for example, shouting to demand attention from adults. Whilst such speech was positioned as more agentic, as intentioned, it was neither adult approved or legitimated. Therefore, it was also not responded to or heard by the adults as 'voice'.

As noted, as part of the referral process, school staff, usually class teachers, were asked to complete questionnaires, some of which used the child's vocalisations as indicators of ADHD. Similarly these assessment tools did not include the views or the voice of the child under eleven, the muting of the younger child's perspectives was routinised. This evidenced the emergence of a dichotomising of children, between the under and over eleven's which settled the ambiguity of the child's voice in practice. Those children over eleven were positioned as being of the age and understanding to contribute their views, children under eleven years of age were not. Yet, even those over eleven, through the questionnaires such as the Behaviour Checklist, were asked to comment on their vocalisation as a problematic object, as an indicator of ADHD, rather than provide their views through these artefacts about living with the condition in general.

The actual child attended the assessment consultation within CAMHS or Paediatrics. As discussed, the decision regarding which referral pathway to use for the child, to CAMHS or Paediatrics, was positioned as determined by the complexity of the child's symptoms, whether their ADHD was simple or complex. Yet, as highlighted within the data, there was
 actually a great deal more negotiation occurring between professionals and parents, aside from the child's symptoms, and as such the decision was more likely to be based on the 'voices' of adults. There appeared to be a strong professional and parental resistance to the ADHD child being considered as "mentally disordered", negative interpretations of mental illness were defined in very adult-centric ways. Work also appeared to be undertaken to ensure a referral to Paediatrics rather than CAMHS, as assessments by the latter were described as a great deal more intrusive (in-depth) which was felt to discourage parents, and much longer waiting times were perceived. A dominant discourse appeared to have emerged which sought to position ADHD as a brain disorder, and the brain as a physical not a mental object. As such, ADHD was claimed, for most children, to be a medical rather than a mental issue. Only those children with additional 'complexities', for example other mental health issues, would be referred to CAMHS. Yet, the professionals accounts of the two assessment processes indicated that they were completed in different ways. Therefore, depending upon within which service the child was assessed, impacted upon not only the assemblage of actants (including artefacts) the child would encounter, but also what was made visible or amplified about the child (for example 'brain', 'genes', or family) as well as the presence, and positioning, of the child's voice.

Salmon and Kemp (2002) found a difference in the working practices of the CAMHS team and Paediatricians in Wales. Like the current study, there appeared to be a greater emphasis upon medical assessments within Paediatrics and more social interventions offered by the CAMHS Psychiatrist. Law (2001) argued that "different modes of ordering produce certain forms of organisation" (2001:3), which can lead to different types of knowledge being produced (for example, ADHD as medical or ADHD as family or mental health related) and different subject positions (which in this study was explored through the child's voice).

In the current study, within CAMHS, there appeared to be more time and space for the child's views to be expressed vocally from the beginning, for example their opinions of school. Yet, within these encounters, the child's vocalisations were also used as 'evidence' of ADHD, as observations of the interactions between the child and parent could be undertaken. Additionally, the questionnaire data (some of which concerned vocalisations) was translated into charts which were shared with children. It was also shown that the child's views were often sought in very adult directed ways and 'voice' was used as a way to achieve the child's 'understanding' and acceptance of themselves as 'different', to enrol the child.
Within Paediatrics, it was acknowledged that the parent voice was the focus of the consultation, particularly at the start of the consultation. The child's vocalisations were ignored or used again as indicators of ADHD symptoms. Again the results of the questionnaires were shared some of which could describe the child's vocalisations as object. When the child's speech was present or evident it was as vocalisation rather than voice. Seeking the child's views could, as within CAMHS, be used as a mechanism to enrol the older child with particular 'understandings' of themselves and their condition.

Medication was the only intervention that was offered through Paediatrics, although in CAMHS, other interventions such as family work or parenting groups could also be offered. The research finding would suggest that medication in the assemblage translated the child ( as well as some parents) from chaotic to controlled. The taking of medication could potentially re-order childhood, by routinising and regulating the child's day. Like Cooper and Shea (1999) found, medication was believed to physically quieten the child's vocalisations and as such the child was perceived to be much more able to 'blend in', for example within the classroom leading to greater inclusion and likelihood of participation. It was argued that older children, particularly those nearing adolescence, could 'use' medication at different times, thus re-positioning them as 'agentic' so for example taking Ritalin on school days rather than the weekends.

Singh (2013) found that medication could potentially offer children moral agency, as children perceived themselves to be able to meet normative expectations. In the current study, medication appeared to offer an opportunity for the child to perform 'self awareness' and responsibility, taking it when 'needed'. These characteristics were likely to increase the chances of the child being re-positioned as more agentic and the views of such children being listened to by the adults around them. Those young people aged over eleven years were also considered able to give their informed consent about whether to accept medication as an intervention.

For younger children, those under the age of eleven, parents were positioned as the decision makers in terms of informed consent to medication and even if a child vocalised an opinion, these appeared to be ignored or dismissed. Parents were also positioned as deciding when the
child took the tablet, rather than the child themselves. This was the same for both CAMHS and Paediatrics.

Social interventions whether delivered by CAMHS or by other professionals such as teachers also appeared to aim to help the child 'blend in', to mute or quieten the child's vocalisations. Alternatively, 'voice' was used as a mechanism to ensure the child's cooperation or compliance in adult directed and approved ways, for example to be involved in the setting of behavioural or educational goals. The rhetoric of choice was also adopted, to encourage adult approved actions. The chair emerged as a significant artefact within the assemblages, for example if a child was seated on it they were more likely to be consulted in an assessment but if they did not, it appeared to be used to materialise the ADHD. Chairs were also used to control the child's body and silence vocalisations as consequences to perceived misbehaviour.

Within CAMHS, diagnosed children could be re-positioned as a 'user' and access advocacy services and participation projects. However, the service relied upon adults enrolling the child and participation was often aimed at older children, with specific adult directed opportunities for voice, for example interviewing and training professionals. Within Paediatrics, parents tended to be positioned as the 'user' and when children had been considered in reviewing the service, the numbers of children had been used, the child as object, rather than their views sought. However the child as object could have an effect within the assemblage, even if not intended for example triggering a diagnosis or service development, which could have been more influential than the child as subject, for example if their views were noted but had no weight or impact.

Therefore the assemblages of actants produced different modes of existence for the child, for example as a user of CAMHS or Paediatrics, as an ADHD child or as a Medicated ADHD child. Different assemblages allowed or enabled different spaces for the child as speaker, as well as different positionings of the child's voice. Overall, as the child moved through the identification, referral, assessment and diagnosis/intervention processes, the child's unapproved vocalisations were problematised and then silenced or translated, so that instead the child's speech became approved, legitimated and controlled by adults (for example through interventions and/or medication), emerging potentially as 'voice', but with certain conditions and pay-offs. Children were dichotomised by age (those under eleven and
those over it), which appeared to settle the ambiguities of 'age and understanding' often present in policy.

9.2.2. Artefacts

I argued that a much more hybrid approach to childhood (Prout, 2005; Lee and Motzkau, 2011) was needed to be able to study ADHD in order to recognise the wide number of actants that are involved and interrelated, particularly when considering if and how the child's voice emerged. Few previous studies have attended to the significance of the role of artefacts in the emergence of the child's voice within professional practice, which this study sought to address. It is argued that in considering the presence and positioning of the child's voice within the process of assessing ADHD, non-human actants also played their part.

As noted above, key artefacts that were identified within the current research that impacted upon if and how the child's voice emerged were questionnaires and medication as well as letters, forms and the chair. There was also evidence of unseen or hidden work of artefacts which positioned, and absented the child under eleven such as questionnaires, and letters. Questionnaires, as intellectual technologies (Latour, 2005) connected a number of human and non-human actants (for example the child in the home to the DSM-IV-TR in the clinic) and served a role of circulating dominant understandings about the child's vocalisations, body and brain as problematic, a role identified by Lakoff (2000) in a previous study.

It could be argued that the questionnaires collapsed the network and transported it into the school and private worlds of the home. Some questionnaire results were also used to enrol children in the network and contributed to the positioning of the child's speech as unapproved vocalisations rather than voice. However, for those young people over eleven, questionnaires potentially provided a way for them to contribute to their assessment, thus re-ordering the assemblage. But the young person was only asked to rate their views on their vocalisations as 'object', for example how often they interrupted others, rather than share their views in general, so participation was in prescribed and controlled ways.

The research findings indicated that medication was also an intellectual technology that collapsed and transported the network from the clinic to the classroom and the home. Medication signified the child's identity as problematic, that they had been diagnosed with ADHD and were viewed as different to other children. Yet, the analysis highlighted that it
was also important to consider the positive impact that medication may have on the presence and positioning of the child's voice, for example it could offer a resource for the older child to use to perform organisation, understanding and self awareness. In examining the connection between the ADHD child and medication within the assemblage, it highlighted that for some children, this artefact enabled a re-ordering and re-positioning of the ADHD child's voice.

So, for older children (over eleven years of age), there appeared to be scope for being involved in the decision making around the prescribing or trialling of medication and for them to be positioned as agentic in terms of deciding when to take it and when to refrain (for example at the weekends). However for younger children it appeared to be an accepted practice that the parent would decide whether a child should be medicated and then also control when the medication was taken, in these instances medication closed down opportunities for the child to be positioned as agentic and have their views included. Lee (1999) evidenced that other actants could extend or supplement children's voice or agency but the current research would suggest that the situation is more complex, the same actor or artefact may extend opportunities for voice for some children, but close them down for others. The same artefacts within an assemblage cannot be assumed to have the same implications for the voices of children, in this example the relationship varied with the age of the child.

It was noted that assessment forms did not routinely ask for the child's views to be recorded separately from that of the parent. Similarly, letters following assessment were sent directly to parents but not to the child, the parent was the obligatory point of passage for the child to access information, and therefore to an increased likelihood of being considered as 'informed'. Both of these artefacts contributed to the absenting and silencing of the child's voice in the network as well as the ordering of the assemblages.

The findings showed that when a chair was included within the assemblage, depending upon how it was connected to the child impacted upon the presence and positioning of the child's voice. The chair appeared to be used to materialise ADHD both within the classroom and in the assessment consultation. Children who did not sit on chairs but instead jumped off them or avoided using them, were perceived to be problematic. Children sitting on chairs signified that they were able to control their bodies, that they respected social norms and adult-child relations. Sitting children were also portrayed as listening children and it appeared that
children sitting in chairs were more likely to be asked to contribute their views. The chair was also used as a way to attempt to regain adult control of the child, for example sitting still as a consequence of misbehaviour at school. This would raise the question of how the child and the child's voice would be positioned if the chair was not present in the assemblage?

Policies and guidance were also artefacts circulating within the network, but interestingly rarely were they specifically referred to by participants. In the day to day practice of professionals, aspects of policies or guidance which referred to seeking the views of the child did not appear to be considered.

9.2.3. Organisational practices
The findings indicated that the network was large, with physical distances between the different human actants. Due to the lack of regular face to face meetings, the representation of the views of professionals and parents through the artefacts described above was necessary. The network felt messy and complicated to those working within it.

The findings also showed a hierarchical nature to the network, which other studies have previously indicated (Rafalovich, 2001; Malacrida, 2004; Brady, 2014). Certain voices were more influential within the network than others, positioned as the 'experts' and obligatory points of passage to diagnosis and medication. For example, the voices of Paediatricians and CAMHS Psychiatrists were privileged in the assessment as they were the only two groups of actors who could formally diagnose ADHD. Certain actants had been moved out, for example the ICD-10, depending upon their current necessity to the effective performance of the network. This was particularly important to note as it could be argued that the younger child's voice was also not positioned as necessary to the effective performance of the network, children could be successfully assessed, diagnosed and medicated without the younger child's views being heard.

There was also evidence that voices of some professionals were silenced, as an example of a Social Worker giving an different view to a Paediatrician showed and strategies were used to discount or question the authority of certain voices and maintain the stability of the hierarchy, for example querying experience, understanding or access to confidential information. These mechanisms could be used to manage the voices of adults as well as children. Lee (2001)
argued that not everyone is in the same position to produce social knowledge, which seemed particularly pertinent to the organisational structure studied.

In certain cases, the position and influence of the actant was scaled up or down, depending upon the need of the network at the time, for example G.P.s or the DSM-IV-TR. However, the research did illuminate certain professional allegiances, for example the CAMHS worker and teachers within the PRU or SEN school, or G.P.s and Paediatricians, as other studies have found (Frigerio and Montali, 2013). This may have impacted on which service (and assessment assemblage) the child was referred to and in turn their experiences of voice.

The hierarchical nature of the organisation of the network had implications for the presence and positioning of the child's voice in a number of ways. Like other voices, the presence and positioning of the child's voice could be scaled up and down (Middleton and Brown, 2002). As previous research has shown (Buetow, 2005), children often relied upon adults to engage them with services and therefore to create spaces for their voice within institutions. If the influence of those adults advocating for the child's voice have been questioned or scaled down, this could impact upon the opportunities for voice or the recognition of the relevance of the child's views within the network. In the current study, the adults (professionals and parents) were obligatory points of passage for the child to voice in the network. As noted, the child's vocalisations only became positioned or translated as voice within the network when adult approved or legitimated.

Another organisational practice that appeared important was how private information was managed within the public arena of the network. What information was deemed to be 'private' and what was framed as 'public' appeared to be important. 'Confidentiality' appeared to be a mechanism by which actants were either included or excluded at different time points of the performance of the network. For example, schools were asked to provide reports on the child but following assessment, letters were sent to parents and they could decide whether the information was shared with schools, this information was considered 'confidential' and the privacy of the information scaled up. Yet, the content of the information shared by the child within the assessment was scaled down in terms of privacy, as not 'confidential', thus parents could remain present.
Lee (1999) has argued that adult institutions require clear and defined categories. As noted, the children within the network were positioned as 'all different' but they needed to be standardised to fit the clear, distinct categories of the referral pathway. Children were dichotomised as simple or complex ADHD, (within Kildea et al's (2011) study it was 'pure' and 'pseudo' ADHD, the latter linked to 'chaotic' parents). Simple ADHD was referred to Paediatrics and Complex ADHD was referred to CAMHS. As the analysis showed, the two services had different approaches to assessment, which may have been warranted by the complexity of the ADHD, but certainly placed different emphasis on different aspects of the child and led to different ways in which the child's voice emerged. Research studies by Hughes (1999), Parr et al (2003) and Salmon and Kemp (2002) have also highlighted the different methods of assessment and intervention between CAMHS and Paediatrics.

Other organisational practices perceived to impact upon the presence of the child's views within decisions about their care was the time available for the assessment. For example, many of the participants noted that Paediatricians spent less time with each child. Interestingly, the child's own views were not framed as crucial information necessary to assessment, diagnosis or intervention compared to measurements of the child's height, weight and head circumference, information achieved through the child as object. Others highlighted that the layout of the room may also impact upon both the presence and positioning of the child's voice. Similarly, seeing both children and parents together was the organisational norm, when the parent's voice was prioritised, perhaps reducing opportunities for the child to speak for themselves.

9.2.4. Professionals and Parents

The research highlighted that professionals were enrolled differently in the importance and valuing of the child's 'voice'. It could be argued that professional training or background could have impacted on the professional's motivation to seek the child's views. For example, it could be hypothesised that those using a medical model 'lens', for example Paediatricians would focus on speech as a developmental object to be observed (as highlighted in the assessment consultation) compared to a Social Worker who might explore the child's views and meanings (as shown in the current study by the Social Worker who tried to explain the child's actions using the child's experiences within his family rather than ADHD).
Some professionals appeared to show more insight or understanding from the child's perspective than others, one professional identified that Paediatricians may differ in how 'child orientated' they were. Therefore, even within one professional group there may be individual differences. Professionals were able to identify their own ambivalences and ambiguities in translating the child's participation into practice, including worrying about over-burdening the child (like Roche 1999), or risking raising the child's expectations about their level of influence.

Professionals also varied in their personal views on the causation of ADHD, which could lead them to focus on different aspects of the child. They may also vary in their perceptions of childhood, for example how it should be enacted or structured, which again may influence the opportunities for the voice of the child to emerge as well as the professional's view on adult-child relations. For example, the worker from the voluntary sector promoted listening to the opinions of children and holding professionals to account, whereas a Paediatrician spoke about how the ADHD child did not "obey" his parents and a teacher stated that she did not agree with involving children in decision making, this should be left to the adults. It would appear that the voice of the child emerged as a controversial concept within professional practice, as well as the ADHD itself.

It could be argued that there was a network trying to establish the voice of the child in professional practice. It had been introduced at policy level and certain organisations, such as the voluntary agency described, were attempting to enrol professionals and parents in the importance of the voice of the child. Some professionals did evidence a certain level of enrolment but ambiguities remained which required settling within professional practice, for example interpreting 'age and understanding'. Therefore, professionals appeared to vary in their views on the value of children's participation, perhaps reflecting a variation in enrolment. Thomas and O'Kane (1999) produced a typology of professional attitudes to children's participation which were evident within the current network, including clinical (a Paediatrician who questioned the capacity of the younger child to consent to treatment), the bureaucratic (those who made reference to the CAMHS feedback forms), cynical (the teacher who did not agree with involving children in decisions that should be made by adults) and on occasion, the value based (the Social Worker who claimed that children should be consulted because the service was about them). Yet, as will be discussed later in the chapter, there were also uses of the rhetoric of the 'voice' of the child, to enrol children in certain understandings.
(Kjohlt, 2002) and to achieve children's compliance, for example with behavioural goals or taking medication.

Similarly, how the child's parents were positioned could also impact on the presence and positioning of the child's voice. The positioning of 'chaotic' parents has already been discussed, however, in the main, parents within Paediatrics were positioned as the user or receiver of services, parents had the 'right' to have their child assessed, diagnosed and treated. Within both assemblages, for younger children, in making certain decisions about the child's welfare, for example whether to medicate, informed consent was sought from the parent rather than the child and the parent was positioned as the key decision maker. This was reflected in the NICE guidance (2008), where reference to the child was absent from decisions about seeking consent for medication.

The professional accounts of the performance of the network also highlighted that the parent may play a role in if and how the child's voice emerged in the assemblage. For example, one participant commented how parents can sometimes act as advocates for the child which, while motivated by good intentions, could silence the child. Parents could hold particular views, for example a resistance to CAMHS, which impacted upon the service the child became enrolled with and in turn, how the child's voice emerged. Parents were also positioned as obligatory points of passage for the child, for example to access assessments or to information in letters from Paediatricians and CAMHS. Children could only access the CAMHS advocacy service and participation projects through their parents.

9.2.5. The Positioning of the Child
Mayall (1994) has argued that how children and childhood are conceptualised by adults will contribute to their level of powerlessness. As noted in the introduction to the thesis, ADHD was used as an example to explore what opportunities and spaces were available for voice within professional practice for one group of children, those who shared the same social process (being assessed for and becoming a diagnosed ADHD child). Using an ANT approach, it was argued that the ADHD child was a mode of existence that emerged as a result of the assemblages of a certain make-up of human and non-human actants. Therefore, within these assemblage different identities and positionings for the ADHD child emerged and were stabilised, which in turn impacted on the presence and positioning of the child's voice.
The findings showed that there was a strong discourse that all ADHD children were different from each other, different from other children and different from most adults (apart from chaotic and/or ADHD parents). Yet, despite being considered very different in terms of symptoms, the participants also described a typical ADHD child, who had certain social characteristics. Therefore, there appeared to be a dominant identity for the abstracted ADHD child; male, between the ages of seven and ten, who found academic work a challenge, lived with ADHD or chaotic parents and was likely to have less social opportunities, coming from a lower socio-economic background. In terms of social status, this child would have a lower social standing compared to peers, in addition to being perceived as a child, a child with the ADHD condition, and if being treated within CAMHS, a potential mental health service user.

Therefore, there appeared to be a number of layers to the positioning of the ADHD child (for example gender, age, and class) which could scaffold their social status and potentially their access to opportunities for voice. Previous researchers such as Horelli (1998) found that there were cultural, individual and gender specific differences in children's participation. Devine (2002) highlighted that boys and those from lower-socio economic backgrounds were more likely to test the authority of teachers within the classroom and less likely to have their voices legitimised. Therefore there may be many additional layers to the positioning of the ADHD child's voice than simply the condition, as Wyness (2009) identified, children may have different subordinate positions in addition to being a child within adult institutions.

The current findings could raise the question of how, as a society, the voices of working class primary school aged boys are being managed and constituted. Professional practices which problematise and marginalise such voices or silence their vocalisations could have a longer term impact for such children and wider society. It must be noted that in the current study, professionals did not make any reference to the ethnicity of the child with ADHD, which may have been a reflection of the cultural mix of geographical area, which was predominantly white British.

It also emerged that different social statuses may interconnect with or scaffold how ADHD is played out, how far the ADHD becomes part of the child's identity within the assemblage. For example, one respondent made reference to how those parents with greater access to resources can scale down the visibility of their child's ADHD behaviours. The usual artefacts
within a child's life, the objects that contribute to different childhoods could also impact on how ADHD is enacted. For example, a child who lives in a family where there are diaries and calendars may be perceived to be more 'organised' compared to homes where they are not. There may be class, gender or cultural differences in how significant or usual such artefacts are within families. There also appeared to be certain discourses about 'good' parenting, which were associated with structure, organisation and routine. This highlighted that there may be a connection between social status, the performance of ADHD and artefacts. Professionals noted that the gender, age, class and profession of those working with the child may also be important, particularly in terms of how able they are to understand the views, meanings or perspectives of the child.

Other researchers have explored how children are valued differently, for example whether they are positioned as a vulnerable or a threat (Hendrick, 1997; Dingwall et al, 1983; Aubrey and Dahl, 2006). The positioning of the child in these different ways, and the various discourses on childhood, have been shown to impact upon the presence and influence of children's rights and participation (Mayall, 1994; Moss et al, 2000). Within the current study, the ADHD child often appeared to be described in terms of their cost or demand on services and adults, now and in the future, rather than their value or as an investment. Previous studies have also found ADHD children positioned as a burden (Parr et al, 2003; Salmon and Kemp, 2002). It could be hypothesised that it would be much harder for children as a social group who are positioned as a threat or demand to have their voice recognised or acknowledged, compared to those positioned as valued or an investment.

There seemed to be a threat that ADHD children could overwhelm services or the care of their parents and teachers. But at the same time children were 'at risk' themselves or 'vulnerable' because of their ADHD which required greater adult supervision and monitoring. However, through diagnosis and medication the child became more valuable within the network, for example to pharmaceutical companies, or to schools if the child was eligible for a Statement of Special Educational Needs, the child's financial value to some was enhanced. However, it was also highlighted that medication could make the ADHD child more costly to G.P.s or to those who financed the Connor's questionnaire. This indicated the fluidity of the positioning of the child, consistent with the findings of Molloy and Vassil (2002) where children with Asperger Syndrome could be positioned as expert or problematic. It also
evidenced again the significance of artefacts within the assemblage, the presence of which impacted upon the positioning of the child in complex ways.

Few respondents spoke of the emotional value of the ADHD child, a minority cited parents who valued their child's lively nature or professionals who enjoyed working with such children. However, most used negative terms to refer to ADHD children, again indicating a lower status or value for such children. The ADHD child was also described as more likely to be isolated or excluded, for example from mainstream classrooms or structured after-school activities. There appeared to be an acceptance that ADHD children were positioned as a marginalised group (Qvortrup, 1994).

The future child (Scott, 2002) also emerged within the data and was also often dichotomised, for example as a professor or prisoner. This was often attributed to how early the child was diagnosed and intervention started, without any real consideration of how gender, class or other social dimensions connected to outcomes for children. The lack of scientific outcome research, particularly for medication, was not viewed as problem within the network and instead, the risk of negative outcomes, for example in terms of criminality or education, was used to settle and stabilise the need for early assessment, diagnosis and medication. Therefore, every child who entered the ADHD assessment assemblage was a potential criminal or gang leader, if not managed appropriately. This may have added another layer to the status position of the child, as a potential threat as well as current demand on society.

Professionals appeared to indicate that a diagnosis of ADHD could offer an explanation for the child's behaviour which would be less stigmatising than being seen as a 'naughty' child. Similarly, medication was perceived to not only physiologically change the child's behaviour, but to offer the child a way to be more positively valued by peers, parents and teachers, to be re-framed as a 'good' child. Participants spoke of how motivated a child may be to receive positive feedback from others and how medication may provide a resource to do so. White (2002) argued that children can move between such categories as bad child to good patient and the current research would also indicate that there was fluidity for these aspects of the positioning of the child. Therefore, a child could move from problematic, to not only good patient, for example by agreeing to medication or to use a chair to stay seated, but even on to a 'good child', when their actions were deemed to meet social norms and rules. As previous research has noted, 'good' children, in the sense of those who behave or act in more socially
acceptable or approved ways, are more likely to have access to opportunities for giving their views on matters that affect them.

The ADHD child was described as developmentally delayed, their brain development slower and out of sync with peers, indicating that all children were expected to mature in set ways at certain times. On the other hand, the ADHD child's bodies, vocalisations and thoughts were described as moving at a much faster pace than for other children. Therefore, the ADHD child did not fit the pacing and timing of usual childhoods. The ADHD child was also perceived not to respect adult's time in the same way as other children, so for example described as more demanding of the professional within the assessment consultation or the teacher in the classroom. At home, the child was perceived to stay up later and rise earlier than peers. Such children were also described as requiring extra adult supervision and monitoring. The bodies and vocalisations of the ADHD child were perceived to overfill such spaces between adults and children, for example moving around the classroom or during the assessment consultation rather than sitting in the chair.

Therefore, the findings suggested that children were meant to fit certain norms around the pacing, spacing and timing of childhood and as such, ADHD children unsettled the adult-child relations and 'normal' childhood that had been stabilised. This unsettling or threat could add another layer to the child being positioned as problematic and therefore their voice being less valued or deemed as less necessary, with few adults invested in advocating for it to be otherwise. Medication could offer possibilities to normalise ADHD childhoods.

Another related thematic strand regarding the positioning of the child that appeared to weave across the performance of the network, was the visibility of certain aspects of the child. During the performance of the network, certain parts of the child (Place, 2000), were extracted, abstracted and circulated through, for example questionnaires, reports and letters, the network made the interior, for example the brain or genes, of the child, more visible. An ADHD brain was indicated through the child's body (over-active and impulsive) and vocalisations (impulsive and inattentive), observed and captured through questionnaires and professional reports. Visual images of the brain were circulated within the network and even used to enrol children themselves.
As noted in previous research in America (Rafolovich, 2001), the current findings showed that for ADHD in the UK there had been a rise in the prevalence and influence of neurobiological theories across professional groups since Malacrida's study (Malacrida, 2001), raising the profile and visibility of the child's brain, as others have found (Rapp, 2011; Blum, 2007; Wastall and White, 2012). Other ANT studies have noted how networks are fluid, which will not necessarily unsettle them (Middleton and Brown, 2002; Singleton and Micheal, 1993). Wrobleswski and Afeltowicz (2013) using an ANT approach in the United States, particularly analysing documentation, claimed that ADHD had emerged as a "neurobiological mental disorder" (2013:357). However, within the current study, many of the professionals resisted the categorisation of ADHD as a mental disorder, despite it being circulated as such at a policy and guidance level. Therefore a strong identity of the brain within the network emerged as a physical rather than mental object. Mental disorder was often understood in extreme and adult-centric ways. Therefore, this could indicate another layer, and differing social status for the child depending upon whether the ADHD was assessed as simple by a Paediatrician or as complex within the Child and Adolescent Mental Health Service. ADHD or the brain as mental only appeared to become visible for children who were referred to CAMHS, where there was a potential space for the brain to be a mental as well as a physical, medical object.

The focus on the child's brain settled ADHD as a 'within child' phenomena. The brain could connect a number of different approaches to and understandings of ADHD, (including biological, social, cultural, and psychological) whilst maintaining a strong visual identity, so it could be interpreted as a boundary object (Star and Griesmar, 1989). However, there was a risk that the ADHD childhood could become naturalised (Cussins, 1998) and the social, cultural and psychological interpretations could become subsumed under or within the biological. The child could, in some way, become reduced to the brain, so that this is what professionals were 'seeing' when they were dealing with the child. Therefore, the brain had a stronger and superior identity within the network and perhaps the whole child had become less visible. Whereas the 1990's was noted for the emergence of the voice of the child, we may be currently witnessing an emergence of the brain of the child (as Rapp (2011) noted), which could perhaps replace the relevance or presence of voice. It could be argued that the focus on the brain could situate the child within the realm of biology, as an object, rather than the social, the subjectivity of voice.
The child's genes, ADHD as a genetically inherited condition, were also discussed within the network, as identified by Conrad and Potter (2000). Yet, there were less visual images circulating of 'genes' within the network and instead their presence appeared to be made visible through references to 'chaotic' parents. The behaviour (bodies and vocalisations) of certain children appeared to be more accentuated as ADHD in the network due to the visibility of their families. Some families were more likely to be problematised than others and positioned as chaotic, not fitting the 'norm' of parenting as organised, structured or routinised. There was evidence that the voices or views of certain parents were sometimes muted or their influence scaled down at particular time-points. Similarly, all of their actions were understood through the 'chaotic' or ADHD lens, for example if a parent did not return a questionnaire to book an assessment appointment, this was attributed to the parent's disorganisation rather than considering the action as an indicator of the parent's intention not to engage.

As noted, there was some association between chaotic parenting and class within the study which would be an interesting area for further research and analysis. In terms of the position and the voice of the child, parents deemed 'chaotic' may have less opportunities to be valued advocates for the child's views and the connection of the child with 'chaotic' parents, may further scaffold or add another layer to the child's social status.

9.2.6. The Context

Previous researchers have indicated that whether a child's views are sought may depend upon the context of the decision to be made (Ruddick, 2007), and whether it is considered complicated or likely to unsettle adult-child relations. Depending upon the decision, the child may be positioned in different ways, for example as vulnerable or as competent. Runeson et al (2002) found that hospitalised children were informed of what was happening but not involved in discussions about alternative interventions. Franklin and Sloper (2006) found that children with disabilities were involved with reviews of their care, but less often in Child Protection Conferences or health care planning. Frones (1994) argued that children's voices are less likely to be included when child and adult opinions conflict.

The current research supported the idea that the issue or decision under discussion may well contribute to if and how the voice of the child emerged, and even the positioning of the child themselves. For example, within CAMHS, practitioners shared how they asked children their
views on school, children fed back on how the waiting room could be improved with
magazines and the voluntary sector organisation involved children in professional training
events. None of these opportunities for 'voice' were positioned as a risk or threat to the child
or unsettled adult-child relations.

Yet, in discussing consent to medication, for children under the age of eleven, the parent's
view was prioritised and the child's view was discounted or simply ignored. Capacity was
settled using the child's chronological age, rather than any other factors for example life
experiences or other indicators of 'maturity', as proposed by the Gillick principle (Gillick vs
Wisbeck and W Norfolk AHS 1985). The decisions about diagnosis and medication were
positioned as much more 'risky' to the child, it was proposed that without medication
outcomes for the child would be poorer. But perhaps the child's non-compliance would also
be a threat to the parent, other children in the classroom and even professionals working with
the child. (It must be noted that for children over eleven years of age, not the focus of the
current study, there was reference to seeking the young person's consent to treatment and a
perceived greater autonomy for this age group in terms of if and when they took the
medication, perhaps indicating a shift in practice)

Buetow (2005) argued from a study of children's access to health care, that whether voice
was afforded to the child may depend on the necessity of the situation. It could be argued that
in decisions about diagnosis or medication, the younger child's voice was not deemed
'necessary' to the outcome, if the parent decided to agree to diagnosis or medication it was
assumed that the child would be diagnosed or take the medication, no matter what their
views. The information that the child held to inform diagnosis or medication was not
positioned as relevant or necessary to the effective performance of the network.

Similarly, there were no mechanisms for the child to hold the decision-makers (parents and/or
professionals) to account (Prout et al, 2006). Whilst there was an advocacy service to
represent the child if they wished to complain or have their views represented, parents were
an obligatory point of passage for the child to access the service and again it was described as
a service for older children.

Alasuutari (2014) found that when children's views were congruent with those of the
organisation, they were more likely to be legitimated or approved. There was a similar theme
within the current research, for both children and certain adults (for example Social Workers
or Parents), that when they showed that they were enrolled with 'common understandings', their views were more likely to be heard and taken into account. Travell and Visser (2006) too found that when young people's views were sought it was usually to seek their consent to medication, with an underlying threat of what life would be like if they did not take the medication. Therefore, as noted in the current study, decisions about medication could be framed in a particular way, for example offering a opportunity to please parents and teachers.

9.2.7. The Child

Although children in their own right were not included within the study for reasons detailed in chapter four, the research findings indicated that it must not be forgotten that for some, the actual child themselves could also have influence upon if and how their voice is present and positioned. Participants shared examples of when older children absented themselves from the assessment consultation or remained silent in order to avoid further questioning. This highlighted, as other research has shown, that it is also important to consider how children use absence or silence as a way to express their views (Armstrong and Galloway, 1996; Lewis, 2010).

The value of using an ANT approach, particularly the notion of hybridity, was to be able to acknowledge the biological as well as the cultural and social. The majority of participants referred to the developmental delay of the ADHD child and physiologically, the child within the network was positioned as different or out of sync with the expected development of other children. If as sociologists we continue to deny this perspective, there is a risk that the claims for all children to be seen as socially competent actors will be ignored or discredited, particularly when developmental understandings of competence or capacity retain such strength in professional networks. If, instead, we embrace the biological and physiological differences of children in terms of speech development and vocalisation as claimed by professionals in the current research, there may be possibilities to move towards using these differences to understand how children's views can be accessed in different or alternative ways, rather than as a reason to discount them.

Similarly, there may also be a greater scope to incorporating life or social experiences into developmental understandings of childhood, promoting development as a social-biological-cultural process. For example, the participants described a social category of children who
were often excluded from the classroom and community activities. Therefore, there would appear to be less opportunities for these children to experience giving their voice in different environments in adult accepted ways compared to other children. Their peers, in contrast, may have greater opportunities to experience sharing their views, for example in circle time, school councils, or at after-school clubs. This in turn could help them to develop, for example their self-awareness or understand the social rules of communication, which may lead to greater opportunities for voice. Therefore, by embracing the biological and social, it could lead to a greater questioning of how methods could be developed to enable the ADHD child to access experiences of 'voice' in different contexts, which could then help them perform self awareness and 'competence', to be re-positioned as a non-problematic speaker.

9.2.8. Assembling Actants

The diagram, Figure 9.1., provides a visual summary of the actants that were identified as impacting upon if and how the child's voice emerged within the network. It has been argued that how the child was positioned, the presence of certain artefacts, the parent, the professional, organisational practices and the context of the decision or issue all play a role in the presence and positioning of the child's voice. It was also highlighted that there was an inter-connection between many of these factors or actants, for example whether an artefact such as the questionnaire or medication extended or closed down opportunities for the voice of the child appeared to depend on the child's chronological age. Similarly, how the child's parent was positioned, for example if they were perceived to be 'chaotic' could impact upon their status in the organisational hierarchy (and ability to advocate for the child's views) or the positioning of the child themselves.

Figure 9.1.- A diagram displaying the actants that appeared to impact upon the presence and positioning of the child's voice within the assessment process.
In analysing the performance of the network as well as if and how the child's voice emerged, a number of complexities were identified that require further sociological consideration, not least that the voice of the younger child is, in practice, a more controversial notion than is often acknowledged in policy and academic theorising.

9.3. The Complexities and Controversies of the Child's Voice

9.3.1. A network of their choosing?

What emerged from the findings, was that the network was independent of the child's choosing (Roche, 1999). Whilst some children may have wished to be assessed and diagnosed, situations were described by professionals where children had absented themselves or resisted engagement. Others commented that children did not necessarily view their behaviour as problematic, it was their teachers and parents who found behaviours difficult. Therefore, asking for the views of children to be included within decisions about their welfare, when they may not have perceived themselves to have the condition could in itself be problematic. On the one hand, it could be argued that this evidenced the child's lack of self-awareness, but on the other it could have been a resistance to enrolment in the dominant discourses about themselves. Within the present study, the child had to accept and be enrolled in the idea that they were different or problematic in order to be positioned as self-aware and show that they shared the 'common understanding', for their views to be taken into account.

As noted earlier, another challenge appeared to be that the child's voice was not recognised as necessary to the effective performance of the network. Buetow (2005) found that the necessity of the situation may impact upon whether the child's voice is heard. Whilst the actual child needed to be present for a referral or within the clinic for an assessment, there was no 'need' for the younger child's voice to be heard within decisions about diagnosis and intervention. The parent voice was used instead. As there was not any routine way of recording the child's voice separately, or any accountability to do so, practice could remain fluid and inconsistent. The seeking of the younger child's views had not been routinised or stabilised, as it was claimed it had in other areas of practice, for example with Looked After Children.

It was discussed that the social policies regarding voice (for example UNREC, 1990), the local literature regarding the consultation of children and the voluntary sector which offered
advocacy and participation projects were trying to create a 'network' around the voice of the child. However, as the study evidenced, some professionals were yet to be or resisted enrolment. Children themselves could not build their own network around the inclusion of their voices and relied upon adults to perform this work.

The child's voice emerged as a much more controversial concept within the network, than is often portrayed. Professionals did not all agree on the value or importance of consulting children, particularly those under eleven years of age. In fact, the child's voice, as vocalisation, was often deemed a threat to the smooth performance of parts of the network, for example the classroom or consultation. Some professionals spoke of how children's views on the side effects of medication were different to the adults around them and Brady (2014) argued that "seeking the views of children sheds light on the complex and ambivalent meaning of ADHD diagnosis" (Brady 2014:226). Yet, it is argued that the very difference in these views or the ambiguity that may result from them, for example questioning a diagnosis or medication, could threaten the effective performance of the network. Therefore continuing to claim that we wish to hear children's views because they offer a different perspective may be a key reason why they are not consulted, in a network where ensuring everyone had a similar or shared understanding seemed to be very important.

9.3.2. Voice as Object and Subject

The findings also indicated that the voice of the child in the network is also complex because it was positioned as both object and subject. The voice as object was present within the questionnaires, referral, DSM-IV-TR and professional narratives. The frequency and content of the child's speech was to be observed as an indicator of ADHD. The agency of the child's vocalisations was attributed to the ADHD rather than the child themselves. The child as speaker, though an object, could also influence the performance of the network, for example triggering a referral or a diagnosis, even if not intentioned by the child.

Yet, there were occasions when the content of a child's speech was positioned as voice, as the views of the child as subject. This was usually accomplished if the child's utterances were delivered at what were deemed to be appropriate times or were believed to show self-awareness or 'understanding', for example giving views about school during a CAMHS clinic consultation. Sometimes, the child's speech as subject even appeared to have influence, for example in the request for more children's magazines in the waiting room, but at other times
the child's views were discredited or dismissed, for instance the child who did not want to take medication due to the death of her grandmother. Therefore, the child's vocalisations as subject, as voice, did not automatically have influence within decisions about the child's welfare.

The research findings suggest that sociologists need to move beyond the object/subject dichotomy and instead look at the fluidity of the positioning of the child's voice. The speech of even the same child may move fluidly between being positioned as object (vocalisation) and subject (voice) within different encounters, or even as object and subject at the same time. Mol and Law (2004) found that the body can be both object (public) and subject (private), which could appear to also be the case for the child as speaker. Cussins (1998) too found that women using a fertility clinic could be co-exist as object and subject.

Also, as noted, subjectivity may not always equate to influence, a child may also have influence as object, whether intentioned or not. It may be time to re-consider the notion of agency and its relationship with the voice of the child. One of the criticisms of the ANT approach has been the questioning of the intentionality of non-human actants, yet the current research highlights that artefacts can have influence or effect, not necessarily with intention, as can humans. If only the 'voices' of those positioned as having intentioned action are considered, the voices of the ADHD child (and many other groups of children) will continue to be silenced.

Middleton and Brown (2002) noted that the agency of the baby on the hospital ward was scaled up and down, proposing agency as a situated, relational concept. Lee (2001) also highlighted, after studying child court witnesses, that a child may be positioned as more agentic when other actants joined the assemblage, for example police, video cameras, television screens and social workers. Therefore, the findings of the current study support the idea that the agency that emerges for a particular actant, in this case the child, depends upon the assemblage. Agency and voice are fluid and relational, rather than static and individualised, taking different forms in different contexts (Vandenbroeck and Bouverne-debie, 2006; Cocks, 2006).

So, for example within the current study, the "extensions" (Lee, 2001:130) that offered some children a position of approved agency within the network, would for example have been the
chair, medication or a questionnaire. Vocalisations could be translated into 'voice' for those children over the age of eleven. But in these circumstances, the child actually would become more dependent upon other people or objects within the network to achieve an agentic position. As Lee (2001) highlighted, agency emerges through dependency and connection rather than independency. The child is dependent upon others for agency and voice, but then so are all of the other actors within the assemblage. For example, even Paediatricians and Psychiatrists rely on the presence of the child within the network for them to retain their voice and social status. However, the research also highlighted, as has been discussed, that the same artefacts or actors may close down (rather than extend) positions of agency for other children. For example, the questionnaire or medication for the child under eleven years of age.

Interestingly, within the current study it was found that the child's vocalisations and actions, being outside of adult control, were not positioned as agentic, but instead attributed to, as discussed, the ADHD condition or different brain. Bordonaro (2012) in a study of street children has highlighted that being positioned as agentic depends upon "which actions are considered appropriate for children" (2012:422) and that "notions of agency rest on the idea that to act freely is to act in conformity with reason" (2012:422). If children act in ways not usually associated with childhood, for example with violence, then their agency is positioned as being constrained by something else. In the case of the current research, it is argued that the child's frequent vocalisations and busy bodies were perceived to be out of sync with 'normal' childhood so were not positioned as appropriate or approved agency for children. Instead, in these circumstances, the child was believed to be constrained or controlled by their ADHD.

9.3.3. Ambiguities and Eligibility
Other ambiguities that appeared to arise and needed to be settled within the network were around eligibility for voice, so which children should be afforded opportunities for voice and within which circumstances. ADHD was presented as a 'risk' to the child in the present and the future, therefore decisions about diagnosis and intervention were positioned as critical and life changing. Professionals did not appear comfortable with allowing young children to make such decisions. This was highlighted within the NICE (2008) guidance on ADHD, when considering informed consent to treatment, the 'child' was absented.
Lee (1999) has indicated that ways in which to standardise children into distinct and defined categories are needed by institutions when it is necessary to generalise and settle ambiguities. The research findings showed that 'age' or generation, provided a way to settle the ambiguity and standardise access to involvement in decision making by dichotomising those children under eleven years of age, and those over it. Whilst a common rhetoric was that all ADHD children were different, there appeared to be a standardisation for the eligibility for a child to be able to speak for themselves. Through the questionnaires and professional accounts, children over the age of eleven appeared to be more likely to be offered opportunities to share their views on assessment, diagnosis and intervention. This supported the work of previous researchers who have also noted that chronological age was a factor impacting on access to voice (Aubrey and Dahl, 2006). Franklin and Sloper's study (2006) too identified the age of eleven as significant.

Yet, it was also important to look beyond age to explore what other related factors were being used as a criteria for voice. Within the network the capacity of younger children was questioned. This appeared to be linked, not just to chronological age, but to a perceived lack of experience. The experiences of younger children were discredited as irrational, for example as mentioned, the child whose grandmother had died following taking some tablets. So even when a younger children used previous experiences to inform their views, this was dismissed as misguided rather than evidence of social competence. Stoecklin (2012) has highlighted the paradox of competency, when it is defined in terms of maturity and rationality. Children have to find a way to 'prove' they are rational and mature, before being afforded a position of being rational and mature. Davidson (2005) has argued that there appeared to be a supremacy of reason over emotion. In having the condition ADHD, children were positioned by professionals as developmentally delayed and de-regulated in terms of emotion, as such it was very difficult for them to be re-positioned as 'competent', as it has been for certain groups of other children (Pupavac, 2001).

Another condition for the eligibility for voice within the network studied, appeared to be that the child had to show 'self-awareness', as mentioned, an acceptance that they were different and their behaviours problematic. This is in line with Ruddick's (2007) study of the seeking of child's views during parental separation. Children who were positioned as 'knowing themselves' had a greater access to voice, those who did not had their wishes and feelings interpreted by adults. However, the child's views in terms of 'knowing themselves' had to fit
what the adults were expecting to hear, otherwise their views were too, attributed to a psychological disorder, and in this case, ADHD.

Policies relating to including the wishes and feelings of the child, often make reference to the 'understanding' of the child, as well as the age. Lee (1999) has argued that the ambiguity of 'understanding' is often devolved to others, in this case the professionals within the network. Some professionals made reference within the study to enrolling actors, including children, within a common understanding of ADHD, namely it's symptoms, causes and medication. Therefore, as discussed, those children who showed that they were enrolled with such understandings, were more likely to have their views sought. This appeared to be the case for some adults as well, such as Teachers and Social Workers. This highlighted that rather than a biological or developmental attribute, within the child, (as it was portrayed in the network), 'understanding' was in fact created socially within and through the assemblage of actants, applied to both adults and children differentially. Understanding was associated with enrolment, those who showed a greater level of enrolment were likely to have greater access to 'voice' within the network.

The value of using an ANT approach was that it enabled an illumination of the processes that were impacting upon the voice of both children and adults, rather than continuing to focus on children alone, which often ironically perpetuates and accentuates the differences between adults and children. Within the network, attempts appeared to be made to sustain the dualism between the rational, experienced, self aware adult compared to the inexperienced, irrational, younger ADHD child. For example, the lack of experience and understanding was cited to undermine the views of more junior professionals who were not enrolled in the dominant views of ADHD. Pentecost and Wood (2002) too found that those longer in service showed greater familiarity with developmental and medical discourses, so this may also have related to how successfully enrolled actors were within the network. The visibility of the 'chaotic' parent within professional accounts, also appeared to unsettle the stability of adult-child dualism, hence the work that was undertaken to portray them as ADHD too.

As noted earlier, children were also required to perform self-control, in terms of their body, vocalisations and emotional regulation, before they were afforded opportunities for voice. Examples were given where children were invited to speak when they had sat down on chairs. Similarly, an instance was given where a child was invited to a meeting when they
were 'calm'. There appeared to be a 'virtuality' (Middleton and Brown, 2002) of the voiced child being circulated within the network - a child who is seated and calm with a still body, silent until vocalisations are adult approved, and whose content of speech evidences an enrolment in dominant ideologies of themselves and others. This child may also have other attributes for instance in terms of age, class and gender. For example, the 'voice' child in the network was over eleven years of age.

Fundudis (2003) found that children's access to 'voice' depended upon perceived age, cognitive functioning, emotional maturity and socio-cultural factors. Within the findings, the typified ADHD child was presented as between seven and ten years, developmentally delayed in terms of cognitive functioning, emotionally immature (unable to regulate thoughts, feelings with possibly poor attachments to (chaotic) carers) and certain socio-cultural factors were suggested, such as being a boy and from a lower socio-economic group. Therefore, it could be argued that the ADHD child was mobilised and circulated as the vocalised child, perhaps an anti-group to the voiced child (Latour, 2005).

9.3.4. Voice and Authenticity
Spyrou (2011) in exploring the complexities of voice, has questioned the value of continuing to think about the child's voice in terms of 'authenticity' and instead proposes the notion of polyvocality. Previous ADHD research has queried the impact of ADHD and/or medication on the identity of the child, and for example, parent's concerns about locating their 'real' or authentic child. In this vein, through the lens of 'authenticity', it could be argued that the voice of the child could potentially be discredited or questioned when the ADHD diagnosis or medication was within the assemblage, for example a questioning of whether they are the 'real' views of the child.

From the current research, it could also be questioned how valuable the concept of 'authenticity' continues to be when discussing voice, not only for children but adults too. Within the study, many of the professionals indicated a valuing of the separation of private thoughts or views and public voices within the network. For a number of the professionals maintaining a public identity, expressing key shared dominant discourses for example on the 'reality' or extent of Childhood ADHD and the use of medication, was important and potentially contributed to the stability and durability of the network. Yet, these same
professionals shared that they held different views in their private lives or in other professional circles with more ambiguity and ambivalence, as Rafalovich (2005) also found.

Yet, the separation of these views was not considered problematic for professionals, there was an accepted polyvocality. But, if the concept of authenticity was applied, it could be questioned which of these views was the professionals 'authentic' or real voice? Does authenticity continue to be a useful concept for trying to understand voices, for either children or adults? Instead, it might be acknowledged that both children and adults may have different views within different contexts, which may depend upon who or what else contributes to the assemblage. A voice in one context may not be any more or less authentic than others. From the current research findings it may be more helpful to consider what impacts or contributes to what is shared and what is silenced, rather than seek or question authenticity. Authenticity locates the voice within the individual, rather than considering it as a relational, situated, contextualised concept.

One of the main aims of the network appeared to be to enable the ADHD child to perform this private-public separation, keeping certain views and emotions hidden, to stop 'blurting out' in public. One way in which a child could show their ability to self-regulate appeared to be perform a public voice and silence the expression of private thoughts and emotions. Medicated ADHD children were described as being able to better regulate their private thoughts and emotions, so that these were less visible as problematic vocalisations in the public domain. There was not a concern within the network about whether the medicated child's voice was 'authentic'. Medication was positioned as controlling and determining child, but in more positive ways, so that the child as speaker was re-positioned as a child with voice. Some Professionals did indicate that for the ADHD child themselves this could be more problematic. They described situations where the child wished to stop taking the medication because it did not make them 'feel' like themselves, but this was not to suggest that their medicated or unmedicated voices were any more or less 'true' or authentic. For older children who were described as choosing when to medicate, for example on a school day rather than weekends, another subject position was available, as a child neither controlled by ADHD nor by medication, but by the child themselves, which in turn offered greater opportunities for the child's views to be heard.
9.3.5. Multiplicities of Voice

The research findings also illuminated that there were a number of different identities to voice, particularly in terms of what was acknowledged and recognised as the child's voice (Graham and Fitzgerald, 2010). Other ANT researchers have previously identified that objects can have multiplicities of identity, for example Mol and Berg's (1994) study of anaemia in policy and practice.

The current research showed evidence of child's voice as relational (Komulainen, 2007; Spyrou, 2011; Alasuutari, 2014) and a social process, different assemblages will produce different identities for the child as speaker, each with its own costs, benefits and payoffs for the children involved. Even when the rhetoric of 'voice' was used, when professionals claimed to be hearing the 'voice' of the child, the 'voices' they described were very different. Roche (1999) argued that we must seek to understand the terms under which 'voice' is being offered, children's different speaking identities and how voice is used as a rhetorical device (Mclaughlin, 2003).

Children within the network were often presented as very vocal, professionals stated that their voices were not hard to hear. Those professionals enrolled in more neurobiological and developmental framings of the child appeared to understand the child's speech as a physical, within child, object, like the brain. Vocalisations were used as indicators of a medical condition and an assessment tool. The child was not often positioned as a legitimated speaker (Ruddick, 2007), they were not positioned as in control of their 'voice' but neither were they held responsible for the vocalisations.

ADHD itself emerged as an object within the network, an immutable mobile (Latour, 1990) as other previous studies have suggested (Reid, 1996; Malacrida, 2001; Singh 2011). Molloy and Vassil (2002) found that Asperger Syndrome could have some value for certain actors, for example parents or educational professionals and this was a finding within the current study. Participants described how ADHD could be a resource, for example for a child or parent to explain the child's behaviour and for the child to be re-positioned in more valued ways. Malacrida (2001) noted that mothers used the medical model, as a resource, to frame their child as worthy and 'brain blame' (Rapp, 2011) could reduce both child and parental responsibility. It could be argued that whilst positioning ADHD as a medical issue, it may position the ADHD child as speaker as problematic and their speech as vocalisations, rather
than 'voice', however the 'pay off' for the child could be an improved social status as poorly rather than a 'naughty' or 'mental' child.

Medication within the assemblage could translate the child's vocalisations into voice on a number of levels, as has been discussed. So, there was an identity for voice related to the medicated ADHD child as speaker, positioned as less problematic. Cooper and Shea (1999) found that some young people perceived medication as a form of social control, but this could be one of the 'pay offs' that children are willing to accept to be included and be re-positioned with voice, and more positively in general. Other studies have found that children are willing to accept the side effects of medication as a pay-off for the positives that taking it can bring (Singh, 2013; Thorell and Dahlstrom, 2009).

Some participants stated that they gained the child's views to access information, for example to understand how the child experienced school. However, the child's voice was also used in this way to engage the child with the assessment, to begin to enrol the child in certain understandings of themselves, as Kjohlt (2002) also found. Therefore voice was used as a mechanism to achieve enrolment of the child within the network. The child, to have their views heard, would have to accept themselves as different and in need of changing.

Voice, or silencing voice, was also used as a consequence to children's misbehaviour, for example sitting on a chair muted for a period of time. Therefore, voice was also used as a mechanism to try to re-socialise the child, as Kjohlt (2002) identified. Voice as choice appeared to be used to enable children to make the 'right' adult approved decisions. 'Voice', or seeking children's views, was openly described by some professionals as a way to seek children's cooperation or compliance, for example with taking medication.

Another way in which a child as legitimised speaker emerged was when they were asked to contribute to setting and monitoring their educational or behavioural adult-directed goals. Opportunities to share their views was offered to children who presented as 'calm', for example within the SEN reviews. Whilst potentially affording an opportunity for voice, the child had to enter the adult organised meetings and take on greater individualised responsibility. The rhetoric of voice was again used to achieve compliance and co-operation. It is argued that there may be a risk that certain identities of voice are emerging as new forms of regulation (Usher and Edwards, 2005).
A small minority defined voice in terms of giving feedback, for example on CAMH service, the 'user voice'. By being positioned as a 'user' within CAMHS, it could be argued that more opportunities for sharing feedback by children were afforded. However, one participant argued that by involving the child as a user of services, it could continue to keep them enrolled in an identity that may not be in their best interests (as a CAMHS user) and their involvement or 'voice' was again in adult defined and controlled ways.

'Voice' was used by some professionals to refer simply to the child's own meanings. A minority of participants shared how they had understood the child's perspective, separate from the ADHD or medication 'lens', for example when a child took food due to hunger or another resisted moving on to a new activity in the classroom. Some also shared the child's insights into the side-effects of taking medication. Yet, this identity for 'voice', children sharing their own views and meanings in non-adult defined or controlled ways was often marginalised within the network. Therefore, when professionals claim to be seeking or hearing children's 'voices', there may be many different identities or understandings for the concept, multiplicities of voice, which adds a further layer of complexity.

9.4. Summary
This chapter has provided a discussion of the findings, locating it within and linking it to previous studies within the sociology of childhood, ADHD and Actor-Network research. It has shown how part of the network's performance was to translate the child's vocalisations into adult approved voice (or silences); blurt out to blending in. It has also highlighted the work undertaken to re-align the child with the spacing, timing and pacing of 'normal' childhoods, and re-assert the ordering of adult child relationships through 'voice'.

It is argued that if and how the child's voice emerges depends upon the assemblage of actants. Those actants deemed significant within the current study were the artefacts, organisational practices, professionals, parents, positioning of the child, the context or decision and the child themselves. Whether the child's voice is present and how it is positioned will depend on how, and in what ways, all of these are assembled. The research also raised a number of complexities and controversies that require further consideration, not least when the decisions are about the child, rather than of their making. Further sociological debate is needed around authenticity and agency in relation to 'voice', for example whether we can continue to seek
children's (or adult's) 'real' views (as opposed to acknowledging poly-vocality) and what adult approved agency means for the child in terms of costs, benefits and pay-offs.

The multiplicities of voice also require acknowledgement, and that voice may have different identities or meanings in different assemblages or for different actors. The rhetoric of voice may be used, but this may not mean that children's own views and meanings are being sought and heard. The research has highlighted that the child's voice is a multi-layered concept, and only by peeling back each of these layers is it possible to further understand if and how the child's voice is being translated within policies and professional practice. Simply calling for the voice of the child to be heard, or the inclusion of children's views, may overlook the complexities and in turn, lead the child's perspective to continue to be ignored or marginalised. A further challenge was also identified. Sociologists often make claim to the different perspectives or views that involving children can bring to a decision or issue. However, for some networks such as the one studied, different views present a threat to the performance of the network and so the very reasons that are being used by some to raise the profile of children's voices, are also perhaps one of the main reasons why their opinions are continuing to be silenced.
10.1. Introduction
The study was undertaken as an inquiry into the presence and positioning of the child's voice within ADHD assessments, guided by an Actor-Network perspective. Following a presentation of a review of the literature on the child's 'voice' and ADHD, an introduction to Actor-Network theory and the reasons for its adoption as an approach were detailed. A description of the research design and methods was then provided, detailing the qualitative interviewing of twenty-two professionals working in one town with children aged four to eleven years who had worked with ADHD as well as the thirteen documents that were included within the study.

The four analysis chapters followed, the first of which introduced the actants that made up the network and some of the ways that 'voice' was managed in general. The second analysis chapter showed how different aspects of the child were abstracted and circulated around the network as the child was identified as problematic and then the positioning of the child as 'different'. The dichotomising of the referral pathways was presented and the negotiations that appeared to determine the child's route to assessment, with a settling of the child's identity as 'simple' or 'complex' and as a potential 'user' of Paediatrics or CAMHS. An analysis of the two assessment consultations in terms of the child's voice was then presented. The last analysis chapter looked at becoming a diagnosed ADHD child and the ways in which the ADHD child was typified which may scaffold their social status and 'voice'. Medication and social interventions were also analysed in terms of their possibilities for the child's voice. It was argued that one of the roles of the performance of the network was to translate the unapproved vocalisations of the younger child (those under eleven) into approved 'voice'; blurring out to blending in.

The last chapter discussed the key actants across the performance of the network that appeared to impact upon if and how the child's voice emerged. These included the positioning of the child, the professionals, the parents, the organisational practices, the artefacts, the child and the decision to be made. It was argued that different assemblages produce different possibilities for the child's voice. The network also appeared to settle one of the ambiguities of voice by dichotomising children into those under eleven and those over eleven years of
age. It was also noted that the same artefact may extend opportunities for some children, while muting others. The chapter concluded with some of the controversies and complexities of the child's voice that emerged.

This final chapter will provide some research implications for the sociology of childhood. It will also evaluate the contribution of using an Actor-Network perspective to study the voice of the child. Certain practice implications from the findings for those working with ADHD children within the field of children's mental health will also be considered. The chapter will conclude with a discussion of the limitations of the study and areas for future research, before presenting some concluding remarks.

10.2. Contributions to Sociology
10.2.1. Sociology of Childhood
The intention of the current study was to move beyond the reliance upon social construction approaches, so often dominant within empirical work within the Sociology of Childhood. The findings indicate a resurgence of biological interpretations of childhood, for example using the 'lens' of the brain, with a risk that sociological and cultural approaches may again become subsumed. Therefore to continue to theorise about childhood without considering how the bio-social dualism can be addressed or overcome, could lead to the marginalisation, if not dismissal, of sociological claims. The current study supports the consideration of the hybridity of childhoods (Prout, 2005).

The research also indicated that such notions as competency, agency and authenticity with regard to the child's voice require further sociological debate. While claims about the child being socially competent in their own worlds are strong, translating the child as socially competent into adult institutions when the stakes regarding the decisions to be made remain high, could be more complex. It could be safer or easier to show how younger children emerge as socially competent in specific situations, for example in managing playground friendships or helping to decide how to spend a budget as part of a school council, but trying to position them as 'competent' within perceived 'risky' decisions, for instance about medication, may be more of a challenge. Similarly, the very ways in which competency and agency are defined may be adult-centric and inaccessible to some children, for example those viewed through the lens of ADHD. Indicators of ADHD would in themselves make it very
difficult for the child to be positioned as competent and agentic; to do so would involve certain 'pay offs', for example accepting themselves as different and as the problem.

The research also again highlighted the need to find ways to re-position the child's voice as necessary or important to the performance of networks and the need to acknowledge the perceived 'threat' of different or alternative views to dominant discourses about the child's welfare. It is often claimed that children may have different views to other decision makers (Buetow, 2005) but perhaps this in itself is part of the controversy. A more developed understanding of why children's views should be included and the benefit to the networks, as well as the children themselves, is required. The current findings showed that if and how the child's voice emerged in an assemblage may have different costs, benefits and pay offs. One or two of those in the study argued, as Sociologists often do, that the taking part in the process was a benefit in itself, but this could be queried. Sinclair (2004) and Katz (1995) have documented some negative outcomes of seeking children's views, and further work, such as that of Thomas and O'Kane (1999) is required to more fully understand and evidence the value of 'voice' to the child, aside from a moral or sociological 'rightness'.

10.2.2. Using an ANT Perspective
As noted, using an ANT approach enabled a sociological study of ADHD that attempted to go beyond social constructionism and avoid a reduction of the debate to the 'over-medicalisation' of childhoods. For example, it was important to be able to understand the relationship between ADHD, the child, the child's voice and medication in different ways, rather than view medication in solely negative ways. It was also useful to have an approach that could move beyond the 'reality' of ADHD debate, with an acceptance that children diagnosed with ADHD share a social category, and social process, becoming an ADHD child. Whilst it is important to retain a critical eye, sociologists must also take into account the influence of the debate about the 'reality' of ADHD has on the emerging identities of children living with a diagnosis.

The approach illuminated the different ways in which the voice of the child was positioned, with perhaps different costs and pay offs, rather than privileging one perspective. Similarly, the role of actants non-human could be explored, particularly the artefacts within the assemblages which influenced if and how the child's voice emerged. Such artefacts may have remained hidden or ignored if alternative approaches had been used. The approach also
allowed a consideration of how the child was abstracted (Place, 2000; Middleton and Brown, 2002) and typified, which could have implications for the status of the child and child's voice.

The capacity of non-human objects to be intentioned has often been used as a critique of the Actor-Network approach (Vandenberghe, 2002). However, as the research highlighted, agency emerged as a relational, fluid concept that could be scaled up and down, for humans as well as non-human actants. Vandenberghe (2002) queried how non-human objects within a network could be considered when they cannot control their movements, express themselves and appeared indifferent to self and yet it struck me that this was exactly how the child was being described and positioned within the network. Whilst raising the profile of artefacts was an important aspect of the research, the issue of intentionality remains uncomfortable. The findings highlighted that the objects had influence within the network, as did the ADHD child, but this was not necessarily intentioned action. It could be questioned whether this matters or instead there is a need to move beyond the consideration of action through the lens of intention. As discussed, an issue for further debate is how agency is currently sociologically defined and valued.

There was a risk, that in raising the profile of artefacts within the research, this very action increased their degree of importance in the analysis. It is important to acknowledge that some participants within the study afforded certain artefacts greater significance when accompanied by a human 'voice', which would question the influence of such artefacts as they stood alone. However, there was also evidence that the influence of artefacts may have been hidden or implicit, for example a number of participants used the exact phrases from certain questionnaires in their own descriptions of the child's vocalisations.

ANT approaches have been previously criticised for managerialism, however Hall (2005) has argued that the perspective can recognise the "social unevenness" (Hall, 2005:2681) of networks. Therefore, it was important to consider social dimensions, for example in terms of the status of the child in the network as well as the power dynamics being played out within the assemblage, for example the hierarchy of professionals. Star (1990) argued that the approach can focus on the marginalised, and Middleton and Brown's (2002) study of a neonate on a hospital ward followed what they referred to as a fragile and powerless actor. As such, the current study was intended to add to and continue this vein of work.
Using an ANT perspective was not without its challenges. It was difficult to decide and justify what to include and what to ignore, particularly within the presentation of the analysis and when to stop in terms of researching and tracing the network. Previous ANT studies rarely provide explicit details of sampling, data management and analysis. It was intended that by using notions from previous ANT studies within the data analysis, it would add rigour and comparability to the research, for example the presence of dichotomies, boundary objects and inscription devices. Key ideas from previous ANT childhood studies were also used to explore the data, including how the child and child's voice were extracted and abstracted (Place, 2000), how vocalisations were scaled up and down, and how the child's voice was circulated (Lee and Motzkau, 2011) as was the analytic framework developed by using Callon's (1986) four moment's of translation.

Undertaking an ANT study of childhood was consuming. It became increasingly hard to resist becoming part of the network, as within the geographical area studied I became known and recognised for my interest in ADHD. The research itself also became part of the assemblage and may have had an influence on the practice of certain professionals, and in turn the opportunities for the child's voice which could emerge in the future,

“[the interview] actually made me think about things we could do differently, back to recording children’s views in a different way, that would be one improvement actually, I've been thinking as I've been talking to you, about some ways we could improve things, so your interview has been actually very therapeutic”.

(015, CAMHS)

I became aware that my ontological positions on both ADHD and the child's voice were changing over the course of the research, and it became important to consistently reflect about whether I, too, was becoming enrolled within the dominant ideologies of the network, and ensuring that the impact upon the objectivity of the analysis was limited.
10.3. Professional ADHD Practice

10.3.1. Hybridity and Assessment

Within the analysis, a number of the participants and documents also pointed to the hybridity and multiplicity of ADHD Childhoods. The ADHD child was linked to 'natural' or biological aspects (their bodies, brains and genes), social aspects (their families and schooling), psychological aspects (their development and attachment), and the technological (for example, the diagnostic tools and medications). This also linked with the claim that all children were different and Childhood ADHD was presented as a Spectrum.

Yet, the research showed, within the referral and assessment process of the geographical area studied, the pathway was dichotomised into 'simple' or 'complex', the child had to fit one of two categories which led to two different assessments and pathways to interventions. The current research could indicate that the simple and complex dichotomy needs to be re-examined or an alignment of the assessment processes is required so that all aspects of the child are included, wherever the child is assessed. Similarly, a consideration of how all children can access both medical and social interventions in non-stigmatising ways may also need to be considered, rather than having to accept a mental health label (as a user of CAMHS) to do so.

I was surprised to learn that the only assessment artefacts circulating that children could potentially contribute to were the questionnaires, based on a deficit model. Yet, the literature review highlighted the existence of quality of life tools that were being used in research to gain the child's perspectives on living with ADHD and managing medication (Varni and Burwinkle, 2006; Klassen et al, 2006; Sciberras et al, 2011). Developing such tools for practice to capture quality of life information could provide an avenue for the formal recording of children's own views about their lived experiences (rather than continuing to solely ask young people aged over eleven to rate their vocalisations as problematic object). Similarly, the recording of children's views separately during the assessment and developing letters to include children, (whilst acknowledging that these are 'enrolment' activities with their own critiques), could also provide a way to raise the profile of the child's voice in professional practice.
10.3.2. Deficits and Disorder

Professionals within the study highlighted that children with ADHD continue to be valued negatively, with a concentration on their deficits. The value of having some of the attributes associated with ADHD was rarely celebrated. Yet, many argued that by helping the child to feel more positive about themselves and valued by parents, teachers and peers it could lessen the impact of being diagnosed as ADHD on the child's mental health. At present, medication within the assemblage appeared to be one resource which children could use to be positioned in more positive ways, but there appeared to be little research circulating within the network about the long-term effects for children. Other alternative ways for children to be re-positioned, to access a more valued social status are required. It could be argued that enabling the child to have opportunities for voice, sharing their views, could be one route to begin to re-dress the balance.

It was surprising that negative stereotype of mental illness continued to circulate within the network among professionals and as such CAMHS emerged as a stigmatised service, as well as being positioned as intrusive to families. Yet, CAMHS remained the only available way that a child could access ADHD interventions other than, or in addition to, medication. It could be argued that the negative perceptions associated with CAMHS may also transfer to the child. As such, work needs to be undertaken to improve relationships and connections between CAMHS teams and other professionals and parents.

10.4. Limitations and Future Research

Due to the challenges of applications to relevant Ethics Committees, and the re-organisation of a Health Trust, children themselves were not included within the study. The focus of the study was the structuring templates (Latour, 2005) for the child's voice within ADHD assessments, the potentials for children's participation within professional practice. However, there were indications within the findings that children contributed to this process, for example by silencing or absenting themselves. They may also try to find other ways for their meanings or voices to be heard, for example through a parent, teacher or social worker.

Therefore, a valuable development to the current research would be a study that could include children and their parents, ideally an ethnographic study to follow a group of children from the point of identification in the classroom or home through to assessment and intervention within Paediatrics and CAMHS. It would be important to include children from
different social strata, age and gender and although not identified by participants within this study, ethnicity.

The other group of participants that proved difficult to recruit and access was General Practitioners. Yet, as part of the referral process and management of medication, G.P.s emerged as an important actant within the network. Finding creative ways to engage these professionals in future research may further illuminate how decisions about referral pathways are negotiated, as well as their role, if any, in gathering or positioning the child's perspectives.

The research sample was smaller than intended, and as such a larger scale study which could continue to include professionals from across disciplines would also be valuable. A further development would be to replicate the study in another geographical area, to ensure that the findings are more widely applicable. If the growing trend is for ADHD to be positioned as a medical rather than a mental condition, assessed within Paediatrics rather than CAMHS, the implications for the voice of the child will require monitoring. It would also be sociologically interesting to replicate the study for other mental health conditions, such as eating disorders or anxiety, where there may be different statuses for the child and conditions themselves.

It became apparent that for ADHD Childhoods little data is accumulated regarding the number of children diagnosed, or accessing Paediatrics or CAMHS. Similarly, at the time of the study, the social dimensions of the child were not tracked, for example class or gender. Therefore outcomes or pathways for different groups of children, are not easily researched. For this group of children, there are missing pieces of information or data that it would be valuable to collate in the future. As well as using information on social dimensions to ensure the "social evenness" (Hall, 2005) of pathways and outcomes, it could also be used to monitor and identify how children of different social backgrounds are sharing their views (Graham and Fitzgerald, 2010).

10.5. Concluding Remarks

This study was undertaken as an inquiry into the presence and positioning of the child's voice in ADHD assessments using an Actor-Network perspective. The research analysis and discussion has illuminated that if and how the child's voice emerges depends upon the assemblage of actants. In the current research this included the organisational practices, artefacts, parents, professionals, the positioning of the child, the child and the decision
context. There may also be a changing relationship between the artefacts and the child, for example medication may extend opportunities for approved agency and voice for children over eleven years of age, but close it down for those who are younger. Part of the performance of the network appeared to be to translate the vocalisations of the child into more adult controlled and legitimated speech or silences. It has been argued that studying the voice of the child under eleven revealed complexities and controversies, not least because the decisions might not be of the child's choosing or making, and the child's vocalisations and voice may present a perceived threat to the performance of the network. Therefore, to conclude, these controversies and complexities need to be more openly discussed to ensure possibilities for the child's voice to be translated from policy into professional practice.
Afterword

Singleton (1996) when she was asked within a radio programme, following her own research on the Cervical Screening Programme, whether women should have a cervical smear found that “politics, theory and self do not always fit easily together” (1996:450). She argued that depending on how she positioned herself, for example as a woman who had previously used the service or as a researcher may lead to different answers. Therefore, she suggested that women ‘could’ have the test and that the ANT approach should be used to explore what are the ‘possibilities’ rather than recommending particular courses of action. During my study, I found these insights useful when considering how my own views on the positioning of the child's voice within ADHD assessments were becoming multi-layered, as a researcher, as childhood sociologist, as a parent, as a Social Worker and as a CAMHS professional.

Whilst the research may paint a rather bleak picture for the potentials and possibilities for the child's voice within mental health practice, revealing rather than simplifying the complexities and controversies, I would argue that it opens up discussions about how recommendations to include the child's views could be translated into professional practice, particularly for children under eleven. It may certainly raise more questions than it answers, but it would be a first important step in raising the recognition and profile of the presence and positioning of the younger ADHD child's voice, placing it firmly on the agenda of professional practice within the mental health arena.
Bibliography


National Institute for Health and Clinical Excellence (2008), *Attention Deficit Hyperactivity Disorder: Diagnosis and Management of ADHD in Children, Young People and Adults*, NICE Clinical Guidance 72, www.nice.org.uk/GG0


Appendix I- The Interview Guide

**Interview Guide : Professionals**

*Thank you again for agreeing to take part in this study.*

1) **Work Role**

Prompts: Job role, where, length of time, types of activities/responsibilities

2) **Professional experiences of working with ADHD Child**

Prompts: How would you describe it?
How would you recognise it?
Why do you think it happens?
What could be the causes?

From your professional experiences, can you describe to me what a child diagnosed or suspected to have Attention Deficit (Hyperactivity) Disorder is like?

From your professional experiences, can you describe to me what it is like to work with a child diagnosed with Attention Deficit (Hyperactivity) Disorder?

3) **Identification/Assessment**

Prompts: How would you identify Attention Deficit Hyperactivity Disorder? What are the signs?
Are any particular ‘tools’ used to identify it?
Whose views are included in the identification process?
How are decisions made about what to do next? Who is involved?
What information is recorded? How?
What information is passed on to others? How and to whom?
From your experience, I wonder whether you could describe to me the process by which Attention Deficit Hyperactivity Disorder is formally assessed? By whom? Using what tools or criteria?
How are assessments recorded and who are they shared with? What information is required and by/from whom? Meetings?
4) Interventions/Treatments
Prompts: What interventions or treatments are offered? By whom?
From your professional experience, how are interventions or treatments decided upon? How are decisions made? Can give some examples?
Whose views are included in deciding upon appropriate interventions and how are such views included?
What information concerning interventions is recorded? How and by whom?
What information is shared with others? How and to whom?
How are interventions/treatments evaluated?

5) Outcomes
Prompts: What are your thoughts on how Attention Deficit Hyperactivity Disorder should be managed?
What do you think are the outcomes for a child thought to have Attention Deficit Hyperactivity Disorder?

6) ADHD as a ‘mental disorder’
Prompts: What are your views about categorising ‘Attention Deficit (Hyperactivity) Disorder’ as a ‘mental disorder’?
Could you describe to me what you understand by the term ‘mental disorder’?
How know if a child is mentally ill?
What do you think causes childhood ‘mental disorder’?
Which professionals do you feel are responsible for working with children’s ‘mental disorder’?
Which professionals do you think are part of the Child and Adolescent Mental Health Service?
What do you understand by the term ‘mental health’?
How do you know if a child is ‘mentally healthy’?
What do you think contributes to children’s mental health?
Who is responsible for promoting children’s mental health?
7) Multi-disciplinary working
Prompts: Information sharing.
In working within a Service supporting children suspected or identified with ADHD, who do you have contact with? How?
Who do you share information with? What sort of information? How?
What are your experiences of working with other professionals involved with Attention Deficit (Hyperactivity) Disorder? What has worked well? What has worked not so well?

8) Service Delivery/Lead Professional
Prompts: What are your views about how services should be delivered to children with ‘adhd’?
What about one professional taking a lead role or the main responsibility for co-ordinating and liaising? Does this happen?
Who should undertake the role? Who should they liaise with?

9) Children’s Participation
Prompts: Do you think that there is scope for the participation of children with Attention Deficit Hyperactivity Disorder? How and in what ways? Could you tell me about any experiences? Could you give any examples?
Do you think that there is scope for information to be shared with children with ADHD regarding their assessment and care? How? By whom? What is your experience of this?
How, if at all, do children contribute to their assessment?
Do you think that there is scope for the views of children with Attention Deficit Hyperactivity Disorder to be included within decisions about their welfare? How? Have you any experience of this?
Do you think that there is scope for including children with ADHD in the planning, delivery or evaluation? How? Have you any experience of this?
What do you think, if anything, may prevent children’s participation?
What do you think, if anything, may prevent children diagnosed with ADHD being involved in decisions regarding their welfare?
What do you think, if anything, may prevent children diagnosed with ADHD being involved in decisions regarding services?
Are there any specific guidelines or documents or procedures relating to children’s participation?
What do you understand by ‘children’s participation’?

10) Professional Training
Prompts:
Can tell me about your professional training background?
Can you tell me whether you have ever been offered any training regarding Attention Deficit (Hyperactivity) Disorder?
Where was the training? When was the training? Who provided the training? What did it involve?
What about children’s mental health and illness?
What about children’s participation?

*Thank you for participating in this study.*
Appendix II-The Recruitment Letter

22nd September 2007

Dear

I am a PhD research student within the Sociology Department at the University of Surrey and I am contacting you to ask if you would consider participating in my study.

I would like to meet with professionals within your field in XXX to discuss views and experiences of working with ‘Hyperkinetic Disorder’, often also referred to as ‘Attention Deficit (Hyperactivity) Disorder’. Your views are very important for the study as your service appears to be particularly significant to the identification and assessment of ‘Attention Deficit (Hyperactivity) Disorder’ as well as to the interventions with and experiences of children.

Attention Deficit (Hyperactivity) Disorder has recently been identified in a national survey of children’s mental health as one of the three most common mental disorders (ONS, 2004). It also sits at the crossroads of many professional services. As such, my research will focus upon the professional network that comes into play when a child is thought to have AD(H)D. In particular, I am interested in what AD(H)D means within different professional arenas and how the different sectors, such as health, education and social services work together to provide a service to children with AD(H)D and their families (as a mental health disorder). I am interested in AD(H)D itself and also as an example of a mental health disorder for which there is a multi-disciplinary response.

I would like to base my study within xxx as your Local Authority has been awarded Beacon status for Child and Adolescent Mental Health Services. AD(H)D is also a prominent issue within xxx. The xxx CAMHS Healthcare Assessment (2004) has identified AD(H)D as one of the most common childhood mental health problems in xxx and the Business Plan has proposed a review of AD(H)D services and the employment of a project worker in order to enable consistent access and referral pathways to services. Previous research within the field of childhood mental health has also often focused upon those children experiencing social deprivation and so I would like to take a broader remit which xxx would offer. I must emphasise that my research will not be an evaluation of services and policies in xxx.
I have identified two locations within xxx to provide an illustrative ‘case study’ and as such your participation would be really appreciated and is particularly crucial to making the study as beneficial and informative as possible. It is hoped that the benefits of the study will include a further understanding of multi-agency practice and an insight into the ways in which children can be effectively supported, as well as those professionals working with them.

Participation would involve a 45 minute individual interview at a place and time convenient to you. Ideally, if you are in agreement, the interview will be audio-taped. Any information that you share will be treated in the strictest of confidence and accessed only by myself, the researcher and my supervisor during the process of PhD supervision. Your identity will be anonymised during analysis and I will ensure you cannot be identified within the final research report. Prior to the interview, I will ask you to sign a consent form which I can forward to you for your information before we meet.

The findings of the study will be used for the purpose of the PhD thesis and related academic writings or presentations. I will also be producing a written report discussing the results to share with health and social care professionals and organising a workshop at the University of Surrey inviting all those who have participated.

If you are able to participate please complete the enclosed form and return it to me in the enclosed stamped addressed envelope. Alternatively, you can e-mail me at a.blood@surrey.ac.uk.

Should you have any further questions or require any other information, please contact me via the above e-mail address.

Thank you for considering taking part.

Yours sincerely,

Amanda Blood.

Department of Sociology
University of Surrey
Guildford
Surrey GU2 7XH
01483 689365 (Tel.)
a.blood@surrey.ac.uk
## Appendix III- Log of Contact with Professionals

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Name</th>
<th>Date Contacted</th>
<th>Type of Contact</th>
<th>Response</th>
<th>Date/Time of Interview</th>
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Appendix IV-List of Documents

6) (Local Authority) CAMHS Partnership Business Plan and Strategy (2005-2008)
7) (Local Authority) Child and Adolescent Mental Health Services, NHS Information Leaflet
8) (Local Authority) CAMHS Healthcare Needs Assessment, October 2004
9) Mapping Report: Mental Health Services in XXX for Children and Young People with ADHD, Jo Moran-Ellis and Amanda Blood, 2007, Department of Sociology and SSMR.
12) The Strengths and Difficulties Questionnaire, developed by Robert Goodman (1997), *Youth in Mind*
Appendix V - Information Leaflet

Information Sheet

What is the study about?
The aim is to explore professional experiences and views of ‘Attention Deficit (Hyperactivity) Disorder’, the network of services available and multi-disciplinary working.

Who is the researcher?
My name is Amanda Blood and I am a PhD student within the Sociology Department of the University of Surrey. My qualifications include a BSc. in Applied Psychology and Sociology and a Masters in Social Research from the University of Surrey and a Diploma of Social Work and MSc in Applied Social Studies from the University of Oxford. I have previously worked as a Social Worker for XXX County Council but I am now a full-time PhD student.

How is the research funded?
The study is funded by the Economic and Social Research Council.

What will my participation involve?
A 45 minute qualitative interview, at your work place or the University of Surrey, and at a time convenient to you.

Why should I take part?
The research has been geographically located within two areas within xxx. As such the views of professionals working in the locations identified are crucial to ensuring that the study is as in-depth and detailed as possible.
It is intended that the study will provide an insight into multi-disciplinary service provision as well as how professionals working with ‘Attention Deficit (Hyperactivity) Disorder’ interact and can be supported. The implications for children and their families will also be considered. Few studies have researched ‘Attention Deficit (Hyperactivity) Disorder’ in this way or explored perceptions and experiences across many professional domains. As such, your participation will ensure a unique and important study can be undertaken and could contribute to the development of academic ideas, professional practice and policy construction.
What will happen to the information I share?
If you are in agreement, the interview will be audio-taped and the audio-tapes will be kept in a locked cabinet. The interview will then be transcribed and analysed using a computer package, the files of which will only be accessed by a password known to me, the researcher. Any information that you share will be treated with the strictest of confidence. Your identity and that of anyone else mentioned in the interviews will be anonymised throughout the analysis and reporting of the data. It would also be appreciated if the identity of any child that you refer to within the interview could be concealed, for example by changing names.
If you wish to withdraw from the study at any point, you are free to do so without penalty. If you have any questions or complaints during the research process, please contact myself or my Supervisor, Jo Moran-Ellis. Contact details are given below.

The findings will be used for my PhD thesis and related academic writings or presentations. The results will also be available to all those who participate within a summary report. I also plan to hold a workshop at the end of the study to which you will be invited. A summary report will also be submitted to Policy Development Teams.

What will happen next?
If you are interested in participating, please complete the enclosed form and return it in the stamped addressed envelope. Alternatively, you can e-mail me at a.blood@surrey.ac.uk. I will then contact you to arrange a convenient time and location for the interview.

How can I contact you?
If would like more information or have any questions, please contact me at a.blood@surrey.ac.uk or my supervisor, Jo Moran-Ellis, at J.Moran-Ellis@surrey.ac.uk or (01483) 686975.
Any complaint or concerns about any aspects of the way you have been dealt with during the course of the study will be addressed; please contact Jo Moran-Ellis, Principal Investigator on (01483) 686975.

Thank you for taking the time to consider participating in this study.
Appendix VI - The Consent Form

Consent Form

Please tick

I, the undersigned voluntarily agree to take part in the study on 'Attention Deficit (Hyperactivity) Disorder'.

I have received and understood the information given to me regarding the study. I have been given a full explanation by the researcher of the nature, purpose, location and likely duration of the study and what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result. I also agree to the interview being recorded.

I understand that I am expected to refrain from using the names of individual children and families and that in the unlikely event that I share concerns that I may have for a child, I will be directed back to my line manager or supervisor to discuss my concerns.

I understand that the study has been given ethical approval by XXX County Council, the University of Surrey and XXX Research Ethics Committee (NHS) and that all personal data relating to participants is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

I agree that I will not seek to restrict the use of the findings of the study on the understanding that my anonymity and that of anyone mentioned in the data is preserved.

No individuals will be identified in any reports by name or other means, although anonymised quotes may be used. I understand that the data will be confidential to the researcher and her supervisor.

I understand that I am free to withdraw from the study at anytime without needing to justify my decision and without prejudice.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions of the study.

Name of Participant: ..........................................................................................................
Signed: ............................................................................................................................
Date: ...............................................................................................................................

Name of Researcher: .......................................................................................................
Signed: ............................................................................................................................
Date: ...............................................................................................................................

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Appendix VII- Example of Early Atlas.ti (5) coding using Pilot Interviews

Code: 'performing' ADHD
Created: 03/03/07 13:23:26 by Super
Modified: 07/03/07 19:23:04
Quotations: 8

Code: Absented child
Created: 03/03/07 13:54:28 by Super
Modified: 20/03/07 17:58:33
Quotations: 26

Code: adhd & other conditions
Created: 20/03/07 18:16:00 by Super
Modified: 20/03/07 18:16:09
Quotations: 1

Code: adhd & time
Created: 03/03/07 12:53:17 by Super
Modified: 20/03/07 18:13:03
Quotations: 30

Code: adhd and 'special needs'
Created: 03/03/07 13:51:11 by Super
Modified: 03/03/07 13:51:19
Quotations: 1

Code: adhd child/normal child
Created: 03/03/07 12:49:46 by Super
Modified: 07/03/07 19:26:57
Quotations: 11

"adhd child compared to other children, teenagers or even adults"

Code: adhd:activity
Created: 03/03/07 12:38:12 by Super
Modified: 20/03/07 18:39:27
Quotations: 27

Code: adhd:concentration
Created: 03/03/07 13:04:37 by Super
Modified: 07/03/07 19:25:15
Quotations: 9

Code: adhd:control
Created: 03/03/07 12:42:09 by Super
Modified: 07/03/07 19:27:52
Quotations: 25

Code: ADHD:GENDER
Created: 03/03/07 13:11:48 by Super
Modified: 20/03/07 18:14:39
Quotations: 13

Code: adhd:needs
Created: 03/03/07 12:43:02 by Super
Modified: 06/03/07 18:25:55
Quotations: 9

Code: adhd:outcomes
Created: 20/03/07 18:10:42 by Super
Modified: 20/03/07 18:13:24
Quotations: 3

Code: adhd:space/place
Created: 03/03/07 12:47:59 by Super
Modified: 07/03/07 19:28:43
Appendix VIII: Example of Early Categorisation Development: Positioning ADHD

1.1. Parents
1.1.1. Parenting
1.1.2. ADHD Parents
1.1.3. Attachment
1.1.4. As cause of ADHD
1.1.5. Contribute to ADHD

1.2. Biology
1.2.1. Brain and Chemicals
1.2.2. Areas of Brain
1.2.3. Wiring of Brain
1.2.4. Genes
1.2.5. Genes and Parent
1.2.6. Brain and School
1.2.7. Developmental Delay

1.3. School
1.3.1. School and Brain
1.3.2. School and Parents
1.3.3. School and Developmental Delay
1.3.4. As a cause of ADHD
1.3.5. Contribute to ADHD
1.3.6. Peers
1.3.7. Classroom
1.3.8. Structure of school day
1.3.9. Organisation of school