ADHD IN BLACK AND WHITE:

A COMPARATIVE INQUIRY IN NARRATIVE AND PHOTOGRAPHS

EXAMINING THE SOCIAL CONSTRUCTION OF ATTENTION-DEFICIT/

HYPERACTIVITY DISORDER IN POOR AFRICAN AMERICAN

AND AFFLUENT WHITE AMERICAN FAMILIES

by

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Abstract

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Attention-Deficit/Hyperactivity Disorder (ADHD) is taken for granted as a neurobiological reality. Despite decades of medical research and treatment, ADHD prevalence continues to rise, with vexing differences between genders, races, and socioeconomic strata. This suggests ADHD may be socially constructed. To investigate, I studied 2 very different families, each including adolescent boys diagnosed with ADHD early in childhood: One, African American and living below the poverty line in a dangerous neighborhood; the other, White and living in affluent security. Using a novel method synthesizing *phenomenology*, *embodied hermeneutic inquiry*, and *auto-photographic ethnography*, I sought to explicate *shared essential structures* of ADHD, while maintaining contact with the *textures* of disparate *lifeworlds*. My hope was to acknowledge the suffering ADHD visits on families, while honoring the complexity of systemic forces at work, particularly for poor, racially oppressed families. By analyzing narratives and photographs from each of 7 participants (*n* = 7) through embodied hermeneutic inquiry, I constructed *thick descriptions* of each family's lifeworld, as organized into Ludwig Binswanger's 3 existential realms: *Umwelt* (environment); *Mitwelt* (relationships); *Eigenwelt* (inner-world). Then, bracketing this knowledge, I phenomenologically reduced descriptions of ADHD that were imbedded in the narratives, explicating 5 shared essential

structures: Reifying behavior; Seeking relief from suffering; Experiencing help; Stabilizing the child-Self; Longing for *the before*. Lastly, reintroducing essence to thick description, I crafted a *Textural-Structural Synthesis* of ADHD, juxtaposing shared meaning with profound contextual differences. I discuss these results, adding perspectives on race, oppression, poverty, social sharedness, and interpersonal neurobiology, among others. This facilitates a social constructionist critique, and an alternative conception of ADHD, the latter via Maurice Merleau-Ponty's theory of *vital structures*. Finally, I envision alternatives for facing ADHD, emphasizing transpersonal and constructionist clinical approaches. This work has implications for changing commonly accepted ideas about ADHD, as well as how clinical and social psychologists study such phenomena.

DEDICATION

May all merit accumulated through this labor of love

benefit all beings without exception.

All experience is preceded by mind,

Led by mind,

Made by mind.

Speak or act with a peaceful mind,

And happiness follows

Like a never-departing shadow.

—Shakyamuni Buddha, *The Dhammapada*

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CHAPTER 1: INTRODUCTION

Tyranny is the absence of complexity. André Gide

The culture at large has almost universally taken for granted that Attention Deficit Hyperactivity Disorder, or ADHD, is simply a neurobiological and genetic reality. As such, it is typically treated by physicians with powerful psychotropic medications (Barkley, 1990), perhaps in combination with other psychosocial and behavioral interventions in a *multi-modal* approach (Arnold et al., 1997). But, in spite of the best efforts of parents, teachers, doctors and therapists, the incidence of ADHD has been steadily on the rise for years, both in America (Robison, Sclar, Skaer, & Galin, 1999) and worldwide (Biederman & Faraone, 2004), while also showing vexing differences in the way it is distributed across gender, racial, cultural, and socioeconomic boundaries (CDC, 2005).

The scholarly community, with the majority of its focus trained upon matters of etiology and treatment, has yet to adequately explain these differences in prevalence. Furthermore, the voices of the people living with ADHD also tend to be rare in the majority of the literature, particularly those from marginalized populations. This study, with its in-depth, qualitative comparison of the lived experience of ADHD as it appears in vastly differing racial and socioeconomic contexts, is an attempt to address both issues, and to contribute to filling a gap in the scientific dialogue.

Motivation: A Call to Poetic Activism

My research into ADHD began with simple curiosity regarding the prevalence data: What is going on here? Why are the prevalence rates so inconsistent across different demographics, not to mention rising across the board? If what we are doing is working, why aren't things getting better? However, as I dug deeper into the literature, these questions

became more contentious, and I slowly took up the mantle of *poetic activism*, described by

Kenneth Gergen (2001) in terms of

> suspend[ing] the taken for granted ontologies of the profession . . . [and] explore[ing] the penumbra of emerging intelligibility, forms of possible but unrealized articulation. I am not speaking here of a myopic accumulation of "psychobabble," but, rather, of the careful and caring development of psychological discourse keyed to specific cultural (moral/political) ends. If psychological language is used by persons for carrying on cultural life, then new forms of language invite alternative futures. Alternative conceptions of mental functioning may favour forms of life more promising to many people than the currently etic role of describing "what is the case" and sets out to forge languages favouring what may become. Detached observation gives way to what we may view as *poetic activism*. (pp. 32-33)

As I began to envision this work as an act of poetic activism, I realized that my aims

were larger than an inquiry about ADHD. I longed for a meaningful departure from

traditional conceptions of understanding. More specifically, I began to call into question the

dualistic commitment of natural science and its hegemonic grip on psychology, thus

challenging the very notions of a "real world on the one side and a mental world on the

other" (Gergen & Semin, 1990, p. 12).

Of course, this attitude stands in stark contrast to the mainstream. The majority of

studies I encountered support the isolation of ADHD in the brain and in the genes, most

often relying heavily upon experimental designs that seek evidence of statistical correlations.

The problem I found with much of the natural scientific research is that the authors of the

studies typically linked statistically significant results not only directly to a definition of

disorder, but they also tended to at least imply *causation*—neither of which is necessarily a

sound conclusion. Even the most seemingly unassailable form of data so often cited by

scientists to support a strictly neurobiological etiology of ADHD—that of sophisticated

neuroimaging studies—has been shown to be severely flawed (Leo & Cohen, 2003),

inconsistent, and unconvincing under the scrutiny of critical comparative analysis

(Baumeister & Hawkins, 2001). This led the American Psychiatric Association to publish a

position paper cautioning against the use of brain imaging studies for diagnosing and treating psychiatric disorders, stating in particular that there has never been a shred of publishable evidence that structural or functional brain abnormality may be linked to a single psychiatric malady. Furthermore, even when significant differences have been discovered between groups, there have also been equally significant overlaps (Flaherty et al., 2005).

From my point of view, the prevailing attitude about ADHD reflects the materialistic bias of neuroscience—namely, that the body alone is sufficient for explaining both the activities of the mind and observable behavior. The problem with that approach where ADHD is concerned is that it is fraught with errors of inference. For example, how can scientists make such authoritative claims regarding the sole involvement of biological factors like neurotransmitter "abnormalities" in creating the symptoms of ADHD (see Kirley et al., 2002, in Slife & Hopkins, 2005), while ruling out nonbiological factors, such as culture or human agency to name only two rather obvious possibilities, as also contributing to the results they observe?

This led me to wonder, if I emphasized matters of race and socioeconomic status in my study, might I begin to plumb the gap between medical science and a more holistic conception of the lived experience of ADHD? Hacking (1999, p. 6) provided the *social constructionist* grounding for such an inquiry. Adapting his theses to my unfolding desires, I began to posit that, in the present state of affairs, ADHD is taken for granted; that is, it appears to be *inevitable*. However, ADHD need not have existed, or, at least, it need not be as it is currently conceived. Furthermore, ADHD, as currently conceived, is quite problematic for a great many people. As such, we may be better served as a society if ADHD and the way in which we conceive of it are at least radically transformed, if not completely eliminated.

Framing the Research Opportunity

As I mentioned previously, research strongly suggests that ADHD is increasing in prevalence and has been for many years. Let me augment such a broad stroke with some finer detail. According to Robison, Sclar, Skaer, and Galin (1999), who cite a National Ambulatory Medical Care Survey spanning 1990-1995, the number of office visits documenting ADHD in America increased from 947,308 per year to 2,357,833 per year. The upward trend appears to have continued unabated. In its most current data, the Centers for Disease Control and Prevention (CDC) (2005, pp. 844-845) estimated the prevalence in the United States of Attention Deficit/Hyperactivity Disorder (ADHD) in children between the ages of 4 and 17 years at 7.8%, or 4.4 million (95% confidence interval [CI] = 4,234,000 - 4,602,000). Within this sample, ADHD diagnosis was reported approximately 2.5 times more frequently among boys than girls, and significantly more often in boys living in families with incomes below the poverty threshold (14.8%) than in families with incomes at 200% or better above the poverty threshold (10.2%).

These numbers alone seem to make a rather unambiguous statement that ADHD presents an expanding challenge for children, parents, and educators alike. However, this tells only half of the story that I see unfolding. What these numbers taken in isolation do not reveal is that as many as 70% of children diagnosed with ADHD also exhibit clinically significant behavioral problems, including Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) (Kube, Petersen, & Palmer, 2002). Furthermore, longitudinal research strongly suggests that these behavioral problems actually tend to worsen and persist into adulthood, as childhood ADHD seems to foretell the development of antisocial personality disorder as well as substance abuse problems (Mannuzza, Klein, Bessler, Malloy, & LaPadula, 1993, 1998). Based upon such findings, it should come as no surprise that

researchers also found a higher incidence of ADHD among prison inmates at home and

abroad (Gordon & Moore, 2005; Retz et al., 2004).

Why Race? And Why African Americans?

Kendall and Hatton (2002) assert that making race a research consideration, as

opposed to ethnicity for example, is important. To be clear, there is a difference between

race and ethnicity that is not often understood. Noted Stanford University scholar on

matters of race and ethnicity, Hazel Rose Markus (2008, p. 654) offers new definitions for

both terms that capture their similarities and differences:

> *Race* is a dynamic set of historically derived and institutionalized ideas and practices
> that (1) sorts people into ethnic groups according to perceived physical and
> behavioral human characteristics; (2) associates differential value, power, and
> privilege with these characteristics and establishes a social status ranking among the
> different groups; and (3) emerges (a) when groups are perceived to pose a threat
> (political, economic, or cultural) to each other's world view or way of life; and/or (b)
> to justify the denigration and exploitation (past, current, or future) of, and prejudice
> toward, other groups.

> *Ethnicity* is a dynamic set of historically derived and institutionalized ideas and
> practices that (1) allows people to identify or to be identified with groupings of
> people on the basis of presumed (and usually claimed) commonalities including
> language, history, nation or region of origin, customs, ways of being, religion, names,
> physical appearance, and/or genealogy or ancestry; (2) can be a source of meaning,
> action, and identity; and (3) confers a sense of belonging, pride, and motivation.
> (Markus & Moya, in press)

> Kendall and Hatton (2002) apply this thinking to looking at healthcare disparity in

general, with regard to ADHD in particular:

> As researchers committed to eliminating health disparities, we need to develop
> strategies that will help us identify, describe, and measure race, racism, and
> discrimination and to account for the complex nature of the political-economic
> processes of health, lived experiences of poverty and discrimination, and the effects
> of cumulative exposures to a racist social system. (p. 25)

To underscore their point, Kendall and Hatton cite Bayne-Smith (1996), who found that

despite gains in income, especially among African Americans, race is a more significant

barrier to good health than class. Bayne-Smith explains that this is primarily due to a combination of residential segregation as well as racial discrimination.

Barbarin and Soler (1993) identify a need for research that looks specifically at African American children. They note that because the prevalence of developmental and psychological disorder among African American children is typically estimated using studies of the general population, as may be seen in the previously cited CDC data, "we are unable to specify the nature of the problems most often affecting African American children" (p. 425). According to Barbarin and Soler, African American children are more likely than the general population to experience economic hardship, homelessness, and live under conditions of poverty for extended periods of time.

This is due in large part to the lingering burden of the legacy of slavery. The place in American life occupied by the African American has continually evolved, according to Loury (2002), under the sway of and often as a reaction to racially oppressive economic and political institutions that are indigenous to U.S. society, and which have endured with both longevity and severity unmatched in the history of our nation. As evidence of the persistence of this sad legacy, one only needs to consider that 62% of an incarcerated population that exceeds 2 million human beings in this country are African American men (E. Smith & Hattery, 2006).

By factoring in the forces of marginalization and oppression, past and present, with the previously cited prevalence trends and data showing the co-occurrence of ADHD with other childhood behavioral disorders, we begin to detect the emergence of the outlines of an insidious sociocultural disaster. In my opinion, the social and healing sciences neglect, at our collective peril, to better understand how poor African American boys are impacted by the medical conceptualization and treatment of their learning and behavioral challenges.

Research Questions

As a response to the urgency I identified via this more holistic take on the prevalence data, I chose to explore and compare the lived experiences of 4 members of one African American family living in a low income community, and 3 members of one affluent White family living among the privileged, each struggling in their own way to love and provide for the needs of boys who had been diagnosed early in childhood with ADHD. Further, I sought to do so in a way that properly honors my opposition to *psychologism*—or the idea that logical truths are dependent upon human modes of thinking that understand the world from the perspective of psychology as a natural science (Giorgi, 2008a). Thus, I formed the following research questions. (Note that italicized terminology will be defined immediately subsequent to this section.)

1. What are the shared *essential structures* of ADHD as viewed through a *phenomenological* lens?

2. In addition to essential structural similarities, how does the *texture* of the *lifeworld* of the poor African American adolescent male diagnosed with ADHD and his family differ from that of his affluent White counterparts? Further, what might we learn from exploring these differences regarding how the diagnosis is constructed in differing contexts, and toward what ends?

3. How does an integration of structure and texture support or refute a hypothesis about the *social construction* of ADHD? Might it be possible to proffer an alternative conception of the phenomenon, and thus envision alternative, more hopeful futures for those who face the diagnosis?

4. What might *transpersonal and social constructionist psychotherapies* have to contribute to creating said alternative, more hopeful futures for children and families facing a diagnosis of ADHD, regardless of their race or socioeconomic status?

Definitions of Idiosyncratic Terminology

In order to fully understand these research questions, it may be useful to provide some brief definitions of the idiosyncratic terms that appear within them—terms which foreshadow my choice of research methods, while also referring to my previously identified theoretical grounding in social constructionism. I will begin by defining in greater detail the latter before turning to the former.

Social Constructionism

As I mentioned previously, this effort is grounded in the social constructionist perspective. It may be helpful to shed additional light upon the meaning of that statement. According to Gergen (1985), social constructionist inquiry is aimed at "explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live" (p. 266). Toward that end, it makes one or more of the following assumptions, all of which apply to this research in some way.

First, "what we take to be the experience of the world does not in itself dictate the terms by which the world is understood" (Gergen, 1985, p. 266). In other words, social constructionism employs what Gergen refers to as "radical doubt" in what is assumed to be true in the world and thus invites the researcher to "challenge the objective basis of conventional knowledge" (p. 267).

Second, "the terms in which the world is understood are social artifacts, products of historically situated interchanges among people . . . the result of an active, cooperative enterprise of persons in relationship" (Gergen, 1985, p. 267). This invites the researcher to

consider the social origins of that which is taken-for-granted—including psychological diagnoses.

Third, "the degree to which a given form of understanding prevails or is sustained across time is not fundamentally dependent on the empirical validity of the perspective in question, but on the vicissitudes of social processes" (Gergen, 1985, p. 268). This has profound implications for the relationship between labeling and social control inherent in the act of diagnosing and treating psychopathology like ADHD, which I will address more explicitly later in this paper.

Fourth, "forms of negotiated understanding are of critical significance in social life, as they are integrally connected with many other activities in which people engage" (Gergen, 1985, p. 268). Gergen reminds us that it is in this aspect that research in psychology has mostly been concerned, in particular with the "prevailing images or metaphors of human action" (p. 268).

Methodological Terminology

As I will address in greater depth later in this chapter and in Chapter 3, Amedeo Giorgi developed a descriptive method for conducting rigorous psychological research that is based primarily upon the early work of the German philosopher Edmund Husserl, as well as French philosopher, Maurice Merleau-Ponty (Giorgi & Giorgi, 2003). According to Giorgi (2008a), Husserl developed phenomenology in 1900 as a response to psychologism. In contrast to a mainstream view that persists to this day, Husserl's position was that logical truths were not bound by the limits of human modes of thinking, or a psychology that was conceived of as a natural science. Rather, logical truths were independent from specifically human forms of thought, although, according to Giorgi, "human consciousness [is] capable of gaining access to such truths" (pp. 33-34).

Husserl sought to describe the *lifeworld*, or "the world of the natural attitude of everyday life," from the perspective of the phenomenological attitude, or "the original, pre-reflective, pre-theoretical attitude," (van Manen, 1990, p. 7). Giorgi provides additional clarity for such ambiguous language. He noted that Husserl's idea of the lifeworld, or *Lebenswelt* in German, was "man's immediate presence to reality, or that world in which everyday life runs its course . . . prior to any reflection upon it as such" (1970, pp. 134-135).

According to Giorgi (1970), the significance of the lifeworld lies in its priority, meaning that it is the first world we all universally come to know simply by being human. All other "specialized worlds," like the worlds of clinical psychology, or qualitative research, or gourmet cooking, for that matter, are more narrow and thus the result of "specialized attitudes" that result in more specificity in meaning. He notes that

> If scientific knowledge has priority, it is not because of the kind of activity of the person who is a scientist. Actually, this demonstrates the priority of the lifeworld once more, since science itself is possible only because of a refinement of a kind of activity that a person already executes prescientifically. But it also demonstrates that what we know in a "common sense" way is not necessarily obvious. This is precisely Husserl's point, and why he feels that every term of concept we use must be clarified because otherwise we are always laboring in at least partial obscurity. This is also the reason that he can take the problem of the Lebenswelt seriously, and why he wants to approach it in the manner of a "rigorous science." (p. 135)

Giorgi goes on to assert, "with respect to its privileged position, the lifeworld is the most basic frame of reference from which psychology must take its point of departure and with which it must be in constant dialogue" (p. 178).

This begs the question, departure toward what end? The sort of discovery unearthed by phenomenology is that of *essential structure*, which Giorgi (1970) defines in terms set forth by French philosopher, Maurice Merleau-Ponty, namely an *invariant meaning* based upon the relationship of discernable parts. According to Giorgi, one of its values to us is that "it is

precisely structure that is the reality that one responds to at the phenomenal level" (p. 179).

He solidifies his point by quoting Merleau-Ponty (1945/1963, p. 429, cited in Giorgi, p. 180)

> what constitutes the difference between the Gestalt [or structural whole] of a circle and the significance "circle," is that the latter is recognized by an understanding which engenders it as the abode of points equidistant from a center, the former by a subject familiar with his world and able to seize it as a modulation of that world, as a circular physiognomy [or, that which is internal, revealed outwardly]. We have no way of knowing what a picture or a thing is other than by looking at them, and their significance is revealed only if we look at them . . . from a certain direction, in short only if we place, at the service of the spectacle, our collusion with the world.

As I will discuss in my methods preview in this chapter as well as in Chapter 3, descriptions of essential structure tend toward abstraction, which, in and of itself can be both useful and interesting. However, in seeking to understand ADHD as a socially constructed phenomenon, particularly across the racial and socioeconomic divide, it was also important to honor the character of the lifeworld in all its depth and richness alongside essential structure. Thus, I sought to discover *texture* as well as structure in the course of this work.

To offer an analogy relevant to my experience as a new father, if ADHD were a child's blanket, I wanted to describe it in terms of its "blanket-ness," all the while maintaining contact with its warp and woof, its smell when freshly laundered, its softness against the skin of my cheek, and the tattered corner where a baby once suckled and teethed.

Transpersonal Psychology

The final term that requires explanation in order to fully understand my research questions is *transpersonal psychology*. Maslow (1967) placed an emerging "Fourth Force" on the developmental horizon of psychology as a science, following the psychoanalytic, behaviorist, and humanistic traditions. According to Maslow,

> The fully developed (and very fortunate) human being, working under the best conditions tends to be motivated by *values* which transcend his *self*. They are not selfish anymore in the old sense of that term. Beauty is not within one's skin nor is

justice or order. One can hardly class these desires as selfish in the sense that my desire for food might be. My satisfaction with achieving or allowing justice is not within my own skin; it does not lie along my arteries. It is equally outside and inside: therefore, it has transcended the geographical limitations of the self. Thus one begins to talk about transhumanistic psychology. (p. 4)

This movement later became known as transpersonal psychology, which, according to Lajoie and Shapiro (1992) seeks discoveries and practices aimed at "humanity's highest potential, with the recognition, understanding, and realization of unitive, spiritual, and transcendent experiences" (p. 91). As I will demonstrate, transpersonal psychology has a significant impact on this study, from my training as a researcher and my choice of research methodologies, to the more hopeful future I creatively envision in my conclusion.

<div align="center">Personal Connections to the Topic</div>

Though the data provides enough motivation alone for me to pursue this topic, I also had a more personal connection to the subject matter. First, I served as a "big brother" for an African American boy living in the inner city of Seattle for over a decade. I witnessed first hand how his single mother struggled to support him and his four brothers and sisters. I also saw the impact on him and on those around him when he was diagnosed with ADHD at the behest of his exasperated teachers. In hindsight, it was a diagnosis he never fully understood or accepted, and which seemed to only excuse his mother, the school, and me from meaningful introspection regarding how we were all somehow colluding to fail to support this child's development and long-term wellbeing.

As I watched his life get steadily more difficult than weekends at my house or marathon tutoring sessions before algebra exams could hope to address, and his grades and self-image deteriorated more precipitously with each passing year, I saw a boy I had come to think of as a son heading for disaster. This downward trajectory only hastened when I moved to the San Francisco Bay Area as he entered High School, leading to an intervention

in his senior year that brought him to a therapeutic boarding school in Sonoma County, along with my ongoing involvement in his life as his legal guardian until he reached his 18th birthday. Under the watchful eye of a caring staff, and in a highly structured communal living environment, he began to turn his life around. However, improvement did not appear to last beyond the summer following graduation. At this writing, he is trying to stay enrolled in a junior college, but has slipped into old, destructive behaviors.

In addition to my experience with this young man and his family, I was moved by the 1,700 hours of service I provided over 2 years while a clinician for adolescent boys and grown men who were all confined to a small residential drug treatment program in the San Francisco Bay Area. Most of them were there as a court ordered precondition for their continued freedom, though the veracity of using such a lofty term to describe their existence as long as they were in our care was debatable.

As a rule, substance abuse and addiction tended to be only one of a collection of ways that they endured abject suffering for as long as most could recall. Almost all of them had been both perpetrators and victims of violent, destructive acts. As might also be expected, they tended to come from economically disadvantaged families riddled with conflict, abuse, and neglect. Many more were members of communities of color than were White. Not surprisingly, all but a few had experienced chronic failure in academic environments throughout their lives. I saw my "little brother" in so many of their sad faces.

Among those of my adolescent clients who were still in school, a substantial number had individual education plans (IEP) designed to target special education services to their needs, which were characterized either in terms of *learning disabilities* (LD) or *emotional disturbance* (ED), or a combination. More often than not, their families named ADHD as a significant contributing factor in the academic failures their children continued to endure.

This appeared to be true for many of the adult men I cared for as well, many of who disclosed that their first experiences of drug abuse came in the form of stimulant medications that had been prescribed to treat childhood behavioral and learning problems. Almost none of my clients, regardless of their age, race, drug of choice, or number of clean, sober days, could seem to easily direct or sustain their attention, nor could they sit still or control their impulses to fidget or interrupt one another. If they forced themselves to sit still, they would frequently fall asleep.

As I worked with my clients, and looked back at my history with my "little brother," I became increasingly more interested in the cultural practice of treating what would be characterized as "deviant" behavior as if it were a medical condition. It did not seem to have worked very well for my clients or for my "little brother." Why was that? As my questioning of these entrenched social and cultural norms deepened, I looked to the literature of social constructionism for inspiration and guidance. Kenneth Gergen, one of the movement's most luminary scholars, wrote that when we take for granted certain suppositions and practices, we stop asking questions. Most importantly, he said, "We fail to ask about the downside—what are the negative repercussions for society?" (1999, p. 17). This statement struck a resonant chord with my clinical experience. Something told me I had been working with "the downside" for years, which led me to wonder more pointedly about the wisdom in the deterministic certitude that tends to emanate from adherents to the predominant natural scientific and medical conceptualizations of childhood behavioral problems, and ADHD in particular.

<div style="text-align:center">Literature Review Overview</div>

<div style="text-align:center">*Increasing Prevalence and the Cross-Cultural Conundrum*</div>

In addition to the increasing prevalence of ADHD in this country as was already

described, Biederman and Faraone (2004) cite both a World Health Organization (WHO) position that ADHD represents a real source of concern all over the world, and a recent initiative by the World Federation for Mental Health (WFMH) that is moving ADHD closer to full international recognition as a legitimate diagnosis. This may help to explain the number of studies looking at ADHD prevalence rates around the world conducted in recent years, which I will address in more detail during my review of the literature. In the studies I sampled, depending upon many complex factors having to do with research design, prevalence rates range anywhere from 1.3% to 23% of the populations studied, with the highest incidence found among Canadian Aboriginal children (Baydala, Sherman, Rasmussen, Wikman, & Janzen, 2006).

<div align="center">*The Prevailing Response*</div>

The prevailing response by medical science to the growing number of children diagnosed with ADHD around the world appears to have been limited mainly to prescribing larger quantities of a stimulant medication developed in the 1930s—a drug called methylphenidate, more commonly known as *Ritalin*. Worldwide sales of Ritalin increased five-fold between 1990-1997—from 2.8 tons to 15.3 tons per year—due in large part to increased demand in the United States, which accounts for 85% of the world's total manufacturing and consumption of the drug (Ghodse, 1999). These statistics do not account for the growing demand for newer ADHD drugs that have more recently come to market—including nonstimulant formulas.

In spite of their ubiquitous presence, pharmaceutical interventions carry potentially serious risks, particularly in a pediatric population. Adverse drug reactions in stimulant formulas include impaired growth (Swanson et al., 2007), insomnia, agitation, hypomania, mania, seizures, physical withdrawal, rebound effects, dependence (Breggin, 1999a), and

psychosis (Breggin, 2000). Nonstimulant formulas also present problems and their manufacturers were recently ordered by the United States Food and Drug Administration (FDA) to include a "black box" warning regarding the potential for increased suicidal ideation in adolescents (Carey, 2005). The black box was subsequently ordered by FDA for some popular stimulant formulas given increased risk of sudden death (Pettypiece & Blum, 2006). In spite of these dangers, as recently as 2006, the National Institutes of Mental Health (NIMH) continued to publish studies touting the possible efficacy of stimulant medication in children as young as 3 years of age (Greenhill et al., 2006).

Remarkably, in spite of the aforementioned risks borne by the many millions of children being medicated for ADHD, research also shows that outpatient treatment visits have concomitantly decreased in the United States (Olfson, Gameroff, Marcus, & Jensen, 2003). This may reflect their effectiveness (Kendall, Hatton, Beckett, & Leo, 2003). Alternatively, this may also reflect what may be an increasing reliance upon these drugs as standalone therapies. Or, it may be partially explained by the widening adoption of a multimodal strategy, which is inclusive of individual and family education, behavioral therapy and school remediation—in addition to medication and/or out-patient counseling (Abikoff & Hechtman, 1996).

Whatever the case, the CDC (2005, p. 845) found that 56.3% of American children diagnosed with ADHD—roughly 2.5 million of them—are medicated. Notably, children in racial/ethnic minority populations and uninsured children are less likely to be medicated (p. 847), revealing how healthcare disparity between socioeconomic strata may also influence the treatment of ADHD (Harrison & Falco, 2005).

A Polarized Debate

Those who, like me, disagree with the wholesale adoption of the conventional view

of diagnosing ADHD as a problem of neurobiology and genetics, and treating it primarily

with medication seem to organize themselves around a hypothesis posed 3 decades ago by

Conrad (1976) in his examination of the phenomenon of hyperactivity in children. Conrad

made the case that the very *discovery* of hyperactivity—or hyperkinesis as it was called then—

may be directly attributed to the interconnection of three factors: (a) the "pharmaceutical

revolution;" (b) "trends in the medical profession;" (c) "government action" (p. 12). The

trouble is that the tenor of the discourse has become rather shrill of late. As a recent

exemplar of this trend, consider this selection from a journal article written by Dr. Jeanne

Stolzer, an associate professor of family studies at the University of Nebraska at Kearney:

> By applying simplistic "band-aid" solutions such as labeling children with mythical
> neurological disorders, we do not have to work to change those familial, societal,
> political, and cultural forces which are at the root of the myth of ADHD in America.
> It is much easier to buy into the myth of ADHD. By accepting this scientifically
> illegitimate disease, we as American adults can continue to live exactly as we are
> living, deluding ourselves into believing that the problem lies within the individual
> child. (Stolzer, 2005, p. 73)

While there is undoubtedly some truth to be found in such polemics, as Safer (2000)

contends, the opposition to traditional ADHD diagnosis and treatment tends to be driven

by anecdote and conjecture rather than hard evidence. In Kearney's article as exemplar, this

manifests in the form of a well-articulated argument based on the demise of breastfeeding

and attachment parenting practices in America and the power of the pharmaceutical

industry. Safer maintains that not only are most of the vocal critics of mainstream ADHD

diagnosis and treatment uninvolved in directly managing these challenging children, their

focus also tends to be "exclusively negative, their philosophical positions . . . impressionistic,

and [their] aim . . . to alarm" (p. 55).

Kendall, Hatton, Beckett, and Leo (2003), in a critique of the dichotomous character of the discourse surrounding ADHD, offer that "the ongoing debate regarding the authenticity of ADHD as a legitimate medical/behavioral disorder circumvents the resources and energy needed to provide these children and families with the services they need" (p. 127). Instead, they call researchers and service providers alike to concentrate upon the real burden of suffering borne by children and families who deal with ADHD. I intend to keep this learned admonition in mind as I resist my own human temptations to contribute a less than reasoned voice to the scholarly discourse.

Methods Preview: An Integration of Three Philosophies

While my research questions were grounded in the social constructionist tradition (Berger & Luckman, 1966; Gergen, 1999; Hacking, 1999), I found myself simultaneously called by the nature of my design toward exploring what shared essential structures, if any, might be found in comparing lived experiences of ADHD that are geographically proximal, yet racial and socioeconomic worlds apart. As I stated earlier, this desire was rooted in my own questioning of the hegemony of psychologism and its inadequacy for explaining the ADHD phenomenon.

With all of that said, social constructionism and phenomenology do not easily collaborate: On the one hand, my social constructionist bent sought to engage with and honor something earthy and embodied, namely, the everyday, culturally imbedded understandings (Gergen & Semin, 1990) of my participants, as well as my experiences of and with them; on the other, the phenomenologist in me desired to explicate something more essential, abstract, and transcendent of the relative. Thus, a question took form: How might I simultaneously communicate the rich complexity and *texture* of human life in the language

of culture, all the while clarifying matters of elegant, essential *structure* in the language of consciousness (Gergen & Semin; Todres, 2007)?

As a point of departure for this endeavor, I turned to the social constructionist literature, wherein Berger and Luckman (1966, p. 20) in their landmark work, *The Social Construction of Reality*, suggest that the method best suited for gaining understanding of the "reality of everyday life" is that of phenomenological analysis. While I found it encouraging that phenomenology was apparently acceptable within this realm of scholarship, that fact alone would not suffice to bring the texture I sought for my analysis.

Todres and Wheeler (2001) provided the bridge I was looking for. While they argue in favor of phenomenology as the best means to ground qualitative research in the lifeworld, they also lament that the results yielded by the method alone, without accompanying hermeneutics (which will be defined in Chapter 3), run the risk of shallowness in the study of complex human experiences. They elaborate further that the limits of thought and language might unduly confine both methodological philosophies without an added existential perspective. In his most recent published work, Todres (2007) expands this thinking, specifically identifying what he seeks beyond thought and language in terms of the "pre-reflective more" (p. 2), which he says is best accessed through the lived body. Gendlin (2003), one of Todres' main influences, explains that while it is true we typically do not sufficiently recognize the role of culture, history, and language, neither can we allow ourselves to go to the other extreme and simply reduce everything to the same. Thus, he calls for a further step, namely "to recognize what is *with* and *after* language" through the body, because "the body is always in a fresh situational interaction that exceeds culture, history and language" (p. 114).

Holding all of these ideas in mind, I sought to creatively engage the tension between the critical realism of phenomenology and the more relativist, postmodern worldview of social construction (Finlay, 2003). The result was a methodological approach that would at once ground the research in the lifeworld as a starting point, while at the same time recognizing fundamental ontological concerns, as well as the positionality and reflexivity of knowledge (Todres & Wheeler, 2001). Toward that end, I joined the phenomenological method (Giorgi, 1985; Maso, 1983; Moustakas, 1994; van Kaam, 1966) with elements of auto-photographic ethnography (Ziller, 1990) and forms of embodied hermeneutic inquiry (Finlay, 2005; Moustakas, 1995; Todres, 2007) in order to yield thickly descriptive (Geertz, 1973) textural-structural (Moustakas, 1994) understandings of ADHD, as the phenomenon arises in starkly contrasting lifeworlds.

Organization of the Dissertation

As I bring this introductory chapter to a close, allow me to lay out a map for the remainder of our journey of discovery. In the following chapter, I present a representative sample of an immense body of scientific literature on ADHD organized in the terms dictated by its predominantly medical conception: epidemiology, etiology, clinical picture, diagnostic practices, and typical treatment options. I also look at a sampling of literature addressing the populations in question, children and families facing ADHD.

In Chapter 3, I provide an in-depth discussion of the research methodology that governed the project, beginning with explanations of the philosophical underpinnings and theoretical foundations of each of the three methods that make up my unique synthetic approach. Next, I address the flow of my data analysis method. Lastly, I reveal the data collection protocol as well as limitations and delimitations of the study.

Chapter 4 is organized into three parts. In Part 1, *Texture,* I begin with a comparative demographic examination of the two communities in question. Against that objective backdrop, I offer background sketches of each family, and then construct thickly descriptive (Geertz, 1973) narratives, consisting of illustrative quotes from participants, and first-person, embodied hermeneutic data obtained through my encounters with them in the field, as well as through my subsequent immersion into over 100 photographs, nearly 11 and a half hours of audio taped interviews, and over 225 pages of typed transcripts.

In Part 2 of Chapter 4, *Structure,* I examine the essential nature of the lived experience of ADHD. Specifically, I elucidate the findings which coalesced, through the means of phenomenological reduction, into shared invariant constituents or horizons of meaning (Moustakas, 1994) of the lived experience of ADHD.

Lastly, in Part 3 of Chapter 4, *Integration,* I return formerly bracketed texture to essence, rendering an integral, textural-structural description (Moustakas, 1994; van Kaam, 1966) of the phenomenon of ADHD. This integration illuminates shared essential meanings (Maso, 1983) of the experience of ADHD, as well as context-driven differences in how the phenomenon is lived.

In Chapter 5, I return to the research questions posed at the outset of the dissertation. Against the backdrop of a brief overview of the study, I discuss the shared essential structures identified in Chapter 4, adding perspectives on race, oppression, poverty, social sharedness, and interpersonal neurobiology, among others. This facilitates a social constructionist critique, and an alternative conception of ADHD, the latter via Maurice Merleau-Ponty's theory of *vital structures.* Finally, I envision alternatives for facing ADHD, emphasizing transpersonal and constructionist clinical approaches.

CHAPTER 2: REVIEW OF THE LITERATURE

This literature review primarily provides a sample of what is a monolithic and continually evolving body of scientific literature on ADHD, organized in terms of its epidemiology (or patterns and prevalence), etiology (or causation), clinical picture, diagnosis, treatments, and outcomes. Lastly, it includes a few representative samples of literature specific to the populations this study examined, namely children and families grappling with ADHD.

I had four intentions for organizing my literature review in this way. First, I hoped to honor the mainstream view by making it a priority for study, while offering well-reasoned, balanced criticism where the literature supported doing so. Second, I intended to construct a point of departure for the study that would allow me to know what my participant families had likely been exposed to in their efforts to help their sons. Third, I felt that this strategy would yield a suitable screen against which I might project my results in Chapter 5 in order to illuminate where my findings supported as well as challenged the mainstream view. Lastly, and perhaps most importantly, I felt that this literature review would enable me to effectively "bracket" what is generally understood to be "true" about ADHD, as well as my critical viewpoints, so that I might come to the exploration with the *disciplined naïveté* (Giorgi, 1997) demanded by my research method.

Epidemiology

Multi and Cross-Cultural Research

As a key part of understanding any phenomenon of disease, or in this case, mental disorder, medical science must study its epidemiology, both within and between differing populations, as well as how it might be changing over time. Thus, in addition to the increasing prevalence of ADHD in this country, as has already been cited (CDC, 2005;

Robison et al., 1999), it is important to examine the occurrence of ADHD around the world. This multi and cross-cultural epidemiological research serves a couple of critical functions in the overall scientific discourse. First, it allows scientists to compare prevalence rates in differing populations around the world. Second, it allows scientists to gauge the degree to which the "psychiatric disease concept or construct [has] cross-cultural (external) validity" (Brewis, Schmidt, & Meyer, 2000, p. 823), which is defined by Goodwin (2003, p. 160) as "the degree to which research findings generalize beyond the specific context of the experiment being conducted."

Worldwide Prevalence of ADHD

There has been growing interest among World health officials in recent years regarding the presence of ADHD outside the culture of its origin, the United States of America (Biederman & Faraone, 2004). I sampled a number of international studies in order to compare prevalence rates in a variety of countries and cultures (see Table 1), including, among others, England (Ford, Goodman, & Meltzer, 1999), Holland (Verhulst, van der Ende, Ferdinand, & Kasius, 1997), Brazil (Rohde et al., 1999), the United Arab Emirates (Bu-Haroon, Eapen, & Bener, 1999), Australia (Gomez, Harvey, Quick, Scharer, & Harris, 1999), French Canada (Breton et al., 1999), and Nigeria (Ofovwe, Ofovwe, & Meyer, 2006). Researchers have also conducted studies to examine prevalence within subgroups of a given population, such as Canadian aboriginal children (Baydala et al., 2006) and South African people speaking the North Sotho indigenous language (Meyer, 1998).

While the studies presented in Table 1 are interesting, their practical utility as stand alone research is limited. However, by directly comparing their results, we can clearly see many potential problems, including matters of interrater reliability, lack of instrument

validity across cultures, the different cultures being studied, and variations in how one

defines *disorder* (Cohen & Riccio, 1994).

Table 1

Comparisons of Cross Cultural Research on ADHD

Population	Assessment and Diagnosis	Prevalence Rate (% of population)
British children and adolescents (Ford et al., 1999)	Development and Well-being Assessment (DAWBA) and DSM-IV	2.23%
Dutch adolescents aged 13-18 years (Verhulst et al., 1997)	Diagnostic Interview Schedule for Children (DISC) to include child report and parent report, the Children's Global Assessment Scale. DSM-III-R Criteria	1.8% (parent); 1.3% (child self-report)
Brazilian adolescents aged 12-14 years (Rohde et al., 1999)	Screening tool based on DSM-IV-TR	5.8%
Primary school children in government schools in the United Arab Emirates (Bu-Haroon et al., 1999)	Conners Teachers' Rating Scale	14.9%
Australian primary school children (Gomez et al., 1999)	Abbreviated Conners Rating Scale and DSM-IV	9.9% (parent); 8.8% (teacher)
French Canadian Children and adolescents aged 6-14 years (Breton et al., 1999)	Self report, teacher report, and parent reports based on DSM-III-R criteria	Ranges from 2.6% (child self-report) to 10.7% (teacher report) within 95% CI
Canadian aboriginal children in grades 1-4 (Baydala et al., 2006)	Standardized parent and teacher questionnaires, Conners ADHD Index, and DSM-IV	23%
North Sotho-speaking primary school-aged children in South Africa (Meyer, 1998)	Teacher rating scales based on DSM-IV	7.1%
Nigerian school-aged children in Benin City, Nigeria (Ofovwe et al., 2006)	Teacher rating scales based on DSM-III, ICD-10, and DSM-IV	8.0% (DSM-IV only)

External Validity of ADHD: A Cross-Cultural Perspective

The problem represented in the wide variation of prevalence data shown in Table 1 is best described as a problem of external validity (Brewis et al., 2000). As has already been mentioned, one way to establish some semblance of external validity is via comparative cross-cultural research. Unfortunately, there have been few studies that directly compare ADHD as it appears in the nation of its conceptual origin, the United States, with other nations around the world.

The first such research, a bio-anthropological study, was conducted in Columbia (Brewis et al., 2000). A later social constructionist project was undertaken in England (Jacobson, 2002). Most recently, researchers examined the cross-cultural validity of ADHD assessment through teacher interviews in Taiwan and the United States (Yang, Schaller, & Parker, 2000). These three studies are particularly interesting to examine, not only because they provide rare cross-cultural findings, but also because they stand in opposition to one another, in methodologies, and what they discovered. Brief summaries of each follow.

The Columbian study. Brewis et al. (2000) conducted a quantitative study using Teacher Rating Scales in the Behavioral Assessment System for Children (BASC) comparing 6- to 11-year-old school children from Medellin, Columbia ($n = 103$) with a similar random sample of children in the United States, broken down by ethnicity—African American ($n = 102$), Euro-American ($n = 958$), and Hispanic American ($n = 43$). Their intention was to "determine if similar degrees of hyperactivity and inattention were associated with different academic and social functioning (degrees of harmful dysfunction) among children in diverse cultural settings" (p. 824). The researchers chose their populations due to the significant distinctions that exist between the cultures, including a higher tolerance by teachers in Columbia for active, noisy behavior, and their more "circular" organization of classroom activities as

compared to their American counterparts. Thus, they sought to ascertain the degree to which "actual data supported or failed to support some preliminary predictions about normal variation in childhood hyperactivity and inattention across populations" (Brewis, Schmidt, & Meyer, 2002, p. 287).

The researchers found that children's hyperactive and inattentive behavior manifested similarly across diverse populations and that they were similarly systematically related to children's social and academic well-being. They pointed to the "real functional consequences associated with certain levels of ADHD-associated behaviors that transcend at least some aspects of specific context," which may "indicate that [some] aspects of the disorder . . . [may] have cross-cultural validity in etic terms" (p. 826).

The British study. Jacobson (2002) conducted a qualitative study comparing three samples: (a) Thirty-two non-labeled fifth- and sixth-grade children plus one fourth-grade boy diagnosed with ADHD (who was incidentally the only child with the diagnosis in a school with a population of 330) from a public school in Oxfordshire, England; (b) Sixteen similarly aged children from a specialist dyslexic school in England (none with diagnosed ADHD); Forty-seven fifth-grade children from a New England public school. For the American sample, Jacobson obtained parental confirmation of one child having ADHD and "anecdotal evidence" of three others.

Like Brewis et al. (2000), Jacobson (2002) found "significant differences between English and American teacher standards with respect to what constituted 'appropriate' classroom behaviors" (p. 284). However, while Brewis et al. found evidence for external validity, Jacobson found that nonlabeled children also exhibit high levels of distracted and hyperactive-impulsive behaviors in both societies (p. 283). He argues that "given current practice any child could be labeled as ADHD if observed at the time that child is exhibiting

maximum ADHD-like behaviors" (p. 285). He suggests that what is needed is a minimal standard in order to make the distinction between "ordered" and "disordered"—in this case, two standard deviations above baselines for normal behavior. Applying this standard, Jacobson contends that "this translates to a minimum of 47.5% of observed behaviors [would be required in order to satisfy the criteria] for distractibility and 50.5% of observed behaviors [would be required in order to satisfy the criteria] for hyperactivity and impulsivity." Jacobson states that it is doubtful any of the children labeled with ADHD in his samples would have met that more stringent standard (p. 285). As such, he calls into question the ethics of current treatments given the "apparent ubiquitousness" of these behaviors, claiming that

> Cultures create disordering categories. Those categories vary across societies, but the "reordering" process by which an individual in a specific place at a specific time is placed within such a category appears to be almost infinitely variable. Therefore, a meaningful contrast between order and disorder may not be present with respect to those behaviors categorized as ADHD. (p. 285)

The Taiwan study. Yang, Schaller, and Parker (2000) asked 121 homeroom teachers to randomly select two boys and two girls and rate them using an ADHD symptom checklist comprised of criteria from three different diagnostic systems—the Diagnostic and Statistical Manual of Mental Disorders, Third Edition Revised and Fourth Edition (DSM-III-R and DSM-IV) and the WHO published International Classification of Diseases, Tenth Edition (ICD-10). The purpose of the study was three-fold: (a) to compare factor structures from Taiwanese teachers' diagnostic definitions of ADHD as described in the aforementioned diagnostic systems; (b) to examine how factor structures of Taiwanese teachers' ratings of ADHD symptoms compare with factor structures reported in research using school-based U.S. participants; and (c) to examine gender differences on factor structures of the teachers' ratings. Their results suggest that Taiwanese teachers observed ADHD in similar terms as

those described by DSM-IV, rather than those included in either DSM-III-R or ICD-10. The authors' main conclusion is that their study supports the concurrent validity of the DSM-IV ADHD factor structures of hyperactivity-impulsivity and inattention. Further, they make the statement that the comparability of these findings support cross-cultural congruency of behaviors associated with ADHD.

From a social constructionist point of view, I find it noteworthy that at the time of their study, ADHD was not a recognized *disability* in Taiwanese schools. The authors state that certain language from the American diagnostic lexicon may not easily or accurately translate from English to Chinese in the construction of a "symptom checklist." For example, they note that the Chinese word for "energetic" was substituted for the key American diagnostic criterion "as if driven by a motor." The meaning of these concepts seems difficult to equate, and calls into question the practice of exporting a diagnosis to a culture that does not have language to diagnose it in precisely the way in which it was conceived. The troubling result in this case appears to be the relegation of a formerly neutral or perhaps positive Chinese descriptor, "energetic," to the realm of childhood pathology.

ADHD Overlap: Selected Research

The raw data already cited describing the increasing prevalence of ADHD presents a significant and complex problem in and of itself. However, the upward trend noted in epidemiological studies, not only in this country but also around the world, does not tell the whole story. It is ADHD's appearance alongside other disorders, particularly more serious behavioral problems that may last well into adulthood that presents what is perhaps the most compelling opportunity for psychology research and clinical practice to help address this troubling phenomenon in a way that will have maximum benefit for society at large.

While a significant cross-section of the ADHD literature refers to the disorder in terms of its comorbidity with other issues, Kaplan, Dewey, Crawford, and Wilson (2001) make the case that applying the concept of comorbidity—or the presence of at least two diseases—in the mental health field is not nearly so tidy as diagnosing, for example, diabetes and asthma. They claim that, unlike general medical conditions, it is not altogether clear where the line is drawn between the symptom of psychopathology and the disorder itself. The authors cite the presenting problems of sadness and anxiety as a case in point, in that the clinician cannot be certain whether or not she is looking at two symptoms of dysthymia, or perhaps a combination of social phobia and major depressive disorder. They claim that the problem similarly exists when looking at ADHD and behavioral problems, and make the case that it is more accurate to refer to this phenomenon in terms of *co-occurrence* or *overlap* rather than comorbidity—a convention I will likewise adopt.

With that said, the first step in addressing the problem of ADHD's overlap with conduct problems is to sample some of the science that has examined it. In epidemiologic research conducted by Kube, Peterson, and Palmer (2002) with 189 American children referred for evaluation of possible developmental disorders, 82 of them (43%) received a final diagnosis of ADHD. Of those diagnosed with ADHD, 38 children (70%) were also diagnosed with clinically significant conduct problems. This is not an atypical finding (Jensen et al., 2001) and helps to explain why longitudinal research strongly suggests that childhood ADHD tends to foretell adult antisocial personality disorder and substance abuse (Mannuzza et al., 1993, 1998).

These findings are similar to the results of a European study by Kadesjö et al. (2003) in which 131 Swedish children diagnosed with ADHD were compared to a control group matched for sex, age, and socioeconomic status. Aside from predictably significant

differences between the groups, within the ADHD group, 60%, or 79 children, also met the

criteria for Oppositional Defiant Disorder (ODD), another predictor of serious behavioral

problems in adulthood. Of those, 74% had the combined subtype ADHD diagnosis, and

only 10 of 131 in the ADHD group showed no symptoms of ODD whatsoever. Taken in

combination, these findings are particularly alarming considering research that suggests

conventional ADHD treatments are mostly ineffective in treating overlapping behavioral

problems (Kidd, 2001).

<div align="center">Etiology</div>

Having briefly sampled the literature examining the distribution of ADHD around

the global landscape, as well as its overlap with other problems, I would like to shift my

attention to *etiology*—or causation. Researchers the world over have linked ADHD to a host

of possible causes, including cerebral blood flow and premature birth (Lou et al., 2004),

maternal lifestyle (Linnet et al., 2003)—including smoking (Milich, Balentine, & Lynam,

2001; Thapar et al., 2003) and fetal alcohol exposure (Bhatara, Loudenberg, & Ellis, 2006)—

reactions to food additives (Eigenmann & Haenggeli, 2004), and environmental pollutants

like toxic metals (Milich et al., 2001). However, the majority of scientific research looks at

the physical and chemical intricacies of the brain, as well as genetic influences, in forming

what is predominantly a neurobiological view of ADHD etiology.

<div align="center">*The Neurobiological View*</div>

To assert the prevailing position of medical science, a statement of "international

consensus," signed by more than 80 of the world's leading clinical researchers investigating

ADHD and related childhood disorders includes the following:

> The central psychological deficits in those with ADHD have now been linked
> through numerous studies using various scientific methods to several specific brain
> regions (the frontal lobe, its connections to the basal ganglia, and their relationship
> to the central aspects of the cerebellum). . . . And neuro-imaging studies of groups of

those with ADHD also demonstrate relatively smaller areas of brain matter and less metabolic activity of this brain matter than is the case in control groups used in these studies. These same psychological deficits in inhibition and attention have been found in numerous studies of identical and fraternal twins conducted across various countries (US, Great Britain, Norway, Australia, etc.) to be primarily inherited. (Barkley, 2002, p. 1389)

Brain Differences

Neurophysiology. According to Culbertson and Krull (1996), the research on neurophysiological factors involved in ADHD include brain dysmorphology (structural differences), electrophysiological processes, and frontal lobe dysfunction—in addition to the corticogenetic (early brain development) risk factors already briefly touched upon. Barkley (2002) points out that one of the most compelling methods of obtaining evidence that ADHD is a structurally-based neurobiological condition comes from MRI scans on monozygotic (MZ) twins discordant for the diagnosis, even though most such twin research has tended to focus upon finding genetic links via behavioral observation (Eaves et al., 1993; Wilcutt, Pennington, & DeFries, 2000).

For example, Castellanos et al. (2003) found that the brains of children with ADHD are markedly different from those who do not fit the diagnostic criteria, specifically regarding the prefrontal-striatal circuitry. Castellanos et al. impute these differences to the potential for a selective vulnerability of the striatum to adverse prenatal environmental factors—though they also rightly point out that their study cannot rule out medication effects, and that the sample size prohibits inferences regarding causation.

Similarly, in a survey of numerous brain imaging studies employing various new diagnostic technologies, Plude (1996) describes a growing body of research that has demonstrated other striking differences between the brains of children diagnosed with ADHD and normal baselines, including global cerebral glucose metabolism (using *Positron Emission Tomography* or PET scan technology) and neural frequencies (using

Electroencephalogram or EEG recordings). These methods are consistent with more current

scientific research reviewed at Duke University by Rabiner (2001), suggesting that cortical

slowing as a possible symptom or marker of ADHD could be detected with 90% accuracy

using *Quantitative Electroencephalographic* or QEEG scanning technology in patients who had

been diagnosed with attention to detail using standard procedures.

Neuro-chemical differences. Perhaps the most commonly cited chemical difference in

brain function between those with ADHD and normal baselines lies in the dopamine

system. Lou et al. (2004) cite Bradshaw (2001) in asserting that the dopamine system has

long been thought of as a key contributor to mental pathology, including that associated with

ADHD—which is a key mechanism in the therapeutic effect of methylphenidate. Lou et al.

further cite other research that supports such an assertion, including that which reveals a

genetic predisposition toward dopamine depletion in the prefrontal-striatal-limbic system

(Teeter & Semrud-Clikeman, 1995).

Lou et al. (2004) primarily sought to explore the possibility that cerebral ischemia, or

low blood flow in the brain at birth might contribute to impairment of the dopamine system.

Using PET scan technology, they examined six adolescents who had been examined for

cerebral blood flow (CBF) abnormalities as a result of having been born prematurely, and

who had a subsequent history of ADHD. The researchers found a significant correlation

between high dopamine receptor availability (empty receptors) and symptomatology—which

seemed to be predicted by low neonatal CBF.

Genetics

The latter finding by Lou et al. (2004) is consistent with the review of literature on

dopamine-related genes in ADHD conducted by DiMaio, Grizenko, and Joober (2003) who

found that the implication of two genes in particular—the dopamine transporter SLC6A3,

and the dopamine receptor DRD4—in numerous molecular genetic studies. According to the researchers, this strongly suggests the involvement of the dopamine system in ADHD. However, they also caution that "more work is required to further these findings by genotype-to-phenotype correlations (in order to) identify the functional allelic variants/mutations that are responsible for these associations" (p. 27).

Grady et al. (2003) sought to support the common variant-common disorder (CVCD) hypothesis, which surmises

> the high prevalence of a given disorder and its associated alleles is attributed to either (1) the interaction with a new environment (such that genotypes associated with the disorder were not eliminated in the past) or (2) the disorder has small effect on fitness (because it is late onset) . . . [or (3)] predisposing alleles in fact are under positive selection, and only result in deleterious effects when combined with other environmental/genetic factors. (p. 537)

Grady et al. also found an unusually high prevalence of novel variations of the 7-repeat (7R) allele of the human dopamine receptor D4 (DRD4) gene—suggesting that heterogeneity of this gene's particular locus may also contribute, in addition to its CVCD association, to the emergence of ADHD.

Genetic research does not have to be limited to looking at the complexities of DNA sequences themselves in order to be compelling; behavioral observation within a twin study may also be informative. For example, Eaves et al. (1993) conducted such research with 84 monozygotic and 63 dizygotic male twin pairs aged 8 to 11 years from among more than 6,000 pairs of school-age twins in the Virginia Study of Adolescent Behavioral Development (VSABD). The researchers administered the Parental Form of the Child and Adolescent Psychiatric Assessment (P-CAPA) designed in 1989 by Angold, Cox, Prendergast, Rutter, and Smirnoff, concentrating specifically upon the data yielded by mothers in separate evaluations of each of their twin sons on 16 items in the ADHD section of the instrument. Though they admit that they could not "arrive at confident clinical diagnoses of ADHD"

based on their raw data, they assert that "the basic intensity data illustrate many important features of the genetic analysis of a complex disorder such as ADHD" (p. 288). They arrive at their conclusions via "latent class analysis" of twin behavior—or a two-stage process similar to factor analysis.

What Eaves et al. (1993) found was that if there is a major gene affecting the risk for ADHD, it is not fully penetrant. The frequency of the high-risk allele was found to be around 15%, which the researchers interpreted to mean that "approximately 2% of the population are homozygous for elevated risk" (p. 300), or that there is "an apparently recessive allele with relatively low frequency" (p. 301), suggesting that "environmental factors alone are sufficient to account for the reduced penetrance of the primary locus" (p. 301).

Limitations of the Neurobiological/Genetic View

From a clinical perspective, the authors of the aforementioned study contribute a caveat to Barkley's (2002) earlier cited assertion regarding genetic factors at play in the etiology of ADHD, as well as that made by Willcutt, Pennington, and DeFries, who stated that "ADHD is substantially the result of genetic influences" (2000, p. 153).

> From a clinical perspective, severity of behavioral expression, especially inattention and impulsivity across activities, which are not simply imposed on the child by others but are self-generated or merely occurring passively, is a crucial facet of the correct identification of the high-risk genotype. All in all, however, approximately 25% of the children defined as being possibly ADHD with the current 16 "intensity" items are putatively heterozygotes and not the high-risk recessive homozygotes. Correspondingly, about 25% of the high-risk . . . genotypes would be assessed as merely fidgety if classification were based only on these 16 items. Errors of behavioral assessment in both directions can lead geneticists to the wrong place as they try to detect linkages between a putative high-risk allele and markers of known genomic location. (Eaves et al., 1993, p. 301)

Further dampening the prevailing opinion regarding the primacy of genetics in ADHD, Levy, Hay, McStephen, Wood, and Waldman (1997), in a twin study that included

1,938 families, suggest that ADHD is best viewed as the extreme of a behavior that varies genetically throughout the entire human population rather than a disorder with discrete symptomatology.

As I already briefly addressed in Chapter 1, there are many other problems with the nearly universally accepted validity of the neurobiological view of ADHD etiology. In perhaps one of the more comprehensive critiques I found by Galves et al., (2002), the authors engage directly with what I would characterize as a perfect example of the complex relationships, many of which are fraught with at least the appearance of ethical problems, that surround ADHD. They issue a pointed letter on behalf of the International Center for the Study of Psychiatry and Psychology (ICSPP) to the Director of the Brochure Project, a joint initiative between Division 29 (Psychotherapy) of the American Psychological Association and Celltech Pharmaceuticals (now a division of UCB Pharmaceutical). Celltech/UCB are the makers of Metadate, a methylphenidate formula that generated over $88 million in sales in 2006 in the United States alone, according to the corporation's 2006 Annual Report to Shareholders (UCBSA, 2006, p. 57). The authors of the letter systematically rebut the following statements, which appeared in a printed piece meant for consumption by the general public:

1. ADD/ADHD is generally considered a neurochemical disorder.

2. Most people with ADD/ADHD are born with the disorder though it may not be recognized until adulthood.

3. ADHD is not caused by poor parenting, a difficult family environment, poor teaching, or inadequate nutrition.

In their substantive literature review, Galves et al. (2002) cite compelling research on topics ranging from neuroplasticity (Schwartz, Stoessel, Baxter, Martin, & Phelps, 1996), to

placebo effects (Khan, Leventhal, Khan, & Brown, 2002; Leo & Cohen, 2003; Leuchter, Cook, Witte, Morgan, & Abrams, 2002). They also offer an exhaustive review of neuroimaging studies that found no convincing evidence for the existence of abnormality in the brains of persons with ADHD (Baumeister & Hawkins, 2001). They further refute the certainty with which the natural scientific community holds up genetic claims about ADHD, including flaws in twin study design (Joseph, 2003), the impact of environmental factors on protein synthesis (Hubbard & Wald, 1993), and the lack of a precisely defined genetic mechanism to demonstrate ADHD's source in the DNA (Ross & Ross, 1982). Galves et al. also cite research that found genetic and pre and perinatal characteristics are significantly outweighed by parental distress, hostility, and marital discord (Cameron, 1977), as well as the presence of hyperactivity in the family, chronic illness as a child, and temperament characteristics (Lambert & Harsough, 1984). Further underscoring the importance of parenting and other environmental factors, the authors cite research that shows ADHD is significantly associated with unmet needs for nurturance in childhood (Campbell, 1990; Goodman & Stevenson, 1989), difficult families (Lambert & Harsough, 1984), and the learning environment (Kohn, 2000; Ross & Ross, 1982).

<div align="center">Clinical Picture</div>

How does ADHD impact various aspects of daily life? Brown (2005) uses the term ADHD *syndrome* to define the following six clusters of symptoms that often respond together in treatment, which also serve to paint a more vivid representation of the clinical picture of ADHD than the simple list of symptoms found in the DSM-IV.

<div align="center">*Cluster 1: Organizing, Prioritizing and Activating for Tasks*</div>

The child has difficulty in getting started with tasks and so often procrastinates. This creates frequent "crisis" situations that help the child to find the motivation to get to work.

The child also experiences a pronounced difficulty in sorting out and assigning priorities, as well as a recurrent failure to notice critical details—which may be exacerbated by the previously mentioned self-inflicted crises. Lastly, the child may also demonstrate a tendency to ignore realistic limitations.

Cluster 2: Focusing, Sustaining, and Shifting Attention to Tasks

The child may experience difficulty in focusing and sustaining attention on tasks until completion. This may also manifest in poor listening or a lack of attentive reading. Reading problems may be particularly pronounced when dealing with assigned material versus that which is self-selected. The child may also be easily distracted, but paradoxically may also tend to "lock on" to activities of personal interest and lose track of all else.

Cluster 3: Regulating Alertness, Sustaining Effort, and Processing Speed

The child may experience drowsiness even when well-rested during lectures, when reading assigned material, or faced with assigned writing. Paradoxically, he or she may also experience difficulty in falling asleep even when tired. The child may have difficulty sustaining effort for tasks not self-chosen. Further, the child may exhibit slow processing of simple tasks or a tendency to too rapidly process more complex tasks. This may all combine to present the appearance of laziness or sloppiness.

Cluster 4: Managing Frustration and Modulating Emotions

The child may display emotional lability. This may frequently look like boredom, demoralization, irritability, or explosive anger. He or she may show a low tolerance for frustration, but may also have great difficulty regulating emotional experience and expression, including hurt, sadness and anxiety.

Cluster 5: Utilizing Working Memory and Accessing Recall

The child may have difficulty in recalling material just read, or may frequently misplace important objects like keys or books. He or she may also have trouble with reciprocal communication. In the classroom, he or she may experience difficulty with math, reading comprehension, and written communication as a result of these memory-related challenges.

Cluster 6: Monitoring and Self-Regulation Action

The child may appear to have difficulty in inhibiting action until the right moment. This may indicate a lack of ability to monitor him or herself while acting, and to envision the consequences of failing to act appropriately.

Diagnosis and Assessment

The DSM-IV-TR

Having looked at the clinical picture of ADHD, I would like to turn my attention to the business of diagnosis, with some specific emphasis upon assessment techniques and their accuracy. According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, or DSM-IV-TR (American Psychiatric Association, 2000; Rappley, 2005), diagnosis codes 314.00-01 for Attention Deficit/Hyperactivity Disorder require evidence of inattention or hyperactivity and impulsivity, or both.

Regarding inattention, six or more of the following symptoms must be present for at least 6 months to a degree that is both maladaptive and inconsistent with developmental level:

1. Often fails to give close attention to details and makes careless mistakes;

2. Often has difficulty sustaining attention;

3. Often does not seem to listen;

4. Often does not seem to follow through;

5. Often has difficulty organizing tasks;

6. Often avoids tasks that require sustained attention;

7. Often loses things necessary for activities;

8. Often is easily distracted;

9. Often is forgetful. (p. 92)

Regarding hyperactivity and impulsivity, six or more of the following symptoms must persist for at least 6 months to a degree that is both maladaptive and inconsistent with developmental level:

1. Often fidgets;

2. Often leaves seat;

3. Often runs about or climbs excessively;

4. Often has difficulty with quiet leisure activities;

5. Often is "on the go" or "driven by a motor";

6. Often talks excessively;

7. Often blurts out answers;

8. Often has difficulty awaiting turn;

9. Often interrupts or intrudes. (p. 92)

All of these symptoms must be present before the age of 7 years and in two or more settings—for example, at home and at school. If onset occurs after 7 years of age, or if it presents without the full criteria, but instead with a behavioral pattern marked by sluggishness, daydreaming, and hypo-activity, then another diagnosis code may be assigned: 314.9 *Attention Deficit/Hyperactivity Disorder, Not Otherwise Specified.* As additional criteria, the behaviors must not occur exclusively during the course of a pervasive developmental

disorder, schizophrenia, or another psychotic disorder, nor may they be better accounted for by another mental disorder.

The diagnosis may also be classified into the subtypes of ADHD previously mentioned. To add further controversy to the debate, according to a review of cluster-analytic and categorical research conducted by Milich et al. (2001), there is a good case to be made that the subtypes ADHD/I and ADHD/C may warrant distinctly separate diagnoses (p. 469).

Assessment

According to Handler and DuPaul (2005), there is comprehensive agreement among psychologists, psychiatrists, and pediatricians that a multimethod approach across both multiple sources and settings is most effective in obtaining accurate information regarding ADHD symptoms, which is confirmed by Christophersen and Mortweet (2001) in their discussion of clinical guidelines provided by both the American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics. Both sources cite a combination of clinical interviews with the parent, teacher, and child; standardized behavior scales completed by parents and teachers; reviews of school information; and clinical observations in differing settings as possibilities for such an approach. However, Handler and DuPaul also mention a National Institutes of Health (NIH) study that notes the wide variability among types of practitioners with regard to the frequency of diagnosis, and with that, the inherent need for consistency in diagnostic practice. This need was underscored previously in my discussion of multi and cross-cultural epidemiological studies. Christophersen and Mortweet include discussions of the following broad categories of assessment tools: Interviewing, behavior rating scales, and clinic-based diagnostic procedures.

Interviewing

In addition to more or less free-form clinical interviews which probe for information in the family history, about the environment, and about the behaviors themselves, Christophersen and Mortweet (2001) also name two standardized formats: the Diagnostic Interview Schedule for Children developed by Shaffer, Fisher, Lucas, Dulcan, and Schwab-Stone (2000), and the Children's Interview for Psychiatric Syndromes developed by Weller, Weller, Fristad, Rooney, and Schecter (2000).

Behavior Rating Scales

Christophersen and Mortweet (2001) detail and evaluate the most widely used rating scales: the Conners Parent Rating Scale (CRS), the Child Behavior Checklist (CBCL), and the Behavior Assessment System for Children (BASC). According to Christophersen and Mortweet, the CRS was designed to assess hyperactivity through the eyes of parents and teachers. It consists of 48 items, which are rated on a 4-point scale. The 118-item CBCL also includes the child him or herself in addition to parent and teacher ratings, which are then sorted for scores evaluating social withdrawal, attention problems, and aggression. The BASC similarly includes the child, teachers, and parents in a comprehensive rating system.

Christophersen and Mortweet (2001) state that all of these methods are fairly time consuming, though the CBCL and BASC both provide computerized scoring. They also address the relative diagnostic utility of each. For example, in one study (see Ostrander, Weinfurt, Yarnold, & August, 1998), the BASC and CBCL both effectively differentiated between subtypes of ADHD, while the BASC was found to be more accurate than the CBCL for distinguishing children with the disorder from those without its symptoms. In addition to where such checklists are effective, however, they caution that behavioral checklists do not provide "specific and detailed information on dimensions of problem

behaviors that may be necessary for developing treatment formulation. For this information, clinicians often turn to direct observation of the child's behavior and, in some situations, self-monitoring by the child" (p. 26).

Clinic-Based Procedures

Christophersen and Mortweet (2001) review the literature on clinic-based diagnostic testing instruments, including the Gordon Continuous Performance Test, Controlled Word Association Test, Hand Movements Scale, Porteus Mazes, Rey-Osterrieth Complex Figure, Stoop Color-Word Association, Trail Making Test, Wisconsin Card Sorting Test, and the Grooved Pegboard Test—drawing the following conclusion:

> Although there is a tremendous need for objective measurement to determine the presence and extent of attention problems, the use of clinic-based diagnostic tests and continuous performance tests has yet to be perfected to a point at which the tests are useful in the diagnosis of children with attention deficit problems. (p. 28)

Accuracy of Assessment Tools in Question

Aside from their critical opinion regarding clinic-based processes, Christophersen and Mortweet (2001) neglect to critically examine the scientific accuracy of the DSM-IV itself, nor do they mention anything about cross- or multicultural reliability and validity in their discussion of the effectiveness of various standardized assessment tools. For example, Wilder (2003) recommends that the BASC be used cautiously with ethnically diverse students and students with low socioeconomic status as reliability for the assessment tools with these subpopulations has not been effectively established.

Regarding the most commonly used assessment tool of all, the DSM-IV, Kirk (2004) states that ADHD provides an example of how a diagnostic system has been continually adjusted for increasing its sensitivity—that is, for making it easier to apply the diagnosis. He states, "Coincidentally, with each revision of the DSM, the American Psychiatric Association's estimate of the prevalence of ADHD in the general population is higher than

before . . . (rising from) 3% reported in DSM-III to 7% in the latest version" (p. 258). Kirk

cites several factors at work, including less stringent thresholds for diagnosis (i.e., six rather

than eight criteria required for diagnosis, as well as descriptive redundancies in the criteria

themselves). This increase in sensitivity is also at work when comparing the DSM-IV to

ICD-10. The Diagnostic Criteria for Research (DCR-10) in the ICD-10 for ADHD are

nearly identical to that of the DSM-IV. However, the DCR-10 requires that 10 of 18

symptoms be present in order for ADHD to be diagnosable, as opposed to the six

symptoms required by the American system (Yang et al., 2000).

<div align="center">Treatment and Outcomes</div>

Next, I focus on the literature regarding treatment and outcomes, including both the

mainstream view, as well as some possible alternatives. Note that a discussion of some

alternatives from the realm of transpersonal psychology is reserved for Chapter 5.

<div align="center">*Traditional Treatment Strategies*</div>

The Gold Standard of the Mainstream: Multimodal Treatment

According to Abikoff and Hechtman (1996), in the late 1970s, James Satterfield and

his colleagues developed a promising new treatment strategy for ADHD that consisted of

methylphenidate, individual psychotherapy, group therapy, educational therapy, individual

parent counseling, group counseling for parents, and family therapy, offered in different

combinations depending upon the unique needs of each child and his or her family.

Research demonstrated that this approach, named Multimodal Treatment or MMT, was

highly successful, spurring great interest, as well as some controversy in the field of child

psychiatry, given that Satterfield's work had not been conducted within the context of

controlled, random assignment, clinical trials.

The Collaborative Multimodal Treatment Study of Children with ADHD, or the MTA (Arnold et al., 1997), arose to address that controversy. The MTA was a multisite cooperative study conducted by the National Institute of Mental Health (NIMH). The study involved 579 children between the ages of 7 and 9, all of whom had been diagnosed with DSM-IV ADHD (Combined Type). The MTA was designed as a one-way, four-group study including 579 children, with four assessment points spanning 2 years—namely at 3, 9, and 14 months of treatment, plus 10 months after treatment. It was designed to compare outcomes between pharmacotherapy, behavioral treatment, and the combination, as well as treatments typically provided in the community.

The extensive data from the study have been analyzed and summarized by numerous authors over many years, including by those who participated as members of the MTA Cooperative Group, such as Jensen et al. (2001). They state, based on MTA data, combined interventions (medication and psychosocial treatment) and medication management (weekly titration) interventions were significantly better—with a moderate effect size of 0.5 to 0.6 (p. 64)—than either behavioral interventions alone or community comparison groups, even though 68% of the children in the community comparison group were also treated with medication (p. 66).

To bring the MTA findings back to an earlier discussion of overlapping conduct problems, Jensen et al. (2001, p. 64) found that in the sample of 579 children, only 31.8% had ADHD alone. Nearly 40% met the criteria for ODD, and another 14.3% met the criteria for CD. The rest showed co-occurring Anxiety Disorder (38.7%), Tic Disorder (10.9%), and Mood Disorders (3.8%). Only the combined intervention showed evidence of statistical superiority over the community comparison group in improving these children's

oppositional, aggressive symptoms, internalizing symptoms, social skills, parent-child relations, and academic functioning.

Rieppi et al. (2002) conducted another relevant study to this research project. They found that among the MTA sample, parental education and socioeconomic status (SES) had a meaningful impact upon treatment response. For example, children from less educated families showed no significant difference between the effectiveness of the combined treatment approach and medication management, while both were found to be better than behavior management and routine community care. In contrast, more educated families showed superior symptom reduction from a combined intervention approach as compared to behavioral treatment, medication management, or routine community care in isolation. Factoring in SES, children from lower income families who were also suffering from oppositional and aggressive symptoms benefited most from combined therapies, while the children of "white collar" higher income parents generally showed no significant difference in treatment response, demonstrating that "families with adequate resources responded well to each treatment modality" (p. 275). According to Rieppi et al., these findings suggest that clinicians need to be aware of a combination of factors in planning effective treatment for ADHD, including SES, along with behavioral problems that may overlap with core ADHD symptoms.

As I soon discuss, researchers have recently updated the MTA research with a long term follow up study that made some surprising new discoveries, particularly about the efficacy of medication. However, before addressing those findings, I would like to look more closely at medication as a treatment strategy for children with ADHD.

Pharmaceutical Interventions for ADHD

In addition to the large body of medical research so briefly sampled here, the quest for a neurobiological etiology has yet another strong basis for support. Psycho-stimulant medications are demonstrably effective in rapidly altering many problem behaviors (Rappley, 2005; Vitiello, 2001), particularly when combined with cognitive-behavioral therapy (Pelham et al., 2000), and as such, are generally the "dominant mode of treatment" (Kidd, 2001, p. 403) for ADHD.

Vitiello (2001) succinctly summarizes the clinical efficacy of Ritalin, as the most common example, in unambiguous terms:

> Statistically, the effect of methylphenidate is considered "large," that is, the difference between methylphenidate and placebo on rating scales of ADHD symptoms is about 0.8 standard deviation or greater. Clinically, this can mean the difference between a child who has major problems concentrating, and is viewed as a problem by teachers and parents alike, and a child who is very close to normal for the age group. The rate of improvement approaches 80% on methylphenidate and is less than 15% on placebo. (p. 1505)

Aside from behavioral symptom reduction, other studies have demonstrated statistically significant improvements in cognition related to medication (Hall & Gushee, 2002; Hood, Baird, Rankin, & Isaacs, 2005; Popper, Hirschfeld, Keck, Yonkers, & Leonard, 1997).

Given their clinical effectiveness, not to mention an obviously growing and ever more lucrative market for them, the list of available pharmaceutical interventions for ADHD continues to expand. According to Hall and Gushee (2002), it includes:

1. Stimulants: methylphenidate (Ritalin); dextroamphetamine (Dexadrine); pemoline (Cylert); amphetamine-dextroamphetamine (Adderall).

2. Tricyclic Antidepressants: imipramine (Tofranil); amitriptyline (Elavil); desipramine (Norpramine); nortiptyline (Aventil).

3. Nontricyclic Antidepressants: buproprion (Wellbutrin); clonidine (Catapres).

A more recent arrival on the scene is Eli Lilly and Company's nonstimulant norepinephrine reuptake inhibitor, atomoxetine HCl, marketed under the brand Strattera.

Dangers in common pharmaceutical interventions. Methylphenidate is both the oldest and the most commonly prescribed medication for ADHD. However, in spite of its almost ubiquitous presence, it is far from benign. According to the United States Drug Enforcement Agency of the Justice Department, Ritalin is classified as a Schedule II substance, and as such, is listed alongside cocaine, morphine, and methamphetamine (DEA, 2005). This goes to the heart of the argument against using stimulant medications, as they appear to act as gateway drugs, which may lead to drug abuse and addiction in adulthood (Kidd, 2001; Molina & Pelham, 2001). Further, like their illicit cousins, they may foster physical withdrawal, including both rebound effects and dependence (Breggin, 1999a, 1999b).

Aside from immediate and future abuse potential and potential physical withdrawal, many undesirable results often spring from the continuum of neurotoxicity that only begins with the therapeutic effects of stimulants previously mentioned. They include obsessive/compulsive activities, insomnia, agitation, hypomania or mania, agitation, seizures, and psychosis. These symptoms may also manifest in apathy, social withdrawal, emotional depression, and docility (Breggin, 1999a, 1999b, 2000).

Of the often minimized risk of psychotic symptoms resulting from stimulant use, Breggin (2000) cites research that places the prevalence of psychotic symptoms at 9% of those children who are placed on stimulant medication, symptoms which cease as soon as medication is discontinued. Unfortunately, according to Breggin, it is more likely that the hallucinations, paranoia, and psychotic mania will be treated with a multiplicity of other psychiatric medications rather than ceasing the stimulant medication. Breggin states that in

his practice of psychiatry, it is not unusual for him to see children taking three, four, and sometimes five adult psychotropic medicines, after their physicians had mistakenly assumed that their drug-induced reactions were some sort of "unmasked" clinical depression, schizophrenia, or bipolar disorder. Thus, it is far from uncommon that a child who began a seemingly harmless methylphenidate medication as a quick and easy response to conflict at home or school or academic problems, ended up on multiple adult drugs, and facing many severe adverse side-effects.

Further, recent research across 3 years of a long-term follow up to the MTA confirmed long-suspected growth impairment in children who take stimulant medication. In this important study, stimulant naïve school children with combined-type ADHD ($n = 88$), were as a group, larger than expected compared to height and weight norms before treatment, but showed significant decreases in growth rates after treatment, without evidence of rebound (Swanson et al., 2007).

In spite of the long list of risks, The United States Food and Drug Administration (FDA) has been slow to respond. Only recently, the FDA began requiring "black box" warning labels on popular amphetamine based formulas including GlaxoSmithKline's *Dexadrine* and Shire's *Adderall* regarding the risk of sudden death (Pettypiece & Blum, 2006). This follows the September 29th, 2005 announcement by Eli Lilly and Company that the FDA had compelled them to include a black box warning on their packaging addressing suicide risk in children and adolescents who take Straterra—a nonstimulant formula (Carey, 2005; Pierson, 2005).

Updating the MTA: New Findings

As was already briefly mentioned, a recent follow-up study to the MTA ($n = 485$ of the original 579 participants) has yielded some important new findings. As was already

mentioned, one substudy as a part of that larger effort confirmed long-suspected growth impairment in children treated with stimulant medication (Swanson et al., 2007). However, the most important finding cast a shadow of doubt over the long-term efficacy of stimulant medication treatment. The group of distinguished researchers, many of whom participated in the original research, examined 36-month outcomes 2 years after the end of the original MTA study. They looked at primary outcome measures of ADHD and Oppositional Defiant Disorder (ODD) symptoms, as well as social skills, reading scores, impairment, and diagnostic status. Recall that the original research found the effects of medication management, behavior therapy, their combination, and usual community care differed significantly at 14 and 24 months. This was hypothesized to be due mainly to the positive impact of the MTA's medication management algorithm when combined with behavior therapy, particularly as compared to behavior therapy combined with the usual community standard of care (Arnold et al., 1997). In the most recent update, researchers found that this advantage had disappeared 3 years later (Jensen et al., 2007).

As has already been mentioned, perhaps most salient to this study, though the research originally suggested that initial symptom severity, sex (maleness), comorbidity (or symptom overlap), socioeconomic status (as defined by participation in public assistance programs), and parental ADHD did not moderate 36-month treatment responses, these factors did appear to predict worse outcomes long-term, regardless of which treatment group to which these participants were originally assigned (Jensen et al., 2007).

Nontraditional Treatments

A Brief Survey of Alternatives to Medication

As has already been discussed, conventional therapies are effective in treating many troubling symptoms of ADHD, but these same interventions, save for the combined

multimodal approach, typically do not have more than a temporary impact upon overlapping conduct problems (Jensen et al., 2001). This fact, combined with the aforementioned safety concerns surrounding medication, point to a convincing case that alternative treatments warrant serious examination. Surprisingly, in spite of how the activist opposition to traditional diagnosis and treatment might paint the situation, there has been genuine interest in alternative treatments for ADHD at the highest levels of government and science, including the National Institute of Health (Arnold, 2002).

Arnold (2002) conducted a comprehensive literature review of the resultant science examining alternative treatments for ADHD. In the category of "unproven," he places the majority of dietary interventions, including essential fatty acid supplementation, l-carnitine, glyconutritional supplementation, dimethylaminoethanol, RDA vitamins, single vitamin megadosage, and herbals. He also includes homeopathic remedies—though a recent randomized, double-blind, placebo controlled crossover trial now suggests they may be efficacious (Frei et al., 2005)—along with laser acupuncture, EEG biofeedback, mirror feedback, channel-specific perceptual training, vestibular stimulation, antifungal therapy, and some types of immune therapy in this category.

Arnold (2002) also lists several alternative therapies as being at best ineffective, and at worst, unsafe. They include various forms of megadose multivitamins (which may carry a risk of hepatotoxicity and peripheral neuropathy), amino acid supplementation, and simple sugar restriction. He also cautions against using such treatments as chelation without evidence of elevated levels of lead in the blood.

In addition to criticism, Arnold (2002) also offers acknowledgment that some alternatives have been proven effective, including the "few foods" or "oligoantigenic" diet

for children who have sensitivities to certain foods. He also lists biofeedback and relaxation training as particularly efficacious, given their low cost and feasibility for group application.

Green Settings and ADHD

One particularly intriguing natural remedy that was not mentioned by Arnold (2002) was the finding by Faber Taylor (2001), later supported by Kuo and Faber Taylor (2004), that exposure to natural green settings reduces ADHD symptoms. Faber Taylor based her doctoral research upon *Attention Restoration Theory* (R. Kaplan & Kaplan, 1989; S. Kaplan, 1995), which holds that natural environments contain qualities that may foster the restoration of attentive capacity in adults by allowing the person to rest the mental faculties associated with directed attention. Faber Taylor wondered whether the same impact might be observed in children. Indeed, she found that nonresidential forms of nature positively impacted the function of children's attention. She also found that children who regularly play in green settings have less severe attention deficit symptoms than children who play in urban settings.

In follow up research by Kuo and Faber Taylor (2004), which began with data from an unpublished controlled experiment comparing the beneficial effects of 20-minute walks in both urban and natural settings upon objective measures of attention, the researchers found that children's performance was significantly better after walking in green settings. In the published study, they then sought to test whether or not these results might hold for a wider range of ages, community sizes, and geographical regions. To find out, the researchers conducted a national, internet-based study. Their data set was comprised of 452 qualified surveys (screened from a total of 1053 initial respondents) whereby parents rated the aftereffects of common after-school and weekend activities on four of their child's most readily observable ADHD symptoms: difficulty in remaining focused on unappealing tasks,

difficulty in completing tasks, difficulty in listening and following directions, and difficulty in resisting distractions. For each activity, parents were asked to rate their child's symptoms as having become much worse than usual, worse than usual, same as usual, better than usual, or much better than usual for the hour directly following.

Kuo and Faber Taylor (2004) found that green outdoor settings significantly reduced symptoms, whether the activities were conducted alone/in pairs or in larger groups, while outdoor activities in man-made or "built" environments were shown to reduce symptoms only when conducted alone or in pairs, which was similar for indoor activities. In contrast, indoor activities tended to significantly exacerbate symptoms when conducted in large groups—begging a question that will be relevant for this study, "Do environmental factors that appear to induce attention fatigue in the general population—noise, crowding, and need for vigilance—exacerbate ADHD symptoms" (p. 1585)?

ADHD in Children and Families

Children's Experiences of ADHD

Kendall, Hatton, Beckett, and Leo (2003, p. 115) sought to explore the notion that ADHD is a "postmodern illness" which they define, citing Morris (1998), in terms of a "changing experience of human affliction that is shaped by convergences of biology and culture." In the process, they provide a rare descriptive, qualitative study that allows for the voices of the children and adolescents who are impacted by ADHD to be heard over the roar of the polarized debate in the literature. Kendall et al. interviewed 39 children ranging in age from 6 to 17 years regarding their perceptions, meanings, and experiences of living with the disorder. The researchers took unusual pains to ensure that African American and Hispanic families were at least equally represented, if not given heavier representation, given "the greater disability from unmet health needs relative to Whites" (p. 117) that they

experience. They also were careful to include researchers on the team who represented each group, and included "community insiders" in order to ensure a culturally sensitive research project.

Kendall et al. (2003) reduced the data from their semistructured interview protocol using *constant comparative analysis* into the following six categories of experience: Problems (learning/thinking, behaving, feeling); Meaning and identity (hyper, bad/trouble/weird, illness/normal); Pills (positives/negatives); Mom; Causes; Ethnicity, race and racism. While space constrains me from sharing a large amount of their data, I think it is relevant to share an example of their findings. I found the following to be particularly moving, and representative of their work:

> Many of these children also described ADHD in terms of how badly they felt much of the time. Feeling sad, mad, frustrated, and ashamed were common themes throughout the interviews, indicating that these children were aware of the emotional effects ADHD had on them. These emotional responses were most often a result of the learning and behavioral problems they were experiencing. As one 16-year-old girl said, "I get frustrated in school. I get frustrated at things. When I get home I get frustrated with people and stuff. I get really sad sometimes. I see my friends who are at the speed of everyone else, and I'm not. I get sad." an 11-year-old boy said, "It feels like I'm a good person. I wouldn't do anything bad on purpose. It just feels really bad." This boy also talked about how sad he felt for his family having to do so much to take care of him. (p. 121)

Kendall et al. (2003) interpret such data as reflecting that children are aware they have problems related to ADHD and that it is not a figment of their imagination, nor is it a condition placed on them unreasonably. They were so moved by the stories of their subjects that they stated that their findings seemed to indicate to them, "While ADHD may be viewed as a postmodern illness embedded in controversy reflective of contemporary values and culture, we believe that ADHD is not a hoax, myth, or distortion of lived reality" (p. 127).

In an earlier related study, Krueger and Kendall (2001) conducted another qualitative study to look specifically at how adolescents as a subset of children experience ADHD. They found that the ADHD adolescent's sense of self was distorted. According to the researchers, the experience of ADHD seemed to be integral to their identity and was "more antagonistic and negative than the researchers expected" (p. 64). The adolescents' descriptions focused upon inadequacy in girls, and upon anger and defiance in boys. Further, the authors state, citing Barkley (1997, p. 13), that the normal development of a sense of self had likely been disrupted as a result of major deficits in the development of normal inhibition, thus creating a "cascade of secondary difficulties throughout the executive system [in the brain]," including self-regulation and inhibition (p. 68). Finally, in addition to neurobiological factors, Krueger and Kendall attribute the development of the ADHD self to environmental and sociocultural factors, particularly those associated with the difficulties inherent in parenting a difficult child, social role expectations, and modeling:

> Several factors complicate the process of healthy self-development in children and adolescents with ADHD. Children who come into the world with biologically based risk factors of disrupted attention span, lowered frustration tolerance, and increased impulsivity may experience increased vulnerability throughout the period of self-development. When an infant displays high irritability, hyperactivity, aggression, inattention, and/or has difficulty being soothed, even "good" parents may respond more often than not with disappointment, anger, impatience, frustration, exhaustion, and guilt. (p. 69)

This may help to explain the findings of Topolski et al. (2004) in their research comparing the quality of life of adolescents with ADHD to adolescents without the disorder and to adolescents with mobility impairments. They found that not only did adolescents with ADHD report significantly lower scores on the Youth Quality of Life Instrument (YQOL-R), particularly in the self and relationship domains, than did their peers without ADHD, they also had scores that were roughly similar to children with impaired mobility.

Families and ADHD

Anastopoulos, Barkley, and Sheldon (1996), citing earlier research by Barkley (1990), state that children with ADHD are at greater risk for experiencing family conflict, especially with parents, who may also be predisposed to higher levels of parenting stress, psychopathology, and marital discord. This calls to the fore the potential importance of family therapy as a part of a multimodal approach (Orr, Miller, & Polson, 2005).

However, simply reducing ADHD to family pathology, though commonplace, is overly simplistic (Malacrida, 2001) and ignores the systemic forces at play. To describe these complex forces, Malacrida (2003, p. 25) cites Jacques Donzelot's (1979/1997, p. 103) philosophical view of diagnoses like ADHD as parts of the growth of the "tutelary complex," which he defined in terms of a system of concentric circles that form around the afflicted child, beginning with the family, which is in turn surrounded by a collection of psychologists, physicians, social workers, special education teachers, and other experts.

In any case, according to Kendall and Pryjmachuk (1999), learning to parent a child with ADHD is a long and arduous process that is helped by engaging in a multistage process. The researchers found that successful parenting of children with ADHD required outlasting the disruption of family life that was described as "chaotic, conflictual and exhausting" (p. 337). To do that, Kendall and Pryjmachuk found that parents must first make sense of the disorder, which included a comprehensive process of acceptance. Second, parents must recast their own biographies through examining their own lives—past, present, and future. Finally, parents of children with ADHD must "let go of the belief that a child with ADHD was just like everyone else and [move] beyond grief" (p. 337). Only after following through on this process did Kendall and Pryjmachuk find that parents were able to reinvest in all of their children, their families, their marriages, and themselves.

Kendall et al. (2003) found that the children in their study lacked much in the way of insight into the effects of their problems on family life. However, the children often reflected that family was important to them—in particular, their mothers. Not only did these children appreciate the help their mothers provided, they also tended to worry about their mothers' health, as well as the effect their ADHD had upon them.

In research specifically about mothers and children with ADHD, Malacrida (2001) interviewed 34 women in Canada and England to learn about their experiences of mothering. She found that mothers were often "objects of surveillance and bearers of blame" (p. 142) in their interactions with multiple helping professionals, which served to place them "in conflict with discourses of good motherhood, family normativity, professional knowledge and risk" (p. 141).

Malacrida (2001) states that treatment doesn't come close to solving the problem.

> Teachers particularly can assume that a child who is on medication, and whose performance still does not improve markedly [which is not atypical, according to Malacrida], has a behavioral or an intellectual problem, or that the problem really was located in family pathology after all. After medication has begun is often when the real school-parent conflict begins. (p. 154)

She found that parents and school officials played out this conflict in ways that employed indirect rather than confrontational strategies. Early on, these strategies might include restating the truth, drawing boundaries around intervention and judgment, and laying claim to services and information on their own terms. "Only after considerable conflict did mothers move to more public and considered action, such as sitting on policy-making committees or lobbying with schools and boards or, ultimately, refusal" (p. 161).

CHAPTER 3: RESEARCH METHODS

This chapter describes how my dissertation research joined the phenomenological method (Giorgi, 1985; Maso, 1983; Moustakas, 1994; van Kaam, 1966) with elements of auto-photographic ethnography (Ziller, 1990) and forms of embodied hermeneutic inquiry (Finlay, 2005; Moustakas, 1995; Todres, 2007) to yield thickly descriptive (Geertz, 1973) textural-structural (Moustakas, 1994) understandings of ADHD as the phenomenon arises in starkly contrasting lifeworlds. Beginning with a review of the case both against and for my creation of a synthetic method, I then provide concise sketches of each method through philosophical and theoretical lenses. Next, I describe their integration into a synthetic methodological schema. The chapter culminates with an outline of the process that governed data collection, as well as a brief discussion of delimitations and limitations of the study.

Methodological Synthesis

The Argument Against Deviating From Pure Phenomenology

Despite my enthusiasm for developing a synthetic methodological approach that includes as its foundation the descriptive phenomenological method, I approached the task with enormous trepidation and respect. Though Giorgi (2006) acknowledges that new approaches are emerging out of the apparent tension between the perspectives of phenomenology and, more generally, psychology as a whole, he suggests that "novel transformations must take place [within] historical guidelines, [taking care to balance] philosophical correctness . . . with scientific rigor" and "concern for practical results" (p. 306). He goes on to underscore the importance of a sound knowledge of philosophical phenomenology, along with a background in research design and strategy in sorting out the decisions made by researchers, who, like me, find themselves in the "no-man's land" that exists between all of the aforementioned competing interests. Though he commends those

courageous enough to attempt to enter into the great unknown in search of new approaches, Giorgi is also careful to point out that not all novel practices are equally defensible, and that he finds many being advocated that are less than favorable. The bottom line for Giorgi is that variations in procedure must be "according to phenomenological criteria" (p. 306), an admonition I have tried earnestly to heed, out of respect for the man and his body of work, as well as the integrity of the method and what it represents—a powerful voice of opposition to reductionistic conceptions of humanity.

With that said, I need to acknowledge that one of the scholars with whom Giorgi (2006) takes exception, Clark Moustakas (1990, 1994, 1995), had a significant influence upon the development of this work. Specifically, Giorgi singles out how Moustakas' development of his own *heuristic research method* influences and distorts his proper understanding of phenomenology:

> [Heuristic Research] refers to a process of internal search through which one discovers the nature and meaning of experience and develops methods and procedures for further investigation and analysis. The self of the researcher is present throughout the process and, while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge. Heuristic processes incorporate creative self-processes and self-discoveries. (Moustakas, 1990, p. 9, in Giorgi, 2006, p. 312)

According to Giorgi (2006), his main issue with Moustakas is that he conflates the aforementioned approach with a Husserlian perspective, and that the two are not compatible the way he expresses it, particularly with regard to the act of bracketing prior knowledge in entering into the phenomenological attitude, or conducting the epoché, which will be explained in detail later. For now, I wish to state unequivocally, that the way in which I conduct myself as a researcher in assuming the phenomenological attitude is purely in accordance with Giorgi's standard.

I allow Moustakas (1990, 1994, 1995) to inform my research in ways that I do not believe violate the philosophical integrity of the phenomenological attitude as conceived by Giorgi (1970, 1985). The first way this occurs is mentioned by Giorgi (2006) in his critique of Moustakas (1994), whereby he takes issue with Moustakas' notion that the researcher should have a personal, vested interest in the phenomenon being studied. He quotes Moustakas directly, who states that a research question ought to be one that "has been a personal challenge and puzzlement in the search to understand one's self and the world in which he lives" (Moustakas, 1994, p. 17, cited in Giorgi, 2006, p. 313).

While, as Giorgi (2006) rightly notes, this may not be the case for everyone in every phenomenological study, this is precisely the case for me in this research, and goes to the heart of my feeling about research in general if it is to be conducted as an act of poetic activism (Gergen, 2001). To quote anthropologist Ruth Behar (1996, p. 177, cited in Adams, 2006, p. 113) in support for this point of view: "Research that doesn't break your heart just isn't worth doing anymore."

The second important way that Moustakas (1994) informs my research is in how I wish to ensure that, as Giorgi (2006) states, the human beings do not disappear into the abstraction of essential structure. Giorgi's criticism is that the notion of understanding a specific phenomenon versus the individual experiencing it may be legitimately studied as separate issues even within the phenomenological perspective. While that may be true, I wish to explore both essence and relativism in a dialectic relationship in order to cast a light upon that which is essential and that which is textural. To that end, I strive to keep the phenomenological reduction and its essential findings separate from that which is interpretive or heuristic in nature in order to maintain philosophical integrity. Bringing them together again in "creative synthesis" as Moustakas calls it, is not an indictment of

phenomenology as practiced by Giorgi, but rather an act of subversion aimed at questioning the status quo in our culture and our science. In short, I hope to inspire a change of heart as well as an expansion of mind.

My Rationale for Methodological Synthesis

Having acknowledged and addressed the argument against straying from a pure execution of Giorgi's (1970, 1985) phenomenology as a stand-alone method, I would like to present my rationale for doing so, in addition to the reasons stated for choosing to allow myself to be simultaneously influenced by Moustakas (1990, 1994, 1995) and Giorgi. Recall from Chapter 1 that my research questions were grounded in the social constructionist tradition (Berger & Luckman, 1966; Gergen, 1999; Hacking, 1999). Even so, I found myself simultaneously drawn toward exploring what essential structures, if any, might be found in comparing lived experiences of ADHD that are geographically proximal, yet racial and socioeconomic worlds apart. This resulted in a strong creative tension between two apparently conflicting worldviews. On the one hand, I felt pulled to engage with and honor something earthy and embodied, namely, the everyday, culturally imbedded understandings (Gergen & Semin, 1990) of my participants, as well as my experiences of and with them. On the other, I sought to explicate something more essential, abstract, and transcendent of the relative. Thus, a question took form: How might I simultaneously communicate the rich complexity and *texture* of human life in the language of culture, all the while clarifying matters of elegant, essential *structure* in the language of consciousness (Gergen & Semin; Todres, 2007)?

As a point of departure for this endeavor, I turned to the social constructionist literature, wherein Berger and Luckman (1966, p. 20) in their landmark work, *The Social Construction of Reality*, suggest that the method best suited for gaining understanding of the

"reality of everyday life" is that of phenomenological analysis. While I found it encouraging that phenomenology was apparently acceptable within this realm of scholarship, that fact alone would not suffice to bring the texture I sought for my analysis. Todres and Wheeler (2001) provided the bridge I was looking for. While they argue in favor of phenomenology as the best means to ground qualitative research in the lifeworld, they also lament that the results yielded by the method alone, without accompanying hermeneutics, run the risk of shallowness in the study of complex human experiences. They elaborate further that the limits of thought and language might unduly confine both methodological philosophies without an added existential perspective. In his most recent published work, Todres (2007) expands this thinking, specifically identifying what he seeks beyond thought and language in terms of the "pre-reflective more" (p. 2) which he says is best accessed through the lived body. Gendlin (2003), one of Todres' main influences, explains that while it is true we typically do not sufficiently recognize the role of culture, history, and language, neither can we allow ourselves to go to the other extreme and simply reduce everything to the same. Thus, he calls for a further step, namely "to recognize what is *with* and *after* language" through the body, because "the body is always in a fresh situational interaction that exceeds culture, history and language" (p. 114).

Holding all of these ideas in mind, I sought to creatively engage the tension between the critical realism of phenomenology and the more relativist, postmodern worldview of social construction (Finlay, 2003). The result was a methodological approach that would at once ground the research in the lifeworld as a starting point, while at the same time recognizing fundamental ontological concerns, as well as the positionality and reflexivity of knowledge (Todres & Wheeler, 2001).

Individual Methodological Approaches: Philosophy and Theory

Grounding the Research in the Lifeworld: Phenomenological Method

Phenomenology's Philosophical and Transpersonal Foundation

Amedeo Giorgi (1970) argued strongly in favor of psychology as a human science rather than a natural one. Primarily influenced by philosophers Edmund Husserl and Maurice Merleau-Ponty (Giorgi & Giorgi, 2003), he posited that if science was to seek true *understanding* of human phenomena, then it must abandon the taken-for-granted dualistic assumptions of naïve realism in favor of a more holistic approach, which, ironically enough, is a motivation that any good social constructionist would heartily endorse (Gergen, 1985)! Unlike social constructionism, however, such an approach, according to Giorgi, would seek to provide direct access to the *essence* of lived experience as it is "given" to a prereflective, intentional consciousness. This would ostensibly lead to the discovery of generalizable structures of human experiences that might transcend organizing principles like culture or, for that matter, our sense-making of said experiences though a lens like social constructionism.

In addition to its application in the realm of the human sciences, the literature also identifies the phenomenological method as a transpersonal research approach, which further increased its appeal for me in conducting this project, in spite of its apparent tension with social constructionism. Hanna (1993a, p. 181) refers to his own article on Edmund Husserl's phenomenology (see Hanna, 1993b), pointing out that Husserl's intent "was to experientially investigate the essence of any and all phenomena and to disclose the mysteries of consciousness and being . . . (thus delivering himself and his student, Heidegger) into realms that are clearly transpersonal in nature." Levin (1997) makes a similar statement in his direct comparison of phenomenology with Buddhism—specifically the 20th Century philosophy of

Merleau-Ponty and the methods espoused by the Indian philosopher Nagarjuna during the 2nd Century of the Common Era. Levin states that both men attempted to deconstruct rationalism and empiricism as doctrinal positions, not in service of nihilism, but rather as a means of returning to lived experience.

Perhaps the most profound example of the transpersonal nature of the phenomenological method lies in the heart and mind of the researcher him or herself. My mentor in the method, Dr. Olga Louchakova (2005), employs spiritual practices in the form of "structured introspection" in the training of her aspirant phenomenological researchers as a means of developing increased capacity for *direct intuition*. Direct intuition is the means by which the phenomenological researcher accesses consciousness itself, which Edmund Husserl (1970, p. 535, cited in Q. Smith, 1977, p. 482), in his Second Logical Investigation, defined in terms of "the entire, real (*reele*) phenomenological being of the empirical ego, as the interweaving of psychic experiences in the unified stream of consciousness." Thus, Louchakova aptly names direct intuition as the "foundational pillar" of Edmund Husserl's phenomenological method (p. 94).

Drawing upon Hesychasm, or the practice of Prayer of the Heart in the Eastern Orthodox Christian tradition, as well as the Hindu traditions of Advaita (nondual) Vedanta and Shakta-Vedanta (i.e., Kundalini Tantra), and the mystical branch of Islam known as Sufism, Louchakova (2005) bridges Husserl's phenomenology and Giorgi's qualitative method (both of which I will address later in more detail, with more weight given to Giorgi given his role as an eminent translator of Husserl's philosophical tradition for use as a practical psychological research method). She does so because, according to Louchakova, all share a common epistemological grounding, specifically, the emphasis of the character of knowing "by presence, [rather than] logical processes" (p. 97). Thus, she teaches practices

specifically designed to increase "internal presence" or "the availability of the phenomena of inner life to awareness" (p. 100).

Louchakova (2005) found that the methods of structured introspection she uses opened up the phenomenological architecture of the self, which is a complex system including many structural "levels," each with its own unique character that may be directly experienced and discerned. She noted that the internal spatiality of the body, primarily in the chest region, provides the venue for a central experience of the "I am" consciousness, which is associated with a complex array of "sensations, feelings, images, verbal thoughts, deeper nonverbal understandings, mental states such as torpor or confusion, and with the experience of *nothingness*" (p. 106).

Louchakova (2005) found these experiences to be organized in successive layers and locales within the embodied architecture of the self, the navigation through which facilitates within the researcher the faculty of epoché, or "the backward motion through the layers of experience toward the explication of ontologically deeper structures" (p. 107), more commonly known in spiritual traditions as "witnessing consciousness" (p. 95), as well as the subsequent processes of the descriptive phenomenological method. Additionally, her students reported an increased ability to bracket their assumptions, an essential aspect of phenomenological research, as well as decreased random activity of the mind. I felt the increased capacity for direct intuition and its attendant benefits would help me to navigate the complexity of this process, as well as to mindfully encounter the strong emotional and spiritual experiences that might ensue from my empathic immersion into the lifeworlds of my participants.

From Philosophy to Method

By interpreting Husserl's (1982) *Ideas I* and the preface to Merleau-Ponty's (1945/2005) *Phenomenology of Perception*, Giorgi was able to begin to adapt what was formerly a purely philosophical project to more practical ends, ultimately delivering a legitimate qualitative research method for psychology as a human science (Giorgi & Giorgi, 2003). The phenomenological research method he envisioned reduces and imaginatively transforms so-called *naïve* descriptions of everyday human experience into *essential* descriptions expressed in the language of scientific psychology that might be suitable as the subject matter for scholarly debate among learned colleagues in the academy.

Giorgi's (1985) method begins with repeated readings of transcribed descriptions in their entirety in order to get a holistic sense of the experience. The phenomenological researcher then seeks to break the whole narrative into smaller units of meaning from a psychological perspective. With "meaning units" identified, the researcher may then begin the work of transforming them into the psychological insights they contain through a series of free imaginative variations. Lastly, the researcher unites the transformed psychological insights in order to construct a cohesive statement describing the essential structure of the phenomenon.

Though it is among the most commonly used phenomenological modalities for studying discrete psychological events, such as an individual's experience of being criminally victimized (Wertz, 1985) to offer a well-known example, I found that Giorgi's (1985) approach strictly applied would not easily lend itself to a more systemically or relationally inclined project such as this. To address this important issue, I found that Maso (1983) offers a Husserlian conception designed to explore sociological phenomena, an approach I used to help modify my application of Giorgi's process. Generally speaking, Maso's method

is based upon the works of Herbert Spiegelberg (1971), from whom Giorgi (2000) also drew

inspiration in the development of his method. But, unlike Giorgi's (1985) approach, which

locates the phenomenon within the realm of the individual psyche, Maso's (1983) adaptation

of Spiegelberg's version of the phenomenological method encourages the researcher to

focus upon a network of domains and seeks to identify essences through *clusters* or *nodes* of

meaning that arise out of relationships within the collective (p. 86).

I will return my attention to matters of procedure later, including how I merge the

spirit of Giorgi's (1985) method with Maso's (1983), among other influences (Moustakas,

1994; van Kaam, 1966). For now, let the previous philosophical and theoretical sketch stand

as a basis for considering the addition of existential thinking to a phenomenological

approach (Todres & Wheeler, 2001), in this case via the use of auto-photographic

ethnography (Ziller, 1990).

Humanizing the Data in the Nature of Existence: Auto-photographic Ethnography

Existential Philosophical Grounding

In one interpretation of Heidegger's existential philosophy, disclosure of *Dasein*, or

Being-in-the-World, is primarily mood-like rather than theoretical (Vycinas, 1961, p. 43, in

Todres, 2007, p. 11). According to Todres, Heidegger (1926/1962) used the term

befindlichkeit to capture this idea:

> that quality of pre-reflective understanding that interprets the mood-like disclosure
> of things. *Befindlichkeit* as a form of understanding is thus always involved when we
> understand another's experience or when we read the text of a human situation—we
> relate ourselves to its mood—and can thus understand with our hearts. (Todres, p.
> 11)

In a related vein of thought, May and Yalom (2005, p. 272) state that understanding

Dasein requires the comprehension of the phenomenal world in which the person exists and

participates, a world that one cannot describe using words alone. They go on to define the

human world as "the structure of meaningful relationships in which the person exists and in the design of which he or she participates." Similarly, Todres and Wheeler (2001) write that one cannot "define man or woman in him or herself as separate from the way he or she occurs in and as world relationships. Human existence *is* world-relatedness: they co-constitute each other and cannot be defined except relationally" (p. 5).

The Swiss existential psychiatrist Ludwig Binswanger (1963, p. 296) broke down this co-constituted world into three realms which helped to guide my collection and organization of the data in this project: (a) *Umwelt*, or environment; (b) *Mitwelt*, or the world of one's fellow human beings; and (c) *Eigenwelt*, or the personal world.

These philosophical tenets in particular inspired my selection of auto-photographic ethnography (Ziller, 1990) as a vehicle for "humanizing" (Todres & Wheeler, 2001) phenomenological data in an existential sense. I hoped to not only capture how my participants saw themselves and each other in relation to their world, I also intended to create a window into the mood-like quality of their existence that I too could enter empathically and reflect upon in an embodied way.

From Philosophy to Method

Auto-photographic ethnography is uniquely suited to illuminate the aforementioned three realms of the participant's lifeworld. According to Ziller (1990, p. 22), the method possesses a unique power to conduct

> a discourse between the photographer, the subject of the photograph, and the viewer. The photographer is compelled to attend selectively to elements of the potential field of interest. Everything cannot be observed at once, so the observer orients to given subjects for a complex set of reasons, often unknown and unstated.

Regarding its practical utility as a tool in social science, Ziller (1990, p. 14) refers to Weick's (1985, p. 568) definition of systematic observation as "sustained, explicit, methodical, observing and paraphrasing of social situations in relation to their naturally

occurring contexts." It is Ziller's contention that "visual social science" in the form of still

photography is an obvious way to record observations, "in close, and from an actor's point

of view" (pp. 14-15). Regarding its utility alongside phenomenology, Ziller and Smith (1977)

make the case that photography may extend the phenomenological method, citing certain

advantages to photography over verbal self-reports:

> The most significant, perhaps is that the camera documents the subject's perceptual
> orientation with a minimum of training and without the disadvantages of the usual
> verbal report techniques. Thus, the "training" doesn't obtrude between the subject
> and his report of the phenomenon. Another advantage is that the subject selects the
> stimulus material rather than the experimenter. The view is that of the experiencer
> with a minimum intrusion by the experimenter or social expectations and coding
> systems. (p. 173)

Ziller (1990) also addresses the cross-cultural utility of the method, which had

particular import to this project, stating that "photography [as] a form of iconic

communication, is a universal language which may be the preferred representational system

to examine value orientations and self theory interculturally" (p. 11). Ziller and Smith (1977)

continue this line of thought by suggesting the method's applicability to improving our

understanding of other persons who may have "difficulty communicating their special

orientation. These include children . . ." (p. 178). Further, the same researchers suggest the

method's efficacy as an approach to understanding "sex differences and similar sociological

variables such as age and race" (p. 182), all of which applied to this research as well.

Ziller and his colleagues conducted many other studies supporting the method's

utility for my purposes, including explorations of the self-concept of an impoverished child

(Ziller, Vera, & Camacho de Santoyo, 1981), the relationship of self, social, and

environmental precepts (Ziller & Lewis, 1981), and the self-perception of children with

asthma and asthma/enuresis (Panides & Ziller, 1981). I also hoped that the method might

enhance rapport between my participants and me, particularly with the children involved in

the study. To that line of thinking, Ziller (1990) states that in contrast to more traditional

"paper and pencil" activities to which subjects often respond with indifference or disdain,

> auto-photography capitalizes on the inherent interest in photographic
> communication. Not infrequently, the subjects request copies of the sets of photos,
> or request to keep the camera for an additional day or more in order to take a
> particularly important photograph. Subject cooperation is high, and there is a general
> atmosphere of sincerity, perhaps because a photograph is not perceived as a throw
> away response, but as a response made in the full view of the self which has the
> permanence of sculpture. . . . Through photography we instantly become artists. (pp.
> 36-37)

As I discuss in Chapter 4 of this work, the experiences I enjoyed with my

participants during the auto-photographic phase of data collection were consistent with

Ziller's aforementioned ideals in virtually every regard. For now, I will focus on completing

Todres and Wheeler's (2001) methodological triad—that of a hermeneutic turn in the form

of embodied inquiry (Finlay, 2002, 2003, 2005; Moustakas, 1995; Todres, 2007).

Of Positionality and Presence: Embodied Inquiry

Hermeneutic Philosophical Grounding

According to Palmer (1969), an interpreter of Wilhelm Dilthey, hermeneutics was the

methodological foundation for what Dilthey called *Geisteswissenschaften,* or a science of

understanding man's art, actions, and writings as historically situated objects. For Dilthey, such

understanding, or *Verstehen,* was best understood in terms of an opening to the world of the

other, and in so doing, to possibilities within oneself. He considered it a "transposition and

re-experiencing of the world as another person meets it in lived experience" (p. 115).

Palmer (1969) noted that *Verstehen* was always rooted in a fundamental knowledge of

what it means to be a human being who experiences life

> in complex, individual moments of "meaning," of direct experience of life as a
> totality and in loving grasp of the particular. These units of meaning require the
> context of the past and the horizon of future expectations; they are intrinsically
> temporal and finite, and they are to be understood in terms of these dimensions. (p.
> 101)

Thus, according to Palmer, Dilthey viewed lived experience as not static, but rather, existing in a dynamic structural unity of meaning which tends to include both past and future in its interpretations of the present (pp. 109-110). Todres (2007) describes the process of moving toward *Verstehen* in terms of a "shuttlecock movement" (p. 10) of the mind that is meant to clarify how understanding unfolds out of disclosing more of what we already understand and experience—in the interaction between the whole and the parts of one's life (Palmer, p. 118).

Furthermore, Palmer (1969) reminds us that since we understand others always from within our own horizon of experience, there can be no position-less understanding of anything. As a father, a man, a member of the dominant culture, a clinician, and a researcher, I was ever mindful of my attempt to explore my participants' meaning-making activities within the context of family, cultural, and community systems while, as Finlay (2003) notes, I was "simultaneously grappling with my own." She describes this in terms of intersubjectivity: "I am both subject and object. I am somehow reflected in my co-participants while they (or perhaps my understanding of them) are part of me" (p. 106). This, Finlay states, is a social constructionist point of view, namely, that the qualitative research project is a co-constituted account and must be recognized as such. Such thinking also accurately captures the character of the tension I experienced in selecting phenomenology as a stand-alone method.

From Philosophy to Method

Finlay (2005) describes a hermeneutic method she calls reflexive embodied empathy. Reflexivity is defined as "thoughtful, conscious self-awareness" (Finlay, 2002, p. 532) and "a process of continually reflecting upon our interpretations of both our experience and the phenomenon being studied so as to move beyond the partiality of our previous understandings and our investment in particular research outcomes" (Finlay, 2005, p. 108).

Thus, while engaged in phenomenological research, I attended to and noted my embodied experience in an endeavor to bracket it for the purpose of the phenomenological reduction, as well as to better understand my coparticipants through empathic connection (Finlay, 2003).

Finlay (2005) organizes such empathic connectivity in three layers. The first she refers to in terms of "connecting of," or the way in which human beings can tune into another's body through their own embodied reactions. The second, she refers to in terms of "acting into," which focuses on empathy as "self-transposal" in a process of "doubling and mirroring." Lastly, she refers to a third layer in terms of "merging with" involving a "reciprocal insertion and intertwining" of subjects in the researcher and vice versa (pp. 279-285).

While Finlay's method was intriguing, I sensed that it lacked something. Moustakas (1995) provided what I longed for, namely a way to satisfy this project's *poetic activist* (Gergen, 2001) bent. He conceives of three ways of recognizing and affirming the nature of being in relationship, whether occupying the role of therapist or researcher. Moustakas talks first about a state of *Being-in*, which, consistent with Finlay's (2005) aforementioned thinking, transports the researcher "to the world of the other" (Moustakas, p. 81). But, unlike Finlay, he does not stop there. Rather, he calls for a subsequent step called *Being-for* (p. 83) the other. In this way of being in relationship with my participants, I *take a position* while in their world that I hope will be experienced as a certain form of advocacy and solidarity as they share their lived experience—whether that means joining in allegiance as we face suffering shoulder to shoulder, heart to heart, or celebrating joy and cultivating hope together. Lastly, Moustakas calls me to find a way of *Being-with* my participants that is also compatible with Finlay's thinking, in which

what another person communicates enters into my own awareness and perception and through a process of indwelling leads me to form my own understandings, beliefs, and judgments . . .[in a] joint enterprise—two people fully involved, struggling, searching, exploring, sharing. (p. 84)

A Methodological Synthesis and Its Limitations

Step 1: Epoché

The first step in my synthetic approach involved a key phenomenological principle, namely, engaging in the process of epoché, which Louchakova (2005) describes in terms of the foundational shift of attention to "witnessing consciousness," or a mental move of "backing up" in order to view the "interior foundational contents of meaning," through reorienting "the vector of attention in the direction of pure subjectivity" (p. 95). This required me to endeavor to be ever mindful of all beliefs, biases, and prior understandings, and to bracket them, so that every subtle shift in meaning I detected might lead me to the discovery of something fresh and new.

Step 2: Apprehending a Sense of the Whole and Gaining Textural Understanding

Having engaged in epoché, the next step was to conduct the phenomenological reduction of combined narrative and photographic data from multiple members of two different families. Following the lead of Giorgi and Giorgi (2003), I began with considering the multimedia "descriptions" of the lifeworld as whole entities. In this case, that equated to more than 3 months of immersion in the data as I engaged in a mindful search for an overall knowing-through-presence (Louchakova, 2005) of the lived experience which Giorgi and Giorgi identify, but in a more comprehensive way.

While I considered whole transcripts as in Giorgi's (1985) method, I also listened to taped interviews, meditated upon the photographic data rendered by my participants, and engaged in hermeneutic reflection as previously described in citing the work of Todres (2007) and Moustakas (1995). Specifically, I employed the shuttle-cock movement of mind

between that which was ever emerging and what had already emerged and/or been

bracketed in the process of epoché, as well as tracking my embodied sense of Being-in,

Being-for, and Being-with my participants as I collected and analyzed my data. This resulted

in the construction of thickly descriptive (Geertz, 1973) accounts of these contrasting

lifeworlds.

Step 3: Horizonalization and Clustering of Horizons Around Nodes of Meaning

Out of what I initially experienced as an overwhelming sense of chaos in a mass of

transcribed data and photographs, I eventually noted an emergent bodily felt sense of a

palpable coalescing of *Verstehen* (Palmer, 1969). Todres (2007) explains this experience citing

Merleau-Ponty (1945/2005): "Structures are lived rather than known and therefore can

never be apprehended passively; but only by living them, assuming them and discovering

their immanent significance" (p. 258).

I used this palpable felt sense of the lived structures of experience in my body as a

signaling mechanism that would enable me to identify the units of meaning (Giorgi, 1985)

from within the narrative descriptions of the lived experience of ADHD, or perhaps more

accurately in this case, the *horizons* (Moustakas, 1994) that revealed different aspects of the

phenomenon from different points of view. Employing Moustakas' take on van Kaam's

(1966) method, I interrogated each horizon for its essential relevance according to the

following criteria: (a) Does it contain a moment of the experience that is a necessary and

sufficient constituent for understanding it? (b) Is it possible to abstract and label it

(Moustakas, p. 121)?

Step 4: Apprehending Shared Essential Structures

According to Moustakas (1994), the horizons that meet these criteria are the *invariant constituents* of the experience, and the aforementioned labels, the core aspects of it. I found that from within these core aspects, nodes of shared meaning also began to emerge (Maso, 1983). Through a process of reflection and imaginative variation (Giorgi, 1985) in working with these invariant constituents and nodes of shared meaning, I was able to arrive at what I determined to be a set of shared essential structures of the lived experience of ADHD within these profoundly different milieus.

Step 5: Textural-Structural Description

Having transformed naïve descriptions from the everyday language of my participants into a language that expresses essential psychological insights, I lastly sought to re-integrate the richness of the original data by constructing a textural-structural portrait of the phenomenon (Moustakas, 1994). This final step included weaving verbatim examples from transcribed interviews, as well as my embodied hermeneutic reflections regarding encounters with participants as previously described—including their photographs—into the five essential structures explicated through the phenomenological method. Thus, the resultant integration illuminated shared essential meanings as well as context-driven differences in how the phenomenon is lived.

Limitations of the Methodological Synthesis

Limitations Inherent in the Phenomenological Method

From a practical standpoint, Kendall, Hatton, Beckett, and Leo (2003) cite multiple peer-reviewed sources supporting both the validity and reliability of conducting interviews as a data collection method with children. They also provide helpful guidelines for questioning children about ADHD, upon which this research based its protocol (see Appendix A).

Kendall et al. also note "interviewing children whose primary difficulties involve problems with focusing, concentrating, and paying attention posed significant challenges" (p. 124), an observation that also proved true in my experience, which will be addressed in detail during Chapter 4.

From a social constructionist point of view, the language of experience examined by phenomenology is itself to be placed in question. According to Gergen (1985, p. 272), the descriptions of experience are "linguistic constructions guided and shaped by historically contingent conventions and discourse." However, Gergen also states that social construction offers no alternative capable of rising above its own critique. Thus, he places the emphasis upon "escap[ing] the confines of the taken for granted" in an effort to "emancipate one from the demands of convention" (p. 272), which, in my opinion, this synthesis of methods effectively accomplishes.

Though the following do not apply to me directly, other limitations include a prospective researcher's ability, or lack thereof, to enter into the world of the other in a way that is consistent with the tenets of the phenomenological method, as I have described previously. Additionally, phenomenology requires specialized training in order to use it properly, along with a keen ability to subtly reflect upon self and other that allows for accurate bracketing of that which is appropriate to bracket, while allowing what is salient to come through in the act of transforming the language of the natural attitude to that of prereflective consciousness.

Limitations Inherent in Auto-Photographic Ethnography

Ziller (1990, pp. 22-23) lists some of the limitations to the method of photo-observation as a general practice in the social sciences, and how his take on the practice addresses some of these limitations. First, Ziller cites Gillespie-Waltemade (1984), stating

that photography as a method of observation may meet with criticism due to the possible involvement of: (a) the photographer's consciousness (which I embrace wholeheartedly as a particular strength of the method in this particular project); (b) use of equipment; (c) darkroom procedures (which is no longer an issue with digital photography); (d) editorial processes; and (e) juxtaposition of photographs. He goes on to state that the "overarching principle of observation which counteracts the shortcomings and dilemmas of observation techniques is explicitness" (p. 24). According to Ziller, explicitness brings into the light understandings of the target of observation, the observer, as well as the nature of the relationship between the observer and the observed, including all efforts to minimize that relationship. In the case of auto-photography, self-observations are made explicit when the target responds to a task to depict the responses to queries or open-ended scenarios—such as "Who are you?" or "Me and my world"—through the nonverbal technique of photographic imagery, about which he writes:

> Under these circumstances, too, the nature of the relationship between the subject and the scientist must be made explicit. How the photographs are to be used or conjecture by the subject as to how the photographs are to be used by the scientist becomes a variable relating to the results. (pp. 24-25)

Limitations Inherent in Embodied Methods

Finlay (2002) acknowledges the concern for reflexive researchers that they must manage the imbalance of power between researcher and participant. Secondly, carrying out reflexive analysis is difficult as our experience is "invariably complex, ambiguous, ambivalent" (p. 541). Additionally, being intentionally concerned with one's emotions and embodied experiences while doing research may skew findings in undesirable ways. Further, the aforementioned power differential may unduly privilege the researcher's voice over that of the participants. Thus I found that a careful balance must be struck between the state of thoughtful self-awareness and detached observation—which requires great skill from an

admittedly novice qualitative researcher. Lastly, in including reflexive data, the project runs

the risk of being characterized as unscientific, self-indulgent, or even narcissistic. In answer

to these potential indictments, Finlay (2002) cautions the researcher to be vigilant in

maintaining a primary focus on the participants, returning to the self only as a part of a

sincere effort to increase insight, a warning I attempted with all my might to effectively heed.

<div align="center">Research Design</div>

<div align="center">*Participants*</div>

I selected 2 participant families, 1 each from local neighborhoods characterized by

wealth and poverty, respectively, to assist in constructing this existential-phenomenological-

hermeneutic investigation. As I explain in Chapter 4, these two communities, though

geographically proximal, are socioeconomic and cultural worlds apart, and thus presented a

compelling opportunity for comparing disparate experiences of ADHD.

Participant Selection and Participation

Participant families were identified through personal contacts and networking with

community health service providers based upon the following criteria:

1. The families must have had at least one adolescent boy, aged 12-16 years,

   diagnosed with ADHD by a physician;

2. The family living in the socioeconomically affluent neighborhood must have

   been of European descent with a household income commensurate with median

   income levels for the area;

3. The family living in the socioeconomically disadvantaged neighborhood must

   have been of African American descent with a household income that would

   place them at or below the current "poverty threshold" as defined by the United

   States Department of Health and Human Services (Federal Register, 2008).

Both families also had to be willing and able to commit to the following process in a timely fashion:

1. Each child participant and at least one parent or primary caregiver had to complete a series of tape-recorded interviews;

2. Children and parents were asked to take one series of at least 12 photographs each (a minimum of two series total from each family), using recyclable digital cameras provided to them, with the intention of expressing their answers to either the question, "Who are you (child participants)?" or "Who is your family (parental participants)?" through representative imagery.

Data Collection

Phase 1: Auto-Photographic Portion of the Project

Kendall et al. (2003) state that the need to build rapport with adolescent research subjects served as a means of overcoming some of the challenges posed by an attentional or behavioral challenges that might be present. Given Ziller's (1990) description of the advantages of his method as previously cited, I hoped to enjoy enhanced rapport by beginning the study with the auto-photographic inquiry.

Auto-Photographic Procedure

Before beginning their participation, each participant signed a consent form that protects their (and their child's) confidentiality (Appendix B), and discloses that only I will see their photographs during the conduct of the project. Any future use of the images they produced, whether for scholarly publication, display at academic conferences or events, or otherwise, is governed by a separate agreement (Appendix C).

I then gave each participant the instructions listed in Appendix A. After completing their photos, participant parents arranged for their family's cameras to be picked up for

processing. After processing the images, I conducted interviews with each participant in

order that they might share and discuss the photographs, placing them in a numerical

sequence as required by Ziller's (1990) research protocol.

Phase 2: Narrative Portions of the Project

Interviews

Following completion of the photographic portion of the research, participants

participated in a semistructured interviewing process (Kendall et al., 2003) protocol

(Appendix A). I conducted the interviews at locations chosen by the participants. For

children, this required parental coordination and permission. Interviews were then

transcribed (transcriptionist's confidentiality agreement is located in Appendix D), and all

narrative and photographic data were analyzed using the synthetic approach previously

discussed in detail, in order to arrive at textural-structural descriptions of the lived

experience of having the diagnosis of ADHD in differing racial and socioeconomic contexts.

Delimitations and Limitations of the Study

Delimitations of this study include first the choice of only one community of color

for participation. The San Francisco Bay Area offers an array of cultural, ethnic, and racial

diversity that reaches far beyond the scope of this project. A further delimitation is the

exclusion of girls from the study, as well as the common co-occurrence of ADHD with

other psychological issues. All of these delimitations represent opportunities to extend the

use of this methodology in further studies with a larger cultural scope.

Limitations include my own cultural competence in the African American

community and in working with adolescents. Though I completed over 18 months of clinical

work in a residential treatment setting with adolescents from varying backgrounds who were

all experiencing a variety of emotional, psychological, and learning challenges, I risked not

being able to effectively connect with any of the adolescents, or with the families in the study. I must also cite as a limitation the lack of experience I have with the methods, particularly in this synthetic combination. This new method is admittedly a work-in-progress that I will continue to develop throughout my career. Though I have used auto-photography in my clinical training as an intervention with one of my clients, I am still a novice. Similarly, I have only limited experience in using phenomenological methods, and as such, relied heavily on the ongoing mentorship of my dissertation chair in this endeavor. Lastly, the small sample size limits the general applicability of this research.

CHAPTER 4: RESULTS

This chapter is organized into three parts. Part 1, *Texture,* begins with a comparative demographic examination of the two communities in question. Against that objective backdrop, I offer background sketches of each family, and then construct thickly descriptive narratives, which consist of illustrative quotes from participants and first-person, embodied hermeneutic data obtained through my encounters with them in the field, as well as through my subsequent emersion into over 100 photographs, nearly 11 and a half hours of audio taped interviews, and over 225 pages of typed transcripts. These narratives are organized into the three existential domains described in Chapter 3: *Umwelt* (World-around), *Mitwelt* (With-world), and *Eigenwelt* (Own-world).

Part 2, *Structure,* examines the essential nature of the lived experience of ADHD. Specifically, I elucidate the findings which coalesced, through the means of phenomenological reduction described previously, into shared essential structures of the lived experience of ADHD.

Lastly, in Part 3, *Integration,* I return formerly bracketed texture to essence, rendering an integral, textural-structural description of the phenomenon of ADHD. This integration illuminates shared essential meanings as well as context-driven differences in how the phenomenon is lived.

Part 1: Texture

Demographics: Neighboring Communities, Worlds Apart

Table 2 compares demographic data for the two communities studied in this project.

Table 2

Demographic Comparison of Participant Communities (U.S. Census Bureau, 2000)

Category	East Palo Alto	Atherton	United States Population
Total Population	29,506	7,194	
White	7,962 (27%)	6,141 (85%)	75.1%
Latino	17,346 (58.8%)	200 (2.8%)	12.5%
Afr. American	6,796 (23%)	50 (0.7%)	12.3%
Asian	657 (2.2%)	704 (9.8%)	3.6%
Pacific Islander	2,252 (7.6%)	30 (0.4%)	0.1%
Education			
High School	48.2%	96.7%	80.4%
College Degree	10.6%	76.2%	24.4%
Economic Data			
Median Income	$45,006	$200,000+	$41,994
Families in Poverty	714 (13.5%)	16 (0.8%)	9.2%
Median Home Value	$302,100	$1,000,000+	$119,600
Homeownership	43.5%	96.3%	66.2%

Note. In combination with one or more races listed, numbers may add to more than the total population and percentages may add to more than 100 because individuals may report more than one race.

As the reader can plainly see, these two California communities, East Palo Alto and Atherton, are racial and socioeconomic worlds apart, even though less than three miles separate the homes of my participant families. What the reader cannot easily glean from the table are cost of living adjustments that will put the economic data in better perspective.

First, it is important to consider the median household income statistics for East Palo Alto. While the median household income for the African American family's community exceeds the national average, this is a potentially deceptive metric, because the purchasing power of those dollars in Silicon Valley is significantly lower than in other parts of the nation. By blending U.S. Labor Department wage data with cost-of-living indices created by the Council for Community and Economic Research, economists from the U.S. Labor Department's Bureau of Labor Statistics estimate that, while the Silicon Valley has the highest average annual wages in the nation, the purchasing power of every income dollar may be discounted by nearly 25% given the excessive costs of housing and food (Abate, 2005). If one applies that adjustment to the average household income in East Palo Alto, it falls to around $33,754, nearly 20% below the national average. This helps to explain why East Palo Alto experiences a poverty rate that is 47% higher than the nationwide figure in spite of its apparently higher-than-average household income.

Second, Table 2 does not accurately reflect the actual value of residential real estate in the Caucasian family's community of Atherton, given that the U.S. Census Bureau does not capture property values in excess of one million dollars. An online search of active real estate listings for the zip code in question, which Forbes.com identified in 2005 as the most affluent in America (Clemence, 2005), found 22 homes for sale ranging in price from $23.5 million to $2 million (Trulia.com, 2009).

In addition to matters of economics, there is another important difference between these neighboring communities, which shows up in Table 3, illustrating crime rates in the African American family's community of East Palo Alto as compared to the Caucasian family's community of Atherton and the State of California as a whole, respectively. As Table 3 shows, East Palo Alto experienced a violent crime rate that was 333% higher than

that of Atherton, including 15 homicides, 21 forcible rapes, and 285 aggravated assaults.

Compare those specific crime figures to the Caucasian family's community, which endured

no homicides, two forcible rapes, and 12 aggravated assaults within the same period of time.

Table 3

Estimated Crime Rate Percentage Comparison Between East Palo Alto and Atherton (A) and Between

East Palo Alto and the California Statewide Average (B)

				Crime Rate Comparison	
Crime Type	E. Palo Alto	Atherton	Statewide	(A)	(B)
Property	2.3%	1.3%	2%	+77%	+15%
Violent	1.3%	0.3%	.5%	+333%	+160%

Note. Estimated crime rates were computed using the following sources and methods: The number of property and violent crimes in both communities was obtained using the Criminal Justice Statistics Center Database (Criminal Justice Statistics Center, 2005). These figures were then divided by population data for 2005, which was extrapolated using Census Bureau estimates for 2007 and 2000 Census Data (U.S. Census Bureau, 2009).

As expected, these economic factors, as well as the relative safety or lack thereof in

their communities, played important roles in the construction of the following family

narratives. I will begin by introducing the "Nortons," an African American family living

below the poverty line in America's high technology capital, Silicon Valley, California.

Meet the "Norton Family"

Descriptive Background Sketch

The African American family who helped me to co-create this study will be known

by pseudonyms in order to protect their privacy. I met the "Norton" family after a 2-month

long networking process within the community healthcare delivery system in East Palo Alto,

aided in particular by the generous efforts of a young African American woman who was in

charge of community outreach efforts for families with children having special needs. My interviews with the family took 4 hours, 31 minutes over a period of 3 days and yielded 94 pages of typewritten transcripts. In addition, the family rendered 55 digital photographs.

The Norton family is headed by its matriarch, "Millie." She provides a home for her long-term boyfriend, as well as her grown daughter, "Helen," who is also a participant in this research, and Helen's four children, who range in age from 10 to 16 years. In addition to Helen's offspring, Millie also cares for three foster children, one of who is a developmentally disabled young adult.

Millie, who is not employed outside the home, completed a high school education and a year of college courses, but remarked that in order to provide for her family, she at one time turned to selling drugs—a crime that led to her eventual incarceration and the loss of everything she owned. She said that she has not sold or used illegal drugs since her release from prison nearly 16 years ago. Her daughter, Helen, whose longest continuous employment experience lasted 3 months, attended high school through the 11th grade and did not earn a diploma. Given their level of education and what appears to be chronic underemployment, the family's household income falls well below current Federal Poverty Guidelines (*Federal Register*, 2008), and as such, qualifies them for multiple government assistance programs including Supplemental Security Income (SSI), food stamps and MediCal (Medicaid).

The family unit as it is currently configured (10 people) has been living together for 8 months in the same small three-bedroom, one-bathroom house that Millie's mother rented for 25 years until her death in 2002. Millie has been living in the house since her mother's death, and expressed pride in being able to provide an important source of continuity and

stability for the members of her large extended family, many of who live in the surrounding neighborhood.

Helen said she is currently separated and seeking a divorce from her second husband after 2 years of heroin-fueled domestic violence. During our interviews, she described a succession of failed relationships with men that began when she had her eldest daughter, "Andrea," now 16 years of age, while she was a student in the eighth grade. After Andrea was born, Helen commenced a relationship with "Big Devon," who fathered "Shelton," now a 14-year-old boy, and "Devon," his 12-year-old brother. She described Big Devon as an illiterate but streetwise drug dealer who was mentally and physically abusive toward her, but who never directly abused the children. Helen said she left him when he was incarcerated. She told me that Big Devon was shot in the back of the head 4 years ago, an event that she says strongly impacted Shelton in particular, as he had a relationship with his father that the other children did not share. Her youngest child, "Tamika," now 10 years old, was born into what Helen described as an emotionally, but not physically abusive marriage lasting approximately 5 years, and which ended in divorce.

All of the children currently attend public schools in East Palo Alto. The two boys who participated in this study have both been involved in special education classes and have had Individual Education Plans (IEPs) that include official designations for both Emotional Disturbance (ED) and Learning Disability (LD). Currently, Shelton is earning good enough grades to stay out of special education classes, but he still has an IEP to address his defiant, and at times explosive behavior. He receives anger management counseling at school. The two girls are apparently doing well in school, although the eldest reportedly experiences harsh disciplinary treatment through guilt-by-association with her brothers.

Regarding the physical and mental health of the family, all of the adults are regular smokers and do so inside the home. Millie, who appears to be over her healthy body weight, reported having diabetes and high blood pressure. Helen, who also appears to be over her healthy body weight, reported that she is in good physical health. She stated that all four of her pregnancies were normal and ended in the delivery of healthy, full-term babies. During the course of the interview, she remarked that though her relationships with the fathers of all of her children were frequently marred by neglect, violence, and drug abuse, the men never harmed her while she was carrying her babies, nor did she use illegal drugs while pregnant. However she said that she "may have" used alcohol while pregnant, though she did not elaborate upon the frequency or amount of her consumption. Helen further volunteered a history of mental health problems that have gone largely untreated, including what she named as a combination of "ADHD, bipolar, and insomnia," which at times leads to her inability to leave her bedroom, and forces her to confine her children to her bedside so she might keep watch over them.

While both of her daughters seem to have developed normally and pose no current challenges to the family either at home or at school, Helen described significant and ongoing developmental and behavioral issues regarding both of her boys. Shelton apparently did not begin to talk until the age of 4, but had set his first fire by the time he was 2, and continues to occasionally burn and cut his skin, as well as engage in petty thievery and property destruction. He has been incarcerated once. His younger brother, Devon, began using language coherently at age 9 and used to hurt himself by repeatedly bumping his head on the ground and on walls when he was very young. Though he no longer harms himself or steals, he has recently begun inappropriately touching grown women in the neighborhood, but he has yet to be charged with a crime.

At the behest of a family friend, and to protect herself against charges of child abuse given their propensity for self-harm, Helen said she had both boys psychologically evaluated through the Social Security Administration when they were 4 years of age. She was also able to establish eligibility to receive the monthly disability payments she continues to collect for both boys. Doctors diagnosed both with ADHD and have prescribed medication for them in the past, including stimulants (Concerta) and antidepressants (Wellbutrin). However, Helen stated that she discontinued using the drugs when they made her sons act "like zombies," and they experienced headaches and nosebleeds. She expressed concern after finding out that Wellbutrin is an adult medication that has not been properly studied for use in children. She also lamented that when the boys were under the care of a physician for their mental health, he would spend less than 10 minutes with the family, an amount of time which seemed to the mother to be long enough to write a prescription, but did not leave room for additional therapy. While Helen was apparently currently in the process of seeking the help of a new psychiatrist for her mental health needs, neither of her boys is currently under the care of a mental health professional. Aside from these myriad challenges, both boys appeared to be in good physical condition.

Researcher's Impressions of the Umwelt or World-around

The first observation that emerged as I considered my experience of the *Umwelt* in East Palo Alto was the starkness of the landscape and a deeply rooted feeling of unease I had every time I ventured into the neighborhood. Even though I worked in the community for more than 2 years as a staff member in a nearby adult residential drug rehabilitation center, I could not seem to shake the ever present sense of unrest as I worked with the family in person, and later, with the data they produced. It felt like fear, but it lacked the requisite specificity for such a label. It was also continuous rather than delimited to a person

or group or situation, which led to the formation of a sort of low-grade hyper-vigilance that

eventually faded from the foreground to become more or less taken-for-granted, like a sort

of disconcerting background noise to my lived experience. The grandmother, Millie,

validated my felt sense in one of our interviews as she described feeling better about her twin

boys both being incarcerated in a California State Penitentiary rather than living in her

neighborhood:

> Your life can end just like that—just by drivin' down the street. A bullet can just
> come from nowhere. It don't have to be meant for you. Just because they do so
> much shooting around here, it can happen. But at least in my heart I know I haven't
> did nobody no wrong. I'm not doin' anything wrong out here in the streets for
> somebody to hurt me. 'Cause with my boys, I feel comfortable that they're locked
> up. I know where they're at. So, I can rest and I can sleep, 'cause I know where my
> sons are. Even though they can get hurt in the prisons, ten times out of one they're
> not. They're gonna be okay. And when they're here in the streets, I'm worried, *Where
> are you*? When I hear a siren or I hear polices or I hear somebody that got shot, first
> thing I do is I'm worryin'.

Even as I gazed at their photos in the safety of a library miles away while I wrote this

chapter, I recalled the bodily manifestations of my aforementioned hyper-vigilance: tightness

in the throat, chest and belly, low-level nausea, blood rushing to my extremities, legs and

hands tingling in anticipation of the need to fight, flee, or freeze. I made sense of these

embodied feelings through my knowledge of neuroscience, the aforementioned crime

statistics, and my intentional emersion into the landscape of East Palo Alto, as well as my

engagement in deeply connecting *into*, as well as feeling *for* and *with* my participants

(Moustakas, 1995) as a convention of my research methodology. I became acutely aware that

I am terribly alien in *their* world, and it did not feel pleasant, particularly as I projected myself

deeply into what I imagined might be their experiences of otherness in *my* world—the world

of a dominant, patriarchal culture of Whiteness, and privilege. Again, Millie provided

validation of my sense of not belonging, warning me to beware during the project, lest I

become the target of police officers looking to make a drug bust. After all, she asked rhetorically, what other reason would a White man have to be driving these streets?

I also gained awareness that it was more than a fear of random violence or the possibility of police harassment that fueled my unease. As I wrote, I felt overwhelmed by compassion, which seemed to arise out of a sense of deep sadness and hopelessness that pervades their lifeworld. This compassion interrupted my sleep for the weeks that I spent with the Nortons, both in body as I interviewed them, and in spirit as I wrote about their lives.

The mood-like quality of the images and descriptions they produced was also encapsulated for me in the bitter irony I recall noting as I drove the neighborhood's streets and found them all named for some of our nation's largest institutions of higher learning. I sensed the despair in the African American and Tongan and Latino boys who stood in loose gaggles on their respective corners, likely unaware of the hope those lofty street names were meant to engender in their hearts and minds, the gift of some distant, well-meaning urban planner in a crisp cotton shirt and silk tie.

Further, the despair of the place emerged like a cold, gray quilt, out of the collage of black and white images the family provided to me. This metaphorical quilt enveloped me in the cruelty of their circumstances. As I gazed into the images with soft eyes and open heart—imbued with the spirit of the Epoché—I connected into the blankness, sadness, anger, and contempt that characterized their facial expressions (Ekman & Matsumoto, 2007) in photograph after photograph. None of them captured a single moment of joy or ease, with the exception of some images of the collection of framed, posed family portraits that covered nearly every inch of wall space in their crowded living room.

I felt the darkness of the mood of their world emanating from the eerie images both of the boys captured of a long-burned-out shell of a small home on their street, one that closely resembles their own, and where both boys described playing games with friends or cutting through without a second thought on their way to the playground. I also found despair in the harsh line of barbed wire that separated their home from the bleakness of the South San Francisco Bay tidal marshes, with only the silhouette of high-tension power line towers revealing themselves in the distant receding fog. I sensed it further through the cold, black iron bars on windows and doors surely meant to protect them all from the dangers lurking on the streets outside, but nonetheless creating the feeling of a prison from the inside. Most of all, I tasted it in the somber images of what I imagine were tear stained, blood soaked sidewalks where Millie's 14 year-old son and Helen's twin, "Gregory" was gunned down in cold blood, an easy walk from where they now live. The grief hung like mist around the soiled edges of a framed image of that dead child that adorns their wall, his innocent face frozen in time, while the memory of his murder still casts a pall 16 years later.

Imagining this world through the eyes of the two boys, the tiny home seemed particularly confining, while the outdoors offered plenty of intrigue and adventure, in spite of its dangers. Devon and Shelton presented their photographs and related, albeit sparsely, their adventures of riding bicycles and motor scooters on the streets and the "back tracks" in the marshes behind the house, and told tales of baseball field heroics, as well as enthusiastically described mowing lawns and the expectant pleasures in growing their own food in a small backyard vegetable garden. In stark contrast, all either boy mentioned about school seemed confined to what they experienced as constant discipline, punishment, and a never-ending battle with boredom.

The family did not appear to feel supported by the community beyond the presence of their family members. This came up in conversations about law enforcement and the school system. Millie had this to say about the family's sense of safety and their value in the community as human beings as she described why she took a photograph of the former police station a part of this process of describing her family for the research project:

> And this is the police station—used to be the police station—now it's for welfare. This is where they taken my twin sons *and* my deceased son, Gregory, when they'd gotten in trouble for what little things they do do, and this is where I went to talk to them about findin' out who killed Greg. And they keep tellin' me there's nothin' they can do. This is the unsolvable case. To this day. But like I told you once before, if we would have been *White* and with *money*, they would have went all the way out to find out *who killed their child*. And when you're *Black* and *poor*, it's like, that's just another dead child. Now, why would it take 16, 17 years to find out who killed a child. And if you go up there and ask them till today, are you investigatin'? What? They don't even know what you're talking about. Because they're not interested. The system doesn't work. And the police are no help to me, and to none of the Black, poor people. Look at all the Black children here that's been killed and none of the killin's been solved. And I believe that's why a lot of kids go out and kill, too. Because they might have found out who killed their family member. And they just retaliate…they take it in their own hands. 'Cause the police *don't* care.

> Helen had a similarly strong indictment of the school system.

> And the people don't want to deal with me, because then I get to whoopin' and hollerin' because I've asked for help time after time after time after time. Explaining to the schools the type of disabilities that the boys have—But they failin' the kids. 'm doing my part. Everything they break, I replace. My income is not long enough to replace everything that my sons do. Then I get to whoopin' and hollerin' at 'em—the system is failin' my kids. I'm not failin' my kids. I go through it all with them. When they cry, I cry. When they hurt, I hurt. When they happy, I'm even happier, because I see it's a little bit of relief there.

Researcher's Impressions of the Mitwelt or With-world

Out of the myriad difficulties inherent in living in a community like East Palo Alto arose a sort of defiant cohesion that seemed to emerge primarily through the web of relationships that was so important to the women who head the family. This showed up in the warmth and good humor that saturated our rich conversations as they told the stories of their lives. One theme was undeniable through all of my encounters with the family, namely,

the resilience of their relational web, and it came through visually in the striking gallery of portraits that adorned the walls of their tiny living room. Helen elaborated upon the family history and their presence in the home for three decades, as well as what that has meant to her and others in her family.

> I guess the house is—our family been living here for almost close to 30 years, if not more. And this house done had a lot goin' on in it. I mean, generations—at one point in time, I think we had six generations living. And this house is like a safe haven for everybody in my family. It's like a safe haven. I mean, you have problems, everybody come here [because there has always been a grandmother living here]. And now my mom is [the] grandma, and she's taken on all that. At first it was my great grandmother, and then it was my grandmother, and now it's my mama.
>
> A lot of people in the family don't see us as stickin' together. But if you look back on the history of our family, we all stuck together through the good times and the hard times. And when you ride past this house and you look at it, this is just our family house. I mean [*little laugh*] . . . this is just the family house. That's why I took a picture of it.
>
> Yeah. Our family—a lot of people in the family think that it's a lot of feudin' goin' on, but in between all that feudin', there's a lot of love.

The home as a hub for this web of extended family relations enabled a palpable felt sense of history. Both Millie and her daughter made note of the importance of multiple generations connecting in the home they now share and where we conducted our interviews. At one point, there were six generations who would gather there, and the photograph symbolizing that sacred memory anchors the family room portrait gallery.

Millie also spoke fondly of her other children and grandchildren, in particular her twin sons. I found the way she talked about them to be indicative of how she made sense of her grandsons and the phenomenon of ADHD. She also reflected the family's and perhaps the community's attitudes about their young men and criminal conduct in general.

> Those are my twin boys. And they are the ones that's in prison right now for attempted murder. Both of them. Same case. They were together when it happened. They didn't kill anyone, but they did a little shootin'. And so they took a deal and went on to prison. And they will be 28 on August the 9th. The older one, "Donny," he's been incarcerated since he was, like, 11. He kept gettin' into little troubles, little

troubles, little troubles, until they locked him up. And he stayed locked up till he was 17. Then he gotten out and then he still keep gettin' into trouble, and he went back till he was 20. And now he's back in. Both of those children have—*is* ADHD problems. They have behavioral problems. And more so Donnie than "Johnnie." Johnnie just loves Donnie so much . . . he tries to do everything Donnie does. Just like when they were in school . . . John does things to get Don to approve of him, because Don is more of the tougher—the booster—he's the one that I told you said that he don't care about taking a life, 'cause he don't care about *his* life bein' tooken. And so he's more of the stronger one. Which, to me, Johnnie is strong, because he doesn't talk like that. I just wish they would get out of prison and do something with their lives, because even now, you know, word on the streets is, *Oh, we gonna kill your boys when they come home.* You know, I've been hearin' that. At first I didn't believe, but then I stopped down the street and asked a couple of the guys, and they said, *Yes.* Especially Donnie. They are talkin' about killin' him, and I don't know what to do, 'cause basically I don't want to go through that again.

Millie talked about her incarcerated boys in a matter of fact tone. This passage in particular reflected what I experienced as an almost ubiquitous *expectation*, or a sort of *given-ness* of imminent tragedy with regard to the young men in the family and in the community at large. This was juxtaposed with the obviously deep love and concern both women reported feeling for their sons and brothers.

My embodied experience of their complex relationships with one another, their extended family, and their larger community might best be described in terms of a rather disorienting, oscillating combination of warmth, terror, pride, frustration, ambivalence, and ultimately, rage. As a reflection of swimming in that mixture of emotions, I found myself short-tempered with others as I conducted this part of my research. I felt almost compelled to cast blame and lash out at the systemic forces that keep existing power structures in place. I also wanted to blame my participants for their continued participation in their own self-destruction. I also judged myself harshly and instead turned the blaming impulse inward, which left me feeling utterly impotent to change anything. In that shift, I found myself frozen into inaction, could not write for weeks, much less look at my data, and I wondered if my experience might reflect how my participants felt. I was aware of feeling hopelessly stuck

between my good intentions to shed light on the difficulties families like the Nortons

endure, and the power of the reality on the ground. What impact could *I* possibly have on

the pervasive and insidious nature of poverty and institutional racism as it seeped into and

infected every possible aspect of community health and wellbeing imaginable? The problems

I encountered felt intractable.

Researcher's Impressions of the Eigenwelt or Own-world

> While I found that I held a deep sense of admiration for her resilience and

generosity, Millie offered a glimpse into how poorly she feels about herself, which likely

defined an important aspect of the mood of the family system as a whole. When asked what

it was like for her to live in East Palo Alto, she said

> Makes me feel sad. It makes me mad. But what can I do? I have no money. I have nothing. I have no voice. What I say don't mean nothin', you know. First thing, they look at me, Well, you was a drug dealer. So, they don't care about what I have to say. They don't look at, *You haven't sold drugs for years.* I look at the system. If I go out here and I get in trouble now, the system don't think about the 16 years that I've done good, that I've hoped, that I've did what I could do the best I can do. They bring up the bad things that have happened.

> Juxtapose this voice of powerlessness with her daughter Helen's words, and her

assessment of the women in the family, including herself, as well as her gratitude toward

Millie in particular.

> My family is—majority is—it's more women than it is men. And one good thing I can say about all the women in this family—that goes for my grandma "Mary," my aunt "Gertrude," my aunt "Emma," my mom, my auntie "Ellen"—all of the women in our family have been through a lot. And I mean they are strong—they're very strong Black women. And us kids done took 'em through a lot, and you had to be strong in order to put up with us. So this family holds a lot of women in it that are strong, 'cause it was more women in here that took care of the family than it was men. And my mom is one of 'em. I look up to her for a lot of things that she did comin' up. Some things I *don't* like. But some things I *do* like, [and they] outweigh the ones that I don't like. Why? Because the first plus she gets is for bringin' me here into the world. And then the second is because she was able to put up with me through all these years, and she's still doin' it, whether she likes it or not. So that says a lot for her. And then my grandma—Mama Mary, she had a strong backbone. Doesn't matter what any of us did, Mama Mary still will be there to take care of us.

I'm proud of being one of the women in the family, because I know that gets passed down to me. Because that knowledge has been installed in me since I was little. Regardless if I like it or not, I still have to be there for my sons, regardless if I like it or not, be there for my daughters. I have to be there for my nieces, my nephews. I might be that lady that everybody depend on.

These two passages reflect the sense of tension that I tapped into within all of the family members' senses of themselves as individuals and as a collective, a tension between the polarity of *buying into* the hopelessness of poverty and marginalization and its opposite— a sort of defiant sense of survivorship and innate worth and connectedness. I experienced the tension in my own bodily awareness as warmth rising in the heart and throat, accompanied by a feeling akin to a righteous sense of indignation. As I entered into the felt sense of warmth with eyes closed, I saw a smoldering fire, fueled with glowing embers in the dark reaches of an ancient cave, waiting for fuel. I interrogated the imagery. Was it a sort of narcissistic grandiosity or martyrdom that glowed in the coals? Or, might it have been the stubborn traces of starving hopes that some latent promise might miraculously ignite? As I sat with the imagery, the flames leapt higher, the coals glowed brighter, with the latter possibility. What seemed to be lacking was the slightest hint of agency, or accompanying movement toward any meaningful action or purpose among the family's membership. There was no fuel readily available to feed that fire, and sadly, none of the adults in the family seemed ready or willing to do much about it.

This theme was similarly, and predictably alive in both boys. Shelton described himself as "smart" and "just like everyone else," but he also defined himself with some authority and rigidity as "lazy." His school experience reflected similar conflict, along with the frequent misunderstanding of his talents and needs. Following is a narrative composite of his school experience.

School give me a education. It's important to get a education so I could play football. I like school. Like [my teacher] was trying to explain to me one time that I might get

it. I might get the problem right. I *will* get it. I'm like a quick learner. I do all my work. [But sometimes] I won't have nothin' else to do, so I just walk around and the teacher get mad and I get mad. She send me to the office. And I go to the office with a attitude 'cause I be done and she be checkin' my answers and the answers be correct. Yeah, and she sends me out to the office. And then I call my ma, and my ma just say just step in the office. My school counselor say, like I guess that if there's stuff on your mind, just try not to think about it. Like, she said when I'm irritated, just don't think about it. When I'm mad [I want people to] just leave me alone. They always try to see what's wrong. If I want help I'll ask for it.

The "attitude" he noted was further illuminated by his grandmother as she lamented the fact that Shelton frequently resorts to property destruction when he is angry. At school and at home, this has included putting his fist through windows and punching holes in walls.

Devon did not see himself as particularly intelligent or capable in school. His descriptions of himself in school and otherwise tended to be limited to sparse terms with little or no narrative quality, and seemed to be divided into concrete categories labeled either "bored or boring" or "fun." However, like Shelton, he too experienced school as a place mostly defined by discipline, punishment, and a lack of understanding of his needs. What follows is a transcript of a segment from one of our conversations about school.

[SPH] Tell me a story about last time somethin' didn't go good for you and you had to turn to your mom or your grandma for help.

[DN] Um, in class.

[SPH] In class?

[DN] My school work.

[SPH] Your school work? Tell me about that. What happened?

[DN] I didn't want to do it and the teacher said kept tellin' me to do it. And I didn't know how to do it.

[SPH] You didn't want to do it and the teacher kept tellin' you to do it?

[DN] No, I didn't *know* how to do it.

[SPH] Oh, you didn't know how to do it. The teacher kept tellin' you to do it. So what happened then?

[DN] She tell me, just call my mama and go home.

[SPH] She told you to call your mama and go home? Mm hm.

[DN] She said, 'cause you don't want to work right now.

[SPH] 'Cause you don't want to work right now, so she just sent you home. Mm. What was that like for you?

[DN] I was just mad, 'cause I didn't know how to do it [and] 'cause, my teacher she was keep yelling.

[SPH] 'Cause the teachers kept yelling? Do you think the teacher was trying to help you?

[DN] No, 'cause I didn't know how to do it.

With regard to ADHD, both boys totally rejected the label. Devon stated that he didn't know what it was, while Shelton said that he "didn't think about it." Shelton said that his mother talked about it a lot, but he did not think it was real. As I interviewed both boys and noted how they did not engage with the topic of ADHD at all, I recalled how in the narrative of the family and community it seems to be equated with "bad" behavior. In East Palo Alto, prison or a cemetery plot seemed never to be far behind a label of *badness*.

My embodied experience of both boys as individuals was one that might best be characterized as deflation, powerlessness, and latent rage. I found myself sapped of energy as I listened and wondered how they might feel in their classrooms. I also found myself at times fearful and guarded with them, wondering if they might do something unpredictable or even destructive during the project. For example, I found myself feeling nervous that one of the boys might take inappropriate or even illegal photographs, and that I might be accused of something untoward when I took their cameras to the photo shop to be processed, and felt deeply saddened that I too expected disaster where they were concerned. Inquiring into this realization deepened my awareness of the strength of the systemic projection of shadow

material into African American boys and men. To their credit, both Devon and Shelton were perfect gentlemen and excellent collaborative partners for the duration of their involvement in this project.

Meet the "Watson Family"

Descriptive Background Sketch

Like the Nortons, the Caucasian family who participated in co-creating this research will be known by pseudonyms in order to protect their confidentiality. I met the "Watson" family through a common interest in a particular Tibetan Buddhist teacher 5 years ago and reconnected with them when we all happened to attend the same seminar regarding the intersection of Interpersonal Neurobiology and Buddhist Psychology in San Francisco. Over lunch, I described my research to "Marcy," who eagerly volunteered her family to participate in the study when she realized that their youngest son fit my criteria perfectly.

Interviews with the family totaled 6 hours, 58 minutes and stretched over 4 days. These interviews resulted in 135 pages of typewritten transcripts. In addition, the family rendered 49 digital photographs.

"Keith" has advanced degrees in chemical engineering and business administration, the latter with an emphasis on mathematical modeling, and works for a large, worldwide technology corporation. Marcy also has an advanced degree and is a successful, licensed psychotherapist in private practice who is currently also pursuing certification in a highly specialized, trauma-oriented bodywork modality. Both have worked continuously in their chosen professions for the past 17 years. Their combined household income places them above the U.S. Census Bureau's threshold of $200,000 per year. The Watsons have been living in the home that they currently own in Atherton for the past 12 years.

They have been married to one another for 25 years and have three children, a girl named "Mindy," aged 17 years, a boy named "Gunther," aged 15 years, and Michael, aged 13 years, whom I have already described as a participant in the research. The couple also employs a nanny who has been a part of the family for the duration of their children's lives. According to Marcy, this relationship began as a "survival" necessity given the demands of their professional lives, particularly Keith's travel schedule during the early years of his career.

All three of the Watson children attend some of the San Francisco Bay Area's most exclusive private schools, as they have all their lives. Marcy noted that their two sons were the first students ever to make the transition from a particular private elementary school designed for children with "learning differences" to an exclusive private middle school for talented and gifted students—a trend that for Gunther has continued into his high school years and looks to be continuing for Michael as well. Mindy also attends an exclusive private high school for talented and gifted students. Current tuition for each of these schools runs at approximately $30,000 per year, per child.

In addition to their formal education, Keith and Marcy both hold black belt designations in Tae Kwon Do, as do Mindy and Gunther. Michael elected to stop training just before earning his black belt, and was thought by his instructors to be among the most gifted students they had ever encountered. This decision on his part was a "big deal" according to Keith, as both parents resisted allowing him to give up before he met his, and their, goal.

Regarding the family's health, Marcy reported that all of her pregnancies were normal. She also disclosed a history of depression since Michael was 11 months of age. Marcy began taking medicine for her depression beginning then and has done so

continuously since, and enjoys excellent symptom relief with minimal side effects. She further noted that when Michael was 2 years of age, she experienced thyroid problems, which she said significantly impaired her ability to function as a wife, mother, and psychotherapist. She described much of this time in their lives as "chaotic," and that she found herself doing her best just to "trudge through" an "awful" time. Marcy also takes great pride in decades of sobriety from alcohol abuse, a lifestyle her husband shares. Like Marcy, Keith reports a history of mental suffering that has at times required medication for effective relief, as well as a self-diagnosis of ADHD, but no other health-related issues.

Gunther and Michael were both diagnosed as young children with ADHD and Dyslexia. In addition, both boys experienced severe ear infections as children. Further, Michael suffered from numerous severe food allergies and faced significant motor-skill, auditory, and visual integration deficits that required multiple specialized occupational therapy modalities in order to successfully correct, all of which made his exceptional giftedness in Tae Kwon Do particularly astonishing. Mindy appears to suffer from no developmental, physical, or mental health problems.

In total, all members of the family appeared to enjoy excellent physical health and all seemed to function at a high level in all domains of their daily lives. My assessment included not only school and professional life, but also interpersonal relations with family and friends, and a variety of leisure time pursuits that ranged from endurance sports and teaching and practicing Tae Kwon Do at the black belt level, to practicing Buddhist meditation and Tai Chi, to playing musical instruments, as well as a variety of the latest computer games.

Researcher's Impressions of the Umwelt or World-around

As I reflected upon my encounter with the world that surrounded the Watson family, the first ideas that came to mind were familiarity and comfort, in stark contrast to my

experiences of foreboding and otherness while visiting East Palo Alto. Using more sensate

language, in Atherton, I observed lushness, order, quietude, and beauty.

The families in Atherton typically resided behind tall, green hedges or ivy covered

walls. The streets and sidewalks were embraced by a towering canopy of old, impeccably

maintained trees. Most driveways, including the Watson's, were crossed at the street by

electronically activated gates.

The family's home was located within an old neighborhood surrounded by a brick

wall, and ornate, architectural gateways at either of two entrances. Beyond these gateways,

the homes varied in size and design from modest, single-storied ranch styles with shuttered

windows and cedar shake roofs, like the Watson's home, to opulent multistoried mansions

with tennis courts and swimming pools and immaculate gardens fit for Silicon Valley's

technology industry elite.

My embodied experience of the setting was primarily one of peace and calm. I felt a

palpable relaxation of my belly, even as I gazed into the photograph of the home underneath

its ancient oaken canopy, while my breathing slowed and became deeper. I recalled the

research suggesting the power of green spaces to reduce ADHD symptomatology and

wondered how this beautiful place might have been helpful for Michael and Gunther's

development. As a graduate student, I also found myself needing to bracket a palpable

longing for and envy of such a life of financial security and comfort, which led me in turn to

wonder what my African American participants might have thought as they imagined living

in a place like this. When I asked Millie about it, she had this to say as she envisioned living

on what she called the "White side" of Highway 101:

> I don't think I could live over there, because I think it would be a lot of prejudice.
> They wouldn't want us over there, especially the way our children act. You know, I
> can live anywhere, because I stay in my house. It doesn't bother me. But if I had to

take the children over there, I wouldn't want to take 'em over there, because the police probably be sent to our house way more than it is now.

I was struck by her reply. She could not imagine what it might look or feel like to live in a large home on a safe, tree-lined street. She could only transpose her current existence as it was, with all of its attendant struggle, onto her mental model of this alien social world. Her focus seemed guided by the primacy of crime and punishment in her consciousness, as well as the trouble her grandsons' behavior would likely cause the family if they lived in a nice neighborhood.

As was the case with the Norton family, Keith seemed to value a sense of history around his home. His awareness also encompassed his family's occupancy of the property as well as its previous occupants, but it extended even further back than did the Norton's, to the original owner of the land during the California Gold Rush. Further, I detected in Keith's narrative what I interpreted as a sort of humility and gratitude for being able to own and live in his home, as well as what I recognized as middle-class fiscal values, all of which were familiar to me from my own upbringing. Keith described his home thus:

> So it's a very beautiful lot that we have. During the Gold Rush there was a guy who overheard these miners talking about this huge lode that they found and that they were going to file the claim the next day. Well, he made sure they had too much to drink and in the morning went down there and filed the claim and got, you know, world class rich, right? And so he had this estate—kind of like a summer estate, and he divided it up in the '40s, '50s, and this was the area where they had their picnic grounds. So it's all these oak trees—really a beautiful area, and they put in this ranch home in the early '50s. We're the third family to live here.

> You know, I think it's—I grew up and spent, you know, a lot of my life as an adolescent, young adult, just walking through the woods in Oregon kind of by myself . . . [it's the kind of] solitude that this environment provides. Marcy grew up in New Orleans, which has a lot of oak trees. You know, it's just a place that felt like home. And, you know, like any house in California, you know, you look at the price tag and what you get, and it's a bit of a shock, but you know, the practical side of me just realized that this is just an incredible investment.

> I don't know, maybe it comes from being kind of, you know, poor, but, you know, you kind of look at things a little bit differently. . . We've raised three kids here—we

are raising three kids and—yeah, it's—it's the shack, you know? And a lot of people come by and they're like, Wow, this is really nice, Dude. And, you know, my response is, Dude, it's a house. I mean, it's a house.

In the same account, Keith also reinforced my impression of the safety of the neighborhood, along with the warmth and openness that characterized his and Marcy's stories about living there, in his description of a young Mindy selling lemonade outside their driveway gate one day, when a carload of strangers stopped in front of the house. Noting what was happening, Keith went outside to encounter a large Chinese family that had just buried its patriarch. The widow had long ago worked in the Watson's home as a live-in maid for a prior owner, during the time when she met her now deceased husband. Keith immediately invited the family inside to show them around in service of supporting an elderly stranger's remembrances as she grieved the loss of her husband. I was deeply moved by the openness to "otherness" that this act modeled for his young daughter, as well as the empathy and compassion he displayed.

In this family's accounts as compared to that of the Nortons, I observed a lack of emphasis in the photographs and narrative upon an explicit awareness of the neighborhood. After a short time, I took for granted the safety, serenity, and pastoral beauty of the surrounds, and imagined that they did as well. This provided stark contrast to the background of anxiety that pervaded my experiences in East Palo Alto. The interesting impact this had on my sense of the *Umwelt* through the eyes of the Watson family was that this sense of safety seemed to free their attention, and mine, to roam in a more expansive universe through their stories and photographs. There were photos of Keith and Marcy while still young graduate students on their honeymoon in Barbados, a father and son trip to San Francisco to shop together at a famous record store in the Haight Ashbury district, and of the local hamburger stand that had become a family tradition. I also heard about dozens

of friend's homes, movie theaters, pizza places and stores, along with family vacations to

Hawaii and Mexico, to say nothing about events like the following one Keith described at

Michael and Gunther's private middle school:

> What they have at this school every year is they have this—it's kind of a competition, like a 2-day event where they basically shut down the middle school—6th, 7th and 8th grades, and they open up the gymnasium, and they basically break kids up into groups of three—a 6th grader, a 7th grader and an 8th grader. Then they assign each group to a country, and then there's an overall governing body like the U.N. And each country is responsible for—and they're real countries, right, like the United States or Japan or, you know, Uganda, or, you know, a good cross-section of industrialized, developing, and third-world. Anyway, they've got real, like, health challenges, environmental challenges, economic challenges, social challenges, religious challenges. They're integrating all this stuff, and then they have to come together as a world community and try to address, you know, severe problems in specific areas—AIDS, for example, or global warming.

Also, in contrast with the Nortons, who found their community to be devoid of

supportive resources in spite of whatever effort they put forth, the Watsons saw the world as

a place of unlimited resources, particularly when it came to caring for their son, Michael.

Marcy and Keith talked about their attitudes with regard to helping him:

> [MW] at this point I just feel grateful, because it's all been—it's all worked out well. But [*pause*] I think one of the things I feel really positive about is if you give kids the help they need, they thrive. It's pretty amazing to me.

> [SPH] You clearly have made some decisions that have worked well for him. If he's in a gifted school now, and obviously—

> [MW] Well, it's not just—

> [SPH] You found a combination—

> [MW] I just followed professionals. I mean, they give you lots of tips and you keep going. I mean, I just wasn't going to leave a stone unturned. And it's definitely paid off.

Researcher's Impressions of the Mitwelt or World-With

The previous conversation transcript serves as a fitting segue to a discussion of my

sense of their *Mitwelt*. I was particularly moved by the attention Keith and Marcy paid to

nurturing relationships within the Watson family:

> [KW] I think that they were really fortunate to have the mom that they had. There are lots of times when you get these insights into this child's mental development or level of, you know, depth of thinking, and it's just a mind-blower. At the same time, it's very easy—and this is I think why my family of origin and why I don't try to— you know, I'm pretty adamant about not doing it is, you know, the old, "Oh, what the F's wrong with you, you're just not trying hard enough," right?

> [MW] And he wasn't going to respond to that.

> [KW] Right, because that's not what it is, right? I mean, you got pretty smart kids… And their behavior is rational, and somehow you just got to get in and figure out, *So why is this rational? What's that perspective?*

My embodied sense during conversations like this was of pure warmth that comes

from validation and regard, not only between husband and wife, but also parents and their

children, the siblings, and as well as with their cat and two dogs. Though I heard many

stories that characterized challenges and conflict as well as immense joy and

accomplishment, I sensed underneath it all a deep well of respect that both parents seemed

to actively tap, beginning with how they held one another. Marcy began her photo narrative

with a photograph of her with Keith on their honeymoon:

> So, we were very in love. That's the root. And we were very young, too. So we got married—I turned 25 the next month, and so anyway we were young and had a lot of growing up to do. We are the kind of people that seemed to have done better together in being able to sort of provide the . . . I don't know, the stability and—like just some sort of pushing off of each other. We both grew a ton. . . . We didn't have kids for 8 years. And so, I'd say we both have come from families where we had a lot of our own individual work to do. But we came together with a ton of love and excitement and enthusiasm, and I think that's been important, 'cause it's been hard. I'm sure any marriage and family has their struggles. So somehow, like, having the foundation be so strong was a really big deal to me.

Keith described why he too included as his first photograph in his narrative a picture of Marcy taken during the first 2 years of their marriage:

> It's a picture of my wife, Marcy. I framed it . . . gave it to myself for Christmas last year. You know, wrapped it up and put it under the tree and everything. And it's the only picture that I have where someone—you know, it's so clear from the expression on their face that they really love you. You know, I don't see that expression as much as I used to, but I think experience the same feeling in a lot of different ways. And yeah, I think it's a good model for me, because of the personal—the comfort that it gives me, the solace in my marriage, and as an example just of, you know, look, this is kind of what love looks like, you know? For me and my family.

Like the Nortons, both Marcy and Keith showed a deep awareness of family history, but in their case it was most prevalently focused around past relational difficulties within their families of origin, and a deep desire not to repeat old, painful patterns. Further, they did not live in close proximity to their families of origin and seldom interacted with them. In contrast, the Nortons lived within an easy walking distance to many members of their extended family, and their focus was almost exclusively upon the web of relationships itself, almost as a structural entity—a way of finding oneself in time and space—with little or no conscious awareness focused upon making sense of intergenerational patterns. I was also painfully aware of the nearly continuous specter of the legacy of multiple traumatic experiences within the Norton family narrative—past, present, and sadly, future.

Also in contrast to the Nortons, Keith and Marcy's family photo gallery was exclusively about their history together and the unfolding story of their children's lives. Again, any mention of the family of origin was couched in an awareness of the psychological legacy that it represented and how the two of them would choose to do things differently with their children than either of them had experienced growing up. As an example of how this impacted their relationships, Keith talked at length about one particular incident where he overheard Michael and Marcy engaged in conflict:

So I picked up this message on my cell phone and it was a message where, you know, this is Michael and Marcy talking, and it was clear that someone had somehow, you know, rung my phone and then not realized that they'd done it. So I was, like, overhearing this conversation. Michael wanted Marcy to take him to the dance at the school. He was in sixth grade, and, you know, there was just I want to say desperation in Michael's voice, you know, *when can you take me, I don't want to get there late…*you know? And Marcy was saying, *Michael, we've already talked about this. I'll take you when I get done taking a shower. I just worked out.* And Michael was saying, you know, *Mom, this is my first dance ever, I'm nervous, I want to get there, you know, kind of early* and whatnot. And Marcy was saying, you know, *I'm done talking about this.* And just the frustration and the desperation in Michael's voice. I mean, I actually—you know, I was kind of listening to it driving back and I got off the freeway, right? And I just got off the freeway and I just sat there and I just listened to this thing and it went on for probably 10 minutes. And it did two things—you know, first it really hit me deeply. And it wasn't just the conversation. You know, what it brought up for me was the repetition of the pattern for Michael that I'd experienced in my family growing up, where, you know, the real message—the emotional—the significance of the event to me—or to Michael—at an emotional level was it's not clear whether it was recognized, but it was steamrolled. I know it's going to sound corny—it really came down to almost a life mission, where it was, like, This is not going to happen in my family. This is just not going to happen, period. You know, I've lived through that and, you know, I feel a lot of trauma. And it's just not going to happen . . . And, you know, Marcy and I talked about it and talked about the reaction, and how, you know, *Look, Marcy, you're just—you've been way overwhelmed and, you know, you need some help here, and I'm stepping in to help.* I mean, that's not Marcy, you know? I mean, some of it is, right? She's very regimented, but, you know, the question isn't, *Look what you've done!* The question is, *Okay, how can I help? Let's get this right.*

I found myself aware of how much I valued this depth of awareness and introspection, particularly as it informed their parenting. What they seemed to be able to access was a lovely sort of freedom to see each of their children with a vividness and freshness that impacted me profoundly. To illustrate, Keith had this to say about Michael:

> Being the youngest, there are lots of things that they're subjected to—their ability to influence the decisions that affect them is significantly less. They tend to get overrun by others' ideas and dominated. And, you know, in a world where everyone's equal, they can tend to be a lot less equal. So Michael is probably the child who has surprised me the most and continues to surprise me. And part of it is his physical size. You know, he's small—he's very small for his age, you know, in relative and in absolute terms. And so the things that come out of his mouth and the things that he's able to do, and the skill with which he's able to do them, and the apparent ease with which he's able to do them just surprises me. Because more than probably anyone else in the family, he's got an incredible set of skills.

This vividness in the way Keith and Marcy looked at their children did not awaken in me a sense the same sense of wanting or needing to protect Michael as I felt with the boys in the Norton family.

Allow me to offer a final example that captures the overall mood of the household as it pertained to relationships. At one point while I was talking with Marcy, Mindy and Gunther arrived elsewhere in the house and were making quite a lot of noise. Marcy was not at all impacted by the commotion. As it seemed completely normal to her, I just took in the totality of the experience, tapping first into her state of remarkable equanimity and ability to stay so present with me, and then into the whirlwind of activity that had suddenly entered the house. As the two teens wrapped up their conversation, we overheard Mindy say to Gunther, with an utterly casual genuineness and warmth that could only arise out of routine, and at a volume that could be heard from her location to where Gunther was, likely at the other end of the house, "I love you!" Gunther answered in kind as Mindy left the house for an after school activity, slamming the door behind her. I noted the lively, happy exchange and expressed my genuine wonderment in what her children displayed with one another, even knowing that a stranger was in their home. Marcy smiled slightly and said that even though they do fight at times, it was a "pretty strong thread" between all of them.

For me, this example, along with Marcy's apparent understatement of their family's connectedness, captured my sense of the family as a whole—their playfulness, a certain boisterous, fiery quality, alongside their marked centeredness, the depth of their goodwill toward one another, and a distinct and genuine humility underpinning it all.

Researcher's Impressions of the Eigenwelt or Own-World

Keith seemed to define himself primarily in terms of the degree to which he was engaged in a process of personal growth, which he mainly measured according to how well

he related successfully with his wife and children. He made almost no mention of his professional or other personal achievements. Time and again throughout my interviews with him, I found that whenever Keith noted something about himself he did not like, he would readily own it and take action to learn from it, as well as move decisively toward making a change in his behavior. This is one of many such instances through Marcy's eyes:

> Keith had come into the family in a major way over the past few years. Like, he started really coming in actively. I think that was a big factor. I think he really reorganized his priorities and became a very active dad. You know, like, he literally reorganized his priorities and decided that the family was the most important thing. But he had some catchin' up to do, 'cause I was kind of the backbone for better or worse, you know? So he wasn't as connected with them. He absolutely is now.

Keith elaborated, providing one specific way this reorganization of his involvement in the family showed up in the household:

> No one spent time in common areas, so we would come home and everybody would go into their room and close the door, and you know, grab food—you know, whenever they felt like it—you know, very little coordination and whatnot. And just kind of being there, right, for those little—I mean, relationships are built, you know, with a long series of small insignificant contacts. And that just wasn't happening. So—and I think one thing that helped was, you know, me just sort of saying, like, look, *this is fucked—this isn't how I'm going to live, this isn't how I want my kids to live.* And so putting myself out in the common area, you know—and invariably, you know, just creates contact. And maybe the contact's only like, *Good night,* you know, or *I love you,* or *Time to get to bed,* or you know, *How long you been on that machine?* But there's contact.

Marcy saw herself as capable and dedicated as a mother and partner, and used her family of origin as a means to define herself. As she noted in the prior quotation, she characterized herself as the "backbone" of the family. However, she did not see herself as performing in that role with particular ease.

> I was really anxious. Like, this whole thing of the learning differences, it was, like, I was just *really* overwhelmed with anxiety. And my mother had done nothing for any of us. I mean, just nothing. We had flocks of help, and I mean, it was just to such an extreme. And I didn't *want* to do any of it, and I was gonna do all of it. You know? So I think that the process of sort of showin' up for them was just really hard for me, and I wasn't gonna leave any bit of it undone. And so I think that Keith was, like—I mean, I probably was pretty miserable to be around. I was, like, this swarm of

anxiety—you know, for years. The first year of Mikey's diagnosis we had seven therapy appointments a week. For the whole year. So it was just, like . . . a bit nutty. There was a lot goin' on for those years. And so at the point where Mikey got into his school, it was, like, *We made it!* You know? So our whole family has gotten to a point where it's like, *We're okay,* you know? On many levels. But that was a big one. 'Cause it's like when one person is still not okay, it's like the whole family feels it. And, like, I remember Mindy saying, like, a year and a half ago, *Nobody in our family has any issues right now.* And it was, like, *Wow!* We're all okay, you know?

The children seem to thrive in the relational environment their parents have created. The result, in spite of their "learning differences" as the family refers to ADHD and dyslexia, and even the motor skills issues Michael faced on top of it all, is a sense of limitless potential and remarkable self-acceptance, as evidenced by the following exchange between Keith, Marcy, and me:

> [KW] Yeah, the other thing that I've noticed and it's kind of a small, but in Michael's case in particular, you know, in terms of balance and coordination and being able to see things coming for fighting—martial arts—I mean, he goes to a school, or did go to a school where they've trained Olympic gold medalists, world champion professional boxers and martial artists, and the instructor said, *You know I think this guy's the most gifted athlete we've had come through here.*

> [SPH] So, a kid that couldn't cross the midline of his body at one point in his life, and now look at him.

> [MW] Yeah, he said, In my 30 years of teaching—

> [KW] And you know, for sure, some of this is specific to Michael and the gene-pool, but more than anything, a lot of it is that, you know, these kids are just kind of—have been, for generations—just squashed as just not trying hard enough. ADHD, it's like, *settle down,* you know, *pay attention, what's wrong with you?* You just don't understand—I'm burning a different kind of gas.

As might well be expected from the descriptions of the environment his parents have created for him, Michael saw himself as talented in many realms—including academics, playing the guitar, Tae Kwon Do, and various video games. He also seemed to have a sense of himself as being able to effectively regulate what might likely be considered impulsive behavior and described knowing where his limits were in order to avoid getting into trouble. This ability extended to being able to effectively understand how to get along with adult

authority figures—teachers and parents alike—even when disagreeing with them. Michael spent quite a lot of time in our interviews describing himself in light of the quality of his relationships with friends and immediate family members. Like his father in particular, he seemed to place a high degree of value on the quality of his relationships as a reflection of who he was.

Regarding the diagnosis of ADHD, and in contrast to his counterparts in East Palo Alto, Michael expressed a good deal of knowledge about ADHD and a marked awareness of not only how it impacted him, but also ideas about what it meant to be diagnosed with it, as well whether or not it was something that ought to be "fixed" or "cured." For example, in answer to my question regarding what the diagnosis of ADHD actually meant to him, he said:

> I actually enjoy having ADHD—because it's just a lot of fun being able to just, you know, go crazy sometimes. You know, like—not literally go crazy, but like if I'm at a party, you know, I can just like, you know, have fun, you know, to the full extent, I guess, in my opinion. So that's cool. And, obviously I don't know—uh, I couldn't answer truthfully to like what it's like to have ADHD, because I can't compare it to how being *normal* is, you know? I mean, I can say for me what it is, but I couldn't say, you know, I like it more for this reason. I guess just seeing how other people are, and, you know, looking at myself, um, it's—um, it's better because, you know, in activities I have a lot of energy. And so I don't get tired as fast as other people. Or, I do; I just recover quicker. Um, so, you know, that's, um, cool. Um, but it's also bad—this is more the AD part—uh, the attention part, but, me and my mom have got that down.

Michael's sense of optimism in himself and in the possibilities that the world offers were infectious. I thoroughly enjoyed my encounters with him and admired him, not only for his obvious talents and abilities, but also for his courage, self-confidence, and resilience. My positive experience of Michael served to further feed what I became aware was becoming a strong idealization of his parents—all of which had to be effectively bracketed to enable the phenomenological analysis of the data that now follows.

Part 2: Structure

Shared Essential Structures of Experience

Reifying Clustered Behavior

Certain clusters of behaviors exhibited by young boys diverged from a felt sense of what were understood to be ideal cultural and familial norms by older members of their families, primarily their parents. These behaviors initially took forms that included wild, chaotic, energetically charged activity, emotional lability, violence, property destruction, and self-injury, in varying combinations depending upon context. Later, school-related behaviors were added to the behavioral clusters, including difficulties in focusing and learning, and resultant poor academic performance. Parental responses to the perceived divergence from normalcy ranged from amusement or mild annoyance, which tended to result in efforts at containment and protection from harm, to embarrassment and fear, the latter of which led to reifying the behavior clusters through the adoption of a normalizing medical diagnosis. Once reified, the thing-that-explained-abnormal-behavior was then able to be properly located as something which was an entity unto itself, not only "in" the child, but also "in" the gene pool and also found "in" numerous others in the community. This newly reified entity could also thus serve as an organizing principle for familial activity ranging from day-to-day functioning to parenting philosophy to education to the *collection* as well as distribution of financial resources, again, depending upon context.

Seeking Relief From Suffering

As the family systems reified their boys' behaviors through a medical lens and moved to organize their myriad activities in response, the expectation of attendant suffering resulting from a newly perceived "affliction" entered into the universe of experience. Because they loved and connected with their children deeply, all parents universally sought

to alleviate their "suffering," and secondarily, to alleviate their own. These efforts took a variety of forms for parents, including self-medication against symptoms of anxiety and depression—interventions that were both medical and nonmedical in nature—and forms of therapy, like bodywork or counseling. They also attempted various treatment strategies with their children including medical, psychological, occupational, and special-educational modalities, harm reduction techniques, and varying forms of reward and punishment, all in differing combinations, and again, dependent upon context.

Experiencing Help

In seeking to alleviate suffering and organize their activities against a common foe, the families experienced help whether through their own agency or being on the receiving end of the acts of others. These ranged from self-help activities like conducting research into possible treatments or special programs, to direct experiences with teachers and administrators in public and private school systems, visits to therapist's and physician's offices, and interactions with governmental financial assistance systems. Help was experienced by parents and children alike as either aligned with their needs and hence, effective, or not.

Stabilizing the Child-Self

Regardless of the character of the experience of the help they sought and received, the families engaged in a process of settling into a progressively stabilizing sense of the afflicted child's identity as a person, a process which mirrored the reification of their behavior, but that did so in terms of its responsiveness to "treatment." That is to say the very nature of the experience of the afflicted child as a person appeared to be continually projected against the backdrop of their perceived affliction, and then evaluated according to

the degree to which their perceived suffering and that experienced by the family as a whole was relieved.

Longing for the Before

Out of the whole of these accounts of lived experience also emerged an overarching essential longing for life before the reification of their children's behavior into a medical diagnosis. This showed up in the form of remembrances of simpler days, like a parent's own childhood or a time before children were born. It also took shape in the perceived transformation of babies from "goodness" and "innocence" into "bad" or "mischievous" school-aged children. It further made itself known in terms akin to longing for something *original* that was felt to be somehow "lost" in the whole of the process.

Part 3: Integration

In this concluding section, I re-introduce the textural character from Part 1, which was effectively bracketed in the process of elucidating the abstract, essential structures of the lived experience of ADHD as were just discussed. This integral *Textural-Structural* synthesis identifies nodes of shared meaning that emerged out of the invariant horizons, as well as points of difference, along with representative language from participant interviews to fully imbue the narrative with the depth and richness it is due.

A Textural-Structural Synthesis: The Lived Experience of ADHD

Regardless of the socioeconomic or racial context, when the children in both families were very young, their parents tended to see them through the twin lenses of innocence and unconditional love. Whether in the "chaotic" but affluent world of the Watson family, or the "violent" poor neighborhood inhabited by the Norton family; even when Keith was largely absent through an intensive business career or Shelton and Devon's dad was incarcerated for a drug crime; while Marcy suffered from thyroid problems and attendant mood disorders

and Helen was a victim of mental or physical abuse prior to her pregnancies; the children all tended to be simply cared for and *allowed to be*.

Ideally, this seemed to free the children while very young to authentically express themselves by naturally seeking and creating the kinds of experiences that were both in service of their developmental needs, and "fun" and exciting to them according to their temperaments and budding personalities. As they grew older, their naturally creative behavior became increasingly more sophisticated and willful, and thus began to come under greater scrutiny with each passing year. As this unfolded, parents and their children in both families began to be judged (and judge themselves) based upon the synchrony between the tandems of parenting practices and their children's emergent personae, and the rules and expectations—whether explicit or implicit—of the nested systems of society, culture, community, and family.

At some point during this transition from innocence and unconditional love to increasing social scrutiny, the boys' behavior in both families began to fall outside the norms of these nested systems, while the girls' behavior did not. Depending upon the context, these departures from normality carried differing meanings, but they generally appeared to produce anxiety and fear in the parents.

In the affluent socioeconomic, White cultural milieu enjoyed by the Watsons, the fear tended to take on a character of "anxiety" or "clinical depression," and an overall sense of being "at the end of one's rope" in the parents. The discomfort was primarily focused upon future achievement gaps, and the looming specter of perceived parenting inadequacy through the lenses of "socialization" and academic success, as well as a keen aversion to repeating less than optimal childhood patterns bequeathed them by their own families of origin.

"Issues" that signaled "learning differences" were spotted by a well-trained Kindergarten teacher in a Waldorf School, and on a family camping trip when Michael nearly injured himself seriously by falling headlong into a log that spanned a hiking trail, and other like scenes. Accompanying "wild" behavior before bedtime, recounted with a wry smile by both parents, as well as a high degree of emotional "sensitivity" observed in Michael led to multiple, intensive efforts to evaluate nutrition as a possible factor and the resultant discovery of several food allergies, as well as the diagnoses of ADHD and Dyslexia by the age of 7 years. In this lifeworld, the whole of the situation became invested with "life and death" significance by Keith as he gratefully recounted Marcy's efforts as a mother:

> And you know, taking that on for the boys was—I mean, saved their lives. It's that simple. They would have been—I mean, no child can try to fit into socially constructive peer groups with those kinds of disabilities. And, you know, peer groups—that's survival, right? That's a requirement for survival. So she really saved their lives.

In the poor African American socioeconomic and racial milieu, the fear took on an entirely different, exceedingly more desperate character for both Millie and Helen, as did the behaviors in Shelton and Devon that precipitated its emergence. The departure from expected social, cultural, and familial norms in this environment included intentional fire setting in Shelton, and self-harm in Devon, both of which were alarming enough to cause a family friend to suggest childhood psychological evaluations as a means of protecting a still teenaged, emotionally, and physically battered single mother from losing her children to Child Protective Services. In addition, Helen became aware that she could receive significant Supplemental Security Income if her boys were found to have "disabilities." This led to her seeking a diagnosis of ADHD through the Social Security System for both of her sons when they reached the age of 4 years.

With diagnoses in hand to explain the behaviors exhibited by their sons at home and in school, parents in both families were then able to locate the ADHD in themselves, thus transforming "it" into a detached presence lurking in the gene pool, as well extending "it" out into the world around them. This gave the reified cluster of behaviors, now ADHD, a certain character of commonality, or a *newly normal* flavor. Thus it became an entity they could all become focused upon and organized against. The latter point inclined both sets of parents toward seeking relief from suffering on behalf of their children, but also for themselves. In broad terms, this took on the character of help-seeking in myriad forms, which were intensely context dependent.

In the affluent, White lifeworld, the emerging cluster of traits and behaviors in both of their boys led Keith and Marcy to "leave no stone unturned" to research and find intensive, specialized therapies in speech, auditory, and visual integration for newly discovered dyslexia, as well as occupational therapy to correct motor skills developmental delay and difficulties in "lateral integration" in Michael. At one point, Marcy and Michael were attending seven therapy appointments per week for a period of an entire year.

Relief from suffering for the Watsons also included medication as well as intensive dietary management, both of which were found to be helpful in relieving Michael's "symptoms." From an educational standpoint, this family was also able to place both of their children with "learning differences" into a specialized elementary school, with a 2007-08 tuition of more than $27,000 per year, per child. At the end of their elementary years, both were accepted into a "talented and gifted" middle school that was known to be "prestigious" and "competitive," not to mention, in Keith's tongue-in-cheek turn of phrase, "for those of the gifted checkbook," leading Marcy to sigh with palpable relief, "We made it."

In the poor, African American lifeworld, the emerging cluster of traits and behaviors led Helen to seek treatment from a psychiatrist, who she said would only prescribe a combination of stimulant medication and adult antidepressants and did not "do therapy," which worried the mother given the side effects her children experienced, not to mention the lack of change in behavior. So Helen ceased the medications and sought relief instead in disciplinary and containment strategies of questionable effectiveness:

> [HN] And then a lot of times I be scared to ask for help for the boys, because I don't want to lose my sons. I'm lookin' at it, you know, they *my* kids, I gave birth to 'em, I love 'em with all my heart. But then sometimes you can go a little bit overboard with asking for the help, because then they might go, Oh no, you can't control your kids, you can't do this, you can't do that. I chastise 'em, I punished 'em, I done spank them—I done did everything under the—I put 'em in punishment, time out—you know, I done did everything I can.

> [MN] Even in Juvenile Hall, they supposed to be watching him. But Shelton took a eraser off of a pencil and made a tattoo on his arm. His skin is just tore up where he made a tattoo on his arm. And I say now, they supposed to be watching him in there. So how do they expect us to keep up with every move they do when they can't even do it?

The help-seeking behaviors engaged by both families in their searches for relief led each to have different experiences of receiving help that were dependent upon context. The Watsons saw the world as full of seemingly unlimited possibilities and endlessly fluid combinations of cutting-edge treatment strategies to be discovered, both allopathic and natural or alternative in nature, as well as specialized schools. They also included themselves in the equation and demonstrated flexible parenting practices that valued respectful relationships and sought intentional alignment of their needs with that of their children and the family as a whole. This extraordinary sense of flexibility and agency translated to a strong felt sense that the world was a help-full place, for the parents and children alike.

The Norton family, on the other hand, experienced themselves putting forth abundant effort, but to no avail. This impotence materialized in a limited number of

forms—mainly evidenced by copious quantities of "paperwork" and "files" and memories of contentious telephone calls to school administrators in an attempt to advocate for their children. The result was a deep resignation that "the system" simply does not work:

> They need to be on some type of medicine, especially Devon, because . . . he's too hyper and he gets into a lot. Shelton gets into a lot, but to me, Devon gets into a lot. And then when they get ready to lock him up or talk about locking him up, then he goes to crying and crying, and I feel so bad for him, because I know he really don't mean what he do. And the people don't want to deal with me, because then I get to whoopin' and hollerin' because I've asked for help time after time after time after time. Explaining to the schools the type of disabilities that the boys have—they failin' the kids.

Based on the effectiveness of the help they experienced, or the apparent responsiveness of their children to efforts put forth by the parents, professionals, schools, community, and society, the family systems begin to unconsciously collude to define their boys' identities—which became progressively more stable with every reinforcing event. Again, this looked radically different depending upon the context.

In the Watson family, the language used to describe Michael was intensely positive. There was a palpable sense of awe in who he was becoming in spite of, perhaps even because of the challenges he had to overcome. He received reinforcement in his mere presence in his schools—first for those with "learning differences" but who were thought to be "highly creative," and then for the "talented and gifted." In combination, this led him to easily embrace "ADHD" as something that he could "use to his advantage," even something "fun." The parents summed this up succinctly with a brief story:

> [KW] What it basically teaches them is, like, *Yeah, you know, you've got some learning differences, but you know, everybody's got differences, and you know we've found some things that can really help you a lot.*

> [MW] Gunther said he thought Mindy a got the raw deal not being dyslexic, because he learned his way around, and he gets things out of the box. And Michael, actually—I've got a quote from last year, and it's pretty amazing. We were driving along and he said, *I wonder when I'm going to find what I'm not good at.* And I said, *Michael, you've already dealt with more, you know—you've already overcome more obstacles that most people*

deal with in a lifetime, and he said, *Yeah, but once I deal with them, they're—I'm good at it.* And I was like, *Whoa!*

In contrast, both boys in the Norton family would scarcely acknowledge the diagnosis of ADHD. The interviews became nearly silent when the topic came up. Melanie and Helen seemed to equate it with "badness" and criminality in the community. Melanie also used the word "crazy" at one point as a surrogate term for ADHD. The result was a seemingly ubiquitous expectation of disaster where the boys were concerned, in part given first-hand experience with murdered and incarcerated young men in the family. The following conversation is illustrative of the sort of discourse that served to stabilize this negative sense of self that the boys were none too eager to introject:

> [MN] Basically a lot of the Afro-American children here have that same type of problem—behavioral problem.
>
> [SPH] A lot of the Afro-American kids do?
>
> [MN] Yes. And a lot of the Black children are into sellin' drugs, behavioral problems with their parents, because I've talked to a lot of parents that have the same problems that I had with my children, and that they're having with their grandchildren. So there's a lot of that goin' on around here. And a lot of the Black Afro-American children think they have to get into sellin' drugs to make it.
>
> [SPH] 'Cause this is something that's prevalent in the community—people sellin' drugs.
>
> [MN] Sellin' drugs. Over half the children here that's black don't think they need to work. You're not gonna catch too many Black Afro-American children that work in East Palo Alto. Most of 'em are selling drugs.
>
> [SPH] They're not workin'—they're just hangin' out on the block and—
>
> [MN] That's it.
>
> [SPH]—doin' what they do.
>
> [MN] Mm hm. Gettin' killed. Killin' somebody. Fighting.
>
> [HN] . . . livin' in East Palo Alto, any city that has turfs or gangs or anything—for Black families and the kids growin' up around here, it's like a big adrenaline rush. I mean it's somethin' that you have no choice but to enjoy. You have no choice,

because you don't have too many opportunities like a lot of the other kids do. You gotta get out there and make do with what you got.

[MN]: And so only thing I can say, you know, is we got to have insurance on these kids to bury 'em all.

[HN]: That's all the parents can do. Is get insurance policies and pray for the best.

This led to a *longing for what came before* the necessity to reify their boy's behavior, particularly in the Norton family. They talked wistfully of when the boys were "good" and "innocent" as they gazed at baby pictures and relished the brief moments when Devon and Shelton were "where they could have an eye kept on 'em." The boys, young-childlike in their speech and manner, described their priorities around "fun" and the avoidance of "boredom."

In spite of the successes enjoyed by Michael, this *longing for what came before* was also strongly present in the Watson family. Keith offered his version of this feeling as he and Marcy reminisced about the family photo gallery that lines one long hallway in their home. Keith spoke almost regretfully about something original in his son Michael that he sensed was somehow "lost" in this whole process:

> You didn't see it when you walked in, but if you walked—go to the back of the house on the walls, there's pictures of Michael as a kid—I mean, all the kids, but, you know, those early ones were . . . I think *Michael* isn't in a lot of the later ones. I mean, *Michael* is just this fun-loving, goofy, high energy kid that I really liked—I mean, I guess I'm kind of like that. And that's gone. You know, that's gone at this point. I think there's two parts of that. All right, one is, you know, why is it gone, and the other is why is dad sad about that? You know, I think I'm sad about that, because there's kind of a set of interactions that would occur around that. You know, I mean, you knew that if you wanted to do something completely stupid and silly but fun, that, you know, you could—you'd know exactly who to ask, all right? And it wouldn't be, like, Gee, I don't know, it'd be like, Yeah! I think that he's probably better socialized, you know? Either from the drugs and the physical manifestations of it and just taking the edge off the anxiety and the level of stimulants, or I don't know what the hell is in that drug, but—it might just be around the home, too. You know? I don't know. He's supposedly a lot of fun at school . . . I don't see that.

CHAPTER 5: DISCUSSION

I have organized this final chapter around revisiting the four research questions posed at the outset of my study:

1. What are the shared *essential structures* of ADHD as viewed through a *phenomenological* lens?

2. In addition to essential structural similarities, how does the *texture* of the *lifeworld* of the poor African American adolescent male diagnosed with ADHD and his family differ from that of his affluent White counterparts? Further, what might we learn from exploring these differences regarding how the diagnosis is constructed in differing contexts, and toward what ends?

3. How does an integration of structure and texture support or refute a hypothesis about the *social construction* of ADHD? Might it be possible to proffer an alternative conception of the phenomenon, and thus envision alternative, more hopeful futures for those who face the diagnosis?

4. What might *transpersonal and social constructionist psychotherapies* have to contribute to creating said alternative, more hopeful futures for children and families facing a diagnosis of ADHD, regardless of their race or socioeconomic status?

Against the backdrop of a brief overview of the study, I discuss the shared essential structures identified in Chapter 4, adding perspectives on race, oppression, poverty, social sharedness, and interpersonal neurobiology, among others. This facilitates a social constructionist critique, and an alternative conception of ADHD, the latter via Maurice Merleau-Ponty's theory of *vital structures*. Finally, I envision alternatives for facing ADHD, emphasizing transpersonal and social constructionist clinical approaches.

Brief Summation of the Study

Given the lack of similar studies I noted during an extensive review of a massive interdisciplinary body of literature that addresses Attention Deficit Hyperactivity Disorder, I chose to qualitatively examine the phenomenon from the contextually disparate perspectives of two very different American families, each with at least one adolescent boy diagnosed with ADHD early in childhood by a physician. The first cohort of participants ($n = 4$) was composed of members of an African American family living below the poverty line in a crime-riddled community within the Silicon Valley region of the San Francisco Bay Area. The second cohort of participants ($n = 3$) was composed of members of a Caucasian family residing in one of the most affluent communities in America, and less than three miles from their African American counterparts.

In selecting a vehicle for my exploration, I chose to create a synthesis of the phenomenological method, auto-photographic ethnography, and embodied hermeneutic inquiry, to discover and explicate essential structures of the phenomenon, while maintaining a deeply empathic level of contact with the rich human textures of these disparate *lifeworlds*. My research process included collecting narrative data through a series of semistructured interviews with each participant. I also asked each participant to take and submit a series of digital photographs as a means of expressing *who they are* using images instead of words. I then analyzed the narrative and photographic data through a process of embodied hermeneutic inquiry, an effort which yielded thickly descriptive accounts of each family's lifeworld as it was organized into three existential realms: The *Umwelt* or World-around, the *Mitwelt* or World-with, and the *Eigenwelt* or Own-world.

After bracketing what I learned in constructing these thick descriptions, I freshly approached the phenomenological method portions of the narrative that contained

descriptions of the lived experience of ADHD. This resulted in the discovery of five shared

essential structures of the experience: (a) Reifying behavior; (b) Seeking relief from suffering;

(c) Experiencing help; (d) Stabilizing the child-Self; and (e) Longing for *the before.*

Lastly, I reintroduced these five, shared essential structures to the textural, thickly

descriptive accounts within which they were imbedded in order to construct a *Textural-

Structural Synthesis* of the lived experience of ADHD. This synthetic description served to

compare shared essential meaning among participants while acknowledging the profound

differences in racial, socioeconomic, and cultural context in which the lived experience of

ADHD arose and unfolded.

<div align="center">Discussion of Research Findings</div>

Out of the process of phenomenological reduction as outlined in Chapter 3, I was

able to discern five shared essential structures of the experience of the phenomenon of

ADHD: Reifying behavior; Seeking relief from suffering; Experiencing help; Stabilizing the

child-Self; and Longing for *the before.* I now discuss each, integrating a discussion of

important textural aspects of the lifeworld, primarily focusing upon racial and

socioeconomic factors experienced by the African American family.

<div align="center">*Reifying Clustered Behavior*</div>

Social Sharedness

This essential structure may be discussed in terms of the concept of social

sharedness (Tindale & Kameda, 2000), or the notion that groups of people (including

families, for the purpose of this research) may share cognitions, preferences, identities, et

cetera. One key principle of social sharedness especially salient to this research is that of the

shared identity of group members. Tindale and Kameda explain that people categorize

themselves on many levels, with most levels defined by group membership. So, when

membership in a particular group—whether it is a family or a diagnostic category—is made important, the self becomes defined, at least in part, by the group to which he or she "belongs." Tindale and Kameda go on to argue that members of a group hold in mind a prototype of the *typical* group member and unconsciously attempt to align their behavior with this mental model. So, if the typical group member, or, to use another of Tindale and Kameda's concepts, the one with the most cognitive centrality, exhibits "disordered" behavior, and it is *defined* as such, other members of the system will be more likely to do the same. Conversely, the degree to which "normal" behavior defines group membership, the more likely other members will define themselves accordingly.

In the Watson family, all of the focus seemed to be directed toward the child's perceived ability to function socially and to thrive academically given his behavior—with an emphasis on high function and achievement defining group membership. In the Norton family, the fear mainly took form in a movement toward classifying the child as a "bad" child. This latter finding is also consistent with Weis (2002), who demonstrated African American parents were less likely to name academic or social role functioning as important to them, in spite of other research data that show one in five African American children is failing in school, due in part to an unusually high prevalence rate of agitation and related behaviors, like fighting (Barbarin & Soler, 1993). This is also consistent with Bussing Schoenberg, Rogers, Zima, and Angus (1998), who found in their mixed-design study of 499 families that African American parents were much more likely than other parents to use a "bad child" or behavioral problem label, and were less likely to apply medical labels.

Perceived Parenting Effectiveness

As a part of explicating the essential structure, *reification of clustered behaviors*, I became aware in both families of a felt sense of wondering as to what their child's behavior might

mean in terms of their perceived effectiveness as parents. With the Watson family, I

interpreted the focus as primarily introspective. That is, they seemed to be wondering, *Am I*

doing everything I can to support my child in ways that my parents did not support me? In contrast, within

the Norton family, the fear of evaluation came not through introspection, but rather from

the potential scrutiny of outside sources, namely, the threat of involvement from Child

Protective Services, in part due to their children's self-injurious behavior. In this particular

case, the family received diagnoses for the two boys as an overt *defense* against the potential

intervention of government agents for suspected child abuse or neglect. This led to another

important difference. When the Norton's received this diagnosis for their boys as a defense

against losing them to foster care, they were also subsequently eligible to be compensated

with Supplemental Security Income payments for their "disabilities." If we reapply the

aforementioned social sharedness theory, we can see how strong the incentive was for the

maintenance of and identification with the "abnormal" as a part of their collective identity,

even as the boys rejected the diagnosis outright.

  Weis (2002) discovered a parenting typology that was unique to the African

American population which appears relevant to my experience of the Norton family, and

relates directly to the sort of stress that drove them to seek diagnoses for their children as a

defensive strategy, not to mention as an ongoing source of income. He called the parenting

type *affectionate-distressed*. According to Weis, affectionate-distressed parents scored highly on

measures of anger and control, and moderately on the dimension of warmth, resulting in

parents who indicate feelings of love toward their children but also feelings of frustration

and anger during parent-child interactions. These parents were found to

> advocate a high level of control over their children's behaviors . . . [as well as
> cognitions that may be characterized as] a desire to socialize children, but the timing,
> frequency, and severity of disciplinary tactics as well as positive attention may be
> compromised by aversive mood states. (p. 154)

This diverges from the traditional conceptualization of the *authoritarian parent*, in that the authoritarian style is typically characterized by high control and low warmth, and typically described as emotionally detached (p. 165). Weis also found that the children of these distressed mothers enjoyed the poorest outcomes, including "earning lower scores on measures of competence and higher scores on measures of behavior problems than the children of other mothers" (p. 167).

Seeking Relief From Suffering

While the essence of the reified behavior was consistent in both families, the context had a significant impact on the outcome. In the Watson family, where there were financial resources and a drive to parent better than prior generations, I heard stories of seven therapy appointments per week for the child, special diets, and high-priced private schools where the children were said to have "learning differences" as opposed to "disorders." All attempts at medicating were purely medicinal. The mother had been successfully treated for depression with medication for many years. Neither parent smoked or drank alcohol.

In the Norton family, where there were scarce financial resources, as well as an apparent lack of introspection around intergenerational transmission of parenting choices—such as Millie's teen pregnancy being repeated by her daughter, Helen, for example—the parents seemed limited to reward and punishment strategies as a primary means of attempting to control their children's behavior, along with a secondary, passive reliance upon whatever "programs" were offered through the public schools. Furthermore, medicating practices were primarily nonmedicinal in nature, coming in the form of tobacco and alcohol use. Any attempts at medical interventions to alleviate psychological suffering had been only sporadically maintained, and at the time of the interviews, nobody in the family was being treated by a psychiatrist.

Allostasis and Allostatic Load

Barbarin (1993b, p. 388) described the kinds of suffering experienced by the African American family living in a poor neighborhood in terms of what he calls the "lethal combination" of economic hardship, limited access to supportive services, and the psychological burden of oppression. He stated that this mixture serves as a source of significant developmental obstacles for African American children, not to mention a tremendous amount of suffering. Barbarin went on to say that the manifestations of these conditions can be observed across the lifespan, all of which were present in this family: increased morbidity and mortality, mood disturbances, academic underachievement, aggression, premature sexuality and childbearing, substance abuse, delinquency, underemployment, high rates of divorce, and instability of family life.

The impact of such stressors on parenting was already briefly introduced (Weis, 2002). However, these stressors as a primary source of suffering and as a mediator in help-seeking strategies may also be relevant to consider—particularly the concepts of *allostasis* and *allostatic load.* According to McEwan and Seeman (1999), the process of allostasis was conceived by Sterling and Eyer (1988) and means "maintaining stability (or homeostasis) through change," in particular how the cardiovascular system adjusts to resting and active states of the body. This concept also involves many other physiological responses, such as the secretion of the so-called "stress hormones" like cortisol and the neurotransmitter adrenaline, which are involved in the "fight or flight" response of the sympathetic nervous system. According to McEwan and Seeman, the concept of allostatic load refers to the wear and tear that the body experiences due to repeated cycles of allostasis as well as the inefficient regulation of the attendant physiological responses. If stress is enduring, intense, and cumulative, as would seem to be the case given the stories offered by the Norton family

during this research, more strain could be expected upon the internal systems than if stress is episodic and relatively minor, as was likely the case with the Watson family. This may help to explain why, according to McEwan and Seeman, "the poor suffer earlier mortality and worse health, on the average, than the middle class, which, in turn, is not as healthy as those who are wealthier and/or better educated."

According to McEwan and Seeman (1999) there are four types of allostatic load. The first type is simply too much chronic stress. This shows itself in the form of repeated events that cause repeated physiological activations over long periods of time—as would be the case in living in a dangerous neighborhood as described by Millie on a number of occasions.

A second type involves a failure to adapt to the same stressor. This leads to the over-exposure to stress responses in the body because of the failure of the body to dampen the fight or flight response to a repeated event (McEwen & Seeman, 1999). An example of this in the data was the repetitive, destructive outbursts displayed by Shelton Norton when confronted with any amount of irritation or frustration, as described by his mother and grandmother.

A third type of allostatic load involves the failure to shut off the hormonal stress response at all. One manifestation of this may be observed in the elevated blood pressure described by Millie. This may have also been present in the depression suffered by Helen. It may also have been a factor in Marcy's chronic depression given the ongoing stress of maintaining her work-life balance (McEwen & Seeman, 1999).

McEwan and Seeman (1999) describe the fourth type of allostatic load in terms of "an inadequate hormonal stress response which allows other systems, such as the inflammatory cytokines, to become overactive," which they note has been linked to "increased susceptibility to inflammatory and autoimmune disturbances due to inadequate

levels of cortisol." I would add what I would consider an allostatic load multiplier to this list that relates back to Barbarin's (1993b, p. 388) previously cited observations. According to Tummala-Narra (2005, p. 20), "cultures of fear" and related attempts to deny racial trauma may be observed in the experiences of ethnic minority groups in the United States, including "tools of violence" deployed by Whites against African Americans throughout our nation's history, which have taken the form of "burnings, beatings, and lynchings." Tummala-Narra cites Daniel (2000) who described her patients' accounts of racial violence across generations within their families, which culminated in experiences of pervasive physical and psychological vulnerability and states of hypervigilance.

This left me to wonder how future research might trace the roots of ADHD-like behaviors to the effects of the sorts of traumatic experiences I found within the Norton's stories on brain development throughout the lifespan. The salience of this idea was confirmed by research conducted with 791 children in Sarajevo following the Bosnian war. The researchers found support for their hypothesis that because the arousal symptoms of Post Traumatic Stress Disorder (PTSD) and ADHD were similar, PTSD might act as a mediator between trauma exposure and attention problems. As one of their key clinical recommendations, the authors noted

> given the potentially spurious relationship between trauma exposure and attention deficits, children with symptoms of poor concentration and hyperactivity should be screened for a history of trauma exposure, and those with positive histories should be further screened for the presence of trauma symptoms. (Husain, Allwood, & Bell, 2008, p. 61)

Experiencing Help

I would describe a key difference between the families as they experienced help in terms of a *sense of agency*. In the Watson family, it was all about agency, or the notion of "leaving no stone unturned." This resulted in innovative combinations of therapies in

multiple disciplines, as well as expensive special schools that were designed for children with "learning differences." The combination resulted in an excellent outcome, including acceptance into another expensive private school for the "talented and gifted." Thus, the White family's experience of help was both positive and empowering, not only for the parents but for their child as well.

In the Norton family, agency showed up in terms of the mother being resourceful and getting what was available within "the system," but there was a certain passivity in the attempt. What was available tended always to be less than what the parents felt was needed or deserved, and they felt powerless to impact "the system" no matter how much paperwork they completed and submitted. This appeared to me to be an extension of the palpable feelings of helplessness and resignation that pervaded their experience of a racist social structure in the community, perhaps most importantly in the conduct of local law enforcement toward members of the African American community, all of which no doubt increased their collective allostatic load.

There was also something telling about how the Nortons painted the schools with the same brush as law enforcement. I think there is little doubt that their children experienced few differences between the two either—as their impressions of teachers were mostly limited to experiences of either being misunderstood as to their needs or abilities, or being disciplined and punished. The best the schools could seem to provide in terms of counseling services in response to their perceived needs was "anger management," with a prime directive to the boys of "Just don't think about it" when confronted with something that caused them irritation. When that failed, the children were sent home, suspended for weeks at a time, until they were "interested" in doing their work.

Education Disparity

Sanchez-Jankowski (2008) cites one key aspect of Banfield's (1974) controversial research which argued that the culture of the lower class was the primary agent of school failures to produce socioeconomic mobility in poor neighborhoods, a concept that seems relevant to my experience with the Norton family. He digested the premise as follows:

> Schools dominated by lower class pupils, regardless of race, ended up being run in response to the way pupils and their families acted. The result, in his view, was an operating condition that was ineffective in building the skills pupils needed to better their economic opportunities. Banfield labeled it "schooling": unlike the operating condition he called "education," which made the school a place where necessary skills were learned for success in the labor market and society, "schooling" made the school a mere holding place for its students that offered them no opportunity to improve their chances for socioeconomic advancement. (pp. 299-300)

In the Norton family's descriptions of their experiences with their children's school system, accounts were dominated by stories about discipline and punishment—all of which seemed consistent with the definition of *schooling*. In contrast, the Watsons' experiences sounded more like *education*. Their family narrative included many details regarding specialized curricula, extra curricular activities galore, and formal intelligence testing required in order to gain admission into the institutions.

<div align="center">*Stabilizing the Child-Self*</div>

This essential structure was primarily reflected in the language the parents used to talk about the boys, and that which the boys used to describe themselves. In the Watson family, where treatment outcomes were positive, the parents spoke of their child and his accomplishments in language that was laden with awe and respect, and the boy wondered aloud if there was anything that he could not be good at.

As previously described, in the Norton family, conversation tended to focus upon "bad" behavior, with an emphasis upon how much trouble the boys were getting into at school and in the community, and how much of a burden that imposed upon the family. In

spite of all of the talk of "badness," the eldest African American boy had a detached grandiosity about him, and saw himself as smart, but lazy. His younger brother could only talk about the things he liked to do. His sense of self was noticeably constrained to concrete concepts that tended to fall into one of two categories: fun or not fun. It was as if they both disassociated from their experience of the world around them and chose instead to live in worlds of their own making—worlds where they are "good" and "just like everyone else" and where there are only "fun" things to do.

Crystallizing the "Bad Child"

The combination of ADHD and conduct problems holds profound implications for the developing child-Self. Gresham, MacMillan, Bocian, Ward, and Forness (1998) conducted a 5-year longitudinal study with 231 third- and fourth-grade students from 32 schools in five Southern California school districts. Their study sought to reveal something of the social and affective characteristics of students at risk for school failure and special education placement. In grade three, their peers rejected 76% of the members of the group identified as fitting the criteria for ADHD plus conduct disorder, which included behaviors like fighting, stealing, truancy, noncompliance, and arguing, compared to 34% of the group displaying both internalizing (i.e., anxiety/depression, withdrawal, somatic complaints) and externalizing (i.e., attention problems, aggression, or rule breaking) behavioral patterns, and 14% of controls. Roughly similar percentages across groups were considered to have "no friends" during the same time period, which, according to Gresham et al. (1998, p. 402) corroborates the findings of research conducted by Parker and Asher in 1987 suggesting that "children who are actively disliked or rejected by their peers are at high risk for negative long-term outcomes such as juvenile delinquency, dropping out of school, and mental health difficulties."

These same groups showed no marked difference with regard to either academic self-concept, social self-concept, or general self-esteem, which I also observed in the Norton family. This prompted Gresham et al. (1998) to caution against interventions that might enhance already inflated self-esteem rather than cultivate self-control and humility. I would add a caveat, inspired by Dr. Larry M. Leitner (personal communication, March 12, 2009), and encourage clinicians choosing this strategy to discern whether there may not also be legitimate sources for positive self-esteem that may be appropriately cultivated and nurtured. Further, a child appearing to have inflated self-esteem may not be authentically expressing him or herself and may in fact be hiding poor self-esteem behind false bravado. In any case, this approach should be undertaken with great care, compassion, and faith in the client's lived experience.

Properly executed, this strategy would appear to be helpful in addressing a related concept that also appeared to be relevant to the sort of behaviors that were described by the Norton family, which included incidents of sexual battery, fire setting, property destruction, and theft. Lynam (1996, 1997, 1998) names certain children *fledgling psychopaths*, hypothesizing that children who are both hyperactive and antisocial are at special risk for continuing antisocial behavior and becoming chronic offenders, and are "at extremely high risk for adult psychopathy" (1996, p. 211). In this early work, he also acknowledges, and rightly so, that this connection is more implicit and indirect, and that a stronger link might be made by demonstrating that children with ADHD and comorbid conduct problems show similar deficits to those shown by adult psychopaths (1996, p. 218).

Lynam (1997) answers his own critique in subsequent research conducted with 430 boys aged 12-13 from the Pittsburgh Youth Study (PYS), "a high-risk longitudinal survey of the causes and correlates of early forms of delinquency" (p. 427). In the study, Lynam

examined caretaker reports on the Childhood Psychopathy Scale (CPS), an instrument he derived from the adult Psychopathy Checklist (PCL) with the intent of "operationaliz(ing), in childhood, the PCL" (p. 427). His results suggest that "psychopathy has a childhood manifestation and that this manifestation can be measured reliably. Psychopathic children, like their adult counterparts, were the most frequent, severe, aggressive, and temporally stable offenders" (p. 433).

In spite of the challenges African American children and families face, Barbarin (1993a) states that the majority are not poorly adjusted, lamenting that media depictions of inner-city African American youth tend to evoke pathos and despair by rendering a distorted or misleading portrait. I was keenly aware of this issue throughout the study and worked diligently to avoid committing such an error. He states "One rarely sees the terms competent, altruistic, resourceful, creative, aspiring, motivated, and spiritual used to describe African American youth" (p. 479). As a response, Barbarin attempts to integrate observations from a review of literature covering sources of risk in psychosocial development, personal resilience, coping as a mediator of risk, and emotional regulation as a mediator of developmental outcome in order to form a model of emotional development for African American children (Figure 1).

Barbarin (1993b) maintains that because emotional development is context driven, researchers must understand these processes in light of the sociocultural conditions from which they emerge—or the child's "social ecology, emotional development, and developmental outcomes" (p. 486). The hope in offering such a model is to encourage the pursuit of more knowledge regarding typical social development as well as the capacities of children to overcome a host of challenges in order to develop both psychosocial competence and psychological health.
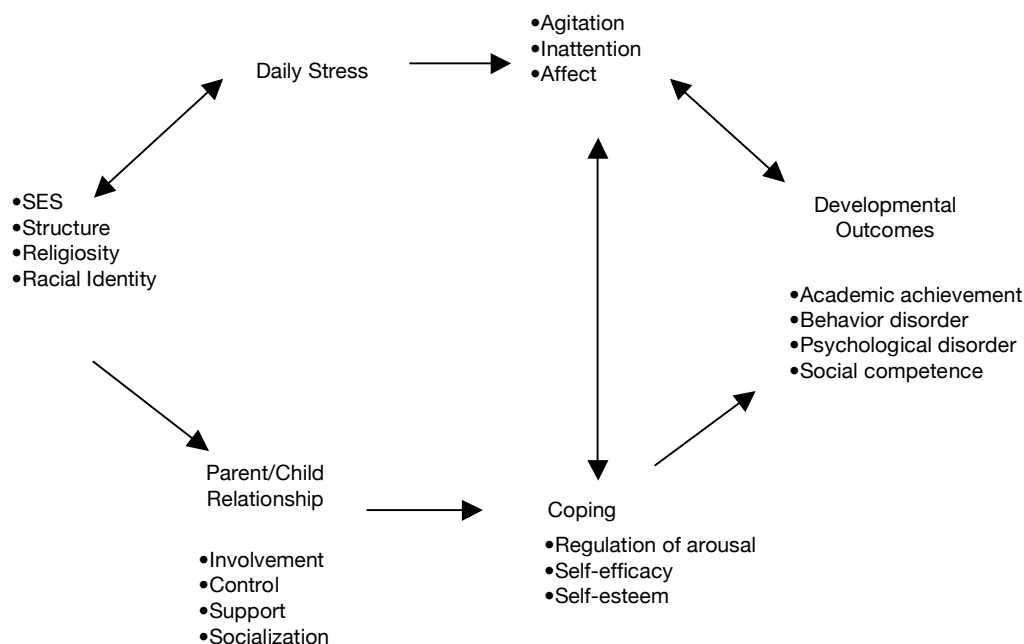
Figure 1. Family model of emotional development of African American children.

Note: Based on the figure in *Coping and resilience: Exploring the inner lives of African American Children,* by Oscar A. Barbarin. Journal of Black Psychology, 19(4), 478-492. © 1993 Oscar A. Barbarin.

One of the daily stressors that Barbarin (1993b) briefly touches upon, which seems to be most alive in this cohort of participants is that of a "marginalized oppressed minority orientation" (p. 384). Seaton (2003) addresses the vital importance of studying the experience of race-related stress in African American adolescents, which has been found to negatively impact academic curiosity, persistence and performance (Neblett Jr., Philip, Cogburn, & Sellers, 2006). This issue also relates back to the prior discussion of *allostatic load*, as it contributes to the essential structure, *seeking relief from suffering.*

Impact of "Badness" on Self-Esteem

According to Solomon, Greenberg and Pyszczynski, (1998) adhering to the standards of appropriate conduct associated with a given culture equates to a perception that one is a "*valuable* member of a *meaningful* universe," which to the authors constitutes the definition of

self-esteem. Solomon, Greenberg and Pyszczynski see self-esteem is the primary psychological mechanism by which human culture serves as a means of managing existential death anxiety, stating that

> Self-esteem acquires its anxiety-buffering qualities in the context of the socialization process by which an utterly helpless and dependent, immature and slowly developing human infant is transformed into a symbol-sharing immortality-seeking member of a culturally constructed universe. (p. 13)

To support their position, the authors cite the seminal work of attachment theorist John Bowlby (1969), in that this process is a function of the human infant's experience of "raw terror" that results from unmet needs and which are so fundamental to the development of physical and psychological attachments to primary caretakers who are able (or unable) to effectively nurture and defend their children. According to Bowlby's theory, such attachments ideally provide the necessary safety and security to the infant to facilitate the development of healthy attachment styles that will impact his or her ability to relate to others throughout the lifespan.

According to Solomon, Greenberg and Pyszczynski (1998), when children have to join their sociocultural milieu through adopting the language, beliefs, and customs of their culture, parental affection "becomes increasingly contingent on the child's behaving in socially acceptable ways" (p. 14). Thus, according to the researchers, children begin to connect "being good" with "being safe" and staying alive, while badness is associated with vulnerability, insecurity, and impending death. These dynamics are also alive in the prior discussion of *social sharedness* as it relates to the essential structure, *reifying clustered behavior.*

Longing for the Before

I found this essential structure to be perhaps the most surprising of all of my findings. In this, I saw awareness in both families of something that had gone missing in their children through the unfolding of this experience. Axelman (2008) gives language to

what I sensed in both families' experiences in terms of a loss of "potential space," defined by D. W. Winnicott (1971/1993, p. 100) as "the place where cultural experience is located . . . between the individual and the environment." Winnicott goes on to equate this with the act of playing, stating that "Cultural experience begins with creative living first manifested in play."

This is consistent with the findings of a Canadian study by Panksepp (2007), who advanced a hypothesis tying the increasing incidence of ADHD with the diminishing availability of opportunities for preschool children to engage in natural self-generated social play. According to Panksepp, play may facilitate behavioral inhibition in growing animals, while psychostimulants appear to reduce playfulness behaviors. However, he appropriately cautions the notion that intentionally facilitated social play in early childhood may alleviate ADHD symptoms remains to be evaluated. Furthermore, in my opinion, directly applying the results of animal studies to human beings is dubious at best. However, future research examining play therapy as an alternative to the use of psychostimulants appears warranted. Panksepp suggests the establishment of play "sanctuaries" for at-risk children in particular, with an eye toward creating optimal conditions for frontal and prefrontal cortical development. According to the emerging interdisciplinary field of Interpersonal Neurobiology (Schore, 2003; Siegel, 2001, 2006) these important brain regions integrate both the complex capacity for self-regulation and the engagement with others in empathic relationship (Siegel, 2006, p. 27).

In the accounts of all participants, regardless of context, there was a longing for innocence, or the essential childlike playfulness and joy that had somehow been collapsed into something that had its own actual, external reality, and which, according to Winnicott (1971/1993), may thus be "studied objectively, and which, however much it may seem to

vary according to the state of the individual who is observing it, does in fact remain constant" (p. 41). The consequence, according to Axelman (2008), is a "limiting [of] the possibilities for creative living, mutual understanding, and flexible ways of relating between youth with ADHD symptoms and the adults who care for them" (p. 1).

I found all of this to be synchronous with Gergen's (2003, pp. 149-150) commentary on the construction of meaning, which I found to be so alive in this particular aspect of my research findings. Gergen begins by noting that meaning is realized within the structure of a relationship. That is, the fundamental meaning is contained in the *linkage* between a signifier and that which is signified, rather than in either entity individually. When this sort of semiotic relationship is applied to human beings, the signifier-linked-to-signified is replaced by action-and-supplement. That is to say the action, or, in this case, the behavior of a child, is granted a "specific potential for meaning" by the supplementor, in this case parents, teachers, physicians, social workers, and the like. Thus, the action or behavior "means this and not that" and "requires one form of action as opposed to another." The result is that while meaning is created on the one hand, it is also simultaneously constrained on the other:

> Because your words [or behaviors] do mean *this*, they cannot mean *that*. In this sense, although I invite you into being, I also act so as to negate your potential. From the enormous array of possibilities, I thus create direction and temporarily narrow the possibilities of your being. (Gergen, p. 150)

This link to the social construction of meaning, and its dynamic mechanism of constricting possibility, serves as a fitting segue to offering a critique as well as an alternative conception of ADHD.

A Critique and an Alternative Conception

In spite of the certainty maintained by many regarding the neurobiological and genetic factors involved in ADHD, not to mention the universally accepted efficacy of pharmaceutical treatment (Barkley, 2002), there is important evidence to be found in the

literature that leaves room for questioning such taken for granted truth claims. I say

important, because, according to Pfenninger and Leitner (2005), a *competition for a claim on*

reality is underway that ought not be passively encountered. Thus, they urge researchers, as I

have intended to throughout this study, to

> unpack the arguments and claims in terms of causation assumptions, worldviews,
> root metaphors, or core constructs (in order to be in a) clearer position to evaluate
> the veracity and truth claims of such competitions, and to appreciate the contexts
> and dynamics of power around the competition. (p. 362)

Openings in the Literature for Critique

In an effort to open space for questioning the veracity of the truth claims of natural

and medical science where ADHD is concerned, I'd like to briefly consider a three key

examples of contradictory research. First, though research has for some time sought to

fortify the position of medical science regarding the heritability of ADHD, genetic research

also suggests that if there is a major gene affecting the risk for ADHD, it is not fully

penetrant, and that environmental factors alone may best explain genetic variations (Eaves et

al., 1993). Second, in spite of myriad studies tying structural difference to disorder, recent

neurophysiological researchers at the NIMH found that when considered in a time-lapse

sequence, these differences show themselves to be a delayed maturation process that

"catches up" in 3 years when compared to the "normal" baseline (Shaw, et al., 2007). This

finding is complemented by a third contrarian offering, a 3-year follow up by a group of

distinguished researchers, many of whom participated in the original "gold standard"

research reviewed in Chapter 2, examining 36-month outcomes 2 years after the end of the

original Multimodal or MTA study. They looked at primary outcome measures of ADHD

and Oppositional Defiant Disorder (ODD) symptoms, as well as social skills, reading scores,

impairment, and diagnostic status. Recall that the original research found the effects of

medication management, behavior therapy, their combination, and usual community care

differed significantly at 14 and 24 months. This was hypothesized to be due mainly to the

positive impact of the MTA's medication management algorithm when combined with

behavior therapy, particularly as compared to behavior therapy combined with the usual

community standard of care (Arnold et al., 1997). In the most recent update, researchers

found that this advantage had disappeared 3 years later (Jensen et al., 2007).

A Social Constructionist Critique

Questioning the Heritability Claim in Particular

Given that the natural scientific argument is not without its contradictions or logical

flaws, let me now answer Pfenninger and Leitner's (2005) call to question its claims on

reality, via a brief social constructionist critique. According to Phelan (2005), this could be

explained in part as a consequence of the revolution in genetic science and our culture's

increased tendency to understand human behavior in genetic terms. Phelan also states that,

according to attribution theory, one might expect a reduction in stigma to accompany a

diagnosis of ADHD, due to reductions in blame, anger, and punishment, as well as increases

in sympathy and help. Unfortunately, Phelan finds little support for such prognostications,

noting instead an increase in the perceived seriousness and persistence of mental disorders,

as well as the belief that siblings and offspring would develop similar problems.

In my research, both of the aforementioned seemed to be true for the Watson

family. On the one hand, there was a reduction in stigma, an increase in help seeking—

which also emphasized the reduction of stigma. On the other, there was also a stated belief

in the veracity of the heritability of ADHD. As evidence, both boys "have" ADHD in the

family, and Keith stated that he felt he too "had" the disorder, even as he questioned the

seriousness with which the symptoms are treated today, versus how they were handled when

he was a child. In contrast, Phelan's (2005) findings appeared consistent with my

observations of the Norton family's experiences, both at home and in the school system.

Millie and Helen both made overt reference to the presence of ADHD in all five males in

the family, as well as to the seriousness of it at home and in the community. Helen also

claimed a belief that she "had" ADHD, in addition to other mental disorders. I observed

anything but a reduction in blame, anger, and punishment.

Questioning the Medicalization of Childhood Deviance

In considering my research results, it would seem that the phenomenon is fed by the

complex social trend toward *medicalization* in general—described by Conrad (2005) as

"defining a problem in medical terms, usually as an illness or disorder, or using a medical

intervention to treat it" (p. 3). According to Conrad (2005), three factors underlie all research

conducted in the 1970s and 1980s regarding medicalization as a social trend: (a) the

expanding power and authority of the medical profession; (b) the activities of social

movements and interest groups to "champion" a medical definition for a problem; and (c)

directed organizational or inter or intraprofessional actions—including the rise of medical

control of childhood deviance.

Medicalizing childhood deviance is far from new. Rafalovich's (2001) conceptual

history details the complex evolution of nomenclature employed by mental health

professionals since the turn of the 20th Century to address symptoms or clusters of

behaviors that "specifically describe childhood deviance" (p. 94), including: Idiocy,

Imbicility, Encephalitis Lethargica, Minimal Brain Damage, Minimal Cerebral Palsy, Mild

Retardation, Minimal Brain Dysfunction, Hyperkinesias, Atypical Ego Development,

Attention Deficit Disorder (ADD), and finally, Attention Deficit/Hyperactivity Disorder

(ADHD). In addition to providing a nosological history, this long list of disorders is also

emblematic of what has been called a long-standing effort to "medicalize unconventional childhood behavior" (p. 94).

Aside from the *medicalization* phenomenon, Rafalovich (2001) provides another sociological bridge to contemporary diagnosis by drawing parallels between the child diagnosed with ADHD, and Foucault's objectified criminal, or *homo criminalis,* which calls to mind once again the notion of Lynam's *fledgling psychopath* as previously discussed. According to Rafalovich, both "represent an object of study who [cannot] fit into the institutional frameworks of everyday life, and [therefore needs], in one way or another, to be molded to meet the demands of these institutions" (p. 102).

This notion of meeting the demands of institutions, in particular, schools, became particularly important as the modern era began, along with the first appearance of a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders, Second Edition (DSM-II), published in 1968. According to Milich, Balentine, and Lynam (2001, p. 464), this is when clinicians began classifying ADHD symptoms in terms of a "hyperkinetic reaction of childhood," which served to underscore their early focus upon "excess motor activity." By 1980, with the advent of DSM-III, a new label came into being—Attention Deficit Disorder or ADD—and along with it, a new emphasis upon difficulties with processes of attention. This was also the first time clinicians used the subtype adding hyperactivity. Thus, according to Milich et al*.,* "the role of hyperactivity in ADD had shifted from being a core component to being a nonessential, concomitant symptom" (p. 464). Later, in DSM-III-R, published in 1987, an undifferentiated category came into being— UADD—which resulted in at least the appearance of the DSM having "abandoned the inattentive subtype" (p. 464). By 1994, with the publication of DSM-IV, researchers had revised their diagnostic thinking once again to the current three-category system reflecting

the possible combinations of both dimensions. These include ADHD/predominantly hyperactive-impulsive type, or ADHD/HI, ADHD predominantly inattentive type, or ADHD/I, and ADHD/C, which denotes a combination of all of the maladaptive behaviors from both subtypes.

What the student of the history of ADHD may best learn from this brief survey appears in the summation of Rafalovich's (2001, p. 113) analysis:

> ADHD, comprised by the plethora of medical discourses that have objectified it are a product, not only of the current era, but also for the discourses that continue to strategize for its ownership. The medical discussion [at the turn of the last century has] demonstrated neurology's interest in medicalizing the morality of the young. The current position of psychiatry towards ADHD exemplifies this century-old medicalizing modality.

Questioning the Practice of Diagnosing ADHD

All of this serves to call into question the act of "diagnosing" itself. Charles Tart (1993) discusses the unique ability the human mind possesses to concentrate its energy in order to activate that which is desired, and to deactivate that which is not. One of the most compelling ways in which this uniquely human skill is deployed takes form in systems like the DSM-IV, and the act of labeling as "pathology" clusters of behaviors like ADHD. According to Wright and Lopez (2002), labeling is an act of conceptual abstraction that names a group in a way that emphasizes shared characteristics and de-emphasizes differences among its members. This "de-individuation is so insidious that all too readily it reaches the ultimate point of dehumanization in which the person is then made equivalent of the disorder" (Wright & Lopez, 2002, p. 38). In the case of children with ADHD, Kendall et al. (2003) expound upon exactly this theme:

> By far the most troubling aspects of these data were the meanings and the over-identification these children placed on having ADHD, as if they had an ADHD identity. . . . These children often talked about ADHD in terms of who they were, rather than the symptoms they experienced. ADHD seemed to define much of who they were. (p. 122)

This is consistent with Honos-Webb and Leitner's (2001) finding that diagnoses may exacerbate clients' symptoms rather than facilitate the healing process. Axelman (2008) cites narrative therapeutic case material from a 14-year-old male client diagnosed with ADHD which would support such a position, en route to a psychodynamic conception.

> For Paul, the diagnosis was something that happened to him. It did not in any way engage his ability to know whether [stimulant medication] was effective or not, or even how he would know if it was effective or not. . . . He was being invited into a view of himself as not being able to take full responsibility for himself because of a neurological disorder, and as not being able to function adequately in his life without psychostimulants. (Law, 1997)

In proffering a psychodynamic conception of ADHD, Axelman (2008) cites Winnicott's (1988, p. 87) half-century-old observation that the most common diagnosis at the pediatric clinic was then the state of "common anxious restlessness." He noted that Winnicott linked the symptoms of this phenomenon, which included overactivity, inattention, and impulsivity, to anxiety and the denial of depressed feelings. The meaning Winnicott made of the clustered symptoms was that they represented "a flight into activity" and away from an "inner feeling of deadness." I found this to ring true, particularly in my embodied experience with the children in the Norton family.

The question given such a Constructionist critique is *what can be done*? It would not be useful to deny the existence of a problem on philosophical grounds alone. To do so would be to invalidate the tangible suffering that I witnessed in both of these families, and which seemed to so severely impact the Norton family in particular. What I believe is called for is an alternative understanding of this phenomenon that eschews the linear causality and reductionism of natural science in favor of a more holistic view, thus setting the stage for visualizing more hopeful outcomes, regardless of race or socioeconomic status.

An Alternative Conception of ADHD

Behavior as Vital Structure

I challenge the mainstream rendering of ADHD as too simplistic in its focus upon linear causality. Maurice Merleau-Ponty (1942/1998) provides a suitably complex means of construing the phenomenon that honors not only its biological characteristics, but that also acknowledges its existence as a constituted historical and cultural artifact.

Merleau-Ponty (1942/1998) sought to understand the relationship between *nature* and *consciousness*. He defined nature in terms of a multiplicity of events external to one another and bound by relations of causality, which is the realm of the mainstream conception of ADHD. What is missing is an acknowledgment of the place of consciousness in our understanding of phenomena. Consciousness was thought by Merleau-Ponty to be the awareness of *objective meaning unities* that are constituted by it, as well as the universal creative force for which the system of experience existed. He saw nature governed by the tenets of *Realism*—namely, that which is deemed to be real exists in space and time and is regulated by causality—while consciousness was the domain of Kantian Critical Philosophy.

According to Giorgi (2008b), this quest to understand both nature and consciousness led Merleau-Ponty to wonder how the split between the Critical Philosophical tradition and the Naturalistic perspective could be allowed stand. In Critical Philosophy, the world is seen as an ensemble of objective relations borne by consciousness. In this conception, the organism is understood in terms of *partes extra partes,* or a multiplicity of events. Through this lens, psychology was limited to being purely analytical, or a collection of judgments behind all phenomena, akin to "analytical geometry, and for the rest, a study of certain bodily mechanisms" (Merleau-Ponty, 1942/1998, p. 3).

Finding this unsatisfactory for interpreting consciousness, Merleau-Ponty

(1942/1998) turned to natural science. According to Giorgi (2008b), this involved a critique

of *materialism* on the one hand, which held that *the mental* was a sector of the real world, and

mentalism on the other, which held that consciousness was a "productive cause or a thing," or

analogous to "a force." In any case, Giorgi states that natural science attributes to parts what

should be seen in terms of the whole. He noted that Merleau-Ponty arrived at his desired

destination through a complex and comprehensive analysis of the concept of behavior,

starting with the "atomistic interpretation" that was first posited by Watson—namely, the

negation of consciousness as an internal reality in favor of physiology and a "sum of reflexes

and conditioned reflexes between which no intrinsic connection is admitted" (p. 4).

Merleau-Ponty (1942/1998) noted that this fails at its most fundamental level, the

theory of the reflex itself, which he deconstructs in exhaustive detail, but he does not stop

there. Merleau-Ponty also took on the atomistic conception of higher levels of behavior

through the lens of Gestalt theory, en route to an ultimate conception of consciousness,

"not as a psychological reality or as a cause, but as structure" (p. 5). Of the whole of this

effort, Merleau-Ponty writes

> It is a fact that contemporary physiology has gone beyond the classical theory of the
> reflex. Is it sufficient to amend it, or ought one to change methods? Might
> mechanistic science have missed the definition of objectivity? Might the cleavage
> between the subjective and the objective have been badly made; might the
> opposition between a universe of science—entirely outside of self—and a universe
> of consciousness—defined by the total presence of self to self—be untenable? And
> if realistic analysis fails, will biology find its method in an ideal analysis of the
> physico-mathematical type, in Spinozistic intellection? Or might not value and
> signification be intrinsic determinations of the organism which would only be
> accessible to a new mode of comprehension? (pp. 9-10)

Merleau-Ponty's (1942/1998) illumination of the inadequacy of reductionist and

deterministic approaches to explain human behavior seems to me to be analogous to the

debate surrounding ADHD that I have framed in this research. I question the taken for

granted notion that it is a phenomenon simply reducible to neurological localities, electrical activity, cognitive processing speeds, genes, and, perhaps most importantly, "effective" dosages of psycho-pharmaceuticals. Given the amount of contradictory evidence and the complexity implied by a social constructionist critique, ADHD seems to me to be a matter best addressed by a new way of understanding, that, according to Giorgi (2008b) transcends cause and effect analysis and instead strives for seeing "the symptoms" as an organismic response to a question from the milieu (Merleau-Ponty, p. 63). Through this lens, "pathology" may be seen in the following terms:

> It is evident here that sickness does not directly concern the content of behavior but rather its structure and consequently that it is not something which is *observed* but rather something which is *understood*. The conduct of the patient is not deduced from the conduct of the normal person by simple subtraction of parts; it represents a *qualitative* alteration; and it is to the extent that certain actions demand an attitude of which the subject is no longer capable that they are electively disordered. (Merleau-Ponty, 1942/1998, pp. 64-65)

For Merleau-Ponty, the relationship of the "sickness" to its "symptoms" is no longer a linear, cause and effect proposition, but is instead a matter of the "logical relation of principle to consequence or of signification to sign" (p. 65). Thus, behavior does not merely have meaning, rather it *is* meaning.

Merleau-Ponty (1942/1998) goes on to assert more clearly that naturalism is not sufficient to account for human behavior. As an alternative, he offers the concept of *vital structures*. According to Giorgi (2008b), vital structures may be understood as a complex of relations in which any element is determined by the significance it has *for the organism*. It is out of a dialectic encounter between the organism and the world that this process of signification unfolds. The world places demands upon the organism, and the organism delineates its task in terms of demands. Thus, vital acts have meaning for the organism and do not "exist" *en soi*, or in themselves.

A Structural Conception of the Self via Cultural Psychology

If we conceive of ADHD in these terms, we can begin to stop treating children as isolated patients with defective brains and bad behavior in an otherwise healthy or normal world. Instead we may begin to see the developing child's Self anew: as a biological, conscious, connected, whole Being, who is both historically and culturally situated and constituted.

Benson (2001) elaborates on such a conception of Self, which, taken as a whole would be compatible with Merleau-Ponty's structural notion of behavior, stating that our biology constitutes our world and serves to locate our position in that world—a world that shapes us in specific ways to its own ends. I also see Benson's thinking as resonant with Interpersonal Neurobiology, which holds that human wellbeing may be conceived of as an irreducible structure consisting of mind, or consciousness, the neurological complex consisting of brain, heart, and viscera, and empathically attuned relationships (Siegel, 2006):

> The described correlates of neural integration are coherence of mind and empathy in relationships. In these ways, neural integration, mental coherence, and empathic relationships can be seen as three aspects of one reality of wellbeing. We do not need to attempt to reduce any one of these into some form of the other. Neural, subjective, and interpersonal, each forms valid dimensions of reality that cannot be simplified into the other. (p. 199)

As a conscious and connected human being (with the term "being" properly taken to be a verb in this context) we may be free to see ourselves in terms of a "self-as-a-story-told," (Benson, 2001, p. xi) or a narrative structure, one that functions to orient us temporally, as a "moral agent," in a way that efficiently stabilizes that orientation within the experiential flow of the lifeworld. According to Benson, the kinds of "moral and symbolic placement" in that narrative structure depend completely upon the "repertoires of cultural-historical options which are available to us and our communities" (p. xi). That is, how a person is located in his community, how that community is held by a wider society, how that society in turn stands

in relation to other societies, and how these relationships "are placed developmentally and currently in history, all have profound relevance for the kinds of mind and self that may be formed" (Benson, pp. 12-13).

Our resultant sense of self is shaped by the linguistic descriptions that we come to internalize. According to Benson (2001, p. 24), such descriptions are "constitutive, not merely reflective." In effect, they serve to define who we are, influence how we act and what we may become, both as individuals and in relationship. Thus, Benson writes, "the metaphorical armature of our ideas about the world and about ourselves have [sic] powerful existential consequences at every level, for our own and for others lives" (p. 24).

In the case of the Watson family, Michael may be readily seen as thriving. Described in a positive light—the discourse of difference versus disorder, if you will—the family's collective identity was characterized by a sense of overall goodness, a valuing of achievement, and powerful sense of creativity and agency that led to unlimited possibility. In contrast, the Norton family was invested in, even financially tied to, a discourse of disorder. Consequently, the family's narrative was dominated by notions of badness, powerlessness, lack, and the avoidance of punishment or premature death as desirable ends in and of themselves.

An Alternative Complex Structural Conception of ADHD

Applying the aforementioned theoretical constructs (Benson, 2001; Merleau-Ponty, 1942/1998; Siegel, 2001, 2006), what ADHD either is or is not for the child or his or her parents depends upon the quality of a dialectic encounter that is ongoing between the diagnosed child and his milieu. This dialectic encounter is not limited to the child's "diseased" brain and its responsiveness to treatment, discipline, or punishment. On the contrary, it involves a complex interplay of an unfolding child Self, which is a biological,

conscious, connected, whole Being, who is both historically and culturally situated and constituted.

This requires us to look with honesty and integrity at how history has shaped the child's and his or her family's experience. For example, if we are talking, as we are in this study, about an oppressed group like poor African American children, then we cannot discuss ADHD or any other "disorder" without also taking a hard look at how the diagnosis is influenced by and in turn influences the perpetuation of oppression and poverty, and how oppression and poverty are in turn linked to historical political practices dating back to the slave trade.

If we are talking about a privileged group, as we also do in this work, who lives essentially "free" from the shackles of terror within their own neighborhood streets, and who does not face racial discrimination or a paralyzing lack of socioeconomic opportunity, we need to look at what *works*. By discovering what works in their private schools and intact, loving, two-parent families, who create and exist within stable households, might we then be able to imagine using what we learn in order to help lift the marginalized out of the depths of their despair?

From a biological and relational perspective, the notion that a child's brain develops independent of his or her family's has been shown by cutting edge neuroscience to be a false claim. According to Morrison (2002), mirror neurons—or the system within the brain that perceives the intentional, goal-directed actions of others and links this perception to the priming of the organism to engage in the same (Siegel, 2006)—may play an important role in the transmission of culture by influencing the likelihood that certain behaviors will be repeated through systems of memory, patterns of excitation and inhibition, and emotion.

As they have been described throughout this work, it is not difficult to see how so-called learning disorders like ADHD and their accompanying conduct problems might be linked to the neurobiology of memory, patterns of excitation and inhibition, and emotion. If we conceive of ADHD and related phenomena in terms of a dialogue with the milieu instead of fixing *causation* to the brain in isolation from other human beings, we may begin to see our way toward intervention strategies that not only help suffering children, but that improve the lives of our families and the culture as a whole.

Indeed, if ADHD does not have meaning *en soi*, in itself, and we see it instead *as* meaning (Merleau-Ponty, 1942/1998), in my opinion, it could easily be seen as a communication from the collective (Leitner, personal communication, March 12, 2009) through the actions of certain human beings who may be especially suited, through a combination of their organismic nature and their ongoing dialogue with their particular milieu, to transmit the message that what we are doing is not in our best interests as human beings living in a global community. This might in turn open the possibility to conduct therapy with larger aims in mind.

In summary, if we begin to conceive of ADHD in complex structural terms, we may cease treating children as isolated patients in an otherwise healthy or "normal" world, and instead begin to see complex networks of interdependent relationships which are situated in historical and social context, all bearing upon one another in chains of circular causality. The result of such a shift is to open up limitless possibilities for the reduction of suffering that transcend traditional notions of sickness and health, and instead move us toward cultural transformation, as we heal ourselves, one another, and the systems we co-create.

Alternative Futures

A Holistic Model for Diagnosis

Recognizing the power of the systemic forces that maintain the "existence" of ADHD as a medical disorder, the question becomes how does one begin the work of cultivating the sort of cultural transformation for which I am advocating within current constraints? One alternative lies in countering the excessive weight placed upon the negative aspects of a diagnosis like ADHD with positively worded characteristics or behaviors, a fundamental principle of Positive Psychology (Wright & Lopez, 2002).

Hutchins (2002) proposes a "radical reorientation" from diagnosis to a holistic assessment framework that includes not only the DSM-IV multiaxial methodology, but also embraces five corresponding asset-based descriptive categories. Hutchins proposes that the process of diagnosing only reveals a part of a whole human being. In keeping with the way in which transpersonal psychology "includes the psychologies that came before it in a larger context" (p. 103), Hutchins proposes an alternative model, the Gnosis Model (Table 4), which provides a broader and more complete picture of an individual's mental health by making the DSM-IV axes a mere "subset of the overall understanding of the person" (p. 103) rather than treating them as defining characteristics. Thus, the Gnosis model fosters a view of the person that is greater than the sum of his or her symptoms of mental disorder and physical disease by embracing and acknowledging the powers of agency, aspiration, and unique ability. Similarly, the model also allows for a view of systemic context that reaches far beyond a list of shortcomings to also include the substantive gifts afforded by family, community, and culture.

Unfortunately, while representing a potential improvement to current systems, Hutchins' (2002) Gnosis model fails to explicitly address matters of spirit save for an almost

dismissive mention of the traditional association of the term with "direct knowledge of God, truth, or reality" (p. 102) and a brief mention of teleological knowing along with the word "soul" in explaining his concept of *calling* (p. 105). Additionally, Hutchins does not include anything other than sparse anecdotal support for his thinking in the form of four case studies—only two of which represent stories of actual clients.

Table 4

Gnosis Model

Axis	Gnosis Criteria	DSM-IV Multi-axial Criteria
Axis I	Calling and Goals	Clinical Disorders
Axis II	Core Gifts and Abilities	Personality Disorders/Mental Retardation
Axis III	Physical Gifts	General Medical Conditions
Axis IV	Psychosocial and Environmental Supports	Psychosocial and Environmental Stressors
Axis V	System Gifts: Family, Community and Culture	Global Assessment of Functioning (GAF)

While in principle his ideas seem to have some merit, a more explicit inclusion of transpersonal developmental concerns is desirable. Further, in my experience, Axis IV of the DSM-IV Multi-axial system fails to acknowledge with sufficient depth and nuance the kinds of stressors experienced by poor or racially oppressed populations. In spite of these weaknesses, I can imagine the potential value in pursuing rigorously designed longitudinal studies comparing groups of children diagnosed and treated for ADHD and overlapping conduct problems using current diagnostic and treatment standards with those diagnosed and treated beginning from a Gnosis-oriented perspective. I would hypothesize better outcomes in the latter group.

Alternatives to Conventional Treatment

In spite of its potentially constructive contribution to addressing ADHD and other so-called disorders, a positive or holistic diagnostic system likely will not solve the problem alone. The relief of real suffering must still be addressed. As has already been discussed, while conventional therapies may be effective in treating some of the troubling symptoms of ADHD, at least for a time, these interventions also carry many serious health risks.

There has been genuine interest in alternative treatments for ADHD at the highest levels of government and science, including the National Institute of Health (Arnold, 2002). One such alternative with a transpersonal bent, meditation, has a long history in clinical research, and may offer some promise for treating ADHD, as well as the commonly overlapping conduct problems that create so much trouble for society at large.

Meditation as a Stand-Alone Approach

Walsh and Shapiro (2006) provide a comprehensive survey of the dialogue between contemplative traditions and Western Psychology in the April 2006 issue of *American Psychologist*. The fact that this article appeared in the American Psychological Association's flagship journal speaks volumes regarding the emerging credibility of meditation, both as a legitimate object of study and as a clinical intervention. In the article, the authors specifically address the subject of enhancing or training attention as a skill. They cite William James (1910/1950, p. 424), who wrote that the ability to control attention "is the very root of judgment, character and will" and that to "improve this faculty would be the education par excellence." According to Walsh and Shapiro, he also opined that "it is easier to define this ideal than to give practical directions for bringing it about," concluding that "attention cannot be continuously sustained" (James, 1899/1962, p. 51), a conclusion that Western psychology has held for over a century.

According to Walsh and Shapiro (2006), proponents of all meditative practice agree that, without training, attention cannot be sustained. The authors suggest, with tongue lightly in cheek, that "we all suffer from some degree of attentional deficit disorder" in this way. However, the authors also maintain that meditative traditions ranging from Christian *contemplatio,* to yogic *samadi,* to Tibetan Buddhist *calm abiding* maintain that attention can be trained, albeit with difficulty, even to the point of unbroken continuity over hours.

The value of meditation as a therapeutic and personal growth practice for adults has been well-documented over the past three decades in both popular and scientific literature (Epstein, 2001; Goleman, 1971; Walsh, 1996; Welwood, 1980). There is also a hint of evidence that meditation with children may be beneficial, even for those prone to hyperactivity (Murdock, 1978).

Moretti-Altuna (1986) looked specifically at the efficacy of meditation as a treatment for ADHD. The researcher randomly assigned 23 boys diagnosed with ADHD to one of three experimental conditions: drug treatment, meditation training, or standard therapy control. After 4 weeks of meditation training, she found that only the meditation-training group showed statistically significant improvement in classroom behavior compared to either drug therapy or standard therapy controls. She found no significant differences among the treatment groups on measures of impulsivity, distractibility, or parent ratings of home behavior, and that all showed significant improvement in both distractibility and home behavior.

These findings would seem to be supported in a recent feasibility study conducted by scientists at the University of California-Los Angeles (UCLA) and the University of Southern California (USC), examining the potential efficacy of an 8-week mindfulness meditation training and practice regimen on adults and adolescents with ADHD ($n = 70$). The training

program consisted of a once-per-week evening session (2.5 hours) and daily at-home practice, along with some psychoeducation about ADHD (Zylowska et al., 2007).

The regimen was developed in accordance with existing clinical models, such as Jon Kabat-Zinn's (2003) Mindfulness Based Stress Reduction (MBSR), along with the ancient tradition of mindfulness meditation. Aside from the acknowledged limitations in this study—which include small sample size, mixed sample in terms of age, greater prevalence of overlapping mood disorders rather than conduct problems than most ADHD samples, perhaps greater overall functioning than what may commonly be expected from most ADHD samples, and the absence of a control group—the results appear to be promising. Researchers observed pre to posttest improvements in both behavioral and neurocognitive measures. Notably, 78% of all participants reported some symptom reduction, with 30% of those reporting greater than 30% improvement—a statistic which was found to be clinically significant. Interestingly, age was found to be inversely associated with improvement, underscoring the potential efficacy of this intervention with children (Zylowska et al., 2007).

In spite of these promising results, without more clinical studies, the efficacy of meditation as a treatment modality for ADHD will not gain meaningful traction within the scholarly or clinical community. Further, as I previously discussed, given that medication management has been shown to be less than effective for ADHD over the long haul (Jensen et al., 2007), and has been shown to be particularly ineffective when conduct problems are also present (Kidd, 2001), I would seriously doubt that meditation would be much more effective if it were used in isolation. In my opinion, a multidisciplinary approach to augment meditative interventions may be desirable.

Wisdom Therapy

According to Robins (1998), a wisdom model "integrates clinical, life-span developmental, affective, cognitive, and personality perspectives," along with "an additional four key components of wisdom; namely, adaptation, humility, meta-cognition, and automaticity, and applies them to cognition-emotion interactions in a variety of clinical categories" (p. 6). The grounding for this framework is what ties it to meditation as a valuable adjunct modality—"the significance of cognition as an antecedent of emotion" (p. 7), which is precisely what Eastern spiritual traditions like Buddhism and Hinduism have studied and taught for millennia. For example, Welwood (1980) describes a classic Buddhist mindfulness meditation in complementary terms:

> This kind of meditation is practice at being with ourselves completely. As we observe our thoughts, which graphically portray what is driving us, we get a very intimate sense of the areas of our life where we are afraid, fixated or grasping too tightly. At the same time, by releasing our attention from these concerns and coming back to the breath, we may also glimpse how we are already free from their grip. Thus, mindfulness is a practice of letting go, dropping our problem-centered focus and returning to simply being here. (p. 4)

According to Robins (1998), the central tenet of the wisdom therapy model is that "alternative appraisals of the same event will respectively facilitate or inhibit particular emotional responses. In particular, appraisals that are consistent with the wisdom components described will lead to lower frequencies and intensities of anger" (p. 7). Robins' (2005) more recent research demonstrates the importance of the metacognition of humility, which he describes in terms of less arrogance and narcissistic grandiosity, as well as an acknowledgment that our perceptions are subjective, tentative, and not "truth." One of the ways in which he proposes cultivating humility is via exposure to certain awe-inspiring experiences. As a topic for further study, perhaps this represents another point of connection between wisdom therapy and ADHD research, namely, the findings of Kuo and

Faber Taylor (2004) discussed in Chapter 2, who found in a novel and well-designed study that exposure to "natural green" settings significantly reduced ADHD symptoms compared to controls.

Robins' (2005) findings in a comparison of student, community, and organizational samples randomly assigned to a control group, a cognitive-behavioral therapy (CBT)/rational-emotive behavioral therapy (REBT) group, or a wisdom therapy group, include the following statistically significant correlations:

1. As humility rose, anger declined;

2. As humility increased, so did a person's sense of having an internal locus of control;

3. As humility increased, a person became less likely to interpret life events in a negative light.

Social Constructionist Clinical Practice

Social constructionist psychotherapies may also hold promise as a part of an innovative clinical strategy for working with children diagnosed with ADHD and related disorders. Leitner (2005) offers one such approach, experiential personal construct psychotherapy (EPCP), which would be consistent with my structural conception of ADHD. EPCP holds that human beings are inherently meaning-making organisms who co-create reality in interactions with the world. Leitner chooses the word "co-create" because

> the world is neither solely an internal construction nor an external given that is discovered. Rather individuals encounter a real world that is interconnected and constantly unfolding but can only know that world through the meanings they have to engage it. (p. 307)

According to Leitner (2005, 2007), the role of the therapist and researcher ought to be to understand the lived experience of beings-in-relation, without imposing some other set of constructs upon them, to include diagnostic systems like the DSM-IV-TR. The goal is for

the therapist [or researcher] to "trust the client's [or research participant's] experiences as revealing profound *truths* about life" (2007, p. 34).

Experiential constructivism is thus focused upon both the joys and suffering of human life as a relational activity. Indeed the theory depends upon the absolute necessity of "deep interpersonal connections" to leading a life that is both rich and rewarding (Leitner, 1985, cited in Leitner, 2005, p. 307). As a result, Leitner (2005) states that human beings are caught between choices that involve great intimacy—with its attendant richness and potential for terror—and withdrawal—with its apparent safety and resultant emptiness. Psychotherapy informed by experiential personal constructivism focuses upon "this vital, alive area of the need to connect with, versus the need to retreat from, others" (p. 307).

Thus, according to Leitner (2005, p. 307), the following tenets guide work by the constructivist therapist, who values the "lived wisdom" of the person with whom he or she is privileged to sit in healing partnership above all else:

1. The person's experience is respected and honored;

2. Relational connection versus distance is explored;

3. The person is seen as actively creating meanings that frame experience;

4. The person is seen as active, agentic, creative, and future-focused.

In keeping with the tenets of EPCP, the approach I would envision would necessarily be driven by the following priorities: establishing a human connection with the client with a genuine intention to establish relational intimacy and increased awareness in the here and now; the instilling of hope in the client; harnessing the power of human creativity (Leitner, 2007).

Narrative Therapy

As will become more apparent in the closing section of this paper, I am particularly intrigued by the possibilities offered by narrative approaches to therapy as a means of harnessing creativity and restoring a sense of agency, hope, and optimism to human beings in despair. The narrative therapeutic model's origins in the French philosopher, Michel Foucault's thinking about the practice of professional therapy as *a process of subjugation* (Monk, 1997), make it particularly appealing as I imagine therapeutic work with marginalized populations. Additionally, according to Monk (1997), Foucault's indictment of the cultural practice of constructing "true" standards of behavior is consistent with the previously mentioned tenets of EPCP (Leitner, 2005, 2007), as well as my aim in this work to challenge the way ADHD is constructed and continues to be taken-for-granted by clinicians, and, under their sway, by the culture at large, as a medical affliction. Monk notes that Michael White, one of the developers of narrative therapeutic approaches, was particularly motivated by Foucault's identification of the harm that arises out of the common practices of the therapeutic (and dare I say the teaching and counseling) professions to classify, judge, and otherwise determine what is desirable, appropriate, or acceptable behavior.

Future Possibilities for Therapy and Research

In summary, the confluence of the following suggests that a viable, multidisciplinary, treatment alternative for ADHD, even with serious overlapping conduct problems, and/or in marginalized populations, may be in the offing:

1. The potentially positive contributions to treatment outcomes of an asset-based, holistic diagnostic framework (Hutchins, 2002) and an avoidance of pathologizing nomenclature (Honos-Webb & Leitner, 2001).

2. The empirically validated efficacy of meditation practice in treating ADHD as compared to conventional, inclusive of pharmaceutical, interventions (Kratter, 1983; Moretti-Altuna, 1986; Zylowska et al., 2007), as well as its potential to benefit neural integration and improved attachment relationships (Siegel, 2006).

3. The potentially positive effect of wisdom therapy upon anger, locus of control, and the impact of negative life-events (Robins, 1998, 2005), particularly if adapted for use with children diagnosed with ADHD and accompanying conduct problems, including those who come from marginalized populations.

4. The power of constructionist approaches like EPCP (Leitner, 2005, 2007) and narrative therapy (Monk, 1997), to fundamentally shift dominant, negative life stories to something more hopeful and desirable (Bridges & Raskin, 2008).

Future Research

The aforementioned sketch of an emergent, structurally-oriented therapeutic approach led me to think about research. For example, what might we learn from the ways in which my participants, Keith and Marcy Watson, were living with and parenting their children? Free of the stressors faced by the Norton family, perhaps they were able to tap some well of innate wisdom to guide their approach to parenting and partnering. This suggests that a large scale study using Appreciative Inquiry (Cooperrider, Whitney, & Stavros, 2003) as its vehicle might help to uncover the best of what is alive in families who successfully deal with ADHD and other challenges to raising happy, healthy children in a variety of racial and socioeconomic contexts.

Where less success is in evidence, I can imagine cutting edge research combining the aforementioned and other clinical practices with what we have learned from attachment research and interpersonal neurobiology, all with an eye toward developing familial and

community based interventions that heal past traumas and foster the necessary and sufficient conditions for raising children with the capacity to form attuned relationships within themselves and with others, even in communities where the chaos they face on a daily basis threatens their very survival.

Creatively Imagining Therapy for Shelton: A Statement of Aspiration

As a means of closing this investigation, I would like to creatively sketch an innovative course of long-term therapy for one of my participants, Shelton Norton. Having logged over 3200 hours of supervised clinical experience, the majority with adolescents, and most of that with boys from communities of color, I feel reasonably qualified to imagine how this might look. I must also acknowledge up front that my experience in "reality" tells me that this vision is an expression of high aspiration, but as I come to the end of this project, this chapter of my life, I feel inclined to do a little dreaming.

A Foundation in Authenticity

Leitner (2005) describes psychotherapy as a "noble tradition of witnessing to the suffering of the heart, not manipulating or controlling (either chemically or behaviorally) the symptoms of human despair" (p. 306). Additionally, he encourages humanistic psychologists (which includes both transpersonal and constructivist psychologies, among others) to pursue the formulation of theories of psychotherapy that are at once rigorous, respectful, scientific, and artistic. Such theories, if properly conceived, come from a place of personal authenticity. When this happens, according to Leitner (2007), interventions come from who the therapist is, and thus cease to be techniques.

If I successfully attain this standard of authenticity, according to Leitner and Guthrie (1993, cited in Leitner, 2005, p. 311) my client might experience life as richer and more

meaningful. Our relationship will continually increase in meaning. My client will bring new material into the therapy. Lastly, my client's level of distress will change.

Holistic Diagnostic Process

Given the literature previously cited, the Gnosis Model (Hutchins, 2002) may prove a good place to start with Shelton as a child diagnosed with ADHD and accompanying serious conduct problems. The balanced perspective it offers between deficits and gifts may satisfy the caveat issued by Gresham et al. (1998) to avoid interventions that indulge an already over-inflated sense of self-esteem, and seek instead the cultivation of humility. This would also set the stage to conduct portions of the therapy according to a Wisdom model (Robins, 1998, 2005), with an eye toward reducing the sort of anger that has caused Shelton and his family so much trouble at school, in the home, and in the community.

Sharing specific pathology with Shelton would be ill-advised as previously noted (Honos-Webb & Leitner, 2001). Thus, I would forego specifically identifying mental pathology reserved for Axis I and II of the traditional multiaxial diagnosis, as well as the General Assessment of Functioning (GAF) on Axis V, which I have found to be essentially useless in working with my clients. For the purpose of this paper, I also refrain from any discussion of general medical conditions reserved for Axis III for the simple reason that I don't have enough information to comment.

Axes I and II (DSM-IV-TR)

Taking into consideration what I do know about the Norton family and Shelton's history in particular as a result of conducting this study, I would begin by evaluating the boy for signs of the impact of traumatic stress on his mind, body, and spirit, as was suggested by the previously cited Bosnian research (Husain et al., 2008). In doing so, I may uncover experiences or behaviors that coalesce in order to fit the description for Post Traumatic

Stress Disorder, but I may just as easily fail to gain such a decisive profile. In any case, an expanded conception of traumatic stress and its impacts would be warranted.

Toward that end, I prefer the work of Robert Scaer, M.D., a noted neurologist-turned-trauma-theorist. According to Scaer (2005), trauma need not be defined by the horrific extremes of human experience, as the DSM-IV would have us believe. On the contrary, it is better conceived as

> a continuum of negative life events occurring over the lifespan, including events that may be accepted as "normal" in the context of our daily experience because they are endorsed and perpetuated by our own cultural institutions. More importantly, I suggest that the traumatic nature of those experiences is also determined by the *meaning* the victim attributes to them. That meaning is based upon the cumulative burden of a myriad of prior negative life events, especially those experienced in the vulnerable period of early childhood. (p. 2)

Applying this definition to Shelton's case and home environments he was forced to endure as an infant and young child, it is not difficult to begin to imagine the weight of the burden of trauma that drove him to begin setting fires at the age of 2, likely as a means of communicating that all was not right in his world.

This brings me to another critical component of my dream course of therapy for Shelton. If I could, I would require that the whole family seek therapy together in order that they might gain new insight into destructive patterns of relating in the here and now, as well as intergenerational patterns and traumatic experiences that may have been unconsciously perpetuated, and that may still be at risk of being repeated with the children currently in the home. This would take the pressure off of Shelton and his younger brother, Devon, who currently serve in the role of the *identified patients* (Satir, 1967) for the family system, and arguably, for the community and society as a whole.

As a part of this, I would also make an attempt to leverage the power of transpersonal practice and interpersonal neurobiology (Siegel, 2001, 2006), encouraging the

adults in the family to participate in a mindfulness-based treatment protocol (Zylowska et al., 2007), in order to begin to impact the executive cortical functioning within the adults in the household. With a stronger neural foundation under construction in the adults, I would then cultivate and energize the collective of mirror neurons (Morrison, 2002), which make up what Siegel refers to in terms of resonance circuitry, within the whole family system. I would do this by teaching the children the same mindfulness skills that their adult caregivers had been experiencing and practicing together. This would theoretically set the stage for improved attachment relationships through a combination of improved interpersonally and intrapersonally attuned communication.

Returning to individual therapy with Shelton, I would exhaust all avenues of evaluation and treatment for traumatic stress, an effort that would ideally include not only neural integration modalities like Eye Movement Desensitization and Reprocessing (EMDR), which has been successful in treating combat veterans (Silver, Rogers, & Russell, 2008), but also body-based therapies like Somatic Experiencing (Levine & Frederick, 1997), which was recently used to help humanitarian aid workers following Hurricanes Katrina and Rita (Leitch, Vanslyke, & Allen, 2009). Only after completing this comprehensive exploration of traumatic experience, and allowing family therapy the time to progress beyond any initial upset of homeostasis (Satir, 1967), including the previously mentioned course of mindfulness protocols for both the adults and children, would I begin to delve into the possibility that other "pathology" may be salient to consider in Shelton's life.

Axis IV (DSM-IV-TR)

On Axis IV, I would include the following, taken from the DSM-IV-TR (American Psychiatric Association, 2000): Problems with primary support group (death of his father and uncle; multiple divorces and separations; loss of home; violence in the household; birth

of siblings); Problems related to social environment (discrimination); Educational problems

(academic problems; discord with teachers; inadequate school environment); Housing

problems (inadequate housing, unsafe neighborhood); Economic problems (poverty);

Problems with access to healthcare services (inadequate health care services; inadequate

health insurance); Problems related to legal system/crime (history of incarceration;

incarceration of family members; victim of assault). We might use this assessment of his

world and relationships to explore the nature of his current narrative and self-construction

within it as a way of externalizing the problem, so Shelton could cease seeing himself as "the

problem" (Bridges & Raskin, 2008). Not only would this set the stage for a course of

creative narrative therapy as I will describe below, it would also be consistent with the

cognitive reappraisal aspect of Wisdom Therapy as previously mentioned, and may support

the reduction of anger and consequent destructive behaviors.

Axes I-III (Gnosis Model)

On Axes I-III in the asset-based column of the Gnosis Model, I would begin by

discussing Shelton's stated goal to play football, and the obviously passionate interest in

sports that came out in the course of our interviews, along with supporting and affirming his

physical abilities and talents. Perhaps, we might spend some time together watching games

or playing catch in the park. Engaging him in this way would not only serve to build rapport,

it might also give meaning and validation to the things he most enjoys and wants to do.

Being more physically active as a part of therapy may also help to diminish his agitation.

I might also seek to engage his love of rap music by developing a specialized, poetic

narrative therapeutic intervention involving self-authored rap lyrics through which he might

revise his previously mentioned deficit-based narrative (Bridges & Raskin, 2008) in order to

envision a more positive future for himself and his family.

Axes IV-V (Gnosis Model)

On Axes IV-V in the asset-based column of the Gnosis Model, I would emphasize the strong family ties Shelton enjoys, and the legacy of love and care that surrounds him, as symbolized by the multigenerational portrait gallery that adorns the walls of his home. We might emphasize his support system through storytelling, perhaps adapting a protocol using auto-photography as a visual narrative therapy modality (Ziller, 2000) in order to facilitate the exploration and appreciation of significant relationships, to include the degree to which he experiences both connection and distance from the people in his life (Leitner, 2005). I might also seek to use this approach as a springboard toward building Shelton's autobiographical sense of self, and in turn, an awareness of his place in the unfolding story of African American culture. The purpose of all of these narrative approaches is to fundamentally shift Shelton's dominant life narratives (Bridges & Raskin, 2008), which heretofore have been anything but empowering.

Capstone: Taking it to the Community

As a capstone to my dream course of therapy, I envision a pair of compelling possibilities. First, taking great care to maintain his confidentiality, I might seek an opportunity to conduct a psycho-educational seminar for teachers and administrators at Shelton's school, and others in his school district. The goal would be to honor my client by taking what I learn from him into the world as an embodiment of poetic activism (Gergen, 2001). I could see myself developing an innovative program to help educators discover and share the most creative approaches to working with children who disrupt their classrooms, as alternatives to discipline and punishment strategies in isolation, or in combination with medical diagnoses. I could also offer an adaptation of the same program to parents in church basements or community center meeting rooms.

Secondly, I might invite Shelton to select and conduct a small service project in his community, one that harnessed his strengths and interests, and perhaps even helped him to make amends for any harm he may have done others in the past. Though it may be a stretch goal to include in my vision, inviting the client to join me in taking what we learned from and with one another back to the community as an expression of gratitude—a gift to something larger than the individual self, the therapeutic dyad, or the family system—is ultimately essential if psychotherapy is to make the kind of impact that I dream our profession might one day make.

In closing, Paris (2008) lends a most eloquent voice to my hope:

> What we are doing is inviting our clients [and, in my opinion, ourselves as therapists] to experiment not only with [our] own personal constructions, but with [our] relationship to the larger social world, and with how it is constructed. Just as process discloses meaning, so a change in meaning can only be evaluated in terms of a kind of process—both personal and interpersonal—it does or does not help to bring about. We cannot know how things will turn out beforehand. However, therapy as a form of social critique helps to create room in clients' relational worlds for such experiments to take place by helping to clarify what the problem is, where it is coming from, and what alternatives might be possible. (p. 358)

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APPENDIX A: PARTICIPANT RESEARCH INSTRUCTIONS AND QUESTIONS

Auto-Photography Instructions (Child)

Place yourself in this situation. You are sending a series of 12 photographs one by one to an internet pen pal from a school in another nearby city. You have never met spoken to, or written to this person, but you will get to meet face to face in 2 weeks. You want to give a true impression of yourself. I want you to take, or have taken, a series of 12 photographs. I also want to know the order in which you plan to e-mail them, so when they are developed, we will sit together and you will number them 1-12, marking the first photograph you would send with a 1, and so forth. The subject of the photographs may be anything you choose, as long as you think it is communicating something about who you are. I am not interested in your photographic skills. The photographs are a way to communicate to a stranger without words who you are. (based on the instructions in Ziller, 1990, p. 57)

Auto-Photography Instructions (Parents)

Place yourself in this situation. You are going to be sending a series of 12 photographs one by one through the mail to a person you have never met, spoken to, or written to. You will get to meet face to face in 2 weeks. You want to give a true impression of your family. I want you to take, or have taken, a series of 12 photographs. I also want to know the order in which you plan to mail them, so when they are developed, we will sit together and you will number them 1-12, marking the first photograph you would send with a 1, and so forth. The subject of the photographs may be anything you choose, as long as you think it is communicating something about your family. I am not interested in your photographic skills. The photographs are a way to communicate to a stranger without words who your family is. (based on the instructions in Ziller, 1990, p. 57)

Semistructured Interview Questions for Narrative Inquiry

Warm up questions: Spend some time connecting with the child/parent through revisiting the auto-photographic data already collected and talking about things of interest to him. Ask questions in a way that is developmentally appropriate and individualized for each circumstance.

1. General Questions

   o Tell me about your day-to-day life. What is a typical day like for you (your family) et cetera…

2. Description of Learning:

   o How would you describe yourself (your son) as a student or learner in your own words?

   o Tell me what it's like for you try to learn something (trying to teach your son). What meaning do you make of the way you (he) learn(s)? What's it like for you? What's easy and hard about it?

   o How would you describe your (your son's) learning style to somebody who doesn't know you (him)?

   o I realize someone may have told you that you (your son) were (was) different than other kids in this way. What was that like for you? How did you feel?

   o How do you know the person who thinks you are (your son is) different understands you accurately? What do you think having a person like a doctor call you (your son) different does to a person? What did it do to you?

   o If you agree with the doctor that you are different, where does it come from? What do you think causes it? Is the difference something that needs to be changed? Why or why not?

3. Help:

   o What do you think helps you (your child) the most? Why is that? What is that like?

   o What kind of help doesn't work for you (your child)? What is that like?

   o When something goes wrong for you (and your child), where do you turn for help?

   o Who is your greatest supporter? Tell me about that.

4. Medicalization Issues:

   o Specifically about this difference we've been talking about. Can you tell me something about how you get help for that from doctors or nurses?

   o What medicines do you (does your child) take and why? What is that like for you?

   o Do you think medicine is helping you (your child)? Why or why not?

5. Contextual Issues: Because African American families bear a greater disability burden from unmet mental health needs relative to Whites, the following questions will be given to African American participants. White participants will have modified versions.

   o What is it like for you to be African American (live in this neighborhood)? How do you imagine your life is different from White people (your neighbors or from poor people)? Tell me what it's like for you.

   o What has your experience been like in (with your child's) school?

   o Tell me about what it's like to go to the doctor or to see the community health nurse.

   o What would you like for your teachers, doctors, and counselors to know about you and your family?

   o What do they need to know about being African American (about what it's like to live in this community)?

   o Do you think that being African American (living in this community) affects how you and your family are treated? How so?

   o Have you ever experienced what you felt was discrimination? Where and how did that happen? What was that like?

APPENDIX B: INFORMED CONSENT FORM

To the Participant in this research:

You are invited to participate in a study that will help the field of psychology to better understand the experience of adolescent boys who have been given a diagnosis known as ADHD by their healthcare provider. The study will also consider the experience of parenting these boys and their family life.

The procedure will involve, in brief:

- o Having your child take a series of 12 to 15 photographs that describe who he is using images instead of words.

- o Having your child participate in a 1-hour audio taped follow-up interview to discuss the photographs.

- o Having you and your partner, spouse, or other caregiver of your choosing take a series of 12 to 15 photographs that describe your family using images instead of words.

- o Having you and your partner, spouse, or other caregiver of your choosing participate in a 1-hour audio taped follow-up interview to discuss the photographs.

- o Having your child, you, and either your partner, spouse, or other caregiver of your choosing each participate in a separate 1-hour audio taped interview about your every day life.

The interviews will take place in a location that we choose together and will be conducted at a time that is mutually agreeable. The photographs will be taken with equipment provided by me and processed at my expense.

For the protection of your privacy, all information received from you will be kept confidential. All data will be password protected and archived on my personal computers. All printed materials will be kept in a locked file in my home office. My three dissertation committee members, a professional transcriber, and I will be the only people with access to the information I collect. Transcription of all interviews will be conducted only after the

transcriber has signed a Confidentiality Agreement. As additional privacy protection, I will use fictitious names in writing and presenting my dissertation. In reporting information in published materials of any kind, any information that might identify you will be altered to ensure your anonymity. If you wish to have your photographs included in any public forums, including both published materials and presentations, you may grant your permission on a separate form.

The study is designed to minimize potential risks to you. If you would like additional psychological support as a result of material discussed during either the photographic or interview processes, I will refer you to appropriate resources, and pay for one session with a licensed psychologist if you so choose.

If at any time you have concerns or questions, I will make every effort to discuss them with you, informing you of options for resolving your concerns. You may contact me at 650-823-8090, or via e-mail at sphatt@me.com. Alternately, you may contact Olga Louchakova, M.D., Ph.D., Committee Chair, or Kartik Patel, Ph.D., Research Ethics Committee Chair, at 650-493-4430.

The Institute of Transpersonal Psychology assumes no responsibility for psychological or physical injury resulting from this research.

If you decide to participate in this research, you may withdraw your consent and discontinue your participation at any time during the conduct of the study and for any reason without penalty or prejudice. Participation in this research does not guarantee that data collected from you will be used in the final results. You may request a written summary of the research findings at the culmination of the study, as well as a copy of all photographic images in both compact disc and printed form.

I attest that I have read and understood this form and had any questions about this research answered to my satisfaction. My participation in this research is entirely voluntary and no pressure has been applied to encourage participation. My signature indicates my willingness to be a participant in this research.

_____   _____
Child Participant's Name and Date   Child Participant's Signature

_____   _____
Parent or Guardian Name and Date   Parent or Guardian Signature

_____   _____
Parent or Guardian Name and Date   Parent or Guardian Signature

Mailing Address and Telephone Number:

_____

_____

_____

_____   _____
Sean Patrick Hatt, M.A., Researcher   Signature

APPENDIX C: PHOTOGRAPHIC USE AGREEMENT

By signing below I grant permission for the researcher to use my photography/image for publication in scholarly journals, publication in scholarly books, and public presentations at seminars, conferences, and the like. Any other use is strictly forbidden. Photographs may not be sold without my consent. In the event they are sold as photographs (not as a part of the approved uses listed above), I will be the sole recipient of all proceeds.

I understand that my identity will not be concealed in these photographs, but that my name will not be associated with any of my imagery.

|	
Child Participant's Name and Date	Child Participant's Signature
Parent or Guardian Name and Date	Parent or Guardian Signature
Parent or Guardian Name and Date	Parent or Guardian Signature
Researcher's Name and Date	Researcher's Signature

APPENDIX D: CONFIDENTIALITY AGREEMENT FOR TRANSCRIPTIONIST

AND PARTICIPANTS

As a transcriptionist or participant, I agree to maintain confidentiality with regard to all participant information, specifically photographs taken by them as well as the tapes from their interview sessions, and any other related written material.

Transcriber/Participant Name and Date	Signature

APPENDIX E: RECRUITING MATERIALS
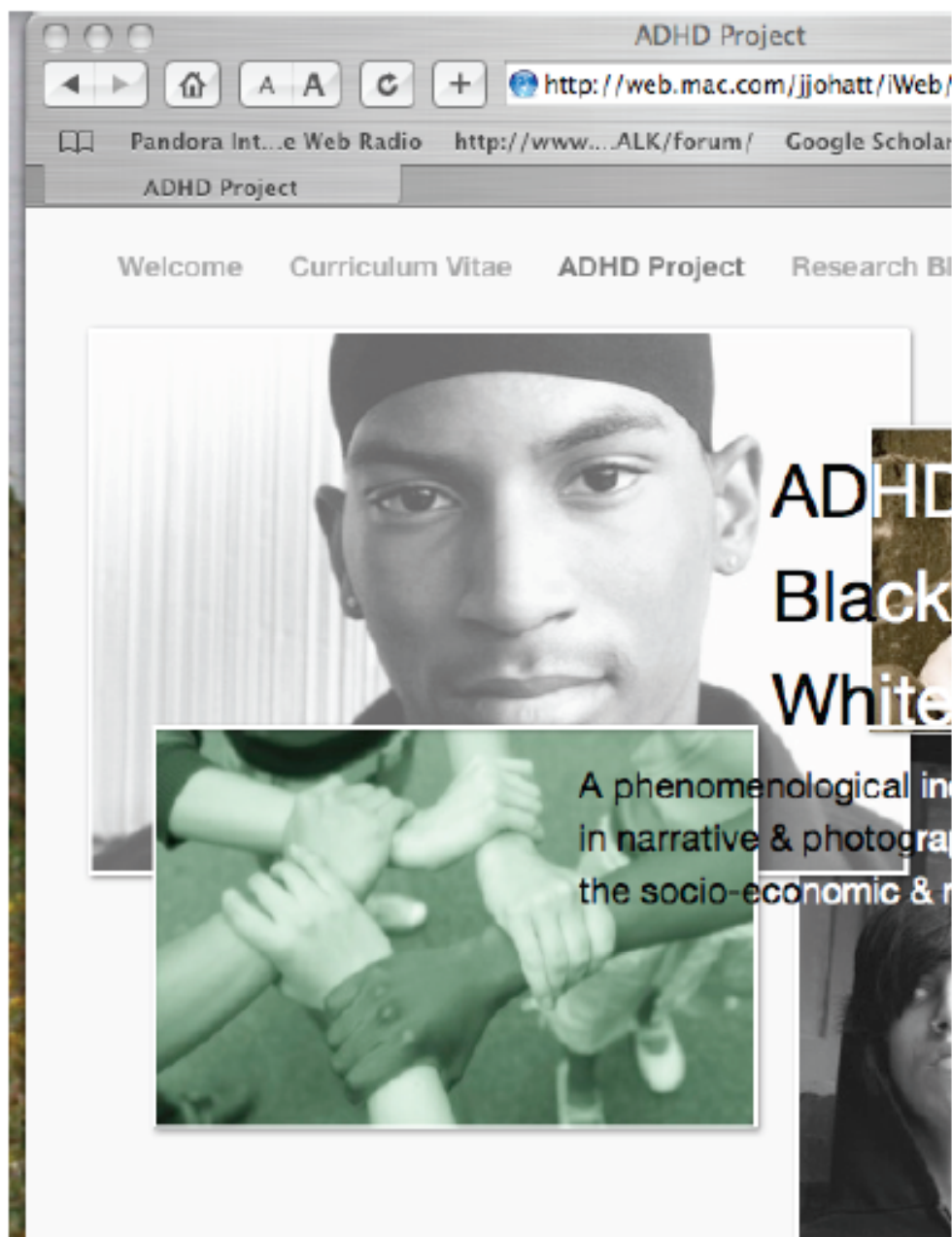
I used a simple website at www.seanpatrickhatt.com to publicize the project and to facilitate contact with potential participants and referral sources.

APPENDIX F: CONTACT INFORMATION

In the event that other scholars wish to contact me to discuss this project or to inquire about access to interview transcripts or samples of the photography rendered by the participants in this study, they may do so by e-mail: SHatt@scu.edu. Any such inquiries will entail the use of confidentiality agreements in order to protect the privacy of the participants in this study.