ADHD defining discourse
An approach to the DSM-V from a Critical Discourse Analysis perspective

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ABSTRACT This research analyses how psychiatric institutional discourse shapes Attention Deficit/Hyperactive Disorder (ADHD) in order to understand how this discourse (i) has an active role in modelling a canonical representation of the illness, and (ii) contributes to the social formation of an identity for the diagnosed individuals. Attention is paid to any evidence of stigmatisation. The investigation is performed through a data-driven critical discourse analysis of the ADHD chapter of the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) (American Psychiatric Association) adopting Halliday and Matthiessen’s (2004) systemic functional grammar and Jeffries’ (2010) analytical toolkit. The prototypical ADHD target is identified with a querulous elementary school-aged white boy. ADHD is defined by its symptoms and established as perilous in virtue of its associated consequences. Insufficient attention and excessive movement or talk are graded according to standards ultimately founded on social desirability. DSM-V not only provides the orthodox description of all categorised mental disorders, it also establishes the standards all individuals have to meet to be sane.

1 Introduction
This study analyses (i) how Attention Deficit/Hyperactive Disorder (ADHD) and its sufferers are constructed as objects of discourse in the Diagnostic and Statistical Manual of Mental Disorders (5th Edition) (DSM-V) of the American Psychiatric Association, which defines all the known mental disorders and regulates the diagnosis procedure, and (ii) gives account of any evidence of stigmatisation in the data. The analysis is based on the Systemic Functional Linguistic (SFL) framework and grounded in the Critical Discourse Analysis (CDA) approach. The study shows how the DSM-V, primarily confined to psychiatric practice, also holds a strong political stance: in describing mental disorders, a definition of the normal is provided, thus portraying the standard social individual.

Stigmatisation has traditionally been bound to mental illness in sociological research; it is related to the cultural conceptualisation and experience of the illness (public stigma),
ADHD defining discourse and has a direct influence on identity construction, usually conditioned by the internalisation of stereotypes (self-stigma) that results in a loss of self-esteem (Corrigan et al. 2005) and hinders a proper recovery (Wahl 2012). Foucault (1972) defined mental illness as the stigma that replaced leprosy once the latter had been eradicated, which originated within a moral of exclusion that enacted relations of differentiation, segregation and purification. Social discrimination, sometimes ‘structural’ (i.e. founded on official policies), has been reported as one of the prevailing major obstacles for people diagnosed with a mental disorder in obtaining employment and living autonomously (Corrigan et al. 2005; Wahl 2012). Discrimination is commonly rooted in the social fear against the different individual (Jamison 2006), and is reinforced by the usual media representations of mental illness and mental health sufferers. Sufferers are depicted as passive individuals overwhelmed by the disorder, and mental illness is associated with criminality, violence and dangerous situations (Coverdale et al. 2002; Bilić & Georgaca 2007). Mental illness is framed within two main discourses: the discourse of dangerousness and the biomedical, which establishes psychiatry as the expert authority empowered to determine abnormality and bring sufferers back to sanity (Bilić & Georgaca 2007). Mental illness stigmatisation and the stigmatisation of people with ADHD diagnosis are recognised as a prevailing reality in Europe (ADHD Europe 2009; Clark 2012; European Commission 2005).

This study understands discourse as the socially constructed representation of reality, legitimised and spread through institutions, that defines what can be known and the different positions subjects can occupy (Foucault 1969; Fairclough 1989: 73). Fairclough’s approach to CDA, which incorporates the Hallidayan metafunctions of language and makes discursive productions and social practices the focus of analysis (Fairclough 1992: 225–240, 2013: 133), is adopted. Halliday and Matthiessen’s (2004) Systemic Functional Linguistics (SFL) constitutes the analytical framework; SFL is based on the multifunctionality of language and directly relates the semantics and grammatical structure of language.

This study examines the following questions:

1. How is ADHD represented in the psychiatric institutional discourse?

2. How are people with an ADHD diagnosis represented?

3. Is there any evidence of stigmatisation in the data?

Section 2 develops the current debate around ADHD. Section 3 accounts for the data and exposes the methodology employed. It follows with a detailed descriptive and interpretative analysis of the ADHD chapter of the DSM-V. The last section presents a discussion of the findings and draws some new lines of investigation.
2 ADHD: A contentious subject

Attention Deficit/Hyperactive Disorder (ADHD) is classified under the category of Neurodevelopmental Disorders, which comprises all mental disorders with onset in the early years of development, and is characterised by personal, social, academic or occupational impairments (American Psychiatric Association 2013a: 31). Inattention is associated with disorganisation, incapacity to focus on tasks or conversations; hyperactivity is mainly identified with verbal and kinetic incontinence (American Psychiatric Association 2013a: 32). Despite the early onset, ADHD is regarded as a potential lifelong disorder with academic, occupational, and social impairments.

Both the general population and part of the psychiatric community share controversial opinions about ADHD (Rafalovich 2004: 44). Laypeople and some clinicians denounce the validity of ADHD as a syndrome, claim an over-diagnosis/misdiagnosis, an overtreatment, and warn against the dangers of psychoactive drugs prescription (Buitelaar & Rothenberger 2004; Rafalovich 2004: 76). The common identification of children as the main target strengthens the controversy.

ADHD prevalence is polemical. The difference in the number of reported cases and the increasing rates frequently accounted in the media have been attributed to the divergence of diagnostic criteria employed in different countries and the methodological differences across the estimation studies (Polanczyk et al. 2007, 2014). Rate variations range from 2.2% to 17.8%, and studies based on DSM-IV criteria instead of DSM-III have been reported to present a higher rate (Skounti et al. 2007). DSM-V and ADHD-Europe establish an average rate of 5% children in most cultures (American Psychiatric Association 2013a; Clark 2012: 61). The increase in ADHD diagnoses is recognised among the psychiatric community, partly attributed to its identification in classroom settings by the educational institution (Buitelaar & Rothenberger 2004; Rafalovich 2004: 66). The increase in psychostimulants has been confirmed, observing a rise in the dosage and intake period (Buitelaar & Rothenberger 2004). The potential side-effects of the medication are likewise admitted among practitioners (Rafalovich 2004: 74–83), recorded in the 10-15% of treated patients in placebo controlled surveys (Buitelaar & Rothenberger 2004).

ADHD diagnosis is attributed an active role in identity (re)construction (Rafalovich 2004: 119). Targets’ identity might become dependent on continued medication, and a loss of the internal locus of control has been reported for some children under medication (Rafalovich 2004: 83). Self-identification with the disorder and self-construction through ADHD categorisation are also observed (Schmitz et al. 2003).

This study aims to contribute to the literature of discourse studies on the psychiatric institution, particularly to those concerned with ADHD (Graham 2007; Danforth & Navarro 2001). Despite the attention received from the sociological and ethnographic
fields and its current social relevance, ADHD is still an under-researched topic in linguistics research. It is argued that SFL offers a rich framework and a consistent methodology to analyse the constructions of representations in discourse by grounding the research in empirical textual data, thus providing good insights to the existent literature. Danforth & Navarro (2001) stress the influence of the dominant discourses about ADHD (identified as the medical and the educational) in shaping laypeople’s everyday linguistic constructions of ADHD. The present study shares their stance in recognising the importance of the institutional psychiatric discourse in ADHD representation, not only relevant in medical settings but as a conditioning factor of its quotidian representation by both sufferers and the general population. Contrarily to some research on the topic (cf. Visser & Jehan 2009), the study does not question the ontology of ADHD, nor affiliates with the pure social constructionist perspective of mental disorders (Conrad & Barker 2010). ADHD is taken into consideration as represented in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (5th Edition), commonly regarded as the gold standard of the orthodox psychiatric practice (Sanders 2011).

3 Methodology

This study is ultimately based on Fairclough’s (1992) synthesis of social and text-analytical traditions, which understands discourse in a dialectical relation with social context, and establishes language as constitutive of social identities, relations and systems of knowledge and belief. Fairclough divides CDA into three phases: (i) description of the textual production, (ii) interpretation of discourse, and (iii) explanation or exhibition of discourse as part of a social practice. Phases (i) and (ii) are offered in the data analysis section; phase (iii) has not been developed due to lack of direct access to psychiatric practice and stakeholders’ views; this more socially oriented research is left for future investigations.

The analysis is grounded in Halliday and Matthiessen’s (2004) Introduction to Functional Grammar and Jeffries’ (2010) language-based analytical toolkit, and is particularly focused on the study of the ideational aspect of language. The analysis is developed along three different axes. Each axis is articulated around one of the major participants in the diagnostic process: (A) ADHD, (B) the patient, and (C) the clinician. Axes A and B study the representations of the disorder and the targets respectively; the presence of stigmatisation is also questioned. Axis C analyses the articulation of the authors in the text in order to understand the position adopted by practitioners, and the room left for institutional responsibility.

All axes structure the analysis around two major linguistic features: naming and transitivity—where the first is concerned with wording, and the latter with the process types (verbal groups that conceptualise the perception of change) and the actors associ-
ated with them (the participants established as agents of the processes). Jeffries’ (2010) ideational linguistic features, i.e. equating, contrasting, enumerating, exemplifying, assuming, and implying, are analysed in relation to transitivity and naming. Theme and rheme, mostly associated to the textual metafunction for their organisational function in discourse, are also employed due to the important ideational effects of information distribution. Theme is the “point of departure of the message” (Halliday & Matthiessen 2004: 64), usually associated with information already given or understood as shared knowledge; rheme constitutes the development of the theme, this which brings the new information of the clause.

Axis C also studies the mood and modality of the data. Halliday and Matthiessen’s (2004: 150) distinction of two modality types is adopted: (1) modalisation, composed by the probability and usuality subtypes, and (2) modulation, composed by the obligation and inclination subtypes. Still, some distance is kept from their conceptualisation of mood and modality as exclusive interpersonal elements and both are also understood as ideational features (Jeffries & McIntyre 2010: 77). Mood is a grammatical device that expresses factivity (indicative), commands (imperative) or unreal situations (subjunctive) (Frawley 1992: 390). Modality is a semantic phenomenon that reflects the speaker’s attitude towards what is expressed (Frawley 1992: 386) and constructs the speaker’s representation of the world (Jeffries 2010: 122).

The DSM-V, the source of the data to be analysed, was selected due to its strong social impact. The first edition of the DSM dates from 1952; DSM-I constituted an attempt to classify mental disorders which aimed to make easier the communication among the community of North American professionals (Sanders 2011). It was with the third edition, in 1980, that the DSM gained international authority and application (Horwitz 2011; Horwitz & Wakefield 2006).

DSM-III was the product of the convergence of multiple historical contingencies. During the decades after the Second World War, psychiatrics experienced an increase in productivity and research (Eisenberg 1986; Eisenberg & Guttmacher 2010). Psychodynamics, the psychoanalytical perspective, was still the dominant trend during the 1950s and 1960s; patient-centrality prevailed, and symptoms of mental illnesses were connected to everyday psychopathology (Eisenberg & Guttmacher 2010). Symptoms were regarded as symbolic expressions of the mind and one symptom could be attributed different significations in function of the patient’s biographical context (Horwitz 2011). During the 1950s psychoactive drugs were introduced to treat psychotic disorders (Eisenberg & Guttmacher 2010; Horwitz 2011), psychotropics were regarded as syndrome specific, diagnosis became essential for an effective treatment, and neurobiology gained force (Eisenberg 1986; Eisenberg & Guttmacher 2010). In the 1970s, the inability in psychodynamics to measure, quantify, and compare diagnostics delegitimised psychiatry as a medical discipline. Psychoanalysis
did not fit the new treatments and the biomedical model had to be adopted to preserve its scientific status (Horwitz 2011).

DSM-III adopted an a-theoretical symptom-based description of mental disorders to distance itself from the psychodynamic perspective (Buitelaar & Rothenberger 2004; Horwitz & Wakefield 2006; Horwitz 2011). The new symptom-based diagnostics presupposed the quantification of symptoms and operationalised and standardised the diagnosis process (Horwitz 2007, 2011). DSM-III adopted the biomedical discourse, and mental disorders were equated to brain diseases (Eisenberg 1986; Deacon 2013). Still, no biological or psychological test has proven to be sensitive enough to attest any psychiatric disorder. Disorders are understood as extreme scores with some given characteristics, and the boundary between normal and abnormal is not crystal clear (Buitelaar & Rothenberger 2004). The effect of biomedical discourse upon stigmatisation is controversial: while some sources affirm that categorising mental disorders as non-volitional illnesses that need treatment has diminished the stigma by encouraging individuals to get medical care (Horwitz 2007), a reinforcement of the conception of mental disorders as chronic and untreatable is also reported, thus fortifying the stigmatisation (Deacon 2013).

DSM-V, the latest edition and source of the data analysed, has been accused of lowering the diagnostic thresholds of common mental disorders (Deacon 2013) and of pathologising normal extreme behaviours (Gornall 2013). The criticisms have come from both non-members and members of the professional community, including leading figures such as Frank Farley, the former president of the APA, and Allen Frances, chair of the DSM-IV task force (Gornall 2013). Depression, learning disorders and ADHD are among the most disputed diagnoses. DSM-V is more oriented than the previous editions to adult ADHD targets and emphasises ADHD’s potential chronic nature; ADHD diagnostic criteria have not changed from DSM-IV, but DSM-V includes more examples of conducts to illustrate the symptoms (American Psychiatric Association 2013b). The long lists of exemplifications may contribute to the conflation of normality and pathology denounced in (Horwitz 2007).

The data analysed, a total of 2622 words, covers the entire ADHD chapter with the only exception of the Differential Diagnosis section, omitted for not being strictly about ADHD.
4 Data analysis

4.1 Axis A: ADHD taken as subject of analysis

4.1.1 Naming

ADHD is commonly referred in DSM-V by its initials and through the naming of the constitutive features of the diagnosis. The long form only appears in the title of the Section and at the end, to name the ‘Other Specified’ and the ‘Unspecified’ Attention-Deficit/Hyperactivity Disorder. These two general references are not interchangeable: ‘ADHD’ is rarely in grammatical subject position or constituted as actor. When stated as actor, ADHD is mainly named by its characteristics. The naming process is creative, as the references established in naming build analogies and equivalences: naming the ‘thing’ by reference to its own name and its qualities easily equates the ‘thing’ to the qualities.

(1) A persistent pattern of inattention and/or hyperactivity-impulsivity [...] (p. 59)

(2) The essential feature of [...] (ADHD) is a persistent pattern of inattention and/or hyperactivity-impulsivity [...] (p. 61)

ADHD is equated to the “pattern” of its symptoms; describing the pattern by paraphrasing the name of the disorder contributes to construct the equivalence.

(3) [...] that interferes with functioning or development, as characterized by (1) and/or (2) (p. 59)

The “pattern” equated with ADHD is characterised by “inattention” and/or “hyperactivity and impulsivity”. Naming the criteria as “(1)” and “(2)” contributes to pack together inattention, and hyperactivity/impulsivity, with all their symptoms. The following examples offer more references to ADHD by its symptoms:

(4) Several inattentive or hyperactive-impulsive symptoms were present [...] (p. 60)

(5) Inattention: Six (or more) of the following symptoms [...] : a. [...], b. [...], c. [...], d. [...], e. [...], f. [...], g. [...], h. [...], i. [...] (p. 59)

Both examples base the definition of the object under study on its manifestations. (4) corresponds to criterion B of the ‘Diagnostic Criteria’. A relation of equivalence is established between the qualities (symptoms) and the object being referred to (ADHD). (5) defines inattention by its symptomatology, presented in a nine-members-list with exhaustive character (Jeffries 2010: 70). Inattention and the symptoms are equated: all the listed conditions are understood to imply inattention, excluding any other possible manifestation. A logical relation is traced between cause (inattention) and product (symptoms):
if six or more symptoms are perceived, then inattention is present. This is not an exclusive relationship: other factors could also manifest inattention, thus the list in (5) is not exhaustive. However, if the conditional is turned into equivalence, inattention and its symptoms are the same thing, the list is exhaustive and no more inattention manifestations can exist. By a transitive relation, ADHD is also equated to the symptoms identified with them—where ‘transitive’ does not refer to Hallidayan SFL but to the logical relationship (cf. for example Badesa et al. 1998: 70). Evidence of this identification is the naming of ADHD subtypes: all of them establish ADHD as the “presentation” of the listed symptoms:

(6) Combined presentation: [...] (p. 60)
(7) Predominantly inattentive presentation: [...] (p. 60)

The naming of ADHD also entails an objectification: ADHD is depersonalised, presented as a disembodied entity possible to be described on its own.

(8) [...] ADHD is associated with an increased risk of suicide attempt [...] (p. 61)
(9) [...] ADHD presentation should still be diagnosed. (p. 61)

(8) presents ADHD and the other disorders as things which exist in themselves; no reference is made to the sufferer. ADHD is established as the goal of the association of the diagnosis and acquires a thing-like status. In (10) and (11), the manifestations of the disorder are reified:

(10) Inattention becomes more prominent [...] (p. 62)
(11) [...] impulsivity may remain problematic [...] (p. 62)

The existence of inattention and impulsivity is assumed, as both are grammatical and logical subjects (Halliday & Matthiessen 2004: 56). Symptoms are equally depersonalised:

(12) [...] symptoms of motoric hyperactivity become less obvious in adolescence [...] (p. 62)

Symptoms are stated as independent of the body that presents them. Sufferers are referred to in an optional adverbial phrase, by alluding to when the symptoms can be perceived. The objectification makes ADHD and the symptoms quantifiable. The thing-like character of ADHD is also constructed by circumscribing it in relations of possession:

(13) [...] individuals with ADHD [...] (p. 62)

This is a common wording in the data. ADHD is turned into an entity that can be possessed and becomes a distinguishing marker. Still, the alternative wording ‘ADHD individuals’ would assign a constitutive character to the disorder and the labelling effect
Table 1

<table>
<thead>
<tr>
<th>Process Type</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existential Process (EP)</td>
<td>5</td>
</tr>
<tr>
<td>Verbal Process (VP)</td>
<td>6</td>
</tr>
<tr>
<td>Identifying Relational Process (IRP)</td>
<td>8</td>
</tr>
<tr>
<td>Attributive Relational Process (ARP)</td>
<td>44</td>
</tr>
<tr>
<td><strong>Total Relational Process (RP)</strong></td>
<td><strong>52</strong></td>
</tr>
<tr>
<td>Material Process Intentional (MPI)</td>
<td>35</td>
</tr>
<tr>
<td>Material Process Event (MPE)</td>
<td>42</td>
</tr>
<tr>
<td>Material Process Supervention (MPS)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Material Process (MP)</strong></td>
<td><strong>78</strong></td>
</tr>
</tbody>
</table>

Table 2

<table>
<thead>
<tr>
<th>Roles attributed to ‘ADHD’</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
<td>9</td>
</tr>
<tr>
<td>Actor</td>
<td>4</td>
</tr>
<tr>
<td>Carrier</td>
<td>4</td>
</tr>
</tbody>
</table>

Finally, ADHD is also named as “disorder”:

(14) Manifestations of the disorder must be present [...] (p. 61)

A ‘disorder’ is considered to be the disruption of physical or mental functions (cf. Oxford University Press 2017). Despite its negative connotation, ‘disorder’ is perceived as more neutral than ‘illness”; it is socially improper to talk about ‘mentally ill people’, therefore the wording ‘people with mental disorders’ is preferred.

ADHD has been depicted as a mental disorder (or illness), identified by its manifestations or symptomatology, and which is possible to be quantified and possessed. This possession possibility turns ADHD into a distinguishing marker.

4.1.2 Transitivity

Table 1 offers a quantitative overview of the different processes associated with ADHD in the document analysed. The substantial presence of material processes evidence the portrayal of ADHD as the outcome of a process, confirming the preference for objectivity in the representation of reality (Barker & Galasiński 2001: 71). Table 2 accounts for the different grammatical roles explicitly attributed to ADHD; in accordance with Table 1, the role of Goal (of a material process) predominates.
Existential  Existential processes (EPs) are always uncommon but important for bringing phenomena into existence (Halliday & Matthiessen 2004: 257). This is the only existence unfolded in text; all other participants are taken for granted. All five EPs (see Table 1) are introduced by the impersonal ‘there is’ construction and establish, from an objective and unquestioned stance, the severity and hypothetical conditional factors and consequences of ADHD, and highlight aspects to be considered during the diagnosis.

(15) There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning (p. 60)

As the existence of “clear evidence” is highlighted, the disorder is turned into a visible impairment in every social sphere.

(16) There may be a history of child abuse, neglect, multiple foster placements, neurotoxin exposure [...], infections [...] (p. 62)

The modal “may” implies a low epistemological commitment to what is announced, yet it is unlikely that readers will doubt the possibility of its existence: EPs establish participants as given entities.

Verbal  Verbal processes (VPs) are scarce. From the six identified (see Table 1), the clinician is the actor in three; symptoms are the actors in the others. The first ones are discussed in Axis C, Section 4.3; the last ones are presented below.

(17) The symptoms do not occur exclusively [...] and are not better explained by another mental disorder (p. 60) (italics are mine)

The determiner “another” constitutes an iterative trigger of logical presupposition (Jeffries 2010: 97), which reaffirms ADHD as a mental disorder.

(18) The requirement that several symptoms be present before age 12 years conveys the importance of a substantial clinical presentation during childhood (p. 61)

(19) Very low birth weight [...] conveys a two-to threefold risk for ADHD [...] (p. 62)

All examples are “Semiosis Indicating” (Halliday & Matthiessen 2004: 255). Whereas in processes like ‘insult’ an action is performed in their realisation, ‘explain’ and ‘convey’ express something. Semiotic capacity is attributed to mental disorders (17), the required presence of symptoms (18), and specific symptoms (19).

VPs are “symbolic processes” (Halliday & Matthiessen 2004: 254) and the Sayer may be extrapolated to non-conscious entities. The semiotic attribution to symptoms adheres
to the Peircean view of symptoms as signs: symptoms have their semiological character for being factually connected to the represented object (ADHD) (Sebeok 2001: 70). The symptoms and the diagnostic are causally related, and the truthfulness of this relationship lies in considering the symptom a sign of an anomalous internal state (Sebeok 2001: 76). From this perspective, the interpreters of the symptoms as a sign (the APA/practitioners) remain overshadowed. The semiotic capacity attribution tacitly invokes the interpreter; therefore the meaning of the signs will differ according to the individual’s capabilities to interpret them (Daddesio 1995: 26). In establishing the symptoms as Sayer, APA’s legitimacy to attribute them the ‘semiotic power’ is acknowledged and their interpretation remains unquestioned.

Relational Relational processes (RP) unfold a state of being of the participant, which is a non-finite process (Halliday & Matthiessen 2004: 210). Identifying relational processes (IRPs) establish relations of identity among different referents. The identifier and the identified are interchangeable, but their relation is not tautological: the identifier usually brings new information (Halliday & Matthiessen 2004: 229). The eight identifying clauses employed (see Table 1) are meaning expansions; the added information is seen as constitutive of the identified, inherent to the thing.

(20) The symptoms are not solely a manifestation of oppositional behavior (p. 59)

A relation of identity between identified (symptoms) and identifier is denied; the identifier is not exhaustive and “not solely” implies the ADHD presence—which, on the other hand, does not deny the oppositional behaviour as a characteristic of the individuals.

(21) Associated features may include low frustration tolerance, irritability, or mood lability (p. 61)

The “associated features” (identified) and the identifier are related by a modalised kind/part relationship. The “features” may be these stated or any others; the set is left open. A causal relationship is established between the features and ADHD (if ADHD, then probably X). The association with ADHD covers the features of negative connotation and tacitly defines what is socially desired by opposition to the attributes ascribed to ADHD—i.e. a stable mood, tolerance to frustration, and not to be easily irritated.

(22) and (23) deny the identification of ADHD diagnosis with biological features.

(22) No biological marker is diagnostic for ADHD (p. 61)

(23) [...] children with ADHD display slow wave electroencephalograms, reduced total brain volume [...] delay in posterior to anterior cortical maturation, but these findings are not diagnostic (p. 61)
In (22), the negation comes in theme position and the rejection of biological determiners is emphasised. (23) offers an exhaustive enumeration of biological aspects that are ultimately denied as diagnostic. In both samples, negations act as pragmatic presupposition triggers (Nahajec 2012: 96): what is negated is regarded as the case and a potential world is evoked by negating its existence (Jeffries 2010: 111).

(24) is the only marked identifying process:

(24) In preschool, the main manifestation is hyperactivity (p. 62)

The Value (the content or added information) is placed in first position and corresponds to the identified; the Token (or expression of which we are given the information) comes later and corresponds to the identifier (Halliday & Matthiessen 2004: 230). The structure highlights that ADHD is already present in preschool.

Attributive relational processes (ARPs) establish relationships of belonging and construct classes according to the assessment of the carrier. The majority of the ARPs presented (ratio 43:44) are intensive, of the form ‘x is a’ (Halliday & Matthiessen 2004: 216). The most frequent carriers are the “symptoms”, specific symptoms (i.e. “inattention”), “disorder”, and “ADHD”; more rarely: generic references to symptoms (i.e. “manifestations”), and disorder “rates”. Symptoms are described as “present” in eight cases; the property of “being here” is attributed to the carrier and symptoms are implicitly established as perceptible entities in the world.

The attribution of ARPs is constructed as inherent to the entity, not as an observation from the outside, which would be more likely to be invalidated. Consider the following examples:

(25) [...] several symptoms that are particularly severe [...] (p. 61)
(26) [...] it [excessive motor activity] is not appropriate (p. 61)

Severity and inappropriateness are asserted as inherent to the symptoms and the motor activity respectively; none of them are stated as the judgement of an outsider. Because symptoms are equated to ADHD throughout the text, the qualities attributed to the symptoms are indirectly attributed to the disorder. Both examples are neutral phases of attribution: the ARP does not unfold over time (Halliday & Matthiessen 2004: 222) and a certain immutability is ascribed to the case. Compare (25) and (26) with these:

(27) [...] inattention becomes more prominent and impairing (p. 62)
(28) [...] impulsivity may remain problematic (p. 62)

“Become” and “remain” assign the attribution with regard to time (Halliday & Matthiessen 2004: 222); symptoms are established as changeable and ADHD acquires the possibility to worsen or ameliorate. The neutral or unmarked phase of attribution, the most frequent
in the data, is the strongest type for its essentialist ascription, especially powerful in the construction of meaning and implications. The most relevant cases are discussed below.

Although DSM is written by the APA and a prime application in the United States is expected, its international use might extrapolate the asseveration.

(29) Clinical identification rates in the United States for African American and Latino populations tend to be lower than for Caucasian populations (p. 62)

The large nominal phrase in theme position implies that Caucasian individuals generally have a higher ADHD probability. The clause is immediately proceeded by:

(30) Informant symptom ratings may be influenced by cultural group [...] culturally appropriate practices are relevant in assessing ADHD (p. 62)

From (29) and (30) it follows that (i) Caucasian populations are attributed more appropriate practices than the African American and Latino populations, and (ii) since the appropriateness of the practices is established from the APA’s standards perspective, the APA’s practices are tacitly established as the maximum authority.

(31) ADHD is more frequent in males than in females in the general population [...] (p. 62)

This example makes one of the few direct relations between ADHD and individuals. The higher ADHD probability in males is stated as constitutive of the disorder. Still, the relation is constructed by an ontological container metaphor (Lakoff & Johnson 1980: 29). Boundaries are put between the body and the rest of physical objects perceived as external, and ADHD is reified and attributed an independent existence.

Example (32) establishes biological transmission as a property of ADHD; the previous rejection of biological determiners is contradicted.

(32) The heritability of ADHD is substantial (p. 62)

(33)–(35) build conditional relations between ADHD and potential dreadful consequences:

(33) The risk of subsequent substance use disorders is elevated, especially when conduct disorder [...] (p. 63)
(34) Traffic accidents and violations are more frequent in drivers with ADHD (p. 63)
(35) [...] peer rejection and [...] accidental injury are most salient with marked symptoms of hyperactivity or impulsivity (p. 63)

Given ADHD, substance use, traffic accidents, violations, and peer rejection are likely to happen. “Especially when” (33) highlights the likelihood of addictions even in conduct
disorder absence. (35) constitutes an overt recognition of the existence of social stigma.

All examples share the same prioritising structure: consequences come first and (except (35)) occupy theme positions, whereas ADHD constitutes the rheme, either referred to by direct allusion or by mentioning the symptoms. The theme sets the concern of the message and usually involves information already known (Halliday & Matthiessen 2004: 89); placing new information in theme position is a prioritising device.

**Material** Material processes (MPs), the most numerous (see Table 1), represent ‘happenings’ or ‘doings’ (Halliday & Matthiessen 2004: 180). The analysis starts examining the intentional type (MPIs) and follows with the events type (MPEs), the most abundant.

Material processes intentional (MPIs) are executed by conscious beings (Jeffries 2010: 40). From the total of 35 processes, 5 are operative (employ active voice), and 30 are receptive (Halliday & Matthiessen 2004: 182). The clinician is the agent in 4 operative processes but is only mentioned twice (see Axis C, Section 4.3). Among the receptive type, the agency always falls on the clinician with three exceptions (‘[...] symptoms ratings may be influenced by the cultural group [...]’ (p. 62), ‘[...] is often interpreted by others [...]’ (p. 63), ‘peer relations are often disrupted by peer rejection [...]’ (p. 63)). Agents are specified when these are neither the clinician nor the APA. The clinician/APA is the agent in a total of 31 processes (88.57%), and the agency is mainly covered. The lack of agency empties the actions of all responsible agents, which are then regarded as the unquestionable state of things, and any external agents’ existence is disregarded. The distinction between material intentional receptive processes (included in the total 35 cases in Table 1) and relational attributive intensive is blurred, especially when time is unmarked (neutral ‘to be’ in non-temporal present). If time is marked, agency is tacitly put on the action.

(36) ADHD is correlated with smoking during pregnancy (p. 62)
(37) While specific genes have been correlated with ADHD [...] (p. 62)

In (36) being “correlated” is a non-temporal process; the correlation is apparently constitutive, in which case it would be relational attributive intensive. (37) presents the correlation as a finished action; the mark of temporality offers a trace of the agent. (39) and (38) offer more exemplifications of this phenomenon:

(38) Academic deficits, school-related problems [...] tend to be most associated with [...] inattention (p. 63)
(39) ADHD is associated with an increased risk of suicide attempt [...] (p. 61)

“Tend to” and “most” (38) add the modal nuance of ongoing action. The possibility of alternative associations helps to bring agency back into the process. Conversely, (39)
draws an atemporal association, regarded as inherent to ADHD. Because all examples, i.e. (36)–(38), could be completed with “by the clinician”, all associations and correlations are understood to have an outer agency: the APA or expert authority. Certainly, all associations and correlations entail the existence of evidence founded in medical research and are common in the textual genre analysed. Still, the loss of all agential reference to the scientific community and the assimilation of the process to an attribute turn the associations/correlations into inherent qualities of the entity, which will be further taken as given reality. Thus, all possibility of taking distance from the asseverations presented and the potential need of further investigations are brought out of question.

Material processes events (MPEs), the most abundant in ADHD representation, are free of human agency (Jeffries 2010: 41). Halliday & Matthiessen (2004: 184) distinguish between transformative (the goal pre-exists the process) and creative (the process brings the goal to existence) MPEs. From the 42 MPEs (see Table 1), 33 are creative and 9 are transformative. All transformative processes have a goal with the exception of (40), where the transformation is experienced by the actor itself:

(40) hyperactivity has diminished (p.62)

All the other transformative processes imply a negative alteration of the state of things, constituted by both negative actions and outcomes. Some examples are offered below. The actor is always related to ADHD, either referring to the symptoms, ADHD traits, or ADHD causes; the goal is an entity desired to remain untouched, and once transformed is considered adverse for the sufferers or society.

(41) [...] symptoms interfere with, or reduce the quality of social, academic, or occupational functioning (p. 60)
(42) [...] disorder is markedly impairing, affecting social, familial, and scholastic/occupational adjustment (p. 63)
(43) These traits [“reduced behavioral inhibition, effortful control, or constraint; negative emotionality; and/or elevated novelty seeking.”] may predispose some children to ADHD [...] (p. 62)

The specification of the negative effects of ADHD tacitly defines the social expectations. (41) and (42) mention the social sphere in the first place, and educational and occupational settings are linked together, constructing the equivalence between school and work. A successful performance is assumed as socially desired and required in all spheres. Symptoms are presented as negative in virtue of what is affected (41); personal traits are established as undesirable because of their disagreement with social standards, and their association with ADHD (43); inhibition and constriction, a positive emotionality, and not being novelty seeking are assumed as desirable qualities. Once the negativity of the traits
has been established, the traits are stated as potential instigators of ADHD (implicitly
denied as necessary or sufficient conditions). MPEs present processes as given facts and
 evoke assumptions as the unquestionable state of things.

The creative type of MPEs is divided between the transitive, with goal creation, and
the intransitive, without goal but with actor creation (Halliday & Matthiessen 2004: 180).
Table 3 offers an overview of the actors of creative events.

Within the transitive type, all goals are negative entities. Consider the examples
below:

(44) Impulsivity may reflect a desire for immediate rewards or an inability to delay
gratification (p.61)

(45) [...] symptoms [...] cause clinically significant distress or impairment in social,
 occupational or other important areas of functioning [...] (p. 65)

(44) presents impulsivity as the cause of undesirable conduct, partly established as negative
in virtue of this causal relationship. (45) offers an enumeration of functional damages:
ADHD is a wide-ranging impairing disorder. Patience, general social competence and
rationalisation of immediate pleasure are established as the common behaviour.

The MPE creative intransitive type shares this description of standard conducts by
opposition to abnormalities. Examples mainly state the occurrence of the actors (e.g.
“occur”), represented as something that happens in the world on their own (cf. Table 3);
the existence of the actor is thus taken for granted. MPEs are the processes that imply
the strongest objectivity.

The following samples show how symptomatology descriptions depict standard pat-
(46) Inattention manifests [...] as wandering off task, lacking persistence, having difficulty sustaining focus, and being disorganized and is not due to defiance or lack of comprehension (p. 61)

(47) Hyperactivity refers to excessive motor activity [...] when it is not appropriate, or excessive fidgeting, tapping, or talkativeness (p. 61)

Both examples present dubious exhaustive enumerations: “as” (46) and “or” (47) leave the lists open to more possibilities. Nominalisations are employed; processes are turned into perceptible factors or behaviour types that denote inattention or hyperactivity (e.g. “fidgeting”, “tapping”). By opposing abnormality, the regular conduct implies persistence, capacity to stay focused, organisation, and remaining quiet when required.

(48) Impulsivity refers to hasty actions [...] without forethought and that have high potential for harm to the individual (p. 61)

(49) Impulsive behaviors may manifest as social intrusiveness (e.g. interrupting others excessively) and/or as making important decisions without consideration [...] (p. 61)

Impulsivity is linked to an excess of speed, a lack of thought, and intrusiveness. Considering actions beforehand is presented as essential to avoiding harmful results, and not respecting turns at talk is considered pathological. Because a non-“social intrusiveness” is impossible (being intrusive implies the existence of the other), the wording emphasises the patient’s social incompetence.

This analysis has shown that when the actor is a human being, this is mainly the APA or the clinician and agency is covered. Material processes intentional (MPIs) are confused with attributing relational processes (ARPs): actors are omitted and processes are taken as inherent qualities of ADHD/symptoms. Material process events (MPEs) are the most abundant type of material processes; the existence of the actors (ADHD, symptoms, comorbid disorders) is taken for granted. Transitive events attribute a negative output to all processes and present all actors as negative. The few existential processes (EPs) present what is being talked about (ADHD, symptoms, outputs, comorbid disorders) as unquestionable. Symptoms are ascribed an entity-like status by the relational processes, and stand as legitimate signs of ADHD due to their semiotic capacity attribution. The description of pathological behaviour positions the DSM-V as a determiner of the standards of sanity.
4.2 Axis B: The patient taken as subject of analysis

4.2.1 Naming

This section analyses how ADHD targets are named in DSM-V in order to understand their representation in the psychiatric institution. Especial attention is paid to constructions of an archetypical target and to acknowledgement of stigmatisation. Six different references are distinguished: (i) omission, (ii) pronouns, (iii) specific reference, (iv) stage of life allusion, (v) the word “individual”, and (vi) gender specification.

**Omission**  ADHD targets are principally constructed by omitting both pronominal and nominal direct references. The ‘Diagnostic Criteria’ do not mention the patient in any of the symptoms. The examples below belong to inattention symptomatology; ‘Hyperactivity and impulsivity’ symptomatology employs the same wording.

(50) Often does not seem to listen [...] (p. 59)
(51) Often fails to give close attention to details or makes careless mistakes (p. 59)
(52) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g. [...] (p. 59)

All examples are declarative clauses without grammatical or logical subjects, and with a marked theme (Halliday & Matthiessen 2004: 74): the frequency adverb “often” is always the theme. The patient is the presupposed subject in all cases. Presuppositions are not strictly semantic (Levinson 1983: 167); they depend on contextual factors, which constitute the textual background (Jeffries 2010: 94). All examples share two assumptions: (i) given an action, a doer exists, and (ii) all the actions being symptoms of inattention or hyperactivity/impulsivity, the doer must be understood as the inattention or hyperactivity/impulsivity target.

The absence of reference to the patient disembodies the symptoms and abstracts all personal traits except those mentioned in the symptomatology. Sufferers are depicted as absent-minded (50), unable to remain attentive (51) and to operate according to scholar and work expectations (52). Abundant exemplifications of the symptoms are offered. Targets of inattention are portrayed as socially incompetent, unskillful in scholastics, work and informal settings.

**Employment of pronouns**  The data only presents two pronominal references to the patient, in symptoms ‘b’ and ‘h’ of ‘hyperactivity and impulsivity’.

(53) e.g. leaves his or her place in the classroom, in the office or other workplace [...] (p. 60)
Often has difficulty waiting his or her turn [...] (p. 60)

Targets are presupposed as the omitted subjects, emptied of all qualities except restlessness. The patient is referred to using third person singular possessive pronouns in goal position, and in (53), as an exemplification (optional phrase). Possessive pronouns are gendered and bring a certain embodiment to the symptoms. Langacker (2009: 84) attributes to possessive expressions the capacity to evoke a reference point (the possessor). ADHD targets are also evoked by the possessive relational process “has difficulty”. Here the possessor is active, whereas in the pronominal expression is passive (Langacker 2009: 85). ADHD targets stand as the reference point in all three wordings, tacitly allocated in grammatical and logical subject positions.

**Specific reference** Patients are directly referred to in terms of age: as “children” in 23 cases, as “adolescent” in 9 cases, and as “adult” in 21 cases. Children are situated as the primary target of the disorder.

- In adults, hyperactivity may manifest as extreme restlessness [...] (p. 61)
- [...] children with ADHD display increased slow wave [...] (p. 61)
- [...] may be cultural variation in attitudes toward or interpretations of children’s behaviors (p. 62)

References to adult targets occur in circumstantial phrases (55), (), whereas children’s references occupy different grammatical positions: subject in (56), direct object in (57). While children targets are syntactically necessary, adults, even if in theme position, are relegated to a second order relevance. References to adolescents are scarce, frequently accompanied by allusion to adults.

- Is often easily distracted [...] (for older adolescents and adults, may include unrelated thoughts) (p. 59)

Although children are not mentioned, the clarifying circumstantial phrase “for older adolescents and adults” implies that the information just given applies to children only.

**Stage of life allusion** Targets are also textually constructed through circumstantial phrases of time that specify when ADHD or the symptoms are presented and patients are evoked as temporality.

- ADHD begins in childhood (p. 61)
- [...] symptoms of motoric hyperactivity become less obvious in adolescence and adulthood [...] (p. 62)
- Inattention becomes more prominent during elementary school [...] (p. 62)
Childhood is presented as ADHD onset (59), when inattention and hyperactivity symptoms are more evident (60), (61), and children are confirmed as primary targets. It is not clear if ADHD can be eliminated with treatment; adolescence and adulthood are attributed milder symptoms but ADHD is still diagnosed.

Target as ‘individual’ The patient is named “individual” on 13 occasions; the alternative wording “individuals with ADHD” is unusual: “individual” is identified with targets only. Gender and age are abstracted from the patient, and all sufferers are exclusively regarded as members of the group ‘ADHD targets’. The following examples design the patient as “individual(s) with ADHD”; abstraction of gender and age is present, but different age groups are contextually evoked: (62) and (63) design children and adolescents, while (64) applies to all ages.

(62) Individuals with ADHD are more likely than peers to be injured (p. 63)
(63) [...] peer relations are often disrupted by peer rejection, neglect, or teasing of the individual with ADHD (p. 63)
(64) [...] individuals with ADHD obtain less schooling, have poorer vocational achievement, and have reduced intellectual scores than their peers [...] (p. 63)

Targets are attributed academic and professional mediocrity (64), and the existence of social stigma is recognised (63).

Reference by gender specification Gender is acknowledged on two occasions only, both in the ‘Gender-Related Diagnostic Issues’ section. Gender omission contributes to the depersonalisation of the disorder, and to the construction of ADHD targets as abstractions, defined by the negative qualities of the symptoms.

(65) ADHD is more frequent in males than in females [...] (p. 63)
(66) Females are more likely than males to present [...] inattentive features (p. 63)

Males are established as the primary target, especially of the hyperactive type. Overall, all references to the patient construct the prototypical target as an elementary school white child (cf. example (29) in Axis A, Section 4.1).

4.2.2 Transitivity

This section analyses the different roles and processes assigned to the patient. Compared with Axis A (cf. Table 1), targets are ascribed fewer processes, mainly material and relational attributive processes—see Table 4.
Table 4

<table>
<thead>
<tr>
<th>PROCESS TYPE</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Existential Process (EP))</td>
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</tr>
<tr>
<td>Verbal Process (VP)</td>
<td>2</td>
</tr>
<tr>
<td>(Identifying Relational Process (IRP))</td>
<td>(0)</td>
</tr>
<tr>
<td>Attributive Relational Process (ARP)</td>
<td>30</td>
</tr>
<tr>
<td>Material Process Supervention (MPS)</td>
<td>17</td>
</tr>
<tr>
<td>Material Process Intentional (MPI)</td>
<td>24</td>
</tr>
<tr>
<td>Material Process Event (MPE)</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 5

<table>
<thead>
<tr>
<th>ATTRIBUTIVE RELATIONAL PROCESSES (ARPs)</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possessive</td>
<td>11</td>
</tr>
<tr>
<td>Intensive</td>
<td>17</td>
</tr>
<tr>
<td>Circumstantial</td>
<td>2</td>
</tr>
</tbody>
</table>

Verbal  Both verbal processes (VPs) are of the activity type, where the activity expressed is to talk, and the Sayer refers to the ADHD target.

(67) Often talks excessively [...] (p. 60)
(68) Often blurts out an answer before a question has been completed (p. 60)

The verbiage is not transcribed and all attention falls to the activity, negative in both cases. The modifier “excessively” (67) and the semantics of “blurts out” (68) denote disproportionate talk and verbal incontinence, features associated with impulsivity. Speakers are assumed to talk according to conventional standards (67) and to respect the turn-taking system (68). Targets are depicted as unable to follow the most basic communicative rules.

Relational  Possessive attributive relational processes (ARPS) (see Table 5) are distinguished in function of the categorisation of the possessor (patient): by omission (5 cases), as “individual” (4 cases), and as “children” (2 cases). The possessed is always semantically negative with only one exception. All examples are inattention symptoms:

(69) Often has difficulty sustaining attention [...] (p. 59)
(70) [...] has difficulty remaining focused [...] (p. 59)
(71) [...] has difficulty organizing tasks [...] (p. 59)

Despite being absent, the possessor is understood as the patient. All actions are nom-
inalised and turned into difficulties that are possible to be possessed; relatively average difficulties are pathologised:

(72) [...] individuals with ADHD obtain less schooling, have poorer vocational achievement, and have reduced intellectual scores than their peers [...] (p. 63)

The comparison between “individuals with ADHD” and “peers” equates ‘individuals’ and ‘patients’. The possessed elements are considered identifying characteristics. Targets are commonly defined by comparison to social standards and attributed negative characteristics only.

Intensive ARPs, the most abundant (see Table 5), share this semantic negativity (with two exceptions); the patient, the most common carrier, is strongly associated with social impairment.

(73) Often unable to play or engage in leisure activities quietly [...] (p. 60)
(74) (e.g. is unable to be or uncomfortable being still for extended time [...] ) (p. 60)

Both examples make use of naturalisation; contradictory concepts are associated and presented implicitly as common sense (Fairclough 1989: 97). Stillness is naturalised as the proper way of being in all social spheres: individuals are presupposed to be used to staying calm and remain peaceful even in spare time activities.

Material The most abundant material processes are the supervention (MPS) and intentional (MPI) subtypes (see Table 4). MPSs designate unintentional actions (Jeffries 2010: 41). Actors are frequently passive agents, mostly omitted; when specified, they are referred to as “children”, “females”, or “individuals with ADHD”. Processes are mostly semantically or contextually negative (e.g. “loses”, “cannot wait”).

(75) Often fails to give close attention to details [...] (p. 59)
(76) [...] individuals with ADHD may exhibit cognitive problems [...] (p. 61)

The patient is treated as an unconscious doer in (75), and as a passive agent in (76)—where ‘passive’ is understood as not being the source of action. Patients are represented as unable to take control of their acts.

In MPIs, actors are divided between the patients (always unnamed, with a single exception where the actor is referred to as “child”), and an external authority: either the practitioner (77) or common knowledge (78) (italics are mine).

(77) Often does not follow through on instructions [...] (p. 59)
(78) Often leaves seat in situations when remaining seated is expected [...] (p. 60)
Patients are omitted and associated with negative processes and goals, and are asserted as pathological behaviour. Because adherence to instructions and conventions is socially desired, patients are attributed a rebellious in character.

ADHD targets fall into two categories: social incompetency, associated with inattention, and unruly personalities, associated with hyperactivity/impulsivity. Both types of targets involve a mismatch between social expectations and patients’ conduct, which is annoying for society and/or problematic for the sufferers themselves. Inattention involves carelessness, distraction, and academic and professional inefficiency. Impulsive dysfunctions are more socially-oriented with verbal and kinetic incontinence, and intrusiveness. The most critical risk attributed to ADHD is a higher probability of comorbidity, addictions and incarceration. The prototypical targets are constructed as a querulous elementary school white boy and a dreamy girl. DSM-V is strongly political: it defines ADHD targets and the standard individual. Symptomatology constructs implications based on a supposedly common knowledge, but many of these assumptions are naturalisations constructed within the text.

4.3 Axis C: The clinician taken as subject of analysis

4.3.1 Naming

The psychiatric community is the producer and main recipient of the text. References to the practitioner and APA are scarce. The clinician is mentioned on three occasions only: once as modifier (79), and twice as subject (80), (81).

(79) Signs of the disorder may be minimal or absent when the individual […] is interacting in one-on-one situations (e.g. the clinician’s office) (p. 61)
(80) […] is used in situations in which the clinician chooses to communicate the specific reason […] (p. 65)
(81) […] situations in which the clinician chooses not to specify […] (p. 66)

The brackets and the ending position of the exemplification in (79) highlight the accessory character. The setting is depicted with minimal or non-existent signs of the disorder, even when the individual is diagnosed with ADHD. Describing the clinical setting as a misleading scenario undermines patients’ positive behaviour. (80) and (81) refer to the ‘Other Specified’ and ‘Unspecified’ ADHD categories. The practitioners “choose” to specify (or not) the “reason” for the categorisation. “Choose” stresses the practitioners’ authority; judgements in compliance with APA standards are presupposed.

Passive structures and evaluative statements, evaluations regarding (un)desirability, importance, usefulness and the like (Fairclough 2013: 172), constitute indirect references
ADHD defining discourse

to the clinician.

(82) There is clear evidence that the symptoms interfere (p. 60)
(83) [...] it is beneficial to obtain ancillary information (p.61)
(84) [...] there is a known genetic cause [...] (p. 61)

The evaluative element is always an adjective: “clear”, “beneficial”, “known”. This raises the question, ‘for/according to whom?’, and the answer would be ‘the clinician’ in all cases. What clear evidence is, what is beneficial, and the knowledge of genetic causes are established according to APA standards. Their desirability is constructed within the APA psychiatric discourse.

4.3.2 Transitivity

The main feature analysed in this section is voice. The clinician occupies the actor role on two occasions only (80), (81); both of them are material processes intentional (MPIs). Due to the preponderance of passive constructions and their importance in terms of responsibility, it has been preferred to adopt what Halliday designated as the other interpretation of transitivity and voice (Halliday & Matthiessen 2004: 280): the ergative model.

The ergative perspective understands the transitive ‘cause’ as ‘agency’ (Halliday & Matthiessen 2004: 300). Agency is not identified with the agent, but a “participant functioning as external cause” (Halliday & Matthiessen 2004: 289). Effective clauses (with agency) may or may not present an agent, but the feature of agency is still there. (85) and (86) present a clear outer agency despite having left the agent out:

(85) [...] symptoms in excess of those required to make the diagnosis [...] (p. 60)
(86) [...] an earlier age at onset is not specified because of difficulties [...] (p. 61)

The agent of the highlighted processes is elided. However, an external agency is still present. This conception of agency supports the position adopted in Axis A, where processes such as (87) were classified as material processes intentional (MPIs) (the major type of processes attributed to the clinician) instead of attributive relational processes (ARPs).

(87) ADHD is associated with an increased risk of suicide [...] (p. 61)

Understanding the clauses through the feature of agency turns the association into the product of an external agent. “ADHD” is the medium in which the process is actualised (Halliday & Matthiessen 2004: 288). The agent is implicit in all effective receptive clauses except (88) and (89): the only occasions where the agent differs from the practitioner.

(88) Informant symptom ratings may be influenced by cultural group of the child and the informant [...] (p. 62)
Inadequate or variable self-application to tasks [...] is often interpreted by others as laziness [...] or failure to cooperate (p. 63)

The agents (i.e. “cultural group”, “others”) are stated as ‘late news’ (Halliday & Matthiessen 2004: 296), thus being the focus of the reader’s attention. Whereas the relevance of the cultural specificity might not be evident (hence it is reasonable to mention it as rheme), mentioning “others” (89) is redundant: any doer is always either the speaking subject or any “other”. Because the interpretations attributed to these “others” were previously stated as erroneous in the ‘Diagnostic Criteria’ section – i.e. the patient was exempted of laziness – the clinician is confirmed as the agent in all of the passive constructions where it is left out.

The predominance of passive constructions without the by-clause is not unique to DSM-V but is the standard in medical writing (Millar et al. 2013); the research is foregrounded at the expense of researchers. Agency omission covers the agent and has a direct influence on how relations are understood, either as outer observations or inherent to the object considered. Passive voice safeguards the objectivity of discourse.

4.3.3 Modality and mood

The indicative declarative is the predominant mood, and information is presented as actual and verifiable (Frawley 1992: 70). However, the imperative mood is employed on a few occasions:

(90) Note: In adolescents or adults, may be limited [...] (p.60)

(91) Specify whether: [...] (p. 60)

Each of the structures above is observed on three occasions (italics in the original). Predicators are in theme position, unmarked in imperative clauses (Halliday & Matthiessen 2004: 76). All commands regulate the diagnosis and are directed to the practitioners, assumed as the target readers. With the exception of these structures, all statements are in the declarative mood.

The grammatical subject is the unmarked theme in declarative clauses (Halliday & Matthiessen 2004: 73); any other form implies a foregrounding. Marked themes are abundant, targets frequently occupy circumstantial themes, and all symptoms are preceded by “often”:

(92) Often fails to give close attention [...] (p. 59)

The example (and all the symptoms noted in the inattention and hyperactivity/impulsivity symptomatology) present usuality modalisation with a medium value of modality (Halliday & Matthiessen 2004: 620). Thus, symptoms show a medium commitment, in frequency
ADHD defining discourse

terms, to the pathological behaviour described. What “often” means is left undefined; instead, plenty of exemplifications illustrate what needs to be accounted for as symptomatic conduct. In (93), “often” is modified and acquires a medium–high value of modality. However, the commitment is still moderate compared to ‘usually’ or ‘always’.

(93) ADHD is most often identified during elementary school [...] (p. 61)

The usuality modalisation is also constructed with lexical verbs and manner adverbs in (94) and (95), respectively. Both examples present a medium value of usuality; this is compared to ‘mostly’, which would imply a high commitment to the facts announced.

(94) Adult recall of childhood symptoms tends to be unreliable [...] (p. 61)
(95) Confirmation [...] typically cannot be done [...] (p. 61)

From the 29 cases of usuality modalisation, 24 employ “often”, 3 “tend to”, and 2 “typically”: all carry a medium commitment to the usuality of the facts accounted.

There are 29 cases of probability modalisation as well. The structure of (96), with “may” as the modal marker, is the most recurrent, employed on 26 occasions. The adverbs “likely” and “possibly”, and the lexical verb “suggest”, constitute the other cases of probability modalisation; all of them show a low value of commitment.

(96) [...] (for adolescents and adults, may include unrelated thoughts) (p. 60)

A low value of commitment to truth presents the statements as mere possibilities (Halliday & Matthiessen 2004: 622; Fairclough 2013: 170); (96) is the only structure where modalisation holds the status of probable. The data is mainly neutral, free of modality, and the employment of epistemological modal markers, as illustrated in (96), always downgrades the truth value.

Use of deontic modality is the least common (6 cases). The most usual modal marker is “should” (3 cases), which presents the statements as ‘supposed to be done’ (97). A medium commitment to obligation is adopted (Halliday & Matthiessen 2004: 620–622; Fairclough 2013: 170).

(97) [...] ADHD presentation should still be diagnosed [...] (p. 61)

In contrast with epistemic modality, there are three instances of high value of obligation:

(98) Manifestations of the disorder must be present [...] (p. 61)
(99) Confirmation of substantial [...] cannot be done [...] (p. 61)
(100) The requirement that several symptoms be present [...] (p. 61)

(98) and (99) present modal verbs as markers of modality; the elision of the modal in (100) strengthens the objectivity of the clause, and a high commitment is implied by the
structure “the requirement that”.

The data analysed (American Psychiatric Association 2013a: 59–65) is mainly in the indicative declarative mood and presents a general absence of modality, which displays the facts as categorical assertions (Jeffries 2010: 120). This is the strongest resource to equate the expressed or non-actual world to the actual or reference one (Frawley 1992: 390). The few references to the practitioner as actor (i.e. (80) and (81)) add objectivity to the narrative voice. Still, modality is a repeated resource, especially used to adopt a moderate stance in symptomatology descriptions and strong asseverations (i.e. (92)–(96)). The exact correspondence between the description and the reality represented is kept at arm’s length, the author authority is freer of commitment, and the DSM-V is kept ironclad.

5 Discussion and conclusion

This study aimed to perform a critical discourse analysis of the institutional psychiatric representation of ADHD and its targets to determine if stigmatisation is recognised in psychiatric textual productions. The division of the analysis in three parallel studies taking different subject positions (ADHD, target, and clinician) as axes, and the merger of Halliday’s SFL and Jeffries’ (2010) analytical toolkit enabled a good management of the material and made possible a comprehensive study.

ADHD and its symptoms are presented as given facts and are objectified and asserted as disembodied measurable entities. ADHD is defined by and equated to its symptoms, which are attributed a semiotic capacity and recognised as legitimate signs. All properties ascribed to the disorder are emptied of the clinician’s agency and are presented as inherent.

ADHD targets are rarely referred to directly. Although they are treated as both responsible and passive subjects, the image of passive sufferers overwhelmed by the disorder (Bilić & Georgaca 2007) prevails. Targets with inattention are attributed a general social incompetence and are described as inefficient, absent-minded, and careless. The hyperactivity/impulsivity category is identified with unruly personalities who are prone to intrusiveness with verbal and kinetic incontinence. Failure to meet common expectations is emphasised, and targets are presented as socially disabled (Rafalovich 2004: 73, 97), annoying for the social group, and a potential danger to themselves—i.e. liable to addictions, violations, and incarceration. ADHD diagnosis entails the pathologisation of ordinary misconducts and discipline (Rafalovich 2004: 118).

DSM-V recognises the existence of social stigma (Clark 2012; ADHD Europe 2009), where ADHD targets are likely to experience rejection and mockery. DSM-V always represents ADHD children by comparing them to their peers, and targets are never described as
normal or in contexts free of juxtaposition. While Rafalovich (2004: 140) only attributes this stylistic feature to the education setting in DSM-V, comparative descriptions apply to all targets in all social settings. Defining symptomatic behaviours and ADHD targets in opposition to social expectations and ‘individuals without ADHD’ is far from being stigma reducing. Against Horwitz (2007), turning mental disorders into brain diseases to equalise them to all other types of disease has not reduced mental illness stigma. Also, a latent tension in the biomedical discourse of mental illness in determining the influence of biological factors in ADHD occurrence has been evidenced. ADHD diagnosis is confirmed as a gendered (Rafalovich 2004: 125) and ethnical (Schmitz et al. 2003) phenomenon: targets are paradigmatically represented as the querulous elementary school-aged white boy and the dreamy girl; adolescents and adults are also mentioned as potential sufferers, and ADHD is presented as a lifelong disorder.

DSM-V is highly assertive, mainly written in the indicative declarative mood and with minimal modality. Modality is especially employed in symptomatology description and strong asseverations regarding potential consequences of the disorder. APA and practitioners’ authorities remain covered, with rare exceptions. This study has evidenced DSM as a political text despite its primary circumscription to the psychiatric sphere: by defining what is considered abnormal or pathological behaviour, it depicts what the standard social individual is expected to be like. Presenting abnormal behaviour as excessive (e.g. as verbal incontinence) echoes the social benchmark of common-sense and implies the adoption of categories that are not restrained to psychiatric discourse; social expectations play an active role in determining eccentric conducts. Society and the psychiatric institution are joined by a dialectical relationship: professional ideology influences society and reflects the values of the society in which it is embedded (Eisenberg 1988).

A comparison between ADHD representation in different institutional discourses such as the educational, political, and the family is left for further research. This could provide a comprehensive understanding of the conceptualisation of the disorder and the potential effects of the diagnosis in identity construction. Also, a comparative analysis of the description of the disorder in the different editions of the DSM could provide a dynamic view of the constitution of ADHD as an object of biomedical discourse.

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