

Introduction

ADHD represents the fastest growing diagnosis over the last decade, reflecting a general trend of increasing levels of mental health diagnoses. It is today one of the most common psychiatric childhood disorders (Stokkeland, 2014), with an estimated 20% of American children aged 9-17 being diagnosed with the condition (Brante, 2013). ADHD has traditionally been viewed to be a child-diagnosis, and it is only more recently that the diagnosis has begun to be applied to adults. This, Kärfe (2013) argues, reflects a general trend within neuropsychiatry of 'child' conditions increasingly being transferred to adult populations, including more extensive use of retrospective diagnoses. Though few studies have established any certain findings, the general adult population prevalence of diagnosis is estimated to be around 4.5% (Faraone *et al*, 2000). Comparing these figures to criminal justice specific studies, it soon becomes clear that ADHD is significantly overrepresented within the justice system. This overrepresentation must, in turn, be situated in the wider context of a higher prevalence of mental health disorders experienced by individuals involved with the criminal justice system generally (Light *et al*, 2013), though this is particularly marked for female offenders (Corston, 2007).

In Sweden, recent figures indicate that between 15-45% of the overall prison population fulfils the criteria for ADHD (Kriminalvården, 2013). For women specifically – though under-researched in comparison – the equivalent figure is suggested to stand at around 29% (Kriminalvården, 2010). While criminological research on ADHD is overall limited, the gaps about ADHD and women involved with criminal justice are particularly large, and more research is urgently called for (Konstenius *et al*, 2012). This paper aims to start to address this gap, offering first-hand perspectives on ADHD diagnoses by a small sample of women in the

Swedish criminal justice system. Recognising that wider contexts, both in terms of criminal justice specifically and society more generally, play a role in diagnostic experiences and processes (Berger, 2015), the broader socio-economic settings of diagnosis are also given attention.

Following a brief overview of the ADHD literature, with a particular focus on offending, treatment and responses, suggested functions and beneficiaries of diagnosis are considered. Produced via a feminist methodology, first-hand narratives on diagnosis by a sample of currently desisting Swedish women are then presented, critically exploring subjective diagnostic functions and purposes. The paper is brought to a close with a conclusionary section. Beyond highlighting the role of ADHD narratives in the women's accounts, wider questions regarding the over-reliance on medicalised treatments and discourses in current criminal justice context are raised, along with calls for more interdisciplinary and critical research in the field.

ADHD and criminal justice

Exploring ADHD and offending populations in an international context, a study by Young *et al* (2011), looking at findings from the USA, Canada, Sweden, Germany, Finland and Norway, found that, overall, half of the adult prison population, and two-thirds of young offenders, screen positive for ADHD. Data thus seem to suggest a link between ADHD and offending populations, however, the nature of this link remains uncertain. In fact, the aetiology of ADHD remains unknown (Savolainen *et al*, 2010), and although literature suggests that ADHD in childhood is a risk factor for involvement in offending in later life, it is important to note that no direct association has been proven (Modre *et al*, 2011). One major issue within research

around ADHD is that of co-morbidities, including overlaps with a range of disorders such as autism, dyslexia, personality disorders, anxiety, depression, and drug and alcohol abuse disorder being common (Young *et al*, 2011). Drug misuse is a factor that is especially relevant for criminal justice populations. For example, a study with Swedish women in prison identified that *all* of the women who fulfilled the criteria for ADHD also reported drug problems (Kriminalvården, 2010). This is not a unique finding. Stokkeland *et al* (2014) found that 93% of their (all-male) ADHD sample in a Norwegian prison reported lifetime drug dependency. With ongoing debates over both the ontological status and the validity of ADHD as an adult psychiatric disorder (Schubert *et al*, 2009), some argue that ADHD is, rather than a condition in its own right, a product of other primary conditions; substance abuse being a key one of these (Saul, 2016). The relationships between ADHD and drug abuse is a complex one. Self-medicalised approaches are a part of this complexity, with amphetamine in particular having been found to be a drug that is connected to self-medication of ADHD, although this is more commonly reported for males than females (Pedersen, Sandberg and Copes, 2015).

Furthermore, there are a range of other factors that may also play a role in the labelling of ADHD. For example, ADHD is linked to both restlessness and lower educational achievement. However, there are, of course, many other factors, including social and environmental factors, which may impact on these. For example, Savolainen *et al* (2010) suggest that a lower socioeconomic standing is closely linked to the diagnosis. This is a finding that has been supported in international studies, with factors such as being a recipient of welfare payments, low maternal education and lone parenthood, doubling the likelihood of ADHD diagnosis (Hjern, Weitoft and Linblad, 2010, cited in Hill and Turner, 2016). Factors of social adversity thus raises further challenging questions about the ability to separate factors. Brante (2013: 90) argues that the recent heightened focus on neuropsychiatric conditions involves the

danger *"that social and cultural aspects of human behaviour is neglected in favour of biological conceptualisations"*. We are reminded, though, that the pathologisation of criminal behaviour is far from a recent invention, with the links between criminal law and psychiatry having dominated especially the European criminological societies since the end of the 19th Century (Schneider, 2001). Psychiatric explanations and solutions have gone through various waves throughout this period. However, recent years have seen a re-emergence of psychiatric language in criminal justice contexts, which has been linked to new ways to define and manage certain traits and deviant behaviour (Berger, 2015). For female offending specifically, we know that biological explanations have a particularly long and persistent history in criminology (Stanko, 1994).

Cultural, social and institutional factors

New diagnoses can be understood to reflect, and re-produce, contemporary cultural themes. Due to their contextual relativity, Hallerstedt (2013) reminds us of the importance of interpreting diagnoses through social, political and cultural frameworks. In terms of Sweden specifically, Andersson (2012) situates the ADHD trends in the particular context of a Swedish tradition of a 'culture of intervention', and a persistent priority of medical knowledge above individual considerations. In criminological terms, this falls in line with the Swedish, and overall Nordic, history of positive criminology (Nilsson, 2013). Indeed, Sweden has a long history of engineering individual well-being (Pratt and Ericsson, 2013), which has influenced prison reform policy, as a part of a wider welfare state policy agenda. ADHD prevalence studies on prisoners have, in fact, their roots in Sweden, dating back to the early 1990s (Andersson, 2012). Some argue that recent years have seen a particular re-pathologization of

offenders in the Swedish criminal justice system, propelled by a new paradigm that aligns with the neoliberal agenda (Nilsson, 2013). Privilege is accordingly giving to certain forms of knowledge and practices, guided by cognitive-behavioural models. In turn, these models emphasise individual responsibility, self-control, and measurable results, creating contemporary therapeutic cultures that 'valorises help-seeking' (Berger, 2015: 124). Nilsson (2013: 35) points out how these discourses very much echo the 'hyper-positivism' that is prominent in some branches of the natural and medical sciences, relying on under-theorised views of the social world.

In this setting, ADHD experts are given an increasingly prominent voice. Kärffve (2013) draws a parallel between Swedish history of eugenics and the contemporary diagnostic system, both emphasising physical hereditary, human behaviours and a complete trust in 'the experts'. While high levels of legitimacy in expert opinion is, in terms of penal policy, commonly seen as a positive (Green, 2007), the dominance of medical knowledge in this sphere raises new questions. Specifically, this is linked to a certain hierarchy of knowledge. For example, in a study by Hill and Turner (2016), power imbalances between professionals in the education field and in the medical field strongly showed that individuals working in education persistently experienced their views and experiences around ADHD as being relegated as unimportant in comparison to health professionals' views and experiences.

Drawing on a Foucauldian analysis, Andersson (2012) proposes a view of ADHD linked to the formation of a governable and self-regulating subject, situated in the context of Western advanced liberalism, and the responsabilisation of the individual. Self-diagnosis and self-medicalisation, identified in studies with drug users in response to ADHD symptoms, fits very well with these ideas of self-reliance and autonomy (Pedersen, Sandberg and Copes, 2015).

Further removing cultural interpretations of behaviour, behaviour that was previously viewed as boredom or dissatisfaction are thus increasingly translated into a neuropsychiatric condition (Andersson, 2012). The diagnosis may, in this way, reflect culturally-biased judgements upon deviant individuals (Rafalovich, 2005). As pointed out by Johannisson (2013), the space for what is 'normal' is continuously shrinking, with conceptions and ideas of what is defined as 'healthy', 'ill', 'normal' and 'abnormal' being in constant flux. Indeed, the cut off between 'normal' and ADHD is becoming increasingly challenging to define (Pedersen, 2014). This is an argument recently echoed in the UK context, when a report of the use of ADHD medications suggested a growing 'intolerance of difference', with children who do not conform to norms seen to have something wrong with them (Weale, 2014).

Responses and treatment

Thinking about responses to diagnoses, recent years have seen an exponential growth of medicalised ADHD treatment methods. Key pharmaceuticals include Adderall, Benxodrine, Dexedrine and Methylphenidate (Ritalin) (Rafalovich, 2005). In the UK, 2007 to 2012 saw a 56% increase in methylphenidate being prescribed to children and young people (Hill and Turner, 2016). Saul (2016) links these trends to a broader 'pill-focussed' culture, where stimulant-use is increasing in a range of populations; from students aiming for high grades, to employees who are required to work long hours. Looking specifically at the use of medicalisation in the Swedish criminal justice system, there are ongoing experimental studies involving prescribing prisoners/offending populations with methylphenidate. The Swedish Prison and Probation Service suggests that methylphenidate can decrease ADHD-symptoms by up to 70% (Kriminalvården, 2013). Another Swedish study (Lichenstein *et al*, 2012) found

that female patients receiving ADHD medication saw a 41% reduction in criminality (compared to 32% of male patients). However, this reduction was only noted during treatment periods, and hence, the long-term effects remain more uncertain. Overall, studies have not found ADHD to be a predictor of reoffending (Grieger and Hosser, 2012), so treatment being 'sold' as a reducer of recidivism is problematic.

The use of stimulants has also been linked to a range of side effects, including chemical dependence in later life (Rafalovich, 2000), although other studies argue that there is little evidence that stimulants are addictive when used for ADHD specifically (Young *et al*, 2011). That said, research indicate that self-medicalisation uses are more closely associated with addiction problems than social uses (Pedersen, Sandberg and Copes, 2015), with some authors arguing that stimulant treatments are a contraindicatory approach for individuals with existing substance abuse issues (Schubert *et al*, 2009). Despite the fact that, according to the official guidelines, medicalisation should always be implemented as part of a broader treatment programme (Young *et al*, 2011), concerns have been raised by professionals working in the field that medicalisation typically takes a primary position over psychological treatments, commonly due to budget constraints in local authorities (Hill and Turner, 2016).

Beneficiaries of diagnosis?

Slee (1997) invites us to critically consider the question of whose interests are served by the discovery and ongoing escalation of ADHD diagnoses. There are, in fact, Slee (1997) goes on to suggest, a range of beneficiaries including students who benefit from the opportunity to receive special educational interventions, parents benefitting from a 'chemically calm' child, as well as special educational workers benefitting from a larger client base. In a time of ever-

growing cuts and challenging funding situations, it is not hard to see the potential benefit of high levels of diagnoses. A diagnosis furthermore plays an important attention focussing function. Specifically, it can remove responsibility from the setting, both familiar and societal, and move the attention to the individual, or rather, to the biological set-up of the individual (Hallerstedt, 2013; Hill and Turner, 2016). Reducing space for cultural interpretations of behaviour indeed fits well with current processes of responsabilisation and risk-need frameworks in criminal justice (Young *et al*, 2011).

Not only can a diagnosis provide potential benefits to surrounding populations, such as parents, teachers and others, but it can also offer personal comfort to the diagnosed. Evidence show that a diagnosis can provide answers, reduce anxiety and stigma (Hill and Turner, 2016), as well as provide a sense of group belonging; something that is especially valuable if the person has experienced forms of exclusion or difference over their lifetime (Kärfve, 2013). The diagnosis can thus provide a useful explanatory framework and can help an individual make sense of circumstances and behaviours. To this end, Johannisson (2013:40) argues that medical categorisations influence how individuals experience the self, that is, once diagnosed the individual *becomes* the diagnosis and accordingly, explanatory understandings of behaviour inevitably follow from this. These labels can, in turn, trap individuals, by limiting how they perceive themselves currently, in the past, as well as in the future (Berger, 2015); embodying a classic example of labelling theory (Becker, 1963).

These new explanatory understandings of behaviour may be especially useful to individuals who are involved in the criminal justice system. For example, in a study by Schubert *et al* (2009), it was found that for a Norwegian (all-male) sample receiving treatment for amphetamine dependency, an ADHD diagnosis allowed them to construct a legitimated drug-

using narrative as an ADHD patient; effectively downplaying their status as an illicit drug user. Deviant behaviour is thus reframed as illness, which is seen to act as a mitigating factor for criminality. As the diagnosis ties into a range of culturally acknowledged medical behaviours, with stimulant use being the most common treatment, individuals become exempted from responsibility and guilt (Berger, 2015). Pedersen, Sandberg and Copes (2015) have found that amphetamine users' ADHD narratives commonly construct their stimulant use as 'medical', therefore shifting the self from a morally problematic social category (i.e. drug user), to a morally neutral status (i.e. 'patient'). Similar functions have been detected in cannabis users' narratives; Pedersen (2014) for example found that ADHD diagnoses were commonly employed to transform cannabis use into a more morally neutral 'illness' narrative, with interviewees marking a strong distance between intoxication for pleasure and use as a response to their condition. Berger (2015) argues that legitimising deviancy through an ADHD narrative in this way functions as an effective 'technique of neutralization' (Sykes and Matza, 1957). Social responsibility is accordingly removed from the individual, with a biological label being attached to behaviour, and at the same time, legal access to amphetamine-based medicines are opened up.

Interlinked to the prescriptive use of stimulants, additional beneficiaries must be noted in the ADHD equation. The pharmaceutical market, ever so willing to provide growing quantities of for example Ritalin, is undeniably a big winner in the diagnosis trend (Kärfve, 2013). Pedersen, Sandberg and Copes (2015) note how the increased legal control of amphetamines since the 1970s have been paralleled by a dramatic increase of misuse of pharmaceutical stimulants. A key tool for diagnosis is the APAⁱ manual, with wide-ranging diagnosis scripts available. There are some critical concerns raised regarding the nature of the relationship between pharmaceutical companies, the construction of the DSMⁱⁱ and corporate links with APA

(Rafalovich, 2005). For example, there is some evidence of strong lobbying forces, funded by Pharmaceutical giants, to get new diagnoses into the DSM (Brante, 2013). In 2013 the American National Institute for Mental Health came out arguing for a move away from classifying disorders via DSM criteria, and called for new, objective, ways to define mental health disorders (Hill and Turner, 2016).

The Stories Across Borders studyⁱⁱⁱ

ADHD was an 'unexpected visitor' in the data that was collected for my doctoral thesis 'Stories Across Border: How female ex-offenders make sense of their journey through crime and criminal justice in Sweden and England'. This was a cross-national qualitative research project, exploring different lived experiences of moving through criminal justice systems by women, who at the time of the interview identified as desisters, across Sweden and England. Grounded in a feminist methodology (Kelly *et al*, 1994; Bloom, 1998; Maynard and Purvis, 1994), the study conducted life-story narrative interviews with 24 women; 12 in Sweden and 12 in England. The narratives produced in the study were primarily used as a method of inquiry (Orbuch, 1997), i.e., used to access other, thematically organised, aspects of the social world. Informed by symbolic interactionism, the thematic analysis exclusively focussed on participants' first-hand interpretations and perceptions of their own lived reality, and no external validation of life-events or experiences were sought for the analytical reading of the data. In line with a feminist research agenda, subjectivity stood at the core of the qualitative approach, which is proposed to make more justice to women's lives, as well as allowing them to define their own problems and perspectives (Barberet, 2014). Feministic methods furthermore replace neutrality and indifference by conscious partiality (Bryman, 2008) and

intentionally seek for emancipatory goals of feminism to be realised, for all those who are oppressed by existing social and power relations (Hudson, 2000).

The participants were, in the main, recruited via organisations working with female ex-offenders, either in a statutory setting or within the charitable sector. The ethical aspects of the study were a key part of its design, and the research was scrutinised and approved by the University of Surrey's Ethics Committee. Placing people and their life-stories at the very heart of the project's data gathering process, the interviews took a narrative life-story format. The narrative interview is a type of qualitative, in-depth interview which moves beyond the question-and-response structure (Bauer, 1996), and this, combined with a life-story format, allowed for subjective conceptions of lived experiences to be linked with wider social and historical contexts (Messerschmidt, 1997; Adriansen, 2012). This type of interview is deemed especially appropriate in research that deals with sensitive forms of personal experience. However, it is important to be mindful of the fact that narratives produced in interviews represent purposeful account-making, which are guided by expectations and shaped by the particular research situation (Jovechelovitch and Bauer, 2000). Moreover, this interview format also has limitations in terms of what it can, and cannot, reveal. As noted by Bryman (2008), it is questionable how far narratives can reflect any underlying 'truth' about events, or indeed to what extent they can access divergent realities experienced by different groups of individuals, including aspects of structural forces that may have a bearing on the lived experience.

Moreover, it is important to note that the narrative data excerpts presented in this paper were not the product of a targeted interview focus. That is, ADHD did not form a part of the interview schedule for the original study, and it was a discourse that was completely absent

in the English data. This is noteworthy, and feed into a key point raised by previous scholars in the field; how individuals describe and frame their behaviour will depend on what narratives and discourses that are available to them (Berger, 2015). In the English data, narratives relating to conditions such as Border Personality Disorder, and Emotionally Unstable Personality Disorder were drawn on, which may reflect a more prominent role of these discourses in the English criminal justice setting. It is noteworthy that these conditions did not have an equivalent in the Swedish data. Berger (2015) argues that the level to which a specific medical narrative is drawn on as an explanatory factor can be used to gage the level of cultural legitimacy that it is given in any one society.

As the fieldwork in Sweden progressed, the number of women who brought up ADHD reflections in the interviews grew. At the start of the project, these stories were brought up unsolicited by the interviewer, and were often mentioned as a side-line within other broader narrative constructions. However, as an increasing number of participants were mentioning ADHD in their storytelling, I began to ask question about it towards the later stages of the data collection process. For these reasons, the data were not suitable for comparison across the two countries, and the area of ADHD was therefore not a focus in the final thesis, nor in the book *REMOVED FOR REVIEW* that followed, which focusses more exclusively on the female journey towards desistance in Sweden and England.

Between a half and two thirds of the Swedish sample identified with an ADHD diagnosis^{iv}. The women within this group ranged in age from 24-37 and were interviewed across three different cities in Sweden. A range of offending types were presented, with some having an extensive criminal record, while others having just a handful of convictions. Most had spent time in prison, though not all, and all the women in this group had a history of substance

misuse, predominantly heavy amphetamine use. The data is here presented in its 'raw' form, and are intended to show first-hand illustrations of female experiences of ADHD diagnoses in the Swedish criminal justice system; thus acting as springboards for critical reflections on ADHD diagnoses in this particular setting. All of the data on ADHD detected in the study were explored for this purpose, and the illustrative examples presented below represent the main subjective perspectives detected therein. Due to the limitations of the data discussed above, the narrative examples and findings are solely exploratory and not suitable for empirical generalisations. The data has been translated by myself, using a 'conceptual equivalence' approach; meaning that I have prioritised 'free' translation, rather than 'lexical comparability' (Birbili, 2000).

ADHD narratives by female ex-offenders

This section will offer illustrations of ADHD narratives that were present in the data, and critically reflect on what different functions and purposes the diagnostic discussions may have. The women's identification with the diagnosis was varied, and are suggestive of different diagnostic functions and frameworks. Two major themes in the data are that the diagnosis provides a retrospective new understanding of difficulties experienced in their youth, particularly in educational settings, as well as offering a framework by which they can understand their drug use. The diagnosis thus allows individuals to effectively reinterpret parts of their life-stories, especially those that may be stigmatising or seen as deviant (Pedersen, 2014). The nature of the women's drug use, and their abilities on the drug-using scene, was by some reinterpreted through the ADHD diagnosis. 'Linda', a long-term amphetamine user who has an extensive criminal record, here for example explains how she

felt that everything fell 'into place' when she received her diagnosis and started to medicate; giving her a new perspective on how she 'functioned' during her drug abusing years:

Linda: Like I get medication today, and I mean that's amphetamines, I get that constantly now. And there it was just like 'ba ba boom', everything just falls into place. [...] Cos' when I used [amphetamines], and of course it's all about quantity, but when I've used I've always started on a really high dose to then trap down and settle for just a little. [...] And I've functioned, you know, people are just like 'aa I must have dope must have dope', like 'fuck, grab a sandwich and go to bed', you know what I mean? [...] I mean I've never taken apart a DVD or, you know, people screw apart their entire homes, people tape their door shut, they...yeah, everything you know. [...]

[I: So you think that has to do with your ADHD?]

Linda: Yeah, well I mean I don't know ... but the fact that I've not had any psychoses, that I've, like I've also many times, even though I might have ended up in lots of tricky situations, but especially now later when I've got more mature in my addiction, I've always been able to read [a situation]. If I'm by myself and a guy comes in who I know sells a lot of drugs and he comes in and *offers* me, like 'No Way', no – Am I gonna do drugs then I'm gonna *buy* my drugs. And they can't take it, 'iiii', cos' then I know, then there's a catch on me, because *that* I'd never give. [...] I've not done like really stupid things like, I've never, you know, sure you end up in situations that are difficult to handle and all that, but still I've always been kind of 'with it'.

In this narrative 'Linda' seems to suggest that her ADHD has allowed her to use drugs (specifically amphetamines) in a more controlled manner. She accordingly makes sense of her

experiences on the criminal/drug-using scene through this very specific lens, and makes her desistance path connected to continued medicalisation. Similarly to other studies (Berger, 2015), the effects of prescription drugs here seem to validate the neurological basis of a more socially accepted medical narrative. Moreover, 'Linda' also identifies how receiving the diagnosis for her produced a sense of 'everything falling into place'. The diagnosis thus offers a meaningful reference for understanding life experiences through a new perspective (Pedersen, 2014). As 'Linda's drug use becomes construed in medical terms, she is effectively distancing herself from drug use as pleasure and/or deviance. From a critical perspective, it is interesting to reflect on what other explanatory frameworks that are being relegated through the dominance of this specific lens. In contrast to common female amphetamine-using narratives that focus on traditional female activities, such as effectively managing a busy family life (Pedersen, Sandberg and Copes, 2015), 'Linda's narrative indicates that her ADHD may have allowed her a higher performing criminal life.

Considering what other explanatory frameworks that have been relegated through this; could for example Linda's ability - as a self-identified drug addict - not to accept free drugs from a man, who she then might be expected to offer something in return to, be interpreted via a lens of individual agency? Could it be interpreted via a sense of choice, of not using sex as a trading tool for drugs? Does this narrative suggest something about what opportunities that are subjectively experienced as available on the criminal scene for women in Sweden? Rather than looking at this through a lens of female agency and self-reliance, 'Linda' instead draws on her diagnosis to explain a level of control within her drug use, which she today links to her methylphenidate prescription use. This is in line with studies that suggest that the use of stimulants can mean that the 'locus of control' for behaviour become dependent on the use of medications (Rafalovich, 2005). In turn, this interpretation of control may have important

consequences for the individual's desistance narrative. Drawing on cognitive transformational desistance perspectives, we know that the internalisation of control, and a subjective sense of ability to overcome obstacles, can be an important factor for a successful desistance identity (Maruna, 2001). While the medicalisation of everyday life can fill the individual with optimism about the future (Berger, 2015), to locate this control specifically within a medicalised path could have a negative effect on the subjective sense of overcoming obstacles without continuing medicalisation. Potentially, this narrative construction could be an explanatory factor as to why the identified reduction in criminality have not been found to be applicable long-term, that is, after medication has been terminated (Lichenstein *et al*, 2012).

A different example of a function of an ADHD diagnosis is found in 'Mia'. 'Mia' has one of the more extensive histories of childhood abuse found in the Swedish data, including experiencing sexual abuse by her father from what she thinks was the age of 3. As a child she was diagnosed with several conditions, and she also experienced extensive periods in various care/institutional settings. In this quote 'Mia' responds to a question about what she remembers from being institutionalised at a young age:

Mia: Like I've just repressed so much, you know, like I've been through trauma therapy just to process all that's happened, eh, and I've just chosen to switch off. Um, I mean, I guess what started it all was when I moved when I was 12, I lived three days a week at home and then the rest I lived in relief families, because, you know, I had severe ADHD and I was impulse-driven and with, like I just had so, like aggression was always the first feeling. Eh, and people just thought, I just got a bunch of diagnoses, ADHD, Asperger's, you know, instead of checking what was going on behind it all. [...] In all of

these assessments my truth was constantly questioned, cos' like it was a good family, we had a good income, both my parents worked, my dad had his own company, my mum had her own shop...

'Mia's narrative brings up a number of noteworthy factors, including the issue of 'silencing' of abuse narratives, which I have written about in other places (see REMOVED FOR REVIEW). In terms of the ADHD aspect specifically, it becomes clear in 'Mia's' story that she subjectively views her diagnoses to have detracted attention from the abusive environment that she was living within. On the surface, her environment seemed 'good', it was a 'good family', as 'Mia' says. She also suggests that these factors, the 'good family', meant her truth was constantly questioned, and she received a range of diagnoses 'instead of checking what was going on behind it all'. 'Mia's narrative here seems to give support to some of the critical arguments highlighted above, namely, how the medical model can dominate on the cost of social and psychological dimensions. From a critical perspective, the key question here is whether a less medical understanding of 'Mia's' aggression problems, rather than judging these through a neuropsychiatric frame, might have helped to identify the abuse 'Mia' was suffering in her home at an earlier time, and possibly also allowed her avenues to start dealing with these in a less medicated way. This data supports Kärfve's (2013) suggestions of how a diagnosis can carry important consequences in terms of removing responsibility and blame from social environments. In fact, some argue that the symptoms that are connected to ADHD could be considered a normal response to extreme adversity, and many symptoms are indeed consistent with those presented by children who have experienced trauma or abuse (Hill and Turner, 2016). What is more, there is also a hint of a lived sense of lack of adequate support

in 'Mia's narrative. Berger (2015) notes how professionals and frontline workers' lack of support can be drawn on to reduce personal responsibility for a stigmatised or negative past.

For our third example, we turn our attention to 'Malin'. 'Malin' has not been diagnosed with ADHD herself and does not identify with the symptoms. However, having spent a couple of years in prison, she had a range of viewpoints on the role of ADHD diagnoses for women in the Swedish criminal justice system. Her narrative gives support to how embedded discourses of ADHD within the Prison and Probation Service (Berger, 2015) may open up individual opportunities for drawing on this medically-orientated narrative in this particular setting. 'Malin' here responds to the question whether she had the experience of going through an ADHD assessment in criminal justice setting:

Malin: Do you know what I've actually battled a lot with people about this, because it feels like, within the Kriminalvården^v, and sure it *could* be the case that many have ADHD, I don't say that isn't the case, but it's just how Swedish society has become, I mean, like as soon as someone makes the slightest, you know, deviant, then it's like 'yup diagnosis'. As if that would explain everything! And in prison, both at X and X, there were *so many* diagnostic groups, you know. Like, I mean, I would estimate that about 80% were diagnosed with ADHD. [...] And as I said, you know, I've never felt that kind of symptoms really [...], so I've not really been interested in it, you know, but I mean would anyone have even the slightest interest to explore that possibility then there's like these big [indicate 'large' with hands] opportunities to do so [laughs]. [...] But then also, if I'm gonna be completely honest, I have to say that there were quite a lot of those who wanted the diagnosis, just in order to medicate. That's something that you might not speak very loudly of, but that was really what was going on.

Although 'Malin' herself does not have a diagnosis, and does not feel the symptoms apply to her either, subjectively she expresses confidence that she could have received a diagnosis if she wanted to. This is in line with other Nordic studies that have shown that prisoners often suggest a huge prevalence of ADHD inside, with 'almost everybody' having it (Pedersen, 2014: 7). Not only is the self-narrative validated by wider cultural scripts (Berger, 2015), but the particular context of the Swedish criminal justice system also appears to offer a setting that invites individuals to construct a medically-orientated self-narrative, through encouraging diagnostic assessment opportunities. Assessment procedures play an important role here, and the way these are used in the criminal justice system have received considerable critique. For example, Stokkeland *et al* (2014) found that assessment tools such as self-report scales and MINI plus diagnostic interviews did not produce valid ADHD results for prison populations. These types of assessment are thus likely to produce over-diagnosis, suggesting over-estimations of the commonality of ADHD in prison populations. Additionally, the specific assessment setting must also be considered. The nature of incarceration may, indeed, produce symptoms associated with ADHD (Grieger and Hosser, 2012) and should be taken into account when assessing. Moreover, Young *et al* (2011) argue that criminal justice professionals often lack the adequate knowledge, skills and training for dealing with ADHD, as professionals are either experts in criminal justice or experts in ADHD. For women generally, and for women with substance use in particular, Konstenius *et al* (2012) suggest that more careful assessments that can enable a distinction of ADHD from substance use, as well as from other psychiatric disorders, is required in order to obtain the correct diagnosis. More comprehensive and detailed assessment are, however, unlikely to fit with shrinking criminal justice budgets. Especially in this socio-economic context, it is essential that we do

not allow pharmaceutical drugs to become 'magic bullets' in the criminal justice system to correct and manage individual behaviour (Moore and Hannah-Moffat, 2005).

An interlinking aspect of the data on ADHD is found in the area of who is the initiator of the diagnostic assessment. Two of the women have very specific memories of this situation, both relating to their solicitor suggesting the possibility of an ADHD diagnosis. For example, 'Linda' here reflects on how she first was introduced to the idea of a diagnosis:

Linda: Well, my lawyer said it, I've had him for several years, and they said it at the jail in X as well, when I was locked up in there for 3 months and they came in and I was reading like three books at the same time. So yeah, everything like that, that was it.

For 'Linda', this was a suggestion she very much welcomed, and she went on to seek out an assessment and was then diagnosed and prescribed methylphenidate, which for her came as a positive. In contrast, 'Carolina' had similar suggestions from her solicitor, but responded in a different way:

Carolina: No, I've never been assessed for it, eh...I don't think I have it, but I'm not sure. [...] I was kind of considering it for a while, cos' I had a solicitor once who told me that I should do it [assessment]. So after that I considered it for a while...but no, I don't think so. [...] He said that he thought that I should do an ADHD assessment and that, like 'most girls who end up here where you are have ADHD', and what else did he say...ah yeah that my body language suggested it. But then I've seen him again since and I asked him, cos' it was something that stayed on my mind, and then he said 'oh really did I say that? I can't remember, it probably had something to do with the way you sat on the chair', or something along those lines. So I didn't take it too serious.

This narrative suggests that the original 'plantation' of a diagnosis may come from a variety of sources within the criminal justice system, and are not exclusive to the prison or sentence context. It is indicative of how labels can and are encouraged by professionals, potentially creating a self-fulfilling prophecy (Hill and Turner, 2016). The fact that the way a woman 'sits on a chair', especially in the setting of custody following a police arrest, would encourage a solicitor to suggest an ADHD assessment is questionable. Again, the context seems to be missing; in this case the stressful situation of being arrested, spending time in custody, and, most likely, starting to withdraw from drugs, which all are likely factors influencing how the person in question would 'sit on the chair'. What is clear in these examples is that it is up to the individual in question whether they interpret the diagnostic possibility as a positive, or if they choose to, as 'Carolina' does, to not 'take it too seriously'. Furthermore, this narrative gives support to previous studies that have found that although many individuals in the criminal justice system welcome a diagnosis, others want to be 'normal' and therefore resist diagnostic opportunities (Pedersen, 2014). Kärffe (2013) suggests that the level of welcoming of a diagnosis is linked to a range of individual and contextual factors, including whether the person has experienced exclusion. Bearing in mind that research demonstrate a link between a lower socioeconomic standing and a positive ADHD diagnosis (Savolainen et al, 2010), we can only hypothesise whether the fact that 'Carolina' was one of the few middle-class participants mattered for her willingness to explore the diagnostic opportunity. The class aspects would certainly be an interesting factor to consider for future research in this area.

It is clear, then, that there can be resistance to diagnosis, and for some, this resistance was specifically linked to access to medicines and attempts to move away from a drug-using narrative. 'Angel' provides an example of this; here talking about how she is currently trying to be creative to avoid boredom:

Angel: It's just like really quiet everything now, if I put it like that, you just have to find, try to be creative and find other stuff to satisfy your ADHD, I mean, if you have to sit still....Yeah it's this thing that you always think something should happen. Like, that doesn't just disappear in a day.

[I: When were you diagnosed with ADHD?]

Angel: Well I'm not, no, I don't give a shit if I have it or not, but it's just something I imagine I could have, but it's not something I really care, if I have it or if I don't, 'cos I don't want to have any medication for it, but yeah the thought has been there plenty of times.

This is an interesting case, as even though 'Angel' 'imagines' that ADHD is something that she may have, she has chosen not to seek out an official diagnosis for it. Self-diagnosis of ADHD is indeed common among drug-users and is typically based on what is known about the condition from networks, the media and lay pharmacological knowledge (Pedersen, 2014). In 'Angel's case, her narrative suggests that for her, to *not* receive a diagnosis acts as a form of self-protection, specifically blocking access to stimulant prescriptions, that supports her desistance path. This also demonstrates the previously identified blurred border between illegal drug use and the use of prescription stimulants (Berger, 2015), as well as how the potential for misuse and dependency of medications such as Ritalin are typically known by potential users (Pedersen, 2014). The pharmaceutical forces towards medical treatments discussed above, together with a criminal justice setting that encourage diagnostic access, must here be critically reflected on via a perspective of individual resistance to dominant narratives. In support of previous studies with incarcerated women and the use of

prescription drugs (Smirnova and Owens, 2017), not only does the woman need to trust the medical professionals, but she must also be able to trust herself to use them in appropriate manner.

Conclusory reflections and future directions

The 'unexpected' ADHD visitor in my study has, in many ways, raised more questions than answers. What role do these diagnostic trends have for subjective interpretations of behaviour by female ex-offenders? Are diagnoses offering helpful answers or unhelpful labels? Are there particular gendered aspects within these developments? And how do they fit with contemporary criminal justice policy and practice? This paper has demonstrated that women in criminal justice both conform to as well as resist ADHD labels and medicalised treatment models. Emphasising the exploratory nature of this study, and the limitation of the data, the aim of this paper has not been to try to establish whether the diagnosis is a medical fact, but rather, to give female voices on diagnosis a space in a typically male-dominated criminal justice (and ADHD) landscape. So how are narratives of diagnosis conveyed first-hand, and what subjective function do they play? It is clear from the data that ADHD can become a narrative resource that individuals can draw on, with some functional advantages. The key question is, of course, to what consequence? The data has suggested a possibility that individuals are, through labels, narrowing subjective conceptualisations of their own behaviour, and thereby relegating other, potentially more empowering, interpretations of behaviour. Moreover, the overreliance on medicalised treatments must be questioned in a broader penal practice perspective: Are medications the most suitable and effective treatment for a particular individual, or are they the most cost-effective and less time-

consuming way to deal with behaviour that may be symptomatic of other underlying issues? It seems unlikely to be a coincidence that the dominance of the medical treatment model has grown in parallel with risk-based criminal justice models and individual responsabilisation frameworks. Situating the global trend of the forceful return of biological explanations (Brante, 2013, Kärfeve, 2013) in current socio-economic processes, biological perspectives on behaviours, and the associated medicated treatment interventions, also fits well with contemporary calls for 'quick fixes' (Hill and Turner, 2016: 20). With welfare agencies being significantly underfunded, it is clearly cheaper to prescribe medications rather than explore other more resource-heavy interventions.

This paper has suggested that the experience of diagnosis can serve a number of functions. Specifically, examples have been provided to show how new explanatory frameworks for previous behaviours can be applied through the diagnostic lens; that diagnoses can be subjectively experienced as deflecting attention from problematic social and environmental contexts; and that some criminal justice institutions offer a particularly 'friendly' setting for diagnostic access and encouragement. For some women in this study, the ADHD diagnosis narratively linked to a new understanding of behaviour, that encouraged a more desistance-orientated – albeit medically-dependent - narrative. In contrast, however, for others a resistance to formal diagnosis acted as a desistance factor, as a diagnosis was deemed to pose a risk to a drug-free self-narrative.

Overall, it is argued that there are important contextual questions that require attention in this debate, including a critical exploration of the beneficiaries of these diagnostic trends and consequences of lived experiences of women in the criminal justice system. Additionally, critical queries about the production of knowledge must also be raised. That is, where and

how is 'expert' knowledge about ADHD produced, and in what ways is it applied? Brante (2013) highlights how the pharmaceutical giant Novartis has funded and supported research proving the use of medicalisation treatments of ADHD. Especially in an increasingly market-driven research climate, the academic community arguably has a key responsibility in scrutinising the links between research funding, dissemination of findings, and the serving of particular interests. Interdisciplinary research practice is accordingly called for, ensuring that different voices are heard, and that no one field, such as the biomedical field, gain a monopoly position of research in this area.

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ⁱ The American Psychiatric Association

ⁱⁱ Diagnostic and Statistical Manual of Mental Disorders

ⁱⁱⁱ This section offers only a brief overview of the methods and approaches used in the original study. For a more detailed description, please see *REMOVED FOR REVIEW*.

^{iv} This figure cannot be precise as there were variations in diagnosis stages and interest in 'formal' diagnosis. For example, one woman was currently undergoing assessment, and thought it was highly likely it would result in a positive diagnosis. Two other women were certain they had ADHD, but they had declined assessments as they wanted to avoid the use of, as well as access to, medications.

^v The Swedish Prison and Probation Service