Paying attention: Diagnosis, values, and meaning-making in the ADHD clinic

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By

> Attention, as you know, is the basic faculty, the mother faculty of what we commonly call intelligence. Those who play a role in education must, above all, provoke and capture that attention.
> *Costa Ferreira, 1920: 140*

In this lecture addressed to primary school teachers, the founder of the Portuguese school of medical pedagogy, Costa Ferreira, called “attention” the mother of all cognitive functions – a faculty of intelligence that, nonetheless, has to be evoked, attuned, and modulated (Filipe 2014; see also Cook 2018, Seaver 2018). What is of particular interest in this quote is the purchase of attention as a cultural and medical matter of concern, which resonates with contemporary debates on the diagnosis, treatment, and management of attention deficit hyperactivity disorder (ADHD).

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric Association (APA 2013), ADHD is based on a triad of neurobehavioural symptoms that include inattention, hyperactivity, and impulsiveness. This collection of symptoms are estimated to affect about 7% of school-aged children and youth worldwide – and up to 11% in the United States alone (Bergey and Filipe 2018). With the twentieth century dubbed “the century of the child” and the twenty-first century labelled “the century of the brain,” ADHD remains one of today’s most pervasive neuropsychiatric diagnoses (Filipe and Singh 2016). A timely, albeit slippery, object of social and anthropological inquiry, ADHD encapsulates the ambiguities of neuropsychiatric approaches to behavioral and learning problems while also acting as a repository for wider cultural anxieties and social expectations faced by parents, teachers, and youth—from issues concerning neurocognitive capacity/diversity and child development to those relating to parental practice and school performance (Rapp 2011, Blum 2015).

Given its increasingly global scope, the diagnosis of ADHD also raises the question of whether its soaring worldwide prevalence and psychostimulant prescriptions rates may be attributed to the globalization of psychiatric

knowledge, diagnostic systems, and pharmaceutical markets, the increasing public awareness of the diagnosis, or the interplay of these and other bio-neuro-social, environmental, and historical factors (Lakoff 2000, Filipe 2016, 2018; see also Rose 2018). Much has already been said in the literature about the medicalization of childhood, the ethics of psychostimulant treatments, and the emerging globalization of ADHD (see for an overview, Singh et al. 2013). Yet surprisingly little is known about how the diagnosis is made and, more broadly, how (in)attention is defined, valued, and negotiated in practice, particularly outside the U.S., where its diagnosis and treatment were originally validated.

As part of my doctoral research (2010–15), I conducted a para-ethnographic study (c.f., Dumit 2004) of a paediatric clinic based in Portugal, which specialises in the diagnosis of ADHD. In addition to observing 46 consultations and 11 psychological assessments involving school-aged children, adolescents, and their families, I conducted an extensive analysis of the diagnostic protocols and instruments used in those consultations, the local news media, and other relevant policy and/or technical reports. I also interviewed and followed five developmental paediatricians and psychologists who were directly involved in the assessment and management of ADHD, observing day-to-day activities, team meetings, seminars, and public conferences.

Drawing on this research, I explore the double face of attention as a neurobiological and moral value and examine two interrelated sets of meaning. The first relates to the idea that “paying attention” is a brain-based cognitive function (or capacity) whose deficit underpins the diagnosis of ADHD and justifies its treatment with psychostimulants. The second is the idea of “valuing” attention where value refers, etymologically, to the idea of *pricing* and *appreciating* as well as *praising* and *appraising* (Dewey 1939), which conjures up a notion of attention as matter of caring for, tending to, and engaging with one another. I propose to untangle this double meaning and its implications by looking at how a small group of clinicians make sense of and ascribe value to “attention” in the ADHD clinic.

Valuing attention

In the clinic that I observed, paediatricians who were assessing children for a possible diagnosis of ADHD combined a DSM-based, simplified questionnaire with a detailed clinical and family history and both developmental and neuropsychological assessments. Through these instruments, the focus of their clinical gaze and diagnostic practice was less on hyperactivity and motility symptoms and more on the impairing, long-term effects of attention deficit.

As one doctor explained, referring to, CJ, a 15-year-old boy: “At this age, the complaints we receive have less to do with rules and behaviours and more with the deficit of attention, [which is] the bottom-line problem and hyperactivity is what worries us less.” In these consultations, clinicians placed great emphasis on rendering ADHD evident as, primarily, a disorder of attention (Filipe 2016) and argued that the appraisal of neurobiological *deficit* must have precedence over the *excess* of behavioural complaints in the evaluation of ADHD.

I was struck by how these clinicians spent a great deal of energy and time in the labour of differentiation (Mol 2002), that is, defining what ADHD *is* by defining what ADHD is *not*. This seeming paradox could be explained by what some have called the “contested” nature of psychiatric categories, the idea that those who live with ADHD may not always be able to advocate and speak for themselves, or by the scepticism with which critics of medicalization and social scientists, like myself, have written about ADHD. Thus, when explaining what ADHD is and does, using the argument of neurobiological function and dysfunction, these doctors also explained what ADHD isn’t, using the argument of moral blame:

> [T]his diagnosis must cease to be *a moral diagnosis*. … which is highly *blaming for the child* and ADHD *is not* – it has been more than *proved that it isn’t – a problem of will*; it is a *dysfunction* or a problem of poor brain functioning. (Garcia, chief paediatrician)

The use of neuroscientific “proof” and other kinds of brain-talk (Pickersgill et al., 2011) seeks to replace the social critique of ADHD with a medical discourse that reinstates both the neurobiological underpinnings of this condition and its clinical validity. In this way, blame is shifted away from the child toward the dysfunctional brain, thereby providing a form of rhetorical relief from vexing questions of moral agency and the public controversy that has often surrounded the diagnosis (e.g., “is it ‘real’?” or “what is ADHD a diagnosis of?”).

Defining what ADHD is by denying what it is not – a disorder of volition, conduct, or willpower – serves here to reclaim it as a brain-based disorder and a matter of clinical concern that requires medical care and, quite importantly, pharmaceutical intervention, as opposed to disciplinary and moral judgements. Indeed, when I asked another paediatrician to talk about the differences and specificities of ADHD she argued that, unlike other conditions, ADHD cannot be accounted and measured through a specific medical exam, which makes it difficult to attribute a biological value to it:

> [I]f there is a test that pins [the problem] down, people have less

> trouble seeing it is a disease of the body… so there is a difficulty in attributing a *biological value to ADHD*. Yet ADHD also affords a medical, a pharmacological intervention that distinguishes it from the other syndromes we tend to in our clinic [and] when the medication works … it is something, you know, really rewarding. (Barbara, developmental paediatrician)

In this and other clinical depictions, doctors described ADHD as a disease of the body that is functionally equivalent to any physical condition such as diabetes, short-sightedness, and even erectile dysfunction and, by analogy, a condition that entails pharmacological intervention, just as insulin is prescribed to patients with diabetes. This conception of ADHD reveals a key practice of valuation in contemporary medicine and diagnostic psychiatry: the attribution of biological and other functional values to disease categories (Rosenberg 2002, 2003) and their assignment, in turn, to specific medical treatments — i.e., by affording a *treatment that works*, the diagnosis becomes something that rewards or *repays*. Inasmuch as ADHD lacks a clear aetiological explanation, it gains a medical *ontology* and *normative* security through the efficacy of psychostimulant drug therapies.

Repaying attention

On the other side of the ADHD diagnosis, psychologists working in the paediatric unit emphasised the importance of how psychometric evaluations and psychological interventions are carried out. As a senior psychologist argued, ADHD is a pervasive trouble that affects the whole person and that begs a different kind of clinical (rather than purely diagnostic) attention and other qualities of care, including a very "careful evaluation" and a "whole set of practices and ways of dealing" with the child:

> The kind of intervention I do is largely related to assessment, to evaluation, right? … *we must be really careful and understand really well how the child functions* in her daily routine, understand the whole person… And then there is a *whole set of practices and ways of dealing with the child that are absolutely vital*. … this is why I tell the parents and teachers: "here is your assignment – verbalise the qualities of this child" because people simply forget to do it. (Andrea, developmental psychologist)

In my observations, clinicians made a link between evaluation and intervention as part of an integrated diagnostic-therapeutic practice. This practice entails meaningful and mutual engagements between children,

teachers, and parents – self-described as a practice of care and proximity. These engagements warrant, in turn, the refiguration of parental anxieties by attuning them to the dynamics of attention and inattention, not only as a matter of medical and parental concern but also an ethic of care. From this point of view, the clinical evaluation of ADHD-related complaints cannot be reduced to the psychometric measurements, DSM-based questionnaires, and behavioural checklists. As one psychologist argued, it has to be grounded in a qualitative appreciation of and relational attention to the child:

> I feel that we must pay special attention to these children [sigh] who are criticised every single day of their lives. Then they get to this consultation and hear everyone talking about them and little attention is paid to them. (Monica, neuropsychologist)

In family-centred practice, diagnosis and intervention acquire meaning not through their intrinsic clinical value but as a way for children, families, and teachers to relate to one another. This approach entails a different way of engaging with troublesome children that is less biased toward negative aspects of their behaviour and cognition and more focused on family life and social environments that tend to neglect other needs, qualities, and relational forms of attention.

The economic, diagnostic, and cognitive model of ADHD as a deficit is overlaid, in this clinic, with a relational model of attention that is mediated in the clinical encounter:

The psychologist begins by asking: w*hat brings you here? And what do you think we are doing here?* Rodrigo, having watched us starting to write down information, replies, *you talk and look at children and take notes about their behaviour*. There is laughter.

Psychologist: *So what is your current preoccupation, your main concern?*

Mother: *That this behaviour will make other people get tired of him. … It's really difficult to deal with him because we need to grab his attention all the time. It's exhausting.*

The psychologist explains that positive reinforcement may work better than criticism and that certain behaviours and traits need not be a source of concern: *we are all too centred on what can go wrong. Pay less attention to what can be ignored!*

Encountering (in)attention

Attention was a core concept in the early twentieth-century medical pedagogy, as it is in the contemporary discourses and practices surrounding ADHD. In the paediatric clinic I observed, attention was defined and valued, on the one hand, as a primary cognitive and neurodevelopmental function that can be identified, quantified and medically treated. From this perspective, the main marker for ADHD resides in a brain-based *deficit* that can be modulated and repaid through psychostimulant medications; this perspective resonates with the *diagnostic* and *economic* conceptualization of cognitive capabilities that has been used in the development of modern neuroscience (c.f., Sacks 1985).

Yet attention may be also defined as a relational quality that mediates between individual biologies and wider parental and moral demands, whose intersubjective meaning is re-negotiated in the encounter between clinicians, children, and their families. From this perspective, a *relational* and *ecological* understanding of attention (c.f., Citton 2017) appears relevant to both clinical and parental practices. This understanding evokes an extended and more layered notion of attention as a value, a practice, and an ethic of care (see for a debate, De la Bellacasa 2017; Ferreira and Filipe 2019).

Combining these two perspectives calls for a situated understanding of medicine and healthcare, beyond culturally normative framings of what it medicine is, means, and does today (e.g., medicalization). Such understanding implies a reimagination of the clinic not only as a space of biomedical “reasoning” and “gazing over” but also as a place of social encounter and normative reflection on different ways of paying attention, caring about, and “being with” one another (Good 1994; Mattingly 2014). As Van der Geest and Kleinman (2009, p. 165) poignantly wrote, to give and receive care – and, one might add, to give and receive attention – constitute some of “the most incisive values that structure our lives as moral beings, in family life as well as in medical settings.”

Paying attention and being attentive is, in this sense, more than a neurobehavioural matter of medical care and parental concern: it is about reencountering attention as a form of valuation that is, at once, diagnostic and relational. By bringing these intricacies to light, the ADHD clinic offers a distinctive site for the development of *new cartographies and ethnographies of (in)attention* in contemporary medicine and in everyday life, while also inviting us to rethink cognitive models of behaviour, personhood, and social theory.

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