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## A CASE OF ADHD DIAGNOSIS:

**Sir Karl and Francis B. slug it out on the consulting room floor**

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### **Abstract**

Drawing upon conversation analysis and critical discourse analysis, and in the frame of what is currently called discursive psychology, we open up a significant macro-social problem – indeed a global problem – to inspection at a local level by reference to a naturally-occurring instance of talk-in-interaction. The problem is the documented increase in diagnoses of ADHD (Attention-Deficit/Hyperactivity Disorder) in recent years – particularly for boys, particularly in Anglophone countries, and particularly by reference to school-based conduct – and its consequent ‘treatment’ by amphetamines (including Ritalin [methylphenidate]) and related medications (Singh, 2002a). The local instance of talk-in-interaction is a transcript of a diagnostic session involving a young boy, his parents and a paediatrician. We aim to show that the local instance can shed light on just how routine and mundane it is for children to be positively diagnosed and medicated merely on presentation for the possibility of the ‘disorder’, even when parents are manifestly sceptical about (even resistive to) the diagnosis and its methodological grounds.

### **Keywords**

Western Australia; ADHD; diagnosis; doctor-patient interaction; discursive psychology; children; drug use and abuse.

### **Running header**

ADHD Diagnosis

## 1. Introduction

In our part of the world, Western Australia, it has become public knowledge that ADHD, Attention-Deficit/Hyperactivity Disorder, is rampant to the point of (even popular) disbelief. This to the extent that even The West Australian – the state's monopoly daily paper, a conservative and populist publication, not known for its scepticism on 'medical' matters – recently ran the front-page headline 'Is ADHD Real?' (O'Leary, 2004); and the tabloid Sunday Times featured a highly critical opinion piece on ADHD in April 2004 headlined 'Diagnosis for Disaster' (Egan, 2004). According to pharmacological research we will refer to below (Berbatis et al, 2002), WA has the highest rate of ADHD diagnosis in Australia, bringing it very close to the US itself, the world leader, ahead of Canada, Australia as a whole, New Zealand and the UK respectively.

For all this, official medical spokespersons consider this state of affairs to be an effect of a surprisingly local enlightenment about a really existing condition rather than of (for example) the over-diagnosis of a pseudo-condition that, via medication with psychostimulants, does little more than aid in the smooth running of the education system.<sup>1</sup> In 2002, then-president of the state branch of the AMA (Australian Medical Association), Dr Bernard Pearn Rowe, went so far as to declare that:

The fact that we have the highest rate of stimulants which are the drugs used for ADHD in Western Australia simply shows we are recognising this condition more readily than the rest of Australia. Far from being embarrassed about them, I think we must be proud, because it shows that we are recognising the condition more than other countries and other states. (ABC Radio National, 2002)

So what are the actual rates of psychostimulant use on children of which Dr Rowe feels we should be so proud? Rowe's comments were made in response to the publication of a paper in the highly respected Medical Journal of Australia by researchers from Curtin University's School of Pharmacy. Constantine Berbatis, Bruce Sunderland and Max Bulsara (2002) drew on data held by the International Narcotics Control Board, and supplied to the it by the Australian federal government's Treaties and Monitoring Unit in the Commonwealth Department of Health and Ageing. They describe their figures as 'the most reliable international and jurisdictional sources of consumption of these agents'. And they go on to point out that: 'in Australia, from 1984 to 2000, the rate of consumption of licit psychostimulants increased by 26% per year, with an 8.46-fold increase from 1994 to 2000. Western Australia ranked first, with nearly twice the consumption rate of total psychostimulants as New South Wales, which ranked second' (Berbatis et al, 2002: np). But what does this actually mean? If the statistics are unpacked the following breathtaking picture emerges:

An estimated 18 000 children, or 4.2%-4.5% of WA's population aged 4-17 years in 2000, received psychostimulants for ADHD in 2000. This equated to yearly estimates of 12.878 million tablets of dexamphetamine and 2.190 million methylphenidate tablets. (Berbatis et al, 2002: np)

This, in itself, is an extraordinary rate of diagnosis and consequent medication. But, even more remarkably, Berbatis et al (2002) report a significant correlation between this licit prescription of ADHD drugs (aka 'speed') and the state's increase in problems with illicit amphetamine use. There's a clear connection – though it need not concern us in this report.<sup>ii</sup>

What does concern us, for the purposes of this paper, is that the supposed condition called ADHD is not only all-but confined to Anglophone nations but is also similarly confined to the institution of the Anglophone school. If we turn to the diagnostic criteria for ADHD, as laid out in the DSM, we find that they predominantly concern how kids behave in classrooms.<sup>iii</sup> Notable instances are the following, reproduced verbatim:

- often fails to give close attention to details or makes careless mistakes in school work, work or other activities;
- often does not follow through on instructions and fails to finish school work, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions);
- often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as school work or homework);
- often loses things necessary for tasks or activities (eg toys, school assignments, pencils, books or tools);
- often fidgets with hands or feet or squirms in seat;
- often leaves seat in classroom or in other situations in which remaining seated is expected;
- often talks excessively;
- often blurts out answers before questions have been completed;
- often interrupts or intrudes on others (eg 'butts into' conversations or games).

(See American Psychiatric Association, 1994).

Given the prevalence of diagnosis and its high likelihood of consequent psychostimulant medication, we speculate that ADHD diagnosis is a very likely outcome of any presentation to a doctor with officially logged problems of conduct in school.<sup>iv</sup> That is, in the absence of the institution of the school, ADHD could hardly be a condition at all – and it could never be a 'physical' or 'brain' condition with perceptible lesions. So the diagnosis may well be a way for the schooling system to cope with pretty much any form of unwanted conduct it may encounter, given decreased human and financial resources, increased class sizes

and a currently-perceived overlap between pedagogic and broader social problems.

As far as we know, the diagnostic session we have recorded and transcribed is the only such case yet collected in WA.<sup>v</sup> It lasts some two hours or more, and it may be the only such detailed case of ADHD diagnosis collected anywhere, given the difficulties of recording and transcribing actual medical consultations and the ethical problems involved.

With full permission of all parties, we asked the doctor involved in this session to take control of the recording itself. This led to some problems with the recording of the event. The doctor — a paediatrician — had complete control over what was and was not committed to tape. So she made the decision to turn off the tape at various points; for example, during her physical examination of Alan, the child subjected to examination (lines 1000-1004). At other points, we also have incomplete materials. For example, a possibly important part of the diagnostic session is the doctor's call to Judy, Alan's school principal (lines 570-711). The tape runs during the call, but only one side of it (the doctor's) is recorded. Then, at the end, the tape is abruptly turned off. We suspect that this is close to the end of the actual session: but that cannot be clearly established.

So what materials we have (running to 1111 'long' lines of transcript) are, to be sure, partial.<sup>vi</sup> But their significance for understanding the ease or difficulty of ADHD diagnosis today cannot be under-estimated. Of course, we cannot present a full analysis of every line of the transcribed session and have chosen to break it

up into the following seven sections – divisions which the participants themselves acknowledge and orient to in their own various ways:

- Prologue: The doctor introduces the session for third-party listeners – as may be expected of her as controller of the recording. (Lines 1-6).
- Discussion of the problem: Alan’s mother and father give their account of what may or may not be wrong with Alan, in response to the doctor’s queries and also, from time to time, ventured by themselves. (Lines 7-569).
- Phone call: The doctor calls the school principal. (Lines 570-711).
- Post-call, pre-test: The doctor and the parents discuss the phone-call (above) and negotiate Alan’s up-coming psychological test. (Lines 712-750).
- Test: The doctor administers what is presented as a standard psycho-diagnostic test to Alan. (Lines 751-999).
- Physical: The doctor examines Alan but (as above) the tape is cut off. (Lines 1000-1004).
- Post-test, medication trial: The doctor and the parents work out a regime of medication. (Lines 1005-1111).

We will now deal with each of these in turn, omitting the phone call and the physical exam for the reasons already noted. We will then conclude with a general discussion of how this diagnosis occurred and its relevance for a broader understanding of the ‘social problem’ of ADHD.

## **2. Prologue**

What we are calling the prologue may seem insignificant; banal even. But it does give us an important clue as to the nature of this diagnostic event. In full, the

Prologue runs as follows:<sup>vii</sup>

(ADHD 13.1.04 1-7)  
Dr: Okay (.) so this is an assessment for Alan Popper  
Mo: Mm↑  
Dr: >date of birth eleventh of December nineteen  
ninety four< (.) er who's been referred by his  
GP erm for (.) assessm'nt of possible ADHD and  
behavioural difficulties (.) ↑so I'd now like  
to get a hist'ry from ↑Mum (.) carry on

Here, the doctor speaks, as it were, directly to the tape: marking this as a kind of official record, rather in the way that a forensic pathologist, for example, might voice-record their procedures during an autopsy. This is important because it establishes the doctor as the one, as it were, in control of the event. She, in effect, breaches the well-known conversational rule that might be called the embargo on the statement of the obvious. That is, the only participants in the talk, at this point, are Alan's father and mother and the details the doctor gives are, naturally enough, well known to them. These are: the patient's name, his date of birth and the reasons for his being the subject of the current consultation. Then, after the final pause, the doctor switches the frame slightly by asking Alan's mother for her own version of his 'history'.

All in all, then, the doctor is doing a particular kind of scene setting. This is to be an event in which there is an expert (the doctor herself) and a consultable collection of witnesses (the mother, the father and, eventually, Alan himself and, by phone, his head teacher). It is not, then, a discussion or a conversation, but a formally-constituted medical diagnostic session, in accord with a certain version of quasi-scientific reportage – for the record, here and now, but also for future



consumption by whomsoever might access this public record (in this case, including ourselves as the known-to-be-upcoming analysts).

A crude way of putting this would be to say that the doctor is 'taking control' of the situation – or in Goffman's (1981) terms, she is putting the event on a very particular 'footing' wherein she establishes herself as the initiator of events and as the one who should decide outcomes, if any. Equally crudely, we could say that, by comparison, the parents are 'marginalised': their position in the session is supposed to be that of lay informants, as opposed to experts in the matter of their own child's problems.

However, there is another way of phrasing this disparity. Harvey Sacks (1972) distinguishes between a Device-R (then a 'Collection-R'), a device with co-equal categories (such as FRIEND/FRIEND or STRANGER/STRANGER) and a Device-K (then 'Collection-K'), a device without such co-equality (such as POLICEMAN/SUSPECT or TEACHER/STUDENT). So we might re-think our cruder (commonsensical and/or Goffmanian) analysis of the prologue by saying that its achievement is to establish the participants as members of a Device-K. In this membership collection device, there are, henceforth, supposed to be two particular kinds of members: an expert and her informants or witnesses. And indeed the doctor's utterance at line 7 – 'so I'd now like to get a history from Mum (.) carry on' – carries not only the lexical items, but also the rather peremptory tone, that one might associate with a subaltern terminating an interaction with his troop sergeant.

As it turns out, though, the father and the mother – and especially the latter – work hard and continuously during the second part of the session to respecify this categorisation of themselves in relation to the doctor. They attempt, against this initial scene-setting tactic, to establish themselves as co-equal ‘experts’ in the matter of Alan’s problems and, as we will see, to out-doctor the doctor herself. Their bid is for this event to become re-construed as working via a Device-R. And that device is, roughly, CO-EXPERT/CO-EXPERT.

### **3. Discussion of the Problem**

This part of the diagnostic session is, in itself, quite long. It runs from line 7 of the transcript to line 569 – whereupon Alan’s mother initiates a phone call between the doctor and Judy, her son’s school principal. Accordingly, we cannot deliver a blow-by-blow analysis of this part. However, we will draw attention to what might be called the parents’ counter-claims to medical scientificity. In summary, we are taking it that their position vis-à-vis Alan’s ‘problem’ is almost strictly Popperian and, therefore according to contemporary canons, standardly and rigorously scientific. They present their case in several ways. The first is by comparison and contrast with their already ADHD-diagnosed elder son, Justin – such that the differences between his ‘symptoms’ and those of Alan become pretty much visible to anyone, let alone to ‘experts’ such as the doctor. The second is in the form of a strict Popperian hypothesis (an account that is the best so far, given available data, but still awaiting falsification): and that hypothesis is that Alan has been merely imitating his older brother and nothing more than that. The

third is that, according to the first and second conjectures and/or hypotheses, parsimoniously, Alan actually has a problem outwith the ADHD category and might, therefore, be in need of one-to-one educational assistance. Let us deal with each of these, while also noting that the analysis must be illustrative and, pending further investigation, incomplete.

The comparison with the elder brother, Justin, is the first thing that Alan's mother turns to when requested (as above) for Alan's history:

```
(ADHD 13.1.04 7-14)
Mo:  u:::m hist'ry of Justin? same as Justin?
      (0.4) ((laughing tone after pause))
Mo:  (couldn't count for tha:t) .hhh ha ha
?:   (   try'n'a ↑think)
Dr:  When were you first concerned about how he
      w's behaving
      (0.6)
Mo:  ↑u:::m I wouldn't say I w's rea:lly conce:rned=
Dr:  =[Mm
Mo:  [>I j's think< (I was) just picking up (.)
      things along the way
```

It's interesting for our purposes here that the mother begins by offering what appears to be (for the transcript is dubious) a positive comparison between Alan's and Justin's histories. The effect of much of her later talk is that the two are not comparable in the strictest of terms – though she does concede overlaps due to 'imitation'. So what we're seeing here is something of an initial approximation. In fact, as things turn out, it's more like a Popperian conjecture that is to be subject to the rigours of falsification. We see this right from the mother's next turn where she denies the idea that she was strictly 'concerned' about Alan. Instead, she was merely collecting fragmented bits of evidence: 'I was just picking things up along the way', as a good scientist indeed might, without coming to any prematurely definite conclusions from such incomplete 'data'. The mother makes this

methodological principle quite explicit, immediately following the passage just quoted:

(ADHD 13.1.04 14-22)  
Mo: >I j's think< (I was) just picking up  
(.) things along the way  
Dr: Mm hm  
Mo: We (.) just basic'ly decided to eliminate  
Dr: Mm hm  
Mo: the possibility  
Dr: Mm hm  
(0.7)  
Dr: So you really hadn't got- had great problems  
until he'd got to schoo:l (mm) °is'at right°

'We just basically decided to eliminate the possibility', that is, shows an equally careful attention to proper scientific procedure — the task here, properly, is to refute a conjecture — and it also sets out the mother's reason for attending the present clinical session. As far as this 'we' (thus including her as-yet silent husband) are concerned, Alan is, and has been, displaying certain forms of problematic conduct, but what this conduct amounts to may or may not be something called ADHD — which she has already experienced as an acceptable diagnosis of the older son, Justin. And while the problems are not explicitly mentioned for now, the mother's careful reading of them is that there is a possible conclusion (ADHD) but that it is still far from proven. Yet, one thing is clear about these conduct problems: they roughly coincided with Alan's second (or possibly first) school year. The doctor, relying on the file notes including a psychologist's report, offers a set of candidate problems:

(ADHD 13.1.04 46-52)  
Dr: So what had you been aware of th- (.) I  
mean th- uh thee school psychologist talks  
about >verbal an' physical aggression towards  
staff and peers non-compliance (within)  
hostility and lack of< (.) inhibition (.)  
>y'know anything about th↑aht<  
Mo: [Yeh  
Fa: [Yeh  
Dr: And wha- at the same time were you (.)  
°finding at ↓home°

Where the transcript shows speeding up (>text<), we can hear the doctor – as in a number of instances during the session – reading from the school psychologist’s report. Hence, the observed adverse conduct apparently consists of:

- verbal and physical aggression towards staff and peers
- non-compliance
- hostility
- lack of inhibition

The doctor then wants this aetiology checked off against the parents’ domestic observations. And this is where important discrepancies begin to arise in what is, presumably, supposed to be the co-produced account. Again, to start with, the mother notes a general comparison with Justin. But this, in turn, is soon accounted for:

(ADHD 13.1.04 52-77)  
Dr: And wha- at the same time were you (.)  
°finding at ↓home°  
(0.2)  
Mo: Basic’ly the same  
Dr: Uh huh  
Mo: He wouldn’ be aggressive towards ↑u:s  
Fa: He’s a ↓wuss  
(laughter)  
Fa: To put it bluntly he’s a ↓wuss  
(laughter)  
Fa: He’ll yell and scream and jump up an down  
bu- he won’t (.) he won’t defy: the same way  
Justin [does  
Dr: [right  
(.)  
Fa: It’s almost as if he’s trying tuh-  
Dr: Mm hm  
(.)  
Fa: He idolises his brother  
Dr: D’s he [hm  
Fa: [hm=  
Fa: =An I think part of it, he may be trying tuh-  
to be like his brother  
Dr: Mm hm  
Fa: But he doesn’t hav- hasn’t got the guts to do  
alotta the stuff his brother does  
Dr: Mm hm  
(.)  
Fa: Chickens out

Now we have not just a comparison between the brothers but also a candidate reason for Alan's problematic conduct. Perhaps unlike the (we may suspect) genuinely aggressive Justin, Alan is a 'wuss' (Australian for someone who is soft and non-aggressive). The father is in fact denying at least two of the school psychologist's claims: those of aggression and hostility. Where there is to be a comparison, though, its source is in copying: Alan idolising his brother, trying to be like him and so forth, but without the guts to be, in and of himself, aggressive. When it comes to the crunch, he 'chickens out'. Whatever the 'behavioural' problem(s), then, Alan is quite distinct from the locally paradigmatic ADHD case, his older brother; he simply does not have such an in-dwelling problem. His nature is different and distinct. So copying becomes the best hypothesis for the comparison so far while, at the same time, leaving the deeper reasons for Alan's particular problems at a distance from those of Justin. Even the doctor accepts this for a brief moment:

(ADHD 13.1.04 89-97)  
 Fa: Which is the same thing his older brother  
 used to do to him  
 Dr: Mm  
 Mo: Mm  
 (0.5)  
 Dr: And around about this time things were  
 really getting hairy with Justin weren't  
 they (.)°↑yeh° so that was prob'ly the other  
 factor °don't ya ↑think°  
 Mo: Yes  
 Fa: Yes (def'nt'ly)

Note the neat refusal of the doctor to directly name imitation or idolisation as the root of the problem. Instead, after a nod to the vernacular ('things ... getting hairy with Justin'), she glosses the parents' preferred reading with a professional pro-term, 'the other factor'. Good as this hypothesis of sibling rivalry/projection might be, and as deeply rooted in psychological thinking as it might be, the doctor is still driven towards (and by) the official clinical notes issuing from the

institution of the school and its associated disciplinary apparatuses. Once more referring to the school psychologist's report, she (the doctor) tries to bring things back to an expert (as opposed to the parents' putatively lay) line of thought:

(ADHD 13.1.04 111-124)  
Dr: No (.) u:m (.) yeh no er basic'ly he he  
ou- ah- outlines >those problems< and then  
he goes on ay risk three that am w's (Edith)  
(.) >the previous [one<  
Mo: [Yeh=  
Dr: =B't she left did she  
Mo: No she still [a↑round  
Dr: [Oh (I just haven't) seen her=  
Dr: =Erm okay so she adminstered that last year (.)  
I mean that would be really worrying that level  
(.)  
Dr: °O↑kay° (.) below av'rage (.) for verbal IQ  
b'low av'rage performance IQ and below av'rage  
for full scale IQ (.) I mean that would (.) y'know  
could explain a lot of his behaviours in the  
classroom

Faced with what, on the face of it, might be thought to be a fairly exhaustive (but 'lay') hypothesis of imitation/idolisation, the assessing doctor now trumps the parents with the invocation of a set of specific numbers placed on Alan by the diagnosing psychologist or psychologists – for there's a mix up as to which psychologist actually performed the assessment (the earlier officer, Edith, or the current one, Ben). The crucial number here appears to be 'risk three', and 'that would be really worrying that level'. Moreover, in addition to what is just a number representing a bureaucratic or administrative risk index, we also have a quoted triplet of IQ measurements to back the summary numeric conclusion viz:

- Below average verbal IQ,
- Below average performance IQ,
- Below average full-scale IQ.

This, here at least, is apparently in and of itself sufficient to 'explain a lot of his behaviours in the classroom' even if the mechanism of causality is left professionally unexplicated. A little later, we hesitate to say belatedly, the doctor

explains this technical result to the parents and offers her own hypothesis as to its cause.<sup>viii</sup> Interestingly enough, the mother finds this explanation in accord with her own view of Alan's problems and their utter difference from ADHD:

(ADHD 13.1.04 135-161)  
Dr: Yeh (.) because i- if that were the case  
then uh you really wouldn't be consid'ring ADHD  
as the (.) main >problem< you'd be looking at  
where he would be better a- at school  
(.)  
Dr: >C'z y'know I mean< are you familiar with  
this exactly  
Mo: I dunno how they work though  
Dr: Well the av'rage is a hundred °o↑kay°  
Mo: Yup  
Dr: So seventy seven is is sort of um we call  
eighty and above borderline seventy seven is  
below that so [it's  
Fa: [°um°=  
Dr: =sorta mild intellectual handicap really (.)  
so he would need special schooling for that  
(.)  
Mo: °Righ'°  
Dr: Is that does that s'prise ↑you (.) I mean  
d'ya think he ↑does  
(.)  
Mo: It's by your definition of special schooling  
Dr: Who needs er additional help you know so th't  
he must be either in remedial classes all the time  
Mo: hhh ((may be crying))  
Dr: What  
Mo: hhh ((may be crying)) I've been saying this  
Dr: Oh  
Mo: For (.) months [and=  
Dr: [°oh I see<  
Mo: =months and they say no no no he doesn't need  
the extra help

We sense here the mother's utter relief at the possibility of a diagnosis of 'mild intellectual handicap' rather than ADHD. This can be considered a more definite problem than the psychological condition, ADHD, that Alan may or may not have. She, herself, has been 'saying this for months' and now she has the possibility of an official medical acknowledgement that could lead to Alan getting direct remedial help at school. Note however, that it is not 'special schooling' (reserved for the seriously intellectually impaired), but rather 'additional help' in the regular classroom that Alan's mother has been calling for. If there are tears – and again the transcript is not clear – they are tears of relief and joy.



Let us reflect on the session so far. What we have seen is rival diagnostic methodologies at work. The doctor, at least initially, prefers the ADHD conclusion – and we will see her returning to this diagnosis following the testing section of the consultation. Indeed, even when faced with the psychological reports which appear to point unequivocally to intellectual disability, she does not jettison ADHD, but rather keeps it in reserve as a factor alongside the ‘main problem ... where he would be better at school’. Her evidence derives (on occasion) from professional reports. The methodology, then, is Baconian: the physical world (in this case Alan’s conduct) generates observations that can categorically amount to a general picture. The parents operate differently, more along Popperian lines, wanting to eliminate the possibility of ADHD if they can. At this point in the transcript the polite solution to the different diagnoses is to arrive at a third way: mild intellectual handicap. This would be consistent, for both parties, with both sibling imitation and problematic classroom conduct. Persons presumably suffering from this condition might well resort to imitating others they admire, even idolise: and they might well also struggle with schoolwork and so ‘need extra help’. Now the doctor’s task, in order for her methodology to win out, is to show that this clinical diagnosis is, itself, not incompatible with ADHD itself. Continuing with a direct reading from the school psychologist’s report, she offers the following (quite stunning) range of possibilities:

(ADHD 13.1.04 180-202)

Dr: Because (y’see) then he goes on to say erm they they did thee child behaviour checklist >he did it and his teacher did it< erm and he was er positive for >anxious, depressed, social problems, attention problems, delinquent behaviour, ‘n aggressive behaviour< on your thing and on the teacher’s report um areas of clinical significance are social problems, delinquent behaviour and

aggressive behaviour

(.)

Dr: Bu:t on the other hand th- ob- observations in the classroom showed Alan to be restless non-attentive and very seldom in his seat >his pers'nal bound'ri- bound'ries were poorly defined and he w's largely non-compliant<

(.)

Dr: .h a:nd then they gotchu and his teacher to fill out >fill out that questionnaire< ↑yeh (.) an both of them rated er both rated (.) the ratings from each are significant in inattention and hyperactivity (.) so they say A- Alan's a child whose behaviour is >severely hampering his education and social development< .h in in spite of having fairly intensive behavioural interventions he continues to behave in >ways that are detrimental to his progress< .h and it was recommended that Alan be sent for paediatric assessment to confirm an ADHD .h diagnosis possibly with >oppositional defiant disorder< so .hh  
( (pages turning) )

These, as it were, stand as quasi-scientific facts: Alan is, as an apparent sheer matter of fact, assailed by a veritable legion of symptoms. He is anxious, depressed, delinquent, restless, non-attentive, possessed of poorly defined personal boundaries, seldom in his seat.... And they have the apparent benefit of triangulation, arising as they do from independent assessments by the psychologist and questionnaire responses by both the teacher and the parents themselves.<sup>ix</sup> Moreover, they do not signal intellectual problems. Alan has, we are told, already had 'fairly intensive behavioural interventions' but continues to exhibit problems of conduct in the school context. So, unlike the parents' Popperian project of eliminating ADHD as a possibility, the formal evidence suggests he undergo paediatric assessment (the current consultation) to confirm an ADHD diagnosis, possibly with the much more serious diagnosis of ODD. Oppositional Defiant Disorder, like ADHD itself, is simply a psychiatric renaming of disobedience. That children may, on occasion, perfectly understandably and reasonably oppose the wishes of their teachers or parents, or even 'defy' them, is – according to the experts – not now a 'normal' part of childhood but rather a

symptom of a serious psychiatric 'disorder'. To be diagnosed with ODD is, effectively, to be placed on the waiting list for involuntary incarceration in later life.

Here we can see the diagnosis beginning to shift direction. The weight of expert evidence now points against mere imitation of the older brother and against any form of intellectual handicap. The mother, naturally enough given her adherence to a falsification model, wants to challenge and possibly refute this account and, in doing so, shows an interesting insight into one of the problems with the fashionability – not to say the plasticity – of ADHD diagnoses: that it is based on the organisational needs of the schooling system rather than on anything specific to the child she knows at home.

(ADHD 13.1.04 203-226)  
Mo: (hh) um he:'s (grabbing at all) stuff ↓too  
Dr: Is he  
Mo: He::: (uh .h)  
Dr: This guy °↑yeh mm°  
Mo: He- he's one 'v those people th't (1.0) makes  
th- like th- say the diagno[sis=  
Dr: [Mm  
Mo: =themselves  
Dr: Mm hm  
Mo: and then expects ev'rybody to agree with [him  
Dr: [Mm=  
Dr: =Mm hm, mm hm  
Mo: E:rm that questionnaire th't he w's talking about  
I filled that out  
Dr: ↑Ye: s  
(Child enters; short inaudible exchange)  
Fa: Knock on the door next time  
Mo: I- it w's all based on (.) ↓school  
Dr: Mm [Mm  
Mo: [The questions were what's he like in  
the [cla:ss[room  
Dr: [Mm [Mm  
Dr: Mm  
Mo: I can't answer that [as a parent=  
Dr: [Mm yes  
Mo: =because I'm not in the cla:ssroom

The original psychologist's supposedly scientific evidence is now severely in doubt for Alan's mother. It's his methodology that's wrong: he grabs at stuff –

with the clear implication that he's trying to fit whatever he can find into a pre-existing pattern: ADHD or, worse, ODD, come what may. 'He's one of those people who makes the diagnosis themselves and then expects everybody to agree with him': and, we may want to ask, is there another such person with the same problematic methodology? Could the doctor, in the present consultation be such a person? Is that the implication?

Then, for good measure, Alan's mother spells out just what is wrong with the questionnaire methodology: 'it was all based on school'. It asked questions like 'what's he like in the classroom?' and, just to make the problem blindingly obvious, the mother puts it bluntly: 'I can't answer that as a parent because I'm not in the classroom'. Could there be a better falsification of the psychologist's conclusions? Would any reasonable scientist accept responses from informants about situations they had never actually observed first hand? The mother is doing importantly careful work here. The official methodology, on her very plausible account, is right in there with ufology, phlogiston theory and alchemy! And here she is, presumably unwittingly, offering the paediatrician a seminar on the thorny issue of psychometric reliability and validity. Put simply, answers to differently-worded questions from those on the official schedule can bear no comparison, whatsoever, to the results of a properly completed questionnaire. In the standard literature on the topic, this requirement for fidelity to the printed questionnaire is utterly stringent, to the extent of disallowing the simplest of paraphrases. The substitution of the total class of situations which the questions ask about (the classroom) then renders, psychometrically, completely invalid the parental scores upon which the paediatrician wishes to rely.

To bring the point home by empirical demonstration, the mother offers a concrete example of the unreliability of the questionnaire, on which, we must remember, Alan's status as the next ADHD case in the state may either stand or fall.

(ADHD 13.1.04 226-256)  
 Mo: =because I'm not in the cla:ssroom  
 Dr: °Yes°  
 Mo: E:rm (1.5) so I had to try:: an (1.5)  
 ? : ( )  
 ? : °Thank you°  
 Mo: Rewo::rd it  
 Dr: Yes  
 Mo: Em (.) to >like outside 'v< the cla:ssroom  
 Dr: Mm mm  
 Mo: Y'know like the question was (1.0) does he  
 concentrate on his school work [for=  
 Dr: [Mm  
 Mo: =long periods a time >an I'd have to sit there  
 'n go< okay the- does he concentrate (.) watchin' TV  
 Dr: Mm  
 Mo: f' [long periods a [time  
 Dr: [Mm [Mm  
 Dr: Mm  
 Mo: An then I'd take my answer from [that  
 Dr: [Mm  
 Mo: So: it w's very:: (1.5) I think once he found  
 out (.) about Ju:stin  
 Dr: Yes  
 Mo: That's where he started grabbing at stuff  
 Dr: Mm hm he jus' wanted to put him in that (.) °↓yeh°  
 Mo: Yeh [one child is so is the]=  
 Fa: [( [ )]  
 Dr: [Mm  
 Mo: =[other child  
 Dr: [Mm  
 Dr: Mm mm  
 Mo: Erm so I don't know

The sequence, for Alan's mother is clear: the instruments utterly required a transfer from the school context to that of the home. It therefore became, in any even vaguely scientific sense, unreliable. It moved from the literal (Does he concentrate on his schoolwork?) to the metaphorical (Can we extrapolate this from his TV-watching skills?). Then – coup de grace for the school psychologist and possibly the whole psychology of ADHD – 'That's where he started grabbing at stuff'; knowing her first child had been given an ADHD reading, so

must the second. Even the doctor has to make concessions at this point, albeit that there is more than a hint of condescension in her response:

(ADHD 13.1.04 257-265)  
Dr: Mm well a'right that w's very [int'resting=  
Mo: [((coughs))  
Dr: =So erm >I mean as you say< I we wd- we would  
not rush to make that that diagnosis in these  
sort of settings wh- when a child er is having  
that many problems possibly (.) .h is in uh- a  
mainstream cla:ss  
Mo: °Yeh°  
Dr: Erm y'know he's bound to lose concentration  
if he's not understanding what's going on.  
↑So that's very helpful

'We would not rush to make that diagnosis'? We continue to wonder. But we must now skip some details. (These mostly concern Alan and Justin's differences and how they could – on a simplistic reading – be reconciled by seeing the former as imitating the latter and by imagining how clinicians might, in line with that simplicity, mistake that for similitude between them.) Accordingly, we now turn to the next section of the consultation for how, prior to the paediatrician's test, the parents and the doctor partly reconcile their previously manifest differences.

#### 4. Post-Call/Pre-Test

During the call to Judy, Alan's school principal, we can just make out the following turn that makes the ADHD outcome all but inevitable. Professionals have consulted and the Baconian version of science is set to triumph:

(ADHD 13.1.04 686-689)  
Dr: Well I mean I c'd certainly make the diagnosis  
'v er ADHD based on the questionnaires plus u:m  
>you know< observations in the cla:ss bu- an-  
and give him a trial of medication and we'll see  
what happens if

The doctor obviously, by now, wants to bring in the ADHD verdict and is not going to be easily swayed from that decision. Talk of medication is already underway. But this is to be a 'trial'. Now this is peculiar in some respects: the doctor is still not certain but wants to see if the response to drugs brings about a concomitant improvement in behaviour. It's almost as if Alan is to become a guinea pig: maybe he's ADHD, maybe not. But, if so, the administration of drugs will tell us. This is the tenor of the doctor's post-call proposition to the parents:

(ADHD 13.1.04 712-750)  
Dr: She is good isn't she [(↑yeh)  
Mo: [°very good°  
Dr: so u:m he- she said th't y'know he's (.)  
erm th't one a the problems is that he um he  
can't (stand ) >she recognises his problems<  
but um y'know >they are addressing that to a certain  
extent< and he- (.) he's actually (uh) quite ↓good  
in numeracy  
Mo: °Mm°  
Dr: So: it's not (uh) all doom and gloom hm [So:  
Mo: [Same=  
Mo: =with Justin  
Dr: Yes  
Mo: numeracy's [>not a problem<  
Dr: [( )  
Dr: So: w'd you be happy to look at a trial of medication  
in that situation  
Mo: Jus' as long as it's not Ritalin [((laughs))  
Dr: [No no no=  
Mo: =Can't [afford two [lotsa that (at the same)=  
Dr: [no [no  
Dr: =No  
(.)  
Dr: She- sh- he should be (.) not on the same  
( as that) °Not the same difficulties (.)  
yeh.° Alright well I would like to (jus) do this  
test with him anyway  
Mo: Yeh  
Dr: Mm  
Mo: °Go f'r your life°  
Dr: (Jus check.) Alright  
?: (What's it ↑called)  
Mo: (D'ya wanna) (.) d'ya need to measure Justin a:n-  
Dr: I'll do- >I'll do all of that< yeh  
Mo: Okay  
Dr: Yeh, but I'll just do this test with (.)  
Mo: Al[an fi:rst  
Dr: [Alan fi:rst yeh=  
Mo: =°Not a problem° ( )  
Dr: So without ↑you  
Fa: Not a problem  
Dr: Thank you  
((3.5 Shuffling, door opens, closes.  
Alan comes in))

There are some notable things about this passage. The first is a mutual point of agreement about Judy's effectivity in Alan's case. The mother has already (in passages not discussed here) praised Judy for her sensitivity to the situation. But now the doctor enlists Judy as a professional educator, and sweetens the enlistment by making the concession that the phone-call included reference to Alan's positive numeracy skills.<sup>x</sup> And so, again, Alan's mother is prepared to concede a similarity between him and his older brother: for all their troubles, both can deal with numbers. All seeming well, the preferred outcome is abruptly enunciated: 'would you be happy to look at a trial of medication in that situation?'

The response is measured: Alan's mother would indeed go along with such a 'trial' so long as the drug is not the notorious Ritalin – presumably Justin is now taking that drug because she says she can't afford two lots at the same time. (What she has left in her pantry is yet to be disclosed.) Having steered her into this position, the doctor then suggests a test. How could a dyed-in-the-wool Popperian refuse a test?: 'Go for your life' (another great Australian expression). Obviously precise measures are important and Alan's mother has now put herself in the hands of any such test. So the parents are asked to leave and Alan comes in. The rest of the encounter is nothing less than tragic.

## 5. The Test Itself

The test begins, somewhat ironically, with a tribute to a potential ADHD person's patience:

(ADHD 13.1.04 751-760)  
Dr: Hell↑o ↑Alan how're ↓you  
(.)



Dr: You've been very patient haven't you  
(2.0)

Dr: Righty oh (hh) so I'm jus' going to do a  
little game with you (.) this is the (six) schools  
year screening test >f'r the evaluation of mental  
status or symptoms< that w's erm (.) e:r devised  
in Sydney an' it's erm ay (.) >screening test< fo:r  
children 'v your age jus' to see wher- where you're  
↑at. o↑kay

The doctor, here, is, to say the least, being somewhat economical with the truth. Ethically she's required to tell the 'subject' the details of the upcoming test regardless of whether the details actually mean much to him – but by no means to disguise it as 'a little game'. Indeed having canvassed a number of colleagues in both child clinical psychology and school psychology, none of them are actually familiar with the measure named. It appears in practice to be an ad hoc melange of items from a number of established measures and/or protocols. But more seriously, in fact, it's anything but a game: it's a screening test for the evaluation of mental status, no less. Quite how this does or does not map on to the 'symptoms' of ADHD as per the DSM is another question. What in practice borrows from measures as disparate as the Present State Examination, the Rivermead Behavioural Memory test and standard Wechsler IQ tests is, somehow, intended to assist in the diagnosis of a 'disorder' not theorised as involving any specific neuro-cognitive impairment, but rather as a generalised failure to control impulsivity and attention. What is certain is that the assessment practices here are not firmly grounded in any theory of ADHD but rather themselves constitute another instance of 'casting around' or 'grasping at things'.

That this exercise in 'diagnostics' is itself Baconian in toto may also be illustrated from a closer look at its details. Canonical testing protocols insist that feedback to the testee on their performance is categorically disbarred. However if we examine

the prosecution of the 'test' closely we see interactions such as this, where Alan gets explicit positive feedback even when his responses are incorrect. For example, when asked to repeat numbers in reverse order, we find such things as:

```
(ADHD 13.1.04 822-825)
Dr:  Mm ↑hm (.) eight three five seven two
      (2.5)
Al:  Fi:ve (.) eight s::: seven six five
Dr:  >↑Good< [now s- ↑spell ↓cat
```

In the absence of the formal written record of the encounter we cannot know whether the doctor may or may not be counting answers such as the above as correct when they are wrong in small details (canonically of course such a response would be indicative of 'failure' as 'correct' responses must be absolutely literal). A further example illustrates this practice of providing what is both psychometrically impermissible, and also – morally – frankly deceptive in response to Alan's errors:

```
(ADHD 13.1.04 777-789)
Dr:  Mm hm (.) okay. Now I've gotta pen and I'm
      gonna put it in three places an' I wanchu to
      remember where I put it=first I put the pen (.)
      under the chai:r
      (1.0)
Dr:  Then I put it on the table
      (1.0)
Dr:  Then I put it behi:nd m- back
Al:  Ye:h I (c'n do) that
Dr:  Okay c'n you tell me (.) where I put the ↑pe:n
      (2.0)
Al:  E:r >under the table on the table and behind
      your back<
Dr:  Well done
```

Once more we see this when Alan is asked to remember an earlier part of the test, where he reproduces (word-for-word) his own previous mistake. Is this a mistake of fact, a mistake of memory or both? Either way – and despite the fact that no diagnostic criteria for ADHD implicate memory deficits in the disorder – the mistake is received with an emphatic 'Well done'.

```
(ADHD 13.1.04 849-853)
Dr:  ↑Good (.) now d'you remember w- the places I
      put my pen be↑fore
Al:  Ye:s:
```

Dr: >What were they<  
 Al: Under the table on the table an' beh- behind  
 your back  
 Dr: ↑Well ↓done

While it might be the case that the provision of positive responses in receipt of incorrect responses can be glossed as a technique for maintaining Alan's engagement, not discouraging him, and so forth, quite how this is supposed to help Alan is opaque. But the tactic is pervasive. In a final example, when Alan is asked to repeat phrases, he may or may not know what the expressions he is repeating means. Here, in two instances, he 'parrots' the doctor's intonation and, in the following case, can't repeat a well-known phrase: yet once again he is assured that an incorrect response is 'good'.

(ADHD 13.1.04 869-877)  
 Dr: I'm gonna say some words and I wanchu to say  
 the same words ↓after me=help  
 Al: Help  
 Dr: Aeroplane  
 Al: Aeroplane  
 Dr: She. is. a good. girl  
 Al: She. is. a good. girl  
 Dr: No ifs ands or buts  
 Al: °No if or buts°  
 Dr: ↑Good

Turning now to other aspects of Alan's test performance, we can see that he is, actually, aware of when in reality he has a good answer and a not-so-good answer. That is, we can see that far from engaging in the ADHD-symptomatic behaviour of blurting out answers to questions from authority figures before they are completed, Alan, in cases where he doesn't know an answer, explicitly acknowledges this in a completely conventional conversational turn structure and, moreover, volunteers information about what (in the same field – in this case basic sums) he does happen to know, whether right or wrong. That is to say, here, where he cannot satisfy the request of his interlocutor with a preferred second turn, he attempts to remediate this discourtesy with perfectly matched

material. (Compare: A: Do you have the time? B: No, sorry, but the town hall clock is just round the corner and that's always right). Once more we are reminded of the assiduous efforts of candidate non-members – such as persons with intellectual disabilities (cf. McHoul and Rapley, 2002) and 'delusional' individuals (cf. Harper, 1996) – to demonstrate to their professional interlocutors that not only are they well-aware that their status is questionable, but also that they are, in fact, rational, sane, happy, numerate or whatever other psychological attribute is at stake.

(ADHD 13.1.04 840-848)  
 Dr: (Nuh) o↓kay (.) now I wanchu to count up by  
 threes (.) b't start at one=so starting at  
 >one plus three< e↑qua:ls  
 (.)  
 Dr: °One plus three↑°  
 Al: >I don't know that< [but I=  
 Dr: [ >don't ↑you<  
 Al: =do kno::w >two plus two that's four<  
 Dr: >Okay that's fine<  
 Al: A:nd twenty plus three that's (t'n) a hundred

This project is not simply a matter of volunteering information however. As in McHoul and Rapley's (2002) analysis of Bob's quality of life test, we see that the candidate incompetent may work hard to show rather than tell that that their examiner's unvoiced suspicions (that they have a poor quality of life; that they are incapable of understanding and following complex requests) are ill-founded. Thus Alan shows considerable creativity in demonstrating his understanding of, and carrying out, the doctor's instructions. When told to fold a piece of paper, he elaborates this into making a paper plane:

(ADHD 13.1.04 885-901)  
 Dr: No:w take a piece 'v paper in y'r  
right ↑hand  
 (2.5)  
 Dr: Fold the paper in half an' put the paper  
 on the floor  
 (.)  
 Al: (°O↑kay°)  
 (2.5)  
 Al: (I c'n really do tha::t)  
 ((5.0 Sound of paper folding, shuffling))  
 Al: (\* )

((\*This with questioning intonation))

Dr: (Y'↑m) Mm hm  
(4.0)

Al: (I made a) paper aeroplane

Dr: H(hh)n h(hh)m  
(3.0)

Dr: ↑Good  
(2.5)

Dr: That's very ↓good well ↓done

In the final section of the 'formal' examination Alan continues to demonstrate not only his sustained attention to the tasks he is asked to perform, but also his equally sustained task-directed activity. In passing, in response to what is hearable as the doctor's exasperation with him, during the introduction to this subtest, Alan provides an utterly mundane collaborative and cooperative reply: 'Okay I could do that'. However Alan's cooperativeness is met, throughout, with condescending (teacher-type) third turns. Note the intonation:

(ADHD 13.1.04 911-931)

Dr: Ny(hh) can I(h) (.) getchu t' draw (.)  
tha- (.) just ( ) here (.)  
(>pick up the pe↑ncil<)  
(The outbreaths sound like exasperation))

Al: Okay I c'd do tha-

Dr: (Oh I'm sorry )

Al: ( )

Dr: Jus' do it like that  
(4.0\*)  
((\*These pauses = Al's drawing time))

Dr: °Hm°  
(13.0\*)

Dr: °Hm°  
(2.0\*)

Dr: That's well ↓done=g'd ↓boy  
(3.2\*)

Al: ( ) ((questioning intonation))

Dr: No that's ↓fine

Al: ( )

Dr: ( that one)  
(15.0\*)

Dr: ↑Good ↓boy well ↓done >w'r all finished<  
(Tape turned off then on again;  
unknown period of time until next segment))

Despite being 'all finished' (see above) there's a further post-test dialogue between Alan and the doctor that seems to touch on his school-based abilities and on his conduct at school. This seems to be an kind of informal assessment unrelated to the formal test, and one which Alan, as candidate sufferer of a

'mental disorder', is sufficiently acute to pick as precisely what it is: a further fishing expedition. This is what immediately follows the last-quoted segment:

(ADHD 13.1.04 932-1000)  
Al: I have lotsa fun at schoo:l  
Dr: Do [<sup>↑</sup>you  
Al: [I:: (. ) do: my wo:rk  
Dr: Mm hm  
Al: I do um (.)<sup>↑</sup>maths  
Dr: Mm hm (.)  
Al: I (.) can (m) spell my <sup>↑</sup>name  
Dr: Mm hm  
Al: I ca::n (.) write my na:me <sup>↑</sup>backw'ds  
Dr: <sup>↑</sup>Can <sup>↑</sup>you  
Al: I can write my name i::n  
(1.5)  
Al: Um  
(4.0)  
Dr: Running writing?  
Al: N[o  
Dr: [Mm  
Al: In A<sup>↑</sup>merican <sup>↑</sup>writing  
Dr: <sup>↑</sup>Oh  
Al: An' I can write my name i::n  
(1.0)  
Al: forwards the right way  
Dr: Mm hm  
Al: A:nd  
(.)  
Al: (I can play in <sup>↑</sup>soccer)  
Dr: <sup>↑</sup>Good  
Al: (I can do my work) at sch<sup>↑</sup>ool  
Dr: Mm hm  
Al: A::nd  
(1.0)  
Al: I: ca:n <sup>↑</sup>read  
Dr: Mm hm  
Al: W'thout >sounding out th' words<  
Dr: Mm hm  
Al: I c'n rea:d (.) a book  
(1.0)  
Dr: Mm hm  
(.)  
Al: ( )=  
Dr: =[Mm  
Al: [A:nd (.) I go to a:rt  
Dr: Mm hm  
Al: I go to the liberry  
Dr: Mm hm  
Al: I go to::  
(5.5)  
Al: PE studies  
Dr: <sup>↑</sup>Mm  
Al: A:nd (.) and sometimes >I go to the office<  
Dr: Ha ha f' being (uh) nau<sup>↓</sup>ghty bo<sup>↑</sup>y (.)  
>(what are you go'in) t' the office for, ya  
gettin' in trouble [for<  
Al: [Uh: I'd sa:y  
(.)  
Al: (Being naughty at pe'ple)  
Dr: Why d'ya (do) <sup>↑</sup>that  
Al: °I dunno°  
Dr: Y' jus' get angry d'you  
Al: Mm that's [<sup>↑</sup>all

Dr: [Mm hm  
 Dr: Yeh. D'they do anything to make you an<sup>↑</sup>gry  
 Al: Nuh  
 Dr: No [( ) A'<sup>↑</sup>right well I'm jus' gonna=  
 Al: [( )  
 Dr: =have a, get you to lay here an' have a listen  
 t'your heart (.) 's -at o<sup>↑</sup>kay  
 Al: <sup>↑</sup>Mm  
 Dr: So I'll terminate this now an' I'll do the physical  
 examination  
 ((Tape turned off))

The interesting feature of this is that, again, Alan is doing being a good student and offering extensive detail of his being so. Like the patient, Bob, in McHoul and Rapley's (2002) analysis, he's making a big deal of being happy, normal, having fun, etc. And like those caught in Harper's (1996) 'rationality trap', he runs the risk of being seen to be diagnosable precisely on these grounds. It's also significant that he directly downplays the negative parts of his experience and conduct at school. He goes to art; he goes to soccer; he goes to the library, he goes to PE ... and sometimes he goes to the office! Going to the office just appears on a list of routine experiences of school that anyone might encounter with any primary school child. It's part of life-at-school-as-usual. It's constructed as nothing spectacular; even though this is an important marker of the very conduct that has led him to the test in the first place. Note the immediate difference in the doctor's uptake of Alan's turn here. Far from the non-committal mm's, oh's and mm hm's of the previous exchanges, here she immediately leaps on Alan's utterance and expands upon it. Note also that it is the doctor who provides the reasons for trips to the office, two of which Alan agrees with: 'being naughty at people' and 'getting angry' – and one of which he denies: that they do things to make him angry. Again, as neither 'being naughty' nor 'getting angry' are officially itemised diagnostic criteria for the condition for which the doctor is supposedly seeking evidence, quite what forensic work these probing questions

are designed to accomplish and what they may or may not have to do with an ADHD diagnosis remains unclear.

## 6. Post-Test, Medication Trial

When the parents return, their Popperian scepticism is dealt a severe blow. They have already been inundated with a litany of test results that point more-or-less in the direction of a confirmation of the ADHD diagnosis. They have heard the risk factors and the preliminary test scores. But now they have to face yet another number (twenty? two) that adds to the confirmation. Eliminating the possibilities is rapidly becoming out of the question. The presumptively 'medical' fact of ADHD now has to be faced – but still not without some scepticism about whether the test does or does not reflect Alan's actual abilities:

(ADHD 13.1.04 1005-1030: abbreviated)

Dr: A:nd he's got (twenty) two: (.) which does  
place him >at risk<  
(2.0)

.  
. .  
.

Dr: Erm b't int'restingly he did very ↑we:ll on  
some things (.) (>see he did<) (.) That's a good  
drawing for his ↑age group erm and he w's w's  
very quick [>y'know< about=

Mo: [M(hh)m

Dr: =um recognising numb'ring, rememb'ring, recording  
sort of er (.) some some sets 'v instructions but  
he's no idea 'v when he w's >when he w's< ↑born=what  
month it was o:r >y'know< those sorts of things so:  
(.) I mean tha- i- it's not (an assesment of intelligence)  
>it's just an awareness of things< so I- I mean what I'm  
trying to say is that it's not a clear cut y'know  
intellectual problem (.) by any means an- tha- (um) I  
think we y'know >as I w's saying to the teacher< that it's  
worth giving both a ↓go  
(0.8)

Dr: They- they're funny they're strange questions but  
they've they've (been worked out) (you c'n see by)  
the sequencing you could say you've got a five and an  
eight an' he couldn't (.) remember that backwards  
(but he w's very good at) forward sequencing  
(.)



Mo: A:LAN WHEN'S YOUR BIRTHDAY ((Said loudly across the room))  
 ?: ( )  
 Al: I do(hh):n't kno(hh)::w ((Kind of laughing,  
 'doing being stupid' tone))

There are some interesting features of the doctor's way of delivering the news that everything but ADHD is now effectively out of the question. We start with apparently the hard cold fact of the test result, but move immediately to mitigation: Alan has done well on certain aspects of the test and much worse on others. Still the overall conclusion from the mixed scores is that 'it's not a clear cut intellectual problem'. The aforementioned 'extra help' at school may still be a possibility ('it's worth giving both a go'); but whether so or not, drugs are becoming increasingly likely. For all this, Alan's mother is still not completely convinced. The son she knows so differently from the clinical tests does in fact know his birthday and Alan – though the exact tone on the tape has to be heard – shows that he knows that she knows by, as we have had to put it, 'doing being stupid' in his denial of the fact. The doctor then moves towards the medication route and, simultaneously all but rules out the 'extra help' unless the more extreme case of ODD can be confirmed at some future point:

(ADHD 13.1.04 1051-1068)  
 Dr: I mean he's at extre::me risk (in this position)  
 and he's basically not going to (get any more) (.)  
 ↓help in the- >in the classroom< there is a question  
 whether (.) if he's diagnosed with oppositional  
 defiant disorder (.) he could get an ai:d (.) or he  
 c'd get some extra help.  
 Mo: °Yeh° ((Mo is hard to hear – she may be responding  
 more often than the tape brings out))  
 Dr: I honestly can't say that from what I've seen today  
 um b't the school psychologist (is somewhere)  
 along those lines so::  
 (.)  
 Dr: I mea- I mean that's not going to help necessarily  
 (.)  
 Dr: But I:: >what I w'd suggest is th't< we have the  
 current teacher fill out a questionnaire no:w (th'n)  
 we'll have a trial of medication and then if (they)  
 c'd repeat it and we'll just ( ) (f'y'know y've  
 got to know him by no:w)  
 Mo: Yep  
 Dr: Okay

Now, then, the 'risk' has been transformed into 'extreme risk' – of what, we are not told, and rarely are in the literature. Being at risk itself appears to have become a condition in itself rather than merely a possible preliminary to one. Popperian scepticism now has no place. The doctor's more Baconian methodology has finally won out and the mother acquiesces. But the acquiescence arrives in a very strange form: a kind of self-medication by proxy. The following passage, then, stands by itself:

```
(ADHD 13.1.04 1069-1093)
Mo:  W'll I've still got some of the
      dexam↑phetamines [at ↓home=
Dr:  [Oh ya ↑ha::ve
Mo:  =Hu(h)h hu(h)h hu(h)h [hu(h)h
Dr:  [E:xcellent
      (.)
Dr:  Enough to- for a ↑trial
Mo:  Oh ye::h because [um
Dr:  [Mm hm
      (.)
Mo:  ↑Wha:t there w's a hu:nd- there's (a) hu:ndred
      pills t' the bottle
Dr:  ↑Yeh
      (1.8)
Mo:  How long w'd ya wanna tri:al it
Dr:  (Six we-) er:rm how long 's it to te:rm
      (.)
Mo:  Eight weeks
Dr:  Eight weeks >is ↑it<
Mo:  (Er it's abou-) no
Dr:  No
Mo:  Six weeks=
Dr:  =Six weeks >w'll that w'd be pe:rfect< yeh
Mo:  Oh well I'll have to ge- I'll prob'ly have to
      get another [bottle=
Dr:  [yes
Mo:  =[It'll depend on how much ya (.) gi:ve 'im
Dr:  [(°Yes it'll depend°)
```

Anyone, practitioner, parent or discourse analyst, who does not find this remarkable as a conclusion to a diagnostic medical interview might like to read the passage again. What we are seeing here is no less than a proposal for off-the-shelf medication. There is no discussion of the appropriateness of the drugs, nor of the dosage, nor of their provenance. There's a bottle of drugs in the cabinet somewhere at home and they are going to be administered to Alan. Even the time

frame for the trial appears to be driven purely by school-organisational, term-time, exigencies (is it six weeks or eight weeks?) rather than any remotely medical consideration. Could there, perhaps, be a problem of side-effects? Well, yes, this does get mentioned but is quickly dismissed by agreement between the parties:

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(ADHD 13.1.04 1095-1111)
Mo: But yeh to start him off I've got some
    at home
Dr: Okay super. Well we may as well start him
    off and see wha- y'know if there're any problems
    with side effects like happened with Justin
Mo: I don't think there [↑will
Dr: [I don't think either
Mo: ↑No:
Dr: ↓No
    (.)
Dr: E:rm yeh >an' then< i- if those things are going
    we:ll and y' s- still >going on the trial just give
    us a ring and I'll send you out a script< (.) ↑yeh
Mo: O↑kay
Dr: O↓kay
Mo: Yep
Dr: A' right [( )
Mo: [( )
    ((Tape ends abruptly))
```

Running this transcript by a parent of a recently diagnosed ADHD boy of about the same age as Alan, we elicited a remarkable response. He said something to the effect of: why not just go score some speed at a nightclub and feed it to your kid? Same effect. Same reliability. Only difference is the price.

So, again, we continue to wonder about the continuing presence of Baconian 'science' in the psy-disciplines and its effects on the collective treatment of our children. Despite the various disciplines' frequently and loudly proclaimed adherence to science — with such things as a 'scientist practitioner' model in clinical psychology, and the repeated invocation of 'evidence-based practice' in psychiatry and medicine more widely — we see, in actual practice, that such an adherence must be considered rhetorical at best, and fraudulent at worst. At the start of the Novum Organon, at least Bacon himself is able to be frank and honest

about his aims. His new-fangled method will, he hopes, lead us to a better understanding of nature, but the noble goal of mere understanding is not the point. The point is for 'man' to be able to manipulate nature for his own ends – the better to increase domination over the uncontrollable, the unruly and everything most-unwanted in a comfortable, civilised life. Apparently, kids who disrupt the smooth running of schools – to whatever degree – are now included.

## **7. Methodological and Theoretical Implications**

As we noted in the first line of our abstract, the methodological position of this paper is hybrid. On the one hand, it orients to what Jim Schenkein (1978) once called the 'analytic mentality' of conversation analysis (CA). That is, while we have paid very little attention to what have subsequently become the classic tropes of CA such as sequential organisation, topic, particle analysis or membership categorisation, we are very much aware of Sacks's own continued interest in showing that many things that are easily confined to 'the mind' or 'the brain' are, on inspection, effects of talk-in-interaction and that it is often necessary (at least methodologically and in the first instance) to put classical psycho-social assumptions to one side and see how persons in the society actually bring off 'social facts' through talk. Sacks's own position was more or less that routine bits and pieces of the 'machinery' generally available to cultural members could account for such things as having a memory of something, inferring, knowing such-and-such or, indeed, for various kinds of professional arrival at

psychopathological diagnosis. We have covered the details of this aspect of CA's analytic mentality elsewhere in some detail (McHoul & Rapley, 2003); but for now it should be noted that Sacks was also fond of drawing upon the permeability of the supposed barrier between lay and scientific reasoning, with a definite implication that the latter was, to all intents and purposes, a variation of the former. Our take on that particular trope of CA's early analytic mentality is that so-called 'Popperian' and 'Baconian' methods for conducting analyses of the brute physical world may have their quotidian equal in contrasting and, importantly, practically implicative methods of talk for generating lay and professional counter-understandings of such ordinary matters as the nature of the 'unruly child'.

In other respects, our investigation of a particular case touches on what is sometimes called 'critical discourse analysis' (CDA). As Fairclough (2001) has noted, CDA's difference from other (more mechanically 'linguistic') forms of discourse analysis is that it starts from important social problems and issues rather than from 'data' corpuses or materials for their own sake. Hence the context for our analysis is very much based on a political concern that our local region should – as a matter of overwhelming statistical and pharmacological fact – be over-represented in (a) sheer ADHD-diagnosed numbers, (b) the prevalence of the administration of amphetamine prescriptions to young children and (c) the apparently connected demographics on illicit amphetamine abuse. What we have hoped to learn from the CA/CDA conjunction, in this investigation – Schegloff and Wetherell (both 1998) notwithstanding – is that a single case, analysed in some degree of detail, may shed light on how, on a day-to-day basis (and as any

'macro'-analysis's always and necessarily missing topic), such gross pharmacological and statistical outcomes could possibly be locally generated. And all of this can stand as at least as a hypothesis for further investigations once more diagnostic sessions are actually recorded and transcribed by ourselves or other researchers in the field.

Lastly, we have tried to conform to some of the main principles of the emergent tradition of discursive psychology (DΨ). DΨ recognises the early Sacks's contention that both the psy-complex's use of mental predicates ('think', 'know', 'remember' and the rest) as well as its decisions about the pathological categorisation of persons (e.g., as 'schizophrenic', 'bi-polar disordered' or 'ADHD') may over-ride the ordinary, everyday, commonsensical uses of such terms in which they are fundamentally grounded. In our diagnostic session, then, we have seen how such lay and professional versions of accounting for a particular child's behaviour come into conflict. We have seen that, on the ground, in an actual diagnostic encounter, there can be conflicting methods for recognising (and subsequently treating or not treating) an array of behavioural 'symptoms', and/or ordinary, (slightly) 'naughty', practices. Moreover, and here we especially advert to Alan's own list of what he routinely does on a daily basis ('... I go to art, the library, to PE, and sometimes I go to the office...'), it would seem that the young person being 'diagnosed' also has a compellingly acceptable version of his own case. In all official accounts and versions, such matters are mostly overlooked. As Cicourel (1964) once pointed out, what may end up as official statistics are always, and in every case, an effect of some (equally routinely overlooked) actual interactional practices. Using this hybrid methodology, then,

we hope to have shed some light upon at least – as we have claimed throughout – one case of ADHD diagnosis; but with a definite implication that this may not be an isolated case. It may not be, but we await further reports.

The literature on ADHD diagnosis as such (as an actual, recordable, retrievable and therefore analysable, real event in the world) is almost non-existent. The ADHD literature is thus, whilst vast, effectively silent when it comes to the specifics of the production of the individual case, as a case. We have already mentioned Singh's (20002a) important general consideration of the historical emergence of the 'condition'. The main things that mesh between our findings and hers are that they involve English-speaking boys who can be somehow connected to their mothers for possible 'blame'. But this will never be enough to convince any 'scientific' community of the problem of over-diagnosis. Indeed, we have already seen a local, but telling, instance of a very senior medical practitioner who finds over-diagnosis to be a positive social indicator (the aforementioned Dr Pearn Rowe).

In addition to her earlier-mentioned article, Singh (2002b: 366) also has a paper on the 'biological' dimensions of ADHD. Her final conclusion runs as follows below. It shows that we need to cross disciplines if we are to further explore our hypothesis that Alan's unfortunate case is by no means unique:

The kind of research I am proposing is as big and messy as the phrase 'bio-psycho-social'; it is possibly based on an ideal of inter-disciplinary research that is difficult to create and even more difficult to fund. I would still argue, however, that these kinds of research projects are essential to a full understanding of ADHD and Ritalin.

By comparison, while the journal literature in the putative fields of 'discourse' and 'society' may, for example, debate correct ways of dealing with transcripts, questions of 'context', and so forth, actual people in the world like Alan go on taking home class-A psychotropic drugs for the best part of their young lives, especially where we happen to live in Western Australia. They do so provably and factually on all the official indicators, though without the specific in-situ details of their supposed 'diagnoses' ever coming to light – at least as far as we know. Yet those details might show how they come to be both part of the official stats and also to suffer as actual persons. This paper is, then, only a minor indication of that problem.



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## Notes

- i. Some of the material immediately below is repeated in a paper to appear in the Melbourne-based journal Meanjin, later in 2004. The current working title is 'ADHD and drug "therapy": Anecdotes and facts from WA and beyond'.
- ii. The Meanjin paper (see above) also makes some further comparisons between the predominantly Anglophone countries in which ADHD is now rife. WA is, to be sure, a local case, but it has claims – on both sides of the debate – to being representative of a global problem.
- iii. The DSM is the 'diagnostic' bible of the psy professions: the American Psychiatric Association's (1994) Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.
- iv. According to Zito et al (1999) in the Archives of Pediatrics and Adolescent Medicine, in 1996, the chances of being medicated merely on presentation for possible ADHD were 76.6%. Our transcript is from 2002.

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v. We are grateful to Tracy Lamb for arranging the original recording and preparing a draft transcript.

vi. Line references are to our original transcript using long, A4-wide lines. Lines as quoted in this paper, however, have been shortened for ease of reading.

vii. The transcription notation is that established for CA by Gail Jefferson. The following are the salient elements of that system:

[	Shows onset of overlap between speakers
=	Talk continues without pause between lines
(n.n)	Timed pause in seconds and tenths of a second
(.)	Micro pause, less than 0.2 seconds
↑	Upward intonation contour on following syllable
↓	Downward intonation contour on following syllable
<u>word</u>	Word is stressed
>word<	Shows speeding up of the talk
(word)	Transcriber's uncertain hearing
°word°	Word spoken quietly
wor-	Word cut off
(h)	Out-breath, possible laughter
wo::rd	Syllable prolonged

viii. Because of the metric of IQ testing, it is not possible to score as anything but 'Below average full-scale IQ' if scores on either the verbal or performance scales are themselves below average. As such, while there is a considerable degree of redundancy in this recital, a sense of totality is conveyed by the three-part listing of Alan's 'deficits'. It is also of note here that the paediatrician does not take account of known standard errors of measurement which mean that a score of 77 is not an absolute, but an estimate of a 'true' score plus or minus 5 points. If Alan's estimated score (77) is, for instance, at the lower end of the Standard Error of Measurement, his actual score may well be as high as 82 – in other words, for administrative purposes, in the category of 'dull normal' rather than 'mild intellectual handicap'. Once again, it is important to note that IQ score cut-offs are entirely arbitrary administrative boundaries.

ix. The triangulation is not as secure as it appears. Although introduced by the doctor as if there were three distinct sources of data – the Child Behaviour Checklist, classroom observations and the unnamed teacher/parent questionnaire – in practice all three overlap, indeed recapitulate, exactly the same categories of conduct. This is triple-dipping rather than external substantiation. Note also how early on is the doctor's attempted recuperation to her preferred view of the parentally completed questionnaire: she suggests that 'areas of clinical significance' can be identified 'on your thing and on the teacher's'.

x. Again a paradox: how Alan has been diagnosed as potentially intellectually impaired on the basis of an IQ test (which examines numeracy *inter alia*) when he is also described as 'quite good in numeracy' is never addressed in the session.