



HAL
open science

Kids out of control? Clinical Judgment and Psychiatric Reception of ADHD in Modern Turkey

Cemre Günes Sengül

► **To cite this version:**

Cemre Günes Sengül. Kids out of control? Clinical Judgment and Psychiatric Reception of ADHD in Modern Turkey. Philosophy. Université de Lyon, 2020. English. ⟨NNT : 2020LYSEN072⟩. ⟨tel-05580293⟩

HAL Id: tel-05580293

<https://theses.hal.science/tel-05580293v1>

Submitted on 4 Apr 2026

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.



HAL Authorization



Numéro National de Thèse : **2020LYSEN072**

THESE de DOCTORAT DE L'UNIVERSITE DE LYON
Opérée par
L'École Normale Supérieure de Lyon

École Doctorale N° 487
École Doctorale de Philosophie

Discipline : philosophie, épistémologie

Soutenue publiquement 18/12/2020, par :
Cemre Güneş ŞENGÜL

**Kids out of Control? Clinical Judgement and
Psychiatric Reception of ADHD in Modern Turkey**

Des Enfants Incontrôlables ? Jugement Clinique et Réception Psychiatrique du
TDAH dans la Turquie Moderne

Devant le jury composé de :

ABELA, Angela, Professor, Université de Malte, Examinatrice

BIANCHI, Eugenia, Assistant Professor, Université de Buenos Aires, Examinatrice

TERZİOĞLU, Ayşecan, Associate Professor, Université de Sabanci, Rapporteuse

TEKİN, Şerife, Assistant Professor, Université de Texas, Rapporteuse

LEZE, Samuel, Maître de conférences (HDR), École Normale Supérieure de Lyon,
Directeur de thèse

Table of Contents

Acknowledgments.....	3
Abstract.....	4
Résumé.....	5
1. Introduction	7
1.1. ADHD as a Psychiatric Diagnostic Category	8
1.2 Social Construction of ADHD	12
1.3. Taking an Anthropological Stance.....	17
1.4. Medical Philosophy	22
1.5. Outline of the Dissertation.....	27
2. Methodology.....	29
2.1. Analyzing Methods.....	29
2.2. Definition of Data	31
2.3. Subjectivity of Researcher	39
2.4. Why did I give up a comparative analysis?.....	41
3. How do Psychiatric Subjectivities Shape the Other Subjectivities?	43
3.1. Psychiatrist as a Part of Social, Economic, and Cultural Landscape.....	44
3.2. Symbolic Interaction of Clinical Judgment	51
3.3. Three Moral Scenes from Psychiatrist's Clinic	55
3.5. Children: Vulnerable Subjects.....	61
3.6. Conclusion	66
4. Social Categorization of a Diagnostic Category According to Expectation and Compliance of Families.....	68
4.1. Childhood vs. Parenthood as Cultural Categories	69

4.2. Parents: Mediators Between Psychiatrist and Kid.....	73
4.3. Social Dimension of Help-Seeking Behavior.....	78
4.4. Conclusion.....	89
5. How are Attention Deficiency and School Success Linked?	92
5.1. Functionality.....	93
5.2. Attention Deficiency & Medicalization of School Failure	98
5.3. Threshold of Defining Attention Deficit in Turkey	104
5.4. Another Agent of ADHD Diagnostic Decision: Teacher	111
5.5. Conclusion.....	116
6. A Risk to Public Health and A Prevention for Social Control: ADHD	118
6.1. Defining ADHD with its Negative Consequences.....	118
6.2. Violence as a Result and Cause of Impulsivity.....	130
6.3. Comorbidity	133
6.4. Psychiatric Power and Social Control.....	135
6.5. ADHD as A Preview of Conduct Disorder	141
6.6 Conclusion	144
7. Conclusion.....	146
8. Bibliography.....	154
9. Annexe - Résumé long.....	177

Acknowledgments

This dissertation would not have been possible without the encouragement from many others. I begin by extending my heartfelt thanks to my research advisor, a great intellectual guide, Dr. Samuel Lézé. I deeply appreciate these four years of learning. I would also like to thank the Dire la Santé Mentale (DSM) team members for sharing their knowledge, insight, and enthusiasm with me, and supporting my study in every step.

I extend a special thanks to my committee members, Prof. Angela Abela, Dr. Aysecan Terzioglu, Dr. Eugenia Bianchi, and Dr. Serife Tekin, who spend their precious time commenting my study. Their immense knowledge and plentiful experience have encouraged me in my further academic research.

I would like to thank my interviewees who took time out of their lives to contribute to my project and often out of genuine interest to help both me and to advance the knowledge of ADHD in our country.

The most challenging part of a dissertation process, as all the Ph.D. candidates know, is stress. Especially, my last year in France was under extraordinary pandemic conditions. Fortunately, I came across great professionals to learn finding my inner peace. I would like to thank Burak Bilen for our meditation classes, David Cornwell for Mindfulness-Based Cognitive Therapy sessions, and Zeynep Aksoy for transforming this pandemic period into a great yoga journey. I will always remember this challenging period as a transformative power for my life thanks to these inspirational people.

I would like to thank my family and friends who have lived through the writing of this thesis with me. Their support, friendship, and encouragement are precious to me. I am privileged to have such great supportive people around me. My special appreciation also goes out to my dear friends Betul Balaban and Dr. Cagri Cevrim for always being there for me.

Lastly, I express my deepest gratitude to my partner Jean-Christophe Vautier, who has a huge part in the completion of this thesis. Thank you for teaching me your language with your endless patience, being a great traveling companion, always trusting me, and being proud of me. Your love and fantastic support over the past four years means the world to me.

Abstract

The discussions about the most frequently diagnosed childhood psychiatric category – Attention Deficit Hyperactivity Disorder (ADHD) – position on the crossroad of the approach that seeks it within neurobiological functions of an organism and the approach that seeks it through superstructures such as Big Pharma. ADHD is postulated as a discursive category and an epistemic object within the scope of my study. I look at this experience through the psychiatrist's acts, who is the ultimate agent of the diagnostic decision. I concentrated on Turkey's clinical judgment experience and collected the data sets between 2017-2019. The psychiatrists' acts were defined as their anonymous statements (10 in-depth interviews), their scientific endeavors (1 diagnosis and treatment guideline, Journal articles in the *Turkish Journal of Child and Adolescent Mental Health*: 2002-2019; and congress presentations as *Turkish Child and Adolescent Psychiatry Congress' abstract books*: 2012-2019), communication with the general public (5 books, and 34 YouTube videos). The study aims to map social and moral context in which clinical judgments shape by scrutinizing the discursive and rhetorical details of these acts. I scanned the data sets except for interviews with content analysis, and analyzed ADHD-related content and interviews with critical discourse analysis. In conclusion, the social imaginary where psychiatrists belong is a crucial component of their clinical judgment and decision-making process. I observed the dominance of the biomedical approach at all the stage of knowledge production. From their point of view, the clinical judgment process is objective and measurable. In comparison with 'a biomedical practitioner' is represented in fundamental argumentation about ADHD, I have met 'a humanistic practitioner' in the depths of language and meaning as well as in-depth interviews.

Key words: ADHD, Turkey, clinical judgment, diagnostic, discourse

Résumé

Les discussions sur la catégorie psychiatrique infantile la plus fréquemment diagnostiquée - le trouble du déficit de l'attention avec hyperactivité (TDAH) se situent à la croisée de l'approche qui la recherche au sein des fonctions neurobiologiques de l'organisme et de l'approche qui la recherche à travers des superstructures telles que les grandes entreprises pharmaceutiques. Le TDAH est considéré comme une catégorie discursive et un objet épistémique dans le cadre de mon étude. J'analyse cette expérience à travers les actes du psychiatre qui est l'agent ultime du jugement. Je me concentre sur l'expérience du jugement clinique elle-même en Turquie. Les ensembles de données ont été recueilli entre 2017 et 2019. Les déclarations des psychiatres ont été défini comme leurs propres déclarations anonymes (10 entretiens approfondis), leurs efforts scientifiques (guide de diagnostic et de traitement, articles dans la revue « Journal Turc de la Santé Mentale de L'enfant et de L'adolescent » (entre 2002 et 2019) ; et abstraits de communications dans le « Congrès turc de psychiatrie de l'enfant et de l'adolescent » (entre 2012 et 2019), vulgarisation pour la grand public (5 livres et 34 vidéos YouTube). L'objectif de l'étude est de cartographier le contexte social et moral dans lequel les jugements cliniques se forment en scrutant les détails discursifs et rhétoriques de ces actes. Les ensembles de données, à l'exception des entretiens, ont été examiné avec une analyse de contenu et le contenu et les entretiens liés au TDAH ont été étudié/analysé par le biais d'une analyse critique du discours. En conclusion, l'imaginaire social auquel les psychiatres appartiennent est une composante cruciale de leur jugement clinique et de leur processus de décision. La prédominance de l'approche biomédicale est observée à tous les niveaux de la production des connaissances. De ce point de vue, le processus de jugement clinique est objectif et mesurable. Contrairement à « un praticien biomédical » qui est représenté dans l'argumentation fondamentale sur le TDAH, j'ai rencontré « un praticien humaniste » dans les fonds du langage et du sens ainsi que dans des entretiens approfondis.

Mot clés : TDAH, Turquie, jugement clinique, diagnostique, discours

1. Introduction

For centuries, madness has engaged the attention of art, philosophy, and science with the problematics of what it means, where it starts and ends, and who decides on it. From Hippocrates, who searched out the madness in bodily fluids and Hieronymus Bosh who drew the ship of fools, to Erasmus who praised folly, and Michel Foucault who wrote the history of madness, in intellectual history, significant effort has been dedicated to interpreting and understanding madness. As Arthur Kleinman (1988) states, each culture perceives certain individuals at specific circumstances as mad and regards them as being extraordinary. Earlier, the concept of madness that included outsiders and the marginal was discussed within the scope of philosophy. In time, the concept of madness evolved to mental disorders as involving more significant populations and as part of this evolution became framed within medical epistemology. In a sense, our perception, labeling, and conceptualizing of madness changed, as well. Every new revision of diagnostic manuals defined new mental disorders, and the other ones disappear or are defined differently during this on-going dynamic process. Moreover, contemporary psychiatry is motivated to search out the causes of mental disorders in physical structures and functions.

Attention Deficit and Hyperactivity Disorder (ADHD) is described as a neurodevelopment disorder with a highly inheritable genetic origin according to standard conception; however, there were many critical definitions and understanding for ADHD (Armstrong, 2017; Timimi, 2005; Maté, 1999). Pérez-Alvarez (2017) summarizes three points of view about ADHD. The first group of researchers defends the standard neurobiological conception. The second one is utterly opposed to this conception, and they have a critical point of view about ADHD. They argue that ADHD does not exist. The third approach can be defined between these two points of view. They accept the existence of ADHD; on the other hand, they criticize overdiagnosis and overmedication.

As the number of ADHD diagnoses increases, the studies regarding ADHD have increased remarkably in recent years. The vast majority of the studies tend to focus on the neurobiological approach. However, compared to these studies, there is another crucial theme in ADHD studies, which is not widespread but it is highly significant: ethnicity and culture. A substantial amount of ADHD and culture studies has an epidemiological orientation. They evaluate culture as a variable that affects the prevalence rates (Sanché et al., 2010; Farbstein et

al., 2014). The use of medication (Gosh, Holman & Preen, 2015) and gender variation (Brewis & Shmidt, 2003) are the other culture-related statistical issues. As a result, the prevalence rates of ADHD are significantly varied (from 1% to 15%) in each culture. The parental attitudes, stimulus effects on attention, drug tolerance in various races, and clinical issues about accuracy and effectiveness of treatments are the other culture-related research topics in the field. All these studies presuppose the standard conception of ADHD; therefore, they interpret culture/ethnicity as a diagnostic and treatment variable.

1.1. ADHD as a Psychiatric Diagnostic Category

According to the *Diagnostical and Statistical Manual of Mental Disorders (DSM-5, American Psychiatric Association, 2013)*, ADHD described with three fundamental symptoms—hyperactivity, impulsivity, and the lack of attention—is the most frequently diagnosed mental disorder in childhood. The medical perspective suggests that ADHD is a neurodevelopmental disorder of highly inheritable genetic origin and accepts it as a self-evident scientific reality (Barkley, 1996). The National Institute of Mental Health and National Institutes of Health defines the causes of ADHD in a less confident and more combined manner: *“Current research suggests ADHD may be caused by interactions between genes and environmental or non-genetic factors. A number of factors may contribute to ADHD such as genes; cigarette smoking, alcohol use, or drug use during pregnancy; exposure to environmental toxins, such as high levels of lead, at a young age; low birth weight; brain injuries.”*

ADHD is generally diagnosed through DSM-based behavioral checklists that have been heavily criticized in skeptical literature, contradicting the paradigm of ADHD as a neurobiological disorder. The critiques are directed at the validity of its existence, diagnosis causes, and the ethics of medicating children (Singh, 2008). The prevalence rates vary between different countries and sometimes even within a country, so ADHD is an indicator of its cultural construction (Davies, 2014). Peter Breggin (2002) argues for an absence of validity of DSM diagnosis for a disorder identified as genuine biological dysfunction.

To medicalize is to pathologize ordinary experiences and present medical solutions to *normalize* these experiences on behalf of pharmaceutical industries (Conrad, 2007). Behavioral problems have been transformed from moral weakness or sin onto the medical level. Treatment is proposed as the only solution to these behavioral problems. According to DePoy and Gilson (2014), medicalization is related to economic profit and social control. Defining behavioral

problem medically excludes all other disciplines, professionals, and ordinary people from discussing the subject since psychiatrists monopolize it. By defining behavioral problems as medical problems, the treatment concludes with psychoactive medications, and in this manner, medical social control is applied. Behavioral problems are principally multidimensional and are reduced to individual biological processes by the medicalization of the problem. Social structure and social problems are left out of the subject. Biological individualization leads to the depoliticization of deviant behavior. Labeling a child with a mental disorder makes it possible to exclude problems with schooling and the educational system from the equation.

The transformation of madness into mental disorders began with Philippe Pinel's attempt, who *liberates mad people from their chains*, as a favorite saying of the field has it, and who localized them in the framework of *medical epistemology*. Pinel has been identified by some as one of the founders of modern psychiatry thanks to this milestone and his contributions to mental disorders classification. In 1798, he demanded the equivalent position with physical illnesses for psychiatry in his book *Nosographie Philosophique* (2012). However, he was also someone who knew very well that "even the most meticulous anatomy cannot uncover the exact place and the characteristics of mental disorders" (Hochmann, 2004; p. 15). In brief, modern psychiatry was established on this basis and it can be observed from psychiatry's roots to its most mature fruit. Despite all the concerns about equalization and the position of psychiatry in medicine, this difference between psychiatry and other biomedicine branches forms the baseline of its critics' arguments. The lack of medical tests for psychiatric illnesses, the lack of identification of etymology, the dominance of symptomatic treatment, and the lack of specific treatment are the fundamental critiques of psychiatry.

Between 1896 and 1909, three landmark movements in the diagnosis of children's mental illness emerged. First, in 1905 the American psychologist Lightner Witmer (1867-1956) founded the first childhood psychological clinic. It was set up for clinical evaluation, treatment, and research, mostly about school-related disorders. Second, in 1907, Alfred Binet (1857-1911), with his colleagues Victor Henri and Theodore Simon, developed the first standardized test of children's *higher mental processes* that creates the intelligence testing movement. This test's primary purpose as a tool to identify children's academic difficulties was to diagnose. Lastly, psychiatrist and criminologist Willian Healy (1869-1963) expanded research interest into children's mental health towards socioemotional problems to prevent juvenile delinquency. Healy's work emerged in the context of the mental hygiene movement of the 1900s.

The beginning of the twentieth century is an essential period in the history of psychology and psychiatry as it was when Freud brought his theory of childhood sexuality to the stage. This theory has shown the importance of childhood in the psychological development of individual and mental disorders. Although Freud himself worked on the influence of childhood in adulthood mental disorders, he supported his daughter Anna Freud's work with children. Simultaneously, behaviorism also contributed to the mental disorders of the children. Theorists working on learning thought that operant and classical conditioning principles could explain both normal and disturbed behavior in childhood and adulthood. John Watson worked with children and young people to theorize the principles of conditioning. Despite advances in psychoanalysis and behaviorism, these schools did not develop a distinctive diagnostic nosology for children. This anti-labeling attitude delayed the nosology of childhood mental disorders until the first half of the 20th century. Psychiatrists such as Adolph Meyer and Harry Stack Sullivan interpreted diagnosing as stigmatization and a self-fulfilling prophecy (Frame & Matson, 1987).

The 1930s and 1940s were a period when psychiatry defined more severe problems in childhood, such as psychoses (Kanner, 1962). Discussions of childhood schizophrenia and autism were raised during this period. Many emotional disturbances that started to be defined in childhood indicated the need for a diagnostic classification system. World War II was a turning point for developing mental health services and psychiatric classification (Shore & Mannino, 1976).

The classification systems and identification of mental disorders have evolved many times since Pinel. The only thing that remains unchanged is the equal position demand of psychiatry with other branches of medicine. It could only have been possible if psychiatry had acquired a steady place in medicine and established its authority—in other words, if it could have been put into practice by explaining mental disorders within the boundaries of neurobiology. Psychiatry, which was defined as a branch of medicine in the 19th century, searched for the roots of maladies in brain lesions or tumors within anatomy and physiology. However, at the turn of the 20th century, Sigmund Freud took the stage, and the paradigm changed. He presented his empirically unobservable concepts regarding structural and topographical theories, and he proposed to understand human's mental world through the agency of mental production, such as conversations and dreams. He maintained the dominance of this paradigm for several decades despite all critical voices.

Biologically oriented psychiatry that sought its basis in medicine and stayed focused on pathologies made an unprecedented move in the 1980s. The genetic and neurobiological causes of disease are one of its fundamental interests. It secures its position based upon the psychoactive drug studies of the previous two decades. Psychiatry has been searching for the development of a measurement system that could be applied to all societies. It results from believing in typical anatomy and physiology that could be exposed to disease independently of culture or society in the manner of biomedicine. DSM-3 appears in this context as a result of searching for a medical standardized clinical assessment instrument.

After the psychoanalysis-oriented DSM-2, DSM-3 arrived with a paradigm shift through biological psychiatry, and the psychiatric nosological category ADD (Attention Deficit Disorder), currently ADHD. Historically, studies about hyperactivity, impulsivity, and the lack of attention was begun by the English pediatricist Frederick Still (1909) in 1902. In 1937 Charles Bradley proposed using Benzedrine for the first medical treatment of hyperactivity (Strohl, 2011). After the Second World War, psychiatry focused on curing traumas gained importance, and child mental health studies increased. Medical doctors described MBD (Minimal Brain Dysfunction) with organic lesions in the brain in this context. In the 1960s, MBD was criticized as proof of hyperactivity, and as a consequence, in 1966, DSM-2 had a new title: “hyperkinetic reaction of childhood”. Nevertheless, in DSM-3, Attention Deficit Disorder (ADD) was defined with two subtypes depending on hyperactivity symptom.

The hyperactivity journey as a psychiatric nosological category continued with DSM-3-R, DSM-4, and lastly, DSM-5. A more significant number of children have been diagnosed with ADHD with every new version of DSM. For example, diagnosis according to DSM-3-R more than doubled the number of children than the previous version DSM-3. Finally, the most actual version of DSM-5 (2013) continues to expand prevalence and broadens some critical criteria for diagnosing adolescents and adults (Schwarz & Cohen, 2013).

The effort for understanding the etiology of the disorder, standardizing the diagnosis, and discovering medical treatment move concurrently. The most accepted medical treatment for hyperactivity, impulsivity, and the lack of attention, methylphenidate was being prepared for use in treatment while the discussions about the name, the diagnosis criteria, the etymology were still going on. Ritalin (methylphenidate) was released in 1956 to treat narcolepsy, chronic fatigue, depression, and erratic behaviors caused by senility. The usage was only for adults because the medication had not been tested in children yet. The experiments with children were started through Leon Eisenberg and Keith Conners’ efforts, who had discussed the effect of

amphetamine in hyperactivity. In the 1960s, Ritalin began to be prescribed to children for curing hyperactivity-like behaviors. However, there began to be a need for measurement methods to standardize the diagnosis. In 1969, Conners introduces his Teacher Rating Scale, as he called it, in his article in the *American Journal of Psychiatry*. He aimed to improve more accurate approaches to prescription (Schwarz, 2016). Standardization attempts appeared concurrently with the release of Ritalin because a standard diagnosis is essential for prescribing. According to the American Academy of Pediatrics, in 2002, around 4 million school children in the US were diagnosed with ADHD, and 2 million of them were prescribed Ritalin. The frequency of use of derivative stimulants such as Ritalin, Adderall, Dexedrine, and Cylert has increased by 327 percent since 1985 (Lipman, 2002).

The reason a physician gives Ritalin to a child, according to Adam Rafalovich (2004, p. 27), is to “make children more *somber*, more *adult-like*, and is a way of *treating* childhood rather than a mental disorder.” For these purposes, drastic alterations in personality and possible psychotic reactions, which are important side effects of stimulants, can be ignored. There are numerous discussions of the possible psychotic side effects of Ritalin and other drugs used in childhood. One of these studies is *A Paradoxical Effect* by Tracey Nicholls (1999 as cited in Rafalovich, 2004), which demonstrates that stimulants like Ritalin can lead to anti-social and self-destructive behaviors.

Another group of clinicians stated that the use of stimulants might lead to substance abuse in adolescence. Studies on this subject contradict each other. Another group of researchers also argue that the use of Ritalin is prevention for drug abuse since untreated ADHD is the cause of drug addictions (Stead et al., 2006). No consensus has yet been reached regarding Ritalin, and the criticism about its ongoing harms is unquestionable for its supporters. Apart from its effectiveness in treatment and its side effects, abuse of Ritalin is also an increasing concern in North America (Marks, 2000), and another study states that Ritalin used with other drugs and alcohol is a legitimate health hazard for college students (Nicklin, 2000).

1.2 Social Construction of ADHD

We tend to perceive social concepts such as childhood, motherhood, and so on as naturally given. However, the concept of childhood, which I try to understand the social construction of childhood, traces ADHD and its effects in society. It has not always had the same meaning but has had various significations in different times and places. According to Philippe Ariés (1997), childhood was discovered in the 17th century. While children’s death

causes tremendous sadness in modern times, there were no records of children's funerals until the late 16th century. Because childhood was an unimportant phase, it was not seen as worthy for remembering a child's existence. In the middle ages, the concept of childhood did not exist, but the reason is not lack of love or child neglect. It is because of a lack of awareness. The fact that surprises us, as people in the modern age, but it was only natural in the social conditions of the time.

In his pioneering book *"L'enfant et la vie familiale sous l'ancien regime"* (Centuries of Childhood), Phillipe Ariès (1997) scrutinizes childhood and the child's place in the family and society from the Middle Ages to the end of the 18th century. He argued that childhood as a unique period of life was not recognized until the 17th century. This work is crucial to discover the evolution of the concept of childhood across periods. He benefits from medieval paintings to analyze the perception of childhood in society. He points out that children were not painted until the end of the 12th century and appeared in the 13th century. The first representations were the small-sized human beings who do not have a particular expression because they were children. According to Ariès (1997), the first marks of separation of childhood from the adult world in the upper class were seen in the 16th and 17th centuries. In this period, they started to dress children—especially boys—in unique clothes designed for children. He interprets this as revealing changing attitudes towards children. The conception of childhood that emerged in this period focused on the cuteness, sweetness, and funniness of children. The conception created the coddling attitude that provokes many critiques in the late 16th and early 17th centuries by writers, historians, moralists, and even pedagogues. At the end of the 17th century, two elements in childhood conception existed; firstly, it could be characterized by the coddling attitude in family and secondly by an attitude that was more rational and based on discipline as children who need to be protected and shaped were perceived as fragile creatures of god. It is possible to talk about awareness of neglected childhood at this point. In the 18th century, another element, hygiene, and physical health, were observed in addition to the previous two elements. Besides, age groups had not been defined until the 18th century. It began with attempts at compulsory military service and was clearly defined in the 19th century. We also continue to organize age groups around institutions in our day. According to Ariès (1997), in the 18th century, the concept of family had completed its evolution as child-oriented and isolated from society.

We need a conception of childhood before a field of child, and adolescent psychiatry can develop. That is the cross-road between the history of childhood and the history of

psychiatry. I emphasize this because one needs historical contextualization for a profound discursive understanding. Many scholars have focused on the social construction of childhood, such as *Constructing and Reconstructing Childhood* (Prout & James, 1997), *Theorizing Childhood* (James et al., 2014), and *Constructing Childhood: Theory, Policy and Social Practice* (James and James, 2004). The main argument is that the concept of childhood is shaped by social and cultural discourses, which indicate as a result of value systems.

James et al. (2014, p. 3-4) differentiate clearly between these two modes of considering childhood. First, the pre-sociological understanding of childhood might be described as the commonplace or accepted everyday sense. Second, sociological understanding relies on more overt, self-conscious conceptualizations of childhood and testing these ideas through gathering evidence. Social constructionism is an invitation to depart from the world's common understanding and take a critical stance. According to the standard understanding of childhood as natural, people's expectations from children are also determined naturally; however, they are shaped socially. Vivien Burr (1995) adduces that childhood is a historical concept, which it is possible to observe through laws and Charles Dickens's novels.

As I discussed above, there are several different understandings of ADHD in medical, psychological, and sociological literature. Social constructionism is the dominant theory on the opposite side of the bio-medical approach. These two views can be positioned as the two different poles of the thought that originates through the discussion of realism and relativism. The two perspectives for understanding ADHD compose the two different philosophical poles. The bio-medical model has a pure realist point of view; on the other side, the social constructionist view identifies ADHD as a speculative fact with a total relativist understanding of reality.

The understanding of modernity that decontextualizes social facts has spread into psychiatry and psychology that relies on the methods of natural sciences. Thus, the causality of mental problems is searched for within the nervous system. To apprehend human behavior within the positivist framework assumes that knowledge waits to be discovered outside of the human being. This normative approach is methodologically experimentally oriented, defines behavior at the limits of biological existence, and excludes socio-cultural context (Goregenli, 2013). As Bauman (2007) highlights, the scientific paradigm of modernity that cannot stand ambivalence is highly standardizing. He characterizes the attempt of terminating ambivalence as a typical practice of the modern mind.

Various researchers describe mental disorders as socially constructed by activities of various organizational settings. The constructionist approach manifests the apparent attachment to the existence of the mental disorders and social processes (Weinberg, 1997). Ian Hacking (2001) defines social construction as a liberating theory. He illustrates his idea with the concept of motherhood, whose meaning is generally fixed to childbearing and rearing and is loaded with responsibility and expectations. It has been formed historically, socially, and ideologically. The conclusions of the deconstruction of motherhood would be liberating for lots of women. However, it is not always liberating. In the case of anorexia, understanding the social construction of anorexia cannot help the women who are suffering from it. At this point, social construction analysis of ADHD, regardless of ontological discussions about it, would be liberating in the context of a vicious cycle of medicalization. One of the fundamental reasons for using social construction has been to raise consciousness.

Hacking (2001, p. 6) defines social constructionism as a critique of the status quo and an attempt against inevitability because if concepts or facts are characterized by the determination of the nature of things, they become inevitable. However, social constructionists comprehend that things need not have existed. If they are not determined naturally, they are not inevitable. In the next step, they tend to criticize the concept or the fact that it is not inevitable because it is quite bad as it is, and they believe in the possibility of making things better or transforming them radically.

Vivien Burr (1995, p. 2-4) sums up four principles of social constructionism: "A critical stance toward taken-for-granted knowledge. Historical and cultural specificity. Knowledge is sustained by social processes. Knowledge and social action go together." According to Burr, social constructionism differs from traditional psychology through seven aspects: "anti-essentialism, questioning realism, historical and cultural specificity of knowledge, language as a pre-condition for thought, language as a form of social action, a focus on interaction and practices, a focus on processes."

Vivien Burr (1995) remarks on the points that raise a question mark in the minds of people who adopt the constructionist or critical approach. For her, the premise of anti-essentialist liberation is attractive. Alternative construction possibilities have interminable construction potential. This offers the possibility of discovering different meanings surrounding us instead of objective realism. At this point, Burr mentions the possible contribution to emancipation, as Hacking (2001) discussed. If we approach both ourselves and others as constructions, and if human beings are the creators of all these constructions, this

means that re-constructions are always possible. So, Burr (1995) does not imply only changing perspectives in the individual level or different interpretations of the world but also re-thinking all social categories such as gender, sexuality, race, illness or disability, etc. Besides, social constructionism proposes its critical reading about the claim of being apolitical in psychology's past. This claim is rather political because it justifies incurable social practices as independent from values or as derived from psychological facts. However, Burr states her disappointment after a while about social constructionism, as this extra relativist argument causes social and individual blocking due to two reasons. First, the abandonment of an ultimate truth idea can be liberating, however, having an infinite number of equally viable options makes it impossible to decide. Therefore, in the case of ADHD, as when criticizing the DSM criteria or globalization the psychiatry, it should be kept in mind that mental health professionals require a standard nomenclature and tools for diagnosis and treatment. As Luhrmann (2001) states, mental problems do not transform sufferers into artists or philosophers when psychiatrists do not diagnosis them. The relativism that is problematic in psychiatric diagnostic and treatment generates a deep discussion. Second, the concept of the agency is about to evaporate. As a result of social construction's relativism, agency becomes a consequence of a discourse hoax.

Carla Willig (2014) argues the liberating characteristic of social constructionism emphasized by Ian Hacking (2001) as a great tool to see another possibility and as a point that blocks the finding of concrete results. According to Willig (2014), the power of deconstruction and discourse analysis is to show that 'things' can be different. However, herein discourse analysts are afraid of reifying of alternative social constructs and then leaving the place to act to others, preferring to remain *observers and interpreters*. They can argue that discourse works ideologically, and they are aware of the effects of discourses in constructing individuals and groups. Still, they avoid making suggestions for social change.

In psychology, the emergence of social constructionism is usually dated from K. T. Gergen's (1973) paper *Social Psychology as History*. As he emphasizes in this paper, I also do not attempt to answer ontological questions about ADHD. Still, I intend to analyze the dynamic process of the social construction of clinical judgments.

".... I am certainly not trying to answer ontological questions about what sort of things exist. The focus is on the way people construct descriptions as factual, and how others undermine those constructions. This does not require an answer to the philosophical question of what factuality is (Potter, 1996, p. 6)"

1.3. Taking an Anthropological Stance

One of the very popular childhood—and recently adult—psychiatric diagnosis categories, Attention Deficit and Hyperactivity Disorder (ADHD), is described as a neurodevelopment disorder with a highly inheritable genetic origin according to the standard conception that composes the interest of this dissertation. While keeping the psychiatric perspective's universal conceptualization, I intend to present the anthropological perspective about ADHD. Tanya Luhmann (2001) indicates that mental disorders themselves, the experiencing them, and their frequency in a community are determined historically. Moreover, the study about world mental health conducted by Desjarlais et al. (1997) concluded that the most crucial risk factor caused to mental disorders is *social disruption*. The examples of counter-arguments to the approach that defines mental disorders as inheritable and biological could be extended.

Anthropology, or in other words, *La Science de L'homme (The Science of Man)*, consists of two branches of psychology and anatomy. Although this classification of anthropology varies according to various authors (Mandressi, 2013; Vidal, 2006 as cited in Carvallo, 2017), it is sufficient to draw this study's relevance to anthropology. Anthropology aims to reflect human perfection to show the privileged place occupied by humans in the creation and justify the analogy between the microcosm and the macrocosm. The perfection of the human soul was traditionally treated based on Aristotle's *On the Soul*, but then doctors sought to discover the perfection of the human body. Thus, a philosopher-physician union emerged that articulates a history of man in the sense of observation or autopsy and a natural philosophy presupposing excellence of human nature. However, this new anthropological project gives rise to a profound reorganization of knowledge about human beings. A. Cunningham (as cited in Carvallo, 2017) analyzes this moment as a reform because doctors reformed medicine by questioning the foundation of knowledge in a similar way to Luther's reform of theology. Without breaking the link with ancient references, but transforming them, they import them into decisive patterns for modernity.

Since the beginning of research into hyperactivity, there has been a tendency to position it in the brain. However, the lack of biological evidence has caused many criticisms (Baughman, 2006; Gonon, 2008; Zametkin & Liotta, 1998; Zametkin & Ernst, 1999). Especially in recent years, many of neurobiological studies have been dedicated to ADHD; despite this effort and quite large budgets, the polemics have continued. Kirmayer (2003) states

that the production and exporting of psychiatric knowledge depend on political economy issues and the cultural dimension of problems. The argument, which advocates that medicine should be based on data, covenant a more rational approach in psychiatric applications. However, the medicine based on data is limited to research literature, and research funding is provided by some communities who desire certain kinds of information. Consequently, scientific knowledge that serves to only strengthen economic and political interests has been produced. One of the antidotes of this potential danger is to criticize the research process itself culturally.

Trying to understand and explain a very sophisticated bio-psycho-social creature through the agency of the bio part ultimately results in biological reductionism. Young (2008) determines the most effective biological reductionism tools that maintain the power of psychiatry, such as biological etiologies, psychopharmacological interventions, and research programs. According to him, as a result of biological reductionism, the human is objectified and dissociated from social, economic, and individual contexts.

Anthropologists have opposed the idea of defining illnesses/diseases as biological facts with different cultural names or with minor cultural effects. They do not signify only biological facts but have essentially cultural qualities (Good, 2003). Does any general category adequately cover a local experience? This is a very common problematic for all social and human sciences. However, when we try to define illnesses as pure biological truth and as a natural category independent of local tendencies, the issue becomes much more complicated (Littlewood, 2003).

The collaboration of psychiatry and anthropology goes a long way back, since the late 19th century. The founders of anthropology, such as W. H. R. Rivers, Paul Broca, and Rudolph Virchow, were physicians who had social-psychological and psycho-somatic orientations. Like Emil Kraepelin and Sigmund Freud, who are important names of psychiatry, they had cross-cultural interests and similarly fundamental anthropologists -for example, Claude Lévi-Strauss, Edward Sapir, and Bronislaw Malinowski- were nourished by psychology and psychiatry (Kleinman, 1987).

All significant figures of psychiatry come from Europe and North America. Despite numerous cross-cultural studies, all theory-building data belong to Western cultures. Moreover, psychiatry is disposed to marginalize the non-western cultures in which 80% of the world population lives. That is why Kleinman (1988) addresses this question: "Can psychiatry be a science if it is limited to middle-class whites in North America, the United Kingdom, and Western Europe?" The emergence of ADHD occurs in the Western world along the same lines.

It was invented in the USA and diffused all across the world. Rafalovich (2004, p. 1) describes ADHD as a mental disorder “embedded in North American consciousness.” Many cross-cultural studies about ADHD have the motivation to promote the disorder and its treatment among ethnic minorities (Bailey & Owen, 2005; Prudent et al., 2005) or in developing countries (Farbstein et al., 2014; Sanchez et al., 2011).

Western psychiatry has been willing to discuss culture-bound syndromes that belong to *authentic* parts of the world. However, it tends to universalize western originated psychopathologies. As Luhrmann states (2001), the fundamental diagnostic categories such as schizophrenia, manic-depressive disorder, major depression, anxiety disorders, etc., are commonly defined as universal; nevertheless, illnesses may be locally experienced in different societies. However, contemporary anthropologists emphasize that all kinds of illness would be identified as *culture-bound*. Our attitudes through illness/disease experiences are socially determined beforehand, and human behavior cannot be thought independently from human actions (Littlewood, 2003). Kirmayer and Minas (2000) describe three effects of globalization on psychiatry; “through its effect on the forms of individual and collective identity; through the impact of economic inequalities on mental health; through the shaping and dissemination of psychiatric knowledge itself.”

Understanding hyperactivity, impulsivity, and lack of attention with a hereditary and neurobiological approach disconnects it from the social domain and does not offer us a realistic understanding. ADHD was born in North American culture and spread around the world. ADHD, defined as a culture-bound syndrome by some researchers (Rose, 2007) was established based on universality by way of mainstream definitions and research approaches. The cross-cultural discourse analysis conducted in this dissertation was designed as a counter-argument to the universality argument of psychiatry.

Most of the cross-cultural studies in the literature of psychiatry focus on proving the universality of mental disorders. Not surprisingly, they emphasize the resemblance with physical illnesses. In other words, mental disorders appear in all societies and can be identified with a standardized diagnostic system. Kleinman (1987, p. 449) identifies the dominant paradigm in cross-cultural psychiatry as “exaggerating what is universal in psychiatric disorders and de-emphasizing what is actually particular.” For him, it is the bias of psychiatry that affects the conclusions of studies. Studies focus on the similarities and avoid highlighting differences. On the other hand, he proposes a crucial complementary anthropological question: “how do psychiatric disorders differ across cultures?” In consideration of Arthur Kleinman’s

question, I ask, “how does ADHD differs across cultures?” and present a case of clinical decision-making about ADHD from Turkey.

Does ADHD exist? Is ADHD a medical condition? These are the most frequent examinations in literature, and each study has a precise position, as I mentioned above. Consequently, I believe that I have to clarify the positioning of my study. This dissertation did not design to prove ADHD as *total fraud* (Baughman, 2006) or ADHD as a social construction (Timimi, 2005, 2007). I will mention the controversies and critical points of view in the literature; however, the study’s main purpose is not to clarify this medical condition but to draw attention to how the discourse differs cross-culturally. I adopt the anthropological stance that does not accept the idea that “forms and functions of mental illness are given in the natural world (Kleinman, 1987)”. I am skeptical of strictly biochemical definitions of mental health, and this study aims to explore the dynamic connections between ADHD and social imaginary.

The studies that investigate the existence of ADHD and describe it as an invention of the pharmaceutical industry stay focused on the problematic of “does ADHD exist?”. This problematic is a good starting point to initiate a discussion; however, it has not been functional while a larger number of children have been diagnosed with ADHD in every new version of DSM. This shows that ADHD as a practical category maintains its functionality despite the controversy over its empirical existence. Consequently, this study prefers investigating the possible answers to the question of “how the diagnostic category of ADHD is established socially and culturally and how it is maintained.”

Before beginning my research journey with psychiatry and culture, I should note two points that were taken under consideration during this journey; firstly, as Byron Good (2003) mentions (2002), it is quite possible to move to the cultural reductionist side when we talk about the concept of culture in psychiatry. Anthropologists can summarize this reductionism as essentialism. When culture is defined as permanent qualities, behavioral features, or belief patterns, it could be thought of as shared by all members of a culture, and thereby it could cause a reduced representation of individuals within their societies. Second, as I mentioned before, a culture will be taken as a structure that emanates everywhere. I want to emphasize the remark of Laurence Kirmayer (2003): if we would like to scrutinize psychiatry, we should keep psychiatry itself as a product of the culture in the back of our minds. In this way, we can be aware of the implicit assumptions in the roots of psychiatric theories and applications. Unless we uncover it, we will continue to maintain the same discourses.

According to Kirmayer (2003), psychiatry may collaborate with social powers to present social and political issues as individuals' own problems, without even realizing it. By way of illustration, he presents a 6% prevalence rate that shows the number of children diagnosed with ADHD and who are prescribed various stimulants at that time. He questions the basis of this diagnostic category: do these children have a psychiatric disorder? Or do they suffer from the attention span resulting from problems in the educational system or television and screen culture? This is why uncovering discourses is one of the fundamental focal points of my study. In this study, I hypothesize that mental health professionals' discourse shows the implicit social, moral, and cultural patterns that affect the decision-making process.

Culture shapes the environment the behavior is acquired, as well as the entities that live in this environment. Moods and motivations, which are a part of everyday life, are also a part of these entities. From this perspective, anthropology understands by analyzing symbolic forms such as subjective vital words, images, institutions, and behaviors. Because people present themselves and others through these symbolic forms (Biehl et al., 2007, p.7), culture is not a variable but created by people relationally. M. J. Fischer (2003, p. 7) suggests that "culture is not a variable; culture is relational, it is elsewhere, it is in passage, it is where meaning is woven and renewed often through gaps and silences, and forces beyond the conscious control of individuals, and yet the space where individual and institutional social responsibility and ethical struggle take place" (2003, p. 7). This formulation suggests the need for cultural analyses that make visible differences of interests, access, power, needs, desires, and philosophical perspectives.

During the dissertation, subjectivity is one of the most crucial notions of understanding ADHD. For Aristotle, the subject is "the very material out of which things are made". The 12th-century *suget* (subject) is "the one who is under the domination of a monarch or reigning prince; one who owes allegiance to a government or ruling power, is subject to its laws and enjoys its protection (Biehl et al., 2007, p.6)." In the 15th century, *subjectivus* (to be subjective) in Latin refers "a characteristic of the political subject" (Biehl, Good & Kleinman 2007). Subjectivity meant "essential individuality, the consciousness of one's perceived states" in the 19th century. There was a particular emphasis on the human mind and individual experience. The tendency to explain the subjective facts in mind arguably corresponds to the scientific world's *objective* views and *the objectification of reality* (Daston & Galison, 2010). According to contemporary anthropologists, subject and subjectivity are dynamic and changing entities, not fixed, stationary forms (Desjarlais, 1997, 2003; Fischer, 2003).

According to Tanya Luhrmann (2006), the notion of subjectivity is frequently used in the general sense by anthropologists. She asserts a psychological model of emotion to make it clearer. “Subjectivity implies the emotional experience of a political subject, the subject caught up in a world of violence, state authority and pain, the subject’s distress under the authority of another (Luhrmann, 2006, p.346).” She adds that “if subjectivity is the emotional experience of a political subject, then to articulate the psychological structure of the emotion only gives us more evidence to argue that power is inscribed upon our bodies and that moral judgment is a visceral act (Luhrmann, 2006, p.359).”

The definition of Sherry Ortner (2005), to which Luhrmann (2006) also refers to understanding subjectivity, corresponds to the situation I mean by subjectivity in the following chapters. “by subjectivity I will mean the ensemble of modes of perception, affect, thought, desire, fear, and so forth that animate acting subjects. But I will always mean as well the cultural and social formations that shape, organize, and provoke those modes of affect, thought and so on (Ortner, 2005, p.31).”

1.4. Medical Philosophy

The most frequently used philosophical theory classification to understand the concept of illness is naturalism and normativism. Ereshefsky (2009) adds a hybrid category as the third to these two categories. Naturalism reflects an objective reality about cells, organs, the function of a system, or dysfunction. “A disease is the sum of the abnormal phenomena displayed by a group of living organisms in association with a specified common characteristic or set of characteristics by which they differ from the norm for their species in such a way as to place them at a biological disadvantage” (Scadding, 1967, p. 877).

Christopher Boorse (1975), following J. G. Scadding (1967), developed contemporary naturalist theory. He named this branch of naturalism *biostatistical theory*. According to him, biological dysfunction is essential and adequate to define the disease. “Autonomous framework of medical theory, a body of doctrine that describes the functioning as disease... This theoretical corpus looks in every way continuous with theory in biology and other natural sciences, and it is *value-free*” (Boorse, 1975, p. 55). Besides, he conceptualized illness as a subclass of disease. Diseases that include “certain normative features reflected in the instructions of medical practice (Boorse, 1975, p. 56)” are characterized as illness. He claims that plants and animals do not suffer from illness to support the idea of disease as value-free. Whether a pet is sick or ill is determined by the relationship that the individual establishes with

them because it is the individual who attributes this to animals. Besides, the illness ensures that the patient receives special treatment and reduces moral accountability because an illness is a morally laden concept, unlike a value-free disease. According to Boorse (1975, p. 56), “a disease is as illness only if it is serious enough to be incapacitating, and therefore is: 1) undesirable for its bearers 2) a title to special treatment 3) a valid excuse for normally criticizable behavior”. Boorse (1977, p. 567) defined disease as “a type of internal state which is either an impairment of normal functional ability, i.e., a reduction of one or more functional abilities below typical efficiency, or a limitation on functional ability caused by environmental agents.”

Another philosophical theory that tries to understand the concept of illness is normativism. It rejects objective necessary and sufficient condition states used to describe the disease. According to this point of view, the concepts of health and illness are influenced by subjective human values. Subjective human values are the beliefs, preferences, and goals that individuals or communities shape their life choices. From the perspective of normativism, disease refers to a situation or an ability devalued by society, culture, or individuals. Instead of a biologically researched concept such as dysfunction, the disease is understood by investigating individuals' values (Sisti & Caplan, 2017).

Normativist scholars cite historical cases of illnesses that develop concerning social, political, and religious values to support their arguments. For instance, drapetomania, which means defining slaves' desire to escape as a disease, is an essential example of the nosological constructs configuration of the relationship between medicine and policy (Cartwright, 2004). Until the 1980s, homosexuality was still medicalized, and as moral values were integrated into the scientific effort that tried to categorize mental disorders, homosexuality continued to be medicalized (Spitzer, 1981).

Thomas Szasz (2010), one of the pioneers of the anti-psychiatry movement, claims in *The Myth of Mental Illness* that mental illnesses are fictions created to justify criminal acts or drive strange behavior out of society. Szasz (2010) may be defined as a naturalist because real mental illnesses are diseases that occur due to brain lesions. He rejects psychiatric diagnosis categories because they are too subjective to agree. R. D. Laing also rejects the conventional categorization of mental illness. For him, mental illnesses arise from the conflict of individual and society's value to build a *good life*.

The models in which naturalist and normative theories are integrated are called hybrid models. The harmful dysfunction model, one of the most important hybrid models, was

developed by Jerome Wakefield (1992). According to this model, it must meet two criteria to define a condition as a disease. First, an organ or a body part should have objectively detectable biological damage or dysfunction (Wakefield, 2007). Second, this dysfunction should cause social harm. Unlike Boorse (1975), biological dysfunction is necessary but not sufficient to define disease or disorder (Wakefield, 2014).

Illness contains emotions and experiences. Anxiety, fear, and pain are included in these phenomena. In other words, illness is positioned in a subjective place, so information about a person's disease can only be obtained by his own statement from a phenomenological stance (Carel, 2013; Svenaeus, 2014; Toombs, 1990). According to Carel (2017), illness is defined as related to bodily and/or mental awareness. Healthcare professionals aim to understand illness to give better care and/or reduce suffering (Hofmann, 2017). Sickness, on the other hand, is constructed by social norms. It differs from place to place. For example, while pelvic girdle pain is a condition where the disease is permitted in Norway, it is not so in other countries (Dorheim et al. 2013, as cited in Hofmann, 2017). Also, although sickness is described as a societal structure, it should not be forgotten that both patients and healthcare professionals are social agents that affect this structure (Hofmann, 2017).

These three concepts exist is for action. Disease serves the purposes of healthcare professionals to identify, treat, and cope with a condition. Illness determines the self-understanding, relationships and activities of individuals. Sickness, on the other hand, determines the status that a person will have in relation to being sick, such as social and economic rights (Hofmann, 2017). Besides, Hofmann (2017) exemplifies the differences between these concepts on ADHD: “Many children with this diagnosis do not feel ill. However, social norms for education and conduct make them sick. Health professionals may not find anything wrong in the children’s organs or functioning, beyond their social behavior. (...) The point is that the concepts of disease, illness, and sickness represent a framework for analyzing controversial cases and for explaining controversies (Hofmann, 2017, p.20).”

There is only one Turkish word to cover the concepts of illness, disease, sickness: *hastalık*. There is also only one word to describe a sick person: *hasta*. Due to the possibilities of the Turkish language, the distinction of disease/illness/sickness cannot be made. However, I think that the only word that exists may indicate the rawest state of the concept. How can we talk about the experience of a disease when a word that includes the disease experience is absent in the language? For example, in the following sentence, chronic illness would be

translated as a chronic disease; there is no difference that may direct a translator towards either disease or illness.

*“ADHD is a **chronic illness**. (...) ADHD treatment may differ according to the severity of the disorder, ADHD subtypes, accompanying diagnoses, and expectations of the child and family (Ercan et al., 2008, p. 13).”*

Clinical decision refers to highly complicated reasoning tasks and actions performed by physicians. It includes diagnosis, treatment options, and prognosis. The philosophical dimension of clinical decision “relates to the status of the reasoning and/or logic that inform clinical judgment (Upshur & Chin-Yee, 2017 p. 363)”. In recent years, the focus has shifted from addressing clinical decisions, and studies have focused on clinical decision evaluation from a statistical, scientific decision, and cognitive science perspective (Upshur & Chin-Yee, 2017). Paul Meehl (1954) divides decision-making forms into clinical and actuarial. The strategy of classifying these concepts is based on the assumption that clinical decision is subjective and actuarial decision is objective. Actuarial judgment is reasoning supported by mathematics and statistics. Clinical judgment is known for numerous biases ascribed to its subjective nature. Engelhart (1979) states that clinical judgment studies are an important part of the evolution of medical reasoning and making medicine more rational. Medical reasoning has rejected metaphysical explanations of the disease since antiquity and encourages physicians to develop their examination skills by observing their patients. Another philosopher of medicine, Edmun Pellegrino (1979), emphasizes that clinical reasoning and judgment are goal-oriented. These concern the application of generalizations to particular cases. Pellegrino (1979) describes the clinical judgment process with three questions: What can be wrong? What can be done? What should be done? The last two questions reflect the inevitable ethical dimension of clinical decisions. At this point, the actuarial approach is inadequate in guiding the clinician because it requires a strategy to be followed according to each patient’s characteristics.

Alvan R. Feinstein (1967) emphasizes that the basis of clinical reasoning is observation and measurement. Feinstein's conceptualization is a descriptive and prescriptive form. Clinical reasoning aims to separate judgment from metaphysics and develop a scientific approach to make it more transparent and teachable. Feinstein (1967) identifies the clinician as an apparatus of scientific measurement. It intends to explain the clinical decision by discussing the nature of the clinical evidence and the types of data involved in the clinical decision process. It defines three types of data: the description of disease with scientific language such as morphologic,

chemical, microbiological, terms; the description of the host in environmental, personal terms such as age, sex, education, social status; the description of the illness, the interaction between disease and environment such as signs and symptoms (Feinstein, 1967, p. 24-25). These three types of data also participate in clinical reasoning. Feinstein (1967) also divides clinical reasoning into two categories as therapeutic and environmental. Therapeutic reasoning treats the patient as a representative case of the disease. Environmental reasoning individualizes the approach to the disease according to the characteristics of the patient. This goes beyond individualizing the treatment, and the clinical practice sees the human aspect framework, which includes communication methods, accommodation, etc. "A clinician's privilege and power in clinical therapy is his ability to make both the therapeutic and the environmental decisions concomitantly. The clinician combines treatment for the patient as a personal case of disease, with concern for the patient, as a personal instance of mankind, into the unified mixture that is clinical care" (Feinstein, 1967, p. 26).

Feinstein (1967) recognizes that although clinical judgment tries to make things more scientific, his approach has some limitations. Evidence-based medicine has had a remarkable effect on it, but recent conceptualization efforts regarding clinical judgment criticize Feinstein's clinical epistemology on two points. First of all, he neglects to develop clinical measures that may be based on the patient's history and symptoms, as he prefers to focus on objective paraclinical data. Besides, he fails to include environmental factors contributing to the value-laden and humanistic aspects of clinical practice into clinical reasoning (Upshur & Chin-Yee, 2017). Although Feinstein (1967, p. 295) says, "clinical medicine, therefore, like most other human activities in an invisible mixture of both art and science," he stays closer to the scientific approach.

Engelhardt argues that clinical judgment and decision-making are complex concepts, which are "in their rich and full sense are freighted with values, including ethical and moral values (Engelhardt, 1979, p. xxii)". The clinical judgment process, which he describes as a journey, begins with collecting data and observation then continues with hypotheses formation and testing. As a result of these two stages, judgments and decisions are formed. Engelhardt (1979) underlines that the concept of clinical judgment is ambiguous. For biomedical practitioners, clinical judgments are based on scientific reasoning and are logical. That is why it works by the rules. But for Engelhardt, clinical judgment cannot simply be reduced to rules or algorithms. "One finds physicians asserting that one can make adequate clinical judgments only on the basis of actual experience, not simply on the basis of general principles of

physiology, pharmacology, pathology, or even on the basis of a reconstruction of past clinical judgments” (Engelhardt, 1979, p. xii).

As a result, the biomedical practitioner and the humanistic practitioner differ sharply in terms of clinical judgments and decision-making capacity. While objective scientific reasoning is created on one side of clinical judgment, subjective, intuitive reasoning creates the other side (Marcum, 2008, p. 123). This study’s central question is shaped within the scope of this discussion: How and according to what are the clinical judgments of the child and adolescent psychiatrist in Turkey shaped? And how is this reflected in their discourse?

George Frederic Still (1909) is the pioneering name of the symptoms of current ADHD. He shared the same point with William James (1995), who argued for the importance of attention as *moral control of behavior*. According to Still (1909), children with hyperactivity problems have a *defect in moral control*. The moral control of behavior means “the control of action in conformity with the idea of the good of all” (Still, 1909, p. 1008). Moral control has been perceived as an output of a conscious comparison with one’s willed choice in the name of the good of all, which is denominated as “moral consciousness” (Barkley, 2018, p. 4).

When we look at the emergence of ADHD, it is easy to realize what behavior is pathologized and its moral roots. However, focusing on neurobiological proofs or drug treatments, on *biological repertoire* with the terms of Horton-Salway (2011), we become desensitized about morality. Horton-Salway (2011) defines two different repertoires while analyzing the discourse surrounding ADHD in the United Kingdom’s newspapers. First, the biological repertoire is based on a biological deficit explanation typically constructed as factual science language. Second, the psychosocial repertoire is fed from the critique of medicalization and argues for environmental factors as a cause of ADHD-like behavioral problems rather than biological ones. ADHD discussions are highly moralized. Consequently, “medicine is far from being the pure intellectual activity of producing diagnoses and dispensing treatment. It is particularly porous to moral categories and moral judgment. Contrary to what has frequently been written, in particular about deviance, medicalization does not erase moralization: it develops new moral forms, less visible, more subtle” (Fassin, 2011, p.90).

1.5. Outline of the Dissertation

This dissertation examines how the clinical judgments and decision-making of child and adolescent psychiatrists are shaped in Turkey. The introduction (Chapter 1) is devoted to presenting different approaches to ADHD and how I position the clinical judgments about

ADHD within the theoretical possibilities of medical anthropology and medical philosophy. Chapter 2, focused on methodology, provides a brief overview of the analyzing method that I utilized, data collection, and a data set description.

The ultimate agent of clinical judgment journey, the *psychiatrist* will be examined within the context where his/her subjectivity is constructed, such as the training they receive, the socioeconomic characteristics of the region they work in, etc. The moral dimension of subjectivity that is shaped in the context, its effect on clinical judgment, and its relation to the construction of a child's subjectivity will be argued in the scope of Chapter 2.

Chapter 3 is devoted to the clinical interpretation of families' help-seeking behavior. The families' expectations and compliance to treatment vary according to their socio-economic status. The families' expectations and their coping skills observed by psychiatrists have a role in the decision-making process and mediate the creation of a child's subjectivity.

The functionality is emphasized as a vital issue for clinical judgment to diagnose and prescribe. The threshold to define functionality has two components: school failure as the indicator of the lack of attention symptom and the lack of self-control that is the indicator of hyperactivity and impulsivity symptoms. The relation between inattention and the medicalization of school failure will be analyzed in Chapter 4.

The diagnosis and treatment of the lack of self-control that is generally observed in social relations with others, and one's control on own body and emotions, is accepted as a necessity to prevent 'more important' problems. The hyperactivity and impulsivity symptoms and their relation with social control will be detailed in Chapter 5.

In conclusion, I summarize the results and discuss their implications concerning the philosophy literature about clinical judgment. Clinical judgment and decision-making process are under the influence of social imaginary. Families' and teachers' expectations, the problems in the education system, the effort to manage risks in society constitute a strong attachment while children and psychiatrists shape clinical judgments. It shows us that ADHD, regardless of its etiology, is a value-laden diagnostic category.

2. Methodology

*“Though this be madness, yet there is method in't.”
Shakespeare (1992, 2.2.195-196)*

In the previous chapter, I discussed the theoretical framework underpinning this study. I will now outline the methodological principles and describe exhaustively the qualitative data collected from various mediums. Lastly, I will bring my position as a researcher into question, because I believe in the importance of sharing a researcher's articulation with his/her qualitative data.

2.1. Analyzing Methods

“Knowledge production which includes how certain linguistic artefacts *-texts-* become certified as knowledge; the possible circulation patterns of these artefacts; and the production of certain attitudes on the part of producers about the nature of the entire knowledge enterprise (Fuller, 2002, p. XII).” In this dissertation, I focused on the *texts* that produce the knowledge of ADHD in Turkey. I have chosen psychiatrists as the actors of the knowledge production process due to their power on diagnostic and prescribing.

The basic definition of discourse is “a particular way of talking about and understanding the world or an aspect of the world (Jorgensen & Philips, 2002, p.1)”. In this study, I would like to draw attention to the dialectical relationship between social construction and discourse. In other words, discourse is considered as a tool that constructs social practices and is also constructed by social practices. Therefore, Fairclough's Critical Discourse Analysis is chosen as for the analyzing method. In CDA, discourse is defined as a socially and historically positioned form with a dialectical relationship with the other social dimensions and as a tool used to shape the world. Within the scope of my research, the social practice is the clinical judgment process of psychiatry. Furthermore, as I stated in the Introduction part, this study does not question ADHD ontologically. I can even say that ADHD is a very efficient tool for studying psychiatrists' clinical decisions and judgments because of its controversial nature. But the focus of this study is the dialectical relation between clinical judgment and discourse.

Fairclough's Critical Discourse Analysis comprises of three dimensions. In the first dimension, text that could be speech, writing, images, or a mixture of them is analyzed at the word level. All these words, images, and characters combined construct the discourse. The

selected words, likewise omitted words, reflect our attitude to the subject. By choosing the word of *disorder* or *illness* instead of *behavioral problem* constitutes our position towards ADHD. The second dimension, discursive practice, is the text level of analysis. Our focus is on the constitution and the structure of texts. The way we compose our sentences forms the emphasis that is attributed to the subject. For discourse analysis, a language that involves values, attitudes, and assessments is not neutral and innocent. The constitution of a sentence correspondingly allows interpreting the meaning. The third and the last dimension of the analysis signify the social practice level. In other words, it is about the organization of social relationships and social structures. Language and the choice of words embody the context of our social world (Fairclough, 2009, 2014).

Fairclough's CAD is a useful tool to work with a text itself. Besides, I used Michel Foucault's approach to discourse to discover clinical judgments' relations with power, knowledge, social facts, and historical conditions. The idea of discourse is central to the whole body of Michel Foucault's works. Foucault uses the concept of discourse to describe a system that produces knowledge and meaning, which is conditioned by history. He states that discourse is, in fact, systematically produces "practices which form the objects of which they speak" (Foucault, 1972, p. 49). Thus, discourse is a way of organizing knowledge that structures social relations through the mass understanding of discursive logic and the acceptance of discourse as a social phenomenon. For Foucault (1972), the logic produced by discourse is related to the episteme of the historical period in which it emerged. However, discourses are produced by the sources of power within the social order, and this ability of power requires specific rules and categories, which define the criteria for legitimizing knowledge and truth in discursive orders. These rules and categories are considered a priori; that is to say, they precede discourse. That is why discourse masks its capacity to produce knowledge. For the same reason, discourse claims an irrefutable historical reality (Foucault, 1972). In short, Foucault argues, "discourse constructs the topic. It defines and produces the objects of our knowledge. It governs the way that a topic can be meaningfully talked about and reasoned about. It also influences how are put into practice and used to regulate the conduct of others" (Hall, 2001, p. 72).

In addition to discourse analysis, I also applied the concepts of rhetorical analysis to understand and interpret persuasive strategies in the language (Posch, 2017). The analysis tools from the systematic theory proposed by Aristotle helped to enrich my analysis. According to Aristotle, the speaker should persuade the audience of three meanings. The first of these, *éthos*,

refers to the character of the communicator. This person, a psychiatrist in my instance, is the source of communication. Second, pathos signifies the emotion of the person or people being persuaded. Finally, logos points out arguments presented in a conversation. It is usually the political language that is analyzed by using these basic categories. Following rhetorical categories in the medical language makes visible political strategies that permeate scientific rhetoric.

Lastly, the content analysis serves my study to scan journals, congress' books, and YouTube videos. In this way, I detach the content about ADHD and categorize the themes in ADHD studies.

2.2. Definition of Data

The data sets were compiled from different mediums focusing on psychiatrists' various *acts* (Husserl et al., 1982). They were collected between 2017-2019. The psychiatrists' acts were defined as their own anonymous statements (10 in-depth interviews), their scientific endeavors (1 diagnosis and treatment guideline, 31 journal articles in the *Turkish Journal of Child and Adolescent Mental Health: 2002-2019*; and congress presentations of *Turkish Child and Adolescent Psychiatry Congress'* in 8 abstract books: 2012-2019), communication with the general public (5 books, and 33 YouTube videos). The study aims to map social and moral context in which clinical judgments shape by scrutinizing the discursive and rhetorical details of these acts. The data sets except the interviews were scanned with content analysis, and ADHD-related content and interviews were analyzed with critical discourse and rhetoric analysis.

In Turkey, I conducted ten interviews in five cities. In my analysis, while I mention the largest cities with their names, I prefer to call small towns with their geographical region. The reason for this is that, in most of the small cities that I conducted the interviews, there are only one child and adolescent psychiatrist, so to assure the anonymity of the participants, rather than naming these small cities, I indicated the geographical region. I do not prefer to declare the hospital names either. The other reason for specifically highlighting the geographical regions is because the psychiatrists argue several daily or life practices rooted in their regions according to them, such as living in extended families in South East region, which is highlighted by a young psychiatrist who is born and grown up in this region, studied in Istanbul and currently working in her hometown.

I describe each of the participants with a letter. According to their gender, I assigned a title as Mr. or Ms. Here, I will present general information to the reader about each participant. During the analysis, I gave brief explanations about the participants; however, since it distracts to the reader from giving repetitious information, the reader can return to this section and access participant's information such as age, city, educational background, and graduation date. Five of the participants are men, 5 are women, and while 3 of them work in a private clinic, 7 of them work in a public hospital.

- Ms. A was born in 1959. She works in her private clinic, and she teaches at a private university in Adana. She graduated from Ankara University Faculty of Medicine in 1983. She completed her specialization in Child and Adolescent Psychiatry at Ankara University in 2002.
- Ms. B was born in 1990. She works in a public hospital in Ankara. She graduated from Ankara University Faculty of Medicine in 2014. She completed her specialization in Child and Adolescent Psychiatry at Ankara University in 2019.
- Mr. C was born in 1986. He works in a private clinic in Ankara. He graduated from Gulhane Medical Military Academy in 2009. He completed his specialization in Child and Adolescent Psychiatry at Ankara University in 2014.
- Ms. D was born in 1990. She works in a public hospital in a small Southeastern town. She graduated from Marmara University Faculty of Medicine in 2014. She completed her specialization in Child and Adolescent Psychiatry at Gazi University in 2019.
- Ms. E was born in 1988. She works in a public hospital in a small Central Anatolian town. She graduated from Ankara University Faculty of Medicine. She completed her specialization in Child and Adolescent Psychiatry at Dicle University in 2019.
- Ms. F was born in 1988. She works in a public hospital in Mersin. She graduated from Gaziantep University Faculty of Medicine in 2013. She completed her specialization in Child and Adolescent Psychiatry at Dicle University in 2018.
- Mr. G was born in 1975. He works in a public hospital in Mersin. He graduated from Uludag University Faculty of Medicine in 1998. He completed his specialization in Child and Adolescent Psychiatry at Dicle University in 2010.
- Mr. H was born in 1983. He works in a private clinic in Ankara. He graduated from Marmara University Faculty of Medicine in 2007. He completed his specialization in Child and Adolescent Psychiatry at Istanbul Bakirkoy Mental Illnesses Hospital in 2012.

- Mr. J was born in 1988. He works in a public hospital in Istanbul. He graduated from Manisa Celal Bayar University Faculty of Medicine in 2014. He completed his specialization in Child and Adolescent Psychiatry at Istanbul Bakirkoy Mental Illnesses Hospital in 2018.
- Mr. K was born in 1979. He works in a public hospital in Ankara. He graduated from Gulhane Medical Military Academy in 2002. He completed his specialization in Child and Adolescent Psychiatry at Ankara University in 2007.

I used the method called snowball or chain for sampling interviews. It was quite challenging to get in contact and make an appointment with psychiatrists. Taking advantage of the Web opportunities, I reached out by e-mail both indirectly to my acquaintances and to the child and adolescent psychiatrists whom I have not known. I have introduced myself and my research and stated that I would be happy to provide more information if interested in participating in my research. Mostly, I have not taken an answer to my e-mails. Along with this, I also came across several replies that have made inquiries about the research ethics without requesting any details about my research. Some people initially said they wanted to help, made an appointment, but then canceled the appointments. The psychiatrists whom I could finally meet were usually the ones I contacted with a reference of a contact person whom I know. I was able to conduct many interviews in Ankara (2nd largest city) because I come from this city, and my colleagues have mobilized their networks to help me. Istanbul and Izmir (1st and 3rd biggest cities) were the cities I have focused most on from the beginning of the research. Still, unfortunately, it was not easy to get a positive response. I would like to state that I have always received positive feedback from psychiatrists working outside the big cities. Besides, the young psychiatrists showed a great deal of solidarity, which I am very grateful for, to motivate their colleagues.

When I conducted the interviews, I was living in France, and the terms of my scholarship from the National Education Ministry of Turkey do not allow me to spend more than two months in a year in Turkey. The distance was also a significant obstacle to organize the interviews. Nevertheless, I intended to make the interviews face to face. I managed to carry out 8 of the interviews face-to-face by traveling to various cities. However, I did the last two interviews online due to time constraints.

Turkish Journal of Child and Adolescent Mental Health is a journal, and the scientific publication of the *Child and Adolescent Psychiatry Association* has been published since 1994. TJCAMH is published in Turkish and English languages. It is an independent international

journal based on the principle of double-blind review. TJCAMH is published regularly three times a year (March, July, November). This journal aims to develop the science and practice of child and adolescent psychiatry by publishing theoretical, scientific, and clinical suitability statements related to its original research and field. TJCAMH primarily focuses on subjects in mental health, genetic, epidemiological, neurobiological, and psychopathological studies of children, adolescents and their families; cognitive, behavioral, psychodynamic, and other psychotherapeutic research; parent-child, interpersonal and family research; school-based settings that include clinical and empirical research.

To have access to all journal articles, I needed to have a membership to the association. Actually, it was also necessary to participate in the congress, as it was costly for participants who are non-members of the association. I contacted the association. They told me that the membership is only available for child and adolescent psychiatrists, and shared a web page that I can access a journal database named *idealonline*. When I tried to access the journal, it is asked for a membership to the association. Then, I contacted the database admin, and explained that I need to access this journal for my research. He was kind to help me; thus, I finally had the opportunity to review this journal's articles. I am giving details of how I accessed these articles because it shows us that the child and adolescent psychiatric community in Turkey is self-enclosed. Even the access to the knowledge that they produce is challenging. As they stated on their web page, "*the target audiences are experts and students in the relevant child and adolescent field.*" However, the field of child and adolescent mental health is narrowed down to psychiatry.

From the beginning of 2002 to the date when I collected this data, May 2019, they published a volume for each year. They routinely published three issues for each year; however, there are three years with two issues. Volumes begin from 9, but the database that was only medium to access to journal had the volumes since 2002. 18 volume includes 336 articles, and 31 of them are related to ADHD. The relation that I defined for my analysis is having ADHD issues or having a result directly related to ADHD. I needed to define this relation, as some of the articles include the word of ADHD in the abstract. However, there is no interest in the body of the work related to ADHD.

The content analysis that I applied to the articles published in the *Turkish Journal of Child and Adolescent Mental Health* between 2002-2019 shows 31 articles related to ADHD out of 336 articles. The most common research interest is about comorbidities; seven of these articles are about other disorders that accompany ADHD. Four of them are about

questionnaires and measurement tools. According to the psychiatrists' clinical practices, published books, and reviewed articles, the most frequently used and researched questionnaires are Conners' Parent and Teacher Rating Scales and Atilla Turgay's Scanning and Evaluation Scale based on DSM-IV for Behavioral Disorders in Children and Adolescents. The four of them are about relations between ADHD and cognitive functions including working memory, audio/visual perceptions, etc. The pharmacologically oriented articles are three; two of them are about methylphenidate, and 1 of them is about atomoxetine as an active ingredient. Two of these four articles focused on the cardiological consequences of methylphenidate usage. The quality of life, which presents a more holistic prospect to the child's life, is the main topic of 4 articles. While two studies were concerned with the diagnostic process, 1 study focused on the effect of birth sequence on ADHD, and another one researched biochemical reaction.

The direct translation of the congress' name is *National Child and Adolescent Mental Health and Diseases Congress*, organized by *Turkey Child and Adolescent Psychiatry Association*. This association likewise publishes the journal that is analyzed in my research. Similarly, the writers of the books analyzed within my study are the members of the association. It shows us that they united around the same professional and epistemological culture.

“Turkey Child and Adolescent Psychiatry Association was founded in 1991. It is headquartered in Ankara and has representatives in various provinces. Turkey Child and Adolescent Psychiatry Association, child and adolescent mental health and disease specialists, and physician assistants have operated as a professional organization. TCAPA is an institution responsible for the Child and Youth Mental Health Journal and professional education. The association organizes National Child and Adolescent Psychiatry Congresses every year in cooperation with the Departments of Child and Adolescent Mental Health and Diseases of various universities. In the Adolescent Symposiums, the first of which was held in 1996 by the Association Adolescent Commission, a separate area of adolescent problems is handled each year. The commissions within the association carry out activities and activities on various issues related to child and adolescent mental health and diseases.”

Eight abstract books were available online, which belongs to congress from the period 2012-2019. Each abstract book is formed in eight parts: a table of contents, preface, organizing committee, scientific program, panels' abstracts, oral presentations' abstracts, poster

presentations abstracts, and author index. The organizing committee presidents write the preface to highlight the main topic of each congress. The organizing committee page has a top-down hierarchical structure. On the top of the page, we see one or several honorary president(s), which are generally the head of the organizing university. Then, there are the presidents of the organizing committee in the second line. The other members of the organizing committee generate the third line. The fourth line is reserved for the local organizing committee, which has its hierarchical structure from top to down professors, associated professors, medical doctors, and psychologists. There are one or two psychologists who work in the hosting university hospital in each local organizing committee.

In addition to the scientific publications shared within the occupational group, the messages distributed by mass media explicitly targeting the parents were also included in the study because mass media is a total institution (Goffman, 1961), which participates in social control discourses. According to Goffman's (1961, p. XIII) definition, total institution signifies "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life." However, in this age "the structure of control goes beyond mere walls, bars, and physical force, and includes procedures and logics to define behavior according to time, place and manner" (Altheide, 1991, p. 63). Therefore, I added five books and 34 YouTube videos to my data set. The books I included in the analysis were selected from among the books found on the shelves of two big bookstores in the city center of Ankara and the first books in the search for ADHD on the most frequently used internet book shopping site. The translation of the titles, authors, publishers, first edition dates, last edition dates, and how many editions they made are summarized below:

- *Attention Deficit Hyperactivity Disorder*, written by Eyüp Sabri Ercan was firstly published in 2008 by the publishing house Dogan Kitap. The last edition of the book, which has 16 printings in 8 years, was published in 2016.
- *Attention Deficit Hyperactivity Disorder from Infancy to Adulthood*, written by Bengi Semerci and Atilla Turgay was firstly published in 2007 by the publishing house Alfa. The last edition of the book, which has 6 printings in 7 years, was made in 2014.
- *Hyperactive Child and Adolescent at School*, written by Yanki Yazgan was firstly published in 2001 by the publishing house Dogan Kitap. The last edition of the book, which has six printings in 11 years, was made in 2017.

- *Hyperactivity and Attention Deficit*, written by Osman Abali was firstly published in 2009 by the publishing house Adeda. The last edition of the book, which has 4 printings in 6 years, was made in 2015.
- *Attention Deficit and Hyperactivity Disorder*, written by Ozlem Surucu is firstly published in 2015 by Bilgi publishing house. The last edition of the book, which has 9 printings in 4 years, was made in 2019.

I tried to create the closest settings to Turkish parents who would do YouTube research; thus, I did the YouTube research when I was in Turkey due to IP settings. I also searched on the Safari search engine with clear history to minimize the impact of my internet search history on the results. I performed two searches in Turkish, namely ADHD and Attention Deficit Hyperactivity Disorder, and evaluated the top 50 results of these two searches. In my search on 08.11.2019 at 13:14 with the ADHD keyword, a child and adolescent psychiatrist presented 23 of these first 50 videos. Two of the videos were the same. In summary, the analysis included 22 videos. In the search that I conducted on 08.11.2019 at 17:45 with the essential words of Attention Deficit and Hyperactivity Disorder, 15 of the first 50 videos belonged to a child and adolescent psychiatrist. 4 of these videos were the same as the first search, so 11 videos from this search were included in the analysis. I have analyzed a total of 33 videos within the scope of my research. The names of these videos, the name of the psychiatrist they belong to, the upload dates, the duration, and the number of views are given below:

- 1- *The real problem in attention deficit is not focusing ...* – By Ibrahim Bilgen- 6:25 min. - Downloaded at 11.12.2018 - 42.453 views
- 2- *What are the treatment methods for ADHD? Is Drug-Free Treatment Possible?* – By Yanki Yazgan - 11:00 min. - Downloaded at 22.06.2019 - 1.027 views
- 3- *Hyperactive Children at School (ADHD)* – By Bengi Semerci - 9 :54 min. Downloaded at – 05.11.2018 – 6.394 views.
- 4- *Solution to Attention Deficit Disorder* - By Bora Kuçukyazici – 1:06:16 min - Downloaded at 29.01.2019 – 400 views
- 5- *Let me love my mind: The use of drugs in ADHD treatment* – By Yanki Yazgan – 10:23 min. Downloaded at 27.03.2012. – 24.261 views.
- 6- *Attention Deficit Hyperactivity, ADHD* – By Arzu Erkan Yuce – 42:14 min. – Downloaded at 18.11.2015 – 7.942 views
- 7- *What are the symptoms of Attention Deficit Disorder?* - By Ibrahim Bilgen – Downloaded at 19.06.2016. – 5:20 min. – 206.726 views.

- 8- *What should families with children with ADHD?* - By Yanki Yazgan – Downloaded at 21.06.2019 – 5:51 min. – 352 views.
- 9- *Attention Deficit and Distractibility Test (ADHD)* – By Bora Kucukyazici – Downloaded at 27.07.2019 – 1:10 min. – 519 views
- 10- *What are the symptoms of ADHD? How is ADHD diagnosed?* – By Hasan Bayar – Downloaded at 24.06.2017 – 1:10 min. – 20.04.2020 534 views.
- 11- *What is Attention Deficit and Hyperactivity Disorder? Tips for approaching to an impulsive child* – By Gokce Kucukyazici – Downloaded at 12.08.2010 – 1:55 min. – 6.254 views
- 12- *What is Attention Deficit and Hyperactivity Disorder?* – By Mustafa Erkan – Downloaded at 20.06.2018 – 4:55 min. – 1217 views
- 13- *Drugs used in ADHD treatment* – By Gulcan Ozer – Downloaded at 02.03.20 – 0:54 min. – 627 views
- 14- *Academic failure and ADHD* – By Veli Kurt – Downloaded at 30.05.2018 – 1:11 min. – 202 views
- 15- *What is Attention Deficit Test? Focus, Study, Success* – By Bora Kucukyazici – Downloaded at 23.06.2016 – 8:54 min – 7631 views
- 16- *Dyslexia and ADHD (Attention Deficit and Hyperactivity)* – By Akin Ucok – Downloaded at 30.01.2019 – 37:29 min. – 144 views
- 17- *What is Neurofeedback? Attention Deficit Treatment* – By Bora Kucukyazici – Downloaded at 25.05.2016 - 3 :17 min – 279 views
- 18- *Attention Deficit Hyperactivity Disorder in Preschool Period (0-6 years)* – By Bengi Semerci – Downloaded at 20.05.2019 – 6:13 min – 1.623 views
- 19- *Suggestions for families with children with Attention Deficit Hyperactivity Disorder* – By Bengi Semerci – Downloaded at 08.04.2019 – 12:45 min – 19.741 views
- 20- *Attention Deficit Hyperactivity Disorder in Children and Adolescents* – By Bengi Semerci – Downloaded at 25.01.2018 – 25:10 min. - 10.219 views
- 21- *Attention Deficit and Hyperactivity Disorder* – By Bengi Semerci – Downloaded at 8.04.2017 – 3:00 min. – 825 views
- 22- *Attention Deficit and Hyperactivity Disorder* – By Yanki Yazgan – Downloaded at 03.09.2014 – 20:13 min. – 11.354 views
- 23- *Attention Deficit and Hyperactivity Disorder* – By Fusun Cuhadaroglu – Downloaded at 14.11.2011 – 1:54:31 min. – 27.922 views

- 24- *What should be the treatment method in Attention Deficit and Hyperactivity Disorder?* - By Ibrahim Bilgen – Downloaded at 19.05.2016 – 5:54 min. – 65.832 views
- 25- *Frequently Asked Questions About Attention Deficit and Hyperactivity* – By Emine Kiliç – Downloaded at 20.06.2020 – 6:21 min – 10.607 views
- 26- *What is the Best Test to Detect Attention Deficit and Hyperactivity Disorder?* - By Ibrahim Bilgen – Downloaded at 19.05.2016 – 5:45 min – 52.802 views
- 27- *What is Attention Deficit and Hyperactivity Disorder? Approach tips to an impulsive child* – By Gokce Kucukyazici - Downloaded at 12.08.2020 - 4:29 min – 6.255 views
- 28- *How should we treat our child with Attention Deficit and Hyperactivity Disorder?* – By Ibrahim Bilgen – Downloaded at 19.05.2016 – 2:43 – 20.568 views
- 29- *Attention Deficit and Hyperactivity Disorder in Children* – By Mucahit Ozturk – Downloaded at 26.03.2012 – 41:51 min. - 16.328 views
- 30- *Attention Deficit, Hyperactivity Disorder and Dyslexia in Children* – By Umit Isik – Downloaded at 19.11.2018 – 31:47 min. - 929 views
- 31- *Attention Deficit and Hyperactivity Disorder* – By Eyup Sabri Ercan– Downloaded at 12.12.2014 – 17:59 min. - 26.717 views
- 32- *Difficulties Experienced by Parents about Attention Deficit* – By Ibrahim Bilgen – Downloaded at 29.01.2019 – 13:26 min.–13.843 views
- 33- *Problems in Executive Functions in the Brain & Attention Deficit and Hyperactivity Disorder* - By Ibrahim Bilgen – Downloaded at 13.11.2018 – 10:09 min. – 26.051 views

2.3. Subjectivity of Researcher

My professional background that begins with the play therapy supervision with the children diagnosed with ADHD and dyslexia for two years continued with the family and children counseling sessions. Then, I have worked in rehabilitation centers with the teachers of special needs, social workers, primary school teachers, psychologists, and in the last instance, indirectly with psychiatrists via their diagnostic and treatment reports. In the last years of the pre-doctoral period, I was working in a private school as a school psychologist, and I was responsible for kindergarten and elementary departments where many ADHD diagnosed children and the children with ADHD-like behaviors study. All these meetings with ADHD diagnosed children and the component actors of this popular diagnostic have generated the first backbone of my research idea.

During this first discovery period, the first thing that I noticed was the lack of consensus. For example, a psychiatrist prescribes a psychostimulant for an ADHD-diagnosed child, but his/her family does not want to use it; or a teacher insists on the ADHD diagnosis, but the psychiatrist disagree with the teacher, but the teacher continues to direct the family to other psychiatrists. Besides, the lack of consensus between various psychiatrists that I have met several times in my professional life was the most fundamental motivation of this study.

I am not a psychiatrist. But I am a mental health professional who has worked for ten years in personal contact with children diagnosed with ADHD. I would like to say to readers, especially psychiatrist readers, that please do not read it as an outsider criticism to your profession because it is an effort to understand my practice and formation. I chose psychiatrists as the object of my study because they are the clinical decision-makers. But I was one of those who directed children to a psychiatrist that you will read during the dissertation. I have organized several psychoeducation sessions for many families to integrate them using drugs regularly. I attended public meetings for parents as a speaker to introduce children's symptoms and apply to a psychiatric service. But my observations, my experiences, and my readings pushed me to deconstruct my practice. Therefore, I would like you to read this study as the effort of a psychologist who tries to examine the knowledge of her field.

In recent years, hyperactive child, hyperactivity, attention deficit, and attention problems had penetrated into our daily and professional language. It became impossible to understand what was happening by looking at DSM. I was working in a private primary school. We could not calm the children down. Every day a new parent is coming to my office with a box of Ritalin, and more and more students were directed to the psychological counseling service -to me- by their teachers because of the ADHD suspicion. Almost every class had at least one student who uses psychostimulant. It was the method that we know, the method we read from books, listened to from our professors, and persuaded by our supervisors. The use of the drug was increasing, the number of diagnoses was increasing, medical adjectives that characterize children were increasing, but at the same time, the noise in the school, the number of students sent to my office, and the complaints from teachers and parents were also increasing. I was trying to direct families to get more psychiatric help and to use drugs regularly. But something was wrong. This study started from the moment when I asked myself what goes wrong.

2.4. Why did I give up a comparative analysis?

In the beginning of my doctoral project, I aimed to undermine the attitudes and clinical judgments of psychiatrists in France and Turkey, and it has continued within this direction for a while. I kept collecting data in both countries. Then, we – with my advisor - decided that this comparison did not work effectively and focused on exploring psychiatrists' discourse in Turkey. In the methodology chapter, I would like to share the reasons that led me to this decision, which resulted from a process that I tried to explore myself as a researcher, the nature of qualitative research, and my research field. It was a stage of my academic maturation, and for me, it was the most instructive stage as a psychologist who meets my own limits in a multidisciplinary ocean.

In particular, my concern was how the discourse of psychiatrists about ADHD differs between France and Turkey. The reason why I chose France and Turkey as target countries can be firstly defined based on language, and culture because Turkey is my country origin, Turkish is my maternal language. I studied psychology there and worked as a psychologist for a few years. This background gives me the ability to communicate facility and acquaintance of psychiatric circles. Also, France, where I have lived for a few years, and I have studied, is my advisor's country origin, and his considerable experience in the medical anthropology field in France assure my possible blind spots in my analysis regarding French psychiatric culture. The second reason is determined according to paradigm difference: France, where psychoanalytic tradition is deeply rooted and where the estimated prescription rates 0,15% to 0,4% (HAS, 2012 as cited in Hervé et al., 2016) and Turkey, where psychological circles are acting in line with the APA's approached and where 84000 boxes of stimulants were prescribed for children in 2004 (Ongel, 2006) and where the annual use of ADHD medication 2.18 times (Oner et al., 2003) were selected to provide rich data.

First of all, I would like to talk about the language problem. Intending to do this study at the age of 29, I came to France and started my language education. At the end of a year, my knowledge of French, which had previously been at the beginning level, had reached the level that universities demanded from international students, and I was able to continue my daily life easily in French. Firstly, I focused on the fieldwork in Turkey, and I thought that the interviews conducted in my maternal language would feed the ones in French. However, when I started the interviews with French psychiatrists, I saw that my French ability to communicate flexibly is not as good as my maternal language. It is not just about mastering the language, but rather, I realized that an in-depth interview that I want to apply discourse analysis is not just about

keeping the dialogue going. It is about being able to ask more sophisticated questions spontaneously, recognizing the changing rhetoric and allusions in the language. Later, when I started transcribing conversations in French, I was again having a hard time. In the meantime, I collected pretty much data in Turkey, and I started to analyze them. I was mastering the social, cultural, political, economic context made it easier for me to analyze the data and affected the quality of the analysis. As Merrigan and Huston (2015, p. 202) point out that “discourse analysis uses thematic categories developed from a talk, or textual data, as well as the researcher’s cultural knowledge of the situation to inform those categorizing decisions, in order to advance explanations of macro-level social order.” Then, I keenly focused on data from Turkey by awakening to all these components. Finally, I – accompanied by my advisor – decided that it would be more realistic to focus on Turkey for a four-year doctoral period.

Moreover, it does not generally address in the methodology chapter of a doctoral study how much the financing issues affected the research process. Of course, we do not shape the fundamental research model according to funding. Still, as the research continues over a long time, both funding and various bureaucratic processes affect the research’s progress. In my work, it was challenging to organize interviews with psychiatrists, so I could not meet the number of interviews I had targeted. I was out of time to persist in making a comparative analysis because I had reached the end of my funding. Furthermore, I also would like to spend time as an observer in hospitals, in addition to interviews, and include data from ethnographic observations in my data set. I was hoping that the knowledge I got from psychiatrists in their professional natural setting would complement the knowledge I gained. Yet, the hospitals cannot accept me as an intern because I do not have student status in Turkey.

Besides, as a medical institution and its spatial representation, hospitals are an institutionally closed space for those who come from other specialties and want to produce knowledge about the medical field. It reminds me that Bekir Onur (2005) emphasized that the research of experience in educational studies has always been lacking because the school is closed to the outside and not even involved in the research. Onur (2005) states that the family is just like this. My experience during this research showed me that the hospital was also closed to eyes from outside.

3. How do Psychiatric Subjectivities Shape the Other Subjectivities?

“Genuine objectivity is the fruit of authentic subjectivity.”
Lonergan (1979, p. 292)

Within this chapter’s scope, I intend to discuss psychiatrist as a subject who is not independent of the cultural, moral, political, and economic context and the power that this subject has to shape other subjectivities.

Biomedical practitioners prefer an objective manner for thinking and reasoning. This is the method of providing scientific knowledge. Nagel (1989) defines it as “the view from nowhere.” This type of knowledge is valid for all time and spaces and is independent of an individual’s values, biases or cultural context. Objective thinking leaves emotions and intentions out of the process (Marcum, 2008). According to Davis-Floyd and St. John (1998, p.33), “intuitive thinking, brainstorming, creative option generation, and open-ended questions are usually taboo”. On the other hand, while humanistic or humane practitioners do not deny the importance of objective thinking in medical practice, they argue that knowledge has a subjective form that includes intuition, values, and “the virtues of the knower” (Davis-Floyd & St. John, 1998, p.97). In medical practice, knowledge is based on doctor’s and patient’s narratives equally (Marcum, 2008). Tauber (2001, 2005) provides a medical knowledge model that blends objective and subjective thinking. “Radical objectivity fails because the view from nowhere leaves Man out of the picture, and with no perspective, there is no significance, no meaning, no order, and ultimately no self” (Tauber, 2001, p.21). When the *object* of knowledge is a *subject*, moral characteristics and values guide knowing, but modern medicine’s passion for objectivity leaves out the discussions of self or subjectivity. “The glue holding together the various epistemological strands of contemporary medicine is of a personal moral character (Tauber, 2005, p.10)”. He defines his proposal as moral epistemology. It is moral, “because clinical evaluation and care value-laden, epistemological because medicine expresses and employs the form of knowledge” (Tauber, 2005, p.9). The facts emerge within a context of values that we can interpret. In order to liberate facts from the objectification of positivism, Tauber recommends a field that combines the values of the medical profession and patients (Marcum, 2008). “Biomedical reasoning may be sufficient to explain the bounded realm of microscopic events and abstract principles, but other kinds of reasoning are necessary when

those principles are applied to the unbounded universe of the real world of physical, phenomenological, and social lives (Hunt & Mattingly, 1998, p.270).”

3.1. Psychiatrist as a Part of Social, Economic, Political and Cultural Landscape

During my first interviews, I noticed that the psychiatrists’ educational and social background has an impact on their motivations in their professional relationships with children. Thus, I added some questions about family backgrounds for the following interviews. For instance, the psychiatrist from a family of farmers, who was born in a little village, was a successful student, had a great result in university exams, and then became a medical doctor motivated to help children from disadvantaged groups. It is a success story in this social context and having a university degree helps climb the social ladder. In this context, the psychiatrist has a depth motivation to help children with attention deficit problems in school success. According to social interaction theory, our backgrounds may even shape our professional decisions. My motivation to ask some questions to discover psychiatrists’ social backgrounds is based on this argument: *Why did you want to study medicine?* Thanks to this question, I have learned a lot about their family background, their motivations, and their experiences with the education system that determines their occupation choice.

Researcher: “Why did you want to study medicine?”

Ms. A: “My father was a (medical) doctor! (laughs)”

R: “Then why did you want to specialize in psychiatry?”

Ms. A: “Because I never liked medicine, I’d like to choose a social field. (laughs)”

The common reason for studying medicine that is not surprising for someone who knows Turkey’s education system is a very successful student. As I mentioned in detail in the previous chapter, secondary school, high school, university, and department choices are dependent on exam results. Faculties of medicine require the highest degrees in university exams. Being a medical doctor is *“the fate of a successful student”* in Turkey, as one of my interviewees states. Further, the traditional authoritarian parental style has a constant power on children’s choice of profession. I observed these in all my interviews except one. Only one young psychiatrist told me that she studied medicine to be a psychiatrist. The rest went to the faculty of medicine because of their exam success and their parents’ demands.

There are many possible professions in children’s and parent’s repertoires since the 2000s, but in earlier periods, alternatives are limited, particularly in rural areas, as one of my

interviewees, who is 45 years old, stated: *“if you are studying in our village, you will be a doctor. Because we didn’t know any other profession”*. Understanding this point may help the reader who is not familiar with the socio-cultural context of Turkey while analyzing the medicalization of school failure (Chapter 4) because even though the number of professions has contemporarily increased, it is still expected that a young person chooses his/her occupation according to the exam score and the security of profession in such an unstable economy. In these circumstances, being a doctor or engineer is always favorable. Mr. G, who was born in a little South-eastern village, underlines the idiom *“kendini kurtarmak”* that I directly translated as *save oneself*. This idiom refers to saving oneself from poverty, so it signifies a change in social class.

Mr. G: “We didn’t know any other profession. Our parents used to say that successful students become doctors and save themselves. You should be either a doctor or a lawyer if you were born in the village. They were the professions that you would make money and save your life. I did not choose psychiatry very willingly and cannot say that it is the profession of my life. I’ve worked in two areas of expertise before. I left both because of some reasons. One was general surgery, I stayed there for two years. Another one was nuclear medicine, and I stayed there for almost two years. I left them for various reasons, and the (specialization in medicine) exam was difficult, too. You make your preferences (for departments) before the exam, so child psychiatry was just one of my preferences.”

A senior psychiatrist, who is also the oldest participant in this study, highlights that the period when she studied was *“a breaking point”* to alter the dominant approach in psychiatric education. She studied at Ankara University and said that they received a psychoanalytically oriented psychiatry education in the 1970s when she was a student. I had another interviewee who also studied at Ankara University and completed her assistantship in 2018. This young lady states that the psychiatric education of the same university is biomedical based in recent years.

Ms. A: “Ankara (University) is more analytical, focused on analytical education. After that, it was less organic-based, things have changed, but still, we all were going to (psycho)analysis, such as traditional education. Psychiatric education had never changed, but we think, a little bit, as the young people of the time used to describe me as “hapçi” (meaning drug dealer or drug addict) (laughs). My name was “hapçi” (laughs). I mean, I was like a drug dealer.”

However, the senior child and adolescent psychiatrist has always been a big supporter of pharmaceuticals independently of psychoanalytical education. She is considerably active in academic production about ADHD and in child and adolescent psychiatrists' occupational organization with over 40 years of experience. She presents herself as *the living history of Turkish psychiatry*. In the following anecdote, she tells the story of her first ADHD case. During her assistantship in psychiatry, DSM-II was being used, and ADHD, which was defined in 1980 with the third edition of DSM, was still known as Minimal Brain Dysfunction.

Ms. A: "As a case example, for instance, there is my very first case, which I will tell you about. I teach the history of psychiatry in the universities, but at the same time, I am the history of psychiatry in Turkey (laughs). When somebody looks at the history in the books, they see my name in various chapters. (...). In my first psychiatric training, we had a clinic with a garden. I saw the butcher of the neighborhood in the garden. He was holding his child and a big butcher knife in his other hand. The guy told me he would cut his son, but he said he could not understand where he got it wrong. He said, 'I have made a mistake, or there is something wrong with my son or me'. 'Is there a mistake?' 'Just tell me what mistake we made... I came to you as a last resort', he said. He died due to a heart attack roughly five years after bringing that kid in, and he was not diagnosed with ADHD at that time. There is no diagnosis in DSM-2, I think. There is no diagnosis in our books. I read, I did research, I found what I didn't know. Minimal Brain Dysfunction was what it was called that time. We tried to treat the child with minimal brain dysfunction. I remember him well, for example. It's a historical case."

Psychiatry has diagnosed ADHD-like behaviors and prescribed Ritalin since the 1960s. In these years, methylphenidate was being prescribed for a diagnostic category that the authors describe as *Chronic Brain Syndromes*. In 1966, Samuel Clements (as cited in Singh, 2007) officially defined Minimal Brain Dysfunction as another form of such syndromes in a Public Health Service report. According to Iina Singh (2007), the effort to gather many symptoms under such a diagnostic category involved children in the Ritalin market used for adults. Samuel Clements gathered many resources to create a diagnostic guide for MBD. According to Clements' review, MBD is defined by at least 38 terms, which includes hyperkinesis and hyperactivity syndrome (Singh, 2007). MBD includes a broad spectrum of symptoms and disabilities such as average intelligence; behavioral disabilities based on the central nervous

system; impairments in visual or auditory perception, difficulties in conceptualization, language, memory, attention, and motor function; minor damage to the brain stem; disabilities based on oxygen deprivation during childbirth (Strickland, 2001). In fact, all childhood behaviors that were defined as unfunctional were gathered under this diagnostic category. The diagnosis system, which started to change in the 1980s, divided all these titles into separate diagnostic categories. Singh (2007) claims that the changes made in diagnostic categories are shaped according to the pharmaceutical industry's needs.

Narrative reasoning that “involves thinking in story form” (Schell, 2003, p. 136) is one of the alternative understandings to biomedical reasoning. This way of thinking gives the doctor information about the disease's effect on the patient's personal life. When the doctor had this experience, narrative reasoning had not been defined yet; however, her style positions a child's symptoms in his social reality as an example of narrative reasoning. While biomedical reasoning, in which she positions herself and her medical understanding, focuses on the more observable/measurable symptoms that the patient has, narrative reasoning draws attention to the fact that the father reaches the threshold of his tolerance and that he is so out of control that he can harm the child. For Kathrine Montgomery (2006, p. 45), narrative reasoning is a must rather than a preference. “Physicians use both the scientific or hypothetico-deductive and the practical or interpretative and narrative, but it is the latter that makes them clinicians.”

Depending on the period when physicians study, the social and political context in which they studied and worked may have an impact on their clinical practice and their way of thinking. I had two interviewees who studied at Gulhane Military Medical Academy (GMMA). GMMA was founded to train military physicians in 1898 during the Ottoman Empire, and as a result of the reform movements in 1908, military and civilian medical schools were united. It was affiliated with the Istanbul University. In 1941, the risk of the Second World War caused to be moved GMMA to Ankara. GMMA, which was affiliated with the Turkish Armed Forces until 2016, was a command of the Turkish Armed Forces training military personnel in medical sciences. After the July 15 military coup attempt, with the law decree issued on July 31, 2016, it was attached to the Ministry of Health and all health units, and its name was changed to Gulhane Training and Research Hospital. Mr. K, who graduated from GMMA in 2004 as a military physician and specialized in child and adolescent psychiatry in the same academy, shared with me that changing the status of their hospital caused essential changes in their clinical practices. All university hospitals have a more privileged status than public hospitals. They are differentiating regarding the patients' social status, and sometimes symptoms, which

I analyzed with details in Chapter 3. However, GMMA also had different status than other university hospitals because it was reserved for the army members and their families. The fundamental effect of opening to the public is a shortening of sessions, according to Mr. K.

Mr. K: "(...) the status of our hospital was formerly university (military university hospital). When our status moved to the Ministry of Health, our examination period, which we could easily have half an hour before, dropped to 10 minutes. As such, you are a little bit [forced to] economize in terms of the interview, but I, first of all, received the complaints and still see the child separately from his/her family after the first examination."

During my interviews, I met another child and adolescent psychiatrist who studied at GMMA. But then he left the army and started working in a private clinic. While I was transcribing and working on their interviews, I noticed a typical attitude such as being sure about their professional positioning, not questioning their clinical practice, and working confidently towards the target behaviors that they approve of. I think that it may be a result of coming from a military education. As a reflection of this attitude, I observe the trust in drugs and not hesitating in giving prescriptions, as in the following extract.

Mr. K: "Suppose the child's functionality has deteriorated negatively; in that case we definitely use the drug because when we do not start (medication), these cases cause severe problems for society and family. For example, the problem is not only in the academic field but also in the social field. When we are in traffic, it is also difficult for us to encounter someone with ADHD in the daily life. In this respect, although I try not to give unnecessary treatment, I am not afraid of drug treatment for needy patients. But of course, you know the criteria of DSM for this (diagnostic)."

I observed an attitude prioritizing social control and discipline in the discourse of these two military physicians. According to Mr. K, we all are exposed to impulsive behaviors in traffic, and he suggests drug therapy as a solution. On the one hand, the other younger psychiatrist Mr. C, who studied at GMMA, asserts that ADHD is a biological problem and that there is no solution other than drugs. On the other hand, he says that the new generation of families cannot draw disciplinary limits for their children, and they cannot improve their self-control. His rhetoric that harshly criticizes families' attitudes towards their children has a significant moral tone.

*Mr. C: “New generation parents are **disgusting!** So we should officially take this child from the family. The child does not want to go to school in the third grade, and his parents say okay. When I saw the boy with a tattoo, nine years old, I went crazy. What the boy said to me was, “You didn’t see the tattoo on my back that I had when I was six years old.”*

He thinks that he is legally responsible for informing the state’s social services because it constitutes child abuse. However, he does not think that the child will have better conditions under state protection neither. While he is criticizing the family morally, he falls into another moral dilemma.

I confronted the other common pattern that repeats during occupation decision-making processes; child and adolescent psychiatry was not always their first field of specialization. In some cases, they finished their previous specializations, but in other cases, they withdrew them. The field of specialization is chosen by an examination as well: TUS (Medical Specialization Examination). As in the extract, a young idealist doctor, passionate about cardiology may change his/her career because of the concrete difficulties.

Ms. E: “In fact, psychiatry is my second specialization. I left the first one. First, I started cardiology. I really wanted to be an academician, and I had a perfectionist personality. I wanted to do the best in my job. But in Turkey, it is not very possible, especially in a department such as cardiology. It means you won’t have a life if you want to do something perfect in such a busy department. Unfortunately, it is like this in Turkey. Why is that? Because I had 13 times 12-hour shifts per month when I was in cardio. I was starting at 7 in the morning. I was leaving at 7 pm the next day. I was starting in at 7 am in the next day. I couldn't handle a routine like that. I left. Then one of the reasons I chose psychiatry was that I like listening and talking. On the other hand, I should say that the absence of intensive night shifts was important for my decision.”

Mr. G prefers to keep what motivated him to general surgery and nuclear medicine secret in the previous extract. But I highlighted that doctors decide their specialization field before the medical specialty exam (TUS). He repeated that the choice of being a psychiatrist was not conscious as well as the choice of being a medical doctor. New policies make it easier to file a complaint against a doctor.

Mr. G: “Hmm honestly, in Turkey, we are now faced with a concept we call defensive medicine. I think this is one of the biggest problems of healthcare workers in developing countries. Because patients report us to the Ministry of Health because of drug side effects or diagnostic decisions, it wasn't like that before. We have additional insurances now. Therefore, it is necessary to be more cautious. I am more cautious than in my first years and make fewer diagnoses.”

In this extract, Mr. G mentions the transformation of government policies towards health professionals, besides he tries to highlight the risk of loss of life with the emphasis on *insurance*. In recent years (the 2010s), tens of doctors have been killed by their patients or their relatives in Turkey. Deterioration in health policies is shown as the cause of the problem. On 2 October 2018, psychiatrist Fikret Haciosman was killed by one of his patients, an 18-year-old high school student. The event frequently took place in the media. I encountered similar cases a few times in my interviews. The importance of homicide for the other psychiatrists is based on the critiques of over-medicalization. Because the accused claimed in his plea that Dr. Haciosman made fun of his problems about hating rich people and said that he would take his drugs, which will end his problems, after this incident, a few articles were published by the Turkish anti-psychiatry circle, which blamed psychiatrists who over-medicalize their patients. On the other hand, although it is considered beneficial for patients to complain easily against doctors, it tries to push the responsibility for deteriorating health policies onto doctors.

Ms. F: “Typically, the examination period is given to a child and adolescent psychiatrist in public hospitals is 20 minutes. But this partly depends on the administration of a hospital, so officially 20 minutes, but if the administration wants to have many more patients, for example, I have friends who have an appointment for every 5 minutes in other cities. Of course, it is tough to evaluate a psychiatric patient in 5 minutes. Look at the throat and prescribe a drug for infection, maybe it can fit in 5 minutes, but this is very difficult in psychiatry. Understanding the child, understanding the family, establishing a patient-physician relationship, arranging treatment—so, unfortunately, that’s our working system. It is not something we can interfere with. But the length of a session is 20 minutes in our hospital. (...) It doesn’t matter to our administration, but it’s quite regional in Turkey. It depends on the city. I have 10 minutes, 15 minutes, but I have colleagues from other hospitals who see a patient for 5 minutes.”

In the previous extracts, psychiatrists describe an ideal session with families. This ideal session could continue 45-60 minutes. However, the reality that psychiatrists told me in the interviews is far from this description. Even in private clinics, where they may have more time, the psychiatrists accept that they generally have 10-20 minutes per session. During this session, the psychiatrist should learn the detailed history and complaints from parents and evaluate a child. All psychiatrists describe some behavioral patterns that could be derived from various causes, such as neurobiological ones, parental attitudes, misbeliefs of parents or teachers, and they presume that they are able to distinguish neurobiological reasons from the others. In the following extract, my interviewee admits that it is not easy to distinguish the behaviors' reasons, and it depends on the level of experience. In addition, he highlights that families sometimes try to manipulate psychiatrists' decisions. He talks about how a psychiatrist can notice manipulations made by parents in the 5th, 6th, 7th session, but as I observed, psychiatrists do not hesitate to prescribe on the very first session. As a result, I asked him how all these remarks could be possible in an average 15-minute-session; he admits that it is not possible.

Mr. H: "It is not easy for us to distinguish behavioral problems that can change by limiting, with inexperienced or amateur eyes. It could cause the child to be diagnosed or use medication. When the problem is connected to the family, it may be perceived as a disease caused by the child, and according to the diagnosis, you prescribe medicine. (...) Of course, there is a difficulty in that the family does not appear as they act in their own home. Here they can draw a perfect portrait for you. If you have seen the patient only once or twice, if they have not come to follow-up, you may be mistaken. After a while, you will sense that the family is trying to manipulate you. In the 5th, 6th, or 7th session, your observation begins to change because something is wrong. As soon as you notice this, you will be interested in the child and start paying attention to the family. But it's a process."

R: "You may find time at the private clinic for this, but what about public hospitals?"

Mr. H: "Absolutely right! You will see many patients in public hospitals in a very short time. It is not possible."

3.2. Symbolic Interaction of Clinical Judgment

Herbert Blumer (1969) outlines three premises of symbolic interactionism. Firstly, human beings' actions follow their meanings that are established for things. But this is ignored

in contemporary social and psychological sciences, which approach meaning as taken for granted and rejects its importance. Secondly, meaning is derived from social interactions; thus, meanings are social products and creations shaped due to their interactions. Thirdly, these meanings are changed through an interpretative procedure utilized by the individual in managing the things he experiences. Modern psychiatry tends to explain human behaviors by biological factors and to ignore social and cultural factors. Also, I would like to recall that psychiatrists, who are the source of decisions that distinguish behaviors as normal and pathological, act on the basis of these meanings. In short, meaning determines acts. In the case of my study, diagnosing and prescribing or choosing another intervention method signifies the act. According to modern psychiatry and apparently psychiatrists' discourse, their acts are meaning and value-free. Yet, I analyze the traces of their individual backgrounds, social norms and values in their decision-making process by undermining the discourse.

Georges Canguilhem (2013) prioritizes the disease's subjective and qualitative nature rather than the objective and quantitative concepts. As I discuss in my analysis, for the medical approach in Turkey, the disease (or disorder for my study) has only a concrete nature that is objective and quantitative. Because of this, while child and adolescent psychiatrists have begun to describe their practice with ADHD, they have precise rates, numbers, statistics in mind. The understanding of medical practice that Canguilhem (2013) forms on subjective judgments can be interpreted as anti-science. However, he fought passionately to transform his profession. He attacked the objectivity, and the scientific method's mathematical certainty argued to be the only way to understand the disease. Modern science assumed that it could transform all experiences into mathematical calculations. Canguilhem (2013) proposed an alternative approach: all assumptions about the disease's nature should be abandoned. The experience of the person who has the disease should be sought. An entirely descriptive method should be adopted. He invited physicians to leave the dominant scientific approach regarding the disease. Hereby, they could discover the qualitative dimensions of their patients' symptoms (Horton, 1995). As a matter of fact, from Canguilhem's point of view, the subjectivity that psychiatrists try to escape from and the uniqueness of each case is substantial.

I would like to illustrate subjective preferences about an objective issue defined by concrete scientific measurements. The effect of methylphenidate on the cardiovascular system is one of the unchallenged topics in neurobiological ADHD studies. There are two articles in the *Turkish Child and Adolescent Mental Health Journal*. According to Pekdemir et al. (2003, p.9), "*methylphenidate increased the ventricular repolarization parameters in ADHD groups.*

In addition to routine parameters in electrocardiography, ventricular repolarization parameters should also be assessed for early diagnosis of possible cardiac side effects in patients on methylphenidate treatment". According to Ozcan et al. (2004), "*methylphenidate decreased the time domain HRV parameters in ADHD group. Therefore, close cardiac follow-up is necessary for the detection of side effects of methylphenidate especially in patients who are under risk for developing cardiac arrhythmias and in patients using methylphenidate together with drugs affecting central nervous system*". The common conclusion of these articles is to recommend a cardiological check-up before prescribing methylphenidate. Nevertheless, only one psychiatrist among my interviewees stated that he demands the opinion of a cardiologist. He prefers putting his finger on individual choice and highlighting *there is no written rule* by explaining this practice.

Mr. H: "I'm sending them to cardiology. Independent of the diagnosis of ADHD due to the possibility of starting methylphenidate. There may be a possibility of accelerating the heart rhythm. So, it's my routine to see if he/she has heart problems. None of this has to comply with written rules."

One of the most fundamental features of psychiatrists' discourses in the interviews is using the first-person plural in their sentences by explaining their procedures to diagnose and treat symptoms. According to Fairclough (2013), different forms of subject modality may be used by different discourses: objective modalities reflect and reinforce the power of the person or institution who used these modalities. In this case, psychiatrists claim that they talk about scientific truths; however, they choose subjective modalities rather than objective modalities. Psychiatrists try to compensate for the lack of objectivity while using *we* because, in this manner, they present a consensus. But it is not an obstacle to see that hesitation in their discourse by critical discourse analysis. It generates a part of creating an *ethos*, which means "*how identities are constructed through language and aspects of the body* (Fairclough, 2013, p. 166)". Ethos is one of the modes of persuasion defined by Aristotle, which represents the speaker's character or the source of communication. It is proof for the person speaking to convince an audience (Posch, 2018). The authority or credibility of the persuader may be the resource of this proof. The proof by ethos is to make a good impression, by the way, you build your speech, to give a self-image capable of convincing the audience by gaining their confidence (Charaudeau & Maingueneau, 2002).

Psychiatrists that I interviewed use "we" as a subject of their sentences while talking about their practices and experiences. "We" signifies all psychiatrists. They are choosing the

topic as ‘we’ signifies that they share responsibility with all other members of the profession. Besides, they take advantage of the power of the status. Being a psychiatrist and adopting the same discourse with all the members of the profession brings the authority of medicine together.

In spite of the certainty of discourse, while psychiatrists conceptualize ADHD’s physiological causes, their discourse transforms into an absolute uncertainty while discussing teachers’ and parents’ declarations. For example, Ms. D, a junior female psychiatrist, works at a public hospital, emphasizes several times that she doubts the accuracy of her diagnostic and treatment decision in the following extract. The possibility of misdiagnosis does not fit well the discursive certainty that they have about a neurobiological disorder. This only changes in one case; while they are mentioning misdiagnosis or unstable, hesitant cases.

*Ms. D: “(...) I often think that **I miss** (the diagnosis of) attention deficit... For example, you know, a teacher says there is no problem, but for the family, there is a problem, or I think I misdiagnosed. I believe in family, and I start (to medicate); for example, the child does not benefit. **I misdiagnose**... So, I think **I misdiagnosed**, the child does not benefit at all (from medication). So, if he/she has ADHD, we expect to observe benefits. Here is the anxiety that can emerge under this. I may lack attention due to anxiety or depression, and I may have missed it and misdiagnosed ADHD.”*

Etiological certainty is not accompanied by diagnostic certainty. It is a feature of clinical judgment. Even for a disease with definitive shreds of evidence such as cancer, the traces displayed may not determine the exact diagnosis because clinical evaluation includes prognosis, uncertain predictions, and patient response to treatment. Certainty should not be reduced to etiology. There are degrees of certainty in clinical judgment. This contrast between neurobiological certainty and diagnostic uncertainty is indeed interesting to study. If neurobiological certainty is not based on a screening test for this person, there is, in fact, no certainty.

On the other hand, ‘I’ takes the place of the usage of ‘we’, when psychiatrists have some doubts. According to alteration of subjects, it may not be wrong to say that these doubts cannot be derived from the psychiatry itself but from the psychiatrist’s individual failures. To understand the *subjects* of the power, we should look at the subjects who speak loudly and consistently, thereby establishing the interactional control (Fairclough, 2014).

Foucault (1982) argues that subjective experience cannot be explained with the universal structures of theoretically determined human nature. Because the forms of experience are historically established to respond to specific needs, they are singular. Thus, subjective experiences should be evaluated within their singular historical context. However, he opposes a pro-Marxist tradition that does this historical analysis within a social context determined by base and superstructure. Otherwise, the subjective experience would be ultimately reduced to economically determined ideological contents. Foucault (1982) shows us how the subject and subjectivity are established via discourse and its relationship with power functions. If we return to our previous example, Canguilhem (2013) explains why subjectivity is not something that we have to escape from; on the contrary, it is a fact that we should embrace. My observations and analysis of my data set in Turkey clarify a continued existence of subjectivity, but it is undoubtedly hidden behind a paradoxical discursive cloud.

3.3. Three Moral Scenes from Psychiatrist's Clinic

In her study, Mikka Nielsen (2018) uses Cherly Mattingly's (2013) Three Moral Scenes model to frame the implications of being diagnosed with ADHD in adulthood. She conducted her fieldwork in Denmark. She focused on the implications of being diagnosed with ADHD. Nielsen (2018) benefits three moral dimensions conceptualized by three moral scenes to explore adults' self-understandings with the ADHD diagnosis. Her study firstly inspired me to argue Mattingly's moral scenes from the psychiatrist's perspective. As a judge in the trial, as an artisan in the workshop, and as a scientist in the laboratory, I analyze their effect on the construction of children's subjectivity as a result of these roles. Secondly, my fieldwork was conducted within a completely different social, moral, economic, cultural context than Denmark. To be able to observe similar moral implications of ADHD diagnosis in these different contexts leads me to think that even if some aspects of discourse is shaped locally, on the other side, specific moral values may globally maintain the validity of ADHD diagnosis, which is the most frequently seen psychiatric diagnosis category in many parts of the world.

The trial, which is the first moral scene, is a setting in which primarily the child is assessed to comply with society's moral values. Then parents, teachers, and even psychologists and some psychiatrists take their share of this moral assessment. The allegory between the psychiatric interview session, which is a setting to evaluate one who has deviated from the society within the scope of mental illness, and the trial in which a person's behavior outside of the society's norms is judged and in which the sentence is decided, is not surprising. Mattingly

(2013) understands the court as the moral scene in which the moral ‘I’ was born. Inspired by Nietzsche, one comes to the courtroom to hear a decision about their acts, so they must speak and try to legitimize their behavior. In contrast to Nielsen’s conceptualization (2018), in a child and adolescent psychiatry session, the representative of children’s subjectivity is their parents, and they must speak to legitimize children’s behavior. Defending children’s behavior is likely defending their parenting because they are responsible in addition to being the representative of the child.

Dr. Osman Abali (2009/2015), who was born in 1972, graduated from Istanbul University Medical Faculty in 1997, and who is the founder of the forensic child and adolescent psychiatry unit at the same university, defines five steps of diagnostic procedures of ADHD in his book *Hyperactivity and Attention Deficit* aimed at the general public.

“The first step is a psychiatric examination by a child psychiatrist. (...) In the second stage, information about attention deficit and hyperactivity is obtained from the child's family and the child's symptoms since we are trying to learn about the past. (...) At the third stage, the behavior of the child at school is evaluated. (...) The fourth step is to do psychometric tests to get detailed information about comorbidities or functionality. (...) Finally, if necessary, organic examinations are performed by the doctor (EEG, blood tests, etc.), and if necessary, a neurological consultation is requested (p. 125-126).”

Psychiatrists take an *anamnesis*, judge the past of the child and family. They also investigate the existence of symptoms since the mother's womb. School success and social life weaknesses are examined, and a clinical judgment is justified. According to my observations in the interviews, the fourth and fifth steps do not really impact clinical judgments. Nielsen (2018) works with adults, so she defines this point after the justification of clinical judgment as to their taking responsibility and fulfilling the requirements. It means starting treatment. However, in my study, there is a family that should take responsibility; in fact, it is not only the child who is judged but also the family. Did the family manage to raise the child, or did they fail? What are their responsibilities in this process? Can they solve problems with behavior manipulation? Can they continue drug treatment without disruption?

According to Annemarie Jutel (2011), diagnosis is like a road map not to be lost. Even if it does not help improve the situation, it helps in understanding it. In the other fields of medicine, a doctor needs a diagnosis to frame the patient’s condition and manage the treatment. After the doctor, the patient needs an explanation to help interpret his/her condition and

cooperate for treatment. In child and adolescent psychiatry, the importance of the diagnostic decision is primarily for parents. It makes the situation for doctors and parents more transparent. Particularly for ADHD cases, clinical judgments include moral judgments for parents, and the announcement of neurobiological disorder confirms that the family does not bear moral responsibility. According to Nielsen (2018), being diagnosed gives rise to some moral questions such as, “Who are you as an individual, and what are your responsibilities?” Because “a specific moral *I* is produced along with the diagnostic process, as responsibility is paradoxically both installed in and taken away from the individual.” Again, in my study, the questions are for parents, as well. Are you a good parent? Or can you really be responsible for neurobiological disorder?

A specific moral *I* is produced by psychiatrists and parents; they take all the responsibility for children or future adults because the subjectivity that they shape through diagnosis and pharmaceutical intervention is crucial while imagining their adult version. One of the main criteria of functionality is school success (Chapter 4). A good school life determines a good professional carrier, and it is essential for a good citizen (Davis, 2006). The other criterion of being functional is controlling impulsion, in other words having the self-control to prevent the risks individually and socially in the future (Chapter 5). Thus, the main interest of shaping a child’s subjectivity may be interpreted as governmentality. In this process, the psychiatrist as a judge is the ultimate decision-maker with his/her authority is capable of judging teachers, families, and children.

Ms. F: “The ADHD symptoms may worsen because the family does not handle them well. Maybe if the family can handle them better, some children can recover a little more without any drugs. I observe that the family can't handle the situation well, or the teachers can't handle it well. Secondary traumatization in the child occurs or will occur or if I see such a risk. I definitely recommend drug treatment because there may be different comorbid things in the future. And the family story is essential. Suppose there are family members with ADHD, behavioral problems, or adult personality pathologies. In that case, the child is more at risk, and I usually inform the family about the importance of drug treatment. If the child does not have a severe functionality problem, the family can handle it well, believes they can do it, listens to our advice, and if he doesn't prefer to use medication, then it is better to recover without medication. Coping skills are also critical here. But our people

(laughs), well generally the socio-cultural level is important. Families who fail to manage well and environmental factors worsen symptoms.”

Cherly Mattingly (2013) defines the second moral scene as the artisan’s workshop, where practices are cultivated. Psychiatrists, who listen to a family and observe a child in their office, are in a responsible role in transforming the dysfunctional material in their hands into a functional one through his/her knowledge and merits. The workshop is where “artisans carefully, painstakingly fashion their craft, following exacting aesthetic standards” (Mattingly 2013: 303). Unlike the trial where judgments are decided, an artisan's shop is a more creative and productive morale scene. Since Nielsen (2018) works with adults, she interprets it as a workshop that the individual uses for his/her own transformation. I only observe this in the psychiatrist’s role because children are still passive here. However, we can say that instead of the child, the family transfers their aesthetic judgments to the psychiatrist and that they are influential in the clinical decision. So, the family takes its role in this workshop scene for the transformation of the child. Shaping the future motivation that the psychiatrist owed herself is building the artisan’s workshop.

Ms. F: “The family story is also important. If there are some family members with ADHD, behavioral problems, or adult personality pathologies, the child has a very high risk. In this case, I am talking about the importance of family members using drugs. (...) So, if they are violent, we may not be able to prevent it. It will worsen the child's troubles and initiate additional problems such as sleep disturbance or anxiety problems. Behavioral issues can be triggered. It is evident that adults cannot change themselves very much. Unfortunately, even though I don't want to, I have to start medication only because the child is exposed to trauma by his/her family.”

Nielsen (2018, p. 901) states that the psychiatrist’s intervention that includes drug prescription, therapy, or daily life tips is “a moral, self-disciplining exercise through which the individual crafts him or herself by addressing certain difficulties and following certain guidelines offered by the diagnosis”. The moral scenes established in a child and adolescent psychiatry clinic is slightly different. Treatment and behavioral interventions are moral and disciplining exercises, but psychiatrists exercise them. In most cases in Turkey, either psychiatrists do not inform children about the diagnosis or explain that they have a problem in their brains. In two cases, they do not have any capability to craft themselves. Our artisans are the only people who have the power to shape children’s subjectivity.

Remarkably, the books that are written for the general public contain many case examples. The narrative in these cases is established from many perspectives, such as family members, teachers, mental health professionals, etc. The narration starts with old “I” from various points of view, then psychiatrists arrive with drug treatment as if touching a child with a magic wand. In this way, the child changes, and ‘a new I’ comes. The language of case studies is not a medical description; it is like storytelling. Transforming the narration of case studies into storytelling aestheticizes the effect of the drug on moral changes.

“Mehmet started kindergarten at the age of 4. His parents realized that after he started walking, he was extremely active. (...) Within the first week of starting kindergarten, his teacher complained about Mehmet's extreme mobility and his inability to fulfill duties. (...) Along with the problems, the tension between the school and the family also increased. They tried many kindergartens until primary school, but the result did not change. The same problems recurred when he started primary school at the age of six. He could not sit down without disturbing those around him. They saw a child and adolescent psychiatrist at the teachers' request, and Mehmet was diagnosed with ADHD. Behavioral therapy and parent education previously tried had not been very useful. 5mg short-acting methylphenidate was given both morning and noon. When the drug dose was 10mg twice a day, positive changes began in both Mehmet's behavior and learning. It is how cooperation between the family and the school was created (Semerci & Turgay, 2014, p.63).”

The third scene is the moral laboratory where everyday experiments are carried out: “Spaces of possibility, ones that create experiences that are also experiments in how life might or should be lived” (Mattingly, 2014, p. 15). In their moral laboratory, psychiatrists test the effects of drugs on behaviors and daily life goals and modify dosage forms (Nielsen, 2018). Mattingly (2014) describes moral laboratories as "experiments in hope and possibility." Since the issue here is working for the person's positive transformation, the daily life practices, doubts, hopes, and choices of the person are examined. Mattingly (2014, p. 63) argues that all ordinary everyday scenes are moral experiences. The daily is defined not only as “routine or the repressive but also by the new and the unexpected.” Nielsen (2018) describes methylphenidate treatment as an "experiment in hope and possibility" for ADHD. It is also a real experimental process because the effects of the drug, usage intervals, and doses are based on observation and experiment. Her study is based on the perspectives of adults with ADHD. This is why she states that the diagnosed person must use the drugs *to become that 'I'*. In my

study, using the child and adolescent psychiatrists' perspective, I observe the agents of creation of the moral 'I'. It is still based on experiments in hope and possibility, but not one's own hope. The psychiatrists' and parents' willingness to help children controlling their behaviors is the primary resource for hope and the transformation for 'good'.

I have encountered almost all of the discussions related to hesitation experienced in determining the symptoms' source. Each psychiatrist adapts his/her methods according to the context of their clinical practice. An experienced, also the oldest participant is a psychiatrist from Adana, a southern city known for the hot temperament of the people living there, describes the prevalence of the bipolar disorder in their region, and states that it is hard to distinguish them. Thus, she sometimes uses the effects of drug treatment to understand the diagnosis.

Ms. A: "(...) For example, bipolarity generally mixes with hyperactivity. There are so many bipolar cases in Adana. The distinction between bipolarity and hyperactivity is complicated in Adana. They are the people of a warm climate, so sometimes the drugs determine the diagnosis. If we cannot decide, we try the drugs. If the patient is bipolar when he takes the stimulant, his symptoms increase. Mostly it's mixed up with bipolarity. (...) Bipolarity is the same as childhood hyperactivity. It could be together."

The same psychiatrist has two areas of expertise, the first one is adult psychiatry and then child and adolescent psychiatry, therefore she can expand her experiments on parents. She has not only a humorous but also a sarcastic tone while speaking about parents. When she says *slap*, she does not mean it literally but figuratively. She describes any intervention to parents' attitudes as a *slap*, so she takes advantage of her adult psychiatry expertise and prescribes drugs to parents. As she emphasized, that is mainly for fathers because they are more aggressive and impulsive. I have other psychiatrists among the participants who have expertise both in adult and child psychiatry, yet her usage of drug treatment for parents, as I see it, is unique.

R: "Do you think parental attitudes are important in the occurrence of symptoms or handling them?"

Ms. A: "Of course, it's crucial because we (Turkish people) do not have any concept of discipline. Firstly, the parents deserve a perfect slap (she laughs). But they are not aware of it, and they think that the kid deserves a slap. But I start the drugs for fathers as well. I say let's use together (she laughs), so then I have two fields of

expertise (adult and child psychiatry), and I am comfortable (she laughs). (...) It is so good to know the side effects, etc. Because sometimes they are afraid of observing it. I recommend first using drugs for fathers, and then for children. It works really well. (...) There are a lot of benefits. At least the guy gets his impulsivity under control. I mean, he's learning not to beat."

3.5. Children: Vulnerable Subjects

In this study, I focused on childhood ADHD and child and adolescent psychiatrists because I thought that it was also possible to read the effects of ADHD on adults while analyzing childhood as a period when the subjectivity was constructed. The other reason why childhood ADHD generated my research interest is that this diagnostic category is identified as a lifelong condition. In other words, ADHD, which defines the children of today, represents the adults of tomorrow. This condition, which has been frequently diagnosed since the 2000s, constructs an ADHD-generation that reaches adulthood by the 2020s. Thus, empirically discussing these adults' subjectivity will be possible in the coming years. However, focusing on the construction of subjectivity through ADHD will allow us to zoom onto this generation's diagnostic culture, as well.

Today, a child diagnosed by a medical institution is now recognized with this qualification of 'being ADHD' or 'having ADHD' both at home and school. This adjective passes to his/her identity. Because of the symptoms, it contains, it is easy to generalize the causes of all situations and movements. It should not be understood only negatively. It is because, as I observed thanks to my data set, children may be stigmatized by their teachers because of taking drugs in some cases, and/or they may have various institutional supports that are legally acquired, such as taking their exams alone, taking additional courses, having an adapted assessment, etc. Moreover, the share of the practical benefit—especially in the education system—of this diagnosis category is crucial in its growing prevalence. As a result, the child diagnosed with ADHD is now most likely to hear this qualification, and he/she is subjectified and objectified with its attribution.

"It is difficult for children to perceive and express the symptoms of ADHD in themselves. In some cases, however, children complain about their excessive mobility, their inability to pay attention to the lesson, or not to behave positively (Ercan et al., 2008, p. 9)."

In the case of Turkey, children are positioned as muted and passive objects during the decision process about diagnosis and treatment. They are not considered as individuals. This approach does not only exist in clinical practice but also is a cultural fact. In Turkey, adults always use an infantilizing language, and they think that children cannot understand anything. So, it is not surprising to see the same attitude in psychiatric clinical practice. Some psychiatrists do not prefer offering any explanations as to why children are using medication.

Mr. K: "I don't explain anything to children. I explain to families. Children generally don't worry about the issue, plus because of the biological aspect, the things in the brain, etc., I think they will get confused when we talk about the genetic factors, I sometimes say something like this; something in the brain works unstably, so we correct its balance. I can explain a little more suitable depending on age and cultural situation, but these questions generally come from the family."

Although theoretical sources define a standard in the diagnostic and treatment process, I have seen that each psychiatrist has his/her own attitudes and behaviors in practice. This feature is also relevant to the issue of where children are placed in the treatment process. Some psychiatrists do not believe that an explanation should be given to them, while others believe in the importance of including them in the process. One young psychiatrist working in Istanbul, at one of the biggest psychiatric hospitals in Turkey, even criticizes his colleagues because of the lack of relationships with children.

Mr. J: "Physicians working with children should remember that they are primarily the doctor of the child. Unfortunately, some of our colleagues forget this."

Taking the previous extract, it is possible to argue that this psychiatrist from a private clinic is aware of psychiatry's transformative power. He objects to the medicalization of children; however, he highlights parents' persistent demand for prescription, as I analyzed with his extract in Chapter 3. According to this, some parents try many different child and adolescent psychiatrists until having a stimulant prescription. Here, he insists again that children's subjectification by the expectations of parents and teachers through psychiatry.

Mr. H: "Especially in the early stages of life, we shouldn't give medication to children unless they are in a tough situation, and we should try to solve problems with drug-free approaches as much as possible. It is my personal disposition. According to WHO, the criteria of being a child should be followed. In childhood, children usually come in line with their family's direction and wishes, but they think

that they have a problem within themselves when they pass into adulthood. At that point, we can talk about the individual's free will. They come through their own decision. But in childhood, the expectations of the family and the educational system bring them to a psychiatrist. Actually, they are victims."

Children are discursively established as vulnerable creatures by some psychiatrists because they need social support in life. According to psychiatrists' discourse, it is essential to prevent a child's self-harm when they are under five years old. The emphasis is evolving on the maintenance of academic success among school-age children. These children should be treated in adolescence before the problems transform into disruptive behavior disorder or substance abuse. Children's vulnerability is derived from the place of a child in a modern society that necessitates profound adult attention. It is easy to follow this modern phenomenon in contemporary Turkey. As a result of late modernization and the survival of rural communities, traditional authoritarian parenting has continued. But the new generation of parents who came into an industrialized world and who were raised by conventional parents adopt revolutionary new parenting against their parents' style. Their parents were the first, or maximum second generation, of migrants to big cities. But the new generation parents were born in big cities, and are relatively well-educated compared to their parents. Several psychiatrists think that the traditional parenting that new generation parents were exposed to cause those parents not to want to draw boundaries as their parents did for them. As a result, parents are not capable of disciplining their children and sometimes cannot even provide the necessary security. The psychiatrists legitimize their defense of intervention to position children in a vulnerable manner because of their parents' unconventional attitudes. In Chapter 3, I argued that psychiatrists' observations vary according to the social status of parents. Here, we also see that this irregular parenting is attributed to more wealthy families.

A young psychiatrist that I interviewed conveyed a quotation from one of her professors in the medicine faculty: "*There has never been a period when children were so cared for but so unhappy.*" Then she added that since she started her profession, her experiences often confirmed her professor's statement.

Secondly, as I scrutinized under the title of social categorization, psychiatrists deresponsibilize parents, and the deresponsibilization of parents signifies the non-functionality of behavioral regulations in the family. Because "*they can't,*" "*they are not capable of*" doing otherwise. This inadequacy generates the second layer of a child's vulnerability for some psychiatrists. Their parents do not help their children. Moreover, many children are exposed to

violence by their parents, particularly in rural areas. The effect of violence on children was described as secondary traumatization by some psychiatrists, and they offer it as a valid reason for the diagnosis, even they are conflicted. The violence makes a child needier in psychiatrists' eyes.

These two reasons that generate the vulnerable position of the children reinforce once again the power of psychiatrists. They perceive themselves as the rescuer of children, but the only tool that helps them is medicalization. They do not have enough time, but if they did, it is unimportant because the parents are not capable of following their instructions. On the other side, they intend to defend children's subjectivity.

"Significantly, the fact that the children say, "Mr. Ercan, I am one of the hardworking students in the classroom now," "I do not upset my mother and father at all, they do not shout at me," "my friends love me now, they want to play with me" makes me like my job even more. When school children say, "my teachers are asking me If I cheated in exams because my grades have increased," "I did not need to fight with my parents that much," "I used to be abused a bit by my friends, now I have a group of friend that is more suitable for myself," "I voluntarily go to my room and study, my parents are surprised" and "I have different plans for the future," all my tiredness decreases (Ercan, 2016, p.14-15)."

Foucault (1982) says that his research interest is not power but the subject. While economic history and theory are tools to understand production relations, linguistic and semiotics are tools to understand concerns of signification. However, there is no tool to make possible the study of power. Just by looking at legal models, we can study what legitimates power, while building power on institutional models, we can focus on the state. But Foucault defends the need to expand the definition of power. By extending the meaning of power, he investigates "the power of men over women, of parents over children, of psychiatry over the mentally ill, of medicine over the population, of administration over the ways people live (Foucault, 1982, p.780)." In my current case, I see that it is possible to argue that the power of psychiatry over parents, teachers, and children—even it is hard to say mentally ill for them—and the power of parents and teachers over children. This exercise of power eventually constructs the subjectivity of children. So, can we say that invisible power practices from all quarters shape individuals in our age?

In my study, I have no tools to demonstrate psychiatrists' power on children and even parents and teachers. But analyzing subjects and subjectivities makes the working of power

visible. It has been 59 years since Foucault wrote the history of madness. And is the power of psychiatry still functioning as he predicted? Or has it changed its methods and practices? What do the madmen who have been locked up in madhouses and the children who cannot focus on their lessons have in common? Is psychiatry always the same psychiatry, and does it work in the same way? What about the political, economic, and social context?

The social and political use of power is the product of the aims and desires of humankind. These goals and desires are in continuous motion. Do we really think we can still construct universal normative criteria during this motion? It is like rejecting the ‘realities’ that can exist and be analyzed in many different ways and choosing a non-existent, fictional, single, and concrete reality as a working object to ourselves. Instead of discussing the phenomena that we should discuss, we are talking about something else and producing its knowledge because this is the position that enables us to have power and sustain it. This is our individual interest, and socially this power allows for social control. Methylphenidate makes the ‘intolerable’ behaviors by a society tolerable, and the psychiatrist who deresponsibilizes all other agents of diagnosis and treatment process precisely this function.

“The conclusion would be that the political, ethical, social, philosophical problem of our days is not to try to liberate the individual from the state and from the state’s institutions but to liberate us both from the state and from the type of individualization which is linked to the state. We have to promote new forms of subjectivity through the refusal of this kind of individuality which has been imposed on us for several centuries (Foucault, 1982, p. 785).”

Foucault (1982) shows that we should not focus on the subject to explain the subjective experience. Still, we should analyze the discourse that constitutes this experience and the power in a mutual and inevitable relationship with discourse. He undermines the inseparable relationship between power and subject and makes a powerful critique of science by revealing the role of human sciences in establishing subjective experience. Foucault’s problematization is based on three dimensions: knowledge, power, and ethics. According to this conceptualization, each experience concentrates a knowledge sphere that includes certain notions and theories and produces its own truth; a power sphere that contains certain norms and orders; and a specific relationship form that an individual establishes with him/herself in the context of these knowledge and power spheres.

“Discipline classifies the components thus identified according to definitive objectives. What are the best actions for achieving a particular result? What is the

best movement for loading one's rifle? What is the best position to take? What workers are best suited for a particular task? What children are capable of obtaining a particular result (Foucault, 2009, pp. 56-57)?"

In Turkey's case, the reasons for the behavior of children are explained by what is going on in the brain, and their solutions are sought there. Discursively, the subjective evaluations, tolerances, and expectations of parents and teachers are observed in this process. However, these evaluations do not cause the diagnosis category itself to be questioned. The socio-cultural status of parents and teachers, the weaknesses of the education system, or the characteristics of our age are being examined. Still, the question of whether ADHD diagnosis should be considered in any other way is not asked because this questioning depends on the existence of conceptual knowledge. I asked the question, "do you follow critical studies/other approaches about ADHD" in my interviews because of the absence of counter-arguments and critical studies according to the analysis of printed and visual materials. All interviewees' answer was 'no,' or that they knew only about speculations and absurdities. The answers show that they do not have any theoretical tools other than a bio-medical approach to understanding or criticizing ADHD. Therefore, they cannot conceptualize their observations and add them to their practices. To sum up, they talk about subjective experiences. Still, they only produce an ambivalent, self-contradictory discourse since there is no place for subjective experience from the theoretical perspective they work within.

3.6. Conclusion

Within the understanding of ADHD, psychiatric discourse conceptualizes a child with ADHD as non-functional. Thus, the aim of the ADHD diagnosis and eventually treatment is to make a child more functional. The need to shape a child functionally is based on the need of functional adults. These adult groups—psychiatrists, teachers, parents—who judge children's functionality theoretically are assumed to be mature and knowledgeable enough to shape and guide children. Children are defined as innocent, needy, and requiring to be shaped like a sculpture in the hands of adult sculptors. When a neoliberal context is added to these definitions, the child is coded as a project. This project should be accomplished both as a medium where families and teachers can exhibit their satisfaction and success in terms of social benefit. Then, at some points, discursively, teachers may be unreliable (Chapter 4), parents may not be capable of handling their children's problems (Chapter 3). The only source for this project's success is the psychiatrist, and the clinical decision is shaped in this way.

In this chapter, I explored these sculptors' self-narratives who have a crucial effect in raising new generations in the modern Turkey of the 21st century. Of course, "the biomedical practitioner" that they introduced in books, congresses, articles, mass media, and the "humanistic practitioner" I have met in the meetings are the same people. But why do we prefer to ignore this humanist practitioner in producing knowledge of psychiatry? The two modes of cognitive functioning defined by Jerome Bruner (1986, p.11) discovers that the manner of knowing determines the differentiation of these practitioners. Paradigmatic knowing "attempts to fulfill the ideal of the formal, mathematical system of description and explanation. It employs categorization or conceptualization and the operations by which categories are established, instantiated, idealized, and related one to the other to form a system" (1986, p.12). Yet narrative knowing "deals in human or human-like intention and action and the vicissitudes and consequences that mark their course. It strives to put its timeless miracles into the particulars of experiences and to locate the experience in time and place" (1986, p. 13). These two types of knowing are complementary. The attitude of producing knowledge that I observed in the Turkish child and adolescent community is based on ignoring narrative knowing. It is possible to discuss these two modes of knowing and the practitioners who apply them to their clinical practices for all the fields of medicine. However, psychiatry differs epistemologically from other types of fields because there are no objective measurements to lead to clinical judgment. Therefore, ignoring narrative knowing becomes more important when discussing the psychiatric clinical decision. So, as Feinstein pointed out, "the clinician is an apparatus of scientific measurement," Therefore, there is a social, cultural context in which this clinical apparatus was born. This apparatus was trained in an education system, where children were studied and judged academically. They grow up with the moral values of the society which these children were labeled as non-functional and naughty. As they tell in their family stories, their future is often shaped around their family's decisions. So, these apparatuses are not independent of social interactions, such as a blood test or MRI instrument, and therefore their decisions are not value-free.

Psychiatric diagnostic categories, which are defined biomedically in Western societies, are self-interpretation tools (Jutel, 2011). Today, more and more people understand and present themselves with these diagnostic categories. Besides, other social actors such as family members, friends, teachers, co-workers also use these diagnoses to frame a person. This diagnostic culture (Brinkmann, 2016), which also creates its own language, is an essential component in the construction of subjectivities.

4. Social Categorization of a Diagnostic Category According to Expectation and Compliance of Families

"In a splintered world, we must address the splinters."
Geertz (2000, p. 221)

This chapter is devoted to the clinical interpretation of families' help-seeking behavior. The families' expectations and compliance with treatment vary according to their socio-economic status and their expectations and coping skills observed by psychiatrists, which has a role in the decision-making process. I will observe parents as a mediator between the private and public sphere and as agents for clinical judgment in this chapter. According to DSM criteria, defined symptoms have to be seen at least in two different settings. One of these settings is the psychiatrist's clinic, where they shape their judgments about a child. The other setting that psychiatrists are obliged to verify their observations is home and school. The parents are the agents of giving information from the private sphere, and the teachers declare the behaviors of children in school. In sum, there are three actors in this process, and the responsibility associated with the three main settings in the life of a child: psychiatrist, teacher, and parents. This chapter's focus is observing parent's mediation to the clinical judgments of psychiatrists, and by these means, I explore the agency of parent's subjectivity in constructing children's subjectivity.

Many scholars in the history of psychology (Bowlby, 2005; Rutter, 1985) highlighted the role of family dynamics in the emotional and behavioral development of the child, and they argued that family dynamics is one of the essential elements of treatment in many clinical fields of child and adolescent psychiatry (Diamond & Josephson, 2005; Josephson 2007; Kazdin & Weisz 1998). However, psychiatry takes a more individual, non-relational attitude under the influence of neuroscientific knowledge, which is the current trend. However, the individualistic approach is not the same as the approach where qualitative research tries to read the individual uniquely. The natural scientific view acknowledges "the individual being studied as explained in general terms" (Moen, 2014, p. 56).

Child and adolescent psychiatrists in Turkey define ADHD as a neurobiological developmental disorder following the dominant scientific paradigm. However, their discourse indicates that they do not understand children independently of the family and that their

symptoms and families' need for psychiatric help are related to their socioeconomic level. The controversy over whether mental illnesses should primarily be understood as biological or psycho-social (Luhmann, 2001) also manifests itself in this data set. The psychiatrists that I interviewed in various cities of Turkey resort to social categorization in the clinical decision process to reduce the uncertainty that exists due to the nature of mental disorders. Social categorization means the process by which people divide themselves and others into groups. This process facilitates the perception and cognition of the social world. It works by detecting similarities and/or imposing a structured mechanism. The fundamental function of social categorization is that it simultaneously allows and limits inductive derivations. People attribute character to individuals according to the groups they create in their minds. Then they generalize these characteristics to the whole group, and these form stereotypes. Social categorization is based on detected similarities. The consistency between these similarities is a matter of family resemblance. Family resemblance categories have uncertain boundaries and tend to correlate with each other (Krueger, 2001).

Within the scope of my dissertation, I choose the word parent to define the caregivers' role in the clinical judgment process. Because the differences in participating in the process of nurturing are not the focus of my study, even if it is in parentheses, I need to share my observation that mothers are more involved than fathers during the ADHD diagnosis and treatment process in Turkey. There are many studies in the literature focusing on this issue. Although ADHD is defined on a neurobiological basis, the studies show that mothers of ADHD children are exposed to mother-blaming attitudes or language in various contexts (e.g., Benett, 2007; Malacrida, 2004; Singh, 2004). Understandings shaped around the *good mother* myth cause mothers to experience this blaming (Singh, 2004). Like the absence of fathers in the ADHD diagnosis and treatment process, their absence in the literature is notable (Brunton et al., 2014). Singh (2003) mentions that fathers make more ambivalent statements in one of the rare studies available and tend to describe their son as "boys will be boys."

4.1. Childhood vs. Parenthood as Cultural Categories

Historically, the connotations of childhood and parenthood vary. Heywood (2001) distinguishes the social history of childhood from its cultural history. The second is more important to him than the first. For him, the cultural history of childhood passes through understanding what adults think and feel about children. Social history, on the other hand, means re-enacting what childhood has gone through day by day. In the pioneering work of

childhood history, Philippe Ariés (1997) concludes that the idea of childhood did not exist in the middle ages. Yet, it does not mean that this society abandons or neglects children. The signification of childhood was different than its contemporary meaning. He defines it with the lack of awareness about the precise nature of childhood, and he follows the awareness level and the forms of relationships with children during centuries. In the 13th century, children did not even need their death records kept but in the 16th century started to be bundle up with a coddling attitude. The moralists and pedagogues of the 17th century objected to this attitude because of behavioral and moral inquietude. Coddling has been belittled and attributed to the lower classes. As the centuries passed, the duration of childhood extended. In Western societies, institutions determine the organizations of age groups. Until the 18th century, the French educational system had a single school. After the 18th century, the system transformed into dual schooling, which is not based on age groups but social classes. Primary education was organized for the lower class, and secondary education was for the middle class. The expectations from children in lower classes were more adult-like to participate in the production system, so they were not dependent on their families for a long time. The 19th century could be defined as the beginning of child-centered societies. The emergence of psychoanalysis, pediatrics, and psychology led to more outstanding knowledge production about children's problems, which also considered parents. Childhood was now defined as a protected time and space (Postman, 1994).

That is to say, the issues that I will focus on in this chapter—help-seeking behavior, interpretation of symptoms, diversifying schooling needs regarding the symptoms that change according to the socioeconomic status of the families—are not historically new issues. In different periods and completely different societies, the child's relationship with the academic life, social and moral values that change according to class determine our expectations from the children and how we shape their behavior.

Transformations after world wars (Ariés, 1997), the shifting place of children in the production process (Zelizer, 1994), and the new school system (Postman, 1994) revolutionized the position of the child both in the family and society. Zelizer (1994, p.3) defines the child's new statue as “economically worthless but emotionally priceless.” Increasing the value of the child brings with it a need to control it. Children have always been a part of society, but adults' pattern of recognition has changed because the relationship of adults with children has evolved from age to age. This relationship's determinant is forms of control shaped based on hierarchy, age, and social relations (Jenks, 1982).

The emergence of the contemporary notion of childhood accompanied the invention of motherhood and fatherhood (Mechling, 2011). Just like the meaning of the child, today is relatively recent; the meaning of parenthood is just as recent. Therefore, modern responsibilities attributed to parents are historically and socially constructed. The necessity of controlling these raw subjects increased based on the increasing moral value of children in Western societies. Correspondingly the responsibilities surrounding children are more structured and institutionalized. "Expectations and responsibilities became more serious and enriched as parents evolved into guardians, custodians, protectors, nurturers, punishers, arbiters of taste and rectitude" (Postman, 1994, p. 44).

Two significant breakdowns can be described historically in the role of the parent. The first stage we can define as the domestication of childhood starts with introducing children from the streets into safe houses. The second is the modern Western world becoming increasingly child-centered. For instance, UNESCO's (2016) strategy plans that have focused on education in the past years have evolved into "education for better health and well-being" in the 2016-2021 strategy plan. The focus on psychosocial skills as well as bodily harm directs international strategies concerning children and childhood. These shifts increased the separation of parenting and competence definitions among gender roles. While the child is restricted to the domestic area, the parents are defined as responsible for the child, providing care and education. In connection with these, childhood is closed to the private space in the missions that actually belong to the public sphere, such as the child's health and education.

Although children's rights are recognized and accepted in the Turkish legal system in line with international conventions, children may face undesirable situations and violations of rights due to various social, cultural, and economic reasons within the social structure (Guclu, 2016). Although Turkey has experienced many changes in harmony with the modern world, today, it is considered as a country between the west and the east with its geographic situation, political history, and cultural characteristics. Turkey is also a country, which, in other words, is in the transition from traditional to modern society and from an agrarian society to industrial. For instance, although there have been important reforms regarding education since the early 20th century, girls' education is still a problem. According to 2008 data of the Turkey Statistics Institution, 61% of the children remaining out of school are girls (Ahioglu-Lindberg, 2012). Guven Gurkan Oztan (2011), in his work titled *Political Construction of Childhood Turkey*, proposes that children were built as children of the republic in the early period of the Republic of Turkey. This child is imagined as equipped with militaristic and nationalist qualities and

capable of meeting a young republic's economic and human power. Within the framework of these goals, child care has been rationalized, and the concepts of obedience to authority and discipline have been placed at the heart of national pedagogy. In this study, Oztan (2011) argues that discovering the children's subjectivity overlaps with the political project of their objectification in Turkey. Parallel to this coincidence, childhood's political construction takes shape within the framework of the ontological superiority attributed to authority and the naturalized didactic style. The authority that is existentially placed in an absolute position is largely the only determinant of infallibility, and the categorization of absolute good and absolute evil is attributed to it.

Bekir Onur (2005), a scholar in developmental psychology inspired by Aries, focuses on analyzing Turkey's social and cultural history of childhood regarding memories. According to him, despite the indifference of Turkey's scientists to childhood, the early Republic literati were aware that the concept of childhood changed depending on time and space. Before sociologists and anthropologists, they stated that the childhood of their period was different from the past and that urban childhood was different from rural childhood. Ahmet Hamdi Tanpınar (1902-1962) writes that child is a discovery of the twentieth century. Tanpınar points out that children in the past have been described as minor versions of adults, but then childhood was treated as a life period in its own right. Onur (2005) gives another example from Yasar Kemal (1923-2015), who grew up in the countryside of Adana, where I also did one of my interviews, and who presented in his works in-depth descriptions of the people and lifestyle of that region. "Nobody treats me like I'm a kid in the village. Neither do they treat other children [that way] ... When I left the village and migrated to the city, I realized that the children were children (Kemal, 1993, p. 48 as cited in Onur, 2005, p.13)". However, he does not claim that children are important in the city and worthless in the village. He adds that they are no different from adults in the town, that they listen to great epics until the morning from the traditional storytellers, just like adults, and nobody says that you are a child, you cannot understand these great epics.

Onur (2005) determines his study's central axis as modernization because the last 150 years of modernization movement in society is also reflected in childhood. He shows various examples from many literary figures who claim Turkish society attributes great importance to its children and interrogates: if this argument is correct, how can we explain the still high child mortality rates even in the Republican period, low schooling, very little participation in pre-school education? He concludes that the educational research in Turkey does not usually deal

with experiences. In other words, it does not examine what children are going through while they are in school or during their education. This is because the researcher does not enter the school, and the school shuts itself and does not allow outsiders to enter, not officially but equivocally. What the child goes through at school in every period as well as in the family is hidden from sight.

4.2. Parents: Mediators Between Psychiatrist and Kid

“Emre cannot stay still in the classroom, never gets along with his friends while playing games, does not pass his homework from the board to his notebook, does not watch the lesson and is busy with other things, and turns the classroom order upside down. Emre has had an ongoing mobility and distraction problem since kindergarten. Let’s suppose his teacher is the most impatient and intolerant in the school. Emre’s parents are also on the brink of separation, and his grandmother takes care of him. The “psychological” conditions of Emre are not very encouraging. (...) The school’s psychological counselor cites possible hyperactivity; the teachers’ reports mention a spoiled child and a careless parent. The grandmother says that the relaxing methods that were valid in the past do not work now, and the English teacher says, “I have no problems.” The father says that it is the school’s problem. Before these issues arose, the mother told the father, “Let’s go to a psychologist, I don’t know how to train or educate this kid. He never listens to me.” Grandma closes the matter by saying that her grandson has nothing and this issue will pass when he grows up (Yazgan, 2010/2017, p.21).”

Yanki Yazgan is one of the most recognized child and adolescent psychiatrists focusing on ADHD in Turkey. Yazgan (2017) explains the context of a child with ADHD symptoms with such a case in his book *Hyperactive Child at School*. It is a very representative case example to show how an explanation to define a problem changes according to the subject's position. One teacher sees a spoiled child, while for the other, there is no problem. I generalize by saying family or parent, but indeed even mother and father do not have the same positioning either, and on the other side, there are other family members. This whole network of relationships interprets some behaviors of a child from their perspective, and they form a first impression of whether this is a psychiatric problem. Therefore, the story of the psychiatric clinical decision starts here.

One of my interviewees' wish is to perform a psychiatric examination on all the criminals in prisons or faulty drivers in traffic. Still, the limits of clinical authority are not so

wide, at least for now. Clinical authority is only able to examine those who demand their opinions—if there is no legal obligation. Parents' expectations are a crucial factor in requesting psychiatric help for children, and these expectations are based on socio-cultural background. Likewise, their judgments about their children are based on their background, which is expected. Expectations and limits of a family become concrete with the word of *tolerance*. Psychiatrist Ms. F, who works in a state hospital in the southern city of Mersin, mentions *the family's tolerance* in the following extract. Tolerance means someone's willingness to accept an opinion, an action, or a situation, and clearly, it is based on this person's subjectivity, which is rooted in their social imaginary. In this extract, Ms. F claims that a psychiatrist is able to distinguish 'real' complaints and 'parent-based' complaints. Psychiatrist advocates his/her role in deciding whether parents are right or wrong. It is like a kind of judge function, but a moral judge. The decision of the honesty of parents or teachers is a highly moral judgment. Without any objective or measurable tool, behind a professional identity, they have the power of not believing parents' or teachers' words.

Ms. F: "First of all, I... How long have these complaints existed? It is important. In which environments, if it exists only at home if the child has no problem in school, teachers don't think there is a problem, and if our examination is such, we don't diagnose. Mostly, (in this situation) there is a family tolerance-related problem or, you know, in a normal childhood, children can have attention problems, they can show hyperactivity in the developmental process. Sometimes it can be something that supports their development..."

Tolerance is the word that describes the moral subjectivity of families from a psychiatrist's perspective. This level of tolerance determines the threshold between normal and pathological for them. As psychiatrists mention and I analyzed in the previous chapter, there is a mass demand by parents to diagnose and prescribe for ADHD. This bottom-up pathologization shows us that parents in Turkey do not have a very high limit of tolerance. This tolerance may shape by the social imaginary, and the same demand probably is the reason for the significantly increased prevalence of ADHD and drug use. Psychiatrists define it as a tolerance problem of family, and it indeed is. Still, when we look at the prevalence and drug use ratios, these tolerable behavioral problems have been diagnosed by psychiatrists while noticing the inaccurate evaluations by parents.

Ms. F: "(...) In most cases, the problem is based on the threshold of family tolerance. Or sometimes, the lack of attention or hyperactivity that occurs as part of the normal

developmental process can be misinterpreted. This can be a process that supports their development. If the symptoms do not affect the child's functionality, but the family cannot tolerate it, we inform the family, provide psycho-education, and make many such recommendations about attentiveness.”

For the tolerance and handle well issues, the psychiatrist positions himself as a source of power because she decides whether a family is able to resolve their problem without the drug. But again, in the light of the rates of drug prescription, and similarly in my interviews, they very often decide that families are not capable of handling it. This decision is based on the psychiatrist's power, and the power of the psychiatrist increased and became omnipotent as a result of the vicious cycle of this decision.

The complaints about expected, normal developmental behaviors are a common issue. So why do parents perceive these behaviors as problematic or pathological? In the first instance of extracts, psychiatrists present it as a misevaluation by parents. However, they find an immediate reason to pathologize the situation. Discursively, they start the paragraph while trying without medication, but they always observe something that does not go well, and medicalization becomes the one and only solution again. I propose conceptualizing this effort as rationalization and how it serves to maintain power relationships, as Foucault (1982, p. 779) points out, by “investigating the links rationalization and power.” “The relationship between rationalization and excess of political power is evident. And we should not need to wait for bureaucracy or concentration camps to recognize the existence of such relations. But the problem is: What to do with such an evident fact? (Foucault, 1982, p. 779)”.

The other materials that I collected from various media types show that psychiatrists always have a great endeavor to promote ADHD diagnosis. If they were so uncomfortable with over-medicalization or parents' over-demand, why did not they publish any article or books that emphasize it? Or, if they are faced with publishing issues, why did not they broadcast any YouTube videos? I located hundreds of videos circulated by the child and adolescent psychiatrists from Turkey on YouTube due to my content analysis at the beginning of my study, and there is no sample that follows these kinds of critiques by psychiatrists.

“Shall we investigate this kind of rationalism which seems to be specific to our modern culture and which originates in Aufklärung? (Foucault, 1982, 779)”. Here Foucault emphasizes that this is the Frankfurt School's approach, and he is not the first one who sees the relation between rationalism and enlightenment. Yet, he suggests another way of “investigating the links between rationalization and power.” The rationalization of ADHD materializes through

a neurobiological approach. Psychiatrists replace some behaviors, which have highly complicated components—cultural, historical, economic, etc.—in terms of their social construction, based on medical reasoning.

Foucault (1978, 1982, 2009) did not choose family as a direct research interest. He ignores intersubjective relations and prefers trying to understand family through the power relations between parents and children. Foucault (1982) analyzes the family's involvement in power relations in connection with his two main interests. Family is suggested as a model for controlling one's desires in *The History of Sexuality* and a mechanism that governs sexuality in *The Will to Knowledge*. The family's other crucial role concerning madness and psychiatry is assigned to arrange the borders between normal and abnormal. Foucault (1982) has a unique understanding of the subject. In his theory, the subject signifies how the human mind is constructed, and a subject becomes an object simultaneously. In the 19th century, linguistic studies began to categorize, measure, and compare the things belonging to humans. Human beings have been objectified, but this objectification reciprocally becomes subjectification. The knowledge about ourselves feeds a new power form as defined by Foucault (2008): bio-power, which is the set of mechanisms through which the human species' basic biological features become the object of power strategies. These implicit power relations encourage us to act in specific ways and obviously subjectifies human beings. Objectifying people requires creating standards that determine which people measure in what way. We need a standard to decide which child is more successful than others, or which children are more attentive than others, or more active than others. A standard is only possible regarding a group, and modern governmentality is only possible in reference to a population. All these practices emerge simultaneously as our modern understanding of a population is related to security, territory, and population. Foucault shows that definitions of the population are used to define the term as repopulating a territory. It had a slightly different meaning than today. In the 17th century, as it begins to take on its modern usage, the population becomes important analytically to study to quantify because the country's population provides workforce, economic development, and agriculture. As it becomes the source of a state's wealth, birth, death, sickness, and productivity rates, it becomes important. As an aggregate, the population creates a mean and average citizen and a normative curve against which exams, tests, and requirements can be assessed. The question can be asked how can the correct sort of population be encouraged. It is only with the modern concept of population that we got the contemporary form of governmentality. Foucault writes, "baldly, at first sight, and somewhat schematically, we could say that sovereignty is

exercised within the borders of a territory, discipline is exercised on the bodies of individuals, and security is exercised over a whole population (Foucault, 2009, p. 25).”

In the 21st century, psychiatric diagnostic classification is one of the most important criteria to define somebody institutionally and individually. ADHD is the most frequently diagnosed childhood psychopathology, and as I see in the interviews and the literature, the most important threshold for diagnosis is the loss of functionality. The loss of functionality is defined by the decrease in academic success and the deterioration of human relationships. So, it means that a functional citizen could be successful in school life and then in professional life. Secondly, he/she could be in harmony with the people around him/her. These are generally classmates and family members: in other words, the people included by the same social institutions. In short, this psychiatric diagnostic category encourages behavior patterns expected from the modern population.

According to many psychiatrists from Turkey, parents and teachers try to manipulate the psychiatrist’s opinion about a child. Teachers and parents are the active subjects of the decision-making process, but psychiatrists objectify them. Teachers and parents declare their judgments and ideas about the personality of a child. These judgments are moral, as is expected. On the other side, psychiatrists are never satisfied with their objectivity level because they assume their clinical judgment is utterly dependent on moral evaluations. However, clinical judgments and decision making are complex notions “in their rich and full sense are freighted with values, including ethical and moral values” (Engelhardt, 1979, p.xxii). The effort of blocking ADHD within neurobiological disorder limits, in other words, as factual scientific truth outgrows from the discourse. On the other hand, parents and teachers have some information about ADHD. They come to visit psychiatrists thanks to this information acquired from the psychiatrists’ discourse distributed publicly. Television broadcasts, social media publications, and printed publications presented by psychiatrists about ADHD describe a child profile that can mainly fit most children. In other words, teachers and parents are charged with false-positive complaints about children; however, their opinion about ADHD is based on long-standing ADHD promotions by psychiatrists. Teachers and parents attribute their judgments according to their medical knowledge learned from psychiatrists. As I see in my data collecting process, psychiatrists are the dominant knowledge producers in the ADHD field. There is no other knowledge resource to consult about ADHD-like behavioral problems.

The clinical approach always assumes a reciprocal, mutual, and shared conception of responsibility. Any clinical approach that deviates from this conception of responsibility not

only loses the deep meaning of the term but also omits the relational phenomena, which nevertheless constitute the terrain of all clinical practice. If responsibility becomes a factor that is no longer shared or shareable, if it is no longer a space of mutual knowledge and mutual recognition, then it will have lost its clinical density. This is the danger of any clinical relationship (Adam, 2012, p. 266). As seen in these quotes, the fact that the majority does not trust parents removes them from the equation. However, while the psychiatrist enters and exits the environment as a catalyst, a child or an adolescent spends his day in the family and school circle. In this process, teachers and parents are the actors to support children and adolescents, to facilitate environmental conditions, or to regulate drug treatment if medication needs to be used. Considering that they lack the capacity to properly assess and interfere isolates both the psychiatrist and the child. Thus, neither the psychiatrist nor the children manage the situation.

Taking responsibility for everything and being all-powerful consolidates authority in one hand. It also reduces responsibility. Clinical practice is moving away from reciprocity and turning into a strength show rather than a healing one. The psychiatrists themselves are not happy with this, as the incident is getting stuck in the vicious cycle of deadlock. Although they claim that drugs work great for the most part, the dilemmas that reveal themselves in discourse show that they have some difficulties collaborating with parents to ensure regular use of the drug. So, the situation is not beneficial for anyone.

4.3. Social Dimension of Help-Seeking Behavior

Contrary to the official materials, in my interviews, I observed that psychiatrists use social status as a tool to understand the needs of families and children. While sharing their experiences about families' demands, they categorize symptoms and families' help-seeking behavior according to their socio-economic background. The child and adolescent psychiatrists that I interviewed judge the request for help as socially determined. A diagnostic category consisting of two groups of symptoms is divided according to this demand: hyperactivity/impulsivity for low-income inattention for wealthy families.

The interviewees differ concerning the ownerships of hospitals where they work, state or private hospitals/clinics, and geographical regions. Six psychiatrists work in state hospitals, but state hospitals also vary; university hospitals situate in big cities, and the parents of their patients generally come from middle-class populations, it is harder to find an appointment, and it is sometimes necessary to make payments to have appointments from the university professors. The psychiatrists who work in university hospitals have much more time-around

30 minutes—for consultations. City hospitals provide service for larger masses, a wide range of patients consult psychiatrists, thus on average, they have 10-15 minutes for each consultation. It can be assumed that the population who accept 10-minute consultations cannot afford any other health care service. Four psychiatrists work in private clinics where they render service to the upper-middle and upper classes. In private clinics, the length of consultation sessions is about 45-60 minutes. In sum, the socio-economic background of help-seekers varies according to the hospitals/clinics where psychiatrists work, and it is one of the significant factors that affect their clinical experience. In sum, three different types of hospitals/clinics host different social classes: city hospitals for the lower class, university hospitals for the middle class, and private clinics for the upper class.

One of the young psychiatrists, who newly graduated and completed her assistantship at a university hospital in Ankara (Turkey's capital) and recently transferred to a city hospital in a suburban neighborhood in the same city, describes the difference this way:

Ms. B: "The families who come to the university hospital are from the middle class, while those who come to the public hospital in the suburban neighborhood are from the lower class. Those who come to university hospitals have a higher educational level. Even if mothers are housewives, they are usually university graduates. I often meet illiterate mothers in the other hospital. There are also many children whose parents are mentally disabled."

Naturally, their class evaluation has not based on any objective, measurable standards. The most common social factor that the psychiatrists mentioned was social class. Although they disagree about their certain impressions, they all have experienced some differences due to their parents' social status. Thus, social status has become a part of their assessment.

Thus far, I have stuck to the terminology of social class used by the participants during my analysis. They express social stratification, including upper, middle, and lower class, and the middle class could be divided into two subcategories as lower and upper-middle class. This categorization is not based on the only economic capital as Marx (2015) defines it. I observed that their intention to state these social categories is not only to emphasize the income levels of families but also to point out their educational and cultural backgrounds. Yet, the family's economic status is incapable of describing the mental resources that psychiatrists intend while helping with the intervention process. They represent a social stratification that includes social and cultural capital, as Pierre Bourdieu (1986) classifies in detail.

Bourdieu (1986) develops the conception of a social space crossed by relations of domination. According to him, social space consists of relatively closed classes, unequally endowed with different capitals: that is to say, a set of resources that the individual can value in various social situations. He distinguishes four types of capital. First is economic capital, made up of all the financial resources of an individual: his income and wealth. Cultural capital, which is the most important for Bourdieu (1986), is about all the knowledge and the well-being possessed by an individual: his school titles, his cultural property. The network of knowledge constitutes social capital that the individual can activate to acquire a social position, and the symbolic capital validates for the individual a certain social prestige in the eyes of others. It makes it possible to value other types of capital. Thus, the place of an individual or a group of individuals in social space depends on their endowment of the various capitals. The social hierarchy thus derives from the unequal distribution of these different capitals. With a quantitative dimension, highly endowed agents form the dominant classes, but this also has a qualitative dimension. Depending on the composition of the overall volume of capital, such as the dominance of economic or cultural capital, individuals' position varies. Bourdieu (1986) thus distinguishes social classes by looking at the possession of these capitals, and the habitus—that is to say, ways of being, thinking, and acting specifically to the members of this class.

Academic life and attendant child psychology and developmental issues are an integral part of social capital. Robert Castel (1981) writes the concept of "*surdoué*" that emerged in France in the early 1980s by putting a hyphen between words (*sur-doué*) uncharacteristically. There is an ideological reason for this, as the hyphen implies a choice made by elites. A good population requires good management. In his book *La petite Noblesse de Intelligence*, Wilfried Lignier (2012) follows the trail of the topic of gifted children. In line with the framework drawn by Robert Castel (1981) in his book *La Gestion de Risques*, he focuses on how some people or groups strengthen their power based on medico-psychological knowledge. Economically and socially advantageous families aim to improve their child's social fate.

In France, intelligence tests have emerged to detect abnormalities in schools in the context of a massive increase in school enrollment. As developed by Alfred Binet (1857-1911), psychometry is defined as from the bottom psychometry. Children who had very high rates on tests were considered random and marginal, and children with low intelligence were directed to special education. The aim was to increase their school success. On the contrary, Americans developed by the top psychometrics in the early 1920s to detect high-intelligence children.

Shortly after the First World War, America began work on the psychometric identification of gifted children. The research was led by psychologist Lewis Terman (1877-1956). The tests were used to select students to reserved schools for the best. According to data, at least 2 million students in 1992 were enrolled in a school as gifted children. In France, discussion of students with high intelligence scores was done much later and in a more cautious way. Although some research was done in the 1950s, it began to be discussed in psychology in the 1960-1970s. The appearance of gifted children in France was also due to political reasons rather than scientific ones. Association Nationale Pour Les Enfants Surdoué, founded in 1971 by psychologist Jean-Charles Terrasier, consisted of rich men with young children who lived in Nice. This substantial homogeneity was not just for creating an intimate atmosphere. It was related to the arrangement of essential resources according to the common need. Even though they were exposed to many criticisms later and had to change their strategy, they put forward the idea that gifted children are national wealth and require special attention in France. They have taken political steps in this regard. Thus, psychological discourse began to be used for the protection of elites (Wilfred, 2012).

In Turkey, an intelligence test industry, which grew over parents' concerns regarding education, has appeared in recent years (Sirin, 2019). In the last 20 years, children with mental retardation and special education needs are evaluated only by university hospitals' tests and reports. As a result of these reports, all private education costs are covered within the scope of health insurance. I also worked at special education and rehabilitation centers in the various cities of Turkey between the years of 2010-2015, coordinated by the National Education Ministry but managed by private capital. We could only process reports from university hospitals. But this intelligence test industry may be defined as by the top psychometrics. Intelligence tests, which are applied in private clinics and only at families' request, enable families to define their children as gifted and demand educational privileges in private schools.

Although the diagnosis of ADHD is not directly related to intelligence tests, it should be read in this context as the wealthy families I will examine below claim that their children are inattentive and need psychiatric support for school success. Pathologizing some behavioral patterns of children, such as inattention or impulsivity, results from the developmental theory based on educational interests and schooling strategies, which national policies or privileged groups determine. Developmental psychology theories and psychometrics exist immanently within clinical judgments. Also, the judgments about the capacity of families develop within the social sphere.

A young psychiatrist from Ankara, who works in private practice, emphasizes that populations seeking help via their clinic are generally families from the upper-class but also a small group of working-class families. For him, the difference is between these two groups is which symptoms they find more important. Lower class families seek out help for hyperactivity and impulsivity. However, “literate, well-educated” parents “have” academic problems. The owner of the problem is not a child but his/her parents.

Mr. C: “It is a private clinic that hosts middle- and upper-class families. That’s one of the reasons for the frequency. But there is something like... well, it is one of the most common psychiatric disorders, I mean in childhood. Secondly, and most importantly, urban life here is Ankara. The families are from the middle and upper class, and so on. Well, there are some families from the lower classes, but their problems are hyperactivity and impulsivity rather than attention deficit. Behavioral issues are at the forefront. Generally, well-educated parents are worried about academic problems. But as I said before, fifty percent...”

Psychiatric help is requested by a family that is worried and defines academic failure as a problem. Here the clinical unit is no longer a child but a family. As a result, clinical judgment relates to the family based on a socio-cultural criterion. According to two social classes, the main product is the observation of dissociation of the diagnostic category ADHD into two groups of symptoms. The same psychiatrist critiques the approach of families to school success:

Mr. B: “Some families can be very avid academically. They bring the children who had two errors in the TEOG (exam taken at the end of primary education) because of inattention. The average score of this child is 95 out of 100. The family came from another city to insist on an ADHD diagnosis. This mother was a teacher. She said that we lack attention, we cannot do homework, we are making errors depending on inattention in the exam.”

He emphasizes that the mother used the first plural by increasing his voice tone. Apparently, he does not think that this child can be diagnosable, and he stated that he also conveyed his criticism to the family. Another psychiatrist who works in very similar conditions says that such families insistently submitted their psychiatric help requests to many psychiatrists. As a result, they find a response to their demands at this point.

Mr. B: "Some families persistently try to diagnose their child. If you refuse to make a diagnosis, they go to someone else. One of them (psychiatrists) is starting the drug treatment. If it is not the fourth, the fifth prescribes. Because they regularly visit psychiatrists until they start drug treatment."

In the previous extract, I observe that moral values are also defined in connection with socioeconomic level. He presents a wealthy degenerated family who endangers the safety of their children, does not ignore legally problematic behaviors, but seeks psychiatric help because of their fear of exam failure.

Mr. B: "Last week [I saw] twins, 17 years-old. Now they are in the last year of high school. They were expelled from four schools. Their father is wealthy. They take their father's car without any permission, drink alcohol, get in accidents... When I ask the mother, she says our problems started last year. We looked at the e-school (it is a national database to see students' grades) together, the grades of the children have been bad since elementary school, and the grades of behavior, too. The family does not even apply for these behavior problems; they only seek help for the university exam."

The school choices of families are a valid social indicator as well as hospitals for psychiatrists. The same psychiatrist indicated that almost all their patients come from private schools. As one of the psychiatrists mean, school choice can be a determinant in the diagnostic and treatment decision-making process.

Mr. B: "Ali is five years old. He is studying at the British Embassy School. Because they have a different system, the child starts school at the age of 5. Still a play-age child (...) Again, we need to speak on a case-by-case basis. I would tell his parents under normal conditions (in the Turkish education system) that let's see him again in the second month of the first grade. His adaption would be completed, and his learning process would start. But in this case, I had to start medication because academic losses have occurred."

In Turkey, the schooling age is currently between 66-72 months. However, this child starts primary school earlier. Ali, who is growing up in Turkey with Turkish parents, tries to adapt to a different education system with another language via totally new discipline methods. The social status of Ali's parents is a factor indirectly affecting the diagnosis. International schools have been the leading schools in education quality since the late period of the Ottoman empire in the 19th century, which is a crucial status indicator. Minorities living within the

Empire started to establish their schools. The Ottoman Empire failed in moving to secular and scientific education, and the empire's multinational, multi-religious, multilingual social structure was suitable for international schools. Contemporarily, education institutions defined as advanced and modern are shown as a promising target in education (Eren,1994).

But of course, the educational status of families is not always presented as a negative variable. One of the psychiatrists from Ankara, who is working in a state hospital, defines parents' intellectual capacity with the word “conscious.” He is glad to see cooperation that they can create with teachers and arrive at his office with a more concrete evaluation.

Mr. K: “Most of the time, conscious families evaluate the situation with the teacher, and they say (to the psychiatrist) that our child may have some attention problems.”

The intervention capacity of parents is defined via their educational and economic level by interviewees. As stated before, intervention choices are highly dependent on families' income levels. First of all, hospital/clinic choice is shaped according to the cost of a visit that varies approximately between 100 - with the support of social security - and 1000 Turkish liras. Secondly, psychosocial interventions such as family education and various therapies generally given by psychologists are outside the scope of health insurance. Therefore, psychosocial interventions are not a choice for people from lower-income levels. A psychiatrist from a city hospital in Ankara summarizes her observations in this way:

R: “What about the families' compliance with the treatment?”

Ms. B: “So, like this, it depends on socio-economic level. Now, if I think of Sami Ulus (a hospital in a suburb of Ankara), they will accept it, usually. Hmm that is, the lower the socio-economic level, the higher the level of acceptance.”

R: “(The acceptance of) medication?”

Ms. B: “Yes, medication... (the families say) these drugs sedate, these drugs are sold with red prescription, such an unnecessary prescription...”

According to her experiences, families from high-income levels have a more critical attitude. This attitude could be due to the variety of their options. On the other hand, families who cannot afford any other intervention option except for state hospital solution, which includes only drug treatment, evidently, readily accept the psychiatrists' suggestions. This psychiatrist was working in a university hospital in Ankara before the hospital where she works now. She describes the attitude of the families there as:

Ms. B: "At a university hospital, parents first refuse drug treatment. Then, a few years later, they come again because of school failure."

I had a unique experience to hear about a different story from some wealthy families in a totally different context when I traveled to Adana for one of my interviews. Adana is one of Turkey's biggest cities, with its population of more than 2 million situated at the eastern end of the country's Mediterranean coast. The city is a leading commercial center in southern Turkey and home to the country's most immense and most fertile plain. Adana is always caricaturized with the hot temperament of its population in public discourse.

In my visit to Adana, after an interview with a psychiatrist, I took a taxi to go to the bus terminal to reach another city in this region for another interview. When I asked some questions about buses, the taxi driver noticed that I am not from this region, and we started talking about why I was traveling. I briefly explained that I am a psychologist, and I have some interviews with psychiatrists about ADHD. It was exciting to him since he is working as a child and adolescent psychiatrist's private driver. They were frequently traveling in the region because this psychiatrist does not have any clinic, and she presents a 'private' service to the houses of their patients. For me, it was unexpected, so I asked why she attempts such a private service. He told me that they visit many villas in this region and the southeastern region, which are surrounded by giant walls and have a few security points by which to enter. According to his anecdote, they passed three security points at once. He added that the psychiatrist thinks in the same way. These families are wealthy and do not believe that their children will be safe outside of the walls. The children always stay inside. For this reason, they have various mental and emotional problems. One of the families with a child diagnosed with ADHD even proposed that the psychiatrist stays with their child during a school holiday. They said that they could pay the cost, but the psychiatrist did not accept.

Without exception, all of the participants mentioned their patients' social class, yet their observations change according to their work because it determines their patient profile. It is a way to describe their profile, which determines why ADHD is crucial for them, their capacity for coping with the symptoms, and what symptoms are vital for them. An experienced senior psychiatrist from Adana, who works in her private clinic, explain this profile below. These two extracts come from two different contexts, but two of them have the same observation about easy compliance among low-income parent groups.

Ms. A: " (...) when you give the drugs to a poor family, they don't question it, they accept it."

Parents who do not have the capacity to define their children are not capable of questioning the drug prescription. This sentence is entirely ambiguous in terms of its connotations. It is possible to interpret it positively, which means a facilitating factor for treatment, making it easier for the family to adapt. On the other side, the argument is based on a humiliating observation that they do not have the capacity to question treatment. The fact that the wealthy family has the ability to question because psychiatrist assume that they are well educated. In other words, the poor are also uneducated. She describes the family profile as poor/rich and literate/illiterate and is disposed to understand families in strict dichotomies and understand the diagnostic of patients. Besides, Turkey, with its significantly heterogeneous economic and social structure, catalyzes generic but de facto categorizations. This dichotomist categorization could be read as an indicator of social inequity in Turkey. A brief comparison of social status gives an idea to a psychiatrist about their needs.

Psychiatrists from big cities and especially from private clinics state that ADHD symptoms or ADHD-like behavioral patterns generate the majority of complaints in their clinics. However, the state hospitals host some other mental conditions that are categorized as rural by psychiatrists. These are generally psychological and physical handicap groups that can profit from state-based rehabilitation centers and financial aid.

Ms. E: "I am working at (a little town) State Hospital... Children from the countryside come to the hospital, so there are a lot of comorbid situations. Like what? Cognitive developmental retardation, intelligence deficiencies, mental deficiencies are obviously frequent. So, we observed these (ADHD) symptoms in company with various comorbidities."

The coping strategies of parents are positively related to their socio-cultural level, according to psychiatrists. Their coping capacity influences the psychiatrists' decisions, particularly about drug treatment. Generally, they observe the need for intervention with a child. They evaluate how parents interfere, whether they can adopt new rules for their family, and whether they can follow the psychiatrist's instructions. If their observations are positive about parents, they may wait for the drug treatment and prioritize family education. A psychiatrist from a big city hospital describes her clinical workload as "up to 60-70 patients a day," and she states that the majority of their patient profile is from low-income levels:

Ms. F: "The ADHD symptoms may worsen because the family does not handle them well. Maybe if the family can manage it better, some children can recover a little more medicine. I observe that the family can't handle it well, or the teachers can't

handle it well. Secondary traumatization in the child occurs or will occur, or if I see such a risk, so I definitely recommend drug treatment because there may be different comorbid things in the future. And the family story is important. Suppose there are family members with ADHD, behavioral problems, or adult personality pathologies, in that case, the child is more at risk, and I usually inform the family about the importance of drug use. If the child does not have a severe functionality problem, the family can handle it well, believes they can do it, listens to our advice, and he doesn't prefer to use medication, then it is better to recover without medication. Coping skills are also necessary here. But our people (laughing), well generally socio-cultural level is important. Families who fail to manage well and environmental factors worsen symptoms.”

As the psychiatrist explains clearly in this extract, their socio-cultural level is seen as an indicator of parents' “handling” capacity. A subtle smile coming after “our people” reflects the ironic disbelief of parents' socio-cultural level in Turkey. The symptoms are “surely” rooted in the brain's neurobiology. Still, on the other side, there is a constant belief in parental attitudes or another environmental factor causing the symptoms to get worse. Another, more experienced psychiatrist from the same hospital caricaturize the parents' profile to better explain it to me. He met many examples where the parents cannot use the word of hyperactivity correctly.

Mr. G: “However, there are many families who cannot pronounce the name of diagnosis even in a right way. They say some words like hipertif, aperitif... (laughs) As a result, our working environment consists of a socio-economically low population.”

A psychiatrist who works in similar conditions describes her patients' general symptom profile as dominantly hyperactivity and impulsivity. Unlike families who apply to private clinics, families who apply to her do not perceive the lack of attention as a problem.

Ms. D: “Hyperactivity and impulsivity symptoms are more frequent in our general patient profile. Because teachers generally guide them. They are driven by symptoms such as hyperactive behaviors, haste, quarreling with friends, and speaking in class. The lack of attention is not noticed. We have an infrequent occurrence with attention-deficit because they are described as intelligent, well-behaved, listening to the teacher, quiet, and calm.”

According to a young psychiatrist from the Southeastern Anatolia region densely populated by Kurdish people, this region quite poor. She studied in Istanbul and had worked in Ankara at university hospitals. She defined frequent inattention complaints in Ankara as school success as an obsession of parents. For her, the region where she works now and other big cities where she worked before are different in terms of parents' expectations.

Ms. D: "In this town, the number of children in families is high. There are families with 5-6-10 children. Of course, the energy of parents decreases for every child. Behavioral suggestions are insufficient. There is no academic success obsession as in Ankara. With less demand for academic success, attention deficit is not perceived as a problem. If the classroom is disrupted, the child is directed to the psychiatrist. Therefore, attention deficit is less frequently, and hyperactivity is more frequently diagnosed."

In the little town where she works, there is the only child and adolescent psychiatrist (out of respect for her anonymity request, I am not naming the city). The anecdotes that she shared with me are based on Kurdish people's language and lifestyle, so that is the only detail that I emphasize.

Ms. D: "ADHD was the most frequently encountered disorder in Ankara when I worked as an assistant. It's different here. People want to take less medicine. They are less diagnosed because they bring their children to the psychiatrist less. They are afraid of being labeled. Although they do not, they think they will. Everyone here knows each other. They live together. They live with relatives. Therefore, everyone is closely witnessing and interfering with each other's lives at the same time."

While the psychiatrist worked as an assistant psychiatrist in Ankara, ADHD involved almost all of her clinical practice. Yet, she diagnoses it very infrequently here, which according to her, is because of the fear of stigmatization. She narrates the lifestyle of the population in this region as 'living together.' Firstly, this signifies that the extended families live together traditionally, but economically as well. There is no particular income source except for animal husbandry. Thus, the local community is impoverished. Secondly, 'living together' means that the people living in the same neighborhood know each other. They spend a lot of time in the streets altogether, but generally, they are relatives because they get married traditionally inside their own families. Based on her comparisons between Ankara and this little Southeastern city,

the local community is not enthusiastic about using drugs. According to her, the reason is again the fear of stigmatization as mad/insane (deli).

We observe two different Turkeys regarding the perception towards psychiatry: the first one is the perception of psychiatry-oriented western big cities. The second is the still ‘old fashioned’ eastern style. The West's diagnostic culture may be interpreted as a result of industrialized, individualized, success-oriented modernization because it is still hard to mention Western-style modernization in the east of Turkey. Even though there is only one official language in Turkey, the local community's maternal language is Kurdish for a remarkable amount of people, and they learn Turkish when they start elementary school—preschool is always not accessible for every child, especially in little villages despite the increase of pre-schooling. The psychiatrist noted that the diagnostic of dyslexia is frequent in the region because of language difficulties. Many parents—generally mothers—still cannot speak Turkish, so the psychiatrist communicates them via her secretary. The other characteristic of the region is having a large number of children in each family. The psychiatrist reports that many families have 5, 6, or 10 children. According to her, the fundamental disadvantage of having so many children is the lack of time and energy for each child. Accordingly, the suggestions about behavioral interventions fail to satisfy.

4.4. Conclusion

Many psychiatrists stated that the symptoms complained of by the parents were determined by their social status in many different contexts. I would like to repeat that I did not ask any questions to indicate it in the interview questions. It was not a result that I could have predicted neither in consideration of the existing literature nor my personal experiences. To summarize, wealthy and well-educated parents focus on the school success of their children. Thus, the lack of attention is visible. They perceive the intervention as urgent for the future of their children’s education. We understand from some examples of psychiatrists' clinical practices working more with upper-income families that they do not see their children's hyperactivity/impulsivity-based behaviors as a problem from the perspective of the moral values of their social class. On the other hand, families from the lower classes prioritize some behavioral patterns that disrupt the social order, and school failure or demanding more school success are not among the reasons that push them to seek psychiatric help.

A psychiatrist perceives and interprets the social aspect of the demand while evaluating the patient. We see that this has an inseparable place in the clinical decision. A family--

sometimes with the direction of the teacher—conveys the request for help to the psychiatrist and is placed in the first step of the clinical judgment process. The indicators that provide information about their social status, such as garments, terminology, the hospital or clinic where they consult, are followed by a psychiatrist concerning expectations and intervention capacity. Psychiatrists proclaimed in the interviews that parents' coping capacity affects their intervention decision and particularly the ability to prescribe drugs. Evaluating parents' coping capacity is based on psychiatrist observations about their social status. This categorization contributes to de-responsibilize parents from dealing with their children's suffering. Their observations reinforce that parents from low income have a low level of education. This is an indicator of my interviewees that they cannot follow behavioral and environmental interventions. Although it may be seen as quick reasoning to start drug treatment, it should not be forgotten that there some physicians who are trying to cooperate with illiterate or non-Turkish-speaking parents. On the other hand, I have heard many times during the interviews that it may not be necessary to give medicine if the family can better care for them. But while 10-20 minutes are allocated to these families, is it a realistic attitude to think that they do not respond well to psycho-education? As we have seen, the families' income and education levels lead the psychiatrist in their clinical judgments. On the other hand, while there are so many unique cases and states, could the medicalization of low-income group children be tied to a deterministic attitude?

I viewed ADHD in entirely different ways, from rural to urban, from city centers to suburbs. For me, an unexpected result of this research was to meet the inequalities in my country by following childhood psychopathology. The literature on children neglects children from different economic conditions and, of course, parenthood. It should be remembered that there may be different parental attitudes, according to different social statuses, but this should not mean that one is superior (Kambuta, 2015). Even the families' expectations and coping strategies depend on socioeconomic levels; the advantages or disadvantages of a family's social status vary for children. As I have heard from some physicians working in private clinics, wealthy families can sometimes request medicalization for their child without any psychopathology, or a literate parent can be unconcerned with their child's school success. However, in a completely different social context, the United Kingdom, Val Gillies (2006) shows in her study that working-class mothers show much more emotional investment and commitment to support their children in school compared to middle-class mothers.

The influence of economic and social inequalities is implicit but destructive in the process of subjectivity's construction (Biehl, Good & Kleinman, 2007). Defining families with their social status is the most significant component of creating their subjectivity. The children's subjectivity is constructed according to their families. Self-control is a crucial component of their subjectivity, considering its relationship with ADHD symptoms. It is not a social imaginary-free issue either, as mainstream psychology had insisted for decades. The famous Stanford Marshmallow experiment (Mischel et al., 1972) focused on delayed gratification. The researcher presents two choices to each child; the first one is a small but immediate reward, the second one is a delayed but two times bigger reward. After the researcher leaves the room, the children can eat the marshmallow, or they can wait until the researcher comes back and can eat two marshmallows. According to the results, children who are able to stay longer tended to have better life outcomes. However, this experiment was recently repeated (Watts, et al., 2018), and the results show that the children who come from high-income level and better-educated families are able to delay gratification more easily. This means that they significantly have more self-control. Better life outcomes are most probably based on their family background advantages.

5. How are Attention Deficiency and School Success Linked?

“Everyone knows what attention is.”
William James (1995, p. 40)

One of the fundamental questions that Wayne Wu (2014) suggests to interrogate the function of attention is “what role attention does attention play?”. In this chapter, I will share my answer to this question with my data set’s contribution. In the first chapter, I have noted that the required threshold is defined inattention, hyperactivity, and impulsivity to define it as a disorder is *functionality* embodied in two areas. One of them is school failure and its relation with the attention that I will examine in this chapter. How do we determine the normative boundaries of attention? How do we define an attentive child/adolescent or an inattentive one? What is the relation of attention with education? And, how do the social, political, economic and cultural context -in Turkey in my case- effects this relation? These are the questions that generate the inquiry of the chapter.

“Everybody knows what attention is” (James, 1995, p. 40) indeed. However, Karl Groos (1898) highlights a long time ago that “there is not only one generating recognized answer” (as cited in Mole, 2011, p. 4). Contemporarily, Wolfe and Horowitz (2004) acknowledge that “there is no single, satisfying definition of attention.” From a philosophical perspective and cognitive sciences, where many concrete types of research conduct, objections to the conceptualization of attention are rising. For instance, Britt Anderson (2011) argues that cognitive scientists create artificial dichotomies about attention, treat it as a cause, and define a group of facts as a theory in his article named “there is no such thing as attention.”

Queries on school failure are scientific, pedagogical, and political. It is scientific because many fields such as sociology, psychology, didactic, linguistic, biology, and genetics explore school failure. It is pedagogical because, in practice, it is necessary to find solutions to problems such as how knowledge should be acquired and transferred. It is political because school meritocracy, which is the most significant part of social justice in a society, is founded on managing different achievements and, most importantly, on inequalities. School failure has been a social problem since the 1960s and 1970s. Causes are often attributed to social, pedagogical, psychological, biological, or genetic domains. There is always competition

between the dominant approaches, and the dominant one varies from period to period. For the past twenty years, school failure and coping methods have been individualized. Psychological interpretations such as school phobia, self-esteem; and genetic, neurobiological interpretations such as dyslexia, precocity are the dominant approaches of these last years. School failure was considered as a socially positioned phenomenon in the 1960-1980 periods. Most of the children were affected by the lower class. After 1980, the period in which failure was tried to be understood for personal reasons is entered. It brings with it the fact that students need special education. As of the end of the 1990s, neurological explanations were brought to learning disabilities (Morel, 2014).

5.1. Functionality

The concept of the function contains values within itself because it is the product of the interpretation of things within a specific range (Fulford, 2001). While defining the threshold of ADHD diagnosis, the formulation is constructed on functionality. All experts explain the distraction and being active or impulsive normatively. So, what is the threshold at which some behaviors go beyond normative order? All the materials I analyzed refer a situation which functionality is impaired. So, what is this functionality? Is it tangible or visible? If the harmony in social relations is disrupted, if children/adolescents are in constant disagreements with their peers, if their relationships with family members are troubled, if they harm themselves and others, if their bodily integrity is at risk due to accidents and sudden movements, and if the schoolchildren fail in their classes, they declare that child has impaired functionality and that he/she has entered the area of intervention. In short, psychiatry defines *a functional child* with two main areas: 1) not harming himself or others, adapting to his / her environment 2) being successful at school.

The notion of function appears since the Antiquity in explaining the phenomena of life in the biological discourse as in the medical discourse. Nowadays, molecular biology uses functional statements in terms of transcription or translation, such as signals. The biology of the evolution that has renewed the explanation that is often reduced to adaptation such as a vital function such as respiration or locomotion is decisive to understand the link that unites function and structure, the latter resulting from a long process of shaping by natural selection. Larry Wright proposed an etiological conception of the function in 1973 by virtue of a trait or a character appeared in history because of the properties that increased the chances of survival in the prevailing environment. Therefore, the function is defined here in terms of its utility in

the past to attribute a feature's function, which makes it to be selected. In 1975, Robert Cummins proposed to resort to non-historical functional explanations, based on the system's decomposition to be explained into its elements. The goal is to identify each component of a system's specific provisions and their way of functioning together. This conception attributes a function to a trait, an organ, or a behavior (Parot, 2008).

Historically, the debate begins with the body structures' connection to the parts of the soul or the faculties. At the end of the 16th century, faculties are not related to organic functions from Galen's point of view. The unstoppable argument for distinguishing faculties and functions then continued with that intelligence is a faculty of the soul, and over time this perspective has survived contrary to organic functions. The vegetative and sensitive soul functions are based on organic support. However, it was impossible to envision rational, immortal, and immaterial soul faculties as body-based. By the 19th century, questions about the soul were receding for the need of a shift in vocabulary. Faculties are tools of the mind, but there is no tool that cannot be designed without its use. According to the model of physiological functions, psychic functions are faculties in action. The gaze turns towards the relations between the individual and his environment, in other words, towards his activity. The use of the term function seems to be required. However, the vocabulary did not change immediately, and it took about a century for the function to replace faculty (Parot, 2008).

Philippe Huneman (2008, p. 49) illustrates this argument with the statement of "the kidney has the function of eliminating toxins, but this kidney is not functioning properly." Hence, any assignment of function establishes a dichotomy between normal and abnormal activity. This feature of the function concept justifies its leading role in anomaly studies in biology and psychology. There is a relationship between the concepts of function and norm, where one points to the other. Psychopathology is based on the study's interest in the normal, and it helps to shed light on mental functions by the method of biological sciences (Huneman, 2008).

Some scholars argue childhood "as the product of socio-economic and macro-structural processes (Davis, 2006 p. 50)". Qvortrup (1994, 2000) states a materialist understanding of childhood: "No child can evade the impact of economic or spatial forces, nor ideologies about children and the family, let alone political and economic ideologies and realities" (Qvortrup, 2000, p.79). According to him, it is not enough to focus on society, mode of production, cultural and historical periods to understand childhood; it is necessary to look at the macro analysis.

The functionality defined as the threshold for diagnosis and prescription by psychiatrists is another relative conceptualization, such as tolerance. In the above quote, even appointing this threshold is hard. Psychiatrist Mr. G states that ‘they’ as I mentioned before, psychiatrists always grammatically use the first-person plural as a subject form. They do not hesitate to prescribe because they aim to improve children’s performance. They assume that highlighting functionality is the threshold for diagnosis, but the relativity of functionality is not problematized. Mr. G, who is in his 40s and works in a public hospital in the South of Turkey, favorably represents the views on functionality in the following quotation. Mr. G says that pathologized behaviors are seen in the whole society, but seeing or having them is not sufficient to diagnose. He says that the loss of functionality that leads the diagnostic decision. He also adds that the functionality criterion is the most significant benefit of diagnostic systems. As other psychiatrists I have interviewed have stated, he classifies the loss of functionality in the main areas: 1) academic failure, 2) problems with peer relations 3) problems in family relations.

Mr. G: “Our mainstay to diagnose is functionality. Classification systems, DSMs, and ICDs are highly criticized, but I think there is an excellent parameter. I think it should always be our main point: Does it disrupt his/her functionality? Does a child’s functionality deteriorate or not? Symptoms of all our diagnostic categories have already existed in almost all normal people. So, he/she is a little bit active, is he/she has hyperactivity? No. I’m a little bit bored, so you are depressed. I have palpitations, so you have an anxiety disorder. No, we don’t say like this. Does it ultimately disrupt his/her functionality in that particular person? What is the functionality of a child? The first one, disruptions of academic performance in the school setting, the second one, disturbances of friend relationships, and the third one disrupts relationships at home.”

DSM-5 gives the main pattern considering functionality to a psychiatrist to follow: “a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development (APA, DSM-5, 2013, p. 59)”. However, there is no concrete measure. As Mr. G states, many pathologized behavioral patterns may be observed in many individuals, but this is not enough to diagnose. For example, under the inattention subtitle, the phrase "often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (APA, DSM-5, 2013, p. 59)". It does not even say school failure but discursively gives an extremely vague statement to a psychiatrist. In my study that I dedicated to child and adolescent psychiatrists in Turkey, school failure is defined as the most

critical indicator of inattention. The most important indicator of functionality is school success, in more concrete terms, the student's grades from the lessons. Getting good grades refers to a *functional child* or adolescent, getting bad grades refers to a *non-functional child* or adolescent. According to the child and adolescent psychiatrists' statements, this information is a prerequisite for the diagnostic decision. Making an introduction to the functionality in this chapter opens the discussion that I also intend to continue in the next chapter. Functionality is evaluated under two main headings according to the statements of psychiatrists from Turkey. As mentioned above, school failure is alleged to be the result of a lack of attention. I will elaborate on the relationship between school failure and attention deficit related discourses in Chapter 4. The other is the criterion of whether the child or adolescent can provide self-control for the protection of social and physical integrity. The lack of self-control is read as a trait of hyperactivity and impulsivity symptoms. It is the subject of Chapter 5.

The words such as parameter, functionality, and classification systems have masked subjectivity behind medical discourse. It is a rhetorical strategy used to reduce ambiguity. It is stopped up by progressing in parallel with naturalism. Psychiatry tries to avoid normativism in order to maintain its controversial position in medicine. This rhetorical strategy is the symbol of that getaway. These terms also point to normative conceptualizations. It is one of the primary purposes of this study to look closely at the values they indicate. As the uncertainty decreases, it will approach more to natural sciences.

Mr. H: "If someone who has already been diagnosed comes to see me, if they have already had an anamnesis or test, I would like to see them (the old reports) confirm the current diagnosis. If I have any doubt, I'm updating tests again."

In this case, an example taken from Eyup Sabri Ercan's book wants to draw attention to the genetic base of ADHD. Leyla seeks psychiatric support for her daughter's attention deficit and learning difficulties, but Dr. Ercan also diagnosed her during their sessions. The author points out that Leyla suffers from her symptoms in many areas of her life. Besides, the limit of functionality is deepened until Leyla's sexual life. The emphasis placed on improving Leyla's sexual life after drug treatment points to dysfunction in this area before diagnosis and treatment. In other words, being functional in her sexual life with the emphasis of a married woman's husband, which is not specified in guidelines or mental disorder classifications, may be thresholds shaped by moral presupposition. I interpret this expectation as moral because, in a Muslim society, for a non-married person, problems in sexual life may not push the

psychiatrist to include it in the clinical picture. Furthermore, heteronormativity also confirms to be functional in a relationship.

*“Leyla, thirty-five years old, mother of three children, was a housewife. Her husband was a driver in a shipping company. Leyla's school success had always been low, and she had hardly finished high school. She had no excessive activity and even was always slower than others. She complained about not being able to keep up with housework while preparing the children for school and dealing with their homework. The fact that her seven-year-old daughter's problems with attention deficit and learning difficulties have also being increased. (...) Her daughter's doctor told her that similar symptoms could be in their families and asked her to complete a test. Leyla's symptoms of attention-deficit were more intense than her daughter's. In the evaluation made after starting treatment, it was observed that there was **an improvement in her sexual life with her husband, as in many areas of her life** (Ercan, 2008, p.74-75).”*

A junior psychiatrist from a public hospital believes that families' medication demands and incontestability of their child's behavior to move to the psychiatric clinic indicate a loss of functionality.

*Ms. F: “If families apply to a psychiatrist with **the request for medication**, it means that some conditions show up that impair **functionality**, and they can no longer cope with them.”*

Mr. K, a graduate of the Military Academy of Medicine, declining in functionality necessitates drug use because it indicates more significant risks in the future. He should catch the loss of functionality at an early stage means eliminating future social problems.

*Mr. K: “I prescribe medication for the cases that disrupt the child's **functionality** negatively because when we do not use drugs, these cases cause **severe problems** for both the society and the family. For example, the problem is not only in an academic field but also in the social field. It is also difficult for us to encounter ADHD in our daily life, in traffic, for example.”*

Every psychiatrist that I talked to within the scope of my study sincerely accept that ADHD-like behaviors may appear for many different reasons, such as parental attitudes, family elders' interference with discipline, other disorders. They also admit that it is not always easy

to make a differential diagnosis. Some psychiatrists attribute the competence to make a differential diagnosis on experience. They claim that different causes of behavior can be seen with clinical abilities acquired through experience. However, whenever the subject matter makes the diagnosis decision, they stated that the keyword that makes them to the diagnosis decision is functionality, without exception. Young psychiatrist Mr. C, who works in a private clinic in Ankara, says that if a child is hyperactive but she/he is not exposed to accidents or self-injuries, he does not prefer prescribing. It is the same for academic success; if a student can manage some attentional problems, for him, the prescription is not necessary. These two conditions outline functionality in the ADHD discourse. Determining the limits of functionality considerably contributes to the construction of children's subjectivity.

R: "How do you make your decision in cases in which you are unsure?"
Mr. C: "Loss. Loss of functionality. If symptoms are observed, but there is no functionality loss, for example, I observe hyperactivity, but it does not cause accidents, I observe attention deficit, but the student tolerates it with intelligence, academic success is not troublesome. Then I send them without prescribing, and I want them to come back in case of accidents, problems in relationships, or academic failure."

5.2. Attention Deficiency & Medicalization of School Failure

While the education system is being built to respond to "fast-moving global employment" (Davis, 2006, p.1), the pressure on professionals, parents, and students increases. Many researchers argue that schooling is possible by the state through family and school-based socialization, and there is a consensus between state and family. For example, Shamgar-Handelman (1994) claims that the student, who is perceived as a good pupil who meets the state's needs, makes more use of the education system to become the future productive workers and citizens of the future. The social capital theorists such as Putnam et al. (1994) and Coleman (1998) mention two oppositional vicious cycles; the first indicates a good citizen and starts with a good childhood, continues with good education, and concludes with good employment. As the opposite of the first one, the second cycle begins with a bad childhood and bad education based on the lack of opportunity and concludes with poor employment (as cited in Davis, 2006 p.51). We can also look at changes in the symptoms that the families ask for help depending on their social status, which we have examined in the Chapter 3, and why education is involved in functionality from the social capitalists' perspective. The demand for psychiatric help for middle- and upper-class families, even when the students' lessons are quite good, is because

the student should stay in this good cycle. The low-income family, who does not complain about it, perhaps accepts that their child has already started with a disadvantage to the life. In Turkey's political context, which includes an education system in a privatization quagmire and increasing unemployment even for college graduates, the social capitalist perspective becomes even more meaningful. Families, teachers, and mental health professionals, who are aware of this social reality, also face an immediate response to the possibility that the distracted student may be disconnected from the system. That is why the possible answer to the question of "what role attention does play?" that I have asked initially may be from this point of view.

According to some psychiatrists, school failure, which is defined as the most crucial indicator of attention deficit, maybe a false reason made up for the failure of parents' children. The following quote is from the *Hyperactivity and Attention Deficit* book of Osman Abali, an experienced physician and scholar. Psychiatrists *believe*, as what we hear from other psychiatrists in the previous chapters, that they are able to distinguish between school failure due to ADHD from other reasons caused to the failure through the clinical skills of a physician. Some *tests*, which point to a highly vague meaning, mentioned here cannot go beyond being a rhetorical tool for embodying pathology in ADHD discourse. There is no test other than Conners' and Atila Turgay's scales, which can help ADHD diagnosis and these scales are based on the declaration of parents and teachers.

*"We see that some of the parents whose children with low course success are bored from the lesson because of other reasons. They use **hyperactivity cover** and do not want to accept their children's other situations that cause course failure. Of course, we see that **they do not want to accept other situations that lead to course failure**. Of course, there are many reasons for course failure, and hyperactivity (DEHB) can be counted among the most important reasons, but other reasons should be considered. These children should be examined whether there is a hyperactivity-attention deficit by detailed psychiatric examination, and if necessary, the situation should be clarified by applying some tests with a child and adolescent psychiatrist. (Abali, 2015, p.21)."*

According to several psychiatrists, attention deficiency is the most common reason families bring children to the psychiatric service. Ms. F, a young specialist in a public hospital in a Southern city, highlights that families considerably pay attention to the lack of attention because the consequences of this symptom are reflected in school success.

Ms. F: “The majority of applications are due to the lack of attention. Families care more about it, perhaps because the attention deficit reflects directly on academic success. (...) Indeed, the most frequent application to child psychiatry really happens in school-age and during the high school period, especially in senior students, before the exam.”

Mr. K, who is more experienced than Ms. F and works at Ankara, shares a similar observation. The reason for seeing the most frequent patients in the clinic where he works is the lack of attention due to school failure.

Mr. K: “ADHD patients are an essential part of our outpatient clinic. Attention problems associated with school problems often constitute an important part of our examination.”

There are two critical reasons under the families' pathologization demands, which are said to increase significantly before the exam periods; the first one is the belief that the use of medication will increase mental performance, and the second one is some advantages that the child diagnosed with ADHD in school evaluations and exams. These legal rights are summarized in the book of Bengi Semerci and Atilla Turgay. Apart from the privileges obtained in schools and exams, the educational therapy sessions for students at rehabilitation centers were also covered within the scope of social security during the period when the book was written. However, this is not currently possible. If children have received another psychiatric diagnosis in addition to ADHD, they may have this right due to that diagnostic category.

“A (medical) report should be obtained about the child’s ADHD and given to the school to benefit from these rights. Thus, children acquire some legal rights in terms of exam and evaluation conditions. (...) Simultaneously, the report ensures that these children take special education out of school, and a part of the education fee is covered by health insurance. (...) Children with Attention Deficit Hyperactivity Disorder benefit from special status in the universities entrance examination (OSS) and secondary education entrance exam (OKS). They can take the exam in a private room and with a separate supervisor because they are quickly distracted. It is necessary to apply to the examination centers with a (medical) report in advance (Semerci & Turgay, 2014, p. 182).”

Starting school is an important limit for children identified by ADHD-like behaviors. The manageable behaviors before schooling show themselves with various behaviors when they enter the school setting. One of the most experienced and well-known child and adolescent psychiatrists in Turkey, Bengi Semerci, indicated in her official YouTube and named Bengi Semerci Institute that school life's organizational skills and rules make it difficult for these children to adapt. The video is named "hyperactive child at school," it takes 9:54 minutes, uploaded in 2018, and viewed 7.404 times.

“Attention Deficit and Hyperactivity Disorder is a lifelong problem that creates problems in all areas of life, but it is most noticeable when it affects children and young people's school lives. (...) ADHD becomes a problem at the beginning of school life because primary school is an environment that requires organizing and following the rules (0:00 – 0:30 min.).”

Semerci started to publish videos seven years ago, but she has been using it more often for the last two years and has uploaded hundreds of videos about child and adolescent mental health and diseases. She produces videos in a broad spectrum such as ADHD and many other childhood psychopathologies, child-education-related suggestions, children's relationship with technology, adolescent problems, problems encountered in education life, planning the summer vacation, and moral education. I included YouTube content produced by child and adolescent psychiatrists within my data to see it as a direct contact point between psychiatrists and families. It is possible to see a very interactive side of the relationship by including the Instagram accounts and YouTube commentaries, which I did not include in my work. These new mediums of communication, which can be consumed much faster than books and reach larger audiences, may have a double-ended function when the content is related to mental health and illnesses. The first one may be to raise awareness of the public, to make the information easily accessible. On the other side, it may increase the demand for pathologization. I have observed these two functions in my meetings with the child and adolescent psychiatrists. For example, a physician working in the village said that a public service announcement about dyslexia broadcasted on televisions made by the National Education Ministry caused the families who have never heard about dyslexia in their life to bring their children to the psychiatric service. On the other hand, in another social context, a physician working in a private clinic in a big city asset that families have an excess demand for pathologization of school failure.

Yanki Yazgan (2010/2017), again one of the country's most well-known child and adolescent psychiatrists, has a book with the same title as this video, “hyperactive child is at school.” It had six printings in 7 years. *Hyperactive* is used increasingly in recent decades for any very active child in Turkish regardless of the diagnosis category. The definition of “hyperactive child” means the child or adolescent who has been or should be diagnosed with ADHD using these psychiatrists. However, the symptom that causes ADHD diagnosis related to school failure is inattention, especially since the books and interviews are particularly emphasized. Although these children are diagnosed due to lack of attention, they carry a *hyperactive* label because the children who are reduced to an adjective are subjected to psychiatric diagnosis.

I do not want to shorten the following extended quotation because it is a rare narrative among the sources I have analyzed, which depicts the details of being diagnosed with ADHD in such a social and political context. Ozlem Surucu was born in Ankara in 1966, graduated from Gazi University Medical Faculty in 1990, worked with children as a representative of UNICEF after her graduation, and then completed her childhood mental health and illness expertise in Ankara University Medical Faculty in 1997. In the extract below, she remarks that the problems of Turkey's education system, changing social structure, the relationships with parents and teachers, children to experience problems related to school and education. She underlines that many children or young people may experience ADHD-like symptoms under these conditions.

“To understand the difficulties that children with ADHD experience in the education system, it is necessary to look at the education system in our country in a realistic way. In recent years, a significant portion of the applications to child mental health clinics is because of school and education-oriented problems, such as school failure, unwillingness to study, behavioral or relationship problems in school. Competitive society structure, families’ anxiety for children’s future and high success expectations resulting from it, exam marathons, increasing class sizes, teachers' difficult living conditions, and other disruptions in the education system all trigger these problems. Even children who have no mental, emotional and social problems have difficulties in this system. Every day, we are faced with children and young people who hate more and more schools, parents who do not know what to do, are overwhelmed, who are looking forward to the end of their children's education, and exhausted teachers who are left with problems and burn themselves out. In such a system, all children show

symptoms similar to ADHD symptoms. At this point, the first thing to do is to distinguish between those who have ADHD and those who do not. Another important issue to be considered in this context is that children and adolescents with ADHD will be much more negatively affected by these complex educational conditions. It can only be understood by a detailed assessment how much of the symptoms in the evaluation process are due to ADHD and how environmentally related (Surucu, 2019 p. 321)."

At the end of the 19th and the beginning of the 20th century, the school system designed a hierarchy between the unknowing innocent child and the competent adults who should teach to children (Postman, 1994). The child, who was signified even with the devil symbol in different periods, was now characterized by innocence in western society (Aries, 1997). In this change, the child was taken to the house, a sheltered area from the street. Domestication of children results from the newly founded innocent child's concept that needs to be educated and protected (James et al., 2014). Since the middle of the 19th century, the spaces produced for children started to increase, including schools, nurseries, playgrounds, hospitals. Of course, the increasing numbers and types of child experts accompanied. In this system, information flow is one-way from adult to child. Therefore, it is believed that even precocity threatens the adult authority and disrupts this hierarchy (Scott et al., 1998). The education system is indispensable in the creative process of the modern subject.

A senior psychiatrist specialized in both child/adolescent and adult psychiatry from the South of Turkey. She is always active in private practice and teaching. She has an undiplomatic style with the confidence that is based on her long years of experience. For many years, the successive changes are made in Turkey about school starting age is the object at issue. With the new education law that entered into force on April 11, 2012, the school starting age was taken one year earlier, and it was decided that children who completed 60 months start school. In the circular published in May, the Ministry of National Education stated that children who have completed 66 months will be enrolled in the school and that children between 60-65 months can be enrolled in the school according to the parents' wishes. With the arrangements made in the following years, different procedures were started to be applied to the school enrollment procedures according to a child's age. A new regulation regarding the school starting age was officially published on 10 July 2019. According to the new arrangement, children between 66-68 months will be able to enroll in a primary school following their parents' written request. School enrollment is compulsory for children aged 69 months and

over. For children aged 69-71 months, school enrollment is compulsory, but it can be postponed for a year with a parent's petition, and the student is directed to preschool education.

Ms. A: "As (Ministry of) National Education goes wrong, we examine much more patients."

R: "Then, can we mention an over-diagnosis or the over-medicalization..."

Ms. A: "There is no over-diagnosis! Unfortunately, that's the problem, for example, there are so many problems even associated with the age of starting school in Turkey, you know. Firstly, the students were starting at 72-months, then they changed it to 60-months, now they changed again, and it is 69 months. The age of starting school changes every year. So, not over-diagnose, but we have to diagnose. That's why we examine many patients. What a pity!"

Ms. A criticizes the education politics, and she warns about the increasing effect of these politics on ADHD prevalence. Nevertheless, when I pronounce the notion of over-medicalization, she definitely rejected it. So, what does it mean that the clinical decision about ADHD is under the influence of starting school age? It refers that every political decision that defines a new age limit creates a new expectation spectrum. For example, regardless of age, a first-year student in a primary school should sit in a chair for 40 minutes, listen to the teacher, and follow the instructions. The student who is five years old will not be able to achieve this, while his/her attention will be easily distracted, another 6-year-old will be able to control his/her attention longer. Absolute normative values define the expected attention span for an age group. However, the criterion that plays a role in the ADHD diagnosis process is not to have the relevance to this attention span but to match the expectations in the student study setting.

5.3. Threshold of Defining Attention Deficit in Turkey

All psychological phenomena are normative (Brinkmann, 2010), and the psychological phenomenon that I will discuss under this title attention is normative, as well. While attention is within the limits of normative orders, it is an interest of psychology; but when it passes the limits of order, namely the side of disorder, it is in the territory of psychiatry. Indeed, specific attention tests measure attention according to psychometric norms, and they may sometimes help shape a psychiatrist's clinical judgment. However, my data set shows that clinical judgments and decisions are based on clinical observations and parents' and teachers'

declarations rather than objective measuring tools. Under the circumstances, language is the only tool to analyze the threshold between order and disorder. Hence, I analyze the words, the phrases, and the idioms used by psychiatrists to define the lack of attention and their significations in Turkish society's norms and values. All psychiatrists accept that every human, every child has a different attention span. The crucial question that leads to diagnostic is at what level this attention span begins to distract a child's functionality. I hypothesis that this breaking point between normal and pathologized attention span is shaped based on the social context.

Svend Brinkmann (2016) defines three aspects of psychiatric diagnosis as an epistemic object: having, being, and doing. ADHD is established as an object that subjects may have or not, be or not. According to my data set, ADHD is an epistemic object that a person can "have" and/or "be" in Turkish. This discursive tool objectifies ADHD as a diagnostic category. When a psychiatric diagnosis category is defined, they are perceived as referring to objects that occupy a space in the world. In these diagnostic cultures where we live, these diagnoses' objective existence is universally accepted (Brinkmann, 2016). "Diagnosis labels define, and predict, and in doing so, helps constitute and legitimate the reality that it discerns" (Rosenberg, 2007, p. 16).

A diagnostic criterion in the recent ADHD guideline (Ercan et al., 2008) was framed within APA-DSM standards, although the formal psychiatric diagnostic classification system is ICD in Turkey because of the law of harmonization code of the European Union. The definition of criteria in the guideline is the direct translation of DSM criteria from English to Turkish. They stay strictly loyal to grammar structure and vocabulary. As shown in Table 1, the discourse avoids from qualifying children's/adolescents' personality, and establish problematic issues through verbs such as "fails to give close attention to details," "makes careless mistakes," "has trouble," "does not seem to listen." Although three adjectives are used to characterize a child/adolescent: "reluctant, distracted, forgetful" in the APA version, in the Turkish version, the only adjective used is "forgetful (unutkan)" by defining diagnostic criteria.

On the other hand, when authors continue expanding on criteria in order to illustrate a profile in their writings and oral presentations, they use many adjectives that directly qualifies children's personality such as "dalgin (absent-minded)," "unutkan (forgetful)," "istikrarsiz (unsteady)," "ruya aleminde (his/her head in the clouds)," "daginik (messy)," "maymun istahli (flighty)." We should accept that they all are negative adjectives that qualify not only as a function of mind but also intellect and character. The discourse changes into a moral tone

through the agency of these adjectives. We do not have any concrete way of evaluating these adjectives. These adjectives are used to define a child and his/her condition of being with ADHD and describe moral components that make a person complete or incomplete, perfect or imperfect. The words used to describe an ADHD child's behaviors are not related to medical explanation. In the case of ADHD, moral judgments about its symptoms are historically the reasons for the beginning of a medical attempt that labels deviant behaviors as disorders.

The emphasis on clinical abilities of a psychiatrist to distinguish a neuropathological problem from the same behavioral patterns with environmental causes continues on discourse about attention deficit symptom. However, mainly young psychiatrists accept that it is not easy to decide about the attention deficit diagnosis (ADD). Children with attention deficit disorder are voluntarily accepted by society. Because they are generally introverted and calm, these children are preferred by society. They did not create any problem for teachers and parents. Docility is a moral criterion. They are noticed by society -via the eyes of a teacher or parents- when they fail in their exams. The only concrete distinctive feature for attention deficit is school failure, according to all analyzed materials.

The desirable moral criteria provide that children who are not diagnosed, but where is the desire for school success in this morality discussion, especially if the owner of this demand is with the parent? Durkheim had proposed pedagogy as the only fundamental instrument of moral education. Nevertheless, does this instrument evolve with advances in the field of neurobiology? Durkheim aimed to end the monopoly of a metaphysical stance toward morality and replace it with a rationalist approach. According to him, some scientific references are necessary to categorize a moral fact. Three elements are described in order to characterize it. First and the most essential is 'discipline' as one of the fundamental elements of education. It is the tool to teach children to control their desires, to restrain their needs, and so in this way to limit their behaviors. These restrictions transform depending on the periods, places, and age groups. In parallel with the changing values, discipline rules change. According to Durkheim (1934), self-control is the essential feature of the discipline element. This is the ability to say 'no' to oneself or the capacity to hide their feelings. He values having control over our desires, passions, and habits. For Durkheim (1934), the reference point for self-control is moral values, which should be taught to children. However, rationalism has transformed in parallel with the values that evolved in time, and moral values no longer have sufficient for rational modern minds as a reference point. The endeavor to ensure the deviant behavior framed scientifically

has evolved to the neurobiological revolution in psychiatry since the 1980s and psychiatry replaces the religious, moral values with scientifically described ‘good’ behaviors.

A junior child and adolescent psychiatrist from a public hospital in Ankara states that the children who have only inattention related problems cannot be diagnosed early enough. Because these kinds of children are generally defined by the moral criteria of docility and kindness, and they do not coincide with the area that gives discomfort. According to her, there is no psychiatric help request until these children reach secondary education (second four-year period, the compulsory education in Turkey is twelve years that includes three four-year-periods), psychiatric help requests come at the point the children are not sufficiently seen in their classes.

Ms. B: “(...) The lack of attention is missed, attention deficiencies come (to a psychiatrist) late, around middle school. They are applying (to the clinic) very rarely. Because they are known as smart, kind, good listeners of teacher, quiet. The family doesn't realize that much, anyway.”

Psychiatrists need to be declared ADHD symptoms at least in two different settings; however, most teachers do not declare any problem about a child with attention problems according to her experience. Similarly, these children pose a problem for their parents exclusively regarding academic failure. She marks that having a consensus about a hyperactive/impulsive type of ADHD with teachers and parents is easier than the attention deficit type.

Ms. B: “(...) According to teachers, (children) may not have an attention deficit problem, but they can have it in reality. (The statements of) teachers may be a false negative. However, when we give teachers questionnaires to know about hyperactivity and impulsivity, generally, they agree with us. For attention-deficit, in self-reports, if they (children) are in middle school, the teacher's and our clinical opinion more agree. Teachers do not specify a significant problem, and parents can be called fifty percent fifty percent for attention deficit (symptom).”

She also underlines that it is easier to observe hyperactivity and impulsivity during a clinical examination. There is a clinically meaningful difference between what is immediately observable and what is not. While observable features help the psychiatrist to make the correct diagnosis, its absence may cause an incorrect diagnosis, according to her discourse. She is the only psychiatrist who pronounces four times the misdiagnosis. Even discursively, they refer to

misdiagnosis, and rhetorically they avoid verbalizing it because the possibility of misdiagnosing undermines the absolute authority of the medicine.

Ms. B: "In other words, hyperactivity and impulsivity, for example, are very easy to observe during the clinical examination. I mean, he/she is moving, he/she doesn't stop, even if he/she is sitting in place, he/she is fidgety. I'm already waiting (for prescribing) for mild levels. They are not very important, but there are so many times that I think I missed out on attention deficit (diagnosis). Hmm, sometimes the teacher says there is no problem. For example, according to the family, there is a problem, or I think I misdiagnosed. I have started (medication). For example, the child does not benefit in any way. I misdiagnose... I think I have misdiagnosed, and then I don't observe any benefit. So, if the child has ADHD, we expect some benefits (from medication). Here is the anxiety that may emerge under this. There may be a lack of attention due to anxiety or depression. I may have missed it and misdiagnosed ADHD."

As I mentioned above, "sitting down correctly" is an important social value in Turkish society like many other cultures. I observed it in psychiatrists' statements, the books, and the videos that I analyzed. The quotations of psychiatrists from parents frequently include complaints about not sitting down or not sitting down correctly. This social value is even valid for adults. One of the interviewees interpreted this social value regarding the relation with authority in Turkish society:

Ms. E: "(...) What we call education in our education system is to sit at a school desk, never get up, listen to what the teacher tells us.... in our society, children are a bit more afraid of the authority figure. Naturally, no matter how bored the children are, they do not get up. Distractions appear in the form of playing with his notebooks and pencils because there is an authority figure in front of him."

She thinks that more children than we observed want to stand up in classrooms, but they cannot because they are scared of teachers. Thus, according to her, the desire to move is being observed as distracting, playing with notebooks or pencils. It is an excellent example to show how a symptom may differ phenomenologically in a specific culture and how social values affect specific desires' behavioral reflections.

Another psychiatrist who works in a private clinic in Ankara highlighted that attention deficit is perceived as a problem, particularly in exam periods, and the families look for help

in these periods. After the second 4-year education period, children and young people are put to exams to transition to high school and university in the Turkish education system. These exams are a social classification method in which students with the best grades can go to the best schools, and unsuccessful ones are directed to the schools where they may continue to fail. As he states, the exam success is the only aim for parents and teachers, and this is partially an output of the education system, but he interrogates the pathologization demand of parents, which is based on their unrealistic expectations. However, again, the same psychiatrist had said, as I had been quoted in Chapter 3, that many of these families were very persistent, insist on many psychiatrists, and force them until they receive the diagnosis.

Mr. C: "In Turkey, attention deficit becomes a problem in the exam periods, which is when families come. Generally, in eighth or 12th grade. Because they have the exam of transition to high school in the 8th in Turkey, and in the 12th grade, there is a university entrance exam. They come here at these points more than mid-grades. It is something the system imposes on one hand. The expectation of parents and teachers is passing the exam, unfortunately. There is also the inconvenience of expectations, and we see many patients like this. We advise many parents to review their expectations and refuse to diagnose and start treatment."

Another psychiatrist from a public hospital in the same city emphasizes the demand for prescribing drugs from families to increase school performance. These two physicians from Ankara state that they have rejected these demands and that their clinical observations do not require diagnosis and prescribing drugs.

Ms. B: "The children talk among themselves, families recommend each other. When someone sees the benefit of the medicine, others want to benefit. However, I don't prescribe medication to someone without a diagnosis. So, it's normal for families to hear more because it's the most common childhood pathology."

The highest rates of diagnosis and stimulant use are reasons why ADHD's reputation between parents and children as stated in the extract, and another reason is the experience share of parents and adolescents who benefit from stimulants. It provokes that the families who focused on students' performance look for more cognitive and/or school efficiency.

Ms. B: "It can be hard to remember when the symptoms begin in adolescents. It is often more difficult to obtain clear information of the type of attention deficit. Attention deficit must have started before 12 years of age. You need to think of other

problems in the lack of attention starting, such as depression, anxiety, and substance abuse. Lately, a high school senior student came to the university and said he had problems with attention for the last 1.5 months. But of course, his problems are caused by anxiety.”

Psychiatrists see excessive demand for ADHD diagnosis and psycho-stimulant prescription by parents and teachers, and according to them, they quickly realize fake cases. Decidedly they do not medicalize these cases; however, as another psychiatrist emphasized that some parents continue visiting various psychiatrists until they obtain the diagnosis and psycho-stimulant prescription.

Mr. H: “Today they come with a confident expectation. They are carelessly googling superficial information. Since there is no background information to unite it, it is as much as they interpret in their minds. They come by saying if their child has this diagnosis. He's already set up something in his head, and he's coming to me to confirm it. In that case, they criticize our practice, but I really don't care. I prefer not to give drugs unnecessarily to a child. They don't like me, then go to another psychiatrist. But at least if I'm not sure, I won't label a child under this diagnosis.”

The anti-psychiatric discussions that keep going since the 1970s argue the responsibility of psychiatrists to promote psychiatrist diagnosis and drug treatments, in another saying, “medicalization from above” (Brinkmann, 2016, pg. 2). Nevertheless, this argument has yielded to “pathologization from below” (McGann, 2011, as cited in Brinkman, 2016), which means a persistent demand by citizens to explain and clear up their sufferings in life with a psychiatric diagnosis. Brinkmann (2016) conceptualizes this phenomenon with ‘diagnostic cultures’ that are an inseparable part of contemporary social life. Pathologization derives from the Greek root ‘pathos’ signifying suffering. Pathologization is “the process by which on experience comes to be seen and approached as something that elicits suffering” (Liebert, 2014, p. 1327). Pathologization can be used interchangeably with medicalization. Medicalization is “inappropriate or abusive instances of medical authority” (Sholl, 2017, p. 265). According to Conrad (1975, p. 12), medicalization means “defining behavior as a medical problem or illness and mandating or licensing the medical profession to provide some type of treatment.” It is more convenient to use pathologization if parents or teachers judge some behaviors as pathological instead of psychiatrists.

I find it useful to share a conclusion of chapter 3 in which I argued the relation between ADHD symptoms and families' socioeconomic status. Because the moral values that determine the normative limits of the attention span discussed in this chapter are also shaped according to socio-economic status, so I would like to consider the results of these two chapters together. A wide range of different socio-economical levels in Turkey generates heterogeneous social structures and varies social values. A group of families does not qualify school failure as a problem in how we see in the extracts from rural and suburban sides of the country. These children defined with attention deficit are characterized with socially approved qualities as being calm, kind, or docile. Another group of family prefers private clinics or university hospital is obsessed with school success, which is criticized by psychiatrists whom I interviewed, but emphasized that other child and adolescent psychiatrists may diagnose them.

5.4. Another Agent of ADHD Diagnostic Decision: Teacher

The two settings that psychiatrists are obliged to verify their observations are home and school. The parents are the agents of giving information from the house, and the teachers declare the behaviors of children in school. While parents' opinion is based on their self-report in the consultations with psychiatrists, psychiatrists generally ask for information from teachers via questionnaires and some scales; the most commonly used one is Conners' Teacher Rating Scales. As an exception, one of the young psychiatrists stated that she sometimes calls teachers to ask their opinions, another senior psychiatrist as an exception stated that she did not ask teacher's opinions because she does not trust their statements.

The children who are described with the lack of attention are easily tolerated by society thanks to their discreet characteristics. On the contrary, hyperactivity and impulsivity are often expressed, especially by teachers, because they are children whom they have difficulty managing in the classroom. According to the following extract, it is easier to have a consensus about hyperactive and impulsive type of ADHD with teachers for a child and adolescent psychiatrist. Nevertheless, in these cases, parents' notifications may be controversial because they tend to show their child more sagely. In some cases, parents' and teachers' interests may be parallel, but they may sometimes conflict.

Ms. B: "(...) the teachers' declarations can be false-positive. But never false-negative. It is the case for hyperactivity and impulsivity, but teachers may not see attention-deficit as a significant problem, but the child could have an attention deficit. When we give questionnaires to teachers, we usually agree with them in

terms of excessive hyperactivity and impulsivity. (...) Regarding lack of attention, either in self-reports - when children grow up when they are in middle school- and our clinical opinion is usually agreed with them. The teacher does not indicate a huge problem, and parents can... let's say fifty-percent for attention deficit. But for extreme hyperactivity, there may be points where parents and teachers disagree, parents may pretend to have a little less symptom, but teachers become more objective than parents."

Moral interpretations of children by adults may determine their demand (or not) for the pathologization of behaviors. The teachers who interpret some behaviors as silence and calmness do not want to pathologize them even if they are not successful in their lessons. Nevertheless, hyperactive/impulsive types are quickly declared as problematic children by sabotaging the class with ease. On the other hand, parents are responsible for raising good children, but they also need to keep their good parental positions. Because of this, they are able to moderate their notifications about their children, as I have observed with my own clinical experience.

The second element of a moral fact proposed by Durkheim (1934) is the 'attachment to a group.' By analyzing the moral features of inattention symptoms concerning education, I interpret schooling as an attachment point to society. Therefore, it is vital to ensure the adaptation of the child to the education system. For Durkheim (1934), the acts of personal purposes do not have a moral value. To accept an act as moral, it should be socially beneficial. Human beings need more superior objectives than individual ones and a more superior entity than all the individuals to serve. After removing the theological order from moral worlds, society--as an observable empirical entity--takes God's place in modern times. So, I propose discussing school success with social attachment, which is highly crucial in modern times. Even the problem of academic failure did not exist 60 years ago, Gabriel Wahl states that the etiological studies about academic failure show that 90% of this problem is derived from medical-psychological causes (as cited in Morel, 2014, p. 7). Academic failure has been a social problem since the 1960s.

The reasons are generally attributed to social, pedagogical, psychological, biological, or genetic roots. The approaches to academic failure compete, and the dominant one varies from period to period. Over the last two decades, academic failure and its solution have been individualized via psychological, genetical, and neurobiological interpretations (Morel, 2014). Rafalovich (2015) remarks that the significant impact of medicalization on school-age children

exists in parallel with the dominance of medical discourse about ADHD. That is to say, the medical discourse that reflects on medical practice dominates ADHD conversations at the extra-discursive level. Particularly in psychiatrists' ADHD discourse towards the general public, ADHD is presented concerning academic life. Likewise, the parents worry about their children's school experiences, which leads them to seek a solution. Attachment to a group also includes the parent's responsibility towards society. They are supposed to bring up their children as socially engaged and responsible for their health and education.

In this extract, Ms. F claims that a psychiatrist is able to distinguish *real* complaints and *parent-based* complaints. But again, the evaluation of a psychiatrist equally subjective. Psychiatrist advocates his/her role who decides whether parents are right or wrong. It is like a kind of judge function, but a moral judge. The decision of the honesty of parents or teachers is highly a moral judgment. Without any objective or measurable tool, behind a professional identity, they have the power of misbelieving parents' or teachers' words. Psychiatrists take this judicial capacity from their authoritarian positions.

Ms. F: "(...) First of all, I... How long have these complaints existed? It's important. In which environments, if it exists only at home if the child has no problem in school, teachers don't think there is a problem, and in our examination is in such way, so we don't diagnose. Mostly, (in this situation) there is a family tolerance related problem or, you know, in a normal childhood, children can have attention problems, they can have hyperactivity in the developmental process. Sometimes it can be something that supports their development."

The complaints about expected, 'normal' developmental behaviors are a common issue. So why do parents perceive these behaviors as problematic or pathological? In the first instance of extracts, psychiatrists present it as misevaluation by parents. However, they find an immediate reason to pathologize the 'situation.' Discursively, they start the paragraph while trying without medication, but they always observe something that does not go well, and medicalization becomes the only solution. I propose conceptualizing this effort as rationalization and how it serves to maintain power relationships, as Foucault (1982, p. 779) points out, for "investigating the links rationalization and power." Because "the relationship between rationalization and excess of political power is evident. And we should not need to wait for bureaucracy or concentration camps to recognize the existence of such relations. But the problem is: What to do with such an evident fact? (1982, p. 779)".

Ms. F: “In school-age children, the observation of the family is more prominent of course, the observation of the family and teacher is more prominent. There is much demand in preschool. When the child starts to walk, in a preschool period, at a distracted age, the child is active in the normal developmental process. At this point, I talked about the developmental stage characteristics and, of course, I recommend follow-up. In other words, if there is nothing enormously destructive if the child is not regularly exposed to trauma because of hyperactivity. But if there are frequent fractures, diseases, and head traumas, frankly, I see that it is appropriate to start medication in the preschool period, and I have started.”

The other materials that I collected from various media types show that psychiatrists always have a great endeavor to promote ADHD diagnosis. If they were so uncomfortable with over-medicalization or over-demand of parents, why did not they publish any articles or books? Or, if they are faced with publisher issues, why did not they broadcast any YouTube videos? Because I located hundreds of videos broadcasted by psychiatrists on YouTube due to my content analysis at the beginning of my study, and there are not any sample that follows psychiatrists’ these kinds of critics. “... which knowledge circulates and functions, its relations to power. In short, the régime du savoir (Foucault, 1982).”

Ms. A, a senior psychiatrist, underlines that a psychiatrist should trust her clinical judgments, and she underlines her lack of confidence in the teacher’s opinion. According to her, teachers may give their ideas based on their judgments, and for her, it is not ethical to shape her decision considering the teacher’s expectations. The fundamental feature that makes reliable the clinician judgments is clinical authority, but not the teachers.

Ms. A: “(...), sens clinique is very important for me. (...) I really don’t care about the information that teachers transfer. They are very misleading. I really don’t care much. I don’t send teachers any form because teachers did many things. For example, they abused the diagnosis a lot. They abused it from two different sides; ah! This child should take drugs, or ah horrible! This child takes the drugs.”

The term of *sens clinique* is adopted by Turkish from French, which means the competence called medical intuition. According to her experience, a group of teachers is overly pushing for pathologization. Controversially the other group is fanatically against drugs, so she prefers to rely on her clinical abilities. Ms. A has a negative attitude towards teachers. She told me that teachers never like her out of these extracts. I think that she is not open to collaboration

with them, and as we see in the following extract, she gets parents to change teacher/class or school as an intervention method for problematic behaviors.

Ms. A: "So, I often get changed the school because I don't support prescribing drugs under the seven years old. I change the school, I can change the teacher sometimes (laughs), but of course, if (child) is obviously hyperactive, there is nothing to do, we start to use drugs."

The psychiatrist who worked in the southern region spoke very carefully about the region and people she worked for and did not want to create an environment for false generalizations or misunderstandings. She emphasized that all evaluations regarding the people of the region may be subjective. She was avoiding general jurisdictions. I think that is why the region has such a condition that is disadvantageous and suitable for othering. (Also, she was the only person who said she wanted to study medicine to be a psychiatrist, and she loves communicating with people.) She said that she absolutely wants the teacher to give his opinion. She either calls or sends a questionnaire. The psychiatrist whom I quoted in the paragraph above claimed the opposite. The trust for teachers' declarations is relative.

Durkheim (1934) adds a third and last dimension, 'individual autonomy,' to his moral understanding after his first two elements, like a system of rules imposed externally to individuals. Moral principles, which take their power from the past, are followed by religious people because they believe in a perfect existence. He argues that it is not a submission or passive behavior. It is conscious participation. It means complying with an order consisting of rules believed to be such as naturally. He proposes establishing a branch of science that investigates the nature of moral principles and the reason for existence. If we know what causes it and become aware of its functions, we can consciously handle these instructions. The third element of moral, which implies consciously choosing to behave morally, is the element that separates rational moral from religious moral that is why he attributes significant importance to the third element. Pedagogy is a primary method to ensure individual autonomy for Durkheim (1934). Durkheim designs these moral criteria to be used in teacher education. Because they are the teachers who will give moral training according to him, and pedagogy should be based on these three moral elements. However, as we see in Turkey's case, the children who cannot be disciplined are no longer within the scope of the pedagogy. Teachers are also just tools to identify and direct the children whose attention cannot be disciplined to the psychiatric service. On the other hand, the solution for an unsuccessful child at school and unable to provide self-control is also sought in medicines based on psychiatrists' experience

that I interviewed. As a result, morale education is medicalized. However, it is not possible to talk about individual autonomy when children are medicalized. The family's persuasion replaces individual autonomy - in some cases, relatives, teachers, or psychologists who have declared against the drug or pushed out of the process.

5.5. Conclusion

Psychology “fabricates normative standards about how to be, act, think, feel and live, and it provides people with tools to reach these standards (Brinkmann, 2010, p. 14)”. Then, psychiatry comes into play for the people who are out of these standards. To make the diagnosis of ADHD, it is considered the most critical threshold that experts can frequently emphasize is focus on not what the subject wants to pay attention to, but the normative order dictates. It determines one of the limits of functionality. Therefore, normative order encodes the school success as a necessity, and the unsuccessful students are sent to psychiatry clinic as a requirement of the 21st century. In this chapter, I tried to show how attention deficit is diagnosed within the scope of school failure. Although psychiatrists who make this diagnosis are aware of the things that are not going well in the education system, they are not interested in questioning whether the necessity of medicalization. This absence of questioning serves to individualize a social problem.

Two moral elements of Durkheim (1934) have a role in the help-seeking and clinical judgment process for ADHD-like behaviors. According to the American psychiatric classification system (DSM-V, 2013), the symptoms of ADHD, which include hyperactivity, impulsivity, and the lack of attention, are defined from the perspective of self-control. Particularly, the symptom of inattention that is defined with a head in the clouds, which I focused on during this chapter. Obtaining the school success and the good parenting that helps raise a healthy child generates the dimension of ADHD discourse that attaches it to society. However, this task that refers to moral education attributed to the already over pedagogy undoubtedly positions within the psychiatry task boundaries in 2020's Turkey. Although Durkheim's pedagogy as the primary moral education tool does not entirely replace it, we may now discuss medicalization as the second way of moral education.

This chapter met with another subject that the children got into a relationship while establishing their subjectivity: teachers. Although they overlook the lack of attention, according to what psychiatrists report, they are always crucial characters that enable families to transport specific problems to psychiatrists. In this chapter, in which we look at ADHD in

terms of the education system and attention deficit, we saw that, in parallel with other chapters, children are completely silent subjects and how education as an institution participated in their creation through ADHD.

6. A Risk to Public Health and A Prevention for Social Control: ADHD

“To heal is good, to prevent is better (...)”

Castel et al. (1982, p. 295).

ADHD has conceptually evolved over the years and is contemporarily considered an umbrella that involves three primary symptoms in different combinations. This chapter will trace the two symptoms that discursively collocate, hyperactivity and impulsivity, concerning their implications concerning risk management in the social and moral context.

Today defined symptoms in relation to ADHD were first investigated as a medical subject by British pediatrician George Frederic Still (1909). He shared the same point with William James (1950), who argues the importance of attention as “moral control of behavior.” According to Still (1909, p. 1008), children with hyperactivity problems have a “defect in moral control.” The moral control of behavior means “the control of action in conformity with the idea of the good of all.” Moral control has been perceived as an output of a conscious comparison with one’s willed choice in the name of the good of all, which is denominated as “moral consciousness” (Barkley, 1995, p. 4). When we look at the emergence of ADHD, it is easy to realize which behaviors are pathologized and their moral roots. However, focusing on neurobiological proofs or drug treatments, on “biological repertoire” with the terms of Horton-Salway (2011), we become desensitized about mortality.

Moral philosophers like Frankena (1973) divide values into two categories. As the first category, moral values point to wrong and right, virtue and vice. Non-moral values, which constitute the other category, include pragmatic, epistemic, and aesthetic values. In the medical context, non-moral values are often discussed regarding physical inadequacies such as illness and injury. On the other hand, moral values are used to understand the mental disorder categories (Sadler, 2014).

6.1. Defining ADHD with its Negative Consequences

Attention deficit and hyperactivity/impulsivity symptoms were separately defined and evaluated in ADHD discourse within texts that I analyzed. While attention deficit is understood

with school failure, hyperactivity and impulsivity refer to uncontrollable, risky behaviors for oneself and society. Psychiatrists describe hyperactive/impulsive child from Turkey as “fidgety (*kipir kipir*),” “like an engine, like driven by an engine (*motor takilmis gibi, motor tarafindan suruluyormus gibi*),” “one who cannot sit still (*yerinde oturamayan*),” “chattering (*geveze*),” “eli dursa ayagi durmaz (*cannot keep one’s hand or foot still*).” The principal verbs that portray a hyperactive/impulsive child are *running, jumping, climbing up, standing up, talking, shouting, falling down, getting injured*. When the symptom of *attention deficit* is being defined, a narrative is established through adjectives. However, I observed many verbs within hyperactivity and impulsivity symptom narratives. The discursive building of ADHD objectifies a psychiatric diagnostic category as an epistemic object with three dimensions: a having, being and doing (Danziger, 2003; Brinkmann, 2016). I analyzed attention-deficit discourse that is enabled by *having* and *being* narrations in Chapter 4. The narration of hyperactivity and impulsivity is constructed by “doing”—in other words, by using verbs that define many movements. The *motor* metaphor, which is frequently used to describe hyperactivity, also refers to mechanical motion according to Turkish psychiatrists' analogy. One can *have* a psychiatric diagnose, like possessing an object or can be identified with an identity based on a psychiatric diagnosis as *being* hyperactive, depressed, or anxious (Brinkmann, 2016). Besides, as I observed in Turkey’s ADHD discourse during mentions of hyperactivity and impulsivity symptoms, “one may *do* or *perform* something hyperactively, depressively or anxiously, which can be referred to as an adverbial dimension of suffering and mental life in general, having to do with the ways in which things are done” (Brinkmann, 2016, p. 28).

While explaining why children with attention deficit are overlooked and diagnosed late, a junior psychiatrist from Ankara explains why hyperactive/impulsive types are directed to psychiatry. Attention deficit-weighted children, which can be defined as “docile bodies” (Foucault, 1978), are known as smart, quiet, and well-behaved, unlike hyperactive/impulsive children. What they define is not any cognitive function or symptom; rather, they glorify a child’s personality as a whole. The hyperactive/impulsive type, which means the opposite, points to an image that is not smart enough, dangerous, and which society does not want to accept. The child's moral presence, which has been affirmed in a positive case, is undesirable, and in an adverse circumstance, is to be taken under control.

Ms. B: “(...) The lack of attention is missed. Attention deficiencies are noticed (by teachers) late, around middle school. They come very rarely. Because they are

known as smart, good, fair, listening to the teacher, quiet. The family doesn't realize that much, anyway.”

This extract is typical of how psychiatrists narrate the teachers' reasons for referring children to them. These children do not obey classroom norms. Children who do not accept the rules in a classroom exist in every phase of schooling history, and the sanction opposing this norm varies according to disciplinary approaches. This sanction could be physical violence at any point in history and in any place on the earth or standing on one foot in the corner of a classroom at another place and time. Following my data set, I observe that this sanction is the ADHD diagnosis in this day and age. A psychiatrist commits the sanction, but a teacher is the first agent in the diagnostic process. Psychiatrists define three dimensions of this process: a teacher's noticing of behavioral and educational evaluations in school, parental declarations, and a psychiatrist's observations. The power of a teacher on diagnosis cannot be ignored. In many extracts, the psychiatrists state the frequent abuse of this power by teachers.

Academic problems do not rank in priority for hyperactivity/impulsivity kinds of complaints. Even if a child is not the best student in their class, school failure does not lead their visiting psychiatrists. In addition to hyperactive and impulsive behaviors, aggressiveness and violence are significant signs. Psychiatrists refer to distinguishing between hyperactivity/impulsivity symptoms and behavioral problems similar to them. As a matter of fact, they are *visually* – because they are observable – the same problems. When psychiatrists describe difficulties with self-control, problems based on parental attitudes, and hyperactivity/impulsivity rooted in the brain, they mention two kinds of issues. But this is a false-categorization because they are defining the same behaviors at the discursive level. Furthermore, they do not have any tool to show these differences objectively. They defend their career experiences as competence in the decision-making process, but it remains hugely subjective.

The latest clinical guideline of ADHD in Turkish was published in 2008 with the title *Attention Deficit Hyperactivity Disorder Clinical Practice Guide* written by Eyup Sabri Ercan as the primary first writer with Ayse Avcı, Nahit Motavalli Mukaddes, Bengi Semerci, Selahattin Senol, and Yankı Yazgan on the editorial board. The following extract is from the *Guide's* Clinical Course title. The single paragraph explaining the clinical course for ADHD is translated below:

“Many of the children with ADHD continue to be diagnosed with ADHD during adolescence (80%) and adulthood (65%) (Barkley 1996, Weiss & Hechtman 1993).

Also, they are exposed to psychiatric conditions such as antisocial personality disorder and alcohol-substance use disorders much more than those without ADHD in childhood; academic problems such as demonstrating school success below their capacity; social risks such as causing accidents, frequent divorces, early pregnancy, low job success or unemployment (Barkley 2004) (as cited in Ercan et al., 2008, p.7).”

First of all, the primary reference here is Russel Barkley, one of the most influential contributors to ADHD medicalization in the last decades and the counselor of pharmaceutical companies. Even though he is a clinical psychologist, this background gives us an idea about clinical practice's theoretical *course*. ADHD, defined as a lifelong disorder, draws attention to the problems that it may create in the future. The urgency of diagnosis and treatment stems from this. Medicalization means to pathologize ordinary experiences and present medical solutions to ‘normalize’ these experiences on behalf of pharmaceutical industries (Conrad, 2007). Treatment is proposed as the only solution to these behavioral problems. According to DePoy and Gilson (2014), medicalization is related to economic profit and social control. Behavioral problems have been transformed from moral weakness or sin onto the medical level. Antisocial personality disorder, alcohol-substance abuse, divorce, or early pregnancy, as illustrated in the extract, are morally constructed, and pathologized behaviors and ADHD is conceptualized as the earlier period phenomenon of these historically unmoral, contemporarily pathological behaviors. The other risk that endangers the economic stability of the society is inefficacy in academic and professional life. Again, ADHD should be intervened to prevent possible failures that the individual will experience in the future. The extract's narrative is established with reference to Barkley (1996) and Weiss and Hechtman (1993). Thus, it is not considered valid in particular to Turkey. However, it can be said that some morally unacceptable behavior patterns that are medicalized in contemporary psychiatric culture are now referred to under the same name in many parts of the world.

In the Turkish language, “illness,” “sickness,” and “disease” are referred to with the same word (*hasta*), so it is not linguistically possible to discuss a difference (for detailed information, see also Chapter 1). However, “disorder” has an exact correspondence as ‘*bozukluk*,’ and the translation of ADHD includes this word *disorder*. Contradictorily, ‘a chronic illness’ is chosen by the writers of the guideline to define ADHD in the following extract. ‘*Chronic*’ signifies the lifelong feature of ADHD, and ‘*illness*’ emphasizes their considerably medicalized approach. The sentence continues with the phrase ‘*if it is left*

untreated' to draw attention to psychiatric, academic, and social *complications* that I may interpret as public health *risks*. Therefore, it is concluded that ADHD must be *medically* treated. Complication (*komplikasyon*) has been included in Turkish with medical terminology in parallel with its meaning in English: "an extra medical problem that makes it more difficult to treat an existing illness." But in time, it has also been included in daily language with its connotation of *problem*. However, this extract is not taken from a daily life dialogue but a diagnosis and treatment guide written by physicians. Therefore, it is significant that the word describing a medical problem is used to describe possible academic and social life problems. Their medicalization is concretized with the connotation of this word.

*"ADHD is a **chronic illness** and can cause major psychiatric, academic, and social **complications** if it is left untreated. In this regard, patients diagnosed with ADHD should be treated effectively (Ercan et al, 2008, p.13)."*

I confronted again with the usage of the word of *illness* to point out disorder in the book of the guideline's leading writer. He used the same formulation of the phrase with precisely the same words. However, this time he uses *disease* and *disorder* as synonyms, which are conceptually defined differently in the international literature. According to philosophical theories, the classification of the concept of disease has been shaped based on the distinction between naturalism and normativism (Hofmann, 2017). Psychiatry has a much more challenging position to identify diseases because most of the problems *exist*, however "no specific biological structures or identifiable causes of mental disorders (Sisti & Caplan, 2017, p. 11).

Turkish lacks vocabulary separating *illness*, *disease*, and *sickness*. However, the difference between illness/disease and disorder is quite clear (see Introduction chapter). The usage in this and the previous quotation is, of course, not accidental. I interpret this attempt as a continuation of the biologization of psychiatry that has been going on since the 1980s. As one can see, Eyup Sabri Ercan is the most pioneering name in child and adolescent ADHD in Turkey. He is the first writer of the guideline, the president of the Turkish Association for Child and Adolescent Psychiatry, has an active role in the National Congress of Child and Adolescent Mental Health and Illness, and the *Turkish Journal of Child and Adolescent Mental Health*. It means that almost 80% of the data reviewed within the scope of this thesis has been published with the consent of a team led by this scholar, and he constructs a biomedical discourse about ADHD, which excludes all other discussions from various perspectives towards ADHD.

*“ADHD, like all **medical illnesses**, is a disorder that responds very well to early diagnosis and treatment. However, it can lead to serious medical, academic, and social problems when it is left untreated (Ercan, 2016, p.19).”*

The guideline’s “*major psychiatric, academic and social complications*” statement is replaced by “*serious medical, academic and social problems*” in the Ercan’s (2008) book titled *Attention Deficit and Hyperactivity Disorder* and published in the same year as the guideline. In connection with the previous quotation, we see that the words *problem* and *complication* are used in the same sense in both the medical and social fields.

As we see in almost all the quotes in this chapter, ADHD is medicalized through the risky behaviors that it may cause in the future, rather than the problems caused by its existence at present. Yanki Yazgan (2017) points to *the consequences in the short and long term*, yet the short-term consequences that affect clinical decisions are school failure, accidents, and injuries that occur in childhood. However, the list of long-term consequences gets longer and longer, and avoiding all these consequences offers us a representation of adulthood: an adult who is well-educated, successful in business life, strong in social relationships, physically healthy, self-confident, respectful to rules and laws, and careful to have a safe sexual life. Thus, what is pictured is a citizen profile whose education, business, social, sexual, and legal responsibilities are regulated, particularly in the books targeting large parent audiences.

*“The frequency and the negative consequences that it can cause in **short and long term** make ADHD an important public health problem (Yazgan, 2017, p.29).”*

I am aware of how much the extracts I quoted repeat each other, and I felt the same, especially when reading the books. However, I only sample a small part here. This narrative, which repeats itself and establishes bad scenarios in a highly-charged manner about the future, terrorizes its readers. As I mentioned in other chapters, it is critical to recall the psychiatrists' complaints working, especially in big cities, about many families' pathologization demands. However, in the same way, the most frequently read books on the market tell parents many pessimistic stories about their children's future and encourage them to find the solution in drug treatment urgently. In addition, there are no works on the market with an alternative narrative that is accessible to parents, not only by psychiatrists but also by other mental health professionals. Likewise, the rhetoric and discourse adopted in the YouTube publications that I have reviewed are similar. In other words, the knowledge production of the psychiatric circle and the complaints contradict each other.

*“When it is **not treated**, it affects every area of the person's life **negatively** and causes **psychological, social, and educational problems** (Semerci & Turgay, 2014, p.49).”*

Until this chapter, while examining how psychiatrists approached their clinical decisions, we saw that they want to position themselves to balance the over-pathologization from below in the social landscape but do not want to use it too much. It is as if that they are always aware of their power but prefer not to use it. Besides, they always advocate for the child's well-being according to their discourse. Teachers and families are depicted through attitudes that try to influence the diagnosis, and in some cases, even force psychiatrists to prescribe. High rates of diagnosis and drug prescription are related to the education system. However, when we look at the information they distribute to the public, they recommend that immediate intervention is undertaken when symptoms of hyperactivity and impulsivity are observed. The problems that may arise in the future are described as even leading to death. Contrary to what they say, this attitude that holds power and uses it for social engineering is concerning. “The new strategies dissolve the notion of a subject or a concrete individual, and put in its place a combinatory of factors, the factors of risk (Castel, 1991, p.281).”

Below is a paragraph that legitimates the medical treatment of ADHD, which is also taken from a book. In the first part, while looking at how the definition of ADHD is made in Turkish, we observed that the definitions were made within the biomedical repertoire, sticking to the English original, but the moral repertoire comes into play when describing a child or adolescent who is diagnosed or should be diagnosed with ADHD. In this quotation, the child is defined as negative, challenging, and tiring as a whole (personality), not symptomatically or with any cognitive function. The medicalization of these behaviors—but in reality, their personality and moral existence—is based on the family's difficulty managing this. It is said that family fatigue can lead to the punishment of children and even child abuse. However, medical intervention into a child's life is advocated without interfering with parents who cannot manage it. While the psychiatric discourse attempts to justify this again for the child's protection, the fact that parents can apply punishment to their children even in *an extreme and damaging way* is legitimized through a diagnostic category.

*“ADHD affects children's family relationships. After a while, the family begins to give a **harsh response to the child's impulsive behavior**. It is difficult to live with a **child who does not understand people, is controversial, harmful, and has difficulty establishing relationships**. The family becomes more and more negative,*

*commanding, and rejecting. Some **parents feel tired and exhausted** with the effort to keep the child under control. This tiredness, fatigue, and even a feeling of **being bored of the child** may lead the family to **punish children** with ADHD in a **powerful and damaging way**. In some rare cases, **child abuse may occur**. Child abuse frequency is higher in children with ADHD than in children without it (Semerci & Turgay, 2014 p.71).”*

No reference is given after a suggestive sentence such as “child abuse frequency is higher in children with ADHD than in children,” and no research examples are included. Nevertheless, the power of persuasion of quantitative rhetoric was used with the words of *frequency* and *higher* and a comparative phrase formulation. In the previous paragraph, the authors legitimize the medicalization of children through family relationships, and in the next paragraph, they mention the friendships and relationships of ADHD people—they are no longer refer as children but people. As a result, psychiatrists’ clinical judgments include friends and families’ moral-laden judgments about children.

*“(...) **Their friends find them irritating, loud, aggressive, and strange**. It is difficult to make friends with such children. (...) One of the reasons that they spoil their relationships is the **inconsistency** in their behavior. It is difficult to relate to a person who is continuously changing and unsure what to do. (...) Sometimes people with ADHD can establish positive relationships with others because of their peculiarity and benevolence. However, **these positive features are poorly developed in most ADHD people**, and some of them are generally **alone** because they cannot establish a close relationship (Semerci & Turgay, 2014, p. 73).”*

In the book *Hyperactivity and Attention Deficit* written by Osman Abali in 2009, it is stated that the frequency of ADHD is 5-10%, but the recent prevalence research (Ercan, et al., 2019) shows that 19% of children are diagnosed with ADHD. This fear of *untreated hyperactive people* has opened the way for more people to be diagnosed. Abali attributes responsibility to the family and the society to guide these people as much as the treatment. According to his discourse, psychiatry is responsible for interfering with the individual's loss of functionality and the functionality of family and society.

*“Hyperactivity is a widespread condition that is seen with a frequency of **5-10%**. In the long term, people who experience **failure, substance abuse, crime, and social problems** are likely to be **untreated** hyperactive people. If it is not treated*

*appropriately and adequately **guided by the family and society**, intervention in this functionality loss should be timely (Abali, 2009, p. 13)."*

Like the other writers, Dr. Osman Abali (2009), who established the Forensic Child and Adolescent Psychiatry Unit at Istanbul University Medical Faculty in 2010, preferred an anecdote-based form of narration for presenting case examples. The apparent audience of these books is parents. Discourse is also set up to make them worry about their children's future and encourage medical treatment as quickly as possible. In other words, a moral narrative is established by excluding scientific rhetoric. In the sentence that he chooses as the introduction to the story, he romanticizes the story by including himself. A classic case example presentation starts with the objective information that belongs to the patient, such as age, gender, and occupation. After this prelude, it is no longer a case but a childhood friend. He draws his portrait of a child and adult as someone who lacks self-control. M, his childhood friend, has had problems and failed in all areas of his life. At the end of the story, he dies because of his impulsive behavior in traffic, which had continued since his adolescence. However, rather than being a case study, this life story ends with an ADHD diagnosis after the person's death, and with the shocking knowledge, he would have survived if he was treated.

*"**In the city where I was born and raised**, M, whom I knew very closely, was an energetic and active child. He did not like to follow the rules and engage in constant fights with **his family**. In addition to being mettlesome and fast, he had a short fuse, got angry swiftly, and many of **his friends** distanced themselves from him because of these reactions. **His school life** did not go well. He started running out of school frequently and eventually barely finished elementary school before beginning to work. During the periods he worked, he started **smoking**, drinking **alcohol**, and consuming **cannabis**. Before he turned 18, he was secretly taking his father's car, and at age 18, these behaviors evolved to using his car in risky ways. Speeding on the streets and **driving fast** was a completely different joy for him. Then years went by, and he got married. He has **severe problems in his social life with the marriage** that did not go well. Many job changes, the progressive alcohol addiction... Finally, **he left his wife**. He quit using substances, but he maintained his haste, impatience, and risky behavior. M, who did not work for a long time and who changed jobs frequently, **died at a young age by having a traffic accident** on the way to his last job. These fluctuating and moving years started in childhood and continued until he died at a young age. **Perhaps with the help of a treatment that would have***

started in the primary school period, M could have been alive now with his children (Abali, 2009, p.8-9)."

In the book, another case is presented right after this story to set up a contrast. This story characterizes a child who is unable to focus, gets easily bored, and is unsuccessful in his lessons. However, the crucial difference here is that the family, who first refuses to receive psychiatric support, eventually begins drug treatment out of fear that their children will be held back a grade at school. According to our narrator, the child's entire life changes with treatment. He has a very successful educational life. However, even the end of the positive story finishes by adding an element of horror, and the reader is left suspicious of what would have happened if the child had not been treated.

*"H was getting bored quickly in his childhood. He did not want to do anything for a long time and often changed activities. When he started school, he was able to handle the situation with his intelligence despite being different from other friends. When the teacher warned his family about his attention problems, his family refused to go to the doctor. Years passed, and his success in lessons decreased; although he was smart, he could not adapt to lessons. **Finally, the family applied to a specialist out of fear that the child would fail the class, and he started receiving the treatment for his attention.** H, who regained his ability to pay attention within weeks, was **among the most successful students of the class** in a short time. Afterward, he **was accepted to the university department of his choice.** If H had not started treatment, his academic state would have deteriorated, and more severe problems would have occurred. Maybe his academic life would be over, and he would not be able to do his job successfully... Who knows... (Osman Abali, 2009, p.9)."*

Osman Abali (2009) adopts a more narrative, moral and alarmist language than the other psychiatrists/authors that I analyzed. Bengi Semerci and Atilla Turgay (2014) try to stick to a more pragmatic style, while Yanki Yazgan (2017) prefers a more pedagogical tone. These psychiatrists' basic arguments are the same but differ rhetorically.

This differentiation in discourse may have an impact on a different style of parents. Nevertheless, the fundamental desire to touch the parent's sensibility about raising a *good* child within the modern world's social and moral values such as being successful, having a consistent professional life, maintaining physical health even-tempered is common to the discourse used in all the books. The *future* consequences of a *delayed* diagnosis present a potential obstacle in raising the "good" child. These types of books, videos on various digital

platforms, and recently Instagram pages of mental health professionals are efficient attempts to *medicalize society from above* (Szasz, 2007).

“Although the necessity of treatment is justified for many reasons, such as protecting children and putting the families at ease (as previously mentioned), the management of society and the budget is the most crucial motivation for diagnosing hyperactivity and impulsivity symptoms. The conclusive chapter of Semerci and Turgay's (2014) book is dedicated to untreated ADHD. This chapter provides a list and table to document the cost of ADHD not being treated. As a result, untreated ADHD is costly for society in terms of labor and direct economic loss.

The price of untreated ADHD:

- ***Reduced life*** (due to the risk of misbehavior, careless driving, quarrels, smoking, drinking and drug abuse, low health quality, high depression, and the probability of suicide)
- ***Being dangerous to others*** (careless driving, aggressive behavior)
- ***Low quality of life*** (both for the patient and the family)
- ***Lack of productivity and efficacy*** in business life
- ***Expensive special education***
- ***Expensive comorbidity treatment***
- ***Expensive medical or psychiatric care for some ADHD patients*** (inpatient care, detention house, or imprisonment)
- ***Also, when ADHD is not treated, not only mental and academic problems but also medical problems increase. Attention Deficit and Hyperactivity Disorder has a significant effect on causing various bodily discomforts and damaging accidents (Semerci & Turgay, 2014, p. 184-185).”***

This scheme can be analyzed from four perspectives: economic, criminality, medical and public health. The first and most dominant is the economic dimension of ADHD. This is a costly disorder for society, which is often emphasized discursively. Second, ADHD is coded as an important component of criminality. Children diagnosed with ADHD are considered in the risk group of criminals, so the task of preventing ADHD treatment is undertaken. Thirdly, ADHD, which is defined as a mental illness, may add new mental and physical complications to the already existing clinical picture, and this increases the motivation of psychiatrists to

intervene at an early stage. Finally, it is evaluated in terms of protecting the physical and mental health of society from a public health perspective. Moral judgment, which is shaped at the intersection of this gaze, emerges to clinical judgment.

Moral judgments imply two aspects. The first one indicates what a good moral citizen is, and the second one concerns the source of immoral behavior. Considering who ADHD is or not, first of all, a definition is given of *the good moral citizen*; being attentive and successful in school and business life, being able to control one's impulses, having good family and friend relations, caring for physical health. The profile that does not meet this definition is determined, and the treatment is undertaken to create *a good moral citizen* or at least to ensure they do not get worse. In this way, the clinical decision is shaped by moral judgments.

On the one hand, it is necessary to ask the question: is this a moral economy? Didier Fassin (2020) reformulates the concept by taking advantage of the complementarity of E. P. Thompson and Lorraine Daston's conceptualizations. Fassin (2020) says that his conceptualization offers a definition parallel to Jean-Baptiste Say's classical political economy concept. "A moral economy is the production, circulation, appropriation, and confrontation of values and affects (Fassin, 2020, p. 218)". However, people exchange things that are not goods but values and effects that appertain to a social object. For example, one can mention the moral economies of immigration and punishment, on which Fassin (2000, 2018) has worked. "The general idea of this conception of moral economy is that what is produced, disseminated, appropriated, or contested is values and affects (Fassin, 2020, p.218)". It is not only goods that are exchanged but values. In moral economies, a value cannot be considered separately from life because it includes how well people live their lives and how long they live. In this process, moral values turn into economic ones. The product produced by the workforce is included in the price as well as human lives.

In the light of this conceptualization, the cost calculation of untreated ADHD refers to a moral economy. It works on these two aspects of moral economies, just as there are two aspects of moral judgments. An adult defined as functional within the definition of ADHD will valorize economic activity participates in society by being careful and having self-control. In the opposite case, a careless, clumsy, hasty person will harm both his own body and the environment in which he/she lives. It has an economic cost for society. Psychiatry both tries to treat ADHD and give it added value while also attempting to reduce the damage that can occur if it is not treated.

6.2. Violence as a Result and Cause of Impulsivity

Increasingly, governments make risk assessments to facilitate governmentality, and risk calculations are also based on various regimes of truth. The discourse of *dangerousness* is an essential component of the risk society created in the 20th century. At the end of the 19th century, the threat coded as a dangerous class or criminal race on the nation's borders began to be sought outside. The dangerous criminals, who were inside, were also interpreted as a threat to individuals, not the state. The individualization of the process was accompanied by statistical techniques, which make it possible to identify dangerous criminals. Recidivists were initially described as ungovernable. Then the perception towards them changed and began to be called risk. The *unknown lives* of these people made governance problematic. In the 20th century, new policies emerged to deal with dangerous individuals. Welfarism and guaranteeing universal security were the first of these policies. “A new type of citizen emerges: it is no longer based on juridical status as it had been during the era of nineteenth-century liberalism; instead it would be based on dependency and reciprocity between individuals and the state and individuals and themselves (Pratt, 1997, p. 38).” However, the understandings that regulate the lives of individuals were developing based on eugenics and medico-psychiatry. Thus, new ways of judging people spread out of the courts and laws. The codes, standards, and maximization of human potential incarnated within health, aging, education, and good behavior demarcated new jurisdictions and made well-being specialists responsible for their application. In this way, the power to judge individuals was linked to other powers, such as those of classification, evaluation, and diagnosis. The power to judge came to be exercised in several places, notably in the case of conferences or in psychiatrists' offices, thus abolishing the exclusivity of the courts (Pratt, 2001).

Impulsivity is seen as the cause of much anti-social behavior, violence, and crime (Foroozandeh, 2017) in the scope of ADHD discourse in Turkey and is used to define both the child and the parent of violent behavior.

*“When **impulsivity** is combined with the nature of adolescence, the adolescent has the problem of not stopping himself. It involves escaping, expulsion from school, school failure, and behavioral disorders. The risk of car accidents, drug abuse, premature and insecure sexual intercourse increases due to quick decision-making. (...) **Impulsiveness can lead to quarrels, injuries, use of weapons, and troubles with the law** (Semerci & Turgay, 2014, p.92)”*

Prescribing drugs in the preschool period is a crucial issue for the psychiatrists that I interviewed. They all specified that they do not prefer prescribing for preschool children. However, there is a description of exceptional cases that all of them make as well. This exception is based on self-harm. If the child's behaviors can potentially cause any danger for him/herself, psychiatrists do not hesitate to prescribe. The high potential self-harm behaviors were described as "*jumping across the road, jumping from high places, constantly falling and injuring him/herself.*" Although rarely seen in the preschool period, "*hitting and hurting his/her friends*" is characteristic as well.

A young psychiatrist from the south of Turkey shares a case example from her proper clinical practice to explain in which cases she may prescribe for children under six years old. She defines the threshold for children under 6 to use medication as mental and physical traumas to which children are exposed. According to her, in this case, the 4.5-year-old child was always physically hurt because of his hyperactivity and impulsivity. She states that she had to start the drug after an accident during which he eventually became disabled. However, interestingly enough, she only mentions physical traumas and not psychological ones.

Ms. F: "Of a four-and-a-half-year-old boy, his family says that he was always very active. He lost all the fingers of one hand in a machine, a tomato sauce machine. He was always very active, constantly exposed to trauma in such a way, and he was falling, getting injured. Four and a half years old, I started a very low dose of medication because he was exposed to a lot of trauma."

Accidents by children, self-injuries, or damaging their own bodily safety may be interpreted as self-directed violence. Someone who harms himself /herself because he/she cannot maintain their self-control may also harm another person because the same psychological mechanism does not work. It is the prejudice that preventing the damage caused by the person to his/her own body, which will lead to a society in the long term.

Adana, another city from the South, is a region known for hot temperament, violence, and high crime rates. A senior psychiatrist, who was born in this region and has worked in Adana for a long time educational and professional experiences in Ankara, highlighted that the rates of ADHD and bipolarity are significantly high in this region as much as in the Black Sea region. She said that it is always hard to distinguish hyperactivity/impulsivity from bipolarity in her clinical practices. For contradictory cases, she takes the diagnostic decision according to the patient's response to treatment. In this case, the treatment decision comes before the diagnosis.

*Ms. A: “For example, bipolarity often mixes up with hyperactivity. There are so many bipolar cases in Adana. **The distinctive diagnosis between bipolarity and hyperactivity is challenging in Adana.** They are Mediterranean people who have the characteristics of a hot climate. So sometimes, the drugs determine the diagnosis. If we cannot decide, we try drugs. If the patient is bipolar when he takes the stimulant, his symptoms increase.”*

According to her experiences, she encounters many impulsive parents, underlining that fathers, in particular, are highly impulsive, and the demonstration of their impulsivity is violence. For her, a valid reason for this impulsivity is based on the region's hot Mediterranean climate. She has the formation of adult psychiatry in addition to child and adolescent psychiatry. Thus, she is entitled to prescribe psychoactive drugs to adults. She said that she takes advantage of this authority and prescribes for some fathers who come for their children. She mentioned that she observes some benefits, notably in stopping domestic violence.

Ms. A: “I encounter violence against children very much. Very very much. By both mother and father. A lot, a lot, a lot. But for them, this is not violence. This is a disciplinary method (laughs). It is not violence, but education!”

However, as we see in the above extract, she says that the violence—which is first attributed to impulsivity—is coded as a method of education by these families. In this case, while the recourse to violence is attributed to a biomedically-defined disorder, she claims that it has another cultural understanding at the same time. This etiological discursive confusion about the source of violence attracts attention at several points.

Another psychiatrist from Ankara stated that she did not encounter violent cases in the university hospital where she worked before but frequently witnesses violence in the public hospital where she was recently transferred. For her, the socio-cultural level of the parents affects whether or not they resort to violence. On the other hand, she states that violent behavior is learned. According to her clinical observations, the child, who sees that his father subjected violence to his mother or has been subjected to violence himself, applies violence among his peers. In other words, although the neurobiological originated stance is reflected as the cause of the violence, psychiatrists do not agree on interpreting the examples of violence in their clinical practice.

Ms. B: “(...) Today a mother hit her child just in front of me during the examination. The child does not have ADHD, a child with lateral hearing loss, or even a hearing instrument. The boy did not answer the questions I asked, and the mother hit the

boy! Families with children with ADHD also use violence against the child when they can no longer deal with it. On the other hand, the child who sees the father hitting the mother takes this as an example, or because he is hit, he starts to show violence at school.”

6.3. Comorbidity

The most significant criticism directed at DSM-V was the excessive increase in the number of disorders, but the less noticeable issue is that one person has more than one diagnosis. Children are also not exempt from this situation (Lovett & Hood, 2014). If a person has more than one psychiatric disorder, it is called comorbidity (Achenbach, 1990). This term has been borrowed from general medicine and epidemiology. According to Mario Maj (2010, p. 268), “the structure of current diagnostic systems, especially that of DSM-IV, is such that the vast majority of patients will qualify for multiple psychiatric diagnoses.”

ADHD discussions also show that a majority of children diagnosed with ADHD meet the criteria for at least one more disorder (Pffner, 2008). Understanding comorbidity in child and adolescent psychiatry involves different motivations in practice and theory. For example, in practice, the treatment of a child with Obsessive Compulsive Disorder may differ according to the state of being depressed. In theory, the highly comorbid ADHD and dyslexia may be due to genetic factors affecting both (Lovett & Hood, 2014).

Lovett and Hood (2014) focus on three philosophical issues that they think lack within comorbidity studies. Firstly, they question how the relationship between different psychiatric disorders and their observable symptoms leads to conceptualizations of comorbidity and different rates of comorbidity. They conclude that if disorders are labeled only for certain observable symptom groups, more comorbid diagnoses will be made. Secondly, they discuss how diseases are classified as dimensional rather than categorical. While categorical categorization is built on the existence and absence of something, dimensional conceptualizations place disorder somewhere on the spectrum. It affects both the frequency of comorbidity and the alteration of diagnostic significance. Lastly, they question the ethical implications of the comorbidity conceptualization and focus on using multiple psychiatric medications due to high rates of comorbidity.

More than half of children with ADHD also have the diagnosis of Oppositional Defiant Disorder (ODD), more than 1/3 have Learning Disabilities, and 1/4 have depression or anxiety disorder (Weiss & Hechtman 1993). Pffner (2008) states that children diagnosed with ADHD

have one or more comorbid conditions, such as disruptive behavior or emotional disorders. The most important reason for the emphasis on comorbidity in ADHD discourse is due to its effect on drug decisions. In the Attention Deficit Hyperactivity Disorder Clinical Practice Guideline, antipsychotic treatment is not recommended for diagnosing ADHD, which is set alone. However, risperidone can be used as an antipsychotic alone or in combination with stimulants in other comorbid cases such as to conduct disorder.

*“Antipsychotics should not be used in ADHD treatment unless it is absolutely necessary due to short- and long-term side effects. However, in patients with ADHD and comorbid behavioral disorder, generalized developmental disorder, or mental retardation, atypical antipsychotics, primarily **risperidone** (in low doses such as 0.5-1.5 mg/day), can be used alone or in combination with stimulants (Ercan et al, 2008, p. 21).”*

One of the psychiatrists I met, Mr. K from Ankara, also stated that the diagnosis of ADHD can be seen together with bipolar disorder in some cases or that it is difficult to differentiate the symptoms. In such cases, he points out that they may prefer atomoxetine instead of methylphenidate. Being unable to make a diagnosis decision but still being able to prescribe medication based on estimation emphasizes the uncertainty of the diagnostic decision, which I will mention throughout the study.

Mr. K: “Sometimes the diagnosis of ADHD can be confused with the diagnosis of bipolar disorder. So, we don’t see a 100% bipolar profile, but we may be suspect it. The profile can sometimes be more compatible with ADHD. In such cases, depending on the comorbidity, for example, we may prefer atomoxetine to methylphenidate.”

Ms. E, from a rural context, underlines the difference of diagnosis in terms of comorbidity in the countryside. According to her experience, she does not encounter so many cases diagnosed with only ADHD. ADHD is generally a condition that accompanies the other diagnostic categories. While she emphasizes that mental retardations are more common in psychiatry clinics within rural conditions, it likely refers to ADHD’s urban characteristics, as several psychiatrists point out (Chapter 2).

Ms. E: “I am working at (a little town) public hospital... Children from the countryside come to the hospital, so there are a lot of comorbid situations. Like what? Cognitive developmental retardation, intelligence deficiencies are obviously

frequent. So, we observed these (ADHD) symptoms in company with various comorbidities.”

The content analysis that I applied to the articles published in the *Turkish Journal of Child and Adolescent Mental Health* between 2002-2019 shows 31 articles related to ADHD out of 336 articles. The most common research interest is about comorbidities. Seven of these articles are about other disorders that accompany ADHD. These disorders are anxiety, depression, learning disorder, oppositional defiant disorder, disruptive behavior disorder. The two leading media where the child and adolescent psychiatrist in Turkey share their professional knowledge production show that the most common subject researched is associated with ADHD is comorbidities.

6.4. Psychiatric Power and Social Control

None of the YouTube videos included in the analysis addressed comorbidity. On the contrary, the most published subject in journals and congresses is comorbidity. I analyzed *Child and Adolescent Mental Health and Illness Congress* abstract books between 2012-2019. Until 2013, there were panels where oral presentations were made and poster presentation sessions in congresses, while after 2013, each congress included keynote lectures, courses, meetings with experts, and workshops. However, I compiled these new titles and panel presentations as oral presentations. Accordingly, 4 out of 54 oral presentations and 2 of 139 poster presentations in 2012 were about ADHD. 5 out of 58 oral presentations, 27 of 138 poster presentations in 2013; 22 of 98 oral presentations and 21 of 88 poster presentations in 2014; 34 of 150 oral presentations and 29 of 142 poster presentations in 2015; 15 of 145 oral presentations and 34 of 149 poster presentations in 2016; 50 of 249 oral presentations and 51 of 207 poster presentations in 2017; 50 of 241 oral presentations in 2018; 44 of the 158 poster presentations; in 2019, 54 of 270 oral presentations and 33 of 113 poster presentations were related to ADHD. These congresses hosted 1265 oral presentations and 1,134 poster presentations in a total of 8 years. ADHD was the main subject of these 234 oral presentations and 241 poster presentations. In other words, the number of studies presented in the national congress on ADHD as oral and poster are 475.

As part of my study, I applied content analysis to these 475 studies. Among the studies that put ADHD in its center, the most crucial issue was the physical and mental illnesses accompanying ADHD. 209 out of 475 studies were about ADHD comorbidities. Some of the

physical illnesses accompanying ADHD are diabetes, epilepsy, cerebral vision impairment, obesity, myalgia, and thalassemia. Among the accompanying mental disorders, there are diagnostic categories from both DSM-4 and DSM-5, such as anxiety disorder, autism, internet addiction, encopresis, oppositional disorder/conduct disorder, bipolar disorder/mood disorders, tic disorders, eating disorders, sleep disorders, obsessive-compulsive disorder, substance abuse. Drug studies follow comorbidity studies in terms of frequency of research. 97 out of 475 studies were concerned with drugs and their effects and side effects on ADHD and its comorbidities. Forty-eight of them focused on the side effects of various active ingredients. The most commonly investigated active ingredients are methylphenidate, atomoxetine, risperidone, and their dozens of side effects. Side effects were an issue that psychiatrists avoided talking about in our face-to-face interviews. They state that it is seen very rarely and usually disappears even if it is seen in the first weeks. On the contrary, we see that it is the second most frequently researched topic in congresses.

Michel Foucault has a unique understanding of the subject. In his theory, the subject signifies how the human mind is constructed, and a subject becomes an object simultaneously. In the 19th century, linguistic studies had begun to categorize, measure, and compare the things belonging to the human. Human beings were objectified. Nevertheless, this objectification reciprocally becomes subjectification. This knowledge about ourselves feeds a new power form defined by Foucault: bio-power, which is the set of mechanisms through which the human species' basic biological features become the object of power strategies. These implicit power relations encourage us to act in specific ways and subjectifies human beings. Objectifying people requires creating standards that determine which people measure in what way. We need a norm to decide which child is more successful than others or which children are more attentive or active than others. A norm, a standard is only possible with reference to a group, and modern governmentality is only possible in reference to a population. All of these practices emerge at the same time as our modern understanding of what a population is insecurity, territory, and population. Foucault shows that definitions of the population are used to define the term as repopulating a territory. It had a slightly different meaning than today in the 17th century and began to take on its modern usage when a population becomes important analytically to study, understand and quantify because the population of a country provides workforce, economic development, agriculture. As it becomes the source of a state's wealth, birth, death, sickness, and productivity rates become essential. As an aggregate, the population creates a mean, an average citizen, and a normative curve against which exams, tests, and

requirements can be assessed, and the question can be asked how can the correct sort of population be encouraged. It is only then with the modern concept of population that we get the modern form of governmentality. Foucault writes, “boldly, at first sight, and somewhat schematically, we could say that sovereignty is exercised within the borders of a territory, discipline is exercised on the bodies of individuals, and security is exercised over a whole population (Foucault, 1978)”.

Foucault (1978), while talking about the legal justice of his epoch, says, “legal justice today has at least as much to do with criminals as with crimes. Or more precisely, while, for a long time, the criminal had been no more than the person to whom a crime could be attributed and who could therefore be punished, today, the crime tends to be no more than the event which signals the existence of a dangerous element - that is, more or less dangerous – in the social body” (1978, p.2). The criminal now means more than the person who committed the crime, so the punishment assigned to him is no longer sufficient. The crime takes the form of an indication of other dangerous situations to which the criminal's social existence may lead. Since the beginning of these developments, identifying the criminal with not only the crime but with his indications has been explained by two requirements. The first was the desire to include more rationality in penal practice. The second is to make the laws and the provisions that they point out more harmonized with social reality (Foucault, 1978). Although this was not planned initially, “the notion of psychological symptomatology of a danger” has been included in discussing whether the individual can take responsibility for his / her acts. At this point, the discussion begins to step out of the legal system. “In this development, psychiatry and psychiatrists, as well as the notion of “danger,” played a permanent role. (He) would like to draw attention to two stages in what one might call the psychiatrization of criminal danger” (Foucault, 1978, p.3).

Psychiatry's intervention in the field of law appears in the early 19th century. Foucault (1978) argues that this is because of a series of crimes committed in different corners of Europe between 1800-1835. The psychiatrists of the period, Metziger, Hoffbauer, Esquirol and Georget, Ellis and Combe, make many references to these cases. These cases were addressed because insanity was problematically defined as forms of dementia, imbecility, or furor in the law by the end of the 18th century and because insanity was obvious in these cases, it was easier to recognize. However, these new cases were appearing without “visible symptoms of insanity.” For example, Henriette Cornier, who worked as a servant at a house in Paris in 1827, insisted that her neighbors leave her child with her, then cut off the child's head and threw it

out of the window. Another reason is that these crimes were not committed as self-defense; they were all severe crimes, and almost all cases included strange cruelties. In short, the seriousness and uncommonness of the cases led the psychiatrists of the period to revisit the problematic of insanity. The thing to remember here is that the psychiatrization of crime comes “from above” (Foucault, 1978). It can be said that the institution of psychiatry decides to understand these cases through the concept of madness and produces its knowledge, and then implements it in the justice and medical system. These concepts do not wait for the scientists’ discovery in a given form, as in the natural sciences. Whether murder is committed because a person is murderous or insane is shaped by the conceptualization of disciplines that try to understand it.

ADHD discourse in Turkey repeatedly stresses that the various problems that will occur if ADHD is not be treated are also included in the scope of crime and punishment notions—such as the fact that a person is driving illegally, getting into an accident, and causing the death of other people, finding himself in the illegitimate situations as a result of substance abuse. The divorce highlighted in many places is a legal issue as well as a family problem. Although ADHD rhetoric is not explicitly referred to as a crime, the persistent emphasis on the behavioral disorder and antisocial personality disorder points to crime discursively. However, the concept expands here and shows more than just killing or stealing. It is a conceptualization in the context of various legal situations that disrupt social life.

In the eighteenth century, biological and medical terms emerged that describe human populations with the development of demographics, urban structures, and labor problems. The knowledge and the terminology of these populations’ housing and feeding conditions, birth and birth rates, and pathological phenomena were produced. The social body was no longer a simple juridico-political metaphor. It was a biological reality and an area where medicine could intervene. Therefore, doctors became technicians of this social body and public hygiene. Psychiatry became an independent science in the nineteenth century. Being able to manage the dangers that could affect the social body gave psychiatry a certain prestige. Mental health professionals of the period were working on themes of mental illnesses’ origins or various therapy techniques, but on the other hand, they all knew they were treating a social danger. Because they attempted to understand insanity in connection with living conditions, the insane one was dangerous for both himself and others and even for the generations after him. “Nineteenth-century psychiatry was a medical science as much for the societal body as for the individual soul (Foucault, 1978, p. 7)”.

What about 21st-century psychiatry? What relationship does this branch of science, which day by day reduces human behaviors more to neurobiological structures and brain functions, have with social risk management? In the light of the data that I collected, I may answer this question specifically the 21st-century Turkey. In Turkey, child and adolescent psychiatry are significantly related to social risk management rather than dealing with the individual. Going beyond the existence of psychiatry as a science that developed from intervening in social problems in the construction of the current position of psychiatry, the social, political, and economic context in Turkey serves to reinforce it. Increased crime rates, the unfair justice system, the education system that no longer has the trust of families or mental health professionals, and unemployment are some of the problems we heard from psychiatrists throughout these five chapters. However, I did not ask a single question about social, political, or economic problems. This context, which I can see as a citizen or anyone watching the world news, determines the majority of the problems that need to be intervened in by psychiatry. In other words, it expands the field of intervention already in psychiatry.

Robert Castel (1981) analyzes the changes in psychiatric practice through two important points. The first one is the birth of the asylum in the early 19th century, which pushes us to consider the concepts of risk and dangerousness. The goal is to manage the categories of the population that pose a problem. The second one is the spread of psychological culture in the 1970s. As a result of this shift in psychological culture, the individual, who became acquainted with her psychological dimension, started to take herself as the center of the social life. Castel (1981) hypothesizes that the management of at-risk populations and the activation of the individual's capacities may constitute the new mode of neoliberal governmentality's guiding principles. Nevertheless, the first mode of risk management has serious shortcomings. On the one hand, it had no preventive value. The patient has to show the symptoms that indicate his/her dangerousness or act to be treated. Namely, the intervention takes place at a later stage. On the other hand, such a demanding application is costly, heavy and its implementation is restraint. These limits have caused medicine to expand psychopathologies over time.

According to Castel (1981), two results of the psychiatric institution were criticized by the anti-psychiatric movement of the 1960s. On the one hand, critics supported the medicalization of mental health, psychoanalysis declined tangibly, and biological research and behavioral therapies increased. On the other hand, it contributed to the spread of clinical information outside of the medical mechanisms. The only problem was the careless widening of the medico-psychological field. This expansion took place in two important areas. The first

was a new psychological culture. In other words, specialists and groups spread medico-psychological knowledge in less therapeutic and more cultural ways, such as personal development. Secondly, of course, far from the logic of care, medico-psychological knowledge found itself in what Castel called “population planning.” He adopts the Foucauldian perspective and integrates the measure of governmentality, including schools, companies, student identification, staff selection, etc. Broadly, he analyzes the public policies and the evaluations of some groups such as children with disabilities and risk groups within the scope of governmentality. The second expansion concerns *gifted* children. Because some children with high intelligence were defined by psychology, as in the example of the disabled, it was a requirement of governmentality. People are classified to manage the optimal. The definition of a *gifted child* structured the emergence of psychology as a figure of social control.

In the example in Turkey, according to the child and adolescent psychiatrists’ discourse compiled from various media, children are diagnosed to maintain good family and friend relationships, to perform their education successfully, to have a good job, not to pose a threat to society and their own lives, and to establish a happy family and serve the continuity of society.

A psychiatrist trained at the military medical academy in Ankara repeatedly emphasized that he trusts drug treatment effectiveness and observes that it is the only solution at the end of the meeting. He stated that if people in prisons can be controlled in childhood, most of them would be diagnosed with ADHD, which would mean that helping children now may reduce the future crime rates. Likewise, for him, many people who cause traffic problems have ADHD-induced behavior problems. Robert Castel (1991, p.283) differentiates risk and dangerousness. “For Classical psychiatry, risk meant essentially the danger embodied in the mentally ill person capable of violent and unpredictable action.” On the other hand, “dangerousness is rather mysterious and deeply paradoxical notion since it implies at one the affirmation of a quality immanent to the subject (he or she is dangerous), and a mere probability, a quantum of uncertainty, given that the proof of the danger can only be provided after the fact, should the threatened action actually occur.” As this military physician interpreted and seen in many quotations, children categorized as with ADHD are perceived as dangerousness rather than a risk that should be managed because they are being judged on what they can do in the future and what they may cause.

The oldest of the models explaining the relationship between patient and doctor are authoritarian models. At the heart of these models is the authority that patients have favored

doctors and medicine (Marcum, 2008). According to Haug and Lavin (1981, p.212, cited by Marcum, 2008), “authority classically is defined as the *right* to influence and direct behavior, such right having been accepted as valid and legitimate by others in the relationship.” They add, “authority is defined as the patient’s grant of legitimacy to the physician’s exercise of power, on the assumption that it will be benevolent.” However, when children come into question, we cannot talk about the authority that the patient attributes to a physician. We talk about the acceptance of the physician's authority by the parents who are legally responsible for the patient. While drawing both the philosophical and legal boundaries of the relationship between the patient and the doctor, we open a parenthesis for children because they do not consent to the situation.

In addition to the authority referred to by the patient to the doctor, Russell Kaulitz (1988) identifies three other sources of the physician's authority. The first comes from the legal rights defined by the state to the physician, including prescribing pharmaceutical drugs and performing surgical operations. Another source of authority stems from the medical profession's nature, which is qualified and used for regulating its own members. The last one is cultural due to technological developments, especially in biomedical sciences. Psychiatry directly takes the authority from the state to regulate children’s behavior with medical methods. These behaviors can lead to more important problems socially and personally based on the knowledge from research depending on technological developments. However, I have no observations about the regulation of the profession and its members in Turkey. Only some psychiatrists talked about an age limit (sometimes 5, sometimes 6, sometimes 7) that they set themselves. They stated that they avoid prescribing any drugs to treat ADHD before this specific age limit, and they tried alternative ways such as behavioral tips and suggestions for parenting. However, in any case, they added exceptional situations that necessitated giving medicine to children under these age limits. “The goal is clearly to treat the child's disruptive behavior. They have now stopped trying to find therapeutic excuses for drug use. The drug is clearly accepted as a control instrument. It is an object that increases the functionality of the brain and allows the child to think and behave more normally (Castel et al., 1982).”

6.5. ADHD as A Preview of Conduct Disorder

The severe problems that psychiatrists have to prevent, and which I encountered in various parts of my data set, are summarized by Bengi Semerci and Atilla Turgay (2014) in

their book *Attention Deficit Hyperactivity Disorder from Infancy to Adulthood* with a figure depicting life with a long arrow:

“The Developmental Effects of Attention Deficit Hyperactivity Disorder

*Preschool: **Conduct disorder***

*School-age: **Conduct disorder**, learning disorders, the lack of self-esteem and self-respect, the lack of social relations or problems in social relations*

*Adolescence: Learning problems, social interaction problems, decreased self-esteem, **breaking the rules and laws, alcohol and other substance abuses, accidents, injuries, dangerous sexuality***

University Period: School failure, dropping out of school, problems in working life, relationship problems, low self-esteem, alcohol, and drug use, accidents and injuries, dangerous relationships

Adult: Low work success, low self-esteem, relationship problems, accidents, injuries, alcohol and drugs, dangerous sexuality (Turgay ve Ansari 2007, Dubin and Turgay 2008; cited by Semerci & Turgay, 2014, p. 89).”

ADHD is represented as a preview of situations described as more *important* psychopathologies that may arise in the future and as an earlier phase compared with conduct disorder or antisocial personality disorder. Psychiatric labels with much clearer boundaries in adulthood are often launched by hiding behind problems related to educational, familial, or social situations in childhood (Castel et al., 1982). Here, while adulthood is labeled more harshly, the situation in childhood has to be seen early, and its solution is presented more quickly. The purpose of diagnosis here is not only to detect abnormal people than normal ones but to detect potentially individually and socially dangerous ones at an early stage. Here enters the strategy of examining everyone by the social group and age category to which they belong. Schools are increasingly being used as a tool to perform separation of normal and abnormal, which is assisted by the experts whose number increases day by day (Castel et al., 1982).

The historical emergence of Conduct Disorder reveals a lot about contemporary child and adolescent psychopathology. In the first half of the 20th century, there was strong enthusiasm for social change in the United States. Social programs were organized, social work was born as a profession, intellectually disabled individuals were interested in education, asylums were replaced by psychiatric clinics, the concept of public health was raised, prisons and criminal justice system were being built, and a broad spectrum of welfare movements was

observed (cited. Sadler, 2014). The driving force of this Progressive Movement shapes the emergence of Conduct Disorder. This psychiatric category classified as Disruptive Behavior Disorders in previous DSM and Conduct Disorder classified in the DSM-III (APA, 1980) results from a social interest in juvenile delinquency. The same interest will also appear in the juvenile courts and justice system. Juvenile courts are institutions of the Progressive Era, and it is believed to have been created as a requirement of poor environmental conditions. These poor environmental conditions include many factors, from environmental toxins to bad parenting. The juvenile courts focused on *saving* children rather than *punishing* them. This is why they meet with the emergence of child and adolescent psychiatry. According to one of the physicians of this period, William Healy (Jones 1999, cited by Sadler, 2014), the child and adolescent psychiatrist emerged to evaluate and treat young offenders. Besides, it is an important task to engage in social interventions, from education to parental attitudes, to prevent delinquency.

*“(...) Children with Attention Deficit Hyperactivity Disorder are exposed to more accidental injuries. Especially arm, leg fractures, and head injuries are typical. As their excitability and aggression increase, accident rates increase. Motor coordination disorders, **the comorbidity of conduct disorder**, and the lack of family supervision increase the risk of accidents (Semerci & Turgay, 2014, p.71).”*

In DSM-I, it is defined as the Conduct Disturbance subtype with the name *Adjustment Reaction of Childhood*. Under the influence of the period's dominant psychodynamic perspective, mental disorders were interpreted as reactions to environmental conditions (APA, 1952; Jones 1999 cited by Sadler, 2014). Within the scope of DSM-II, this diagnostic category was divided into two groups; *Behavioral Disorder of Childhood and Adolescence* and *Group Delinquent Reaction of Childhood or Adolescence*. In DSM-III, it is called Conduct Disorder as we know it now. The criteria and categorization of Conduct Disorder were mostly unchanged in DSM-IV and minor changes in DSM-V.

In his analysis of DSM-IV-TR diagnostic criteria, John Z. Sadler (2014, p. 170) states that “in the opening comments for the (A) criteria, the disorder is broadly described as one in which the ‘basic rights of others’ or ‘societal rules or norms are violated,’ then refers to 15 criterion items, only three or more of which are required for the diagnostic”. For him, *rights* refer to human rights, “which typically are used in the context of political discussions, not medical ones,” and he adds that human rights are “political concepts also share an ethical and moral meaning”. The other point that he draws attention to is 'societal rules or norms' violated

in this condition. Then by analyzing the 15 criteria themselves, he highlights the use of many vice-laden value terms such as “bullying, cruel, stolen, destroyed, lies, cons, shoplifting, forgery, truant.” As a result, “the disorder describes the popular image of the mid-twentieth-century delinquent in the language of today” (Sadler, 2014, p.170).

Explaining mental disorders with vice-laden terms conveys mixed messages, whether it means disease or wrongfulness to society. This increases the stigma that occurs due to mental illnesses (Sadler, 2014). However, the representation of ADHD conveys the CD's bad reputation to ADHD. The second problem of vice-laden diagnostic concepts is the social welfare role attributed to psychiatry. Defining mental disorders in terms of immoral and criminal behavior patterns gives the psychiatric profession a social power to prevent them (Sadler, 2014). Since I looked at ADHD from the child and adolescent psychiatrists' perspective, I observed that they accepted this role and power without questioning. This is a problematic positioning both in the construction of the profession and in creating patient subjectivities.

6.6 Conclusion

In this chapter, I tried to understand what ADHD means for the adult imagination. In other chapters, I asked who wants to create these subjectivities, while here, I preferred to ask what psychiatry wants to create and why. While undermining the concept of functionality since the beginning, I have met with two critical parameters: one was school success, and the other was self-control. The child who cannot engage in self-control means the child who cannot control his/her movements and urges. This directionlessness frightens society because of the problems to which they may lead. It becomes a danger, like a bomb warning in a public space. The bomb may explode, but also it may not explode. Nevertheless, since the risk of explosion is more dangerous for society, an intervention is made just in case. The intervention method is defined as a medicine, and that is closed to discussion.

The psychiatric circle in Tukey builds an ADHD narrative to reinforce the fears of families about their children's future. Therefore, the hypothesis of many psychiatrists' underlying the demand of *pathologization from below* related to attention deficiency symptom is not compatible with my analysis in this chapter. They still serve a *medicalization from the top* while defining children with ADHD as potentially criminal, unsuccessful, or dangerous.

The motivation to protect public health is shaped by moral values that indicate what is wrong, what is right, even what health is, and supporting social control leads to clinical

judgments. “To heal is good, to prevent is better, but to maximize output by adjusting each individual to his social role and by calibrating change to the social dynamic as required by the necessity to reproduce the social order is surely the ideal of policy without politics (Castel et al., 1982, p.295).”

7. Conclusion

“Medicine medicalizes reality. It creates a world.”
Engelhardt (1996, p. 189)

Pioneering author of the history of childhood Philippe Aries (1997) shows us how a little human being became a child. Subsequently, various other writers (Crubellier, 1979; Onur, 2005) in various cultures and various epochs defined the landscape of childhood. After I conducted this study, I am of the opinion that ADHD and psycho-stimulants will be a crucial element in writing the history of childhood for the 21st century.

From a historical perspective, it is useful to turn to the theory and practice of child mental health that emerged at the end of the 19th century and the beginning of the 20th. As I mentioned in the Introduction Chapter, Lightner Witmer (1913) founded the first child mental health clinic. The studies conducted there were more school-oriented, using the test developed by Binet and his colleagues to diagnose academic difficulties and Healy's concern with childhood mental illnesses to prevent juvenile delinquency. The ADHD diagnosis in contemporary Turkey is defined and understood in parallel with this historical background. The diagnosis and treatment of ADHD are made based on two critical areas of the functionality on which the mental health of children is established: academic performance and prevention of juvenile delinquency.

To reach the most comprehensive discourses about ADHD produced by child and adolescent psychiatrists, I reviewed academic journals, professional congresses, books written for the general public, and YouTube videos. In addition, I performed semi-structured in-depth interviews to get information from the experiential side of the clinical practice. As a result, knowledge about ADHD produced by child and adolescent psychiatrists in Turkey does not represent the various type of knowledge from different points of view regarding ADHD/hyperactivity/attention deficit. I can say this based on the strengths of the interviews and other materials that I collected from books, videos, and scientific publishing. Producing the knowledge of counter-arguments is only possible with a philosophical and humanities background. With a prevalence rate of up to 20% (Ercan et al., 2019), ADHD is the most common reason for applying to almost all psychiatry clinics, and the demand for psycho-

stimulants from families, which psychiatrists complain about are essential indicators that this issue is over-medicalized.

The knowledge produced by the Turkish psychiatric community and practice is contradictorily irrelevant to their clinical experience. As I observed in congress and journal data, neurobiological studies about ADHD are among the most popular research interests; however, as I observed in their clinical practice, neurobiological arguments do not render any service to the clinical judgment of psychiatrists. On the other side, the complexity of clinical judgment, and the influences of social imaginary on it, is was the main issues in our interviews. They have many questions about this issue, but there is no journal article and little discussion in congresses. I am not referring to any critical or anti-psychiatric discussion, but psychiatrists completely ignore their clinical experience and likewise the experience of *patients* and social context. Ignoring and not producing knowledge on this subject pushes it out of the discussion area. As I see in my analysis results, there is a lack of tolerance towards all other approaches. Knowledge is being monopolized, which brings authoritarianism. Is not such disconnection of science and human experience from the dialectical method a spectacular form of blindness?

In every chapter, we see that psychiatrists create social reality. In this reality, children are vulnerable, and parents and teachers do not have enough information or capacity to manage the situation; psychologists just try to take their market share. Thus, they attribute the responsibility of taking care of the problem to themselves and eternal power. This is not coming from a negative social control motivation; instead, for them, it is based on a positive supporting attitude, but in the end, it serves medicalization and the physician's authority. Foucault (1982, p. 779) points out the importance of "investigating the links between rationalization and power" since "the relationship between rationalization and excess of political power is evident. Moreover, we should not need to wait for bureaucracy or concentration camps to recognize the existence of such relations. Nevertheless, the problem is: What to do with such an evident fact?" (Foucault, 1982, p. 779). My answer to this question is based on the production of knowledge of resistance—in other words, the ability to deconstruct the dominant paradigm. Thus, one of the important conclusions of this research is the absence of alternative arguments and the discourse that I have collected. I care about this result because there is uniformity in the political field within Turkey's last twenty years. I see the reflection of this uniformity in knowledge production, which manifests in the same way. This increases psychiatrists' authority day by day and pushes psycho-social approaches to behavioral problems into the background.

During the interviews, I listened to many different clinical stories, both according to the physicians' different backgrounds and due to the heterogeneous nature of the populations with which they worked. The educational and economic background of parents also affects their perception of ADHD and their help-seeking attitudes. Middle-class and well-educated parents are more success-oriented than lower-class families for their children's academic life. Their fundamental complaint is the children's lack of attention. In large part of this help-seeking, psychiatrists share that children do not need any diagnosis or treatment. Besides, they have considerable experience with parents' medicalization demands to increase children's exam performance. In this context, psychiatrists are against the medicalization of school success. On the other side, the parents who come from the countryside, suburbs, or other lower-class settings consult psychiatrists for hyperactivity and impulsivity. This help-seeking's primary reasons include physical injuries due to impulsive reactions, shifts into Conduct Disorder, problematic behavior patterns in class, and a tendency toward violence. In these cases, according to psychiatrists, children have various vulnerability levels; they have to study at off-grade schools, their parents are not capable of supporting them with their attitudes, and they may not have much stimulus growing up. Thus, even if it is not necessary to conduct any ADHD diagnosis and drug treatment, psychiatrists state that they may make a diagnosis and propose methylphenidate treatment because they have a motivation to support a vulnerable child in the best way they know-how. At this juncture, clinical judgment has been shaped under the influence of the psychiatrists' belief that their authority can help these *poor* people and their moral attitudes that position them at a self-righteous point, which has no relation to the statistical and scientific proofs of ADHD. Thus, they establish and maintain their authority, deresponsibilize parents and children, and attribute a very passive position to themselves.

ADHD is defined by three symptoms in DSM-5: hyperactivity, impulsivity, and attention deficit. They may exist in three different types: combined, predominantly inattentive, and predominantly hyperactive-impulsive types. These symptoms are detailed with specific behavior patterns in DSM-5 and clinical guides. However, one of the remarkable critiques of ADHD is the subjectivity of this criteria. I would like to elaborate on this problematic because, in my research, I consider whether a behavior is low, excessive, or decisive according to how they (we) define the threshold in society and language. I discuss those social and moral values as a measuring tool in determining this threshold. In other words, both society—to identify a behavior as problematic and bring it to the psychiatrist—and the psychiatrist—to determine the deviation from society—need these tools. For example, a psychiatrist might think that it is

challenging to notice children with attention deficit because they fit into society's moral criterion of docility. Such children are always preferable for teachers and parents. The only problem that brings a child to a psychiatric clinic is school failure, and the psychiatrists generally have difficulty in making a diagnosis. On the contrary, hyperactive and impulsive children are undesirable for everyone—teachers, classmates, parents and psychiatrists---highlight that it is easy to *observe* them at the clinic. Therefore, we may say that the psychiatrist can see non-compliance with norms shapes the diagnostic decision.

As I discussed in chapter 5, school failure is defined as the most crucial indicator of ADHD. In the following chapter, I want to ask: Is school failure an individual situation? Biologization and medicalization of school failure detach the educational issue from its institutional and political context. As psychiatrists mentioned during the interviews, they are aware of the educational system's problems; however, they believe that they are only able to help children via prescription. The Turkish educational system is based on central selection and placement exams. Today, after the 8-year primary education phase, all the students in the country take the same exam, which determines the high school they will attend. Then they have a second exam after high-school whose results determine the university and the department where they will study. For this reason, both teachers, parents, and students are exam-oriented. Psychiatrists state that parent's visits are more frequent before the exam periods. They also think that disruptions in the education system and frequently changing policies increase the number of applications. In the decision-making process, this corresponds to another level of children's vulnerability. The institutional privileges of a child in the daily school context and especially for exams after he/she has had a diagnosis play an important role in the parents' demands and psychiatrists' motivations in clinical judgment.

Another motivation leading to ADHD diagnosis and influencing clinical judgment is preventing *more* important problems that may arise at a more advanced age. A few of the 'more important problems' defined in my data set are alcohol and substance abuse, criminal acts, familial problems, and divorce. ADHD diagnosis and treatment are positioned as prevention. In other words, preventing things from getting worse is one of the *social responsibilities* assigned to this psychiatric diagnosis category and the *better* project that I discuss in the first chapter. One of the psychiatrists, a military physician, said that if we could scan prisons now, almost all criminals could be diagnosed with ADHD.

Clinical judgment is a complex process in which the psychiatrist processes all the obtained evidence and incorporates it into his clinical judgment, as Feinstein (1967) argues.

For virtue-based clinical epistemologies, clinical evidence is defined on a broader spectrum, and while quantitative, evidence-based information may be in the background, humanistic data is given priority. When I look at the knowledge and experiences produced by child and adolescent psychiatrists about ADHD on a discursive level, I conclude that humanistic data inform clinical decisions more than statistical data. The region where psychiatrists were born, their age, the schools they were educated in, the social status of the families they come from, the cities and hospitals they work in: all create a background for interpreting the information that comes from patients. Based on this background, social and moral values are formed, and the information first passes through this filter. For example, although there is no information in the literature that the symptom which families seek psychiatric help for differs according to their social status, psychiatrists have a judgment about it as a result of their experiences. So, where does the information about the social status of the family come from? As far as I have seen from the interviews, it is unclear whether the family is asked about their income. Information such as the parents' external appearance, their cultural level, the language they use, their expectations from their children, and the schools their children attended constitute a social status profile for psychiatrists. There is not quantitative, evidence-based information, nor even the kind of analysis we often make with awareness. Social categorization is a quick cognitive process, and a considerable part of the humanistic data comes from this kind of information. When we look at clinical practice, we cannot see the usage of various tests and scales claimed to be involved in the clinical decision process. Thus, this is a journey (Engelhardt, 1979) that does not include any measurement, actuarial judgment (Meehl, 1954) in the process of making the ADHD diagnosis. Statistical tools certainly have obvious benefits that support clinical reasoning, and, in this case, it is necessary to take advantage of them. However, it would also be unrealistic to reduce clinical reasoning to actuarial inputs only (Upshur & Chin-Yee, 2017). In making the treatment decision, the statistical information from the drug's use, which drug should be used for which age group, and the scientific knowledge of side effects all help. As Upshur and Chin-Yee (2017, p. 368) underline, "a balanced account of clinical judgment would then have room for both styles of reasoning. There are good grounds for striving to value both." Within the scope of the data that I collected from Turkey, I observe that although these tools help draw a general statistical profile of ADHD, humanistic information plays a more important role in shaping the diagnostic decision. Feinstein (1982) conceptualizes *clinimetrics* as a field that examines measurements of clinical issues that do not fit into traditional clinical taxonomy. These topics include the type of symptoms, severity, disease progression rate, the severity of comorbidities, functional problems, and medical treatment reasons. It also takes many aspects

of daily life into account. The diagnosis of ADHD is also based on much of the information described in clinimetrics (Meehl, 1954) by its nature. The clinician regards himself as an apparatus of scientific measurement (Feinstein, 1982) and forms clinimetrics for ADHD.

The idea that both clinical and statistical judgment should be valued equally arises from the fact that the nature of clinical practice meets the limits of medical knowledge. The information received from the patient generally does not allow for a holistic understanding of the disease and the patient's condition. This is the nature of the clinical practice. A provisional diagnosis is formed with the information acquired in fragments. Even when the diagnosis is definitive, it is rarely guaranteed to predict the effectiveness of the treatment. An illness's prognosis is shaped within uncertainty (Upshur & Chin-Yee, 2017, p. 368). The information I received from the interviews shows that the diagnosis is made with certainty only in sporadic cases. There are few encounters, which are defined as children who need to be diagnosed with ADHD, in a way that leaves no doubt. In terms of time and content, the greater extent of my face-to-face interviews was about pending cases and the strategies the psychiatrist develops to evaluate them. For example, while someone gets another child and adolescent psychiatrist's opinion, one prefers to regulate environmental factors and follow them without medication; while another is not sure of the diagnosis decision, he prescribes medication and goes from treatment to diagnosis according to the efficiency of the drug. These strategies arise due to the need for uncertainty related to diagnosis, treatment and prognosis produce. Djulbegovic et al. (2011) advise for comprehensive classification of uncertainty in clinical medicine. They state that "uncertainty is inherent in medicine. It occurs at every level of clinical practice and research. It has multiple causes, with important implications for decision-making, quality of care, and patient management. It will remain a central feature of medical practice" (Djulbegovic et al., 2011, p. 347). Uncertainty originates from lack of evidence, conflicting interpretations of this evidence, limited access to evidence in time, the difficulty of applying statistical information to individual situations, and the patient's unclear preferences and values. In other words, all clinical encounters contain uncertainty in themselves.

I borrowed the term of subjectivity from anthropology, which helps me comprehend the function of ADHD in society and the agents' role. Subjectivity refers to "the ensemble of modes of perception, affect, thought, desire, fear, and so forth that animate acting subjects. But I will always mean as well the cultural and social formations that shape, organize, and provoke those modes of affect, thought and so on (Ortner, 2005, p.31)" in the scope of my research. While I conceptualize the actors whom I came across during the clinical decision-making

process, I tried to understand them with their social, cultural, economic, moral backgrounds in which their thoughts, emotions, desires, fears are shaped. ADHD is just an example to observe the role of subjectivities on clinical judgments, but it is a good example with its controversial nature. I am aware of my analysis about subjectivity may be only an introductory part to deepen the discussion in the context of Turkey. However, I aim to dig out this topic enthusiastically in my future publications.

To summarize the limitations of my study, I should emphasize two important points: time management and bureaucratic/spatial limitations. I think the time is never enough for any doctoral dissertation, but I could not use it efficiently by concentrating a large portion of the time on doing a comparative study and trying to collect data from both countries. This limited the time left for analysis and writing. However, although this effort challenged me, but so instructive, as well. Above all, it taught me as a researcher to see my own limits and to hang out when it is necessary. The other bureaucratic boundaries and the problem of living/researching between two countries limited me in methodological terms. Without any hesitation, I can say that all the data that enriched the discussion came from 10 in-depth interviews. I used other data to consolidate the ground for interviews, not to overlook the various discussions, and of course to access the generated ADHD information from every medium. Being able to do more interviews and observations in a hospital would enrich the data too much, but it couldn't be possible. Besides, not getting a positive response from many psychiatrists and the lack of cooperation is an important factor in the inability to increase the interview count. But I have to add that I am grateful for the solidarity of the new generation of psychiatrists. Their enthusiasm for interdisciplinary work, continuing our discussions and communication excited me that more detailed studies could be carried out in the future.

8. Bibliography

- Abali, O. (2015). *Hiperaktivite ve dikkat eksikligi*. Adeda Publishing.
- Achenbach, T. M. (1990). "Comorbidity" in Child and adolescent psychiatry: Categorical and quantitative perspectives. *Journal of Child and Adolescent Psychopharmacology*, *1*(4), 271–278. <https://doi.org/10.1089/cap.1990.1.271>
- Adam, C. (2012). Responsabilisation et déresponsabilisation dans le traitement des délinquants sexuels en Belgique. *Déviance et Société*, *36*(3), 263. <https://doi.org/10.3917/ds.363.0263>
- Ahioglu-Lindberg, E. N. (2012). Çocuk yetistirme açısından Türkiye’de çocukluğun tarihi. *Pamukkale University Journal of Education*, *31*(1), 41–52.
- Altheide, D. L., & Snow, R. P. (1991). *Media worlds in the postjournalism era*. Aldine de Gruyter.
- American Psychiatric Association (Ed.). (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed.). American Psychiatric Association.
- Anderson, B. (2011). There is no such thing as attention. *Frontiers in Psychology*, *2*, 1664–1078. <https://doi.org/10.3389/fpsyg.2011.00246>
- Ariès, P. (1997). *L'enfant et la vie familiale sous l'Ancien Régime*. Eddu Seuil.
- Armstrong, T. (2017). *The myth of the ADHD child: 101 ways to improve your child's behavior and attention span without drugs, labels, or coercion* (Revised edition). TarcherPerigee.
- Bailey, R. K., & Owens, D. L. (2005). Overcoming challenges in the diagnosis and treatment of attention-deficit/hyperactivity disorder in African Americans. *Journal of the National Medical Association*, *97*(10), 5–10.

- Barkley, R. A. (1996). Attention Deficit/Hyperactivity Disorder. In R. A. Barkley & E. Mash (Eds.), *Child Psychopathology* (pp. 63–112). Guilford Press.
- Barkley, R. A. (2018). *Attention Deficit Hyperactivity Disorder: A handbook for diagnosis and treatment*.
- Baughman, F. A. (2006). *The ADHD fraud: How psychiatry makes “patients” of normal children*. Trafford.
- Bauman, Z. (2007). *Modernity and ambivalence*. Polity.
- Bennett, J. (2007). (Dis)ordering motherhood: Mothering a child with Attention-Deficit/Hyperactivity Disorder. *Body & Society*, 13(4), 97–110.
<https://doi.org/10.1177/1357034X07085539>
- Bhugra, D., & Mastrogianni, A. (2004). Globalisation and mental disorders: Overview with relation to depression. *The British Journal of Psychiatry*, 184(1), 10–20.
<https://doi.org/10.1192/bjp.184.1.10>
- Biehl, J., Good, B., & Kleinman, A. (2007). Introduction: Rethinking subjectivity. In J. Biehl, B. Good, & A. Kleinman (Eds.), *Subjectivity* (pp. 1–23). University of California Press.
- Binet, A., & Simon, T. (1907). *Les enfants anormaux*. A. Colin.
- Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Prentice-Hall.
- Boorse, C. (1975). On the Distinction between Disease and Illness. *Philosophy & Public Affairs*, 5(1), 49–68. JSTOR.
- Boorse, C. (1977). Health as a theoretical concept. *Philosophy of Science*, 44(4), 542–573.
- Bourdieu, P. (1986). The forms of capital. In J. Richardson (Ed.), *Handbook of theory and research for the sociology of education* (pp. 241–258). Greenwood.
- Bowlby, J. (2008). *A secure base: Clinical applications of attachment theory*. Routledge.

- Breggin, P. R. (2002). *The Ritalin fact book: What your doctor won't tell you about ADHD and stimulant drugs*. Perseus Books.
- Brewis, A., & Schmidt, K. L. (2003). Gender variation in the Identification of Mexican children's psychiatric symptoms. *Medical Anthropology Quarterly*, 17(3), 376–393.
<https://doi.org/10.1525/maq.2003.17.3.376>
- Brinkman, S. (2016). *Diagnostic cultures: A cultural Approach to the pathologization of modern life*. Routledge, Taylor & Francis Group.
- Brinkmann, S. (2010). *Psychology as a moral science: Perspectives on normativity*. Springer Verlag.
- Bruner, J. S. (1986). *Actual minds, possible worlds*. Harvard University Press.
- Brunton, C. G., McVittie, C., Ellison, M., & Willock, J. (2014). Negotiating parental accountability in the face of uncertainty for Attention-Deficit Hyperactivity Disorder. *Qualitative Health Research*, 24(2), 242–253.
<https://doi.org/10.1177/1049732314522108>
- Burr, V. (1995). *An introduction to social constructionism*. Routledge.
- Caci, H., Cohen, D., Bonnot, O., Kabuth, B., Raynaud, J. P., Paillé, S., & Vallée, L. (2016). Health care trajectories for children with ADHD in France: Results from the QUEST survey. *Journal of Attention Disorders*, 24(1), 52–65.
<https://doi.org/10.1177/1087054715618790>
- Canguilhem, G. (2013). *Le normal et le pathologique*. Presses Universitaires de France.
- Carel, H. (2013). Illness, phenomenology, and philosophical method. *Theoretical Medicine and Bioethics*, 34(4), 345–357. <https://doi.org/10.1007/s11017-013-9265-1>

- Carel, H. (2017). Illness and its experience: The patient perspective. In T. Schramme & S. Edwards (Eds.), *Handbook of the philosophy of medicine* (pp. 93–108). Springer Netherlands.
- Cartwright, S. A. (2004). Report on the diseases and physical peculiarities of the Negro Race. In A. Caplan, J. McCartney, & D. Sisti (Eds.), *Health, disease, and illness: Concepts in medicine* (pp. 28–39). Georgetown University Press.
- Carvallo, S. (2017). *L'homme parfait: L'anthropologie médicale de Harvey, Riolan et Perrault (1628-1688)*. Classiques Garnier.
- Castel, R. (1981). *La gestion des risques: De l'anti-psychiatrie à l'après-psychanalyse*. Editions de Minuit.
- Castel, R. (1991). From dangerousness to risk. In G. Burchell, C. Gordon, & P. M. Miller (Eds.), *The Foucault effect: Studies in governmentality with two lectures by and an Interview with Michel Foucault* (pp. 281–298). Harvester Wheatsheaf.
- Castel, R., Castel, F., & Lovell, A. (1982). *The psychiatric society*. Columbia University Press.
- Charaudeau, P., & Maingueneau, D. (2002). *Dictionnaire d'analyse du discours*. Seuil.
- Clarke, J., Hall, S., Jefferson, T., & Roberts, B. (2006). Subcultures, cultures and class. In S. Hall & T. Jefferson (Eds.), *Resistance through rituals: Youth subcultures in Post-War Britain* (pp. 1–57). Routledge.
- Cohen, L. (2003). Where it hurts: Indian material for an ethics of organ transplantation. *Zygon Journal of Religion and Science*, 38(3), 663–688. <https://doi.org/10.1111/1467-9744.00527>
- Cohen, L. (2006). *No aging in India: Alzheimer's, the bad family, and other modern things*. University of California Press.

- Coleman, J. (1998). Social capital, human capital, and investment in youth. In A. Petersen & J. Mortimer (Eds.), *Youth unemployment and society*. Harvard University Press.
- Conrad, P. (1975). The discovery of hyperkinesis: Notes on the medicalization of deviant behavior. *Social Problems*, 23(1), 12–21. <https://doi.org/10.2307/799624>
- Conrad, P. (2007). *The medicalization of society: On the transformation of human conditions into treatable disorders*. Johns Hopkins University Press.
- Crunellier, M. (1979). *L'enfance et la jeunesse dans la société française: 1800-1950*. Armand Colin.
- Daston, L., & Galison, P. (2010). *Objectivity*. Zone Books.
- Davies, A. J. (2014). *'It's a problem with the brain': A discursive analysis of parents' constructions of ADHD* [PhD, The Open University]. <http://oro.open.ac.uk/id/eprint/42697>
- Davis, J. (2006). Disability, childhood studies and the construction of medical discourses: Questioning Attention Deficit Hyperactivity Disorder: A theoretical perspective. In G. Lloyd, J. Stead, & D. Cohen (Eds.), *Critical New Perspectives on ADHD*. Routledge, Taylor & Francis Group.
- Davis-Floyd, R., & St. John, G. (1998). *From doctor to healer: The Transformative journey*. Rutgers University Press.
- Denziger, K. (2003). Where history, theory, and philosophy meet: The biography of psychological objects. In D. B. Hill & M. J. Karl (Eds.), *About Psychology: Essays at the crossroads of history, theory, and philosophy*. State University of New York Press.
- DePoy, E., & Gilson, S. F. (2014). *Branding and designing disability: Reconceptualising disability studies*. Routledge.

- Desjarlais, R., Eisenberg, L., Good, B., & Kleinman, A. (1997). *World mental health: Problems and priorities in low-income countries*. Oxford University Press.
- Desjarlais, R. R. (1997). *Shelter blues: Sanity and selfhood among the homeless*. University of Pennsylvania Press.
- Desjarlais, R. R. (2003). *Sensory biographies: Lives and deaths among Nepal's Yolmo Buddhists*. University of California Press.
- Diamond, G., & Josephson, A. (2005). Family-based treatment research: A 10-year update. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44(9), 872–887. <https://doi.org/10.1097/01.chi.0000169010.96783.4e>
- Djulgovic, B., Hozo, I., & Greenland, S. (2011). Uncertainty in Clinical Medicine. In F. Gillford (Ed.), *Handbook of the philosophy of science: Philosophy of medicine* (pp. 299–356). Elsevier.
- Durkheim, É. (1934). *L'éducation morale*. Falcan.
- Engelhardt, H. T. (1979). Introduction. In H. T. Engelhardt, S. Spicker, & B. Towers (Eds.), *Clinical judgment: A critical appraisal*. Springer International Publishing.
- Engelhardt, H. T. (1996). *The foundations of bioethics*. Oxford University Press.
- Ercan, E. S. (2016). *Dikkat Eksikligi Hiperaktivite Bozuklugu*. Dogan Kitap.
- Ercan, E. S., Avci, A., Mukaddes, N. M., Semerci, B., Senol, S., & Yazgan, Y. (2008). *Dikkat Eksikligi Hiperaktivite Bozuklugu Klinik Uygulama Kilavuzu Turkiye*. Janssen-Cilag.
- Ercan, E. S., Polanczyk, G., Akyol Ardıc, U., Yuce, D., Karacetin, G., Tufan, A. E., Tural, U., Aksu, H., Aktepe, E., Rodopman Arman, A., Başgöl, S., Bılac, O., Coşkun, M., Celik, G. G., Karakoc Demirkaya, S., Dursun, B. O., Durukan, I., Fidan, T., Perdahlı Fiş, N., ... Yıldız, N. (2019). The prevalence of childhood psychopathology in Turkey:

- A cross-sectional multicenter nationwide study (EPICPAT-T). *Nordic Journal of Psychiatry*, 73(2), 132–140. <https://doi.org/10.1080/08039488.2019.1574892>
- Eren, N. (1994). *Türk Milli Eğitiminde Yabancı Okullar* [Master, Istanbul University].
<http://nek.istanbul.edu.tr:4444/ekos/TEZ/23624.pdf>
- Ereshefsky, M. (2009). Defining ‘health’ and ‘disease.’ *Studies in History and Philosophy of Science Part C: Studies in History and Philosophy of Biological and Biomedical Sciences*, 40(3), 221–227. <https://doi.org/10.1016/j.shpsc.2009.06.005>
- Fairclough, N. (2009). *Discourse and social change*. Polity Press.
- Fairclough, N. (2013). *Critical Discourse Analysis: The critical study of language*. Routledge.
- Fairclough, N. (2014). *Critical language awareness*. Routledge.
- Farbstein, I., Mansbach-Kleinfeld, I., Apter, A., Auerbach, J. G., & Ponizovsky, A. M. (2014). The Israel survey of mental Health among adolescents: Prevalence of Attention-Deficit/Hyperactivity Disorder, comorbidity, methylphenidate use, and help-seeking patterns. *Israel Medical Association Journal*, 16(9), 568–573.
- Fassin, D. (2000). Repenser les enjeux de santé autour de l’immigration. *Hommes & Migrations*, 1225(1), 5–12. <https://doi.org/10.3406/homig.2000.3506>
- Fassin, D. (2011). This is not medicalization. In G. Hunt, M. Milhet, & H. Bergeron (Eds.), *Drugs and cultures: Knowledge, consumption, and policy*. Ashgate Publishing Limited.
- Fassin, D. (2018). *The will to punish*. Oxford University Press.
- Fassin, D. (2020). Are the two approaches to moral economy irreconcilable? *Humanity: An International Journal of Human Rights, Humanitarianism, and Development*, 11(2), 217–221. <https://doi.org/10.1353/hum.2020.0010>
- Feinstein, A. R. (1967). *Clinical judgment*. The Williams & Wilkins.

- Feinstein, A. R. (1982). An additional basic science for clinical medicine: IV. the development of clinimetrics. *Annals of Internal Medicine*, 99(6), 843.
<https://doi.org/10.7326/0003-4819-99-6-843>
- Fischer, M. (2003). *Emergent forms of life and the anthropological voice*. Duke University Press.
- Foroozandeh, E. (2017). Impulsivity and impairment in cognitive functions in criminals. *Foresic Research & Criminology International Journal*, 5(1), 232–233.
<https://doi.org/10.15406/frcij.2017.05.00144>
- Foucault, M. (1972). *The archeology of knowledge*. Pantheon Books.
- Foucault, M. (1978). *The history of sexuality*. Pantheon Books.
- Foucault, M. (1982). The subject and power. *Critical Inquiry*, 8(4), 777–795.
- Foucault, M. (2009). *Security, territory, population: Lectures at the Collège de France 1977-78* (A. I. Davidson, Ed.). Palgrave Macmillan.
- Frame, C. L., & Matson, J. L. (Eds.). (1987). *Handbook of assessment in childhood psychopathology*. Springer US.
- Frankena, W. K. (1973). *Ethics*. Prentice-Hall.
- Fulford, K. (2001). ‘What is (mental) disease?’: An open letter to Christopher Boorse. *Journal of Medical Ethics*, 27(2), 80–85. <https://doi.org/10.1136/jme.27.2.80>
- Fuller, S. (2002). *Social Epistemology*. Indiana University Press.
- Geertz, C. (2000). *Available light: Anthropological reflections on philosophical topics*. Princeton University Press.
- Gergen, K. J. (1973). Social psychology as history. *Journal of Personality and Social Psychology*, 26(2), 309–320. <https://doi.org/10.1037/h0034436>

- Ghosh, M., Holman, C. D. J., & Preen, D. B. (2015). Use of prescription stimulant for Attention Deficit Hyperactivity Disorder in Aboriginal children and adolescents: A linked data cohort study. *BMC Pharmacology and Toxicology*, *16*(1), 35.
<https://doi.org/10.1186/s40360-015-0035-8>
- Gillies, V. (2006). Working class mothers and school life: Exploring the role of emotional capital. *Gender and Education*, *18*(3), 281–293.
<https://doi.org/10.1080/09540250600667876>
- Goffman, E. (1961). *Asylums: Essays on the social situations of mental patients and other inmates*. Doubleday (Anchor).
- Gonon, F. (2008). *L'hypothèse dopaminergique du TDAH : Faits, interprétations, conséquences*. ERES.
- Good, B. J. (2003). Kulturlerarasi arastirmalarin psikoterapi uygulamalari acisindan onemi. In K. Sayar (Ed.), *Kultur ve Ruh Sagligi: Kuresellesme Kosullarinda Kulturel Psikiyatri* (pp. 33–55). Metis.
- Goodhart, J. F. (1910). *The Diseases of children*. The Blakiston Company.
- Goregenli, M. (2013). Sosyal psikoloji'den hareketle sosyal bilimlerde olgu-değer ilişkisi uzerine düşünceler. *Asosyal Psikoloji Yazilari*.
<http://melegoregenli.blogspot.com/2013/12/sosyal-psikolojiden-hareketle-sosyal.html>
- Groos, K. (1898). *The Play of Animals* (E. L. Baldwin, Trans.). D. Appleton.
- Güçlü, S. (2016). Çocukluk ve çocuklugun sosyolojisi baglaminda cocuk haklari. *Sosyoloji Dergisi*, *34*(1), 1–22.
- Hacking, I. (2001). *The social construction of what?* Harvard Univ. Press.
- Hall, S. (2001). *Discourse theory and practice: A reader* (M. Wetherell, S. Yates, & S. Taylor, Eds.). SAGE.

- Heywood, C. (2001). *A history of childhood: Children and childhood in the West from medieval to modern times*. Polity Press.
- Hochmann, J. (2004). *Psikiyatri Tarihi*. Dost Kitabevi Yayinlari.
- Hofmann, B. (2017). Disease, illness, and sickness. In *The Routledge companion to philosophy of medicine*. Routledge, Taylor & Francis Group.
- Horton, R. (1995). Georges Canguilhem: Philosopher of disease. *Journal of the Royal Society of Medicine*, 88(6), 316–319.
- Horton-Salway, M. (2011). Repertoires of ADHD in UK newspaper media. *Health*, 15(5), 533–549. <https://doi.org/10.1177/1363459310389626>
- Huneman, P. (2008). Le projet aliéniste, la nosologie et la décomposition des fonctions mentales. In F. Parot (Ed.), *Les fonctions en psychologie*. Mardaga.
- Hunt, L. M., & Mattingly, C. (1998). Introduction: Diverse rationalities and multiple realities in illness and healing. *Medical Anthropology Quarterly*, 12(3), 267–272. <https://doi.org/10.1525/maq.1998.12.3.267>
- Husserl, E. (1982). *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy*. Springer.
- James, A., & James, A. L. (2004). *Constructing childhood: Theory, policy, and social practice*. Palgrave Macmillan.
- James, A., Jenks, C., & Prout, A. (2014). *Theorizing childhood*. Polity Press.
- James, A., & Prout, A. (Eds.). (1997). *Constructing and reconstructing childhood: Contemporary issues in the sociological study of childhood*. Falmer Press.
- James, W. (1995). *The Principles of Psychology*. Dover.
- Jenks, C. (1982). Introduction: Constituting the Child. In C. Jenks (Ed.), *The Sociology of childhood: Essential readings* (pp. 9–24). Academic and Educational Ltd.

- Jørgensen, M., & Phillips, L. (2002). *Discourse analysis as theory and method*. Sage Publications. <https://doi.org/10.4135/9781849208871>
- Josephson, A. M. (2007). Practice parameter for the assessment of the family. *Journal of the American Academy of Child & Adolescent Psychiatry*, 46(7), 922–937.
<https://doi.org/10.1097/chi.0b013e318054e713>
- Jutel, A. G. (2014). *Putting a name on it: Diagnosis in contemporary society*. JHU Press.
- Kambuta, R. (2015). *Programming parents: Care of Supernanny* [PhD]. University of Otago.
- Kanner, L. (1962). Emotionally disturbed children: A historical review. *Child Development*, 33(1), 97. <https://doi.org/10.2307/1126636>
- Kazdin, A. E., & Weisz, J. R. (1998). Identifying and developing empirically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology*, 66(1), 19–36. <https://doi.org/10.1037/0022-006X.66.1.19>
- Kirmayer, L. J. (2003). Kulturel psikiyatrinin gelecegi: Uluslarasi bir bakis. In *Kultur ve ruh sagligi: Kuresellesme kosullarinda kulturel psikiyatri*. Metis.
- Kirmayer, L. J., & Minas, H. (2000). The future of cultural psychiatry: An international perspective. *The Canadian Journal of Psychiatry*, 45(5), 438–446.
<https://doi.org/10.1177/070674370004500503>
- Kleinman, A. (1987). Anthropology and psychiatry: The role of culture in cross-cultural research on illness. *The British Journal of Psychiatry*, 151(4), 447–454.
<https://doi.org/10.1192/bjp.151.4.447>
- Kleinman, A. (1988). *Rethinking psychiatry: From cultural category to personal experience*. Free Press.

- Krueger, J. (2001). Psychology of social categorization. In *International Encyclopedia of the Social & Behavioral Sciences* (pp. 14219–14223).
- Liebert, R. (2014). Pathologization. In T. Teo (Ed.), *Encyclopedia of Critical Psychology* (1st ed., pp. 1327–1333). Springer-Verlag.
- Lignier, W. (2012). *La petite noblesse de l'intelligence: Une sociologie des enfants surdoués*. La Découverte.
- Littlewood, R. (2003). Antropoloji ve yeni psikiyatri: Kulture bagli sendromlarda fail ve zorunluluk. In K. Sayar (Ed.), *Kultur ve ruh sagligi: Kuresellesme kosullarinda kulturel psikiyatri* (pp. 120–121). Metis.
- Lloyd, G., Stead, J., & Cohen, D. (Eds.). (2006). *Critical new perspectives on ADHD*. Routledge.
- Lonergan, B. J. F. (1979). *Method in theology*. Seabury.
- Lovett, B. J., & Hood, S. B. (2014). Comorbidity in child psychiatric diagnosis: Conceptual complications. In C. Perring & L. Wells (Eds.), *Diagnostic dilemmas in child and adolescent psychiatry: Philosophical perspectives*. Oxford University Press.
- Luhmann, T. M. (2001). *Of two minds: An anthropologist looks at American psychiatry*. Vintage Books.
- Luhmann, T. M. (2006). Subjectivity. *Anthropological Theory*, 6(3), 345–361.
<https://doi.org/10.1177/1463499606066892>
- Maj, M. (2010). Is it true that mental disorders are so common, and so commonly co-occur? In T. Millon, R. F. Krueger, & E. Simonsen (Eds.), *Contemporary directions in psychopathology: Scientific foundations of the DSM-V and ICD-11* (pp. 263–274). Guilford Press.

- Malacrida, C. (2004). Medicalization, ambivalence and social control: Mothers' descriptions of educators and ADD/ADHD: *Health*, 8(1), 61–80.
<https://doi.org/10.1177/1363459304038795>
- Marcum, J. A. (2008). *An introductory philosophy of medicine: Humanizing modern medicine*. Springer.
- Marx, K. (2015). *Kapital* (M. Selik & E. Özalp, Trans.). Yordam Yayınları.
- Maté, G. (1999). *Scattered: How attention deficit disorder originates and what you can do about it*. Dutton.
- Mattingly, C. (2013). Moral selves and moral scenes: Narrative experiments in everyday life. *Ethnos*, 78(3), 301–327. <https://doi.org/10.1080/00141844.2012.691523>
- Mattingly, C. (2014). *Moral laboratories: Family peril and the struggle for a good life*. University of California Press.
- Mechling, B. M. (2011). The experiences of youth serving as caregivers for mentally ill parents: A background review of the literature. *Journal of Psychosocial Nursing and Mental Health Services*, 49(3), 28–33. <https://doi.org/10.3928/02793695-20110201-01>
- Meehl, P. E. (1954). *Clinical versus statistical prediction: A theoretical analysis and a review of the evidence*. University of Minnesota Press.
- Merrigan, G., & Huston, C. L. (2015). *Communication Research Methods*. Oxford University Press.
- Mischel, W., Ebbesen, E. B., & Raskoff Zeiss, A. (1972). Cognitive and attentional mechanisms in delay of gratification. *Journal of Personality and Social Psychology*, 21(2), 204–218. <https://doi.org/10.1037/h0032198>

- Moen, J. (2014). Child and Adolescent Psychiatry between Neuroscience and the Family Perspective. In C. Perring & L. Wells (Eds.), *Diagnostic dilemmas in child and adolescent psychiatry* (pp. 56–79). Oxford University Press.
- Mole, C. (2011). *Attention Is cognitive unison: An essay in philosophical psychology*. Oxford University Press.
- Montgomery, K. (2006). *How doctors think: Clinical judgement and the practice of medicine*. Oxford University Press.
- Morel, S. (2014). *La médicalisation de l'échec scolaire*. La Dispute.
- Nagel, T. (1989). *The view from nowhere*. Oxford Univ. Press.
- Nielsen, M. (2020). *Experiences and explanations of ADHD: An ethnography of adults living with a diagnosis*. Routledge, Taylor & Francis Group.
- Öner, P., Öner, O., & Aysev, A. (2003). *Dikkat Eksikliği Hiperaktifite Bozukluğu*.
<https://www.ttb.org.tr/STED/sted0303/dikkat.pdf>
- Ongel, U. (2006). ADHD and parenting styles. In G. Lloyd, J. Stead, & D. Cohen (Eds.), *Critical new perspectives on ADHD*. Routledge, Taylor & Francis Group.
- Onur, B. (2005). *Türkiye'de çocukluğun tarihi: Çocukluğun sosyo-kültürel tarihine giriş*. İmge Kitabevi.
- Ortner, S. B. (2005). Subjectivity and cultural critique. *Anthropological Theory*, 5(1), 31–52.
<https://doi.org/10.1177/1463499605050867>
- Ozcan, I. T., Toros, F., Pekdemir, H., Cicek, D., Camsari, A., Yurttas, M., Akcay, B., & Konukcu, I. (2004). Dikkat Eksikliği Hiperaktifite Bozukluğu tedavisinde metilfenidat kullanımının zaman bağımlı kalp hızı değişkenliği üzerine etkisi. *Çocuk ve Gençlik Ruh Sağlığı Dergisi*, 11(3), 117–122.

- Öztan, G. G. (2011). *Türkiye’de çocukluğun politik inşası*. İstanbul Bilgi Üniversitesi Yayınları.
- Parot, F. (2008). Introduction générale. In F. Parot (Ed.), *Les fonctions en psychologie*. Mardaga.
- Pekdemir, H., Toros, F., Camsari, A., Cicek, D., Yurttas, M., Parmaksiz, T., & Katircibasi, T. (2003). Dikkat Eksikliği Hiperaktivite Bozukluğu tedavisinde metilfenidat kullanımının kardiyovasküler fonksiyonlar üzerine etkisi. *Çocuk ve Gençlik Ruh Sağlığı Dergisi*, 10(1), 17–21.
- Pellegrino, E. D. (1979). The anatomy of clinical judgements: Some notes on right reason and right action. In H. T. Engelhardt, S. Spicker, & B. Towers (Eds.), *Clinical judgment: A critical appraisal*. Springer International Publishing.
- Pérez-Álvarez, M. (2017). The four causes of ADHD: Aristotle in the classroom. *Frontiers in Psychology*, 8(928), 1–13. <https://doi.org/10.3389/fpsyg.2017.00928>
- Pfiffner, L. J. (2008). Comorbidity as an organizing principle. In K. McBurnett & L. J. Pfiffner (Eds.), *Attention Deficit Hyperactivity Disorder: Concepts, controversies, new directions* (pp. 51–61). Informa Healthcare.
- Pinel, P. (2012). *Nosographie philosophique ou la méthode de l’analyse appliquée à la médecine*. Nabu Press.
- Posch, C. (2017). Rhetorical Analysis. In R. Wodak & B. Forchtner (Eds.), *The Routledge handbook of language and politics*. Taylor & Francis Group.
- Postman, N. (1994). *The disappearance of childhood*. Vintage Books.
- Potter, J. (1996). *Representing reality: Discourse, rhetoric and social construction*. Sage Publications.

- Pratt, J. (1997). *Governing the dangerous: Dangerousness, law, and social change*. Federation Press.
- Pratt, J. (2001). Dangerosité, risque et technologies du pouvoir. *Criminologie*, 34(1), 101–121. <https://doi.org/10.7202/004756ar>
- Prudent, N., Johnson, P., Carroll, J., & Culpepper, L. (2005). Attention-Deficit/Hyperactivity Disorder: Presentation and management in the Haitian American child. *Primary Care Companion to the Journal of Clinical Psychiatry*, 7(4), 190–197. <https://doi.org/10.4088/pcc.v07n0409>
- Putnam, R. D., Leonardi, R., & Nanetti, R. (1994). *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton Univ. Press.
- Qvortrup, J. (1994). Childhood matters: An introduction. In J. Qvortrup, M. Bardy, G. Sgritta, & W. Helmut (Eds.), *Childhood matters: Social theory, politics and practice*. Avebury.
- Qvortrup, J. (2000). Macroanalysis of Childhood. In P. Christensen & A. James (Eds.), *Conducting research with children*. Falmer Press.
- Rafalovich, A. (2004). *Framing ADHD children: A critical examination of the history, discourse, and everyday experience of Attention deficit/Hyperactivity Disorder*. Lexington Books.
- Rafalovich, A. (2015). ADHD: Three competing discourses. In M. O'Reilly & J. N. Lester (Eds.), *The Palgrave handbook of child mental health: Discourse and conversation studies* (pp. 79–95). Palgrave Macmillan UK.
- Rose, N. (2007). *The politics of life itself: Biomedicine, power, and subjectivity in the twenty-first century*. Princeton University Press.

- Rosenberg, C. E. (2007). *Our present complaint: American medicine, then and now*. Johns Hopkins University Press.
- Rutter, M. (1985). Family and school influences on behavioral development. *Journal of Child Psychology and Psychiatry*, 26(3), 349–368. <https://doi.org/10.1111/j.1469-7610.1985.tb01938.x>
- Sadler, J. Z. (2014). Conduct disorder as a vice-laden diagnostic concept. In *Diagnostic dilemmas in child and adolescent psychiatry: Philosophical perspectives* (pp. 166–181). Oxford University Press.
- Sánchez, E. Y., Velarde, S., & Britton, G. B. (2011). Estimated prevalence of Attention-Deficit/Hyperactivity disorder in a sample of Panamanian school-aged children. *Child Psychiatry & Human Development*, 42(2), 243–255. <https://doi.org/10.1007/s10578-010-0213-2>
- Scadding, J. G. (1967). Diagnosis: The clinician and the computer. *The Lancet*, 290(7521), 877–882. [https://doi.org/10.1016/S0140-6736\(67\)92608-6](https://doi.org/10.1016/S0140-6736(67)92608-6)
- Schell, B. A. B. (2003). Clinical reasoning: The basis of practice. In E. B. Crepeau, E. S. Cohn, & B. A. B. Schell (Eds.), *Willard and Spackman's Occupational Therapy* (pp. 131–139). Lippincott Williams and Wilkins.
- Schwarz, A. (2016). *ADHD nation: Children, doctors, big pharma, and the making of an American epidemic*. Scribner.
- Schwarz, A., & Cohen, S. (2013, March 31). A.D.H.D. seen in 11% of U.S. children as diagnoses rise. *The New York Times*. <https://www.nytimes.com/2013/04/01/health/more-diagnoses-of-hyperactivity-causing-concern.html>

- Scott, S., Jackson, S., & Backett-Milburn, K. (2016). Swings and roundabouts: Risk anxiety and the everyday worlds of children. *Sociology*.
<https://doi.org/10.1177/0038038598032004004>
- Semerci, B., & Turgay, A. (2014). *Bebeklikten Eriskinlige Dikkat Eksikligi Hiperaktivite Bozuklugu*. Alfa.
- Shakespeare, W. (1992). *The tragedy of Hamlet: Prince of Denmark*. Washington Square Press/Pocket Books.
- Shamgar-Handelman, L. (1994). To whom does childhood belong? In J. Qvortrup (Ed.), *Childhood matters: Social theory, practices and politics*. Avebury.
- Sholl, J. (2017). The muddle of medicalization: Pathologizing or medicalizing? *Theoretical Medicine and Bioethics*, 38(4), 265–278. <https://doi.org/10.1007/s11017-017-9414-z>
- Shore, M. F., & Mannino, F. V. (1976). Mental health services for children and youth: 1776–1976. *Journal of Clinical Child Psychology*, 5(3), 21–25.
<https://doi.org/10.1080/15374417609532722>
- Singh, I. (2003). Boys will be boys: Fathers' perspectives on ADHD symptoms, diagnosis, and drug treatment. *Harvard Review of Psychiatry*, 11(6), 308–316.
- Singh, I. (2004). Doing their jobs: Mothering with Ritalin in a culture of mother-blame. *Social Science & Medicine*, 59(6), 1193–1205.
<https://doi.org/10.1016/j.socscimed.2004.01.011>
- Singh, I. (2007). Not just naughty: 50 years of stimulant drug advertising. In A. Tone & E. Watkins (Eds.), *Medicating Modern America* (pp. 131–155). NYU Press.
- Singh, I. (2008). Beyond polemics: Science and ethics of ADHD. *Nature Reviews Neuroscience*, 9(12), 957–964. <https://doi.org/10.1038/nrn2514>

- Şirin, S. (2019). *Yetişin çocuklar: Bebeklikten ergenliğe çocuk yetiştirme kılavuzu*. Doğan Kitap.
- Sisti, D., & Caplan, A. (2017). The concept of disease. In M. Solomon, J. R. Simon, & H. Kincaid (Eds.), *The Routledge companion to philosophy of medicine*. Routledge, Taylor & Francis Group.
- Sisti, D., Young, M., & Caplan, A. (2013). Defining mental illnesses: Can values and objectivity get along? *BMC Psychiatry*, 13(1), 346. <https://doi.org/10.1186/1471-244X-13-346>
- Snodgrass, J. (1984). William Healy (1869-1963): Pioneer child psychiatrist and criminologist. *Journal of the History of the Behavioral Sciences*, 20(4), 332–339. [https://doi.org/10.1002/1520-6696\(198410\)20:4<332::aid-jhbs2300200403>3.0.co;2-j](https://doi.org/10.1002/1520-6696(198410)20:4<332::aid-jhbs2300200403>3.0.co;2-j)
- Spitzer, R. L. (1981). The diagnostic status of homosexuality in DSM-III: A reformulation of the issues. *The American Journal of Psychiatry*, 138(2), 210–215. <https://doi.org/10.1176/ajp.138.2.210>
- Stead, J., Lloyd, G., & Cohen, D. (2006). Introduction: Widening our view of ADHD. In J. Stead & C. David (Eds.), *Critical new perspectives on ADHD*. Routledge.
- Still, G. F. (1909). *Common disorders and diseases of childhood*. Frowde : Hodder & Stoughton.
- Strickland, B. B. (Ed.). (2001). *The Gale Encyclopedia of Psychology*. Gale Group.
- Strohl, M. P. (2011). Bradley's benzedrine studies on children with behavioral disorders. *The Yale Journal of Biology and Medicine*, 84(1), 27–33.
- Surucu, O. (2019). *Dikkat Eksikligi Hiperaktivite Bozuklugu (DEHB) anne baba ogretmen elkitabi*. Bilgi Yayınevi.

- Svenaesus, F. (2014). The phenomenology of suffering in medicine and bioethics. *Theoretical Medicine and Bioethics*, 35(6), 407–420. <https://doi.org/10.1007/s11017-014-9315-3>
- Szasz, T. (2007). *The medicalization of everyday life: Selected essays*. Syracuse University Press.
- Szasz, T. (2010). *The myth of mental illness: Foundations of a theory of personal conduct*. Harper Perennial.
- Tauber, A. I. (2003). *Henry David Thoreau and the moral agency of knowing*. University of California Press.
- Tauber, A. I. (2005). *Patient autonomy and the ethics of responsibility*. MIT Press.
- Timimi, S. (2005). *Naughty boys: Anti-social behaviour, ADHD, and the role of culture*. Palgrave Macmillan.
- Timimi, S. (2007). *Mis-understanding ADHD: The complete guide for parents to alternatives to drugs*. AuthorHouse.
- Toombs, S. K. (1990). The temporality of illness: Four levels of experience. *Theoretical Medicine*, 11(3), 227–241. <https://doi.org/10.1007/BF00489832>
- UNESCO strategy on education for health and well-being: Contributing to the sustainable development goals*. (2016). <https://unesdoc.unesco.org/ark:/48223/pf0000246453>
- Upshur, R., & Chin-Yee, B. (2017). Clinical Judgment. In M. Solomon, J. R. Simon, & H. Kincaid (Eds.), *The Routledge companion to philosophy of medicine* (pp. 377–385). Routledge, Taylor & Francis Group. <https://doi.org/10.4324/9781315720739-43>
- Wakefield, J. C. (1992). The concept of mental disorder: On the boundary between biological facts and social values. *The American Psychologist*, 47(3), 373–388. <https://doi.org/10.1037//0003-066x.47.3.373>

- Wakefield, J. C. (2014). The biostatistical theory versus the harmful dysfunction analysis, part 1: Is part-dysfunction a sufficient condition for medical disorder? *The Journal of Medicine and Philosophy*, 39(6), 648–682. <https://doi.org/10.1093/jmp/jhu038>
- Watts, T. W., Duncan, G. J., & Quan, H. (2018). Revisiting the marshmallow test: A conceptual replication investigating links between early delay of gratification and later outcomes. *Psychological Science*, 29(7), 1159–1177. <https://doi.org/10.1177/0956797618761661>
- Weinberg, D. (1997). The social construction of non-human Agency: The case of mental disorder. *Social Problems*, 44(2), 217–234. <https://doi.org/10.2307/3096943>
- Weiss, G., & Hechtman, L. T. (1993). *Hyperactive children grown up: ADHD in children, adolescents, and adults*. Guilford Press.
- William, J. (1995). *The principles of psychology*. Henry Holt and Co.
- Willig, C. (2014). Discourses and discourse Analysis. In U. Flick (Ed.), *The Sage handbook of qualitative data analysis* (pp. 341–353). Sage Publications Ltd.
- Witmer, L. (1913). Children with mental defects distinguished from mentally defective children. *The Psychological Clinic*, 7(7), 173–181.
- Wolfe, J. M., & Horowitz, T. S. (2004). What attributes guide the deployment of visual attention and how do they do it? *Nature Reviews Neuroscience*, 5(6), 495–501. <https://doi.org/10.1038/nrn1411>
- Wu, W. (2014). *Attention*. Routledge.
- Yazgan, Y. (2017). *Hiperaktif çocuk ve ergen okulda: Öğretmenler, psikolojik danışmanlar, rehberlik servisleri ve anne babalar için temel bilgi ve öneriler*. Dogan Kitap.

Young, A. (2008). A time to change our minds: Anthropology and psychiatry in the 21st century. *Culture, Medicine, and Psychiatry*, 32(2), 298–300.

<https://doi.org/10.1007/s11013-008-9093-3>

Zametkin, A. J., & Ernst, M. (1999). Problems in the Management of Attention-Deficit–Hyperactivity Disorder. *New England Journal of Medicine*, 340(1), 40–46.

<https://doi.org/10.1056/NEJM199901073400107>

Zametkin, A. J., & Liotta, W. (1998). The neurobiology of Attention-Deficit/Hyperactivity Disorder. *The Journal of Clinical Psychiatry*, 59(7), 17–23.

Zelizer, V. (1994). *Pricing the priceless child: The changing social value of children*.

Princeton University Press.

9. Annexe - Résumé long

Le trouble de déficit de l'attention et d'hyperactivité (TDAH) est décrit comme un trouble du développement neurologique avec une origine génétique hautement héréditaire selon la conception standard; cependant, il y avait de nombreuses définitions et compréhensions critiques du TDAH (Armstrong, 1995 ; Timimi, 2003 ; Maté, 1999). Pérez-Alvarez (2017) résume clairement trois points de vue différents sur le TDAH. Le premier groupe de chercheurs défend la conception neurobiologique standard. La seconde est totalement opposée à cette conception, ils ont un point de vue critique sur le TDAH. Ils soutiennent que le TDAH n'existe pas. La troisième approche peut être définie entre ces deux points de vue. Ils acceptent l'existence du TDAH, en revanche ils critiquent le sur-diagnostic et la sur-médication.

Les études qui enquêtent sur l'existence du TDAH et qui le décrivent comme une invention de l'industrie pharmaceutique restent focalisées sur la problématique du « TDAH existe-t-il ? ». Cette problématique est un bon point de départ pour lancer une discussion, mais elle n'a pas été fonctionnelle alors qu'un plus grand nombre d'enfants ont été diagnostiqués avec un TDAH dans chaque nouvelle version de DSM et qu'ils ont été médicalisés. Il montre que le TDAH en tant que catégorie pratique maintient sa fonctionnalité malgré la controverse de son existence empirique. Par conséquent, cette étude préfère rechercher les réponses possibles à la problématique « comment la catégorie diagnostique du TDAH est établie socialement et culturellement et comment elle est maintenue ? »

Selon le *Diagnosical and Statistical Manual of Mental Disorders* (DSM-5, American Psychiatric Association, 2013), le TDAH est décrit avec trois symptômes fondamentaux - hyperactivité, impulsivité et manque d'attention - est le trouble mental le plus fréquemment diagnostiqué dans l'enfance. La perspective médicale suggère que le TDAH est un trouble neuro-développemental d'origine génétique hautement héréditaire et l'accepte comme une réalité scientifique évidente (Barkley, 1995). L'Institut National de la Santé Mentale et Les

Instituts Nationaux de la Santé définissent les causes du TDAH d'une manière moins certaine et plus combinée : « Les recherches actuelles suggèrent que le TDAH peut être causé par des interactions entre des gènes et des facteurs environnementaux ou non génétiques. Un certain nombre de facteurs peuvent contribuer au TDAH tels que les gènes ; le tabagisme, la consommation d'alcool ou de drogues pendant la grossesse ; exposition à des toxines environnementales, telles que des niveaux élevés de plomb, à un jeune âge ; faible poids de naissance ; lésions cérébrales. »

Le TDAH est toujours diagnostiqué au moyen de listes de contrôle comportementales basées sur le DSM qui ont été fortement critiquées dans la littérature sceptique contredisant le paradigme du TDAH en tant que trouble neurobiologique. Les critiques portent sur la validité de son existence, les causes du diagnostic et l'éthique de la médecine des enfants (Singh, 2008). Les taux de prévalence varient selon les pays et parfois même au sein d'un même pays, le TDAH est donc un indicateur de sa construction culturelle (Davies, 2014). Peter Breggin (2002) plaide en faveur d'une absence de validité du diagnostic DSM pour un trouble identifié comme un véritable dysfonctionnement biologique.

La médicalisation est de pathologiser les expériences ordinaires et de présenter des solutions médicales pour « normaliser » ces expériences au nom des industries pharmaceutiques (Conrad, 2007). Les problèmes de comportement sont passés de la faiblesse morale ou du péché au niveau médical. Le traitement est proposé comme la seule solution à ces problèmes de comportement. Selon DePoy et Gilson (2014), la médicalisation est liée au profit économique et au contrôle social. La définition d'un problème de comportement exclut médicalement toutes les autres disciplines, les professionnels et les gens ordinaires de discuter du sujet car il est monopolisé par les psychiatres. En définissant les problèmes de comportement comme un problème médical, le traitement se termine par des médicaments psychoactifs et de cette manière, le contrôle médico-social est appliqué. Les problèmes de comportement sont

également principalement multidimensionnels, mais sont réduits à des processus biologiques individuels par la médicalisation du problème. Les problèmes sociaux sont laissés de côté. L'individualisation biologique conduit à la dépolitisation des comportements déviants. Étiqueter un enfant avec un trouble mental permet d'exclure de l'équation les problèmes de scolarité et de système éducatif.

Tout en gardant la conceptualisation universelle du point de vue psychiatrique, j'ai l'intention de présenter la perspective anthropologique sur les particularités culturelles de la réception du diagnostic du TDAH. Tanya Luhrmann (2001) indique que les troubles mentaux eux-mêmes, leur expérience et leur fréquence dans une communauté sont tous déterminés historiquement. De plus, l'étude sur la santé mentale dans le monde menée par Desjarlais et al. (1997) ont conclu que le facteur de risque le plus crucial causé par les troubles mentaux est la « perturbation sociale ». Les exemples de contre-arguments à l'approche qui définit les troubles mentaux comme héréditaires et biologiques pourraient être étendus.

Depuis le début des recherches sur l'hyperactivité, on a tendance à la positionner dans le cerveau. Cependant, le manque de preuves biologiques a suscité de nombreuses critiques (Baughman, 2006; Gonon, 2008; Zametkin et Liotta, 1998; Zametkin et Ernst, 1999). Surtout ces dernières années, de nombreuses études neurobiologiques ont été consacrées au TDAH ; malgré cet effort et des budgets assez importants, les polémiques se sont poursuivies. Kirmayer (2002) affirme que la production et l'exportation des connaissances psychiatriques dépendent de questions liées à l'économie politique et à la dimension culturelle des problèmes. L'argument qui préconise que la médecine devrait être basée sur des données engage une approche plus rationnelle dans les applications psychiatriques. Cependant, le médicament basé sur des données est limité à la littérature de recherche et le financement de la recherche est fourni par certaines communautés qui souhaitent certains types d'informations. Par conséquent, des connaissances scientifiques qui ne servent qu'à renforcer les intérêts économiques et politiques

ont été produites. L'un des antidotes de ce danger potentiel est de critiquer culturellement le processus de recherche lui-même.

Essayer de comprendre et d'expliquer une créature bio-psycho-sociale très sophistiquée par l'intermédiaire de la partie bio aboutit finalement à un réductionnisme biologique. Young (2008) détermine les outils les plus efficaces du réductionnisme biologique qui maintiennent le pouvoir de la psychiatrie, tels que les étiologies biologiques, les interventions psychopharmacologiques et les programmes de recherche. Selon lui, à la suite du réductionnisme biologique, l'humain est objectivé et dissocié des contextes sociaux, économiques et individuels.

Les anthropologues s'opposent à l'idée de définir les maladies / maladies comme des faits biologiques avec des noms culturels différents ou avec peu d'effets culturels. Pour eux, ils ne signifient pas seulement des faits biologiques mais ont essentiellement des qualités culturelles (Good, 2003). Une catégorie générale couvre-t-elle correctement une expérience locale ? C'est une problématique très courante pour toutes les sciences sociales et humaines. Cependant, lorsque nous essayons de définir les maladies comme une pure vérité biologique et comme une catégorie naturelle totalement indépendante des tendances locales, la question devient beaucoup plus compliquée (Littlewood, 2002).

Cette thèse n'a pas été conçue pour prouver le TDAH comme une « fraude totale » (Baughman, 2006) ou le TDAH comme une construction sociale (Timimi, 2005, 2007). Évidemment, je mentionnerai les controverses et les points de vue critiques dans la littérature ; cependant, le point principal de l'étude n'est pas de clarifier cette condition médicale mais d'attirer l'attention sur la façon dont le discours diffère d'une culture à l'autre. J'adopte la position anthropologique qui n'accepte pas l'idée que « les formes et les fonctions de la maladie mentale sont données dans le monde naturel (Kleinman, 1987) ». Je suis sceptique quant aux définitions

strictement biochimiques de la santé mentale et le but de cette étude est d'explorer les connexions dynamiques du TDAH et de l'imaginaire social.

La maladie contient des émotions et des expériences. L'anxiété, la peur et la douleur font partie de ces phénomènes. En d'autres termes, la maladie est placée dans un endroit subjectif, de sorte que les informations sur la maladie de cette personne ne peuvent être obtenues que par sa propre déclaration à partir d'une position phénoménologique (Carel, 2013 ; Svenaeus, 2014 ; Toombs, 1990). Selon Carel (2017), la maladie est définie comme liée à la conscience corporelle et / ou mentale. Les professionnels de santé visent à comprendre la maladie en termes de prestation de meilleurs soins et / ou de réduction de la souffrance (Hofmann, 2017). La maladie, en revanche, est construite par des normes sociales. Cela diffère d'un endroit à l'autre. Par exemple, si la douleur de la ceinture pelvienne est une condition où la maladie est autorisée en Norvège, ce n'est pas le cas dans d'autres pays (Dorheim et al.2013, cité dans Hofmann, 2017). De plus, si la maladie est décrite comme une structure sociale, il ne faut pas oublier que tant les patients que les professionnels de santé sont des agents sociaux qui ont un effet sur cette structure (Hofmann, 2017).

La décision clinique fait référence à des tâches de raisonnement très complexes et à des actions exécutées par les médecins. Il comprend le diagnostic, les options de traitement et le pronostic. La dimension philosophique de la décision clinique « concerne le statut du raisonnement et / ou de la logique qui éclairent le jugement clinique (Upshur & Chin-Yee, 2017 p. 363) ». Au cours des dernières années, l'accent est passé sur la prise en compte de la décision clinique, et les études se sont concentrées sur l'évaluation des décisions cliniques d'un point de vue statistique, scientifique et cognitif (Upshur et Chin-Yee, 2017). Paul Meehl (1954) divise les formes de prise de décision en cliniques et actuarielles. La stratégie de classification de ces concepts repose sur l'hypothèse que la décision clinique est subjective et que la décision actuarielle est objective. Le jugement actuariel est un raisonnement soutenu par les

mathématiques et les statistiques. Le jugement clinique est connu pour de nombreux biais attribués à sa nature subjective. Engelhart (1979) déclare que les études sur le jugement clinique sont une partie importante de l'évolution du raisonnement médical et de la rationalisation de la médecine. Le raisonnement médical a rejeté les explications métaphysiques de la maladie depuis l'Antiquité et encourage le médecin à développer ses compétences d'examen en observant ses patients. Un autre philosophe de la médecine, Edmund Pellegrino (1979), souligne que le raisonnement et le jugement cliniques sont orientés vers des buts. Celles-ci concernent l'application de généralisations à des cas particuliers. Pellegrino (1979) décrit le processus de jugement clinique avec trois questions : qu'est-ce qui ne va pas ? Ce qui peut être fait ? Qu'est-ce qui devrait être fait ? Les deux dernières questions reflètent l'inévitable dimension éthique de la décision clinique. À ce stade, l'approche actuarielle est insuffisante pour guider le clinicien car elle nécessite une stratégie à suivre en fonction des caractéristiques de chaque patient.

Feinstein (1967) reconnaît que bien que le jugement clinique essaie de rendre les choses plus scientifiques, son approche présente certaines limites. La médecine factuelle a eu un effet remarquable sur elle, mais encore une fois, les efforts de conceptualisation contemporains concernant le jugement clinique critiquent l'épistémologie clinique de Feinstein (1967) sur deux points. Tout d'abord, il néglige de développer des mesures cliniques qui peuvent être basées sur l'histoire et les symptômes du patient, car il préfère se concentrer sur des données paracliniques objectives. De plus, il n'inclut pas les facteurs environnementaux contribuant aux aspects chargés de valeur et humanistes de la pratique clinique dans le raisonnement clinique (Upshur et Chin-Yee, 2017). Bien que Feinstein (1967, p. 295) dise "la médecine clinique, donc, comme la plupart des autres activités humaines dans un mélange invisible d'art et de science", il reste plus proche de l'approche scientifique.

Engelhardt soutient que le jugement clinique et la prise de décision sont des concepts complexes, qui « dans leur sens riche et plein sont chargés de valeurs, y compris des valeurs éthiques et morales (Engelhardt, 1979, p. xxii) ». Le processus de jugement clinique, qu'il décrit comme un voyage, commence par la collecte de données et l'observation, puis se poursuit par la formation et le test d'hypothèses. À la suite de ces deux étapes, des jugements et des décisions sont formés. Engelhardt (1979) souligne que le concept de jugement clinique est ambigu. Pour les praticiens biomédicaux, les jugements cliniques reposent sur un raisonnement scientifique et sont logiques. C'est pourquoi cela fonctionne selon les règles. Mais pour Engelhardt, le jugement clinique ne peut pas être simplement réduit à des règles ou à des algorithmes. « On trouve des médecins affirmant que l'on ne peut porter des jugements cliniques adéquats que sur la base de l'expérience réelle, pas simplement sur la base de principes généraux de physiologie, pharmacologie, pathologie, ou même sur la base d'une reconstruction de jugements cliniques passés » (Engelhardt, 1979, p. xii).

En conséquence, le praticien biomédical et le praticien humaniste diffèrent fortement en termes de jugements cliniques et de capacité décisionnelle. Alors qu'un raisonnement scientifique objectif est créé d'un côté du jugement clinique, le raisonnement intuitif subjectif crée l'autre côté (Marcum, 2008, p. 123). La question principale de cette étude est formulée dans le cadre de cette discussion : comment et selon quels sont les jugements cliniques du psychiatre pour enfants et adolescents en Turquie ? Et comment cela se reflète-t-il dans leur discours ?

Dans le cadre de cette étude, l'ensemble de données a été compilé à partir de différents médiums en se concentrant sur les différents actes des psychiatres (Husserl et al., 1982). Les ensembles de données ont été collectés entre 2017-2019. Les actes des psychiatres ont été définis comme leurs propres déclarations anonymes (10 entretiens approfondis), leurs efforts scientifiques (1 directive de diagnostic et de traitement, articles de revues dans le Journal Turc

de la Santé Mentale des Enfants et des Adolescents : 2002-2019 ; et présentations au congrès comme Livres de résumés du Congrès turc de psychiatrie de l'enfant et de l'adolescent : 2012-2019), communication avec le grand public (5 livres et 34 vidéos YouTube). Le but de l'étude est de cartographier le contexte social et moral dans lequel les jugements cliniques se forment en scrutant les détails discursifs et rhétoriques de ces actes. Les ensembles de données, à l'exception des entretiens, ont été scannés avec une analyse de contenu, et le contenu et les entretiens liés au TDAH ont été analysés avec un discours critique et une analyse rhétorique.

Dans le cadre de la compréhension du TDAH, le discours psychiatrique conceptualise un enfant atteint de TDAH comme non fonctionnel, ainsi le but du diagnostic de TDAH et éventuellement du traitement est de rendre l'enfant plus fonctionnel. Le besoin de façonner un enfant de manière fonctionnelle est basé sur le besoin d'adultes fonctionnels. Ces groupes d'adultes - psychiatres, enseignants, parents - qui jugent théoriquement la fonctionnalité des enfants sont supposés être suffisamment matures et informés pour façonner et guider les enfants. Les enfants sont définis comme innocents, nécessiteux et nécessitant d'être façonnés comme une sculpture entre les mains de sculpteurs adultes. Lorsqu'un contexte néolibéral est ajouté à ces définitions, l'enfant est codé en tant que projet. Ce projet doit être réalisé à la fois comme un support où les familles et les enseignants peuvent montrer leur satisfaction et leur réussite individuelles, et en termes d'avantages sociaux. Ensuite, à certains moments, d'un point de vue discursif, les enseignants peuvent ne pas être fiables (chapitre 5), les parents peuvent ne pas être capables de gérer le problème de leurs enfants (chapitre 4). La seule source de succès de ce projet est le psychiatre et la décision clinique est ainsi façonnée.

Dans le chapitre 1, j'ai exploré les auto-récits de ces psychiatres qui ont un effet crucial sur l'éducation de nouvelles générations dans la Turquie moderne du 21^e siècle. Bien sûr, « le praticien biomédical » qu'ils ont présenté dans les livres, les congrès, les articles, les médias de masse et le « praticien humaniste » que j'ai rencontré lors des réunions sont bien sûr les mêmes

personnes. Mais pourquoi préférons-nous ignorer ce praticien humaniste dans la production de connaissances en psychiatrie ? Les deux modes de fonctionnement cognitif définis par Jérôme Bruner (1986, p.11) découvre que la manière de savoir détermine la différenciation de ces praticiens. La connaissance paradigmatique « tente de réaliser l'idéal du système formel et mathématique de description et d'explication. Il emploie la catégorisation ou la conceptualisation et les opérations par lesquelles les catégories sont établies, instanciées, idéalisées et reliées les unes aux autres pour former un système » (1986, p.12). Pourtant, la connaissance narrative « traite de l'intention et de l'action humaine ou semblable à l'homme et des vicissitudes et conséquences qui marquent leur cours. Il s'efforce de mettre ses miracles intemporels dans les particularités des expériences et de situer l'expérience dans le temps et dans le lieu » (1986, p. 13). Ces deux types de savoirs sont complémentaires. L'attitude de production de connaissances que j'ai observée dans la communauté turque des enfants et adolescents est basée sur l'ignorance du savoir narratif. Il est possible de discuter de ces deux modes de connaissance et des praticiens qui les appliquent à leurs pratiques cliniques pour tous les domaines de la médecine. Cependant, la psychiatrie diffère épistémologiquement des autres types de domaines car il n'y a pas de mesures objectives pour conduire à un jugement clinique. Par conséquent, ignorer la connaissance narrative devient plus important lors de la discussion de la décision clinique psychiatrique. Ainsi, comme l'a souligné Feinstein (1969), « le clinicien comme appareil de mesure scientifique », et donc il existe un contexte social et culturel dans lequel cet appareil clinique est né. Cet appareil a été formé dans le système éducatif, où les enfants ont été étudiés et jugés académiquement. Ils grandissent avec les valeurs morales de la société que ces enfants ont été étiquetées comme non fonctionnelles et méchantes. Comme ils le racontent dans leurs histoires familiales, leur avenir est souvent façonné autour des décisions de leur famille. Ainsi, ces appareils ne sont pas indépendants des interactions sociales, comme un test sanguin ou un instrument IRM, et par conséquent, leurs décisions ne sont pas sans valeur.

Les catégories de diagnostic psychiatrique, qui sont définies biomédicalement dans les sociétés occidentales, sont des outils d'auto-interprétation (Jutel, 2011 ; Rose 2013). Aujourd'hui, de plus en plus de personnes comprennent et se présentent avec ces catégories de diagnostic. De plus, d'autres acteurs sociaux tels que les membres de la famille, les amis, les enseignants, les collègues utilisent également ces diagnostics pour encadrer une personne. Cette culture diagnostique (Brinkmann et al., 2014), qui crée également son propre langage, est une composante importante dans la construction des subjectivités.

Chapitre 4 est consacré à l'interprétation clinique du comportement de recherche d'aide des familles. Les attentes des familles et l'observance du traitement varient en fonction de leur statut socio-économique et de leurs attentes et capacités d'adaptation observées par les psychiatres, qui ont un rôle dans le processus décisionnel. Dans de nombreux contextes différents, de nombreux psychiatres ont déclaré que les symptômes dont se plaignaient les parents étaient déterminés par leur statut social. Je tiens à répéter que je n'ai posé aucune question pour l'indiquer dans les questions d'entretien. Ce n'était pas un résultat que j'aurais pu prédire ni en tenant compte de la littérature existante ni de mes expériences personnelles. Pour résumer, les parents aisés et instruits se concentrent sur la réussite scolaire de leurs enfants, ce qui fait que le manque d'attention est visible. Ils perçoivent l'intervention comme urgente pour l'avenir de l'éducation de leurs enfants. Nous comprenons à partir de quelques exemples de pratiques cliniques des psychiatres travaillant davantage avec des familles à revenu élevé qu'ils ne voient pas les comportements liés à l'hyperactivité / impulsivité de leurs enfants comme un problème du point de vue des valeurs morales de leur classe sociale. D'un autre côté, les familles des classes populaires privilégient certains comportements qui perturbent l'ordre social, et l'échec scolaire ou l'exigence d'une plus grande réussite scolaire ne font pas partie des raisons qui les poussent à rechercher une aide psychiatrique.

Un psychiatre perçoit et interprète l'aspect social de la demande tout en évaluant le patient. On voit que cela a une place inséparable dans la décision clinique. Une famille - parfois sous la direction de l'enseignant - transmet la demande d'aide au psychiatre et est placée dans la première étape du processus de jugement clinique. Les indicateurs qui renseignent sur leur statut social tels que les vêtements, le langage, l'hôpital ou la clinique où ils consultent sont suivis par le psychiatre en relation avec les attentes et la capacité d'intervention. Les psychiatres ont proclamé dans les entretiens que la capacité d'adaptation des parents influait sur leur décision d'intervention et en particulier sur leur capacité à prescrire des médicaments. L'évaluation de la capacité d'adaptation des parents est basée sur les observations du psychiatre sur leur statut social. Cette catégorisation contribue à déresponsabiliser les parents face à la souffrance de leurs enfants. Leurs observations renforcent le fait que les parents à faible revenu ont un faible niveau de scolarité et c'est un indicateur de mes interviewés qu'ils ne peuvent pas suivre les interventions comportementales et environnementales. Bien que cela puisse être considéré comme un raisonnement rapide pour commencer un traitement médicamenteux, il ne faut pas oublier que certains médecins essaient de coopérer avec des parents analphabètes ou non turcophones. D'un autre côté, j'ai entendu à plusieurs reprises au cours des entretiens qu'il n'est peut-être pas nécessaire de donner des médicaments si la famille peut mieux prendre soin des enfants. Mais si 10 à 20 minutes sont allouées à ces familles, est-ce une attitude réaliste de penser qu'elles ne répondent pas bien à la psychoéducation ? Comme nous l'avons vu, les revenus et les niveaux de scolarité des familles conduisent évidemment le psychiatre dans ses jugements cliniques. D'un autre côté, s'il y a tant de cas et d'états uniques, la médicalisation des enfants des groupes à faible revenu pourrait-elle être liée à une attitude déterministe ?

J'ai vu le TDAH de manière complètement différente du rural à l'urbain, des centres-villes aux banlieues. Pour moi, un résultat inattendu de cette recherche a été de répondre aux inégalités dans mon pays en suivant la psychopathologie de l'enfance. La littérature sur les

enfants néglige les enfants de différentes conditions économiques et, bien sûr, la parentalité. Il ne faut pas oublier qu'il peut y avoir des attitudes parentales différentes, selon les différents statuts sociaux, mais cela ne doit pas signifier que l'on est supérieur (Kambuta, 2015). Même les attentes et les stratégies d'adaptation des familles dépendent des niveaux socio-économiques, les avantages ou les inconvénients du statut social d'une famille varient selon les enfants. Comme certains médecins travaillant dans des cliniques privées m'ont dit, les familles aisées peuvent parfois demander la médicalisation de leur enfant sans aucune psychopathologie, ou un parent alphabétisé peut être indifférent à la réussite scolaire de leur enfant. Cependant, dans un contexte social complètement différent, au Royaume-Uni, Val Gillies (2006) montre dans son étude que les mères de la classe ouvrière font preuve de beaucoup plus d'investissement émotionnel et d'engagement pour soutenir leurs enfants à l'école que les mères de classe moyenne.

L'influence des inégalités économiques et sociales est implicite, mais destructrice dans le processus de construction de la subjectivité (Biehl et al., 2007). Définir les familles avec leur statut social est la plus grande composante de la création de leur subjectivité. La subjectivité des enfants est créée en fonction de leurs familles. La maîtrise de soi est une composante cruciale de leur subjectivité compte tenu de sa relation avec les symptômes du TDAH. Ce n'est pas non plus un problème social sans imaginaire, comme la psychologie dominante avait insisté pendant des décennies. La célèbre expérience de Stanford Marshmallow (Mischel, 1972) s'est concentrée sur la gratification différée. Le chercheur présente deux choix à chaque enfant ; la première est une récompense petite mais immédiate, la seconde est une récompense différée mais deux fois plus importante. Après que le chercheur ait quitté la pièce, les enfants peuvent manger la guimauve ou ils peuvent attendre que le chercheur revienne et ils peuvent manger deux guimauves. Selon les résultats, les enfants qui peuvent attendre plus longtemps ont tendance à avoir de meilleurs résultats dans la vie. Cependant, cette expérience a été récemment

répétée (Greg et al., 2018) et les résultats montrent que les enfants issus de familles à revenu élevé et mieux éduquées sont capables de retarder plus facilement la gratification. Cela signifie qu'ils ont beaucoup plus de maîtrise de soi. De meilleurs résultats dans la vie sont très probablement basés sur les avantages de leur contexte familial.

L'une des questions fondamentales que Wayne Wu (2014) suggère pour interroger la fonction de l'attention est « quel rôle l'attention joue-t-elle ? ». Dans le chapitre 5, je partage ma réponse lorsque je pose cette question à mon ensemble de données. Le seuil requis qui est défini l'attention, l'hyperactivité et l'impulsivité comme un trouble, à savoir l'écart par rapport à la normale, est la fonctionnalité, et cette fonctionnalité est incarnée dans 2 domaines. L'un d'eux est l'échec scolaire et sa relation avec l'attention.

La psychologie « fabrique des normes normatives sur la façon d'être, d'agir, de penser, de ressentir et de vivre, et elle fournit aux gens des outils pour atteindre ces normes (Brinkmann, p. 14) ». Ensuite, la psychiatrie entre en jeu pour les personnes qui ne respectent pas ces normes. Afin de poser le diagnostic du TDAH, il est considéré comme le seuil le plus important sur lequel les experts peuvent fréquemment insister : se concentrer non pas sur ce à quoi le sujet veut prêter attention, mais sur l'ordre normatif. Cela détermine l'une des limites de la fonctionnalité. Par conséquent, l'ordre normatif encode la réussite scolaire comme une nécessité et les étudiants qui échouent sont envoyés en clinique psychiatrique comme une exigence du 21^e siècle. Dans ce chapitre, j'ai essayé de montrer comment le déficit d'attention était diagnostiqué dans le cadre de l'échec scolaire. Si les psychiatres qui font ce diagnostic sont conscients des choses qui ne vont pas bien dans le système éducatif, ils ne sont pas intéressés à se demander si la nécessité de médicaliser tous ces enfants. Cette absence de questionnement sert à individualiser un problème social.

Deux éléments moraux de Durkheim (1934) jouent un rôle dans le processus de recherche d'aide et de jugement clinique pour les comportements de type TDAH. Les

symptômes du TDAH selon le système de classification psychiatrique américain (DSM-V, 2013) qui incluent l'hyperactivité, l'impulsivité et le manque d'attention sont définis du point de vue de la maîtrise de soi, en particulier, le symptôme d'inattention qui est défini avec un la tête dans les nuages, sur laquelle je me suis concentré pendant ce chapitre. Obtenir la réussite scolaire et la bonne parentalité qui aident à élever un enfant en bonne santé génère la dimension du discours sur le TDAH qui l'attache à la société. Cependant, cette tâche qui fait référence à l'éducation morale attribuée à la pédagogie déjà excessive se situe sûrement dans les limites de la tâche de psychiatrie en Turquie de 2020. Bien que la pédagogie proposée par Durkheim comme principal outil d'éducation morale ne la remplace pas complètement, nous pouvons maintenant discuter de la médicalisation comme deuxième voie d'éducation morale.

Dans ce chapitre, nous avons rencontré un autre sujet que les enfants ont mis en relation tout en établissant leur subjectivité : les enseignants. Bien qu'ils ignorent le manque d'attention selon ce que rapportent les psychiatres, ce sont toujours des personnages cruciaux qui permettent aux familles de transmettre certains problèmes aux psychiatres. Dans ce chapitre, où nous examinons le TDAH en termes de système éducatif et de déficit d'attention, nous avons vu que, parallèlement à d'autres chapitres, les enfants sont des sujets complètement silencieux, et comment l'éducation en tant qu'institution a participé à leur création à travers le TDAH.

Au chapitre 5, j'ai essayé de comprendre ce que le TDAH signifie pour l'imagination des adultes. Dans d'autres chapitres, j'avait demandé qui veut créer ces subjectivités alors qu'ici j'ai préféré demander ce que la psychiatrie veut créer et pourquoi. Tout en sapant le concept de fonctionnalité depuis le début, j'ai rencontré deux paramètres importants : l'un était la réussite scolaire et l'autre la maîtrise de soi. L'enfant qui ne peut pas se maîtriser signifie l'enfant qui ne peut pas contrôler ses mouvements et ses pulsions. Cette absence de direction effraie la société à cause des problèmes auxquels elle peut conduire. En fait, cela devient un danger, comme un avertissement à la bombe dans un espace public. La bombe peut exploser, mais aussi ne pas

exploser. Pourtant, le risque d'explosion étant plus dangereux pour la société, une intervention est faite au cas où. La méthode d'intervention est définie comme un médicament et est fermée à la discussion.

Le cercle psychiatrique en Turquie construit un récit du TDAH pour renforcer les craintes des familles quant à l'avenir de leurs enfants. Par conséquent, l'hypothèse de nombreux psychiatres sous-jacente à la demande de pathologisation par le bas liée au symptôme de déficit d'attention n'est pas compatible avec mon analyse dans ce chapitre. Ils servent toujours une médicalisation par le haut, tout en définissant les enfants atteints de TDAH comme potentiellement criminels, infructueux ou dangereux.

La motivation de protéger la santé publique, qui est façonnée par des valeurs morales qui indiquent ce qui ne va pas, ce qui est bien, voire ce qu'est la santé, et de soutenir le contrôle social conduit à des jugements cliniques. « Guérir c'est bien, prévenir c'est mieux, mais maximiser le rendement en ajustant chaque individu à son rôle social et en calibrant le changement à la dynamique sociale comme l'exige la nécessité de reproduire l'ordre social est sûrement l'idéal d'une politique sans politique » (Castel et al. 1982, p. 295).

D'un point de vue historique, il est utile de se tourner vers la théorie et la pratique de la santé mentale des enfants qui ont émergé à la fin du 19^e siècle et au début du 20^e. Comme je l'ai mentionné dans l'introduction, Lightner Witmer (1913) a fondé la première clinique de santé mentale pour enfants. Les études menées là-bas étaient plus orientées vers l'école, utilisant le test développé par Binet et ses collègues pour diagnostiquer les difficultés scolaires et la préoccupation de Healy concernant les maladies mentales infantiles dans le but de prévenir la délinquance juvénile. Le diagnostic de TDAH dans la Turquie contemporaine est défini et compris en parallèle avec ce contexte historique. Le diagnostic et le traitement du TDAH reposent sur deux domaines fonctionnels importants sur lesquels la santé mentale des enfants est établie : la performance scolaire et la prévention de la délinquance juvénile.

Afin d'atteindre les discours les plus complets sur le TDAH produits par des psychiatres d'enfants et d'adolescents, j'ai passé en revue des revues académiques, des congrès professionnels, des livres écrits pour le grand public et des vidéos YouTube. De plus, j'ai réalisé des entretiens approfondis semi-structurés pour obtenir des informations du côté expérientiel de la pratique clinique. En conséquence, les connaissances sur le TDAH produites par le psychiatre pour enfants et adolescents en Turquie ne représentent pas différents types de connaissances de divers points de vue concernant le TDAH / l'hyperactivité / le déficit d'attention. Je suis en mesure de dire cela en me basant sur les points forts non seulement des entretiens, mais également d'autres documents que j'ai recueillis dans des livres, des vidéos et des publications scientifiques. Produire la connaissance des contre-arguments n'est possible qu'avec une formation philosophique et humaniste. Avec un taux de prévalence allant jusqu'à 20% (Ercan, et al., 2019), le TDAH est la raison la plus courante de postuler dans presque toutes les cliniques psychiatriques, et la demande de psychostimulants de la part des familles dont se plaignent de nombreux psychiatres sont des indicateurs importants que ce problème est trop médicalisé.

Les savoirs produits par la communauté et la pratique psychiatriques turques sont en contradiction avec leur expérience clinique. Comme je l'ai observé dans les données des congrès et des revues, les études neurobiologiques sur le TDAH sont l'un des intérêts de recherche les plus populaires ; cependant, comme je l'ai observé dans leur pratique clinique, les arguments neurobiologiques ne rendent aucun service au jugement clinique des psychiatres. D'un autre côté, la complexité du jugement clinique, et les influences de l'imaginaire social sur celui-ci, sont les principaux enjeux de nos entretiens. Ils ont de nombreuses questions à ce sujet, mais il n'y a pas d'article de revue et peu de discussions dans les congrès. Je ne fais référence à aucune discussion critique ou antipsychiatrique, mais les psychiatres ignorent complètement leur expérience clinique et de même l'expérience des patients et le contexte social. Ignorer et ne pas

produire de connaissances sur ce sujet le pousse hors de la zone de discussion. Comme je le vois dans les résultats de mon analyse, il y a un manque de tolérance envers toutes les autres approches. La connaissance est monopolisée, ce qui amène l'autoritarisme. Une telle déconnexion de la science et de l'expérience humaine de la méthode dialectique n'est-elle pas une forme spectaculaire de cécité ?

Dans chaque chapitre, nous voyons que les psychiatres créent une réalité sociale. Dans cette réalité, les enfants sont vulnérables et les parents et les enseignants n'ont pas suffisamment d'informations ou de capacités pour gérer la situation ; les psychologues essaient juste de prendre leur part de marché. Ainsi, ils s'attribuent la responsabilité de s'occuper du problème, mais aussi une puissance éternelle. Cela ne vient pas d'une motivation négative de contrôle social ; au contraire, pour eux, il repose sur une attitude de soutien positive, mais en fin de compte, il sert la médicalisation et l'autorité du médecin. Foucault (1982, p. 779) souligne l'importance de « rechercher les liens entre rationalisation et pouvoir » puisque « la relation entre rationalisation et excès de pouvoir politique est évidente. Et nous ne devrions pas avoir besoin d'attendre la bureaucratie ou les camps de concentration pour reconnaître l'existence de telles relations. Mais le problème est : que faire d'un fait aussi évident ? » (1982, p. 779). Ma réponse à cette question est basée sur la production de connaissances sur la résistance, c'est-à-dire sur la capacité à déconstruire le paradigme dominant. Ainsi, je pense que l'une des conclusions importantes de cette recherche est l'absence d'arguments alternatifs ainsi que le discours que j'ai recueilli. J'attribue une importance à ce résultat car il y a une uniformité dans le domaine politique au cours des vingt dernières années en Turquie. Je vois le reflet de cette uniformité dans la production de connaissances, qui se manifeste de la même manière. Cela augmente au jour le jour l'autorité des psychiatres et repousse les approches psycho-sociales des problèmes de comportement.

Au cours des entretiens, j'ai écouté de nombreuses histoires cliniques différentes, à la fois en fonction des différents parcours des médecins et en raison de l'hétérogénéité des populations avec lesquelles ils travaillaient. Les antécédents scolaires et économiques des parents influent également sur leur perception du TDAH et sur leurs attitudes en matière de recherche d'aide. Les parents de la classe moyenne et instruits sont plus axés sur la réussite dans la vie scolaire de leurs enfants. Leur plainte fondamentale est le manque d'attention des enfants. Dans une grande partie de cette recherche d'aide, les psychiatres partagent le point de vue selon lequel les enfants n'ont besoin d'aucun diagnostic ou traitement. En outre, ils ont une expérience considérable des demandes de médicalisation des parents dans le but d'améliorer les performances des enfants aux examens. Dans ce contexte, les psychiatres sont contre la médicalisation de la réussite scolaire. De l'autre côté, les parents qui viennent de la campagne, de la banlieue ou d'autres milieux populaires consultent les psychiatres pour hyperactivité et stagnation. Les raisons fondamentales de cette recherche d'aide comprennent des blessures physiques dues à des réactions impulsives, des changements dans le trouble des conduites, des comportements problématiques en classe et une tendance à la violence. Dans ces cas, selon les psychiatres, les enfants ont différents niveaux de vulnérabilité ; ils doivent étudier dans des écoles secondaires, leurs parents ne sont pas capables de les soutenir avec leurs attitudes, ils peuvent ne pas avoir beaucoup de stimuli en grandissant. Ainsi, même s'il n'est pas nécessaire de réaliser un diagnostic de TDAH et un traitement médicamenteux, les psychiatres déclarent qu'ils peuvent poser un diagnostic et proposer un traitement au méthylphénidate car ils ont une motivation pour accompagner un enfant vulnérable de la meilleure façon qu'ils savent. À ce stade, le jugement clinique a été façonné sous l'influence de la croyance des psychiatres que leur autorité peut aider ces pauvres gens, et de leurs attitudes morales qui se positionnent à un point d'autosatisfaction, qui n'a aucun rapport avec les preuves statistiques et scientifiques. du

TDAH. Ainsi, ils établissent et maintiennent leur autorité, déresponsabilisent parents et enfants et leur attribuent une position très passive.

Le TDAH est défini par trois symptômes dans le DSM-5 : l'hyperactivité, l'impulsivité et le déficit d'attention. Ils peuvent exister sous trois types différents : types combinés, principalement inattentifs et principalement hyperactifs-impulsifs. Ces symptômes sont détaillés avec des modèles de comportement spécifiques dans le DSM-5 et les guides cliniques. Cependant, l'une des critiques remarquables du TDAH est la subjectivité de ce critère. Je voudrais élaborer sur cette problématique, car dans mes recherches je prends en considération si un comportement est bas, excessif ou décisif selon la façon dont on définit le seuil dans une société, et dans une langue. Je discute de ces valeurs sociales et morales comme outil de mesure pour déterminer ce seuil. En d'autres termes, tant la société - pour identifier un comportement comme problématique et pour l'amener au psychiatre - et le psychiatre - pour déterminer l'écart par rapport à la société - ont besoin de ces outils. Par exemple, un psychiatre pourrait penser qu'il est difficile de remarquer les enfants ayant un déficit d'attention parce qu'ils correspondent au critère moral de la société de la docilité. De tels enfants sont toujours préférables pour les enseignants et les parents. Le seul problème qui amène un enfant dans une clinique psychiatrique est l'échec scolaire, et les psychiatres ont généralement du mal à poser un diagnostic. Au contraire, les enfants hyperactifs et impulsifs ne sont pas souhaitables pour tout le monde - enseignants, camarades de classe, parents, etc. - et les psychiatres soulignent qu'il est facile de les observer à la clinique. On peut donc dire que le fait que le non-respect des normes puisse être vu par le psychiatre conditionne la décision diagnostique.

Comme je l'ai mentionné dans le chapitre 5, l'échec scolaire est défini comme l'indicateur le plus important du TDAH. Dans le chapitre suivant, la question que je souhaite poser est la suivante : l'échec scolaire est-il une situation individuelle ? La biologisation et la médicalisation de l'échec scolaire détachent l'enjeu éducatif de son contexte institutionnel et

politique. Comme les psychiatres l'ont mentionné lors des entretiens, ils sont conscients des problèmes du système éducatif ; cependant, ils croient qu'ils ne peuvent aider les enfants que sur ordonnance. Le système éducatif turc est basé sur des examens de sélection et de classement centralisés. Aujourd'hui, après la phase d'enseignement primaire de 8 ans, tous les élèves du pays passent le même examen, dont le résultat détermine le lycée qu'ils fréquenteront. Ensuite, ils passent un deuxième examen après le lycée dont les résultats déterminent l'université et le département dans lesquels ils continueront. Pour cette raison, les enseignants, les parents et les élèves sont axés sur les examens. Les psychiatres affirment que les visites des parents sont plus fréquentes avant les périodes d'examen. Ils pensent également que les perturbations du système éducatif et les politiques en constante évolution augmentent le nombre de candidatures. Dans le processus décisionnel, cela correspond à un autre niveau de vulnérabilité des enfants. Les privilèges institutionnels d'un enfant dans le contexte scolaire quotidien et en particulier pour les examens après avoir reçu un diagnostic jouent un rôle important dans les demandes des parents et les motivations des psychiatres dans le jugement clinique.

Une autre motivation menant au diagnostic du TDAH et influençant le jugement clinique est l'objectif de prévenir les problèmes plus importants qui peuvent survenir à un âge plus avancé. Quelques-uns des « problèmes les plus importants » définis dans mon ensemble de données sont l'abus d'alcool et de drogues, les actes criminels, les problèmes familiaux, le divorce, etc. Le diagnostic et le traitement du TDAH sont positionnés comme la prévention. En d'autres termes, empêcher les choses de s'aggraver est l'une des responsabilités sociales qui a été assignée à cette catégorie de diagnostic psychiatrique, ainsi que le meilleur projet dont je parle dans le premier chapitre. L'un des psychiatres, un médecin militaire, a déclaré que si nous pouvions scanner les prisons maintenant, presque tous les criminels pourraient recevoir un diagnostic de TDAH.

Le jugement clinique est un processus complexe dans lequel le psychiatre traite toutes les preuves obtenues et les intègre dans son jugement clinique, comme le soutient Feinstein (1967). Pour les épistémologies cliniques fondées sur les vertus, les preuves cliniques sont définies dans un spectre plus large, et bien que des informations quantitatives fondées sur des preuves puissent être en arrière-plan, les données humanistes sont prioritaires. Quand j'examine les connaissances et les expériences produites par les psychiatres d'enfants et d'adolescents sur le TDAH au niveau discursif, je conclus que les données humanistes éclairent la décision clinique plus que les données statistiques. La région où les psychiatres sont nés, leur âge, les écoles dans lesquelles ils ont été formés, le statut social des familles dont ils sont issus, les villes et les hôpitaux dans lesquels ils travaillent : tout cela crée un arrière-plan pour l'interprétation des informations provenant des patients. Sur la base de ce contexte, des valeurs sociales et morales se forment et les informations passent d'abord par ce filtre. Par exemple, bien qu'il n'y ait aucune information dans la littérature selon laquelle le symptôme pour lequel les familles recherchent une aide psychiatrique diffère selon leur statut social, les psychiatres ont un jugement à ce sujet en raison de leurs expériences. Alors, d'où proviennent les informations sur le statut social de la famille ? D'après ce que j'ai vu dans les entretiens, il n'est pas clair si la famille est interrogée sur ses revenus. Des informations telles que l'apparence extérieure des parents, leur niveau culturel, la langue qu'ils utilisent, leurs attentes vis-à-vis de leurs enfants et les écoles fréquentées par leurs enfants constituent un profil de statut social pour les psychiatres. Il ne s'agit pas d'informations quantitatives fondées sur des preuves, ni même du type d'analyses que nous faisons souvent avec conscience. La catégorisation sociale est un processus cognitif rapide et une part considérable des données humanistes provient de ce type d'informations. Quand nous regardons la pratique clinique, nous ne pouvons pas voir l'utilisation de divers tests et échelles qui seraient impliqués dans le processus de décision clinique. Il s'agit donc en fait d'un parcours (Engelhardt, 1979) qui n'inclut aucune mesure,

jugement actuariel (Meehl, 1954) dans le processus de diagnostic du TDAH. Les outils statistiques présentent certainement des avantages évidents qui soutiennent le raisonnement clinique et, dans ce cas, il est nécessaire d'en tirer parti. Cependant, il serait également irréaliste de réduire le raisonnement clinique aux seules données actuarielles (Upshur et Chin-Yee, 2017). Lors de la prise de décision concernant le traitement, les informations statistiques sur l'utilisation du médicament, quel médicament doit être utilisé pour quel groupe d'âge, et les connaissances scientifiques sur les effets secondaires sont utiles. Comme le soulignent Upshur et Chin-Yee (2017, p. 368), « un compte rendu équilibré du jugement clinique aurait alors de la place pour les deux styles de raisonnement. Il y a de bonnes raisons de s'efforcer de valoriser les deux. » Dans le cadre des données que j'ai collectées en Turquie, j'observe que si ces outils aident à dresser un profil statistique général du TDAH, les informations humanistes jouent un rôle plus important dans l'élaboration de la décision diagnostique. Feinstein (1982) conceptualise la clinimétrie comme un domaine qui examine les mesures de problèmes cliniques qui ne rentrent pas dans la taxonomie clinique traditionnelle. Ces sujets comprennent le type de symptômes, leur gravité, le taux de progression de la maladie, la gravité des comorbidités, les problèmes fonctionnels et les raisons du traitement médical. Il prend également en compte de nombreux aspects de la vie quotidienne. Le diagnostic du TDAH est également basé sur une grande partie des informations décrites dans la clinimétrie (Meehl, 1954) de par sa nature. Le clinicien se considère comme un appareil de mesure scientifique (Feinstein, 1979) et forme la clinimétrie du TDAH.

L'idée que le jugement clinique et le jugement statistique doivent être valorisés de la même manière découle du fait que la nature de la pratique clinique rencontre les limites des connaissances médicales. Les informations reçues du patient ne permettent généralement pas une compréhension holistique de la maladie et de l'état du patient. Telle est la nature de la pratique clinique. Un diagnostic provisoire est formé avec les informations acquises par

fragments. Même lorsque le diagnostic est définitif, il est rarement garanti de prédire l'efficacité du traitement. Le pronostic d'une maladie est façonné dans l'incertitude (Upshur et Chin-Yee, 2017, p. 368). Les informations que j'ai reçues des entretiens montrent que le diagnostic n'est posé avec certitude que dans de très rares cas. Il y a peu de rencontres, qui sont définies comme des enfants qui doivent recevoir un diagnostic de TDAH, d'une manière qui ne laisse aucun doute. La plus grande partie de mes entretiens en face-à-face, en termes de temps et de contenu, portait sur des cas incertains et les stratégies que le psychiatre développe pour les évaluer. Par exemple, si quelqu'un obtient l'avis d'un autre psychiatre pour enfants et adolescents, on préfère régler les facteurs environnementaux et les suivre sans médicaments ; tandis qu'un autre n'est pas sûr de la décision diagnostique, il prescrit des médicaments et passe du traitement au diagnostic en fonction de l'efficacité du médicament. Ces stratégies surviennent en raison du besoin d'incertitude liée au diagnostic, au traitement et au pronostic. Djulbegovic et coll. (2011) recommandent une classification complète de l'incertitude en médecine clinique. Ils affirment que « l'incertitude est inhérente à la médecine. Elle se produit à tous les niveaux de la pratique clinique et de la recherche. Elle a de multiples causes, avec des implications importantes pour la prise de décision, la qualité des soins et la gestion des patients. Elle restera une caractéristique centrale de la pratique médicale » (Djulbegovic et al., 2011, p. 347). L'incertitude provient du manque de preuves, des interprétations contradictoires de ces preuves, de l'accès limité aux preuves dans le temps, de la difficulté d'appliquer les informations statistiques à des situations individuelles et des préférences et valeurs peu claires du patient. En d'autres termes, toutes les rencontres cliniques contiennent en elles-mêmes une incertitude.