Metaphors & Meaning
Expressions of ADHD in the Netherlands

Andrea Kalvesmaki
July 2010
University of Amsterdam
Amsterdam’s Masters of Medical Anthropology
AMMA

Advisor: Anja Hiddinga
“It is poetry that is lost in translation.”

- Robert Frost
Summary

This thesis explores how language used by psychiatric professionals in the Netherlands explains and shapes the diagnosis of ADHD, through common words and terms. Language is the glue by which we bind everyday experience. Through words and descriptions, we give meaning to the world that surrounds us. Medical professions use language to define what deviates from normal, in the form of diagnoses. These diagnoses can be seen as shaped by the specific words describing them. But sometimes, their words can even change a local language in a way as to explain phenomenon in simplified terms.

ADHD is a diagnosis originating in the United States, where the term ‘hyperactive’ has come to be synonymous with the disorder. Attention deficit/hyperactivity disorder is now a psychiatric diagnosis recognized in cross-national contexts due to the expansion of professional practices. This research has found that the language used by Dutch diagnosing clinicians expresses tensions in how the disorder is applied in their local context. One word used to describe the symptoms of the diagnosis was also used to explain societal and environmental situations, in essence creating a local metaphor for ‘ADHD’. The use of the word ‘druk’ illustrated by these clinicians suggests interpretations for what the disorder represents, independent of its psychiatric definition. While professional standards and protocols require the use of the diagnostic term ‘ADHD’ in the Netherlands, the use of this diagnostic category is also a product of demands placed on the professional. This research indicates that the term ‘ADHD’ itself has become a symptom of a change in professional and social processes that make the diagnosis apparent in Dutch society.

The findings from this research indicate that language is an important element in understanding how a diagnosis becomes relevant in a local context. Terms employed to describe symptoms and developments in one location may differ from those applied in other settings. It is these terms that lend insight into meaning and use for an illness category. This research places the psychiatric professional as reflective of the society they are located in, socially and linguistically. The common language of clinicians in the Netherlands reveals specific interpretations of the diagnosis ADHD.
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Introduction

“Just calm down, don’t be so ADHD!” is a new popular expression in the Netherlands that takes an old metaphor and adds a new twist (Boon 2009:10). The abbreviation ‘ADHD’ is replacing the local word ‘druk’, showing how a diagnosis can become a popular adoption into everyday language of a society.¹ Or maybe, it is an expression showing how influential the diagnosis has become. In the United States and around the world, epidemiological rates of ‘ADHD’ are on the rise. Attention deficit/hyperactivity disorder (ADHD) has expanded internationally as both a common diagnosis and a common expression over the last 30 years since its inception in the psychiatric lexicon of the United States. Statistical rates of the disorder, warning signs, and checklists are prominently available on the Internet in dozens of languages. Books abound on the subject. In the Netherlands, the term ‘ADHD’ came into both clinical and common everyday use late into the 1990’s.² Recently, local Dutch media proclaimed “ADHD is in,” both as recognized mental illness and a social phenomenon (Radio 1 2010). It has definitely become recognized, as both a buzzword and a diagnosis.

ADHD is a classification of the Diagnostic and Statistical Manual of the American Psychological Association (current: DSM-IV TR)³ and it is a disorder that has had much controversy, scientific debate, and even media attention since its very inception into the DSM. Sociologists have led the forefront on theories to explain the emergence of the disorder and its relevance both professionally and socially.⁴ Most anthropological work regarding the disorder, however, has taken either the stance that it is a ‘relativistic’ disorder resulting from the culture created by American society, or that it is ‘universally’ apparent because of epidemiological rates and statistics (for full debate see: Canino and Alegria 2008). However, ADHD is also a descriptive, as diagnostic category and a classification of symptoms, a term used by the mental health profession. This descriptive category has meaning for those who define and apply the criteria, and also those who identify with it. Yet to date, few studies have examined the language

¹ “Doe maar even rustig, doe maar niet zo ADHD!” is a twist on the expression “Doe maar even rustig, doe maar niet zo druk” where the term ‘druk’ has been interchanged as equivalent to ‘ADHD’.
² The adoption of ADHD as a term for both Dutch psychiatry and the Diagnostic and Statistical Manual of the American Psychological Association is explored in depth in the literature review (chapter 2).
³ See annex 8.2 for a copied diagnostic criteria of ADHD from the DSM IV TR
⁴ See Literature & Theory section of this thesis
and use of this term as a descriptive, especially outside of the United States. When we hear the expression “don’t be so ADHD!” used in Dutch everyday speech, this becomes a point of entry.

The diagnosis of ADHD is a relatively recent addition for Dutch psychiatry, yet it has already been at the forefront of many studies. The Health Council of the Netherlands published a report in 2000 indicating both pros and cons of the diagnosis. This report also identified an “urgent need” for qualitative research to understand what was happening behind the scenes, so to speak, for both the diagnosing process and public perception (Health Council of the Netherlands 2000:9). ADHD, up until recently, has often been seen exclusively as “an American diagnosis” (Faraone, et al. 2003:104). This perception has shifted due to epidemiological rates reported from nations such as the Netherlands. Dutch policy concerning the diagnosis has been exemplified in the European psychiatric network, and has been used as an example for a need to create a uniform European understanding of the disorder. However, it is far from ‘universal’ across Europe, in both descriptions of what ADHD is, and how it is recognized and treated (DAMP 2004). While much ADHD research has emerged from within the Netherlands over the past few years, it has remained epidemiological and reproductive of United States’ studies. There have been no qualitative analyses published regarding how the diagnosis is perceived or enacted specific this particular setting, either through interpretation of the diagnostic criteria or internal descriptions. Perhaps that is because no one is sure where to begin.

The diagnosis of ADHD did not originate in Europe or the Netherlands. It has been appropriated, and rather recently. Public media has criticized this due to rising diagnostic rates, and general concern over the disorder with fingers often pointed directly at the psychiatric professionals (Rondom 10 2010). However, in a published interview with retired Dutch child psychiatrist Fritz Boer, he turned the ADHD concept into a question of language that has become popularized both in the psychiatric profession and by the public:

“I don’t have any reason to believe that there are now more children with problems such as ADHD or autism. But still more and more children are getting the label of ADHD or autism placed on them. The word ADHD has become commonplace. When I began [as a psychiatrist] the condition existed, but it was not incorporated into our language. Now it has become a Dutch word for which you can say to your friend: just calm down, don’t be so ADHD” (Boon 2009:10).
If a psychiatrist, a professional who diagnoses, indicates that the term has become a word, now incorporated into Dutch vocabulary, we are provided with a starting point for analysis. When a mental diagnosis term has come to play a metaphorical role in common everyday language, the meaning of the illness category as well as its use becomes immediately relevant. The use of language around this diagnosis in a nation that has adopted it as a mental health concern may provide insight to both the diagnosis itself, and its applications across social and professional contexts.

A recent publication on childhood disability indicated that understanding local terms and words for what could be classified as the psychiatric term ‘conduct disorder’ were imperative to understanding the social implications and treatment options for children exhibiting distress (Mpofu 2010). In that Zimbabwean context, the term ‘ADHD’ was also compared to local words and terms for behavior that expressed a general concern with child rearing. The study of psychiatry and its specific symptom terms has long been an interest of anthropology because it is believed that psychiatric ‘illness’ gives clear examples of how the social world cannot be extricated from medical concepts (Kleinman 1978; 1988). In fact, psychiatric disorders are defined by emotions and physical behaviors viewed as ‘abnormal’ within their particular environment. The terms expressing what is considered ‘abnormal’ are partially the psychiatric professionals’, but they also come from within their socio-linguistic environment (Kirmayer 2001; 2005).

My father once said, ‘no one councils the counselor’. It is easy to overlook the private thoughts and common expressions of the professionals who interpret the symptoms of others. We often assume that especially mental health professionals represent uniform, clarified answers. Or that is what we want to believe. There is comfort derived from thinking that we can go to a doctor to receive a diagnosis for a complaint, feeling the problem has somehow been solved. It is easy to forget the doctor, the psychiatrist, or the psychologist is also just an individual member of the same society, often with his or her own doubts and questions about what symptoms represent. Their interpretation of our symptoms may come from experience, belief, or simply the practice of their profession. To ‘council the counselor’ means to listen to their words expressing the very topics we seek answers to ourselves. If Fritz Boer’s quote is any indication, listening to how Dutch psychiatrists describe ‘ADHD’ may give us insights into the particulars of this diagnosis in the setting of the Netherlands.
2 ‘ADHD’ in Context

2.1 The language of ADHD

Dutch authors and historians have already placed importance on the relevance of understanding language in the context of psychiatry generally, and the ADHD diagnosis specifically. In 2008, *Kinderen van hun Tijd* was published in the Netherlands and has received much subsequent attention ([Children of their time](Bolt and de Goei 2008)]. A history of psychiatry and the development and use of the ADHD diagnosis, this book is highly significant for two reasons. The first is that while it builds on premises of prominent social science theory of the ADHD disorder (Conrad and Schneider 1980; Rafalovich 2004) it traces a history of the diagnosis in parallel to the history of child psychiatry in the Netherlands. This is a first of its kind, and not surprisingly since there is little sociological or historical work on the diagnosis from nations outside ADHD’s origination in the United States. Its second level of significance is that the authors traced not only the history of the diagnosis, but the language used to describe both childhood disorders and the emergence of the term ‘ADHD’. Placing a level of importance on understanding how language can parallel public social or private professional processes, ADHD is put into historical perspective. Since diagnoses are *terms* chosen to classify and label a phenomenon of experience, understanding their development over time can place the current use of a diagnostic label in a socio historical framework. The second chapter of the book was devoted specifically to language terms and wording from the early 1940’s literature into the present day descriptions of the disorder. The authors showed that Dutch terms of ‘ongedurige’ (restless) and ‘nerveuze’ (nervous) used to describe childhood disorder during the 1940’s were linked to specific European philosophies. The term ‘ongedurige’ closely aligned to German psychiatry while ‘nerveuze’ followed the work of French child psychologist Alfred Binet (p. 29). The term ‘onrust’ (disquiet/unease) began to appear in written and spoken psychiatric terminology in the 1970’s, and was used to describe internal feelings of either a challenging child, or those affected by them (p. 36). This word came into use right as the system of health was shifting toward a ‘uniform’ national system, which included the incorporation of outpatient family clinics. The authors point was to illustrate that by the time the term ‘ADHD’ came into prominence in the 1990’s, a longer heritage of common language and linguistic terms begat its acceptance.
From the United States, it has been educational psychologists who have examined the use of ADHD symptom terms as they are used both publicly and professionally. *HyperTalk* (Danforth and Navarro 2001) illustrated that the language of the specific symptoms of ADHD linguistically create and reflect the dominant ideologies of the American medical and educational systems. Terms such as ‘hyperactivity’, which is abbreviated by the ‘H’ of the ADHD title, as well ‘impulsivity’, a diagnostic requirement, are vague descriptives of behavior deeply embedded with social meaning (p. 175-178). The authors suggested that the descriptive category of ADHD has come to *embody* an American philosophy through its very terminology, and that the specific symptoms as listed in the DSM are expressive of this in their diagnostic language. This becomes significant when applying descriptive terms of symptoms from one language to another, in a different social setting. For instance, the term ‘hyperactivity’ could mean something very different when applied to a child in a different cultural context. Mental illness categories, of which *attention deficit/hyperactivity disorder* is considered example, can be considered an ambiguous grouping of physical symptoms that is interpreted through specific terms and language. The historian Lynn Payer (1990) suggests that American dominance for linguistic terms in psychiatry superceded the historical elements of European nosologies. American medicine and its ways of diagnosing were summed up in a single word: “aggressive” (p. 23). The European traditions of classifying illness, especially mental illness, would be effectively replaced by sweeping general terminology that could also be adopted as part of ‘standardizations’ of medicine (Payer 1990). This places terminology of specific disorders as if they have no longer a cultural or social significance, while the embedded understanding of their language terms may imply connotations not applicable to adoptive contexts. This can be seen in the symptomatic terms of ‘ADHD’ as it has become a category of classification outside of the United States.

2.2 A Brief History

Developments in psychiatry, medicine, and the terminology of diagnoses change over time. When World Wars I & II introduced both new methods and new horrors to warfare that directly impacted local society, European psychiatrists and doctors were quick to note to the subsequent widespread effects of anxiety and stress on the public. British and Dutch psychiatrists pioneered work acknowledging that social factors could interplay deeply with biomedical make-ups of individuals to create expressions of mental distress. Psychiatry, as a European profession
of social and scientific relevance, was established and promoted (Gijswijt-Hofstra and Porter (Eds) 1998). By 1948, Dutch psychiatrists were among those leading concepts of mental distress and health internationally. In fact, the term ‘mental health’ became a popular term emerging directly from the ‘mental hygiene’ movement in the Netherlands (de Goei 1998:68). The concept of children’s disorders came along as a part of this as both Dutch and British systems had been long concerned with children’s issues. For the first time, the International Classifications of Disease (ICD) incorporated diagnoses for mental distress such as ‘shell shock’ and ‘hyperkinesis disorder’ for children. As the psychiatric professions across Europe became concerned with both identifying early markers of mental disorder, and preventing mental illness from occurring, children became a major focus for this (de Goei 1998). Whether this was a direct response of the profession to the climate left over from the terrors of WWII and the rise of a ‘mad man’ to power in Germany or not, it is uncertain. However, the European psychiatrists were very quickly directing energies to understand the social and biological components of mental illness and how to detect and prevent it.

In the wake of World War II, American psychiatrists sought to establish a close link to European professional developments and the first two versions of the DSM were employed to this end. But by the preparations for the third edition in the 1970’s, the American position was to assert epidemiological research over traditional psychodynamic perspectives, effectively altering its course from close alignment with European standards. In *The Selling of the DSM: the rhetoric of science in Psychiatry* (Kirk and Kutchins 1992) the dominance of the United States perspectives on the development of a ‘uniform’ psychiatric manual brings present day psychiatric diagnoses into socio-historical focus. The DSM III omitted the emphasis of clinical experience and psychodynamic theories in favor of statistical concepts such as ‘Kappa’, a statistical model (p. 51). The goal to create uniformity in diagnoses meant the assertion of a model for classification that would bring worldwide psychiatry into a perceived unilateral profession. Nowhere was this more apparent than in the section on childhood disorders, which now included for the first time the diagnosis listed as attention deficit (hyperactivity) disorder. It is to be noted that even in the United States, there was much controversy over the development of the childhood diagnoses in this version of the DSM. Prominent childhood psychiatrists were

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5 The ICD has roots as the International List of Causes of Death dating from the 1850’s. It incorporated disease in 1948 under the World Health Organization’s administration (see: http://www.who.int/classifications/icd/en/)
excluded from the team of researchers, and more diagnoses were added than in any other section (p. 101). This ‘new’ DSM (DSM III) is considered to have revolutionized American psychiatric conventions, and with that, those of other nations. With the marketing of the manual internationally for research and training purposes, the perceived ‘uniformity’ of diagnoses was introduced on an unprecedented level. This effectively created a public and professional assumption that international appearances of DSM diagnoses validated their classifications.

For the last century, Dutch psychiatry had established itself as a biomedical system with strong social roots. During the 1960’s, predating the emergence of the DSM III and even the use of ‘onrust’ in Dutch psychiatric lexicon, a new trend emerged in the Netherlands. This was a proactive movement determining that relatively healthy people “with a deficiency in their personality structure or development” could receive treatment or care (Oosterhuis and Wolters 1998:215). Children, low-income or middle class individuals with ‘minor’ cases of mental illness became a major focus for treatment, seen as a social intervention. Yet Bolt and de Goei (2008) suggest that Dutch psychiatry was fairly reluctant to follow the American model of DSM diagnoses for childhood disorders, of which ADHD was included. In fact, until the early 1990’s, Dutch psychiatrists remained reluctant to use the diagnostic term of ADHD, favoring diagnoses from the ICD or early versions of DSM (Bolt 2009; Bolt 2010). This changed after the 1980’s financial crash of the Netherlands. The Dutch Health Council requested that the psychiatric system create ‘a clear profile’ for their purpose and their forms of intervention, in order to keep up with the demands of society and maintain a lucrative profession (Bolt and de Goei 2008). The DSM-IV TR, the then current edition of the manual, was adopted at the same time that insurance agencies and government policy in the Netherlands shifted to incorporate diagnoses as reimbursable items for treatment, in the early 1990’s. At that time, the diagnosis ADHD became an official classification term for childhood disorder, along with autism (ASS), conduct disorder (CD), and other diagnoses of the DSM. [For specifics of ADHD as a sub specialization of Dutch psychiatry see: (Bolt 2009; Bolt 2010; Bolt and de Goei 2008)].

2.3 Classifications & Diagnoses

It is important to acknowledge that ‘diagnoses’ are a form of gathering of symptoms together into a bundle of experience that can define an answer for a patient. They evolve over time, often to give explanation as to the cause of the experiences, or to give relief for the
symptoms usually in the form of treatment. When understood this way, classifications such as diagnoses can be very fluid things depending on circumstances and need. In the volume *Differences in Medicine* (Berg and Mol 1998) Dutch authors and researchers explore how diagnoses can actually form identities for themselves for either clinician or patient, but strangely are often based on hidden protocols such as a mandated policy. Diagnoses can actually be seen as multi-dimensional entities that are shaped by both the larger society and also the practice of particulars. The motivations and reasons why a diagnosis could be used in a particular context can vary dramatically, but often remains a hidden process. Diagnoses can define what treatments are available to patients, and can also be deeply affected by policies governing a medical setting (Berg 1992). Seen in this way, diagnoses become tools or functions of professional trade.

When considering the history of the psychiatric profession in the Netherlands and the developments of using diagnoses and classifications from the American DSM, it is important to gain perspective on the use of these classifications. The ICD, developed by the World Health Organization, was the manual most used by the European psychiatric profession until the introduction of the DSM III. The American DSM was meant to bring the professions into alignment, but the two differ in that the DSM is used only for categories of mental illness and psychological distress, while the ICD incorporates biophysical disease categories as well. Both manuals are available online for the public, and are imperative tools for the trades of physicians, of which psychiatrists make up a portion. These classification systems are not just tools of the trade, however. They were created by teams of professionals operating under the guidance of government and medical agencies in an attempt to uniform the disease classification process. The roles and rules governing the classification systems of the DSM and ICD and their subsequent diagnosis are critically examined in *Sorting Things Out* (Bowker and Leigh Star 1999). The authors of this detailed history argue that the medical diagnoses of our developed and globalizing world cannot be considered in depth without also understanding the ways in which they were constructed and how they are appropriated. The DSM and ICD manuals are systems for organizing professions as well as disease and illness categories. These systems provide diagnoses and practices that are “material as well as symbolic” by their very nature of defining experience for both professionals and the public (Bowker and Leigh Star 1999:39). Diagnoses provide

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access now to funding and third party reimbursement, making them ‘material’ entities. In addition, specific classification terms can take on public and professional meaning where a single diagnosis can be used to ‘explain’ many subtle hidden processes. The classification becomes impenetrable as a concept used for organizational purposes, and instead solidified as a diagnosis.

In 2007 an anthropological study of a specific psychiatric diagnosis became a book of widespread public interest. *Bipolar Expeditions* (Martin 2007) traced the rise of the bipolar ‘epidemic’ in the United States, as the diagnosis became both popularized and alarmingly frequent in occurrence. Closely following the training and practice of the psychiatric profession, the pharmaceutical industry, and the society demands on ‘behavior’ in America, the book’s overall theme suggested that an *en magnitude* mental illness diagnosis could be a reflection of the society it is occurring in. A year later, a similar book regarding the diagnosis of depression shook the literary and scholarly world in the Netherlands. *De Depressie Epidemie* [*The Depression Epidemic* (Dehue 2008)] linked the local concepts of happiness, rest and relaxation in the Dutch society with the ever growing tensions of the demands of a shifting environment. How could the ‘happy’ Dutch public have such high rates of this mental illness, the author asked, unless it also was linked to changes in the social environs. Both authors referenced the ADHD diagnosis as another example of the development and propagation of mental illness categories into common lexicon. Industries of medicine, the development of a profession, and the public demand for ‘quick fix’ answers, all promoted the use of diagnostic terms that could ultimately be ambiguous fill-ins for social developments.

### 2.4 A Socio-Linguistic Perspective

Classifications can be seen sometimes as a catch-all category, a way to group a set of attributes together to make meaning out of them. The attributes can vary depending on time, place, or motivation for classification. In the case of psychiatry diagnoses, the ambiguity of a classification can be seen in words and descriptions for symptoms that can be vague enough to be applied across multiple contexts. The diagnostic terms of ADHD were accepted into psychiatric lexicon and subsequent public use during the 1980’s, with the publication of the DSM III. *Why* it has come to be the prominent childhood disorder that it is has been the focus of much debate. While the specific terminology of ADHD has been accepted in use as a DSM category worldwide, what remains ambiguous is how the symptom terms are defined and applied
across contexts. For instance, if ‘hyperactivity’ is a linguistic term that emerged from American psychiatry, we can question if this is applied with the same embedded meaning in another linguistic location.

As shown, the historical works of Dutch psychiatry have linked the development of diagnoses and their use to political and social processes. Specific word usage played a part in detecting and illustrating this (see: Bolt and de Goei 2008). Word use and the terms defining a classification can indicate its purpose and relevance. In fact, Bolt (2008; 2009) built the study of the development of ADHD terms in the Netherlands on theories of how something once considered ‘common’ could become medicalized. His historical work specifically expanded on Rafalovich’s discourse analysis of ADHD, which suggested that the historical framework of language gives meaning to a diagnosis in its current application (Rafalovich 2004). In Framing ADHD Children (Rafalovich 2004) the social constructivist approach to understanding ADHD as an aspect of medicalization was explained through the use of discourse theories. Clinician dialog allowed the deeper complexities of what constitutes medical ‘realities’ of diagnosis and treatment in the ADHD disorder to be revealed. The American clinicians interviewed expressed the diagnosis as a tension between psychodynamic and neurological theory and they focused on the particular wording of what constitutes ADHD to explain this (see: Rafalovich 2004). The medical ‘reality’ of ADHD became a matter of which theoretical position was preferred by a clinician. From the socio-constructivist perspective, medical theory may suggest that common behaviors can become classified as ‘illness’ when these terms are used as part of a diagnosis. In the case of the Netherlands, one term that illustrates this point was the use of ‘onrust’, which emerged as a diagnostic term in the 1970’s, predating ‘ADHD’. Significantly, it was already a common description for many problem situations with children since the early 40’s and 50’s (Bolt and de Goie 2008:34). When the diagnosis of ADHD ‘matched’ symptoms described by ‘onrust’ the diagnosis could take shape in the Netherlands as a more concrete medical reality. The term is now a descriptive element of the Dutch DSM translation for ‘hyperactivity’. This illustrates how the particular language of ‘medical knowledge’ and diagnosis can be couched in socio historical frameworks that lend it significance.

Deviance and Medicalization (Conrad and Schneider 1980) linked the developments of the ADHD diagnosis with a transfer of behavioral terms constituting ‘badness’ to symptoms

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7 See Appendix 8.3 and 8.4
constituting ‘illness’. ‘ADHD’ was listed as one of many diagnoses based on behavior that, in many contexts, became arbitrary measurements of interpretation. How one behaves ‘badly’ becomes expressed in terms of what is now called ‘hyperactivity’. Conrad (1992) suggests that medicalization is often a process of classifying groups of behaviors together as ‘illness’ in order to establish social control. In the case of ADHD, its symptom terminology is one way of seeing its particular use in society. This includes new developments to expand the ambiguous symptom terms and categories to encompass those not originally included in the disorder category, such as adults (Conrad 1992; Conrad and Potter 2000). This socio constructivist viewpoint can lend an interpretation of the ADHD diagnosis in other contexts. While the category is now defined by set criteria in a diagnostic manual from a particular society, namely the United States, it is also applied into other socio-linguistic contexts.

When a diagnosis was created with the terminology and specific intent of classifying behavior in one context but becomes applied elsewhere, we can question the ‘whys and hows’ the category comes in to practice. The practice of using a psychiatric diagnosis can both influence and be influenced by socio cultural norms and values, especially when considering psychiatric diagnoses are based on classifying behaviors. The question shifts from understanding why particular symptoms are described as problematic to why this is helpful (Horwitz 2002). This positions studying mental illness categories not just by the language used to describe a category, but also by its practice in particular locations and contexts. ‘Deviance’ or ‘normal’ are terms full of social significance, and vary greatly from situation to situation. Since the diagnostic psychiatry of the DSM has expanded significantly across the globe, various local practices may apply vague terms such ‘inappropriate’ or ‘expectable’ according to their own social contexts (Horwitz 2002:15). The significance of why a category is used has much to do with how it is interpreted into a specific context, based on the interpretation of a clinician through language and custom.

Discursive theories are tools employed for understanding the socio constructivist viewpoint, such as used by Rafalovich (2004). When applied to various linguistic contexts, they need an additional layer of sensitivity. Local language can affect, or be affected by, a categorization of illness, as diagnoses are a way to shape ‘realities’. In this way, an ambiguous diagnostic term from one setting could be applied quite differently in another social and linguistic context resulting in a different effect or purpose for a diagnosis (Horwitz 2002).
International psychiatrists often have to interpret DSM classifications from English into their local language. This can be both problematic and revelatory. Discursive approaches need to follow linguistic analysis whereby common local terms in the language of clinicians allow meaning for a diagnosis to emerge (Kirmayer 2001; 2005; 2006). In as much as diagnostic terms can be ‘common’ terms appropriated to illness, specific words clinicians employ for describing diagnoses can express social or medical metaphors (Kirmayer 2006). The linguistic philosophy of meta-messages means detecting that by detecting common terms used to interpret diagnoses or place them in contexts gives indication of social meaning beyond their use as a classification. The meanings of a diagnosis can vary widely, and can be based on clinical processes, scholarly advancement, or even political changes, let alone the symptoms of a particular patient (Kirmayer 2006:134). This theory asserts that both the rhetorical and practical uses of language reveal both why a diagnosis is relevant and how it might be constructed (Kirmayer 2005). Diagnostic terms can explain both why a diagnosis is used, and create a social or professional ‘metaphor’- a rich meaning for a diagnosis simplified through common language.

2.5 Applications toward understanding ‘ADHD’ in the Netherlands

The result of this rich background in language terms, history, classifications and understanding the sociological perspective of a diagnosis helps us to place ‘ADHD’ in the Netherlands. We can suggest that the diagnosis is part of a complex phenomenon with many facets. The history of ADHD in the Netherlands indicates that language is imperative to understanding the disorder in terms of its social significance, while the policy and political changes of the psychiatric profession may have determined much of its usage. To understand the diagnosis of ADHD in the Netherlands, or any nation for that matter, is to incorporate a larger sphere of reference beyond the category of illness into both why it is used, and an understanding of the profession required to determine its usage. This review lends a framework to an examination of the diagnosis in its current inception in the Netherlands, expressed through the language of diagnosing professionals.

Combining the social constructivist perspective with linguistic analysis position this current research uniquely as an exploration of both a diagnosis and the culture of psychiatry in a specific language setting. A local discourse is revealed: what the Dutch psychiatrists are saying about ADHD, in their specific context, in their specific terms.
This research seeks to examine:

How does the language of Dutch psychiatric professionals express understanding and use of the ADHD diagnosis in the Netherlands?
Do specific words generate metaphors of meaning for this local context?
3 Methodology

The aim of this research has been to understand how Dutch clinical professionals express the diagnosis of ADHD and its use in the Netherlands. The methods of interview and information gathering were facilitated through an approach of peer, or ‘practice near’ research (Cooper 2009). This form of research acknowledges that those coming from within a professional background may be the best to be critical of it. This is often because trust is assumed based on professional affiliation and privy to information, which allows for depth and understanding difficult to obtain from ‘outside’ researchers. While I am not a Dutch clinical professional authorized to diagnose a patient, my training and background in psychology and neurology (specific to ADHD) allowed an ‘in’ as a peer-professional for this research.

In the Netherlands, a variety of professionals are allowed to give psychiatric diagnoses. These include psychiatrists, psychotherapists, GZ psychologists, and psychiatric GGZ clinics, of which a variety of professionals are included. Respondents were recruited for this project through emails, postings on professional websites, and a ‘snowball’ method of referrals. Psychiatrists comprised the majority of respondents, and were dispersed from many cities across the Netherlands. Dutch authors on ADHD, psychiatric philosophy and psychology methods contributed to the development of the project by adding theory, literature, and comments. One clinic invited my participation and observation in their ADHD diagnostic process for children, and another allowed access to the ADHD diagnostic interview given to adults.

At the culmination of the research period, I attended the Transcultural Psychiatric conference hosted this year by the Netherlands Psychiatric Association (Nederlandse Vereniging voor Psychiatrie- NVvP), which allowed access to many professionals to discuss both the process of diagnoses and the psychiatric profession in the Netherlands. Unfortunately, due to time constraints of the research period, not all respondents who were referred or contacted could be interviewed for this project.

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8 Professionals must be legally registered with a “BIG registration” (Beroepen in de Individuele Gezondheidszorg, Individual Health Professions) to issue diagnoses. This is issued by a division of the Dutch Ministry of Health.
9 The abbreviated terms GZ (gezondheidszorg) and GGZ (geestelijkegezondheidszorg) differentiate mental health professionals who commercially obtain a license to issue diagnoses.
3.1 Respondents

The respondents interviewed for this project included various diagnosing clinicians, non-diagnosing psychologists, local researchers and historians. Four child psychiatrists, two adult psychiatrists, two psychiatric assistants from a GGZ clinic, and one GZ psychologist gave permission to use their interviews for analysis. These professionals came from a variety of institutional facilities, from public hospitals to private practice. They also came from various towns and cities across the Netherlands. This helped to frame the dialog of professional practice in terms of what were ‘general’ concerns for clinicians rather than specific to their practice or location. The emails, unpublished works, and input from other researchers on ADHD in the Netherlands helped to frame the dialog I encountered in interviews, and assisted with the interpretations in analysis.

3.2 Interviews

All interviewees were visited at their clinical or professional practice location. They were each provided with a research disclosure, and asked for permission to record and use the interviews in analysis. Interviewees were asked to give their opinions on ADHD, what it is, how the diagnosis is determined and used, as well as an invitation to discuss what they thought were the most relevant topics regarding the ADHD diagnosis in the Netherlands. The transcripts were all recorded, transcribed, and translated by this researcher. The quotes list professional position and city of location in place of personal identity markers. This is to respect the anonymity of respondents who might have professional or personal concerns with providing information for this research.

It is important to note that the two clinical psychiatric assistants provided more than just interviews for this project. I was warmly welcomed and included in the observation of a lengthy child diagnostic process, following multiple patients. Their clinic, certified as a psychiatric practice (GGZ clinic), was expressly concerned with providing an ‘alternative’ diagnostic process, and I was allowed access to many materials. Although all interviews were provided with a disclosure on the research intent, I signed a separate disclosure form for this clinic, in order to protect privacy of clients and professional materials. For this current analysis, only the interview concerning their thoughts on the diagnosis of ADHD is included.
3.3 Language

Interviews were conducted in the Dutch language, apart from two in English. As Dutch terminology and expressions were the primary focus for analysis, the interviews in English included asking for Dutch translation for specific words. These included descriptions of what ADHD is, as well asking specific points to be re-articulated in Dutch terms. My working knowledge of the Dutch language, based on living in the Netherlands from the years 1989-1997, provided a base for both communication and translation. I relied on the input from respondents to point out specific words or phrases I found crucial, to check my understanding and interpretation. To this end, various Dutch friends, multiple dictionaries and even a local word game\textsuperscript{10} were used to reference translation efforts for analysis.

The transcripts presented in this research include language that has been translated into English and key words that have not. The choice to leave specific words in Dutch came from the process of analysis, spurred by the second research question to understand if specific words would indicate meaning or relevance for the diagnosis.

3.4 Analysis

All interviews were transcribed first in Dutch, and grouped for themes. The original intent was to have a complete understanding of ‘what ADHD is’ as revealed by clinician language. To this end, the descriptive words of the diagnosis, its symptoms, and terminology were first sought for across all texts. Themes brought up in discussion as of specific interest for the clinicians were grouped together. Transcripts were kept in the original language of Dutch in order to do this.

The analysis of texts emphasized how clinicians described the ADHD diagnosis, their understanding, and its use. The first step was to separate descriptives of symptoms from general themes and cross-compare for analysis. It was this step that highlighted key words that might have been missed had they been first translated to English. All languages have words that can be used in various contexts with meaning derived from how the word is used rather than a set

\textsuperscript{10}“Het Spreekwoorden Spel” (The Phrase Game) is a card game for Dutch speakers, explaining the use and history of common Dutch phrases. Available through Scala leuker leren bv, Groningen. \url{www.scalaleukerleren.nl}
definition. One word appeared across all transcripts, as both a theme brought up for discussion by the clinician and a description of a diagnosing symptom. That word was ‘druk’.

This word became the guide to search for other themes that might emerge. What occurred was interesting. Instead of a theme, the tensions and themes already highlighted by the professionals became clarified. The word, and its counterpart, ‘rust’ were used repeatedly to emphasize, explain, and articulate various attributes surrounding the diagnosis of ADHD. This included patient, situational, and larger societal descriptions.

After the themes and key words were located in the texts, the transcriptions were translated into English for this paper, with those words left specifically in Dutch. The following chapters highlight why this is of significance.

This research does not aim to be a linguistic anthropological analysis. Rather, language is used as a tool to locate the clinician in their respective cultures: that of professional and that of their society. It is used to place the theoretical position of a social construction of ADHD in direct relation to understanding that language codes for specific meaning. The use of words and metaphors gives us a way to effectively ascribe a meaning to a diagnosis in a given context. Since language itself is a social creation, then the social theories of diagnosis development cannot be extracted separately from the words used to discuss that diagnosis. Hence, the aim of this analysis is to allow the use of common words to reveal tensions and insights embedded in the discourse of clinicians.
4 ADHD is

4.1 Simply put, ‘ADHD’ is a diagnosis…

‘ADHD’ is an abbreviation for the diagnosis attention deficit/hyperactivity disorder in the American Psychological Association’s DSM-IV TR, the current diagnostic manual used in most worldwide psychiatric settings today. It is defined primarily by symptoms of inattention, hyperactivity, or impulsivity, originating in childhood, simply classified as a ‘behavioral disorder’. The sociohistorical critique of the term ‘behavior disorder’ suggests that the conversion of what could be common ‘behaviors’ to categorical ‘problems’ is a way to create elements of social control (Conrad 1992). ADHD is usually considered a diagnosis of childhood, with the diagnostic criteria detailing behavioral attributes that could be problematic typically in a classroom setting. However, the trends to diagnose the disorder now in adults reinforces the socioconstructivist position that the disorder is an element of social organization rather than a category of ‘illness’ (Conrad and Potter 2000). This comes from studies on the literature and language that emerges from research in the biomedical fields and how DSM criteria are applied in professional practice. Rafalovich (2004) was one of the first to position the socioconstructivist view of ADHD directly in the actual voiced discourse of clinicians. Among the concerns of clinicians, whether ADHD was actually ‘socially created’ was debated against biomedical perspectives for the sake of classifying what ADHD is. To understand how Dutch clinicians articulated what ADHD is became the entry point of this research. Exploring the words and terms they used to describe the category, and those who fit in it, is the first point in positioning this disorder’s relevance in the Netherlands.

The process for diagnosing ADHD in the Netherlands is not uniform. I was provided six different explanations for ‘how it is done’. The common component for all diagnoses was the reliance on the American DSM and checklists for defining the criteria. The DSM is not translated into Dutch, it is kept in English and used as a reference. Some of the checklists are translated to Dutch while some are not. The available Dutch translations of the diagnostic criteria do parallel the areas of description in the American DSM, describing ‘inattention, hyperactivity, and impulsivity’ in descriptives applicable to the Dutch context. Of these, the term ‘onrust’ is used to
help describe symptoms of the category ‘hyperactivity’. Dutch websites describing ADHD often list ‘bodily’ or ‘physical’ onrust and ‘internal’ onrust as a way to identify the disorder. While the clinicians explained how the checklist and DSM criteria are the only basis necessary for diagnosing ADHD, they all stressed the importance of ‘a full diagnostic’. In the Dutch setting, this means multiple interviews to gain a full history of a client. This is not required to give the diagnosis of ADHD however.

When explaining what ADHD is, the clinicians all responded: it is a diagnostic. In fact, I often got the feeling when asking a doctor to clarify what ADHD is, that this was a moot point. The tensions expressed by the American clinicians regarding debates of what ADHD represents on a diagnostic level (see: Rafalovich 2004) were not reflected here. Answers would remain short: ‘it’ is a classification, ‘it’ is a concept, ‘it’ is from the DSM. At first this proved confusing. A typical explanation is outlined here:

“ADHD is a relatively simple problem. It is simple. Much more than developmental problems… Yes, ADHD is a simple question.”

(Child psychiatrist - clinical hospital Amsterdam)

This would then quickly be followed by an explanation of the checklist, the only requirement for actually determining the disorder:

“You can say that generally, there is little difference between American and Dutch organization. Because, it is a DSM IV classification, a DSM IV diagnosis, and the criteria is then guaranteed. The checklist, the criteria for DSM IV are guaranteed for everyone. From family doctors to psychologists…they can take that checklist in their hands and look to see if a child fulfills the criteria.”

(Child psychiatrist - clinical hospital Amsterdam)

In fact, asking the clinicians to express what ADHD is became a common theme: ‘ADHD’ is a relatively ‘simple’ process of fulfilling a checklist. Then, protocols were explained. How the

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11 See appendix 8.3 for a table comparing the diagnostic criteria of ADHD from the DSM to the translated version approved by the Trimbos Institute (www.trimbos.nl) – (retranslated back into English for comparative purposes)

12 See http://nl.wikepedia.org/wiki/ADHD;
checklist was given or filed, which particular checklist one preferred. It was almost as if they were humoring me. When asking what ADHD is, the protocol process of how the diagnosis was determined was more often an answer, and was a relatively frustrating loop at first. A doctor would ‘explain’ the diagnosis of ADHD always in terms of the procedure of taking a checklist to match behavior to the DSM. The classification system was always emphasized over a particular set of behaviors or type of patient.

One explanation for this could be because the use of the classification system of the DSM for all psychiatric disorders is still a work in progress. Criteria for diagnoses, the descriptions of patients, need to match the protocol process they are in. It was not a matter of defining a patient, but rather, explaining that the what of a diagnosis is how it is structured as a part of protocol. The ICD was the manual most often used by clinicians in the Netherlands until recent changes in the mental health system, and the professionals are still in a process of adaptation. One psychiatrist explains how this affects the diagnosis of ADHD in particular:

“There was a short time when the criteria were more stringent in England, and now, we use the English version DSM, same as the Americans. England used the ICD, the European. And that gives a bit of a difference. In Utrecht they have still used ICD, and here (Groningen), and Rotterdam, where I originate from, we only use the DSM. In essence, overall throughout psychiatry, we use the DSM.

“Also with ADHD, the criteria are higher in the ICD. The threshold is higher. And that has given a difference in the behavior observations between the English and American researchers. But we have already long been aligned, and now I think in England as well, with the Americans. But, how we use it, how it is handled and unfolds here, maybe gives subtle differences between the Netherlands and America.”

(Child psychiatrist- academic hospital Groningen)

The focus is placed on the criteria of the diagnosis. The ICD does not use the term ‘ADHD’ and its diagnostic criteria are ‘higher’. The ‘behavioral observations’ are not used to describe attributes of what constitutes the diagnosis however; it is used to describe how research and protocol practice is affected. This provides a subtle difference in terms of protocol- the DSM is a
relatively new form of classification for the Netherlands, as is the ADHD diagnosis. The Dutch clinical practices of diagnosing ‘behavior disorders’ incorporated the ICD classifications through the 1990’s. At that time, diagnostic terms such as ‘minimal brain damage’ were still in use, borrowed from the version of the DSM still aligned with ICD terminology, the DSM II. ‘Minimal brain damage had long been debunked as a diagnostical concept, but its late use in diagnostic practice illustrates a point (Bolt 2010). The introduction of the DSM as a uniform diagnostic tool in the Netherlands from the 1990’s onward has brought with it its terms and classifications, as part of a change in professional practice. The psychiatrists are well educated on this fact, and illustrate that to classify behavior is to place it in a diagnostic. This, however, does not explain what that is. It becomes a different question.

The system of classification has changed, and with it, dictated protocol processes. The Netherlands is using DSM for classification purposes now, and with it, its diagnoses. Yet the psychiatric professionals are well educated on what this implies. The DSM is a manual whose original intent was to conduct research and to unify the professional practice of psychiatrists, not aid in the diagnostic process. This becomes a distinguishing point, as illustrated here:

“Ok, well, that is naturally the whole discussion about the DSM. The DSM was created to be able to conduct research worldwide. You could better use the ICD 10, and, we’ll see if the DSM V goes more in the direction back towards the ICD. Actually we need far more dimensional descriptions, and not so classifying as it is now. Because now it is being used as diagnostic material, but it isn’t. That also was not its intention.”

(Child psychiatrist- private clinic De Bilt)

What these psychiatrists point out is that ADHD, as a disorder, is determined by the classification system and protocol practice of using that system. ADHD is simply a clinical concept. The debates as they ranged in the United States were not of the same concern with these clinicians in the Netherlands. In fact, with every single interview of psychiatrists and psychologists, the tension highlighted by Rafalovich seemed irrelevant. The discussions of what ADHD is, what it defines, was replaced with the knowledge that their understanding of a ‘classification’ did not really ‘explain what is’. Classifications are instead seen as professional tools, and the ADHD diagnosis is included in this.
One psychiatrist illustrated this point well. Trying to classify the *what* of a ADHD as a an expression of a biomedical or organic issue versus a social issue missed the point. The psychiatric philosophies of the Netherlands have a long history of understanding that social and biomedical functions cannot be so easily separated in nosology (see literature review). The point of a classification, a diagnosis, was something separate from this. ‘ADHD’ is explained here in terms of both organic and social, but the clinician also emphasizes that this is not where the focus should be placed:

“At some point, you can’t make that distinction any more. Look, I think that with the ADHDers, it’s organic. I think they have ‘unripe’ brains. Because what turns up is that ADHD, shows up in all sorts of situations, where they don’t want it, and it gives them problems, such as interacting with the wrong crowd, because they are attracted to them. So, at a particular moment of course you see behavior, and you can even say that an ADHDer has become asocial. But if you look at where it is coming from, then you can understand why it is happening. Just as well as why we understand that someone is depressed if they have ADHD. You see, I think it is very complex… and I would be very critical of it.” *(Adult psychiatrist- clinical hospital Amersfoort)*

The significant aspect here became the discussion that ‘ADHD’ is complex, and needs a critical view. This quote is one of many wherein a doctor would skim quickly over the idea of a brain versus social construction question to highlight a different aspect. Defining ADHD, to them, was not what was relevant. ‘ADHD’ is a clinical concept well described in terms of ICD or DSM protocols, checklists, and set criteria. The clinicians emphasized shifting the question of asking what ADHD *is* by placing it in a critical context.

4.2 A critical view shifts emphasis

Considering the fact that clinicians described ‘ADHD’ as a ‘simple diagnosis’ based on a list and criteria of the DSM, their assertion that one must be critical of it led to placing the diagnosis in their perceived context. The diagnosis is now a part of protocol, a professional practice. It can be determined using a checklist and the DSM criteria, but they still stressed a a desire for a ‘full diagnostic’. The DSM criteria and checklists for ADHD must be applied into
the language, but also the practice, of the clinician. It seemed it was this aspect of applying the diagnosis that provided a beginning point for understanding the complexity and the need for a critical view of ADHD:

“Of greatest importance is the question of a culture change, isn’t it? This is a gulf. Just like you said, indeed ADHD is spread out from the U.S. And that creates an intermediary effect, a gulf that we must overcome. What that means is that the naming of a problematic situation for a child under ‘ADHD’ is directly affected by culture and knowledge. It is a problem of recognition. You can have a very druk (busy) child, and a father with ADHD, that can easily be… because ADHD is a clinical diagnosis- that is just a title for instance- because ADHD is just that: a clinical diagnosis. So, you have to clinically use your judgment as a therapist: clinically seeing all the information together as a clinical diagnosis. That means, only the checklist, only the history, only observation- it is not enough. You have to bring it all together to make a clinical diagnosis.”

(Child psychiatrist-clinical hospital Amsterdam)

To be critical of the diagnosis is to understand that ‘ADHD’ is ‘just a title’. It is the aspect of creating a clinical diagnosis encompassing the new DSM protocols and also a history, observation, and ultimately, a clinical impression, that ‘make a clinical diagnosis’. But it is also acknowledge that the title of ADHD is affected by ‘culture and knowledge’ and given a clinical position. This quote expresses the need to understand a clinical diagnosis in broader terms. He describes a child as ‘druk’, with a parent who could have ‘ADHD’, but then emphasizes that this becomes a clinical judgment. In a separate interview, another psychiatrist uses a similar term to explain the diagnostic of ADHD. The ‘clinical’ theme was reiterated: “that outside appearance, the drukte\textsuperscript{13}, we apply a clinical theme to it”.

As clinicians explained the need to be critical, the word ‘druk’ appeared as a way to describe symptoms or situations. It is difficult to translate the term ‘drukte’ here without giving a lengthy explanation. Unlike ‘druk’ in the quote above, which could describe a child as being ‘busy’, the use of the term in this sentence changes. ‘Druk’ is a term that often came up in

\textsuperscript{13} The term ‘drukhheid’ was used by this doctor to create an emphasis on the encompassing aspect of all that is ‘druk’. It is not, however, a Dutch word. The actual term is ‘drukte’, used here.
interviews when describing aspects of ADHD, but this was not confined to symptoms. It could also define location, situation, or just a way to explain how the diagnosis of ADHD fits into the clinical system. Kirmayer (2005; 2006) suggested that the use of common words to explain aspects of diagnoses can become metaphors, and a point for understanding their relevance.

The application of diagnosis ‘ADHD’ begins to take on a depth of nuance when looking at this use of language. To put it in context, the DSM diagnostic criteria list in English does not include the word ‘busy’ in it. ‘Druk’ is also not a term included in the diagnostic descriptive of ADHD in Dutch, rather it seems to imply a larger scale interpretation of the diagnostic criteria. Mental illness diagnoses are usually ascertained by studying and classifying behavior. If one just assumes that the word ‘druk’ classifies behavior that is ‘deviant’ as is suggested by sociological works on ADHD (i.e. Conrad and Schneider 1980), a crucial element is missed. The clinicians were pointing out that the classification, the title of a disorder, is ultimately irrelevant. It changes based on protocol processes and clinical interpretation. ‘ADHD’ is classified as a ‘behavior disorder’ in the DSM. The understanding of how the term ‘behavior disorder’ is translated into Dutch gives insight into how ‘ADHD’ becomes a term that is emphasized as just part of a protocol, rather than a definition of character.

“‘Behavior problems’ are really vague. You can’t really completely describe what a behavior problem is, can you? ‘Gedragsprobleem’, ‘behavior problem’, is a really Dutch word. That is not a psychiatric term. You can have children with a behavior problem, or you can have problems with parents or educators have problems with the behavior of a child. Naming it does not make the child ‘disordered’.”

(Child psychiatrist - private clinic Amsterdam/Zandaam)

In the introduction, a psychiatrist mentioned that ‘ADHD’ has become a ‘Dutch word’ effectively replacing the word ‘druk’ in a colloquial expression (Boon 2009). Now we hear that the classification of ADHD as a behavioral disorder becomes immediately placed in a local concept that already existed. ‘Behavior problem’ is a ‘really Dutch word’, but it does not mean that someone recognized with this kind of problem is ‘disordered’. The language of the clinicians interpreting both ‘ADHD’ and ‘behavior problem’ into the Dutch context make it almost seem

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14 See appendix 8.3 for a table of diagnostic terms with comparisons from the DSM to a translated Dutch version.
amusing. A behavior problem is something that is considered *typically Dutch*, yet here is this protocol process that is now imposed, insisting for a diagnosis encompassing this. But, what is ‘this’? The Dutch clinicians bring this question again and again back around to the fact that ‘it’ doesn’t clarify anything about ‘what is’:

“Now, all in all, they are happy that the ‘different feeling’ has a name. But, that is always true, with everything, so that is also an issue, isn’t it? The last doctor is always the right one. But yes, if you have a diagnosis, then at least you have a direction. But, we just say it. ADHD is something we just say.” *(Adult psychiatrist- clinical hospital Amersfoort)*

The ‘different feeling’ still remains unqualified and elusive. ADHD remains ‘just something we say’, and it is debatable. Through this quote we see that the clinicians themselves view a diagnosis of any kind as subjective. Diagnoses give a direction, but the ‘last doctor is always right’. That implies irrelevance. When describing the diagnostic category of ADHD the language of the clinicians quickly deflects from a categorical assumption to why the diagnosis is now incorporated into both their protocol and language. The diagnosis itself is a descriptive, a concept for the clinician.

We begin to see that the ‘subtle difference’ in the Dutch understanding of the diagnosis lay in its application, rather than its definition. The issue of the diagnostic element of ADHD becomes more a matter of why it is applied than what it is. A local family physician explained how diagnoses can be applied in terms that are not so defined by the symptomology construct, but more by a cultural process of making a diagnosis fit. “Look, that is what is cultural here. We are taught to follow the scientifics of neurology and biology, but we really believe that what is happening in daily life makes a huge impact. That is what is subtle. And sometimes you make a decision (diagnostic) based on *pluis* or *niet pluis*.” Translated, ‘pluis’ or ‘niet pluis’ means a gut feeling about what is ‘right’ or ‘not right’. A diagnosis then becomes ‘just a term’ for describing something that is happening on a broader or deeper context than might be contained by either socio or biological factors, but might be difficult to pinpoint as an exact make-up of a diagnosis. Rather, it ultimately gives a direction for an outcome.

This ultimately is what the clinicians express regarding *what ADHD is*. It is a classification, part of a protocol process that their clinical judgement and practice must align to.
It is considered a ‘simple’ diagnostic, but in this, the clinicians themselves stress a need to be critical. It is asserted that a diagnosis does not define anything, rather, a term most used to describe the diagnosis, and its setting are not included in symptomology. The next chapter will look specifically at the word ‘druk’ in light of this.
5 The ‘Druk’ of ‘ADHD’

5.1 How a word becomes a metaphor

Language terms are used as part of a diagnostic process or clinical interpretation of symptoms. What terms are used, and how, is a critical aspect of applying the social constructivist view to the use of classifications (Horwitz 2002). Using this perspective, Bolt (2008; 2009) identified the Dutch term ‘onrust’ as emerging prominently in Dutch society in a particular time period to both socially and clinically describe certain behaviors of children. ‘Onrust’ is a term used in Dutch translations of the DSM criteria for ADHD, and is accepted as an explanation for some ADHD symptoms of ‘hyperactivity’. However, the word ‘hyperactivity’ has been suggested to be a ‘meta-metaphor’ for the diagnosis in what it implies. Danforth & Navarro (2001) indicated that as the word itself is contained in the name of the diagnosis, the culturally embedded connotations of its use in the United States follow it. While ‘hyperactive’ is not something one wants their child to exhibit in school, it is actually seen as an American ‘commodity’ embodying the traits of successful business and media professionals (Martin 2007).

As a diagnostic term of ADHD criteria, ‘hyperactivity’ is directly translated into Dutch as ‘hyperactiviteit’ and encompasses a whole category of symptoms. Two of the symptoms under this category are clarified with the term ‘onrust’ or a form of it.15 A derivative of the term ‘rust’, the term ‘onrust’ can express a type of unease, and clinicians did use this to describe symptoms of behavior or expressed feelings. The term ‘druk’, on the other hand, was used to describe symptoms as well as larger tensions of concern.

When clinicians would speak about ADHD, when they summarize what it is, how it is classified, and the contexts of the diagnosis, the word ‘druk’ was most often used. The word ‘druk’ is a common everyday word that can be used to describe multiple situations, it is not a symptom descriptive. While closely linked to ‘onrust’, there is a differentiation in how they are used. Clinicians would describe using ‘druk’ to detect an individual who fits the general diagnostic description, as if it were a symptom, but then stress ways in which it encompassed far more than symptomology in its implications. Common local language terms can become metaphors when applied across multiple contexts to summarize a situation or feeling. It is through understanding these common words used in clinical speech that we gain an insight into

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15 See appendix 8.3 for the symptom list compared with ‘onrust’ identified; appendix 8.4 for a Dutch symptom list.
how a diagnosis is described (Kirmayer 2005; 2006). For this reason, the term ‘druk’ emerges as an embedded metaphor in clinician speech. This chapter addresses how understanding this word, as it appears in the language of clinicians, highlights the meaning of the diagnosis and its local relevance.

5.1 A brief explanation of terms

Many languages have common, everyday words that can be used across multiple contexts. The term ‘druk’ can mean ‘busy’ when describing behavior of an individual or the situation of a crowded room. It can also mean ‘pressured’, as in the emotional response to stress. Its counterpart is the term ‘rust’, which also can vary in meaning depending on circumstance. It is included in this table alongside ‘onrust’, which is used as a descriptive symptom in the translation of the DSM-IV ADHD criteria. ‘Rust’ is both a term and a value of the Netherlands. It is the antonym of ‘druk’.

<table>
<thead>
<tr>
<th>Term¹⁷</th>
<th>Druk (/drukke)</th>
<th>Rust (/ rustig)</th>
<th>Onrust (/onrustig)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary meanings</td>
<td>busy, bustling, fussy, lively, noisy, restless loud (as in patterns), rushed (traffic or schedule) pressured (as in feeling), leaving a mark (impression, ‘indruk’)</td>
<td>rest, repose, quiet, tranquility, calm, peace, at ease, to quiet down, settle down, subside, soothe</td>
<td>unease, unrest, agitation, turmoil</td>
</tr>
<tr>
<td>Secondary meanings</td>
<td>close, stuffy, an emotional ‘load’, a form of anxiety</td>
<td>a way to be (also a value, a worth), an action of letting go</td>
<td>Commotion, turbulence, trouble</td>
</tr>
</tbody>
</table>

¹⁶ See appendix 8.3
¹⁷ Brief translations taken from the HVP Complete Woordenboek Engels-Nederlands & Nederlands-Engels, Editie 2000 HVP Amsterdam/Hoorn, cross referenced with local Dutch speakers
5.3 The diagnostics of ‘druk’

The clinicians interviewed for this project all diagnosed ADHD in patients using the English language DSM, apart from two who diagnosed using a Dutch language checklist in place of the DSM criteria. When describing a patient, many would use the word ‘druk’ to encompass a variety of behaviors, much in the same way ‘hyperactivity’ is a list of diagnostic criteria. However, the term ‘druk’ was not just used to describe symptoms. It could also be used in other ways and contexts. As we heard in the previous chapter, ‘that outside appearance, the drukte,’ receives a clinical diagnosis. Yet, what is meant by that ‘outside appearance’ deserves more explanation. Throughout interviews, the clinical diagnosis is explained as applying to situations, not just symptoms. A look at the same quote in context helps to explain this:

“What is happening, what could be playing a role, is that children with ADHD, well the demands on children are higher now, and the expectations on parents are high as well. Parents hebben het druk (are under a lot of pressure/are very busy), often having even a side job. So society is definitely changing in a way where children with ADHD have a more difficult time than 20 years ago.

“So that outside appearance, the drukte (actual: ‘drukheid’), we apply a clinical theme to it, but what sits underneath is how our companies and businesses work. So these children function less than optimal, and these themes are encountered, even dormant when the children turn 17 and become less druk. Because the symptoms remain, such as planning problems, people don’t then push them into higher education […] This creates an active effect of disadvantage that builds upon itself throughout a development. In this way ADHD can have an enormous impact on a child’s life direction.”

(Child psychiatrist- academic hospital Groningen)

This passage highlights the use of the word ‘druk’ to explain the symptoms of a patient, but also the pressures of a parent. The ‘druk’ expressed by this clinician indicates that the ‘demands from society’ are placing a sense of pressure on both parents and children. This results in a ‘druk’ that a parent experiences or a child expresses. Both of these senses of the word ‘druk’ are
encompassed in the term ‘drukte’, which the doctor emphasizes by creating a use of the word that is uncommon. The actual term he uses, ‘drukheid’, is a made-up word implying a stronger connotation, illustrating the encompassing aspect of all that is ‘druk’. This all encompassing aspect is explained as what receives the diagnosis, ‘but under it is how our companies and businesses work’. The term ‘druk’ suddenly takes on multiple dimensions: personal, clinical, and societal. The diagnosis of ADHD, that clinical theme, is applied to this ‘drukte’, used as a descriptive metaphor encompassing the social system and the patient within it. This may explain why clinicians were circular and redundant in their initial explanations of what ‘ADHD’ is. By being placed in a position of applying a clinical concept to a situation they feel is not completely defined by patient symptoms, this negates a much larger tension.

5.4 ‘Druk’ reveals a tension

We can already see how the translation of the term ‘druk’ is affected by the context it is placed in. If we simply translate this term in the transcripts, however, the ways in which the term have meaning for the clinician lose relevance. The patient can represents ‘druk’ behavior, but this needs to be placed in a context. Describing this aspect highlights tensions for some of the clinicians. To isolate the behaviors that are ‘druk’ from the situations in which they become apparent would be to miss a major element of the picture of ADHD in the Netherlands.

In a visit to an adult psychiatric unit, two psychiatrists illustrated what they see as the tension of equating the ‘druk’ of behavior alone to a clinical diagnosis. If ‘druk’ is translated to just explain the behavior of a patient, it could easily be equated to the term ‘hyperactivity’ as represented in the DSM classification of the diagnosis. They highlight two elements, that ‘druk’ can come to represent a certain type of individual, missing those who might really need help, and that this representation is a result of what they see as a process of modernization:

“But really, it is such a label, such a focus on the ‘h’ of ADHD, on that hyperactivity, that the attention deficit disorder now is now hardly recognized. Those that are druk are found. It is not so difficult to find the little boys hanging in the curtains! Those super drukke people, those that are always moving, that is not so difficult. Those are easily found. But the others are found much later, and they also come with a much sadder story. The quiet ones. Dreamy. Really in their heads. With children, that is altogether a
problem, those introverted children that are missed. The extroverted children, they are always acknowledged. That is a real issue” (psychiatrist 2)

“That is a challenge for the whole drukke group, and those were there in the past as well, but now they just show up more. Because now everything has become intellectualized, everything has to be done through the head so to speak. Boys who could do things with their hands, something where they could be druk, walk around…” (psychiatrist 1)

“The accent has been shifted from doing to thinking. And that is also a shift in accent from man to woman. The whole educational system has become feminized.” (Adult psychiatrist (2)- clinical hospital Amersfoort)

As a descriptive, ‘druk’ in this interview is not the issue, the interpretation of it is. ‘Druk’ is equated to doing, to being an extrovert, and even to boys. They gave a lengthy explanation of this, pointing out that the ‘drukke’ behaviors described in the DSM are common in young boys as early as age three. Many interviews echoed this sentiment, with one psychiatrist describing typical boy behavior between the ages of three to six as “normal druk” (Amsterdam) while another described the DSM criteria list used in diagnostic sessions as “basically made about the behavior of little boys! 8 year old little boys” (de Bilt). The concern was that to emphasize the ‘h’ in ‘ADHD’ meant to focus only on what was ‘druk’ in an expression of behavior, while the environment and other factors also come to play strongly in the equation. This was a common theme among the clinicians, explaining that the ‘druk’ defined just in behavior is not enough to explain the overall situation. In fact, to emphasize this is suggested to be problematic. The term can be used to isolate key individuals, such as extroverts, or boys, while the larger situation can be ignored.

This became a key component of understanding ‘druk’ and the context of ADHD in the Netherlands: that the educational system had ‘shifted’ and now also expressed or emphasized these behaviors, but also this overall situation. Another clinician expresses how this is deeply problematic for both the educational system and the children that are targeted as ‘druk’:
“So then you will also notice that it remains something of a field of tension. Because with the diagnosis of ADHD, or autism, it is always going to mean that the others, the teachers, the parents, have to really think about how they have to interact with that child. They can’t just do what they would naturally, especially if parents have a child with a diagnosis and they can go to the school and say, ok, you guys have to now do this, you must now do that. Then I can really understand that a school, or the teachers, feel onder druk gezet (put under pressure). They just don’t have the time for it. They still have all the other children in the class. It is always difficult. And, it is complex. The classes are too large and everyone heeft het druk (is busy/is under pressure) and then you get the three children in the class with PDD-NOS\textsuperscript{18}, ADHD, and whatever, and then maybe still another that is not cognitively, well, he needs more attention… now, yeah. One teacher. Not going to go well. And that is always… and always the system changes a bit, and then you get new rules for special education, and then after another short time… now, the way it is I believe, you know, it just can’t go well…But, not all drukke children are ADHDers of course.” (GZ psychologist- private practice Voorschoten)

This quote expresses ‘druk’ as an internal pressure in the system of a school, whereby a teacher is dealing with a difficult situation. Those that receive a diagnosis, that are pinpointed as cognitive or behavioral problems defined by ‘drukke’ behaviors, are also going to emphasize an atmosphere of bustling activity or pressure in this setting. Yet, it is pointed out, ‘not all drukke children’ are ‘ADHD’. This is the tension the clinicians highlight. The focus on the ‘h’ of ADHD was to place emphasis on problematic behavior. ‘Onrust’ is a term that describes this and is included in the translation of the diagnosis. On the other hand, by using the term ‘druk’ clinicians highlight that the behaviors are expressions of a system under pressure as well.

5.3 ‘ADHD’ as ‘druk’ in practice

The term ‘onrust’ is considered part of the translated clinical criteria. The application of the clinical criteria in a diagnostic process, however, is a complex issue. The tensions expressed by clinicians expressing ADHD in terms of what is ‘druk’ highlight this. The diagnosis of ADHD is well understood by clinicians to be a ‘concept’. One clinician explained why

\textsuperscript{18} PDDNOS is a diagnostic term for ‘pervasive development disorder not otherwise specified’ (DSM IV-TR)
understanding this concept, as an interpreted reality in the Netherlands is a critical factor to understanding the use of the diagnosis. He expressed the diagnosis process “a question of tolerance and acceptance...so, what you are seeing in a child really depends on your way of looking, and the criteria you use. That is why it is a clinical diagnosis.” *(Amsterdam)* What he meant to illustrate was how ‘druk’ came to embody a way of understanding the ADHD diagnosis. He elaborates:

“You do have serious situations, of behavioral problems or school problems where the children really appear *druk*, but for the child itself it doesn’t make such a difference. But because the system is demanding more and more, you see this also in schools, these children get more and more grief. Society is demanding more and more from people, also from our children. Maybe 20 years ago you could leave a child with ADHD in *rust*, letting him go his own way. But now the society now demands that a child also has to complete schooling. Has to get a certain type of job. The system can’t allow anymore that a child becomes a drifter or becomes addicted to drugs, or dependant on care. The system is pulling a child higher and higher you could say. It is about demanding maximum capacity from people, that system of ‘always maximum capacity’. And, it used to be that the ‘system’ was about harmony and peace, but now, not it is achievement to the maximum. And that is on an individual basis. And I don’t mean to say this is wrong that the system also demands the maximum capacity from our children, but the acceleration, the speed at which the system demands this, is much higher than people can deliver. That includes parents, and the family. Then that means that you have to pull up, rise up, always through the system, and people have to achieve more, and the children also have to achieve more. That is also the *druk* that comes purely from our system.” *(Child psychiatrist - clinical hospital Amsterdam)*

This is a long quote, but it places the diagnostic practice of determining behaviors that are *druk* in the context of a ‘system’ that is ‘demanding more and more’ from children and people in general. This could even mean the clinician. ‘*The druk that comes purely from our system*’ is placed as a burden upon the behaviors of a child, the behaviors a clinician diagnoses. We hear the term ‘*rust*’ used to explain this. In this case, leaving a child ‘in *rust*’ is equated to both the
state of the individual and the state of the environment. The ‘rust’ of a society that ‘used to be about peace and harmony’ is juxtaposed in direct contrast to the ‘druk’ of ‘maximum capacity’, and the high-speed demands placed on individuals.

When we highlight specific words that appear across contexts in the speech of clinicians, clarity emerges in the application of the diagnosis ADHD. This is encapsulated in the word ‘druk’, which is used to describe both symptoms and situations. The tensions highlighted by these clinicians show that ‘druk’ can be equated to many things, of which only the behavior contained in the diagnostic category of ADHD is not sufficient to answer. For the clinicians, ‘ADHD’ as symbolized by ‘druk’ indicate that the diagnosis is part of a shifting process in society as a whole. The terms ‘druk’ and ADHD are not interchangeable, though the term ‘druk’ indicates why the diagnosis is relevant. When we listen to the expressions of ‘druk’, which clinicians ‘apply a clinical theme to’ resulting in the diagnosis of ADHD, we hear that this is not without tension. The common word that can explain a person, place, or situation, becomes a metaphor for the greater attributes the diagnosis represents: all that is hurried, fast, and pressured in a changing modern society. This brings up problems in the educational system, questions of gender, or what the diagnosis misses by focusing only on the outward symptoms of this category. Tensions emerge where ‘druk’ becomes positioned juxtaposed against the value of ‘rust’, an element that is excluded from expressions of the diagnosis. In fact, ADHD, when expressed through the term ‘druk’, becomes a symptom itself of system change- educational, environmental, and even a sense of what is now ‘valuable’.

Understanding the terms used to express the diagnosis of ADHD help to place it in context. Language defines the scope of how a diagnosis is used or interpreted (Kirmayer 2006). Horwitz (2002) suggested the use of language describing a diagnosis can lead one to question why it is used. In this case, understanding the tensions represented by ‘druk’ highlight the need to explore further. The research questions take on a scope of understanding the necessity of the ADHD diagnosis as a practice of protocols for the Dutch clinicians, and the tensions this presents.
6 The diagnosis of ‘ADHD’ in practice

6.1 An applied diagnosis

The diagnosis of ADHD did not originate in the Netherlands, it has been applied through the particulars of professional practice. Historically, the psychiatric practice of the Netherlands long had a framework for understanding childhood disorders and issues, often with specific local terms such as ‘onrust’. The American diagnostic term began to be applied late into the 1990’s, when health care system reforms demanded uniform protocol measures from psychiatrists (Bolt and de Goei 2008; Bolt 2009). The ADHD diagnosis was often seen as a ‘label’ and concerns of its prescribed treatment methods, primarily medication, were of great concern (Bolt and de Goie 2008:67). Now, however, based on the rates of treatment for the disorder, the ADHD diagnosis has reached an ‘epidemic’ status in the Netherlands (Bolt 2010). Dutch media extensively covers the concerns of this growing trend, where most of the blame for increasing rates of the disorder is placed squarely on the diagnosing clinicians (Radio 1 2010; Rondom 10 2010). However, the diagnosis can also be viewed as a “trend” based on the fact that its diagnosis process, categorization, and even administration have been recent developments in the Netherlands (Bolt 2010).

As we have seen so far, the clinicians present ‘ADHD’ as a diagnosis that is ‘simply’ or ‘just’ a clinical concept. The words they use to describe both symptoms and situation, however, reveal a tension in what the diagnosis represents. Its clinical attributes present themselves as ‘druk’ behaviors, while the clinicians point to the greater ‘druk’ of a modern society placed under pressure to compete. The historical perspective supports the critical view of the clinicians, who have placed ‘ADHD’ in a broader tension. This takes on new dimensions when the focus shifts from what ADHD represents, to why it is diagnosed, and to the rates that it is. Horwitz (2002) suggests that it is the why of a diagnosis that gives it significance. Diagnostic categories can sometimes become a ‘force in the world’ in terms of their demand and use (Bowker and Leigh Star 1999:39). This means to say that their intentions can shift from a concept of classification to a response for supplying a need. In this way a diagnosis can be seen as a ‘fit’ rather than a construction, as may be the case in the current context of its use in the Netherlands.
In interviews with clinicians, my research questions often were quickly shifted. The clinicians wanted to talk about why the diagnosis was used to the degree it is currently. They often would turn my own research questions around and ask me questions such as, ‘why aren’t you asking about other diagnoses that aren’t being diagnosed?’ or, ‘the question to ask is why this particular diagnosis is given?’. As seen in the first two chapters, the diagnosis is easy to apply in the Netherlands, especially based on simple diagnostic criteria. The question even the clinicians pose is why. The clinicians in the Netherlands placed their own emphasis on why the diagnosis is used, as part of a larger tension. The why’s for the classification provide a set of answers that lend insight into tensions in the profession, hinted at already through the explanation of what ADHD is, and what it represents, in the last two chapters. This chapter highlights the expressed answers of clinicians expressing their view of motivations behind the ADHD diagnosis as it is applied in practice in the Netherlands.

6.2 The necessity of a diagnosis in “Subsidized Land #1”

When we shift the question from what ADHD is to why it is used, a strong theme emerges. In interviews, clinicians often explained that their preference was not to classify ‘ADHD’. This comes from explaining that while it is a ‘relatively simple classification’ following the checklist of the DSM, understanding the tensions expressed by ‘druk’ reveal that this can be problematic. But when asked for why the diagnosis is used in light of this tension, the clinicians all said, ‘ADHD moet.’ It is a must. It is necessary. It was also described as a ‘need’ for either the client or the clinician. The ‘need’ and ‘necessity’ for the diagnosis predisposes use of the term ‘ADHD’, whether the clinician agrees with what it is classifying or not. This immediately recalls the clinical express wish for a critical view of what ADHD is, simply a classification. One clinician explains how the category of ADHD becomes irrelevant to the diagnostician, apart from what it provides for a patient:

“Yeah, you know, we just want to know what is happening with a child, and not per se that they have ADHD, which I find to be an exhausting discussion. Because you know, I do definitely think very often that you are not so sure if it is ADHD or a reaction, or that they are just not so smart, or that there is just a lot of stress at home, or something like that. Come on, you just don’t always know. And for me, then I am thinking that if I don’t
know it, then there is not someone better who does. Everyone has… look, some very learned and experienced people look at (a child diagnostic) and say oh yes it is autism, while some very learned and very experience people say, no, really it is more a case of ADHD. And what is truth? That is very vague. In my opinion you just don’t always know, you can’t always know what is happening, and that isn’t necessary either. And, parents also don’t want that, because it is just only needed for… for help.”

(Psychiatric assistant- private clinic Hoorn)

The ambiguity of placing a diagnosis of ADHD on a problematic situation, or the expression of behavior of a child, is expressed in this quote. What it is becomes irrelevant in the face of what it does. ADHD is a diagnosis category described as ‘vague’, and it is viewed critically. This clinician also suggests that any diagnosis is ultimately irrelevant. What is relevant is what it can be used for, namely, receiving help. The criteria of the diagnostic can be seen an arbitrary measurement, used to fit the current situation. It is a term that does not define the individual, or even the situation, but it begins to place the reason for the diagnosis.

However, help in this case may not mean ‘treatment’ in the sense that one would expect. Many clinical professionals explained that diagnoses in the Netherlands are the “beginning of a trajectory”, and once a diagnosis was established, treatment could be offered. A main form of treatment for ADHD is medication, however, when clinicians were asked if this is why the parents or client (if an adult) needed the diagnosis, they stressed a different answer. Recent law changes allowed for special funding to be provided for the patient to be used in education, or sometimes, work situations. During interviews, one psychiatrist cut me off at the beginning of my research questions. He explained that more than 50% of the children referred to his clinic were suspected cases of ADHD. While he employed two different versions of diagnostic checklists, with lengthy interviews, he “happily” reported most of the children did not have the disorder. His concern was the increase of diagnoses due directly to the need for this particular form of financing, rather than treatments:

“Then I first send the parents to the school, to make it clear that there is no ADHD, and what helps does the school actually need? Sometimes the school just wants money. Because, the enormous increase in ‘ADHD children’ is really about money. We have
here…. Look, the Netherlands is a subsidized country. You know that, right? The Netherlands is *Subsidized Land #1*. You can get money for every problem. And, now for some years, you can get money for psychiatric diagnoses. It used to be that the schools themselves had money. Every school had a fund for special education. But that has been disbanded now, and it is only available if there is a label applied—now it is not about the school, but about the child. With the introduction of the *leerling gebonden financiering* the finances are not distributed to schools themselves, but according to individual students. Then, if we make labels necessary for these claims, then of course we will see a surge of psychiatric labels. The one creates the other. So if you want to really know what is happening, follow the money. Follow where the money is directed and then you will understand why it is the way it is.”

*(Child psychiatrist - private clinic Amsterdam/Zandaam)*

The Netherlands is described as “Subsidized Land number one”, and to this psychiatrist, the recent law changes implicated the diagnostic picture. Educational law in the Netherlands now allows special funding for children who have a learning disability, or are diagnosed with a behavioral disorder. The two primary behavior disorders able to receive funding are ADHD and autism spectrum disorder (ASS). *Leerling gebonden financiering* (pupil-based funding) is also simply known as the ‘*rugzak*,’ a.k.a. ‘the backpack’. Children can ‘go to school with the backpack’ and have services provided which otherwise would be unavailable.19 This creates a problematic situation for a clinician who understands the law, and the simplicity of an ‘ADHD’ diagnosis.

In the previous chapter, education was one of the examples brought up in the expression of ‘*druk*’. It also represented a tension. This becomes more clear when clinicians explain that their role in providing a diagnosis gives access to funding that is, ultimately, quite separate from them. They do not receive the ‘*rugzak*’, and questions such as forms of treatment, including medication, become a moot point in the face of this necessity: the diagnosis as a way to access funding. After explaining the tensions of ‘*druk*’ and what ADHD may or may not represent, a clinician specifically pointed to this fact:

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19 *Leerling gebonden financiering* (LGF) is part of a governmental fund for education. In 2006 this funding was extended to include middle school pupils in addition to elementary students. A good website detailing this, and also giving explicit instructions to parents how to go about ‘getting the rugzak’ is: [http://www.rugzakinmbo.nl/](http://www.rugzakinmbo.nl/)
“It’s not like a diagnosis really clarifies everything. […] Well, that depends. That is a point, you see without the diagnosis you aren’t able to get a certain kind of help so quickly, such as in education. But if you need money, or facilities, and you know that can be paid for, such as how in the Netherlands we have the rugzak, well you definitely need a diagnosis for that.

(GZ child psychologist- private clinic Voorschoten)

Could this be the expression of a diagnosis becoming a ‘force’ in both society and professional practice? If a psychiatrist is placed in a position of having to give a diagnosis whether he believes the condition truly exists or not, then the motivation for defining criteria is irrelevant. Who ‘fits’ the diagnosis is someone who ‘needs’ it the most. Facilities, educational help, and funding are provided by a diagnosis, specifically, ADHD or ASS. The diagnosis ‘does not clarify anything’ apart from its usage. The clinicians especially recognize it as a means to an end.

6.3 A backpack of money and a ‘flipped’ diagnosis

The financial backpack provided under educational law, that ‘rugzak’, might be possible for parents of a student to get without a diagnosis, but it is very difficult. This places the clinician in a position that shifts a diagnosis purpose. I would position that most mental health care workers come to the profession with a desire to help patients. They are drawn to a profession whose mission it is to ease the suffering of individuals, and by doing so, better society. They do not imagine themselves as ‘brokers’ of diagnoses where a patients’ main concern for receiving a psychiatric label will be a matter of recompense. They explained how the diagnosis has become a demand placed on them, often by parents of children seeking the label for easy access to the ‘rugzak’:

“I was very surprised when I realized that at a given moment in my career, parents really wanted diagnoses. I used to never give diagnoses. I used to write a letter to the family doctor- a medical letter describing what was occurring for a child. All of a sudden, at a given moment, the parents wanted diagnoses. They also want this very soon. I want to explain what is happening with a child, but now they demand a diagnosis immediately!
Ok then, you get your diagnosis. Great. This is the phase we are now in, where the parents become disappointed if their children do not get a diagnosis. They are disappointed! Disappointed if there is no diagnosis because without a diagnosis the schools can’t help the child to the optimal capacity. Because the school asks for the diagnosis because that diagnosis gives a sack of money. That means that the true value of a diagnosis has been flipped around.”

(Child psychiatrist- private clinic Amsterdam/Zandaam)

The ‘true value’ of a diagnosis was the ability to really clarify a situation for a parent or a child, and by doing so, provide help. This psychiatrist explained how previously he would provide many sessions of parent or family therapy without ever giving a diagnosis. Now, parents ‘are disappointed’ if a diagnosis is not immediately given. They are seeking psychiatric ‘help’ for the access it will give them to other resources. The pupil-based funding in the Netherlands can be issued without a diagnosis, but to do so means going through a long bureaucratic chain in the school system. A psychiatric diagnosis gives quick and easy access to funding. As one clinician puts it, this ‘has nothing to do with psychiatry’, yet a psychiatrist can still feel quite bound to provide access to the system. He explains:

“It is more difficult. It used to be easier, but now it is always a question of money, and that is always paid out by another. Actually we often want to still give a diagnosis for the rugzak for example. The rugzak for school you know, but that can still happen without a diagnosis. It can be given if the school requests it, such as from the teacher, because the child has this sort of problem, or the parents say that the child is falling behind. Then a rugzak can happen without the diagnosis of ADHD. This is possible.

“It is changing all the time. I can’t follow it any more, it changes every two years. Look, the rugzak is really a school-bound counseling apparatus, so to speak. Rugzak does not have anything to do with psychiatry. Rugzak is for the children who are having trouble at school, and the school requests this rugzak, and there is a budget given to the school, directly to the school for a particular child. They give a particular amount and the school determines how to apply that to the child, and sometimes that is with counseling on
learning process, or sometimes it is counseling for social development, sometimes counseling just for ADHD attributes. It has nothing to do with psychiatry.

A: So do you really need a diagnosis?

“It isn’t necessary. But, if it helps that kid, it helps. Because, there is a committee for the rugzak, and they have to grant it. And, if the child has a set diagnosis, it helps this process enormously.” (Child psychiatrist- clinical hospital Amsterdam)

This doctor points out that the sense of purpose in practice may be shifting. If to ‘help’ a child means to give a psychiatric diagnosis that will allow a parent access to funding and assistance for their student, then that is what will be provided. He explains that though a clinician may know there is another route toward funding, ‘we often still want to give a diagnosis for the rugzak’. This presents a tension. Some clinicians actively oppose the use of a psychiatric diagnosis for the sake of funding, they are uncomfortable with it, as our earlier quote shows. Others, such as this one, seem to accept it as a new role in providing care and assistance to patients, and are supportive of it.

Some clinicians express a third position. These were often the psychologists or privatized clinics outside of the nationalized health care system. This position is one of more expressed ambivalence, a middle road in the tension. The term of the diagnosis for this position is expressed as irrelevant, as is their role in providing access to more services. An example of this is illustrated here:

“So you give the diagnosis. Then you can use all the facilities you need, you can get the help. You can give the explanation, but that is always more of an explanation for the parents. But if you take that term away, then that term won’t be so known in ten years time. But now we have that term. And the parents know the term, and they look it up, and read about it, and there are books available. But if in 10-20 years there aren’t any books about it any more, then it is … until it makes a comeback. But, if it doesn’t make a difference for help, and in that case then the diagnosis doesn’t really matter, because I am just giving my impression with parents about what I see, and then we can say, ok, this is
the diagnosis, say autism or ADHD, but this is the child, just as he is, and where his is having trouble, and we need to do something with this. And then the diagnosis is of course more for the bureaucracy and for the insurance. But, this is also more for the parents as well of course, because parents think this is, in the first instance, the most important thing. They come in for the diagnosis. Of course, not all parents, but of course many, because they hear about it and wonder, does my child have ADHD or not?”

*(GZ child psychologist- private clinic Voorschoten)*

In this quote, the giving of both the diagnosis and services that come with it seem to be second in importance to the term applied- the ADHD explanation of what is happening for a child. It is brought back to a ‘term’ that can change, and that what matters is ‘this is the child, just as he is, and where he is having trouble’. Providing for a solution for patients can be *both* the diagnosis and the funding it provides. What matters more is to respond to the demand, the need, in a way that is *recognized*. This quote almost expresses needing to validate the profession of providing a diagnosis at all.

This section highlights a tension in the need for a diagnosis, presented as a demand for financing in place of ‘treatment’, which some clinicians feel as negative while others view it positively. What it highlights is a change in the professional role, which, in essence, makes the term of a diagnosis irrelevant. The clinician shifts from a diagnostician and treatment professional to a broker of commodities for patients, in which the label of a psychiatric diagnosis becomes what patients seek.

### 6.4 A professional shift based on demand

The clinicians indicate that they feel their own professional position is shifting. Typically, diagnoses are seen as ways to provide for treatment for patients. Importantly, the diagnosis of ADHD allows for funding, but it also allows for state services of mental health care to be provided. Treatments ranging from medication to parent management classes are offered as part of a ‘package’ for all those with the diagnosis. For the clinicians, this was considered an imperative component to the diagnosis process, and considered part of the ‘true value’ for its recognition. The national health service of the Netherlands has long offered mental health care as
a form of support for parents raising children\textsuperscript{20}. Dutch parents of young children are used to seeking support for questions regarding their children, from family doctors to many websites provided by the government to answer common or complex health questions. The clinicians often expressed wanting to really help parents work with and manage true issues with their child. The tensions lay in the role for the psychiatrist in order to do this. If Dutch parents are well acquainted with the terminology of a diagnosis, and what services can be offered when it is given, then the question becomes in the role of the clinician. To respond to a parent or patient need for an answer can be displaced by what is expected already from the encounter. The psychiatrists link this directly to the changes in professional practice that facilitate this:

“I think that has to do with the developments in child/youth psychiatry. I think that is the most important factor. Child and youth psychiatry has developed to where parents overall, not always, but overall, have become very used to asking for advisory help, that is one thing. We have become a real value whereby … a large cluster of parents can come to us for that reason, and it is of course very understandable that parents can use help. That is what we offer. For me then, two factors. One is the way in which the mental health services have become something that parents really value. But the other side is that in the press and through the Internet, more and more is known about ADHD. And sometimes people come in here for their first visit with a packet of information tucked under an arm, already a ‘half-expert’ about what their situation is. So the threshold of knowledge becomes much broader, which also lowers the threshold for the diagnostic. And yes, parents definitely have more knowledge, they know more ahead of time, and the theme is very known. That then broadens the perspective of parents of a ‘new’ mental health service that can really profit them.”

(Child psychiatrist - academic hospital Groningen)

This quote positions the clinician in a health care system that provides a ‘real profit’ for parents. This is the expected role of the clinician, and yet it also highlights a tension in that parents can

\textsuperscript{20} The Netherlands Ministry of Health, Welfare and Sport provides and emphasizes various forms of assistance and programs for mental and physical health problem prevention, and treatments for all ages. The official website with all currently offered services is found at: http://www.rijksoverheid.nl/. In English: http://english.minvws.nl/en/

Papers such as Child Guidance and Mental Health in the Netherlands by Nelleke Baker detail long histories of how mental health care has been provided for children since the early 1900’s.
come into the diagnostic ‘already a half-expert’ about ADHD. This is due to the prevalence of information available to parents through media, Internet, or the wide availability of publicized medical knowledge. The tension for the clinician is that the ‘diagnostic threshold’ for defining what is or is not problematic is affected by this. Clinicians are placed in a position of responding to parent expectation and demand, not just the needs of the diagnosis for the services it may provide. Parents are described as utilizing the mental health services to provide them with the answers they seek, whether the clinician feels this may be justified or not. When I asked one clinician if a parent seeking a diagnosis for their child could have a real advantage knowing ‘what the issue is’, he put this in context:

“Are there advantages? Advantages over what? That children have something? Now, if you are sick, and you think ‘oh I feel so bad’, then it is nice to know for instance, that you have a heart disease and that there is something you can do about it, and that you will still live much longer. But with psychiatric illness this is not the case, that you get to live a little longer. With psychiatric illness it is also not really demonstrable in the brain. Psychiatric illness- that is behaviors that are put together. That is a psychiatric disorder. And, you can’t just demonstrate that in the body. But, it is really nice to know what is happening with your child. Because then parents can also hear from the child psychiatrist what they should, or shouldn’t, do. And, we take the school into consideration. If there is space at school, and also attention, and interest in the child not just as part of the group, but as an individual, I think that is good. But to do that you do not especially need a psychiatric diagnosis. I can counsel parents how they can operate with their child without a psychiatric diagnosis. I think that the benefits are that you might know what is happening for you, and your family. I think it is always better if you know something than if you don’t.” (Child psychiatrist- private clinic Amsterdam/Zandaam)

To this psychiatrist, a diagnosis can shed light into what is happening in the moment, but he also points out that a diagnosis is not the relevant aspect. The relevant aspect becomes a parent receiving help, which he suggests could occur without a diagnosis ever being set. We are reminded that the ‘advantage’ of a diagnosis as a solution for a patient has been ‘flipped around’. Another interview puts this in perspective. Diagnoses do provide benefits for patients, answers
for parents of children with real problems, but this can be misused. This is not the value of the diagnosis that is misplaced, but rather what is suggested as a mis-appropriate focus for a clinician in giving a diagnosis:

“But there are also benefits (to the diagnosis), because I think that there are children now who can get help who used to not be able to. The parents had no interest, or would say, yes, he’s crazy just like grandpa who was also crazy. I don’t know that there are a lot more, maybe just more that get a diagnosis, but I don’t think there are necessarily more. There is of course a difference, because everyone claims a diagnosis as part of saying ‘I am so different’. It is better known. We are also better trained to recognize it. It definitely is referred more, but it is also misused. It is really nice for parents to hear: your son has ADHD and that is why he acts like an idiot.”

(Child psychiatrist- private clinic De Bilt)

In this strong quote it is again parents who drive the demand for a diagnosis for their children. But the point is to illustrate that the value of the diagnosis, the reason a classification of ‘behavior disorder’, which is what ‘ADHD’ is, can be then mis-appropriated. This is another example of a response by the clinician to a demand placed on them, however. It is not seen as their solution for a patient.

These quotes indicate how clinicians express their role as a determiner of what is, and what is not diagnosed as ‘disordered’ as shifted. The clinical work of determining a diagnosis is placed into a system by which parents drive the demand for a ‘solution’, or a clinician feels they are responding to expectations for their role in the diagnosis process. The demand drives the diagnosis, both as a way to provide needed services (i.e. money), or as an expectation of their role as a clinician.

6.5 Professional division

Already in considering why ADHD is used as a common diagnosis in the Netherlands, we see that tensions emerge in the professional role of clinicians. They feel placed in a position forced to respond to a need or a demand for the diagnosis, regardless of their own view of it. This is not to say that all professionals disagree with the diagnosis. On the contrary, many
clinicians expressed a strong belief in the symptoms expressed by the disorder and even in the clinical DSM definition. Their tensions with the disorder lay in the motivations for which it is applied, as a response to demand that shifts their professional role as diagnostician.

It is through looking at this shift in roles that one final tension emerges. The change in mental health diagnostic practice in the Netherlands is not just a matter of perceived role reversal, but of actual practice. Psychiatrists remain directly under the supervision of the government-run national health service of the Netherlands. However, demand for more easy access to mental health care services for ‘common’ issues by the public led to the expansion of diagnostic services into the private sector. This has, for the most part, been seen as a positive development in mental health care in the Netherlands and has resulted in many independent clinics which can provide diagnoses or treatments (Boer 2005). Up until this moment, the dialog of clinicians in this thesis weaves seamlessly together in a fairly unified expression of the expressions of ADHD from a professional position. However, the particulars of professional practice do differ for some of these professionals. GZ psychologists and GGZ clinics are private commercial enterprises of the mental health care system. Their diagnoses vary in form from psychiatrists only in their professional designation, as unregulated entities.21

The psychiatrists interviewed for this project made clear distinctions between the private GZ and GGZ enterprises and their own practice. They actually explained the rise in diagnostic rates of ADHD as stemming directly from this development. They put the ‘profit’ of the system and the demands for diagnoses as connected to the widespread and unmonitored accessibility of these services. The following quote illustrates how the ‘trajectory’ of treatment actually becomes a shift toward the ‘trajectory’ of the mental health care system:

“On the other side of that issue with the “backpacks” (rugzakjes) is that there has been this wild growth of practitioners who are outside the formal mental health process, like a situation like this one, where they are private practices who have to pay rents and bring in business in order to keep practicing. And no one really monitors that. Of course, the

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21 GZ is an abbreviation for gezondheidszorg: health care system. GGZ is an abbreviation for geestelijke gezondheidszorg: the mental health care system. They are differentiated by this title from psychiatrists, governed under the national health care system. All three can issue diagnoses. GGZ diagnoses are considered equivalent to a psychiatric diagnosis as a psychiatrist must be associated with the clinic. However, the clinic remains privatized and independent of the overall system. The GZ psychologist can diagnose, but these are not registered as psychiatric, and are considered short-term diagnoses.
political sector thought that one up... but no one really understands how that affects everything. We know exactly what is happening in this (hospital). But we have to make reports about all of that, where those private practices that just have their own space, they don’t have to answer to anyone I believe. So that could very well be an element that is playing into it, but I don’t believe it is simply just one. And I don’t think I could give evidence here, but you could well have this shifting internal threshold that is turning mental health into a new trajectory.” *(Child psychiatrist- academic hospital Groningen)*

While this psychiatrist is not clear as to the particulars of the privatized practice, such as how this affects diagnostic rates, it is clear that this is still a tension. He implies that the educational law providing ‘rugzakjes’ lends itself to shifting the mental health profession into ‘a new trajectory’, one that is exempt from outside scrutiny. This allusion to the law becomes clearer in the following quote of a different psychiatrist:

“Two things. I think that this is really a question of money, and I also think that it becomes a question in the upsurge of so many GZ psychologists. Over the last 20 years we have gotten so many more of these psychologist in the Netherlands. So many. And the GZ psychologists are not ‘regular’ psychologists, but they are psychologists that have followed a specialization in the GZ. And this means they get a registration that allows them to diagnose, even though they are not a psychiatrist. So, in that moment that you give a whole large group of people license to hand out psychiatric diagnoses, fully registered, then you are going to get many illnesses of course! And, if you just have a few psychiatrists, they you will also not see so many children with psychiatric disorders. If you suddenly have many psychiatrists, which we do not have, and suddenly so many diagnosing psychologists, who have just streamed out of the universities these last 20 years, well, then you are going to get a whole lot of psychiatric labels. So- the money, and then, so many GZ psychologists who can give the diagnosis, and again, that money. It is that combination. If you would ask me, are the children in the Netherlands getting ‘sicker’? No, I don’t think so. You really need to follow the law. Look at the rules and regulations. Look at the link between law and this recent explosion.” *(Child psychiatrist- private clinic Amsterdam/Zandaam)*
Both of these quotes are laced with emotion as the professional roles have not just shifted, they are in a sense, being given away. Diagnoses are ‘being given out’ by those approved by law as appropriate trained, while the psychiatrists question this. They assert that if a group of individuals is trained and privatized with the *express purpose* of giving diagnoses, this will result in a fulfilling effect: more mental illness will be diagnosed. Whether this means that actual rates of a disorder are on the increase or not is questionable. This is in direct reference to ADHD, for which there is much public scrutiny placed on psychiatrists as mediators of the diagnosis.

Throughout interviews, even psychiatrists who *agreed* with the diagnostic criteria of ADHD in the DSM, those who thought it a *valid* disorder, were often very opposed to giving the diagnosis. One psychiatrist explained to me how the ‘new psychologists’ are being trained, as a system of protocol and processes geared to checklists where criteria are easily fulfilled. She links this aspect to insurance reimbursement, the main source of funding for the independent diagnosticians:

“I know it is stubborn, because I was also not trained this way. I always give long, written out diagnoses: like, from this and this type child and such and such an environment, blah blah blah, until suddenly a whole page is there. And you know, I have to make a final classification, and I think that is terrible. Really terrible. That doesn’t solve anything! It says nothing about the type of child. It is only for the insurance. For the insurance. And, it is misused.” *(Child psychiatrist- private clinic De Bilt)*

The role reversal is again apparent here. A classification ‘says nothing about the type of child’, it is a matter of funding- for patient, or for clinician. These sentiments are echoed by another psychiatrist who directly questions the use of diagnoses by the private clinics, for the sake of reimbursement:

“I do think that clinics often lean heavily toward diagnosis, to be paid. And, I hope that is always fair. I don’t know if always… that diagnosis that the child gets, also has to do with the state of the child.” *(Child psychiatrist- private clinic Amsterdam/Zandaam)*
What could be of interest to ask here is why psychiatrists are reluctant to give diagnoses at all, even when they know that there are real issues with a child or a patient. These quotes lament a loss of being able to avoid a diagnosis, which is expressed as ‘saying nothing’ about the patient. This speaks volumes to the kind of practice they feel health care is moving away from. What this means exactly is not clear here, nor it is revealed in this research, but it is a point worth considering. Instead, what becomes apparent is again a focus on the diagnosis in relation to finance, this time as a form of third party reimbursement for a clinic. This is not a surprising connotation, as the use of mental health diagnoses are often part of a protocol process that implies third party reimbursement (Bolt and de Goei 2008; Bowker and Leigh Star 1999; Kirk and Kutchins 1992). In fact, the ADHD diagnosis is suggested to have come into use at the same time mental health care became a reimbursable item for health insurance in the Netherlands (Bolt and de Goei 2008). While this again leads back to the question of ‘money’, this time, the ADHD diagnosis is considered as part of larger process for those independent practitioners to fulfill their own need for reimbursement. This is not an accusatory statement to mental health practitioners from the GZ system, but rather, as a critique of the system itself, affected directly by laws and policies brought into recent existence. As was suggested, if there are a great deal of people and institutions available that can now offer a diagnosis, then the prominence of diagnoses will also increase. This is not an ascription of fault, but as another aspect of need. The profession, and the individuals who provide professional services, must also survive as business entities. And diagnoses, of which ADHD is one of many, can help fulfill this.

The diagnosis of ADHD is needed for what it provides. Clinicians were quick to point out that the diagnosis was ‘the beginning of a trajectory’ which could mean a variety of things to a patient, but allows access to long or short-term treatment in the mental health care system regardless. The treatment for ADHD comprises of medication, group therapy sessions, parent training, student counseling, and sometimes additional help in the home or school environment. The diagnosis gives access to these services. The differentiation comes in whether these services are privatized or ‘monitored’ agents. It is important to note that psychiatrists might or might not offer treatment services to clients. Often, they acted as diagnostic and referral bases, prescribing treatment based on a diagnosis, but ultimately used as a service for receiving a diagnosis. In a GZ or GGZ setting, however, a patient can receive both a diagnosis and treatment, often in the
same session. The psychiatrists highlighted this particular tension. A diagnosis could easily become a commodity for a patient seeking services, whether internal to the system as a form of treatment, or outside the system as a ‘backpack of money’, or a diagnosis could become a commodity for a private clinic needing to also survive as a business entity.

How this interplays is not contained in the scope of this thesis. The point is rather to highlight tensions around the diagnosis of ADHD as presented by clinicians. With that in mind, this final tension expressed by psychiatric professionals in the Netherlands warrants a final response and illustration. The clinicians of the small private GGZ clinic I visited to observe three diagnostic processes brought these points up without prompting. They detailed the same situations as the psychiatrists, but from within an internal perspective of a for-profit clinic. The diagnosis was still expressed as a response to a need or an expectation of a client, but they admit that this also has implications for the professional practice. The position of having to give the diagnosis is put in a dual perspective:

“Now, you have a large group of parents who come in saying: ‘I am not looking for a label for my child. I don’t want to put my child in a box.’ But, it still occurs because, look, if you have that diagnosis it gives you access to extra money, to extra care... it gives you the feeling so often that you have to give the diagnosis, because otherwise parents can’t get the help they need. But I tell you, for us it is not about whether he has ADHD or autism or whatever...

“Because also, with us (the clinic), if you don’t have a diagnosis, you can’t be helped by us. Because we are geestelijke gezondheidzorg (GGZ) and that requires a diagnosis for treatment.” (Psychiatric assistant- private clinic Hoorn)

The necessity of giving the diagnosis dominates this clinical picture. While this clinician expresses ambivalence about putting a child or specific behaviors into a category, the category is a necessity to provide assistance for a parent and a patient, as well as provide for the clinic. She goes on to explain:
“It is because this kind of help is paid for by the health insurance, and if you don’t have a diagnosis, you of course have to pay for it yourself. Or it’s this slow process with much bureaucracy, and people say, yeah, we’re not going to do that. Then they come to us, asking us to supply what they need because they don’t want to have to pay it themselves, and then you sit there and think… Yeah, ok... that it is really very important they get that help, but also because if we go to help those people without a diagnosis, then we also have to worry about being paid. Then you get this process where our system is totally full of people who might not have ‘right’ to it, and that just isn’t fair. Then it becomes a real dilemma. (Psychiatric assistant- private clinic Hoorn)

The dilemma of the ‘system’ being full of people who ‘may or may not have a right to it’ is interesting. The diagnosis as providing access for both patient and clinic to funding is placed under scrutiny. This clinician expresses wanting to help individuals who do not have a diagnosis, yet being bound to those who do. This could be another way of reiterating the tension expressed when the word ‘druk’ was used in explanation of ADHD, or expressing the same sentiment as the psychiatrists who question the relevancy for a diagnosis. For this private clinic however, the tensions as expressed by ‘druk’ or the desire to not give the diagnosis are replaced with another issue. The system is ‘full of people who might not have a right to it’ for the very reason they fit the criteria, and know how to seek the services. This is expressing the same concern as psychiatrist in how the ‘value’ of a diagnosis can become a role reversal for the clinic.

The diagnosis gives access to institutions such as private clinics, which offer specialized services. This particular clinic offers artistic and motor/behavior therapy in a region limited to this kind of psychiatric service. They are the only clinic of its kind in the surrounding area, and some patients were known to come from other cities to receive services. It was explained that because of their registration as a private GGZ clinic, once a psychiatric diagnosis was established, a patient had “unlimited” access to their services. At the same time, the dialog of the diagnosing clinicians indicates a struggle with this:

“And I sit there and think privately, now why do we have to make this differentiation between who has and who doesn’t have a diagnosis? We don’t solve anything this way. We need to bring it together into one thing, but now it is this sense of ‘never or not’, and
you are always on that border where you have to investigate and think: what am I doing, just to be able to give help?

“Because, it is really all the same. It is really about ‘rust, reinheid, en regelmaat’ for all children. It is what is personally very frustrating.”
(Psychiatric assistant- private clinic Hoorn)

This clinician uses an old phrase to explain her frustration. “Rust, reinheid, en regelmaat” is a colloquial expression whose literal translation is rust (rest/repose), reinheid (cleanliness), and regelmaat (regularity). The expression is often applied to children with the concept that child rearing is a balance of elements, a regulation of time, limits, and the core value of ‘rust’. Her use of this expression is tied to the concern of ‘who and who doesn’t have a diagnosis’. If all children require the same elements in life to do well, this clinician suggests, then giving the diagnosis ‘just to be able to give help’ is going to create an automatic conflict. Maybe even especially for the privatized clinic whose survival depends on the reimbursement that comes with a diagnosis.

Concluding with these quotes brings us back to the tensions revealed in this chapter as to why the diagnosis of ADHD is used and why it is relevant. It also summarizes a position that ultimately agrees with the psychiatrists: doubt in the use of a diagnosis to provide for actual versus demanded needs of patients. In this case, patients are expressed as all members of society needing the same things, a balance of the core value ‘rust’, to which the ADHD diagnosis as expressed by ‘druk’ is in direct opposition.

When directed by the discourse of clinicians, my own research questions adapted to encompass their own position. Questioning why this diagnosis is used in the current context is very relevant. This chapter reveals that clinicians might very well be reluctant to apply the clinical diagnosis of ADHD to a set of symptoms, or a patient situation, yet they feel bound to do it. The diagnosis is driven by particulars of professional practice. The diagnosis of ADHD provides access to services and specifically, finances. The federally funded ‘rugzak’ creates an element of supply and demand where parents and educational law now ‘require’ professionals to have to classify
something that may truly be problematic. Some professionals are bound to this system in order to receive reimbursement. A major finding here is that the type of professional practice shapes this demand. ‘Commercial’ health care in the form of GZ and GGZ practices are differentiated from psychiatrists. This presents a tension in the change of the profession, and may drives rates and interpretations of the diagnosis. Overarching this, however, is a common sentiment that the diagnosis of ADHD does not resolve actual needs they see in patients and the larger society. How this can be resolved is not within the control of the diagnosing clinician, who express that they feel their own professional purpose and what is considered the ‘true value of a diagnosis’ has been changed or somehow lost.
7 Discussion

When Rafalovich (2004) interviewed psychiatrists and diagnosing clinicians as part of a sociological perspective on attention deficit/hyperactivity disorder, his was a first to ‘go behind the scenes’ to speak directly with those who determine who or what attributes fit the term ‘ADHD’. By listening to psychiatrists speak about ADHD in their practice and profession, a “nexus point” of theory emerged, that of a divide between professions as to the causes of ADHD and what it constitutes (Rafalovich 2004:44). Horwitz (2002) postulated that mental illness categories will always revolve around a debate of who or what fits into the classification, but the question to ask in place of what a classification entails is why it has come to be used.

The common, everyday language of psychiatrists can often reveal more about their own thoughts and positions on an illness classification than the symptomology lists they use in practice (Kirmayer 2005; 2006). Their words can illustrate their private thoughts or ambiguities, or can highlight local tensions that arise in a practice straddling the world of scientific theory and social interactions. When common words become incorporated into defining both illness categories while implying societal values, ‘meta-messages’ emerge in which the illness description is placed in a societal perspective. An example of this is the term ‘hyperactivity’, which is considered an American word deeply embedded with meaning, in fact implying a behavior that can also be a commodity (Danforth and Navarro 2001; Martin 2007). This thesis expands upon all these premises to place a social science study of attention deficit/hyperactivity disorder, ADHD, within the socio-historical and linguistic context of the Netherlands. This work has aimed to place a mental illness diagnosis in a context for which it has been appropriated. ‘ADHD’ was not coined in the Netherlands, it has been adopted as a diagnostic category rather recently. The use of language around this disorder clarifies its position in this social and professional context.

‘ADHD’ is described by Dutch clinicians first and foremost as a classification, a concept and symptom list of behaviors coming from the American Diagnostic and Statistical Manual. This is relevant it that it immediately differentiates the concerns of Dutch psychiatric professionals from their United States’ counterparts (see: Rafalovich 2004). For the clinicians interviewed for this project, debating what ADHD is or incorporates becomes something to be
critical of. Words are used to explain both the symptomology of a patient and the larger societal and environmental situations that might not be encompassed by the diagnosis. By considering one word in particular, ‘druk’, we hear that the common language expressing the diagnosis of ADHD also reveals a tension for the clinician. It places the focus of diagnosis and treatment only on particular aspects of behavior and situations, while ignoring broader issues. This specifically brought up concerns around issues in education, gender discrimination, institutional practice, and the law. As was illustrated by the use of the word ‘druk’, the clinical diagnosis may or may not adequately address situations of real concern in the Netherlands. In essence, ‘ADHD’ becomes its own symptom, that of the professional practice.

In the final chapter the research questions for this project have been turned around by the professionals themselves who critically address why the diagnosis is being used. Specific concerns emerge with the classification as it is used in practice. The tensions lay not in whether it was ‘valid’ or an accurate description of symptoms, but rather in the motivations for which it is applied. The demand for the diagnosis as a tool to access educational funding and privatized services cause many professionals to feel there is a shift in their role as practitioner. They express the developments in professional practice as changed, whereby issuing a diagnosis of ‘ADHD’ effectively shifts their position from mental health care worker to a broker of commodities. While the behavioral attributes of ‘hyperactivity’ can be seen as a commodity in the United States (i.e. Martin 2007), the commodity in the Netherlands becomes the diagnosis itself. ‘ADHD’ means access to money, a ‘recognized’ disorder that when issued by a psychiatrist, becomes a tool for a patient to obtain services.

This is where the linguistic approach applied to this word becomes relevant. It is easy to apply concepts of the medicalization of ‘deviance’, that targeting of behavior outside of the norm (i.e. Conrad and Schneider 1980) or the concept that finance and protocol processes define demand for a classification (Bowker and Leigh Star 1999). However, the rich detail provided by understanding the term ‘druk’ as expressed by clinicians puts theory into a relevant context. The Dutch public have coined the term “Just be calm, don’t be so ADHD”22, creating a synonym of ‘ADHD’ with the Dutch word ‘druk’. The clinicians do not make this equation, however. The term ‘druk’ may very well embody the symptoms of ADHD, but ‘society’ is also ‘druk’, people are under pressure, and ultimately, so is the clinician. It is through hearing a common term evoke

22 The term in Dutch is: “Doe maar even rustig, doe maar niet zo ADHD”
meaning for the clinician that goes beyond its assumption that gives insight into tensions and dynamics that might be missed otherwise.

It is important to note here some limitations in this project. This linguistic analysis and the emerging themes were those presented by a handful of clinicians in the Netherlands. While they represent a professional position, they cannot be assumed to represent all psychiatric or diagnostic professionals in the Netherlands. The research sample was small due to time and project constraints, and so we cannot generalize assumptions across all practitioners. However, the common expression of ‘druk’ captured in these interviews does reveal that the term is used by both public and professionals alike to place the ‘ADHD’ diagnosis in their local context.

The truly interesting question to ask might be why the Dutch psychiatric professionals would prefer not to give a diagnosis, even when they agree the symptomology of a patient warrants treatment. In the Transcultural Psychiatry conference hosted this year by the Netherlands Psychiatric Association (NVvP) a major theme under discussion was a desire for an overall reduction in the amount of diagnoses both included in the DSM and used in practice. Panels included critiques on the influence of pharmaceutical companies in the appearance of illness and the widespread use of many diagnostic terms. The very terminology of diagnoses and known popular medication treatments for them creates ‘looping effects’ wherein the demand for the diagnosis by public or professional practices results in the diagnosis being ‘more apparent’ in the symptoms of patients (Kirmayer 2010). This was of grave concern for most psychiatrists present, who in the framework of a private professional conference could discuss openly among their peers what might not be observed by the public. During the conference, I approached the vice president of the NVvP and explained my current research, asking him to comment on why the ADHD diagnosis is so popular now in the Netherlands. “Two things,” he said, “Money and Medication.” He then added, “Psychiatry needs to be different”.

In recent history, the profession of psychiatry has come to be defined by its diagnoses. Long gone are the names and knowledge of great philosophers that originally ascribed its traditions. Names like Pinel, Freud, and Jung have been replaced with ‘Schizophrenia’, ‘Bipolar’, and ‘ADHD’ in public dialog and media. The professional practice of psychiatry may well dominate the concepts of mental illness categories and diagnoses. Or, that could be our

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23 (Nederlandse Vereniging voor Psychiatrie) 2010 Transcultural Psychiatry Conference website at www.tp2010.nl
24 Phillipe Pinel (1745-1826) was a French physician often credited as the “father of modern psychiatry”. His philosophies on ‘care of the mind’ led to psychodynamic theory development across Europe.
perception. As M. Scott Peck says, “rather than being the illness, the symptoms are the beginning of its cure.”25 If the controversial diagnosis ‘ADHD’ has replaced old psychiatric ideologies, it can also be seen as a symptom of its profession. When seen this way, ‘treating ADHD’ may mean ‘curing’ the profession of the very thing that ails it. In the Netherlands, this means acknowledging the psychiatric professionals are caught in the same web we are, just trying to make sense out of shifting positions in a modern society where ‘ADHD’ has come to embody all that is ‘druk’: what is pressured, harried, and a pain in the ass.

8 Annexes

8.1 Abbreviation List

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADHD-</td>
<td>attention deficit/hyperactivity disorder (DSM IV classification)</td>
</tr>
<tr>
<td>ASS-</td>
<td>Dutch abbreviation for autism/autistic spectrum disorder</td>
</tr>
<tr>
<td>DSM-</td>
<td>Diagnostic and Statistical Manual of the American Psychological Association</td>
</tr>
<tr>
<td>DSM III-</td>
<td>Third edition DSM</td>
</tr>
<tr>
<td>DSM IV-TR</td>
<td>The most recent version of the DSM, fourth edition, revised</td>
</tr>
<tr>
<td>GZ-</td>
<td>gezondheidzorg (health care)</td>
</tr>
<tr>
<td>GZ psychologist</td>
<td>health care psychologist- a psychologist certified to issue diagnoses</td>
</tr>
<tr>
<td>GZZ-</td>
<td>geestelijke gezondheidzorg (mental health care)</td>
</tr>
<tr>
<td>GZZ clinic</td>
<td>mental health care outpatient clinic- psychiatric level of certification</td>
</tr>
<tr>
<td>ICD-</td>
<td>International Classification of Disease (World Health Organization)</td>
</tr>
<tr>
<td>PDD-NOS</td>
<td>Pervasive Development Disorder Not Otherwise Specified (a diagnosis in: DSM-IV TR)</td>
</tr>
</tbody>
</table>
8.2 DSM-IV TR Diagnostic Criteria: ADHD

Attention-Deficit/Hyperactivity Disorder Diagnostic Criteria\(^{26}\)

A. Either (1) or (2):

1. Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

   *Inattention*
   a. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
   b. often has difficulty sustaining attention in tasks or play activities
   c. often does not seem to listen when spoken to directly
   d. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
   e. often has difficulty organizing tasks and activities
   f. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
   g. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
   h. is often easily distracted by extraneous stimuli
   i. is often forgetful in daily activities

2. Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

   *Hyperactivity*
   a. often fidgets with hands or feet or squirms in seat
   b. often leaves seat in classroom or in other situations in which remaining seated is expected
   c. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
   d. often has difficulty playing or engaging in leisure activities quietly
   e. is often “on the go” or often acts as if “driven by a motor”
   f. often talks excessively

   *Impulsivity*
   (g) often blurts out answers before questions have been completed
   (h) often has difficulty awaiting turn
   (i) often interrupts or intrudes on others (e.g., butts into conversations or games)

\(^{26}\) Copied from the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text revision (DSM-TR-IV 2010): Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.
B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.
C. Some impairment from the symptoms is present in two or more settings (e.g. at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Development Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).
### 8.3 Comparison Table: DSM Diagnostic Criteria Dutch Reference

<table>
<thead>
<tr>
<th>DSM IV TR Symptom List</th>
<th>Trimbos DSM Symptom List (translated)</th>
</tr>
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<tbody>
<tr>
<td><strong>Inattention</strong></td>
<td><strong>Inattention</strong></td>
</tr>
<tr>
<td>j. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities</td>
<td>• Insufficient attention to detail or makes careless mistakes</td>
</tr>
<tr>
<td>k. often has difficulty sustaining attention in tasks or play activities</td>
<td>• Difficulty keeping attention on tasks or games</td>
</tr>
<tr>
<td>l. often does not seem to listen when spoken to directly</td>
<td>• Does not appear to listen</td>
</tr>
<tr>
<td>m. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace</td>
<td>• Cannot follow directions or finish tasks</td>
</tr>
<tr>
<td>n. often has difficulty organizing tasks and activities</td>
<td>• Difficulty organizing tasks</td>
</tr>
<tr>
<td>o. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort</td>
<td>• Avoidance or reluctance for tasks that require lengthy mental exertion</td>
</tr>
<tr>
<td>p. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)</td>
<td>• Losing things that are needed for tasks.</td>
</tr>
<tr>
<td>q. is often easily distracted by extraneous stimuli</td>
<td>• Easily distracted.</td>
</tr>
<tr>
<td>r. is often forgetful in daily activities</td>
<td>• Forgetful of daily schedule/affairs.</td>
</tr>
<tr>
<td>Metaphors of ADHD</td>
<td>Kalvesmaki</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------</td>
</tr>
<tr>
<td><strong>Hyperactivity and Impulsivity</strong></td>
<td><strong>Hyperactivity and Impulsivity</strong></td>
</tr>
<tr>
<td>g. often fidgets with hands or feet or squirms in seat</td>
<td>• Restless movements of hands and feet or spinning on his/her chair. (‘onrustig’)</td>
</tr>
<tr>
<td>h. often leaves seat in classroom or in other situations in which remaining seated is expected</td>
<td>• Standing up/getting up when sitting is expected.</td>
</tr>
<tr>
<td>i. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)</td>
<td>• Running or climbing inappropriate locations.</td>
</tr>
<tr>
<td>j. often has difficulty playing or engaging in leisure activities quietly</td>
<td>• Difficulty playing calmly or participating in relaxing activities (‘moelijk rustig kunnen spelen’)</td>
</tr>
<tr>
<td>k. is often “on the go” or often acts as if “driven by a motor”</td>
<td>• Hectic/driven to be constantly busy</td>
</tr>
<tr>
<td>l. often talks excessively</td>
<td>• To talk non-stop/no pause</td>
</tr>
<tr>
<td>(j) often blurts out answers before questions have been completed</td>
<td>• Blurtting out answers before questions are finished.</td>
</tr>
<tr>
<td>(k) often has difficulty awaiting turn</td>
<td>• Difficulty waiting for a turn.</td>
</tr>
<tr>
<td>(l) often interrupts or intrudes on others (e.g., butts into conversations or games)</td>
<td>• Disrupting the activities of others.</td>
</tr>
</tbody>
</table>
8.4 Symptoms of ADHD (Dutch version- from the Trimbos Institute)

De verschijnselen van ADHD bij kinderen en jeugdigen hebben te maken met aandachtsproblemen, hyperactiviteit en impulsiviteit.

Volgens de DSM-IV heeft iemand in de leeftijd van 4 tot 16 jaar ADHD als hij/zij zes of meer van de volgende aandachtsproblemen vaak (de meeste dagen van de week) heeft:

• Onvoldoende aandacht voor details of achteloos fouten maken.
• Moeite om de aandacht bij taken of spel te houden.
• Niet lijken te luisteren.
• Aanwijzingen niet opvolgen of opdrachten niet kunnen afmaken.
• Moetie met organiseren van taken.
• Vermijden of afkeer hebben van taken die langdurige geestelijke inspanning vragen.
• Dingen kwijt raken die nodig zijn voor taken.
• Gemakkelijk afgeleid worden.
• Vergeetachtig bij dagelijkse bezigheden.

Iemand heeft ook ADHD als hij of zij zes of meer kenmerken van hyperactiviteit of impulsiviteit vaak (de meeste dagen van de week) heeft.

De kenmerken van hyperactiviteit zijn:

• Onrustig bewegen met handen en voeten of draaien op zijn of haar stoel.
• Opstaan als zitten blijven verwacht wordt.
• Rondrennen of overal op klimmen als dit ongepast is.
• Moeilijk rustig kunnen spelen of ontspannende activiteiten uitvoeren.
• In de weer zijn of maar doordraven.
• Aan een stuk door praten.

De kenmerken van impulsiviteit zijn:

• Het antwoord eruit gooien voordat de vragen afgemaakt zijn.
• Moeite hebben met op de beurt wachten.
• Verstoren van bezigheden van anderen.

Bovenstaande symptomen als rusteloosheid, impulsiviteit en gebrek aan concentratie komen bij veel kinderen in verschillende gradaties voor. De diagnose ADHD is op te vatten als het uiterste eind van een continuüm.

This is a direct copy of the translated ADHD diagnosis available for both public and professionals. Online through the Trimbos Institute official website:

http://www.trimbos.nl/onderwerpen/psychische-gezondheid/adhd/symptomen
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