Appropriation and ADHD, weaving a new 'disease' into Indian fabric

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Introduction & problem statement

Attention deficit hyperactivity disorder (ADHD) is a much-debated mental disease category that is rooted in western medicine. While the associated symptoms have been subject to research for over 100 years, no clear individual physiological markers have been found yet. The amount of people, mostly children, that are diagnosed with ADHD has in the past few decades greatly risen in the West (Hinshaw et al. 2011; Polanczyk et al. 2014). The rising rate of ADHD diagnosis, combined with the uncertainty surrounding the disease category, has led to the proliferation of scientific debate. According to Illina Singh (2008b) positions can be discerned along a spectrum relating to the validity of the diagnosis category, it's aetiology and legitimacy of associated drug treatment. One group of authors think ADHD to be 'real' or 'valid', and that it is caused by: biological factors alone; a combination of biological and social factors; or environmental factors alone. Whereas a biological aetiology legitimates drug treatment, a socio-environmental aetiology does less so. At the other end of the spectrum a group of authors are sceptical about ADHD being a real disorder, linking it to sociological critique. ADHD is portrayed as a myth created in order to make social problems into medical ones. In the name of science seemingly objective and authoritative knowledge is created that functions to enhance social control (Griffiths 1983) over the individual who displays (potentially) deviant behaviour. While this sociological critique helps us problematize the boundaries between what is normal and what is pathological, it fails to integrate the clinical realities of the children and families involved and the (positive) impact medicalization can have on their daily lives (Singh, 2008, p.349).

Due to the global spread of knowledge and marketing, the diagnostic category of ADHD is now taking root around the world. The diagnosis prevalence of ADHD varies between countries (Polanczyk et al. 2015), as do the scales of institutionalization and the cultures in which it is embedded. The global variation in ADHD diagnosis brings to question the universality of the disorder and its validity in non-western contexts. The latest scientific understanding of ADHD highlights the complexity and heterogeneity of the disorder (Singh, 2008, p.960) and it is suggested that ADHD shows niche variation between different cultural contexts (Singh, 2012b; Bröer & Heerings, 2013; Bröer et al, 2016). This seems to suggest a diversification of ADHD, which challenges the dichotomy of mental illnesses as universalistic or culture bound phenomena and points to something in between. While it is likely that ADHD has a biological base, it seems to also be triggered by socio-environmental factors and gain meaning in accordance with the social ecology

in which it is embedded. There is a call for culturally sensitive research on ADHD, it's increased prevalence, and variability in intervention procedures and treatment around the world (Hinshaw et al., 2011; Lee & Neuharth-Pritchett, 2008). In writing this thesis I try to answer to this call by studying the uptake of ADHD in the (educational) context of India where it was introduced recently and is currently being implemented.

In India, the diagnosis and treatment of ADHD is on the rise, especially among the middle class (Mukhopadhyay, Misra & Mitra, 2003). However little systemic research on the topic has yet been done (Naik et al., 2016). India has a history of colonisation and stigmatisation of mental health care, and hosts a strongly stratified society. However, Indian society is changing and policy is being implemented to improve both social mobility and mental health care. In this research I will explore if and how such local contextual or cultural factors play a role in the uptake of ADHD and how niche variation is created. What happens when the disease category of ADHD is introduced in the Indian political, cultural and institutional context? What are the effects on local ideas on illness and care and how do these, in turn, influence the meaning of ADHD? In order to find answers these questions I will study how ADHD is embedded in local needs, explained, and dealt with by school counsellors in the city of Pune.

The chapters that follow will guide you step by step to an understanding of ADHD in Pune, India and provide answers to the questions posed above. First you will read about theory that provides insight in ADHD on a global level and in India, situating it in the school environment and putting forward a conceptual framework to understand the reworking of ADHD. Next follows a short chapter on methodology. The empirical chapters are divided along the four phases of appropriation: cultural appropriation, objectification, incorporative action and transformation. This thesis is finalized with the conclusion in which you will read about the empirical conclusions and their theoretical implications, followed by a short reflection on this study and a recommendation for further research.

Theoretical framework

The global spread of ADHD and pharmaceutical intervention

There is a global rise of ADHD diagnosis (Conrad & Bergey 2014; Hinshaw et al. 2011). The prevalence of ADHD (in line with the DSM or ICD-criteria) is stated to be about 5% for the worldwide population but holds significant regional variation, (Polanczyk et al. 2007; Singh 2008a). Hinshaw et al. (2011, pp.459-463) claim that there is "huge variation of both the treated prevalence of ADHD and treatment practices for individuals with this condition." This variation is found both within countries and between them and is mainly attributed to disparate diagnostic practices. According to Conrad and Bergey (2014, pp.31), diagnostic migration is taking place and "medicalization is [becoming] an increasingly global phenomena". In their comparative study Conrad and Bergey (ibid., p.36) found five vehicles that lead to the globalisation of ADHD, being: "1) the transnational pharmaceutical industry, 2) the increasing influence of biologically-oriented American psychiatry as a standard, 3) the adoption of DSM-IV criteria for diagnosing ADHD, 4) the Internet, including the availability of specific and simple screening check- lists, and 5) ADHD advocacy groups." Fulton, Scheffler and Hinshaw (2015) found in a study in the US that policies focusing on educational performance of low-income children positively influence the prevalence of ADHD diagnosis, whereas psychotropic medical laws are associated with fewer ADHD diagnosis. This indicates that differences in political and institutional contexts influence the spread of ADHD diagnosis.

Apart from the worries of the spread of ADHD as a diagnostic category, there is a growing concern on the legitimacy of providing children with drugs as a countermeasure to ADHD. The consumption rate of methylphenidate, sold as Ritalin and Concerta, has dramatically increased around the globe (Singh, 2008). These drugs have been marketed as a solution to problematic childhood behaviour and academic underachievement in the west for the past 40 to 50 years as indicated by picture 1, 2 and 3, displayed on the next page. Polanczyk et al. (2014) state that while ADHD diagnosis and treatment have increased throughout the past few decades, "There has been no evidence to suggest an increase in the number of children in the community who meet criteria for ADHD". One explanation they give for this discrepancy is that changes in diagnostic criteria, local policy and awareness of- and access to medical services may account for the increase in ADHD diagnosis. Another explanation they give states that: "pressure from pharmaceutical industries contributes to increasing rates of diagnosis and consequently of prescriptions for treatment of the disorders." (ibid. p.436). Also according to Peter Conrad, ADHD is currently going global due to the influence of the American psychiatric

profession and 'opportunistic drug companies' (Conrad, 2010, p.527). In the period 1993-2003 the global use of ADHD medication has risen threefold. This increase accounts for both developed and developing countries (Scheffler et al. 2007).

Hinshaw et al. (2011) conclude that social context greatly influences the perceptions and diagnosis of ADHD and that cultural stigma and belief systems influence choice of treatment options. According to Singh (2002, p.363), differences in the use of medication for ADHD "tell an important story about the extent to which the ADHD diagnosis and approaches to treatment are culture-bound phenomena".

Pictures 1, 2 & 3: Marketing ADD/ADHD medication. Respectively: 1971, 1987, 2005.

Globalisation and (bio)medicalization theory

The growing prevalence of mental disease and spread of associated medical categories in the last couple of decades have led social scientists to create an abundance of theory about this process. Central to this theory is the concept of medicalization. Medicalization is defined as: "the expansion of medical jurisdiction, authority and practices into new realms" (Clarke et al., 2003, p.161). Essentially this comes down to defining problems (previously perceived as non-medical) in medical terms and using medical interventions to treat the problem. According to Conrad (2005, p.11), medicalization is becoming an increasingly international phenomenon due to the expanding dominance of western medicine, which is caused by multinational drug companies and the global reach of mass media.

Conrad (ibid.) claims that previously medicalization was mainly fuelled by the power and authority of the medical profession (leading to medical colonisation); social movements and interest groups, and pharmaceutical innovation (related to insurance policy). Nowadays pharmaceutical and biotechnology industries have become dominant in the process of medicalization by promoting their wares to physician and the public.

Children's problems labelled as ADHD constitute a growing market and spending on behaviour drugs in the west is growing sky-high (Conrad, 2005, p.7). In addition, self-medicalization is said to become increasingly common, fuelled by the widespread availability of medical knowledge to the general public, via for example the internet. This is happening in line with the neoliberal shift from the patient to the consumer and changing relations between doctor and patient. Lastly, Conrad claims that 'managed care' plays a significant role in the process of medicalization by shaping what treatments are covered by insurance. Coverage for psychotherapy has been severely limited whereas coverage for psychiatric medications is more liberal. Rafalovich takes a more Foucauldian approach and claims that: "the medicalization of childhood and the rise of the disease entity of ADHD stems from the transformation of children and childhood into object of study." (Rafalovich, 2013, p.343).

While the process of medicalization has been going on for quite a while now, we are now said to have entered the age of bio-medicalization (Clarke et al. 2003; Rose 2003). With the introduction of state of the art knowledge from molecular biology, genomics and medical technology, medical jurisdiction has moved from illness, disease and injury to health itself (Clarke et al., 2003, p.162). According to Nicolas Rose (2003) the growth in knowledge from biotechnologies made us understand ourselves as "neurochemical selves". This entails a: "recoding of everyday affects and conducts in term of their neurochemistry (…) we have come to understand our minds and selves in term of our brains and bodies." (Rose, 2003, p.46).

According to Ethan Watters (2010) there is a worrisome rise in the globalisation of the knowledge that is developed in the process of (bio)medicalization in the West. Under the auspice of the DSM that claims to hold a shared language for mental illnesses worldwide, the American Psyche is colonizing the world, however:

> offering the latest Western mental health theories in an attempt to ameliorate the psychological stress caused by globalization is not a solution; it is part of the problem. By undermining both local beliefs about healing and culturally created conception of the self, we are speeding along the disorienting changes that are at the very heart of much of the world's mental illness. (Watters, 2010, p.253).

If what Watters claims is true, people worldwide will be influenced by the same process of (bio)medicalization, leading to what Timini (2010) calls a "Macdonaldization' of Children's mental health." However, the question remains to which extent 'western' medical concepts and modes of self-conception are replacing local modes of knowledge, being introduced alongside them, or are being adapted. In the field of cultural psychiatry, it is acknowledged that in practice "cultural worlds are open-systems, shaped by forces of migration, globalisation and hybridization." (Kirmayer, 2006, p.163). Different cultures, not bound to national boundaries, continually coincide and influence each other in a multidirectional and unpredictable manner. This process Kirmayer (ibid) calls

creolization. Instead of essentializing cultures and communities, Kirmayer advises us to view cultures as "distributed systems of meaning" that people can creatively use to create mixed and hybrid forms of culture and identity in a continuous manner (ibid, p.165). This means that while medical concepts are spreading across the world, these concepts gain particular meaning only in the local setting. It is therefore likely that ADHD has different meanings in different settings. Singh (2011, p.890) argues that "Children's behavioural development must be seen as fundamentally situated and relational process in which there is an on-going and mutual process of shaping and transformation between child actors and their immediate and proximal social and physical spaces." To make sense of the meaning of ADHD we therefore have to look for "ecological niches": macro and micro factors that influence the definition and categorization of problematic behaviour (Singh 2011; Singh 2012a). This concept has already been used in a couple of studies of ADHD in different contexts. Singh, (2012) found niches that were associated with national differences: in the US a performance niche was the modal niche environment, whereas in the UK it was a conduct niche. In a study conducted on ADHD discourse in the Netherlands Bröer & Heerings (2013) found a Spiritual niche. A study in Ghana suggests that ADHD might be a way of dealing with disrespect in the context of a gerontocratic society (Bröer et al. forthcoming).

Schools pose a fertile ground for ADHD diagnosis

According to Singh (2006, 2008) the modern school does more than provide basic educational skills. Schools have responsibilities to care for both the body and soul of the child and socialize children with cultural values and expectations. They have become both the instrument for shaping and monitoring the development of the child. In distinguishing between normal and deviant child behaviour, the school environment acts as a mediating mechanism to ADHD diagnosis. It follows that the cultural and institutional context in which the school operates influences both what is considered deviant behaviour and the degree to which it is medicalized. Malacrida (2004), claims that medicalization is often accomplished through the everyday work of non-medical personal, especially so in the case of ADHD. She mention that children are identified and assessed by teachers, special educators and school psychologists. It therefore seems valuable to study the work of school counsellors in India in relation to the implementation of ADHD. Malacrida interviewed mothers of ADD/ADHD children in Canada and the UK. In Canada where medicalization is high and little methods of social control are available to educators, they seem more willing to identity problems and press for medical treatment. In the UK where medicalization is less high and more alternative methods of social control are available, educators seem to act more like gatekeepers who refuse to label and are reluctant to push for medication (ibid.).

What little is known about ADHD in India

As indicated before, little study has been done on ADHD in India. Estimates of the prevalence of ADHD among the child population vary widely (Naik et al, 2016; Duggal et

al, 2014) and no epidemiological studies were found in which both the rural and urban population was included, making it hard to compare. The disease category of ADHD (in India) is said to be specifically linked to the school environment (David, 2013). Because of the stigma associated with psychiatric help and low levels of awareness of mental health conditions, a lot of disability issues remain undiagnosed. Neena David claims that therefor there is a need for: "ADHD identification and treatment from culturally sensitive paradigms". In her empirical study David found that the overwhelming majority of teachers do not have awareness of the term ADHD, and that they do not explain hyperactivity in students in accordance with to the biomedical model. Instead it is attributed to a "mixed set of volitional and age specific behaviour that deviated from classroom norms for behaviour". Some teachers frame ADHD as a positive trait and others saw it as a problem rising from the child specific context. Teachers found behaviour that impacted other students the most challenging and focused on the group as a whole to rate the severity of disturbing behaviour. They also expressed concern about behaviour that challenged their authority. As causes of ADHD-like behaviour teachers mentioned: parental disengagement, changes in family structure, inadequate consequences for their actions and a limited sense of appropriate versus inappropriate behaviour (David, 2013, p.10).

According to Wilcox et al. (2007) parents of children who receive an ADHD diagnosis in Goa are reluctant to accept the biomedical explanatory model or consider the child's difficulties as a disease. Instead they explain the difficulties with: psychological models, learning/memory difficulties or blame themselves or spouses. Going to the child development centre is seen as a last resort, after first trying educational or religious interventions.

A study on the prevalence of mental disorders and their correlates among adolescents in Goa, India by Pillai et al. (2008), showed that the prevalence of any DSM diagnosis was 1,82%. For ADHD it was 0,2%. Prevalence was higher in urban areas, for girls who face gender discrimination and lower for people whose family comprise their primary source of social support. The researchers found that in Goa mental disorders are associated with: "an outgoing 'non-traditional' lifestyle (frequent partying, going to the cinema, shopping for fun and having a boyfriend or girlfriend), difficulties with studies, lack of safety in the neighbourhood, a history of physical or verbal abuse and tobacco use." (ibid. p.45). Archana Simon (2016) claims that "early risk factors for Attention Deficit Hyperactivity Disorder among Indian children include poor maternal health, maternal stress and speech delay."

Appropriation: a conceptual framework

In order to analyse how the biomedical concept of ADHD is being incorporated into the Indian educational system and local modes of understanding I make use of Hahn's (2004) model of appropriation. This model can be used to understand the workings of

globalisation on local levels (Hahn, 2008, p.191), or more specifically, “how local cultural systems and biomedical technologies interact to shape understandings of disease categories” (Brijnath & Manderson, 2011, p.504).

Previous studies on the globalisation of medical categories are done using the concepts of hybridization or creolization (Kirmayer, 2006; Slagboom, 2014). While these concepts help explain cultural diversity without denying the reality of globalization, they paint a mechanical picture of local creativity and take for granted the questions as to whether people voluntarily agree to integrate something new and under which conditions global influences are adopted, transformed or rejected (Hahn, 2008, p,197). While to my knowledge this is the first study applying the concept of appropriation to ADHD, this concept was shown to be helpful in studies on dementia (Brijnath & Manderson, 2011) and depression (Lang & Jansen, 2013) in India. By applying Hahn’s theoretical model, I believe to be able to both create sensitivity for the agency of local actors and grasp the contextual factors that influence the process of appropriation, like stigma and educational policy and practice. Hahn’s model consists of four phases (described shortly below). These occur neither sequentially nor separately. However, in order to create a snapshot of the current state of appropriation of ADHD in Pune, these are used to structure the chapters. It shall become clear that the phases are intricately intertwined.

The first phase is material and/or **cultural appropriation** of an object or idea. What was formerly unknown becomes part of what already is, and people become familiar with it. This is the point of contact and acquisition. The second phase is **objectification** within established local discourse. “The new objects are categorized and, in the process, classified according to the same of similar categories and those used for known objects, or are demarcated from them.” (Hahn, 2004, p.220). An idea or concept gets classified according to categories (discourses) that are already known. These acts have the intention of transforming or redefining the appropriated cultural element. The third phase consists of the **incorporative actions** related to this new object or idea. How is an idea used? What role does it play in interaction and what are the consequences for the actors’ perception? The fourth and final phase is **transformation**, which redefines a concept according to the local context. Transformation leads to the creation of local traditions enclosing particular forms and specific ways of dealing with the appropriated element. When completed it “Indicates that an object is subject to locally defined, societal norms and restrictions, with all their consequences.” (Hahn, 2004, p.222).

Methodology

Research location

This study was conducted alongside a follow up study[1] of one previously conducted[2] in Pune, India. The site was chosen earlier based on a relatively high density of medical facilities and availability of psychiatrists, psychologists and paediatricians. Pune is part of the state of Maharashtra and is a densely populated city with over 3 million inhabitants including a child population of over three hundred thousand[3]. Pune has a strong history of social stratification tracing back to the Brahmin rulers of the Maratha kingdom before 1818. According to Bapat (forthcoming) some schools still require details about caste or sub caste upon admission of a child. The main languages are Marathi, English and Hindi. The city is known for it's booming IT industry, is considered as one of the wealthiest and safest cities in India, and is known for its educational facilities.

Respondents

One of the goals of this research was to map the role of the school environment in the appropriation of ADHD. In the urban areas in India there is a growing number of people that are trained as psychologists and work in the school environment in the position of school counsellor. Since it is the job of the school counsellor to intervene/mediate with children's' problems they make for a good point of focus. In order to get an impression of the school policy and context, principals were included in the study as well. For further contextual information, I interviewed a teacher at an institute for gifted children and a homeopathic doctor.

All respondents were informed about the research and informed consent and permission to make notes and/or recordings were done verbally. Based on Nienke Slagboom's previous research experience in Pune, no informed consent papers were developed because respondents found this a strange habit. This was checked with a local Pune researcher who confirmed it.

Data collection

The population of school counsellors were reached via the snowball method starting with existing contacts from previous research, the researchers personal network, and attendants of multiple drama-therapy workshops conducted by my fellow researcher. The research activities consisted of visiting schools and interviewing school counsellors, observing a work day of a school counsellor, and observing expressions regarding children in everyday live.

[1] A mixed method study using Q methodology in order to map the different of clinicians in Pune.
[2] The results of which can be read in: Slagboom, 2014
[3] With a girl/boy ratio of 9:10.

In total 20 respondents were interviewed: 14 school counsellors, 3 principals and 1 former principal, a researcher in child mental health, 1 teacher and 1 homeopathic doctor. The respondents worked in a total of 8 different schools. Since these were all private or funded-private schools they are not representative for all schools in Pune but do give an impression of the schools in which school counsellors are present. Most interviews where recorded, resulting in 17 hours of recordings. Additionally, a report was written on observations done following one of the respondents while working and about a hundred photos were taken in different settings. Additional literature that was not available from the Netherlands was collected, providing information on the educational system, visions of childhood in India and about children in the city of Pune. The interviews were transcribed verbatim and imported into Atlas.ti version 7, for data analysis.

Data Analysis

The transcripts were coded following the basis of Grounded theory (Charmaz & Smith 2003; Glaser & Strauss 1998), but focusing on themes relating to explanatory models for ADHD and incorporative actions. In moving back and forth between interview data, empirical literature and theory an iterative process was followed leading to the detection of dominant discourses and themes. A total of 326 codes were created that were grounded in 669 quotes. All codes were thematically divided under code families and related codes were merged into super codes. In order to distinguish the different discourses, explanatory models, labelling actions and roles of the school counsellors, network views were created in which the relations between the different codes, super codes and families were indicated. This helped to bring the analysis to a higher level and build a 'grounded' theory. Part of the coding was checked by- and discussed on two occasions with my supervisor, Christian Bröer. Ideas and preliminary theories were also discussed with co-researcher Nienke Slagboom.

Ethical challenges

To guarantee the anonymity of the respondents, their names, the names of the schools they worked at, and any other identifying markers were left out of the transcriptions. All documents containing names and contact detail of respondents were saved under password protection. On several occasions respondents asked which other schools were part of my research and how other counsellors coped with ADHD. I kept confidential which I schools I visited. After the interviews I did often continue discussing the subject of ADHD and medicalization, and spoke in general terms of what other counsellors told me and what I knew from literature. While this might have influenced the way some counsellors think of ADHD, I found it justified because they explicitly expressed uncertainty and the need to talk about the subject.

While most counselors were keen to safeguard matters of confidentiality, in one instance a supposed miscommunication led to an ethical dilemma. When I entered a

counseling center, thinking I had an interview appointment, I was asked to observe a couple of counseling sessions for which I had no permission from the parents of the children involved. During these sessions the counselors stressed the Indianness of their counseling techniques which I found intriguing, but also made me uncomfortable because it was clear that my presence was influencing the interaction between the counselors and the child. I asked the counselor to ignore me and go about her normal routine. During the session I only made methodological notes and the observations done were left out of the research.

Lastly, some ethical problems arose because people had very differing views of who I was, despite my clear introduction as a student and research assistant. I was at times mistaken as: a medical doctor, a ADHD specialist, a school principal and even a famous American actor.

Context of appropriation

Conditions and policy that shape how ADHD is adopted, transformed or rejected

Mental health care: shifting stigma and biomedical dominance

The first mental health facilities in India were set up under colonisation by the British rulers (Banerjee 2001). They first introduced western healing practices for soldiers who fought against the Indian princes and officers of the East India Company under the 1852's "Lunatics Removal Act". In the following 50 years a succession of similar laws were introduced that in essence served "to segregate those who were considered dangerous to the society by reasons of mental illness. Asylums were the places where insanes were kept for safe custody and not for proper treatment." (ibid.). The living conditions in these mental hospitals/prisons were gruesome. In reaction to public resentment during the turn of the 20th century, an attempt was made to bring the Indian situation more in line with modern British law. This resulted in the Indian Lunacy Act of 1912. Under this law, mental hospitals left the grip of the Inspector General of prisons and the role of specialists (psychiatrists) in the treatment of patients was recognized. However, as a successor of previous laws the Indian Lunacy Act was still focused on detention and not treatment. The conditions in the mental hospitals therefor kept deteriorating until almost the end of the 20th century. At the end of the 50's an unsuccessful attempt was made to amend the 1912 act. However, from the 60's onward knowledge and understanding of mental diseases increased and society's attitude towards the mentally ill changed, leading to a call for better treatment of the mentally ill.

Years later, while struggling with the lack of legitimacy and credibility of the colonial psychiatry (Jain & Jadhav 2008), this resulted in the Mental Health Act, which came into force only in 1993 with local implementation being delayed and imperfect in many parts of the country (ibid). In line with this act, the Indian government launched the National Mental Health Program (NMHP) to "lower the burden of mental illness in the community" and to deal with the "absolute inadequacy of mental health care infrastructure in the country" (website of Nation Institute of Health and Family Welfare India). Under the NMHP the District Mental Health Program (DMHP) was launched in 1996 in order to: (a), train general physicians for diagnosis and treatment of common mental illnesses and train health workers in identifying mentally ill persons; (b), increase awareness & reduce stigma related to mental health problems; (c), provide service for early detection & treatment of mental illness in the community; (d), provide valuable data & experience at the level of community. In 2008 the Government of India further decided to add to the DMHP that: "Life skills education & counselling in schools, College counselling services, Work place stress management and suicide prevention services should be provided" (DMHP).

The history of mental health care in India brought forth a strong stigmatization of mental illnesses. It seems however that policy wise, India in currently in the process of making a shift regarding mental health as indicated by Patel and Copeland (2011, p.407):

> This is a unique moment in our history when there appears to be both political will and financial resources to support a range of actions to improve access to mental health care and promote human rights of persons affected by mental illness. Such an opportunity for a radical transformation comes once in a generation, if at all.

By developing policy such as the NMHP and DMHP India is considered a pioneer among low-income countries. According to Jain & Jadhav (2008, p.562) there are however major problems with implementation since they are "incongruent with local experiences of suffering", indicating a further needs for culturally sensitive research relating to mental health. Furthermore, there is often a gap between the clinical mental health professionals and the everyday experience of local (rural) communities, who often link misfortune to cosmologies or supernatural agents (ibid). While in the 60's and the 70's effort where made to integrate Indian cultural traditions such as Ayurveda into mental health, thereafter mental health services became dominated by international forces and mainly the World Health Organisation (WHO).

Whereas India previously was known for its indigenous medical practices, today the pharmaceutical industry is claimed to form a key component to the health care industry (Banerjee et al., 2014, p.54). In the 70's and 80's the WHO, Unicef and the Indian government made a joint effort to set up local pharmaceutical research institutes which led to unprecedented growth of local of domestic medicine makers. India has now become a major player in the global market of medication. Banerjee et al (Ibid.), further claim that in order to keep up with their multinational counterparts, Indian companies have joint the trend of pharmaceuticalization and commodification of health services. As a result the main focus is no longer on development and enhance of medication, but on market penetration. Given the growing access to education in India, and the overrepresentation of school-aged children among the population, a huge market for ADHD medication seems to be there for the taking.

The pathway to privatized and segmented education

As a first step to understand the appropriation of ADHD in the educational environment in Pune, it is important to have a closer look at the educational system itself, the development of which was very much path dependent. Due to the historical processes described below, India hosts a highly segmented, privatized and competitive schooling system. The educational policy that is being introduced marks a shift towards inclusive education and recognition of mental health care for children. This institutional context creates the niche in which ADHD is appropriated in Pune, India.

Under colonisation the Indian educational system, which at the time supposedly compared favourably to that of the British, was "crippled" (Anandalakshmy, 2010, p.23). While the British conceived higher education as a means to consolidate their economic, political and administrative interests (Agarwal 2007), it was not in their interest to support widespread schooling. Because they did not impose democracy, it would not benefit from an educated electorate and "an educated populace was only more likely to demand self-government and threaten the stability of colonial rule." (Chaudhary 2007a, p.26). Instead, elitist schools were set up for only part of the highest caste and class with the goal to create a new type of Indian that acted in the interest of the Crown:

> We must at present do our best to form a class who may be interpreters between us and the millions whom we govern, a class of persons Indian in blood and colour, but English in tastes, in opinions, in morals and in intellect. To that class we may leave it to refine the vernacular dialects of the country, to enrich those dialects with terms of science borrowed from the Western nomenclature, and to render them by degrees fit vehicles for conveying knowledge to the great mass of the population. (Macaulay, 1835).

It was expected that English educated upper class Indians would in turn provide the lower classes with basic education but this expectation was not met. Education was implemented in a decentralized manner without taking into account the initial condition of Indian society, where many social groups were competing over the limited resources that the British Crown provided. The high caste elites that dominated local expenditure preferred to invest in local infrastructure over schooling and thwarted development of education for the masses (Chaudhary, 2007b, pp.501-503). Also, the straightforward introduction of "western knowledge" though education into India was problematized by the "plural and esoteric nature of indigenous knowledges", that caused the "western" knowledge system to materialize in different manners across time and space (Anand, 2008). Overall literacy remained low with large differences between social groups. Chaudhary speculates that the disparity that is present even in the present day has roots in "inadequate development of mass primary education during colonial times" (Chaudhary, 2007b, p.502).

Upon gaining independence, the Indian government inherited a poorly funded educational system with large local differences (Chaudhary & Garg, 2015). In the decades that followed the expenditure on education increased. This was first focused primarily on secondary education. In 1968 the National Education Policy called for further increase of expenditure (to 6% of GNP) and shifted attention to primary education. In the 60's and 70's the government began to actively set up colleges and universities and took over the financial responsibility of pre-existing private institutions. With the introduction of this public funding these schools lost part of their autonomy, which is claimed to have led to a decline in the standards of education (Agarwal 2007, p.199). In the 80's growth

of business and industry brought forth a sudden rise in demand for (higher) education. The government had a hard time meeting this demand because of financial constraints and did not take additional responsibility. In line with a growth of a middle class that could afford high educational fees, private education became a “viable enterprise (Ibid.) and private schools thrived. Until the 90’s these private institutions were affiliated to government universities and regulations. However, they felt that this affiliation was: “holding back their growth; they were not allowed to fully exploit their market potential.”, and they persuaded state governments to allow new fully autonomous private institutions. This has led to a unprecedented proliferation of private educational institutions that exist until the present day.

Education in India

Schools in India can nowadays be divided according to the authority under which they are run and financed (Bapat, forthcoming). Firstly, there are government run or public schools, which are financed by the Central government or by local bodies. Secondly there are privately aided schools, which are run privately but are subsidized with government sources. Lastly there are private unaided schools, which run independently from the government. In addition to these schools, there is a rise in “low fee private schools”. These are schools that provide low quality English education to the lower classes for a relatively low fee as compared to regular private schools. Often these schools are not accredited.

The schools in India, and in Pune follow different syllabi that are affiliated to governing boards of education. The boards that were mainly encountered in this study are the ‘Central Board of Secondary Education’ (CBSE), and ‘Indian Certificate of Secondary Education’ (ICSE) that fall under the central syllabus. Furthermore, International schools were included that follow the International Baccalaureate program (IB). Apart from these boards there are schools in Pune that follow: Maharashtra State Board (state syllabus); National Institute of Open schooling; and there are some religious and linguistic minority schools. The state syllabus is relatively easy as compared to the central syllabus. The state syllabus is followed predominantly by government schools whereas the central syllabus is adopted more by private schools (Kapur, 2008, p.172).

Malavika Kapur studied the effects of different kind of schooling systems in India on the academic achievement of students and the prevalence of learning difficulties. She concludes that poor functioning of schools has significant influence on the skill acquisition among children and therefore “Academic Skill Deficit profiles”, that are used to indicate learning disability, relate to deficiencies in the school system (ibid, 178). Furthermore, she concludes that: “The central syllabus in India evidently over burdens the children. If the basic skills at the first level are not achieved by a majority of children, they are likely to be more vulnerable for acquiring more deficits in higher classes.”

According to Bapat (forthcoming), teaching methods in most schools does not promote critical thinking but relies wholly on rote learning. Respondents mentioned that teaching is very much geared towards preparation for standardised tests. This is confirmed by Anandalakshmy (2010, p.25), who claims that: “children seem not to be central to schooling or educational planning. It is the examination that dominates and determines everything that comes before it”.

During this study it was found that many parents who can afford it, put their child up for “tuitions” after school in order to make up for inadequate teaching at school and enhance their academic performance (Bapat, forthcoming). This practice is considered problematic because it causes a performance gap between children from different backgrounds. Parents from a lower socio-economical background often have lower education and can do little to support their children academically, neither can they afford tuitions. This is further fuelled by the perceived importance and dominance of English education.

Figures from the National Achievement Survey (2014) show that “Performance of students of Maharashtra [province] is significantly above the national average”, and an overrepresentation of top scoring students (above 75%). Keeping in mind the high level of the syllabus that is followed in private schools, plus the importance attached to test results, it follows that the parents who can afford it make their children follow tuitions in order to keep up. It is interesting to note here that a causal relationship is implied between the school system and vulnerability toward deficits, which in turn could be interpreted as part of a disability.

Educational policy: towards inclusion and identification of the ‘disabled’

There are two laws that have been recently introduced in India that are of particular relevance for this research and that influence the work of the school counsellor. The envisaged effects of these laws are a growing awareness and identification of mental health problems or disability in children, better care and educational chances, and reduced stigma.

India has a long history of rigid class relations and social reproduction because of the former caste system. While this system is officially banned, it still leaves its mark. In order to reduce class differences, and thereby reduce poverty, policy was made. In 2009 the Right of Children to Free and Compulsory Education (RTE) act was inserted in the constitution of India (Government of India, 2016) claiming free and compulsory elementary education for all children in the age group of six to fourteen years as a fundamental right. Under this act all schools are required to reserve 25% of the their seats to children from lower socio-economic class. Furthermore, the RTE Act states that

a child suffering from disability, as defined in the Persons with Disabilities Act 1996, shall have the right to pursue free and compulsory elementary education. Chapter 4 on education in the Persons with Disabilities Act (1996) dictates that local authorities shall endeavour to promote the integration of children with disabilities in normal schools (integrated schools) and these children have right to free special equipment needed for their education. Furthermore, it states that curriculum should be restructured for the benefit of children with disabilities and that suitable examination systems should be sought. (Right to education act, 2009, ch.4.).

In 2014 a bill concerning an updated replacement of the Persons with Disabilities of 1996 was introduced that is still waiting to be passed (PRS legislative research, 2016). The most relevant points of which are to:

- provide necessary support individualised or otherwise in environments that maximise academic and social development consistent with the goal of full inclusion
- detect specific learning disabilities in children at the earliest and take suitable pedagogical and other measures to overcome them
- to conduct survey of school going children for identifying children with disabilities, ascertaining their special needs and the extent to which these are being met;
- to make suitable modifications in the curriculum and examination system to meet the needs of students with disabilities such as extra time for completion of examination paper, facility of scribe or amanuensis, exemption from second and third language courses

In 2013 Montague et al. published a paper on the expected impact of DSM-5 changes on LD and ADHD. In this paper Sunil Karande wrote the chapter on India (ibib., pp.62-63). She claimed that as of that moment ADHD was not recognized as a disability by the national government of India nor by the state governments, but that the proposed changes would “empower professionals and advocacy groups in their negotiations with the national government of India and state governments to recognize ADHD as a disability category. Under the RTE act adequate funds should become available to train teachers to provide interventions in the classroom and to provide free medication. Lastly, it was predicted that change in the age of identification of ADHD would result in more children being diagnosed (ibid.) Note again that there seems to be a connection between policy, the prevalence of ADHD diagnosis and the way it is treated.

While the pending bill concerning the Persons with disabilities does not literally mention ADHD as a disability, the definition of disability is broadened from 7 to 19 conditions, now including learning disability. During the fieldwork in spring 2016, respondents noted that ADHD was already recognised as a disability under the CSBE and ICSE indicating a further shift in policy. In order to illustrate the possible impact of this policy

change on the prevalence of ADHD diagnosis we will now look at the concession policy under the CBSE.

The CBSE enables "differently abled students" to make use of certain concessions such as extra time, different study/exam material, a reader or a prompter when it comes to the board exam that students do in the 9th and 10th grade. These exams are considered extremely important since they determine access to higher education. Therefore these concessions are deemed valuable. In order to make use of these concessions, permission must be sought from the CBSE. To do so the school head must send a recommendation letter accompanied by a medial (disability) certificate (CBSE, 2016). As prescribed in the Persons with Disabilities act of 1996, this certificate should be issued by a hospital controlled by the Central or State government and, linked to the type of disability, has a limited period of validity. Thus, the right to concessions is explicitly linked to an official diagnosis. Awareness of the concessions that are linked to certain disabilities, is being promoted by means of circulars that are send to the heads of all the schools that are affiliated with the CBSE.

The introduction of inclusive education, which originally aimed to break the chain of class reproduction, is widening its focus to inclusion of children with disabilities. This shift in policy creates a space in which mental health problems in children can be recognized, acknowledged and categorized. The recent introduction of ADHD as a disability category is a perquisite to medicalization of ADHD-like-behaviour. Seeing that the institutionalisation of ADHD under the disability category brings with it educational advantages, and previous research shows how introduction of such policy led to an increase of ADHD prevalence (Hinshaw & Scheffler, 2014), this can be expected to positively influence the amount of referrals for ADHD assessment/diagnosis.

Struggling for admission

With the introduction of the RTE act came strict guidelines for schools regarding the admission of students. It clearly states that: "No school or person shall, while admitting a child, collect any *capitation fee* and subject the child or his or her parents or guardian to any *screening procedure*", and that: "no child admitted shall be declared failed/held back in any class or *expelled from school* till the completion of elementary education in a school" (RTE, 2009, p.6, italics added). While under the RTE every child has the right to enter any school without screening or additional payment, the reality is different. Partly because of the reserved seats under the RTE, and presumably because of the growth of the middle class, there is a shortage of seats in (primary) schools in Pune. During this research I got the impression that some of the respondents were hesitant to speak about the reality of the admission procedure in their schools. They did however give some hints concerning discrepancies between official policy and practice:

> Counsellor: Actually we don't take any interview with the children because it is not allowed here.
>
> Jonathan: Generally?
>
> Counsellor: yes. In this school also, but it is a government rule that we cannot interview any child. Every child has the right to enter any school and then this is the way we usually work. But if we see the child has special needs, then definitely we do counselling to the parents and we request them, we do little testing were the child is lacking, so if we feel that the child needs to go to some different school, then we definitely suggest. But it depends upon the parents whether they want to continue with us or they want to take the child there.

This indicates that at least some screening takes place in order to identify children with special needs. According to another respondent: "Maharashtra gives a boost to inclusive education but still not all the schools allow children with special needs.". This filtering process seems to be fuelled further by the way in which schools profile themselves and request application of 'normal' children[4]. While this practice comes close to violating to RTE admission policy, not all parents are aware of their children's' rights (Manju, 2015). The parents' difficulty of to get children admitted feeds into a very hierarchical relationship between those working in the school and the parents, where the power lies with the school: "teachers and principal are close to like, you know [gestures praying], you obey. So, obeying is a thing and you don't ask questions.". This is especially the case with lower-middle and middle class schools. It was mentioned at several occasions that parents were reluctant to have their child referred for assessment or to accept labelling because they feared their child would be expelled or not accepted at other (future) schools. Another aspect of the RTE policy that can be different in reality concerns the matter of the capitation fee. It seems that while it is forbidden, this custom is still practiced in some of Pune's schools, thereby further enhancing the power of the school and suppressing social deviancy.

The shortage of seats in Pune's schools and persistent selection procedure instil a fear in parents of having their children labelled as abnormal. While the selection procedures that underlie this fear are certainly not present at all schools, the fear seems to live more generally. Even parents from children in schools that follow a strictly inclusive educational policy expressed their fear to label the child and refused to cooperate in referral procedures suggested by the school. This seems to have a negative effect on the amount of children that are referred to be tested for LD, ADHD and other disabilities, as cause of which the needs of some children suffering from a condition can remain unmet.

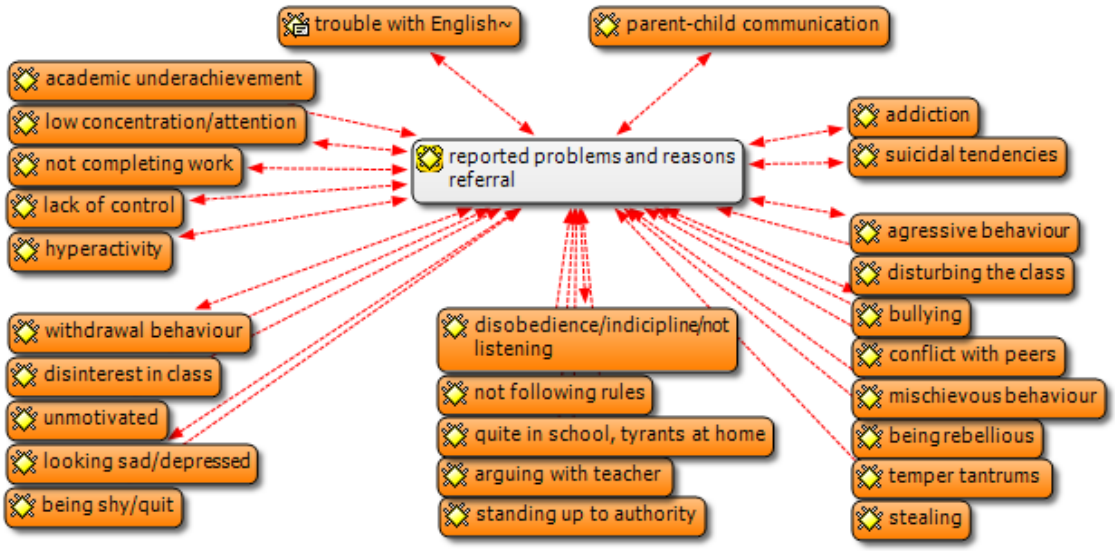
[4] How this translates into practise should be subject of further research.

Job and function of the school counsellor

School counsellors in India are a relatively new phenomenon. Only female school counsellors where encountered in this research, which according to respondents was no coincidence. Only a small portion of the schools has school counsellors and they are mostly to be found in a handful of private or semi-private schools in the urban area. However under the RTE, as part of the shift towards inclusive education, funds have become available for the training of educational staff and appointment of school counsellors. Therefore it can be expected that the amount of school counsellors and their role in the educational system will grow.

Generally speaking the school counsellors in this research mentioned that they watch over the children's' wellbeing: the social and emotional development of the children and their functioning within the school/classroom setting. They work on both prevention and problem resolution. There are differences in how schools counsellors approach problems, in for example student-teacher conflicts, which seem to relate to the different school systems in which they work. On one side of the spectrum there is a counsellor who said to always side with the children, whereas on the other side of the spectrum a counsellor feels forced to work in the interest of the institution and calls herself "an institutional goon".

Children are referred to school counsellors by teachers, parents and some children come on their own initiative. Furthermore many school counsellors mentioned that they monitor children on the playground and observe them in class. The problems that they observe in children and the reasons because of which they are referred are various. The ones mentioned in this research are shown in the following figure:



According to Karande (2005), children with ADHD are almost conclusively referred for clinical assessment when their academic achievement suffers. In this research the most

often mentioned reason for referral to the school counsellor was academic underachievement. ADHD diagnosis in India can only officially be made by clinical psychologists, psychiatrists or paediatricians. Within the schools where school counsellors are present, they are the first point of referral and they therefore play an important role ADHD's pathway to care. In order to refer a child for clinical assessment, the consent of the parents is needed. Whether a child is referred therefore depends on both the attitude of the counsellor and the parents, and the interaction between them. The school counsellors play a mediating role between the child and his/her parents, and other professionals that they work with. School counsellors refer children, or provide parents with information they need to refer their child themselves.

Tension between professional and lay knowledge

The concept of ADHD is beginning to become part of the everyday language of the urban middle and upper class. According to counsellors a problem is that while people, including teachers, know of the names of ADHD and comparable concepts, they are not aware of what they constitute. People are said to use them very liberally and are labelling any energetic child as ADHD. One school counsellor explains that because ADHD has become such a lingo it is literally being used "for anybody and everybody", while people "don't understand the seriousness of what ADHD can be.". This is supposedly fuelled by people becoming "Google doctors"; finding their own information online and making (faulty) diagnosis. The lay conception of the term seemingly differs from the clinical-professional conception. This marks a tension between different kinds of knowledge and regarding the questions: who can use the term and when it is legitimate to do so? A principal and sociologist explains the predicament behind it:

> Labels should be used in a clinical context by professionals. … Because we understand as professionals that there is a clinical interpretation of these labels. But a commoner will not have a clinical interpretation of the label. He would say, that person is very lazy or very dumb. So those interpretations are what is debilitating. So label is very import but it has to be a clinical context and a profession context to use it.

Childhood difficulties reframed as clinical reality

For the last 10-20 years, ADHD as a biomedical technique has been entering the fields of medicine and education in India, mainly through education of professionals. The Indian medical system consists of both a clinical medical realm and that of 'alternative' medicine. During this research is was mentioned by respondents that ADHD is part of the education of both clinical- and Ayurveda/homeopathy doctors whose fields of knowledge overlap. School counsellors are mostly educated in psychology and all know of ADHD. Because of growing attention in the media the term was also found to be slowly becoming part of the vocabulary of the urban middle class. The introduction of ADHD makes possible a reframing of problematic childhood behaviours as a clinical problem and to transform signs of distress into symptoms of biological pathology. As a result, children who were previously seen to display bad behaviour and punished as a consequence, are transformed to children who bare a burden of disease and are in need of clinical intervention. This seems to be changing patterns of social interaction in the school environment and exemplified by a school counsellor:

> I would say that in India people have probably started using it last 15 years or so. I would say 15 or 20 years, that when people started using it. Before that, if I think of when my parents are in school or any of that, it was just bad behaviour…. back in the times when ADHD was unknown in India, these kids were probably be made to stand outside of class or in schools were they did beat children, they were probably the kids who beaten every other day or given punishment of something every other day. … We were probably calling it something else. And then when it came, when people in India found out about it. That's when they started using the term, and then attributing certain behaviours to it.

Just as this happened with the introduction of MRI technology described by Brynath and Manderson (2011, p.508) this translation work re-organizes lay and expert categories of knowledge, favouring "biomedical categories over common-sense understanding" of childhood behaviour. Since no single laboratory test can determine whether someone has ADHD or not, behavioural symptoms (that are difficult to distinguish from normal childhood behaviour) have to be clinically assessed (Singh, 2008b, p.960) and interpreted. Only professionals with specialized training can diagnose ADHD using standardized techniques to distinguish the pathological from the normal.

In the school environment the introduction of ADHD flows largely through school counsellors. They are seen to negotiate a new way of understanding ADHD by using both clinical and social explanatory models. The concept of ADHD is embedded in what Brynath and Manderson (2011) name as a biosocial explanatory model. Within this model certain suffering is understood as mental illness with somatic causes. Causation is sought in the body, brain, cells and neurons as illustrated by a school counsellor:

> ADHD is not something you get. It is something that is. The basis of course is, like I said, neurological. I might not know the exact words for it, but we are talking about neurological connexions in the brain which make it difficult for the child, which has an effect on attending, … the part of the brain that is responsible for impulse control [is] a little inhibited.

School counsellors appropriate the language of neurology in both their personal understanding and in communication with parents. They strongly link ADHD to the biosocial mode of understanding and place ADHD in the physiology of the child. To be more specific, they link problematic childhood behaviour to an interplay between A): genes, brain and neurology, and B): inheritance, pregnancy, and chemical imbalance. When asked about the aetiology of ADHD, some remarks point to genetic inheritance or to the mother's behaviour during pregnancy. It is said that nowadays more women drink alcohol and smoke during pregnancy and that 'substance abuse' is related to development of ADHD. Even the birth is perceived to hold a relation to ADHD as one respondent explains a caesarean section might be one of the causes. Another explanation of ADHD focuses on the chemical structure of the child's brain where chemical imbalance in seen to cause involuntary (impulsive/hyperactive) behaviour in children that needs to be fixed with external help by for example, medication. Lastly ADHD is linked to metabolism and causation is sought in changing feeding patterns and additives, or consumption of packaged foods (in contrast to 'natural' or 'homemade' foods). This leads to the conclusion that ADHD is not something that you are born with, but something that you can get. When talking about their explanatory models of ADHD, school counsellors often refer to what they have read in scientific articles or learned during their education.

One school counsellor claimed that in India it is believed that when the child is in the womb, knowledge and characteristics can be imparted to it, and this leads women to feel they are to blame for their child's ADHD:

> A lot of doctors say that if a mother has been not in a positive state of mind during pregnancy, those are the children that would have attention issues. So that's when the mothers start feeling, 'Ok, have I caused the ADHD?'.

While the biosocial conception of ADHD is seen to be largely appropriated, this explanation seems to hold an almost spiritual element by referring to transference of state of mind. This indicates the first of the subtle ways in which biomedicine not only shapes local conception, practices and institutions on the local level, but itself is shaped accordingly.

As can be seen in the previous chapter, by means of the guidelines for inclusive education and concessions policy a biomedical conception of ADHD is becoming institutionalised within the educational setting. The appropriation of the concept causes

a transformation in the way problematic childhood behaviour is perceived and places it in a biomedical mode of understanding. However, this does not rule out social and psychological explanations, which are often used simultaneously. ADHD is perceived as a clinical reality but, mostly so, in cases of severe ADHD. For less severe cases many counsellors seem wary to use the clinical definition or even speak of misuse of the term. While it seems to be commonly accepted that ADHD is a somatic condition, the question of aetiology remains unclear. When asked about this, many counsellors say they do not know or do not know for sure. Except for severe cases, how one gets ADHD and what explains the rise of ADHD is often explained from a socio-cultural or socio-environmental perspective. These bring forth the local modes of understanding according to which ADHD becomes adapted and objectified.

Embedding ADHD into 'Indian' modernity

When an idea or concept gets introduced, it gets classified as belonging to one or more categories that are already known (Hahn, 2004; 2007). Upon introduction in Pune, the concept of ADHD was embedded in the historical context, socio-political/economic structure and local cultures. School counsellors categorize and merge ADHD into existing frameworks of understanding and objectify it by adapting it in accordance with ideas on modernisation, erosion of family function and motherhood, and ideas on stigmatisation.

While many school counsellors believe that ADHD has a biomedical base, often, explanatory models are used stressing the importance of environmental and psychosocial factors. Central to this is the idea that the fabric of Indian society is changing. There is talk of modernisation, globalisation, and westernisation leading to the introduction of new technologies, lifestyles, and family structures, all of which are seen to relate to (ADHD-like) problems in children. By linking the aetiology of ADHD to socio-environmental changes and placing it in the cultural ideas of stigma, school counsellors 'fit' the biomedical category of ADHD in the local context. An in depth description of how school counsellors merge ADHD with 'local' processes and modes of understanding follow below. There seems to be fuzziness in the way school counsellors interpret and classify ADHD. Not only are there differences between school counsellors, but individual counsellors give a variety of explanations and draw reflexively from different models to create their own professional standpoint.

Technology causes ADHD

Firstly, ADHD is seen to be objectified by relating it to ideas on the effect of technology on the everyday lives of children. A much heard explanation for ADHD and ADHD-like-behaviour in modern day children is the rise of media exposure. The gist is that these children are constantly overburdened with impressions, which is negatively affecting their psychological wellbeing and leading to hyperactivity. Related is the introduction of mobile technology, which according to an older principal, is giving rise to a new type of children she calls "the screen age children". The preoccupation of children with media technology and gaming (sometimes seen as addiction) is believed to cause a lack of concentration, affect sleeping patterns and health, which ultimately comes down to the child not performing in school, at the moment of which the child ends up with the school counsellor. It seems indeed that in Pune mobile technology and access to the internet are entering many facets of your children's' lives in Pune, as displayed on the pictures four and five on the next page.

Picture 4: (left): Wi-Fi on the cricket field.
Picture 5: mobile technology in preschool.

ADHD as the downfall of the Indian family function

Secondly, ADHD is seen to be objectified by relating it to ideas on societal change, parenting, family structure and -function. According to my informants, India traditionally had an extended family setup, but a shift is being observed towards a nuclear family structure. It is said that in the extended family setup parents gradually leaned parenting under guidance of the grandparents[5]. Is it mentioned by multiple counsellors that in the nuclear family structure parenting is being "pushed" onto parents in a context where they have to combine the responsibility of parenting with the "churn of everyday life". Due to the "rapid paced development in the industry sector in the recent past", Pune is now known as an "employment hub" and the percentage of working women is rising (Vasagadekar, 2014). It was found ADHD is linked to idea's on working parents, parental responsibility and motherhood, and objectified as such. The explanation is that when both parents work, they have no time for the child, leaving the child's relational needs unmet as exemplified by a counsellor: "so no bonding, no communication among them. The child is left alone at home. The child is disturbed so then all the anger, attention seeking, all of that, we see here [in school]". ADHD-like-behaviour is explained as the frustration that the child suffers at home which is replicated in the school environment.

Access to healthcare in urban areas has increased and wage structures are improved. Because of this parents no longer have many children in order to increase the family labour force, but opt for a small family in their hopes and plans for upward mobility (Anandalaskshmy, 2010, p.13). In extended families, children were being brought up together, and it is said that if one child was a little more troublesome, this would not become an issue. However now that some children are being raised in isolation, and some parents have only one child, all attention is directed at that child. More than once it is mentioned that the lack of time for, or singular focus on, the child leads to a very restrictive home environment that triggers or fuels ADHD-like-behaviour because the

[5] It is claimed by one of the counsellors that ADHD children are getting diagnosed faster because the parents don't know what to do with them and have a tough time handling them.

child has no place to play and builds up excess energy. This energy is said by the principal of a funded private school to come out in the school environment because of the more relaxed environment. In contrast, while a counsellor in another school recognized the restrictive home environment as conducive to ADHD-like-behaviour, she mentions that in her schools upmost discipline is expected and is further fuelling this behaviour.

> Even in classroom setup the expectation is utmost discipline, like, not a word, be quiet, I am teaching. The more strict the environment gets, the more we see these children exhibiting these symptoms, the more they seem to want to open up.

According to Anandalaskshmy (ibid.), globalisation and the IT boom cause parents to look at the child's education as a mean of future affluence, and in the process lose touch with traditional 'Indian' values. In accordance it was claimed by one of the older principals that in the urban areas there is a change in social norms due to: "too much exposure to the West". This is perceived by several respondents to lead to marriage problems, divorce and second marriages. ADHD-like-behaviour in children is framed as a reflection of these 'problems' in the home environment and thus objectified according to local values and ideas on marriage and family live.

The changes that come about under modernisation are not only framed as cause of ADHD but are also related to the way problems are dealt with. In one case lifestyle was said to influences the inability to cope with problematic behaviour:

> Right, so if I have a diagnoses of ADHD then my lifestyle has a huge role to play in how am I managing my ADHD versus how am I perpetuating it or aggravating my symptoms. I know that with globalisation, with technology with all of that, lifestyles are changing in India, a lot, drastically. ... the fabric of the society is still evolving in many ways. And there is a lot of western influence definitely in both senses. So lifestyle is also changing it is also getting westernised in many contexts. … And I know that when that changes of course it also has an effect on, you know, how I am managing my difficulties.

This focus on Indian versus western lifestyles seems to imply that social problems are inherent to life and that what matters is how you cope with it. ADHD thus becomes objectified according to a culturally bound conception of life style and transformed into something you can (and have to) learn to live with.

When ADHD is embedded in relation to the changing social environment of the child, attributed to external factors, it is placed in a web of meaning building on social psychological or even sociological notions. Whereas urbanisation and technological advancement pose a pretty neutral explanation of ADHD (no single individual is responsible), the part of that relates to parental responsibility does not. While the position of the parents, their struggles and failures can be seen as the result of societal changes, the responsibility for the child remains with them: "In our country, if

something's not right with the child, the first thing you'd say: 'What are your parents teaching you? What have your parents taught you?". By embedding ADHD or ADHD-like-behaviour in accordance with local family values, it becomes objectified as something that holds a connotation of blame towards the parents.

Stigma and prestige as a barrier or bridge for ADHD diagnosis and treatment

Lastly, school counsellors are objectifying ADHD by embedding it into local ideas on stigmatisation of mental health categories and care, and family prestige. As described before, mental health in India has a history of stigmatization. Respondents claim that this stigma prevails and strongly influences parents' willingness to accept mental health care, as exemplified by a school counsellor:

> Parents don't want, because you know, we are compared here as how good we are, …, so it is family pressure you could say. So if it runs in our family it's a shame. It's not supposed to be like that you know, what he has to feel when he goes to psychiatrist or counsellors, we have some problems that it is still there in their minds, that means that child is mad. Then if a child is going to a counsellor, it is a family problem, it's a shame to the family. So parents don't want to accept it. "ok my child whatever it is you punish him, do whatever", but we'll not accept this. So families definitively have their values attached to it, so if the child has some needs, they are not comfortable with it. And the community also, if the child is seen as mad, is the child is labelled outside also, though my child is so beautiful or my child cute and plays around and has many friends, but then you'd see he has problems, it might stop EVERYTHING, and the prestige issue, this might happen.

The meaning of the child to the family is described in relation to notions of class mobility, social prestige and family status. The child is seen as representative of the family. Because of this any deviancy from 'normal' childhood development is considered highly problematic. Indian classic literature depicts the child not only as a bliss for the parents but as a source of joy for the entire family and community (Gopal, 2010). None of the classical texts however make any notion of children failing to function normally (Anandalaskshmy, 2010, p.12). The silence surrounding children's' problems or deviancy seems to reverberate into the present reality. School counsellors claim that parents hide their children's' difficulties from their social environment, because they are protecting themselves or their child as being seen as flawed, or being criticized. One school counsellor told that some of the teachers in her school do not accept ADHD to be real, and react on ADHD-like-behaviour with punishment. As a consequence of lack of awareness- or acceptance of ADHD as a clinical reality, children who display ADHD-like-behaviour can be seen as "bad", "naughty" or "mischievous", leading to social exclusion and worsened "self-concept" of the child. The perceived reluctance of teachers and parents to appropriate the concept of ADHD causes a tension between them and the school counsellors who do accept the concept and creates the starting point for the negotiation described in the next chapter.

Since ADHD-like-behaviour is often explained in relation to parental shortcomings. If a child is acting abnormally or his academic achievements are low, the parents or the teacher are easily blamed. However by steering the acceptance and objectification of ADHD towards a biomedical framework the label of ADHD can be used to divert blame from the different parties involved which is said to be liberating the child. By objectifying ADHD in accordance with ideas of the child as prestige to the family and framing it as a means to achieve academic potential, its use can be legitimized. The tension between the desire for a normal child caused by stigma, and the desire for extraordinary academic performance seems to shape the different ways in which parents reject or appropriate ADHD in Pune.

It was mentioned by several school counsellors that slowly the social stigma surrounding mental health is becoming less. This was illustrated by supermodel and Bollywood actress, Deepika Padukone. In 2015 she publicly revealed to be suffering from depression (Hindustan times, 2015) and has been advocating acceptance and treatment. One of the counsellors claims that while not much advocating is being done by actors about ADHD, it is something that is talked about more. This seems to be partly due increasing media exposure and growing acceptance of the field of psychology. Meanwhile, the awareness of ADHD in the school environment is said to be boosted by means of conferences and travelling NGO's who sensitize teacher about the prevalence of ADHD.

The variety of explanations and in which ADHD is embedded creates the space in which school counsellors reflexively give meaning to ADHD and work with it. The various actors who are involved in their work have different conceptions of the ADHD and different concerns relating to it. Because of this, the interaction between them becomes a struggle or negotiation over knowledge and language that is embedded in ideas about stigmatisation, parental responsibility and family prestige. The result of this struggle determines if, on an individual basis, children get referred or diagnosed, but at the same time adds to the consolidation of a specific localized meaning of ADHD. It is in this struggle that the school counsellors make their mark on the introduction of ADHD in the context of Indian education.

Incorporative actions, how ADHD is used

According to Watters (2010) a single definition of the mental illnesses is seen to enter and dominate the minds of people worldwide. In this study however it was found that while clinical categories where mostly accepted to true, when and how the use of the concept was valid is contested and carefully weighed in accordance with local needs and values. Partly, school counsellors' actions lead to bio-medicalization but they are also seen pragmatically medicalize or demedicalize. While their actions are structured by social policy and the institutionalisation of ADHD within the clinical setting, differing practises show that counsellors indeed have spaces of agency in which their choices and actions influence conceptions of illness and care in children. School counsellors use the concept of ADHD to help families make sense of problematic child behaviour, needs and coping possibilities. In the interaction between parents and teachers ADHD gets incorporated while balancing the tensions caused by stigmatisation, ideas of blame and ADHD as a mean to academic potential.

There seems to be variety in how school counsellors understand and deal with the concept of ADHD. The choices they make and their actions are embedded in ideas on aetiology, stigma, and childhood. In accordance with socio-environmental explanations for ADHD most counsellors start treatment with social interventions aimed at adapting the child's environment or with therapy. However when ADHD-like-behaviour manifests itself more strongly medication is sought (by means of referral). When it comes to treatment, borders become blurred. What Kirmayer (2006) and Slagboom (2014) call creolization takes place at this very moment; practices from a variety of medical traditions are combined in the treatment of ADHD. This calls into question Timini's MacDonalisation theory on children's mental health care.

(Bio)medicalising

A counsellor is seen to be medicalizing when her actions lead to the recognition, assessment, diagnosis and treatment of ADHD as a clinical disorder. (Bio)medicalization in the school environment in Pune must however be understood as the outcome of interactions and knowledge exchange between children, teachers, school counsellors and clinical professionals. School counsellors were found to incorporate the biomedical concept of ADHD by setting up or enhancing monitoring systems, priming teachers and by pressuring parents.

Identifying ADHD: Priming teachers & the study of children

First of all, school counsellors play an active role in the process of medicalization by introducing the concept of ADHD in the school environment. It is mentioned by multiple counsellors that until recently (2-5 years) teachers were not aware about concepts such as ADHD or LD. This is conform the findings of Neena David (2013), who claimed that teachers do not use the biomedical model to explain hyperactivity. Awareness of

children's' special needs among teachers is said to be necessary to ensure referrals. By organising workshops counsellors are priming teachers to think of certain types of behaviour as symptoms:

> So we would do a general talk on learning disabilities, ADHD, behavioural and social issues, like for example, social withdrawal, isolation, now these are also things that the teacher needs to be looking at, not just academic issues. So we would give them a spectrum of any kind of psychological socio-emotional issues so that they can, you know, if they hear or see something, then in alarm they can know and they can get back with us.

Due to the work of school counsellors I expect a shift among teachers towards a more clinical conception in ADHD-like-behaviour in line with the biomedical explanatory model. Some of the schools have a checklist (or are developing one) for ADHD and LD that the teachers can use. The teachers are becoming part of a monitoring system that is being put into place in order to identify 'abnormal' children and classify according to disability or illness categories[6]. Especially in the younger children, development is monitored attentively. School counsellors spend time on the playground and in the classrooms in order to identify children with difficulties. By incorporating a monitoring system aimed at identifying difficulties, disability, or illnesses (among which ADHD), the child is transformed into an object of study. The knowledge that is produced in the process changes people's perception; it transforms behaviour into symptoms and creates the foundation for medicalization.

Pressuring parents

Because of the lack of knowledge about ADHD and the stigma associated with mental health care, school counsellors spend a lot of time counselling parents. They say they "psycho-educate" them concerning the profession of the counsellor, mental health in general and about ADHD specific. They introduce the concept of ADHD, explain the symptoms and teach parents that children's problems can be understood in relation to their brain or neurological wiring. In the interaction between the counsellor and the parents, trust was found to play a crucial role. Getting parents to cooperate can be a daunting task. During this research the counsellors told of many pressing examples in which parents refused to have their child assessed or to accept help other than aimed directly at academic achievement. In order to overcome this resistance some of the schools will pressure the parents:

[6] Meanwhile it was noticed that school counsellors help extend the reach of the realm of medicine and it normalising techniques and help interweave it with the field of education. Counsellors collect and prepare information for clinical testing centres, which is essential because in order to diagnose ADHD following DSM-5 guidelines, symptoms must be found in different settings such as the school and the home. In order to find out if a child is eligible for an ADHD test, the observations done by the counsellor in school are checked with the parents' observation of the child at home. The counsellor provides checklists for the parents and collects information.

> So when it's really the last stage, we feel that the child is suffering a lot or is just not able to cope in class, then we send a letter, a formal letter saying please get this done by this date. You know, the school then becomes the overriding figure. You have to get this done, otherwise we won't give you the report for this term or this won't happen.

One principal mentioned that in extreme cases, for the benefit of the child, he/she is threatened to be removed if no action is undertaken by parents. Interestingly, it was indicated by different counsellors that they were searching for the boundaries of their 'spaces of agency', not knowing how much room they had to work within the school or how much pressure they could put on parents. Her we see that ADHD is being incorporated by counsellors by carefully navigating the tensions that are seen to be caused by local ideas on stigma and blame. By incorporating ADHD as a (bio)medical truth school counsellors hand parents an opportunity to counter some of the blame that comes with moral explanations of ADHD-like-behaviour.

The incorporation of ADHD is embedded in concerns over family prestige. The child's educational success is seen as a means for future family affluence and social status. In the highly competitive school environment that is exemplary for Pune education, the academic performance of the child means everything. Counsellors mention that it is (part of their) job to "to ensure that a the child is able to achieve their academic potential at school" and that the ADHD label is said to be helpful to do so:

> We give this as a tool and not as a crutch. We should use this as a tool and not as a crutch to wave off and make it easy so that a child is not fully challenged. There is probably more potential but the label should help me to pull the child out of it and get the best out of a child.

An ADHD diagnosis empowers the school counsellor to both modify the educational and home environment of the child because it legitimizes intervention. Medical certificates are seen as 'proof' a child needs help to reach his full potential and legitimizes special needs and deviant behaviour. Within the institutional setting, the child is given more freedom, for example to leave the class and thus prevent disturbances. The diagnosis also leads to a more understanding and forgiving attitude of teachers, and to a more relaxed punitive policy.

Furthermore, the institutionalisation of ADHD within the educational setting comes with education advantages, and is therefore seen to help school counsellors convince parents to send their children for assessment. As described in the chapter on educational policy an official diagnosis grants access to concessions for the 9^{th} and 10^{th} grade exams. Children with a medical certificate with ADHD diagnosis are said to get extra time, a reader or prompter during the exams. One counsellor mentions that before these concessions were granted, many of these students, who could not cope with the syllabus portions, would drop out of school. However, due to the concessions they can now pass

out with a 10th grade certificate that will help them get admission to higher education. Children with (diagnosed) ADHD also gain educational advantages throughout their education in shape of a shadow teacher, extra breaks or soft corrections.

By introducing the concept of ADHD, priming, convincing, pressuring of forcing people to let ADHD enter into their lives, school counsellors are seen to incorporate ADHD in a framework of academic success and ideas and family prestige. In the work of counsellors and the institutional context that shapes it, the spheres of education and medicine have become intricately interwoven. The logic and logos of biomedicine is seen to be colonising the field of education and the life worlds of those involved by promising solutions for everyday worries.

Pragmatic (de)medicalization

During this research it became apparent that part of the job of the school counsellor is about distinguishing when the ADHD label is applicable or not and when it is functional or not. They put to question the assessments of teachers, parents and clinicians alike and normalize behaviour (that could otherwise be categorized as ADHD) by incorporating it in framework of childhood and adolescence. In negotiation with the different parties involved they put to the front an image of childhood that is being affected by the perversities of modernisation, including a critique on standardised and essentializing practices of biomedicine.

When asked how school counsellors differentiate between ADHD-like-behaviour as a clinical problem (c.q. ADHD), as a social problem or not a problem at all, a variety of answers are given. First of all, school counsellors mention they look for consistency and frequency of problematic behaviour. If a child functions properly with one teacher and not with the other, or if problems can be traced back to the home environment, the problem is social in nature and not medical (not ADHD). It is mentioned that the checklists with ADHD symptoms, are not sufficient to make the distinction, but that the level of intensity of the symptoms that are being played out should be taken into account. Because the social environment of the child said to both relate to the level of tolerance of symptoms (big classroom, busy parents: low tolerance), and can aggravate or alleviate them, this indicates a individualistic and relativistic approach to ADHD diagnosis.

Labelling is a choice

While there are upsides to labelling children with ADHD, counsellors see that the label can also work debilitating when not used properly. Due to the different meanings that counsellors, teachers and children respectively give to ADHD, the label can become harmful in translation. Therefore some counsellors avoid using it. When a child is suspected to be suffering from ADHD, is remains a choice whether to medicalize or to

use labels at all. Naming a child is sometimes regarded unnecessary, even when an official diagnosis has been made. The label is kept aside and talk is confined to how to support the child. One particular counsellor showed to make a very pragmatic choice weighing advantages when making a decision on whether or not to send one of her students for assessment and saw a diagnosis to be functional only when it can help boost academic performance. By weighing advantages and disadvantages, the school some counsellors seem to decide whether or not to enter a negation over referral for assessment. A couple of pragmatic considerations where found to be conclusive to their decision. These are:

- Does the child suffer?
- Do attention difficulties repress academic potential?
- Can the child's behaviour be managed in the school?
- Are other children being affected?

The reflexive way in which school counsellors seem to approach ADHD and take into consideration both everyday concerns and advantages/disadvantage that exist in relation to the local sociocultural context seems to refute a simple theory of medicalization as social control (Malacrida, 2004).

Disenchanting ADHD with notions of childhood

We have seen that school counsellors are introducing the concept of ADHD to parents and teachers that were previously unaware of the concept. However, they also function as gatekeepers for teachers and parents who seek to medicalize. It is mentioned at several occasions that parents send their child for assessment when they can't control them at home. However in doing so, they sometimes act from what school counsellors perceive as an erroneous conception of ADHD. The counsellor then has to convince parents that their child is normal:

> Some parents are like so much concerned we have to convince them like 'your child is not abnormal'. They do their diagnosis. Even teachers also, we have told them like the list of symptoms so we have to tell them like if you see like don't directly go to the conclusion that children are having ADHD. So they are telling like 'my child is having little bit ADHD' so we have to tell them it's a general childhood innocence or hyperactivity, it's not ADHD.

Some school counsellors explain elements of ADHD as being part of normal childhood behaviour and development. In doing so they partly reject the biomedical category of ADHD and locate the symptoms of the disorder in the cultural category of childhood. They say it is normal for children to be not able to concentrate sometimes and that being active is part of a healthy childhood. Behaviour that is being problematized by parents as ADHD is explained as proper teenage behaviour parents just have to deal with. At the same school counsellors frame ADHD-like-behaviour as an idiom of distress. Some parents are said to be "control freaks" who act way to strict and don't allow the child to

be himself. Because of the strict and authoritarian home environment the child is being denied the possibility to display normal childhood behaviour. All free time must be spent in the interest of academic achievement and children are said to be "missing out on childhood". The resulting distress is expressed in the school environment. It's mentioned more often that problems at home result in behaviour that can be falsely interpreted as symptoms of ADHD. One example are children who learn violence as part of their upbringing, who at one point undermine authority and hit back, or act violently towards peers. Another example concerns children who receive a lack of attention at home and disturb the class in order to get attention or who purposefully achieve badly academically in order to catch their parents' attention. School counsellors are seen to incorporate ADHD and influence perception by pressing for a reinterpretation of ADHD-like-behaviour along the lines of normal childhood behaviour, or as a normal response to an abnormal home environment. They influence ideas of illness and care by shifting focusing on the counselling of parents.

ADHD misdiagnosis as a vessel of critique

It was found that some parents send their child for testing on their own accord and come back with an ADHD diagnosis. Sometimes the counsellor does not recognize nor accept this diagnosis, which necessitates them to enter into negotiation. While this negotiation takes place between the counsellors and the parents, the underlying tension translates in a critique on the field of clinical medicine. In this commercially driven field parents are said to 'summon a professional' for an ADHD diagnosis. It is said that clinicians are diagnosing "children with ADHD at the drop of a hat", medicalizing cases in which ADHD-like-behaviour actually be traced back to the social environment of the child, and can thus lead to misdiagnosis or over-diagnosis:

> Clinicians or psychologist are diagnosing multiple children with ADHD at the drop of a hat. Whereas they might just show a few symptoms and it's something that can be dealt with if you delve into the children's' lives and see what is it that is causing that concern. I think that there are some cases that are definitely extreme cases where their diagnosis is valid. Where the ADHD is valid, but I think clinicians need to show a little bit more constraint when they are diagnosing.

The perceived practise of misdiagnosis is seen by some counsellors to stem from the standardized impersonal system of testing in which clinicians label children without ever 'seeing them' or based on a single observation. By demedicalizing children in interaction with parents and by advocating a more personalised and context sensitive approach to ADHD and medicalization, school counsellors are seen to work counter a straightforward and universalistic implementation of ADHD. Instead they try to consolidate ADHD in accordance with local explanatory models, values and ideas of care.

Incorporating ADHD in local medical systems

Lang and Jansen (2013) claimed that in Kerala the bio-psychiatric notion of depression became hybridized with local categorizations of mental distress under Ayurveda resulting in an 'Indian' approach to depression. I suspect that a similar process is currently taking place with the concept of ADHD. It was found that in reaction to ADHD diagnosis, in addition to counselling, school counsellors often refer to Ayurveda and homeopathic doctors or for flower therapy. In doing so, they are helping to incorporate the biomedical concept of ADHD with 'local' medical systems. While parents must eventually make the choice of treatment, the school counsellors are in most of the cases important link in the pathway to care. Parents' decisions are not made in a vacuum but in interaction with the counsellors who inform and steer them. They provide parents with referral options, leading in many cases to treatment other than, or additional to, allopathic medication. Some counsellors perceive, or claim that parents perceive, allopathy to be highly stigmatized, and that side effects of allopathic medication can be tenacious. Because of this these parents and counsellors will only send children with severe ADHD, who cannot be helped in any other way to a psychiatrist or for allopathic medication.

While school counsellors are seen to pragmatically medicalize and add to the creation of something that we could label as an Indian practice of ADHD, it is interesting to note that the treatment part that distinguishes this practice, is also partly rooted in the west and a product of continuous globalisation. Whereas the medical tradition of Ayurveda is seen to belong to India, it is said to have travelled around the globe many centuries ago and in the process laying the foundations of western medicine (Anandalakshmy, 2010). In any case Ayurveda is strongly linked to the development of homeopathy in 18th century Germany. Flower therapy was, in turn, developed on the basis of homeopathy at the beginning of the 20th century in Britain. While there can be said to be a intermingling of medical traditions when it comes to ADHD, it is thus hard to pinpoint whose tradition these actually are. This put to question and problematizes the notion of *indigenous context* and *local knowledge* that is central in appropriation theory.

Transforming ADHD: family prestige and appropriation by 'alternative' medicine

The last phase of appropriation; transformation, leads to the creation of local traditions enclosing particular forms and specific ways of dealing with the appropriated element.

Or, in the Hahn's words: "The accomplishment of making a thing into something different, new, and locally defined without changing its material form." (Ibid, p.223). ADHD is in Pune is currently seen to be given meaning and dealt with in accordance with an aetiology linked to modernisation, negotiated in fields of tension that arise of local ideas of stigma and family prestige, and embedded and treated in a variety of medical systems.

While the introduction of ADHD in India is progressing and changing peoples' understanding of illness and care, the transformation has not been completed. The clinical category is still unfamiliar to the majority of the population, as indicated by school counsellors' need to introduce and explain it. Policy is being put into place in which children's mental health care is a priority. As more schools will appointed school counsellors, awareness of diagnostic categories will likely grow and consequently result in a growing amount of children who are identified to be suffering from ADHD. However, while the implementation of ADHD is seen to help rending problematic child behaviour meaningful by framing it as a clinical problem, the appropriation of ADHD is not a straightforward process. ADHD's place and meaning in the context of Indian education is still being negotiated. There are stark differences between school counsellors and schools, and it was found that individual counsellors are looking for meaning and insecure about their ways of appropriation. Some patterns can be discerned which indicate that ADHD is not uncritically accepted and is in the process of being adapted to local ideas and needs.

First of all is seems that ADHD is being transformed by linking its aetiology to the perceived effects of modernity. Implementation of new technologies is seen to lead to an overstimulation in children, in turn leading to ADHD-like-behaviour. Nuclearization of the family is seen to lead to a decline in family function and westernization to a decline in family values. All these changes create an environment of the child that causes distress and is conductive of ADHD-like-behaviour. This perception or form of ADHD is connected to school counselors' practice of social interventions in the sphere of the family and can hold a connotation of blame towards parents.

Furthermore ADHD in embedded in labeling local labeling practices that are shaped by the prevalent stigma on mental health care. Some counselors were seen to carefully weigh the advantages of granting a diagnosis and when these do not weigh up to the stigmatizing effect, find a way to work around it. They don't utter the term but do instigate treatment in the shape of social interventions. In their decision making process and the interaction with parents that follows, the contextual factor of family prestige comes to the front. It seems that ADHD is being negotiated amidst a tension that exists because ADHD can both pose a threat to family prestige, and be a means toward it by enabling academic potential and success.

Lastly it was indicated that the biomedical concept of ADHD is being incorporated into 'local' medical systems. School counselors were found to take part in networks of both clinical, homeopathy and Ayurveda medical systems all of which seem to have appropriated the diagnostic category in own ideas and their logic of illness and care. How ADHD is appropriated in these medical systems and transformed in the process is beyond the scope of this paper, but poses interesting questions for future research.

Conclusion

In order to understand the introduction and appropriation of ADHD in India, one has to take into account the (history of) local institutes of mental health care and education. Mental health care is highly stigmatized and linked to discourses of madness and family shame. In the past decennia, policy has been implemented creating more awareness and acceptance of mental health needs and putting a system in place to address these needs. The history of Indian education has led to the development of a mostly privatized and segmented educational sector. India has a highly stratified society in which education previously functioned mainly in the interest of the coloniser and became a mean to class reproduction. The recent introduction of policy claiming education as a fundamental right however marks a shift towards education as a mean to class mobility. This policy not only focuses on inclusion of the lower classes, but also of children with disabilities and heightens awareness of children's' mental health. The fields of medicine and education are merging. Because of the heightened awareness of mental health, the growing accessibility of education and the advancement of the profession of school counsellors, more children, parents and teachers get into contact with mental illness categories such as ADHD. However when and how ADHD-like-behaviour becomes medicalized is dependent on many factors that come together in the interaction between parents, teachers, school counsellors, clinical psychologists and psychiatrists.

School counsellors play an intricate part in the travels of the concept of ADHD in India and the biomedical attachments, c.q. screening procedures that come with it. According to Rafalovich (2013) the transformation of children and childhood into an object of study leads to medicalization and a rise in ADHD. Policy measures such as the NMHP and DMHP are creating awareness and acceptance of mental health care and mental health professionals in India. As part of the shift towards inclusive education and recognition of special needs a monitoring system is being put into place in which school counsellors play a crucial role. They teach teachers about disabilities and how to recognise symptoms in children. The children thus become object of study and can be categorized according to medical categories. In line with the work of Nichter (2010) it can be said that the diagnostic category of ADHD here creates a new space for the articulation of distress, that "renders meaningful an incoherent and disruptive experience, and opens up possibilities for managing and living with the symptoms." (Broom & Woodward, 1996, p.376). One of the possibilities is to categorize problems formerly associated with bad children, or bad parenting, within the biomedical discourse as a physiological problem and treat it accordingly. Medicalization is furthered by the inclusion of ADHD as a disability category under some of the educational boards, giving right to concessions. In a society where academic potential is placed on a pedestal, the possibility of making use of concessions is seen to positively influence school counsellors' decision to send children for assessment. The tangible benefits of this policy

seem to weigh up to the stigma involved. This confirms the conclusion of Scheffler and Hinshaw (2014) that political context and social policy influences the spread of ADHD diagnosis and sheds some light on the intricate ways this come to be. The extent and the particular ways in which ADHD screening/treatment is institutionalized thus provides a viable analytical focus for the study of ADHD's spread around the globe. However it was also found that the use of the concept ADHD is sometimes contested or rejected and opens up alternate possibilities of managing ADHD-like-behaviour by reframing it as a socio-environmental problem. The framework of appropriation can help see how travelling medical techniques are embedded in local socio-economic context, webs of knowledge and medical traditions, both shaping local ideas of illness and care and being transformed itself.

According to Watters (2010) and Timini (2010) western medical theories are spreading across the world, presumably leading to a MacDonaldization of children's mental health and colonisation of the mind. While it might be true that the introduction of the medical category of ADHD is changing how ADHD-like-behaviour is thought of, school counsellors were found to reflexively give meaning to ADHD by drawing from different explanatory models, thus transforming the concept. They interpret and apply the concept in interplay between social and biological explanatory models and use their authority within the school setting to influence local understandings. They appropriate and challenge the concept of ADHD by linking it to a modernisation discourse and the medical knowledge systems of Ayurveda and Homeopathy. The concept of ADHD is not uncritically accepted. In severe cases, when the child is perceived to be suffering or behaviour is unmanageable and influencing other children by disrupting the class environment, school counsellors are seen to categorize according to the biomedical conception of ADHD. However, it's use for medicalization of mild ADHD-like-behaviour is seen to be rejected by categorizing this behaviour in accordance with socio-environmental explanations, or by invoking idioms of childhood, adolescence and child development. Childhood is framed as a space where the medical realm has little jurisdiction. In this case, ADHD-like-behaviour is normalised or the child's behaviour is demedicalized. Watters' colonisation theory does not do right to the different meanings that are given to ADHD and to the different ways that the concept of ADHD is used in practise. While the clinical definition is mostly accepted, when the label is used and what is done with it, is something completely different. Actors are reflexive, are aware of the social possibilities and restrictions of the concept within different settings and use it pragmatically in accordance with local needs. Furthermore in India medical traditions are not as separated as this theory implies but coexist and complement each other, confirming Kirmayer's (2006) theory of creolization. Indications were found that the diagnostic category of ADHD is being appropriated by both Ayurveda and Homeopathy doctors to which school counsellors refer. Lang and Jansen (2013) claimed that depression, conceptualized as a neurochemical imbalance is compatible with Ayurvedic

notions of the body, mind and mental distress and is being incorporated in this medical system. Since I found that ADHD is partly framed in neurochemistry as well it is possible it is following a similar path of appropriation.

Where the concept of creolization helps us see the fluid and progressive character of culture, Hahn's model of appropriation shows how factors that exist on different levels are manifested in everyday decisions and interactions. In this study on globalisation of medical categories we have seen macro (global), meso (policy and discourse) and micro (interaction) come together. When it comes right down to it, culture is performative. It is not something that exists apart from people or can be forced upon then. People take elements from different 'cultures' and create meaning to their lifeworld within the boundaries of the webs of knowledge that are available to them. When new concepts and ways of understanding are introduced in a society, these are categorised according to pre-existing modes of knowledge. They are accepted to a certain extent and adapted to fit 'local' modes of understanding. In the end the concept becomes what is done with it in the context of social ecology. This creates space for various meanings of the same concept. In the case of ADHD in Pune we saw that different conceptions exist among the population and how this becomes the object of a power play over knowledge. These interactions are structured by the power positions of the institutes of education and medicine. While the field of (bio)medicine is entering the field of education in India, there is resistance among educational professionals to fully accept the biomedical discourse and logic. There is a paradox in play where the technique of medicalization seems to be inhibited by one particular function of education, which is the protection of a child's wellbeing. Part of the child's wellbeing is the ability to have a 'normal' childhood, to be part of the group, to grow up and to struggle, to play and to misbehave at times. What distinguishes ADHD in Pune's school environment is not only what it means, but how and by who its meaning and use are contested.

On the basis of this study I argue that while ADHD is likely to have a biological basis it is appropriated locally in accordance in what Singh (2002) calls the ecological niche. I did not find that local ideas of illness and care were replaced but that they instead are being merged with the clinical concept of ADHD. In this process of appropriation slightly different variants of ADHD and care are created which influence how problematic childhood behaviour is interpreted and treated. This nuances the discussion about the study of mental illness as a universalistic (Watters, 2010) or culture bound (Nichter 2010). I argue that by combining the perspectives of creolization and appropriation this divide can be bridged. This could help create a more nuanced understanding of globalising processes and at same time can help guide a more culture sensitive implementation of medical interventions to reduce unnecessary suffering.

Discussion

The time available for the fieldwork of this study was limited. Beforehand I did not know exactly how the school environment in Pune would look like or what the role of school counsellors in the educational system was. Therefore it took a while before I knew what I was actually researching and the interviews developed as the research progressed, which lead to a low reproducibility of the study. Furthermore the finding must be situated in a very specific setting. The study was conducted in a relatively wealthy city with counsellors who work at schools that are mostly frequented by families with a high socioeconomic status. While this is likely to be the point of introduction for ADHD, these findings are in no way generalizable to less affluent schools or to rural areas, were school counsellors are said to be non-existent and ideas of illness and care are likely to differ. As one respondent explained, people in the west and high class educated people living in the Indian metropoles are very alike, while the differences between Indians from different classes within the city and between those living in the urban and the rural area are vast.

While this study focuses partly on what school counsellors do with the concept of ADHD, the findings were based on interviews. Otherwise said, the description of what school counsellors do is based on what they say they do. While the talk in the interviews can be seen as performative, is might be true that what school counsellors do in practice differs from what they say or are aware of. For future research is therefore might be valuable to conduct a more observation based study. Also this study misses the perspective of the child. One of the counsellors in this study spoke of a child who had a negative experience with allopathic medication, refused to use it further and to visit the counsellor out of fear for being medicalized. This shows a possibly important focus of children as social agents and co-constructors of their social world. It would be interesting to pursue the topic of the child's role in medicalization further. It was found that in India ADHD mostly manifests itself and is diagnosed in the age group of primary education. For future research it can be valuable to focus on this age group. Lastly, indications were found that ADHD is being appropriated in 'alternative' medical systems. In future research it would be valuable to study how this relates to diagnostic and treatment practices surrounding ADHD.

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