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GLOBAL PERSPECTIVES *on* ADHD

SOCIAL DIMENSIONS OF DIAGNOSIS AND TREATMENT IN SIXTEEN COUNTRIES

EDITED BY

Meredith R. Bergey, Angela M. Filipe, Peter Conrad, *and* Ilina Singh

Global Perspectives on ADHD

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Global Perspectives on ADHD

9

The Journey of ADHD in Argentina

From the Increase in Methylphenidate Use to Tensions among Health Professionals

Silvia A. Faraone
Eugenia Bianchi

This chapter focuses on the rise of attention deficit–hyperactivity disorder (ADHD) as a childhood behavioral disorder in Argentina. In this country, diverse health and education professionals (with diverse theoretical and therapeutic positions) are intensely debating issues regarding the diagnosis and treatment of this condition.

The Argentine case is of particular interest owing to, among other factors, the coexistence of psychoanalytical and biological psychiatric approaches in the practices of health professionals and the cultural and political influence of psychoanalysis in the country. The current conflict in approaches to the diagnosis and treatment of ADHD is between the more psychoanalytical approach and the more biology- and psychiatry-oriented one. Psychoanalysis-related professional groups are resistant to what they call tendencies toward the medicalization and pathologization of children. Psychoanalysts postulate that the iatrogenic effect provoked by stimulants and the use of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) for diagnosing mental pathologies in children violate the Ley Nacional de Salud Mental 26.657 and the UN Convention on the Rights of the Child, which Argentina ratified and adopted through the *Convención sobre los derechos de niños* (Ley 23.849) in the 1990s.

The Ley Nacional de Salud Mental, which was passed by Congress in 2010, empowered professional groups that stand against the pathologization of childhood because it devoted central attention to the concept of mental suffering; in doing so, it confronted medical-pharmaceutical hegemony. The UN Convention on the Rights of the Child (adopted by the General Assembly of the United Nations and ratified by Argentina in 1990) led to the inclusion of these rights in the Argentine Constitution, which guaranteed children the right to receive health-related assistance and to be kept safe and sound, protected from cruelty, negligence, and injustice.[1]

To explore the conflicting approaches to the diagnosis and treatment of ADHD in children in Argentina, we present the results of three studies carried out by the authors between 2007 and 2012. We include data from national and international specialized literature and newspaper articles. We also evaluate statistical data from the Confederación Farmacéutica Argentina (or COFA, a professional association of colleges) and the Administración Nacional de Medicamentos, Alimentos y Tecnología Médica (or ANMAT, the national agency that regulates, certifies, and monitors drugs, foods, and medical devices). In addition, we include data from 63 in-depth individual interviews and 2 in-depth group interviews with health professionals. Some further interviews were carried out with key informants such as renowned child psychiatrists and pediatricians, chief pharmacists, and pharmaceutical sales representatives. In addition, scientific and academic publications on ADHD from Argentine authors were analyzed, along with psychiatric manuals used to assist in diagnosis and treatment. These manuals were chosen because of their widespread use in Argentina and the frequency with which professionals referred to them.

Drawing on this nationwide research, this chapter provides information on the increasing sales of methylphenidate since the 1990s and, more recently, the growing distribution of these sales in the country. We also describe the ways in which the conflicting views and tensions among professionals have influenced diagnostic and therapeutic decisions. These decisions are intertwined with children's-rights perspectives, state-orientated demands, and professionals' critical views on their own practices. Even though it is not possible to delineate a single map of the alignment of the various disciplines and organizations, this chapter anticipates some future areas of conflict and resistance.

Medicalization and Biomedicalization

According to the canonical definition, "medicalization" is the process by which previously nonmedical problems become defined and treated as medical problems (Conrad 2013: 196). Today, medicalization is characterized by issues that go beyond those of the pioneering studies a half century ago that dealt with the influence of doctors and law reformers as well as medical and scientific discoveries. Studies carried out during the 1970s from a medicalization perspective identified physicians, social movements, and interest groups, as well as organizational or inter-professional activities, as the core forces of these processes. Since then, medicine has undergone significant changes through which other forces have come to contribute substantially to the current medicalization process.

In the twenty-first century, the three key actors that guide medicalization worldwide are biotechnology, consumers, and managed care (Conrad 2007: 133). As Conrad examined in a 2007 analysis, many of the key studies of medicalization were completed more than a decade or even two decades ago; however, some changes in medicalization have occurred in the context of important changes in medicine such as the widespread corporatization of health care, the rise of managed care, the increasing importance of the biotechnological industry (especially the pharmaceutical and genomics industries), and the growing influence of consumers and consumer organizations (Conrad 2007: 16). Although actors involved in this global trend are similar, they differ in their emphasis, as indicated by the fact that important zones of medicalization are moving from a medical-professional predominance to a market predominance (Conrad 2005: 10).

Other authors have incorporated these transformations and reconfigured topics in medicalization as part of "biomedicalization" (Clarke et al. 2003: 162). Following Michel Foucault's theory of "biopower" and Paul Rabinow's concept of "biosociality," these authors emphasize that biomedicalization is focused on health as a moral mandate, and it is characterized by the internalization of control, vigilance, and personal transformation. Biomedicalization has acquired a wider scope than medicalization, but both concepts still exist and coexist, and they share a similar focus on actors, strategies, technologies, frameworks, and practices.

The Argentine health sector has undergone a silent reform since the 1990s (Iriart, Faraone, and Waitzkin 2000: 62). Deep transformations have occurred without a declared global project and without explicit objectives from the gov-

ernment or multilateral credit organizations. It is within this framework of micro- and macro-politics, within contradictory developments, that the medicalization and biomedicalization processes in Argentina constitute a paradigmatic case for the context of Latin America. Underlying this framework are the social security sector in Argentina (*obras sociales*), which handles a high percentage of the overall public expenditures, and the unions, which directly run many of the institutions that offer services in this sector. These institutions play a central role in the development of medical social care in Argentina, and the reform of the system that comprises them may be analyzed in parallel to the incidence of multilateral credit agencies on health investment for Latin American countries (in Argentina, especially the World Bank and the International Monetary Fund, or IMF) and their allied administrations (Iriart, Faraone, and Waitzkin 2000: 61).

An Introduction to the Argentine Panorama

In Argentina, the analysis of the interplay of various perspectives of ADHD has a special significance. The recent extension of the phenomenon, the shortage of comprehensive studies, and the coexistence of pediatric medicine with biological psychiatry, neurology, cognitive behavioral psychology, the neurosciences, and psychoanalysis in professionals' training and practices create a particular and interesting view of the problem.

Psychoanalysis has an important role, too. It has been part of the field of mental health in Argentina since the 1960s (Dagfal 2009: 299) and has gradually gained considerable influence in the education and practice of institutions and providers who care for persons with physical and mental health problems. However, since the mid-1990s, there have been two coexisting realities. On the one hand, there has been an ever-growing emergence of many new so-called alternative therapies such as mental control, transcendental meditation, and self-help techniques (Visacovsky 2001: 41). On the other hand, there has been a growing influence of all branches within the neurosciences, so that psychoanalytical primacy has given way to biological hegemony in the conception and treatment of mental suffering.

Outside these advances and growing influences, the position that psychoanalysis has occupied within Argentina is unique as compared with its role in other Latin American and European countries. In Argentina, psychoanalysis has numerous staunch supporters among professionals, and through them, it has had an effect on clinical practice. In cities such as Buenos Aires, São Paulo, and Rio

de Janeiro, psychoanalysis exceeds clinical practice in terms of mental health care, and its influence has spread in the urban culture (e.g., in the language, as Visacovsky's observations reveal in the following paragraph). Professionals in the academic, research, and clinical practice worlds in these cities have contributed to sets of regulations for the country that favor certain actions in mental health issues.

The dissemination of psychoanalysis in Argentine society was also analyzed by Visacovsky (2001: 31). He describes the quantity and impact of institutions such as the pioneering Asociación Psicoanalítica Argentina, which was founded in 1942 and associated with the International Psychoanalytical Association (IPA). He also mentions the Asociación Psicoanalítica de Buenos Aires, or APdeBA, which split from the APA and was founded in 1977. Today, there are more than 100 psychoanalytical institutions, most of them of Lacanian scope. Among these, there is the Buenos Aires's Escuela Freudiana de Buenos Aires, or EFBA, founded in 1974, and the Escuela de la Orientación Lacaniana, or EOL, founded in 1992.

Visacovsky (2001: 31) also describes the profusion of psychoanalytical concepts in everyday language, even if the terms do not retain their specialized meaning. He suggests that psychoanalysis can be considered a worldview or a culture that has an authorized public voice, opining on the most varied issues in the mass media.

The problems in Argentina differ from those in other countries such as Uruguay (Miguez 2010: 326). In Argentina, ADHD is identified mainly among persons in the middle and upper classes (mostly urban) who have access to education and health benefits. Whereas prescription of methylphenidate has a function of "domination and control" in Uruguay (as Miguez has documented), in Argentina it is used mainly for reinsertion and performance enhancement in high-exigency education modalities, with personalized treatment strategies (which are characteristic of the types of education expected in these social classes).

The controversy regarding ADHD in Argentina derives from the problems created by the reintroduction of methylphenidate in the market in the 1990s (its withdrawal during the 1970s will be expanded on in a later section) and the increase in ADHD diagnoses given the extension of the use of the *DSM* and its broader categories. These problems were presented by teachers and parents in a series of congresses, conferences, and symposiums intended for health professionals. They were also expressed in several books (Joselevich offered a compilation in 2003, re-edited in 2005; and Janin wrote another one in 2004, re-edited

in 2007) and in specialized journals such as *Terremotos y Soñadores* (*Earthquakes and Dreamers*), which began to be published in 2000.

A wide variety of Argentine authors have deepened the analysis of the problematics of ADHD. They have created dense academic works from various perspectives, including psychoanalysis clinical theories (Untoiglich 2011: 10), neoliberal politics in mental health (Barcala 2011: 220), and teaching conceptions (Dueñas 2011a: 145). Various books have also been published from the perspective of health and mental health. Moyano Walker (2004), Stiglitz (2006), Benasayag (2007), Janin (2007), Dueñas (2011b), Joselevich (2005), and Benasayag and Dueñas (2011) compiled health professional works from backgrounds such as medicine (pediatrics, neurology, and psychiatry), educational psychopedagogy, psychology, psychoanalysis, and journalism. However, in Argentina few studies approach ADHD from the perspective of the social sciences.

Argentina: An Emblematic Case

We now consider ADHD as a representative case for the debates on medicalization and biomedicalization—particularly in the use of psychopharmaceutical agents for the treatment of children. We offer some results of our investigation that map out the actual situation in Argentina.

When It Comes to Diagnosis: Actors and Struggles

Key historical moments mark peak levels of ADHD diagnosis in Argentina, and it is possible to systematize them. Initially, there was a marked growth and consolidation of the disease in the 1990s, with two significant events. First, a series of political, economic, social, and cultural transformations in Argentina (Barcala 2010: 70) translated into the implementation of a government program with a neoliberal bias. In addition, the fourth edition of the *DSM* (APA 1994) was published in the United States, and there was consequent global penetration of its use. In it, ADHD is typified for the first time. From 2001 on, in parallel with the deep social and political crisis in Argentina, there was a verifiable increase in psychopharmaceutical sales (Lakoff 2004: 248) (this will be described in detail later in the chapter). Various interviews show how groups and institutions, with their corresponding written publications and meetings (both scientific and professional), began to think about the problematic effects that psychopharmaceuticals have on children.

During interviews in the course of our fieldwork, we documented a variety of positions related to the existence and status of ADHD diagnosis and treatment (Arizaga and Faraone 2008: 177). Most of the professionals we interviewed

(especially pediatricians and neurologists belonging to health services) expressed their agreement on the existence of the clinical features or psychiatric classification of ADHD. However, they admitted a significant diagnostic imprecision and certain confusion due to diagnostic masking (resulting from other pathologies or problematic situations, such as social or family issues such as violence or abuse) (Bianchi 2012: 1034). They also noted high comorbidity (allowing for the observation of simultaneous pathologies such as child psychosis, Asperger's syndrome, or other disorders, while ADHD appears as a main diagnosis) (Bianchi 2012: 1034).

Moreover, these professionals asserted that ADHD is an old-fashioned diagnosis, based on outdated classifications in older versions of the *DSM* or old denominations such as "minimal cerebral dysfunction" (Strother 1973: 6), and they insisted that the changes in its iterations throughout the years were only at the denomination level, while its essence was maintained. This perspective focuses on the recognition of ADHD as a real disorder and one that is widely recognized as such (Mayes, Bagwell, and Erkulwater 2008: 157).

However, in Argentina, and linked to the field of psychoanalysis, ADHD has aroused criticism and refutations of a varied nature, practically from the time of its configuration in the *DSM-III-R* (APA 1987) as a behavioral disorder in childhood. Apart from the creation of a critical battlefront on the existence of ADHD, the most resounding polemic involves the very existence of the diagnosis as a clinical entity. These perspectives, mainly ascribed by the educational community, emphasize the subjectivity involved in treating each child with her unique symptoms or personality characteristics. Certain ideals of the era are critically questioned (i.e., "performance," "success," and "consumption") as the main conditions of the production of subjectivity in the care of children and their families. In our interviews with teachers, this problem was illustrated as the case in point of a student who had lunch in the middle of a class because he had to attend meetings with so many professionals (psychopedagogists, neurologists, and psychologists) that he was completely overwhelmed by the whole situation and no longer cared about anything (fieldwork interview with a group of teachers from a private school of high exigency in the northern area of Greater Buenos Aires, socioeconomic status [SES] middle to high, from Arizaga and Faraone 2008: 130).

Approaches and Treatments: A Troubled Journey

An emerging result from the interviews is the differentiation of diagnoses, depending on which health subsector the professionals work in. Mental health professionals who specialize in children and work in the state public subsector

often receive referrals to take care of more complex cases than those with ADHD. These professionals postulated that certain lower socioeconomic populations were being underdiagnosed, and they associated this underdiagnosis with the presence of other social and cultural problems in childhood and adolescence. In more vulnerable and marginalized sectors, both inattention and hyperactivity in children are often referred to as "behavioral problems" or as a "characteristic of the child's personality." From the interviews with teachers, we verified that "there are no expectations or learning possibilities attributed to these children, except that they do not disturb the classroom, and pass the primary school subject examinations" (Arizaga and Faraone 2008: 268).

As these professionals pointed out, most children diagnosed with ADHD are cared for by health care providers belonging to the social security subsector or the private subsector (through prepaid plans). According to data from the Instituto Nacional de Estadísticas y Censos (INDEC), in Argentina only 7% of the population has prepaid medical insurance, 45% of the population receives health care services through their social security coverage, and 48% of the population has coverage from the state public sector (INDEC 2013).

A possible interpretation is to associate diagnoses with the various social classes at the different stratification levels of the health care system, according to social status and the expectations of the population who have access to it. However, another important indicator of the process in Argentina is the differentiation in discounts on prescribed medication and benefits according to the health care subsector the patient belongs to. The drug kit distributed by the Argentine state to public health care providers through the program called REMEDIAR (i.e., the public subsector in which health care is accessible free of charge) does not include methylphenidate. However, it does include drugs of a varied nature in keeping with its aim of "contributing to prevent the worsening of health conditions of the poorest families in the country, guaranteeing timely access to adequate treatment and medicines for at least 90% of their 'prevalent pathologies'" (AGN 2011). This makes access difficult for persons in these sectors who are generally of low or middle-low socioeconomic levels. Under the *obras sociales*, 40% of the cost of methylphenidate is covered, whereas some provincial medical insurance policies such as those in Tierra del Fuego, one of the jurisdictions selected in this research given its high sales margin, cover up to 70%.

So, the progression of the problem in Argentina is particular for its focus mainly on children who are not characterized by social vulnerability or social exclusion, or by deprivation of rights or health care access. Instead, these children

are described by health professionals as being from educated middle- and upper-class families who regularly go to consultations with health professionals. The extension of medicalization and biomedicalization to this population illustrates the multiplicity of forms of social control for childhood sectors that were not reached by other earlier historical mechanisms. This multiplicity is focused on what Donzelot defined as the "tutelary complex" (Donzelot 1998: 99) and what Rose termed "technologies of government" (Rose 1999: 131) that are aimed at working-class families and children by means of moralizing, coercive, and persuasive mechanisms (Rose 1999: 132).

Nevertheless, health care systems and medication coverage have been and remain central to the debates concerning ADHD in Argentina. On the one hand, existing movements led by patients and families, some specialists, and even the pharmaceutical industry strive to have medical social security cover 100% of methylphenidate costs—as is the case for children who receive state coverage. One strategy to achieve this end is to have ADHD included as a disability (Superintendencia de Servicios de Salud 2015). On the other hand, other social actors, among them multidisciplinary professional associations, confront this situation by establishing a strong polemic against the prescription of psychiatric medication for children. Thus, a diverse range of positions supports both the appropriateness of psychopharmacological therapy and its inadequacy.

One of the results of our investigation relates to the polemics concerning the psychoactive medication used in ADHD treatment. In one of the provinces studied (included in the core section of low methylphenidate sales), cases of neuroleptics and antidepressant prescriptions were documented for the treatment of ADHD. For instance, in the provinces of Tierra del Fuego and Corrientes, besides methylphenidate, the use of anxiolytics such as clonazepam (the most common brand of which is Rivotril) or neuroleptics (such as risperidone in Dropicine or Risperin) was documented. These drugs are intended to reduce or control anxiety levels, and doctors remarked that some antidepressants are used for the same purpose since all types of psychoactive drugs of this kind are used "for everything" (as a pediatrician said). Only one of the key informants interviewed referred to the lack of rigorous longitudinal scientific studies involving children in relation to these psychopharmaceuticals.

Pharmacological Therapy for ADHD

As already mentioned, our analysis of the interviews during fieldwork reveals a trend in the increase in ADHD diagnoses in Argentina in recent decades. In

addition, our review of statistical documents reveals an increase in the dispensation of methamphetamines as a response to the symptomatic framework of ADHD.

Nosological categories and psychopharmaceutical therapy today appear to be joint aspects that should be considered together. In some specific cases, both dimensions are articulated in different ways. Several authors worked on various aspects of the relationship between the diagnosis of depression and the use of antidepressant medication—depression constituted an example of reformulated nosology through psychopharmaceutical advances. Similarly, Ehrenberg pointed out that biological psychiatry is not so strict with respect to the correlation between biochemical alterations in the nervous system resulting from antidepressants and their therapeutic effects, and therefore the biochemical heterogeneity of forms of depression is not constrained within all antidepressant medication options (Ehrenberg 2000: 177). Caponi emphasized that antidepressants have a preponderant position in the rationale behind the characterization of the depression diagnosis (Caponi 2009: 334). Finally, Shorter remarked that systems for classifying diseases do not tell us which patients will respond to which drugs (Shorter 2009: 5). In the case of ADHD, the link between psychopharmaceuticals and nosology is different. Even when new psychopharmaceutical agents such as atomoxetine (which entered Argentina in 2004) were incorporated, changes in nosological criteria were not primarily led by the introduction of these new drugs.

In our fieldwork analysis, methylphenidate emerged as the first drug of choice in the treatment of ADHD, and methylphenidate is the drug with the highest sales in Argentina for the treatment of this condition (fig. 9.1). The ratio of national sales between methylphenidate and atomoxetine is 3.5 to 1, as figure 9.2 illustrates.

Therefore, in the case of ADHD, it is possible to assert that methylphenidate itself has undergone a process of modifications in terms of forms of administration (ER, or extended release; MR, or modified release; OROS, or osmotic release oral system; SODA, or spheroidal oral drug absorption system; and the transdermal patch, among others) by virtue of its association with nosology. This emphasizes the fact that the depression model, despite being frequently chosen by researchers, does not bear out the explanatory possibilities of medicalization processes in the twenty-first century. Although other drugs such as atomoxetine have been used, research on them is not as significant as it is for new antidepressant drugs, and nosological criteria are not driven by the introduction of

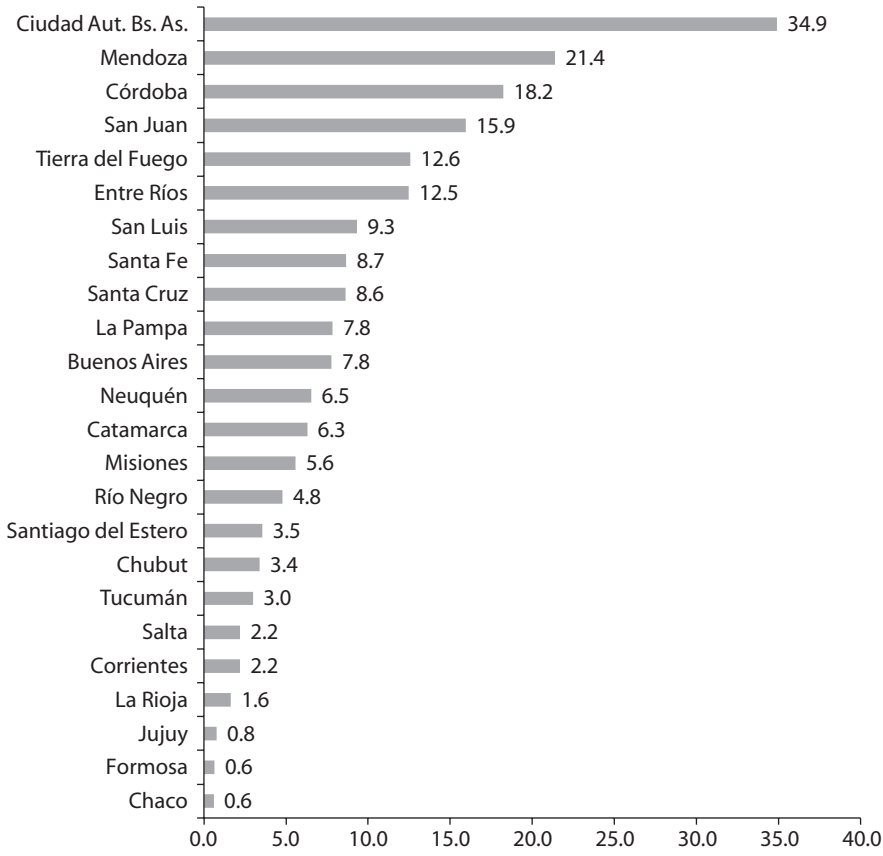

Fig. 9.1. Dispensed units of methylphenidate per 1,000 children aged 5–19, by province, 2006. *Source*: COFA

new drugs. In this way, the association with nosology has been sustained and continuous—predominantly by the administration of the same psychopharmaceutical, methylphenidate—and what changed throughout time was its form of administration, in order to adjust the intake to the requirements of the child's daily life.

Methylphenidate Behavior

Not many statistics on the prescription and consumption of psychostimulants have been published in Argentina. However, as our fieldwork interviews revealed, different professionals, medical associations, and journal articles have referred to the continuous increase of methylphenidate sales.

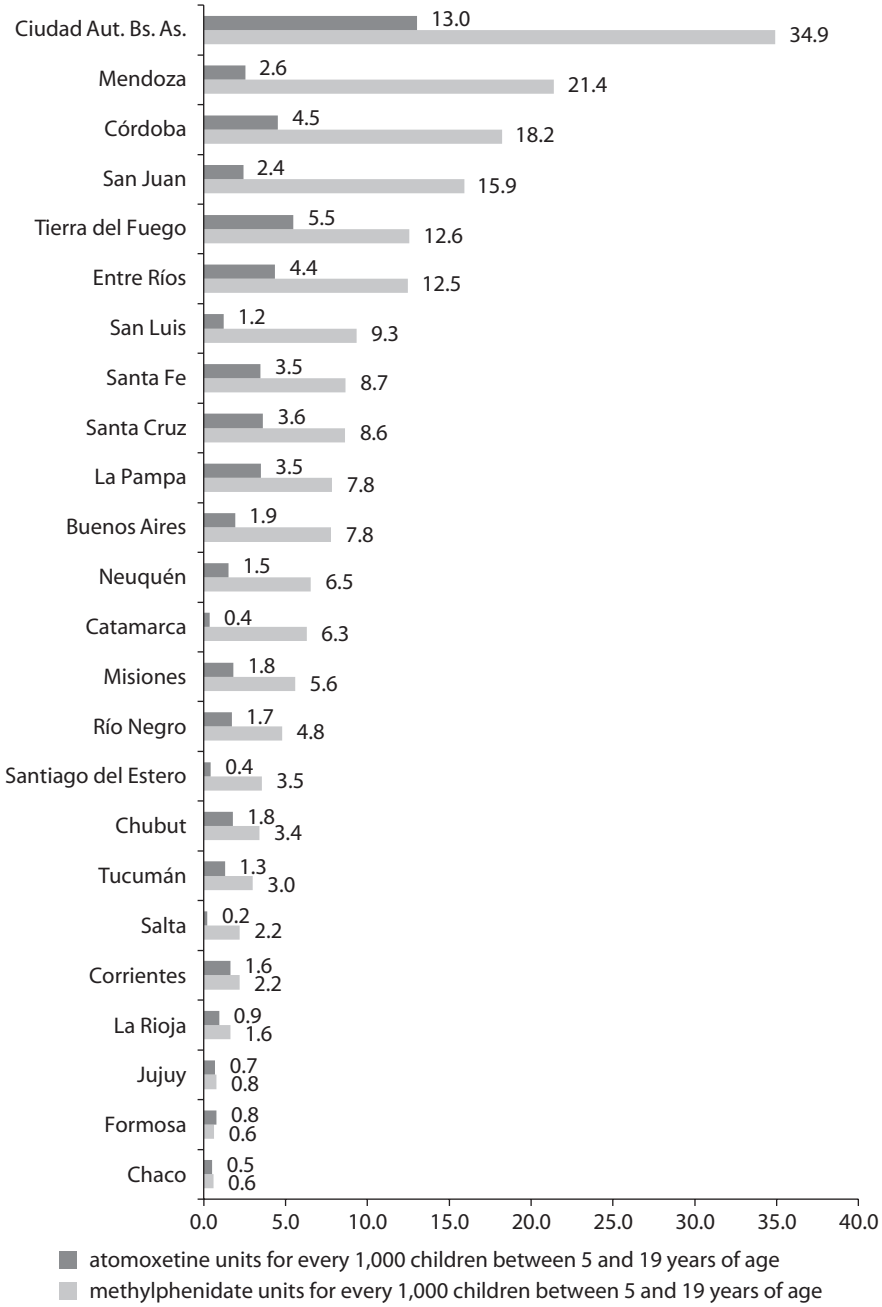

Fig. 9.2. Dispensed units of methylphenidate and atomoxetine per 1,000 children aged 5–19, by province, 2006. *Source*: COFA

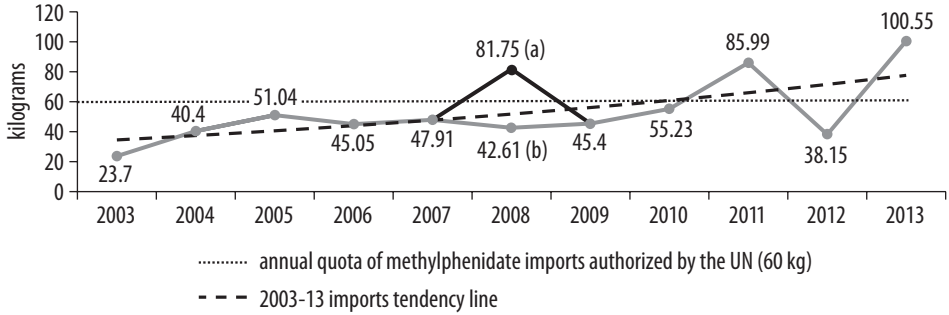

Fig. 9.3. Methylphenidate annual imports in Argentina (kg). *Sources*: Carbajal 2007; Arizaga and Faraone 2008; Maniowicz 2011; pers. comm. with ANMAT, 2014

Information provided by the Argentine Administración Nacional de Medicamentos, Alimentos y Tecnología Médica (ANMAT), from the Departamento de Psicotrópicos y Estupefacientes, identifies 2004 as the year in which the quantity of active ingredients imported into the country began its escalation from 23.7 kilograms in the previous period to 40.4 kilograms, in an upward trend that has been consolidated ever since (as figure 9.3 illustrates). The Departamento de Psicotrópicos y Estupefacientes does not have records about atomoxetine (which is classified as an antidepressant) because the drug is not included in its psychotropic lists. Atomoxetine is commercialized and sold in Argentina by 2 laboratories in 10 formulations and 5 different concentrations.

As can be deduced from the previous analysis, the prescription and consumption of methylphenidate is a crucial element in the current configuration of ADHD in Argentina. This psychostimulant had not been marketed in the country for several decades when its use became popular among university students in the 1970s. It was commercialized as metamphetamine racemate and was used to optimize academic performance. Due to the death of some women who were using it in order to lose weight, the Sociedad Argentina de Cardiología warned against its effects in the adult population and it was withdrawn from the pharmacological market all across the country. Later, as we pointed out, it was reintroduced for sale in the 1990s, this time as methylphenidate and in response to a demand from parents and physicians (see Carbajal 2007: 238, though the author does not specify from which interest groups this demand came) who were interested in accessing the drug without having to manage purchases from the United States. At present, sales require the submission of an official prescription issued by the Ministerio de Salud, and physicians must have acquired this prescription

form previously with the subsequent authorization of the Ministerio de Salud. Prescriptions are handled in triplicate and under a filing procedure by ANMAT. Since reintroduction of the drug in the 1990s, methylphenidate has been exclusively prescribed for the treatment of ADHD, and the trend of the annual importation quota for its commercialization is markedly upward (as fig. 9.3 illustrates). This tendency is consistent with the global trend, as expressed by the International Narcotics Control Board (INCB) in its 1995 and 2006 reports.

The reintroduction of the drug can be seen as the expression of the establishment of a new relationship among parents, professionals of diverse specialties, and pharmaceutical laboratories, centered around the acquisition of a fundamental supply of certain therapeutics. The reintroduction of methylphenidate in Argentina (with the exclusive prescription for ADHD treatment) opens the possibility of the emergence and proliferation of a diagnosis that includes the use of this drug as the first-choice treatment. This reintroduction also gave way to "possibility conditions" (in the Foucauldian sense) involving a whole series of discourses and practices in specific child health field sectors and pressure groups that offered—and still offer today—strong resistance, formulating and proposing diagnostic and therapeutic modalities that are not centered on the drug. Presently, methylphenidate is produced in Argentina by 5 laboratories in 17 formulations and 8 different concentrations, and it is distributed in fast-acting and extended-release forms.

Despite the limitations and difficulties related to obtaining data on methylphenidate, we reconstructed the series of its importation for the years 2003–13 from various sources that ANMAT uses as data providers. The 2003–4 series was taken from Carbajal (2007: 239); for the 2005–8 series, we used Arizaga and Faraone's research (2008: 81); for the 2008–10 period, we obtained data from Maniowicz (2011); and for the 2011–13 period, we requested data directly from ANMAT.

Figure 9.3 records discrepancies in the values in 2008: Arizaga and Faraone referred to values over 80 kilograms (81.75, see [a]), and Maniowicz referred to a lower value (42.61, see [b]). These differences are significant because the quota that Argentina agreed to with the United Nations is established at 60 kilograms/year. However, as a tendency, all sources appear to indicate a sustained increase in the importation of methylphenidate.

In this polemic scenario of strong public debates around the consumption of psychotropic medication, an important milestone was the publishing, in 2005, of the "Consenso de expertos del área de la salud sobre el llamado Trastorno por Déficit de Atención con o sin Hiperactividad" ("Health Area Experts Consensus

on Attention Deficit Disorder with or without Hyperactivity"), a statement signed by approximately 200 renowned professionals of various specialties on the issue (it has more than 1,100 signatures). It was addressed to the Argentine Ministerio de Salud and submitted to it through the executive power, including a formal information request on ADHD diagnosis. The document criticized the spread of the ADHD diagnosis and the psychopharmaceutical prescription for its treatment, and it highlighted some side effects of methylphenidate. It also proposed that only expert professionals in the field assess children, that medication be a last resort only, that the child's family and social context be taken into account, and that the broadcasting of information about ADHD in the mass media be restricted, given the controversies among professionals on the very existence of the symptomatic frame (Forum Infancias 2015). The document was reviewed by Congreso Nacional, the Argentine Cámara de Diputados Nacional in 2006, and the Comisión de Acción Social y Salud Pública, de Educación y de Familia, Mujer, Niñez y Adolescencia. Moreover, in 2007, ANMAT ordered the laboratories that sell both of the main psychopharmaceuticals used in ADHD treatment (methylphenidate and atomoxetine) to improve their package leaflets so that they included warnings, precautions, and associated contraindications (ANMAT 2007).

Strategies of the Pharmaceutical Industry and the Biomedical Technologies

As already pointed out, the pharmaceutical industry has a central role in the medicalization and biomedicalization of childhood processes. Conrad (2007: 133), Moynihan and Cassels (2007: 19), Cabral Barros (2008: 580), and Iriart (2008: 1623) note that the pharmaceutical industry and biotechnology are the main actors in the new configuration, in which psychoactive medication is integrated as a fundamental piece in the institutionalization of pharmacologization in the first years of a child's life. Conrad analyzes the global picture in his 2004 study: consumers become the target for market expansion, with physicians largely remaining as gatekeepers prescribing treatment. In private medical markets, due to limits in types of permitted promotion (e.g., for off-label uses), corporations offer promotions indirectly to providers or consumers (e.g., on the Internet). Thus, consumers are the prime driver for demand—generally without insurance support—and must pay directly for medical products or services. Then, physicians are necessary facilitators for treatment and sometimes promoters (i.e., entrepreneurs) of the product (e.g., cosmetic surgery) as well.

Contributing to this scenario, the pharmaceutical industry has occupied new niches as it puts forward other ways of advertising to the general public, such as indirect promotion to providers via off-label use or to consumers on the Internet (Conrad and Leiter 2004: 168). This global trend, which is no stranger to Argentina, has erupted in recent decades as a radical transformation from the concept of health users to the idea of health consumers. Broadly speaking, this notion can be analyzed through Michel Foucault's considerations on the spread of the *homo œconomicus* model, typical of American neoliberalism, into all forms of behavior. In Foucault's words, *homo œconomicus* is "someone who is eminently governable" (Foucault 2004: 270). The adoption of this model results in the concealment of the social dimension of these processes because it turns claims and demands on health rights into health services acquisition issues and places access to medication and treatment in the place of a free choice (Conrad and Leiter 2004: 169).

In our analysis of pharmaceutical industry sale strategies in Argentina, we observed a mixture of a physician-oriented marketing model (in which the physician is the main target) and a direct-to-consumer–oriented one (family and school included). In the analysis of the former, especially within the medical field, our research revealed a close monitoring by the pharmaceutical industry of what and when doctors prescribe, through important marketing companies (Jara 2007: 197) and the growing use of sales representatives. In the analysis of the latter, an essential component is the uneven relation between pharmaceutical companies and family and patient associations.

With regard to the physician-oriented marketing model, in Argentina the main market research companies are International Market Survey and Close Up. For the latter, Lakoff (2004: 258) has analyzed how data are registered per doctor, product, and prescribed quantity according to the copies of microfilmed prescriptions obtained from big pharmaceutical brands in the city of Buenos Aires. Within this model, pundits play another important role in pharmaceutical marketing strategies: pharmaceutical sales representatives detect and value physicians according to their role within their specialty, and those physicians are then promoted as part of the "expert" category. As experts, they spread their latest findings on diseases and possible pharmaceutical therapies in journals, scientific sessions of all kinds (lectures, meetings, conferences, etc.), and guidelines for consent based on evidence. These experts generally belong to prestigious private institutions in the city of Buenos Aires and elsewhere in the country.

With regard to the consumer-oriented marketing model (and in a parallel fashion), some family and patient associations have gradually gained stature as new relevant actors. In the case of ADHD, one of the most important associations in the United States is Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD). Conrad (2007: 139) and Moynihan and Cassels (2007: 73) agree that these groups, whose speakers support pharmaceutical research and treatment, are in some cases funded by pharmaceutical companies. As Conrad and Bergey (2014: 36) pointed out, the pharmaceutical industry is expanding its marketing strategies to nonmedical professions. These authors have found these groups mainly in the educational field and named them "sickness and treatment brokers" or "disease spotters": they constitute a main element in the circuit of referrals and treatment for ADHD since teachers contribute to its diagnostic evaluation by filling out forms and the like.

In Argentina, the alliance between industry and parents and patients is still in an emerging phase and lacks the development acquired in the United States and some European countries. Our fieldwork in Argentina revealed the existence of collaboration among teachers and educational psychologists in the diagnosis and early detection of ADHD (Faraone et al. 2010: 494). This takes shape in two different ways. First, pharmaceutical sales representatives—with or through medical specialists—go to schools or carry out informational talks in educational psychology offices (these encounters are referred to as *mesas de ayuda* [help desks]). The second involves teacher-oriented information in the form of handbooks, manuals, and briefs that include statistical data, general advice for profile detection, and detailed information on psychopharmaceuticals.

These modalities (both help desks and the use of these publications) are not allowed in Argentina because, as already mentioned, they constitute a violation of the Ley Nacional de Salud Mental passed in 2010 (INFOLEG 2010). Apart from this, according to national legislation on control of technical and economic norms on medicines through Ley 16.463 of 1964, all forms of publicity on prescribed medicines are forbidden in Argentina (INFOLEG 1964). We were able to document some other modalities of pharmaceutical publicity and marketing aimed at the education community in Argentina, including the distribution of merchandising in the form of school stationery at Buenos Aires institutions (in both the city and the province) with logos, images, and slogans of both the laboratory and the specific drugs. We also found the dissemination of academic articles on ADHD in specialized magazines for teachers and psychopedagogists.

In conclusion, both marketing models can be observed in Argentina: the physician-oriented model and the consumer-oriented model. Within the latter, four modalities can be found in relation to educational institutions: the use of help desks, the distribution of merchandising inside schools, the publishing of booklets on ADHD-related information addressed to teachers, and the dissemination of academic articles on ADHD in specialized magazines for teachers and psychopedagogists.

Mental Health Law and Classification Manuals

As mentioned before, the process of the nosological redefinition of ADHD is central in Argentina, especially since the global spread of the use of the *DSM-III* (APA 1980) because it reveals an increase in the diagnosis and psychopharmacological treatment of ADHD and suggests close relationships among classification manuals, diagnostic constructions, and the pharmaceutical industry (Bianchi 2012: 1029). It seems that the *DSM* has a core role in the problematics of ADHD in Argentina. References to other manuals were marginal in our interviews. For example, the *ICD-10*, which is published by the World Health Organization (WHO), was seldom mentioned even though it was obligatory for diagnosis and statistics on public health in the country. Mentions of the *Classification française de troubles mentaux de l'enfant et de l'adolescent* (*CFTMEA*) were even rarer.

The repetition of definitions, references, and allusions to the *DSM* as the almost exclusive source of conceptualization for ADHD during our fieldwork interviews shows the preeminence of this manual over other available references (Stagnaro 2006: 339). This manual is referred to as the primary instrument for practice or as the basis of a theoretical framework. However, it is not exempt from tensions since it has become the source of doubts, debates, and questions. These polemic expressions link to the concept of a mental disorder that has defenders and detractors and the questioning about whether it is a valid concept with which to approach childhood problems.

In the case of ADHD in Argentina, the criticisms of the *DSM* are also currently related to the Ley Nacional de Salud Mental. In its first article, the aim of this law is defined as "the enjoyment of human rights of those people with mental suffering" (INFOLEG 2010). This definition often leads to intense debates in legislative chambers because the concept of "mental suffering" displaces, on the one hand, the concept of a "mental disorder" and, on the other hand, medical-pharmaceutical hegemony. In relation to this concept, the law emphatically expresses the need

for an interdisciplinary approach to populations with "mental suffering" and reserves the use of drugs exclusively for therapeutic ends, never as a punishment or for the benefit of a third party. These two assertions are deliberate; they explicitly depict the permanent struggle among the professional sectors involved in the field of mental health. In the case of ADHD, the law strengthens groups that, as we have pointed out, are positioned against the pathologization of childhood.

Conclusion

In Argentina, the pharmacologization of childhood that derives from the use of methylphenidate for ADHD treatment has caused and still causes many controversies. The panorama that is outlined is extremely complex and involves multiple actors (from fields such as health, education, economics, and politics) and their related frameworks. This panorama also presupposes the deployment of legislation, norms, classifications, and technologies, with no unitary or lateral effects to the process. ADHD appears as the meeting point for all these fields and actors. It is an arena in which they intersect, and far from developing it in harmony, they fill it with tensions and debates. At the same time, it is an arena in which strong articulations take place.

Although the *DSM*-5 (APA 2013) was published in Spanish in 2014, even before its publication we have documented various scientific meetings, conferences, and gatherings of a different nature offered to professionals in Argentina in order to guarantee that the manual will prevail. In light of the actors involved in the problem, we do not dismiss the fact that the emergence of the *DSM*-5 will reignite the conflicts with associations that have already established deep disagreement with the manual.

Another aspect worth mentioning is the distinctive configuration of ADHD's problematics in Argentina. Three matters emerge as relevant. First, there is the focus on rights (in the Ley Nacional de Salud Mental, with its human rights perspective, and the UN Convention on the Rights of the Child, which Argentina ratified and links to its legislation in general and the law mentioned in particular) and the stance taken by some professionals who contest the validity of a pharmaceutical-centered treatment of ADHD and the pathologization of childhood. Second, actions from diverse psychoanalytic-related therapeutical-clinical perspectives and from different professional associations tend to halt the advances of the pharmaceutical industry and of the classification of the *DSM*. Third, there is the target of diagnosis and treatment for ADHD: children of middle-class families. In this sense, the high costs of methylphenidate and its exclusion from

health care coverage end up constituting an obstacle to a bigger expansion. However, within the middle-class sectors, certain familial and pedagogical expectations are reconfigured as health services for consumers' demands and are accompanied by personalized treatments.

Yet another aspect of legislative matters is the verification of active normatives that can be a frame for controlling the expansion of the sales of psychopharmaceuticals for use in children. By and large, as Conrad and Bergey describe (2014: 36), countries that impose strong legal constraints on the use of stimulants represent an obstacle for the penetration of pharmaceutical companies' marketing strategies; conversely, countries that impose laxer constraints result in more accessible markets. This is the case in Argentina. Moreover, as we have described, it has coincided in recent years with the opening up of pharmacological industries' marketing strategies, which have directed their efforts toward consumers and familial organizations and toward educational communities. Even if these actions are forbidden by legislation proper, within their gaps specific actions consolidate therapeutic strategies in which the prescription of psychostimulants is a first choice for treatment.

NOTES

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1. Local psychiatric associations, particularly the *Asociación de Psiquiatras Argentinos*, or APSA, vigorously resisted the Ley Nacional de Salud Mental. The law's first article guarantees full enjoyment of human rights for people with mental suffering. When the bill was proposed in Congress, this definition provoked intense debate for two reasons. First, the concept of "mental suffering" displaces the notion of "mental disorder" used by biological psychiatry. The eighth article of the law promotes the creation of interdisciplinary teams that should include psychologists, psychiatrists, social workers, nurses, occupational therapists, and professionals from other disciplines to care for patients. Second, the law confronts medical-pharmaceutical hegemony by stating that medications must only be prescribed for therapeutic purposes to people undergoing mental suffering; they should never replace therapeutic accompaniment or special care. Moreover, the 12th article of the law also establishes that psychopharmaceutical treatments must be used in the frame of interdisciplinary approaches. Finally, the UN Convention on the Rights of the Child and the local law based on it guarantee human health care rights to all children in Argentine territory. This questions the very nature of pathologization as a valid claim for treatment. Thus, on a regulatory level, this was another

element that helped some sectors resist the increase of the ADHD diagnosis and the rise in psychopharmaceutical use related to it. As will be seen in the analysis, from both exclusively medical perspectives and regulatory approaches, Argentina has traced a unique path regionally and worldwide.

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