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Care entanglements: Upholding difference through the uses of mental health diagnosis in Chilean schools

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Abstract

This article draws upon findings from fieldwork conducted with Chilean mental health practitioners and school staff to explore how children's mental health diagnoses can be used in the school setting as a particular rationale to mobilise and convey new forms of care practices (Mol, *The logic of care: Health and the problem of patient choice*, 2008). Inspired by the framing of care as an interrelational, interdependent and more-than-human affair promoted by Science and Technology Studies, and drawing from conceptual tools offered by post-humanist approaches, we focus our examination on the diagnosis of attention deficit-hyperactivity disorder (ADHD). Following the diagnosis since its formulation by clinicians in the public sector to its enactment in an urban school in Santiago, Chile, we explore how certain caring/uncaring practices are enacted in relation to the diagnosis, reconfiguring the classroom by incorporating (non)human actors to care for the diagnosed child. However, care is ambivalent, and the diagnosis can be put into action for other purposes as it interweaves with educational policies and other agendas. Thus, to produce policies that truly foster inclusion, attention must be given to the micropolitical level where disabilities and disorders are enacted, developing

appropriate ethico-political and affective sensitivities to care accordingly.

KEYWORDS
care, disabilities, entanglements, posthumanism, STS

INTRODUCTION

Once again, an Inclusion Programme member discreetly enters the classroom, heading directly to where Valentin is sitting down. *"How are you doing?"*, she asks, to which he replies he is doing fine. The SEN teacher puts her hand in her pocket, and takes out a piece of candy, which she then leaves on the table in front of Valentin. *"Here, a treat for your effort"*, she says to Valentin. He looks at her and gratefully smiles, proceeding to unwrap the candy and eat it, as the SEN teacher leaves the classroom. I follow her to the hallway and ask her about Valentin and her motivation to hand him the candy. She replies: *"He's rather restless, but he also has a special bond with Amanda, the Headmistress of the school. Although he's on medication, he doesn't receive any specific intervention from us [the professionals of the Integration Programme]. He's a good student, with good grades. He is just restless. Go figure that this is his medicated self! Without the medication he probably would never remain inside the classroom. Our job with him is more behavioural than cognitive, it's to be with him and guide him [in navigating his time at school]"*.

(Field note, 11 November 2021, Spanish class)

Episodes like the above mentioned have grown increasingly common in the Chilean classrooms during the last 2 decades. Particularly since 2009 when, as part of a series of educational reforms, the Chilean government developed and implemented the *Programa de Integración Escolar* [School Integration Programmes] or PIE programmes, aimed to promote inclusion into a mainstream school setting. The PIE programme established a particular logic, where State funds are directed to hire specialists to work with children with Special Educational Needs, thanks to the legal framework provided by the promulgation of Decree 170. Through this decree, the Chilean State commits additional resources to public and private voucher schools—private schools that receive a state subsidy per student enrolled—that have students with disabilities or that are diagnosed with any of the mental health conditions listed in the decree (Ministerio de Educación, 2016).

Schools can join the programme on a voluntary basis. Once the school incorporates the programme, only students with a disability diagnosed by an expert external to the school can receive permanent or transitory support to ensure school learning. Since the Chilean educational financing system works through subsidies on demand, diagnoses must be renewed year after year, in order to maintain the additional funds allocated to the identified children. Schools may decide not to join the PIE programme, although the *Ley de Inclusión Escolar* [School Inclusion Law] demands that integration and inclusion happen at all educational institutions (Biblioteca del Congreso Nacional, 2015). The PIE programme and Decree 170 operate as a guide on what to do in cases of dealing with special educational needs, inspiring private schools to create similar

support programmes of their own. This decree conceptualises special educational needs as barriers to learning and participation that certain students experience—permanently or temporarily—as a result of a disability.

The PIE programme has, however, been under scrutiny by local experts. Specifically, amidst the accountability policies shaping the educational institutions currently in Chile, the use of mental health diagnoses seems to act as technologies of normalisation oriented by neoliberal principles (Rojas Navarro, 2019). As such, they frame disabilities as abnormalities in search of correction (Davis, 2013) or as identity markers that solely conjure detrimental effects (Harwood, 2006). Moreover, the interlinks between the PIE programme, accountability politics in education and the use of mental health diagnoses have been deemed as dangerous ones, as they set an economic incentive for schools to diagnose children in order to incorporate them into the programme, securing extra funding in the process. Yet, and despite the criticism that this practice has received, the PIE programme seems to have set a new image of how inclusion should happen in urban schools, even in those educational institutions that have not implemented the programme. But without these financial incentives found in public and subsidised schools that push for diagnoses to be performed, could they operate otherwise? Can such policies be enacted in a more careful way, following different logics and prompting different effects?

In this article, we examine how children's mental health diagnoses can unfold in the school setting to convey care and caring practices aimed at upholding difference and granting diagnosed children with alternative means for participating in the everyday dynamics of the school. Mainly, we focus on one disability diagnosis which has been highly disputed and controversial: attention deficit-hyperactivity disorder, or ADHD (Bergey et al., 2018). Our interest in ADHD lies precisely in its contested nature as a biomedical diagnosis, since it was highlighted by Peter Conrad as an illustrative example of how biomedical authority was being used to sanction deviance by framing it under biomedical terms, following a process that came to be known as medicalisation (Busfield, 2017). Although we agree that psychiatric knowledge can be used in power relations to foster control and dependence, we believe that this process is more nuanced and open-ended than it is commonly credited with in medicalisation literature. Scholars working in the field of Science and Technology Studies (STS) have illuminated other possible relationships with biomedical knowledge. However, this requires thinking about individuals not threatened by or opposed to biomedical technologies but collaborating with them, affecting each other and thus unfolding together (Rojas Navarro & Vrecko, 2017; Thompson, 2005).

To think about this collaboration in our research, we turn to the concept of care, and explore how the ADHD diagnosis can be enacted for caring purposes. Care, as a critical concept, enables the illumination of an alternative set of everyday activities and affects, composing the micropolitics of the school. These practices offer a complementary standpoint to more traditional theories and accounts found in medical sociology and disability studies, that commonly encompass a rather narrow notion of care, which risks reducing care relationships and practices to issues of power and dependence (Thomas, 2007). Taking inspiration from conceptualisations of care developed in Feminist Theory and STS, we argue that care involves an ethico-political sensitivity that comes into play in everyday affective and material relations (Latimer, 2018). *Care is a doing*, happening in everyday practices that take place in a micropolitical dimension (Puig de la Bellacasa, 2019). Such a notion of care offers an alternative lens to think about how mental health diagnoses operate beyond determinism, not as top–bottom technologies that need to be contested to keep biomedical colonialism at bay (Conrad, 1979), neither as labels exclu-

sively used to foster dependency (Smart, 2004), but rather as conjurers of human and non-human actors that can simultaneously work together in different ways. As we explore in this article, mental health diagnoses can also prompt careful interactions, enabling new forms of negotiation and collaboration between those diagnosed and the other actors present in the school premises and beyond (Rojas Navarro, 2019, 2022).

Our article does not attempt to dismiss previous contributions highlighting the limitations of School Integration Programmes both globally (Singal & Muthukrishna, 2016) and locally (Apablaza, 2017). Indeed, much has been written about how these programmes link ideas of disability and inclusion in ways that are prone to being criticised, as they tend to rest upon the idea that it is the diagnosed child that needs to adapt to the environment, and not the other way around. This has the effect that, in practice, the integration programmes work by excluding the very same students that they are supposed to include, by labelling them as 'different' and pulling them out of the quotidian pace and rhythm of activities happening in the classroom. Our contribution recognises this significant backdrop but takes a different direction. As Puig de la Bellacasa (2019) argues, 'critique is just not enough', and our duty is to add an additional amount of awareness and engagement to the struggles happening in classrooms. To do so, we seek to understand why diagnoses were performed by medical practitioners in the first place, and what were their ideas of how they would unfold in the school setting. As expected, caring for the child was at the centre of this process, as it was for the educators and professionals working in the integration programmes.

Moving beyond the analytical lens provided by thinking about diagnoses solely as a top–bottom dynamic allowed us to explore a different framing of the problem on a micropolitical level. By paying attention to those 'devalued labours, effects and technologies' linked to the integration programmes beyond mere critique, we dispute diagnoses from neoliberal practices that have tied them exclusively to ideas of ableism and exclusion (Davis, 2013). Hence, this article contributes to illuminating a different aspect of mental health diagnoses: their capacity to convey care in a way that does not foster dependence, but collaboration, allowing the emergence of caring entanglements in the school setting.

METHODS

This article draws upon a 3-year study, starting in October 2019 and lasting until October 2022. Considering our aim to explore how the diagnosis of ADHD, as a non-human actor, can convey care as it gets interwoven with other human and non-human actors in the classroom setting, we aimed at involving all those taking part in such an entanglement. Therefore, the research project mobilises three different modes of data collection:

(1) Interviews with 10 mental health practitioners who have worked performing mental health diagnoses for educational purposes, either for accessing the PIE programme, or for remaining part of it. We also conducted five interviews with educational psychologists working in PIE programmes in different nationally distributed schools, and eight interviews with teachers and professionals working in a PIE-like integration programme at a local school in Santiago, Chile.

(2) We conducted quasi-ethnographic research (Jeffrey & Geoff, 2004) at a school with a PIE-like integration programme. Although initially we intended to conduct ethnographic research in

three schools, due to Covid-19 restrictions we narrowed our scope and, after negotiation with the schools and listening to their concerns and interests, we conducted a more focussed and briefer version of the traditional ethnographic approach in only one school.

(3) We conducted documentary analysis of official documents and guidelines shaping the everyday actions inside the school.

This article draws mainly on interview data, with the addition of some excerpts from the fieldwork to better elucidate how the concerns of clinicians and of educational staff unfold daily in the school.

Participants in the interviews were initially contacted via an invitation posted on the research project's social media accounts and website, and on the researchers' social media accounts. After being interviewed, most participants spontaneously offered to contact and invite other colleagues to participate, following an enhanced snowball sampling method (Kirchherr & Charles, 2018). Information sheets and consent forms were distributed to participants. Interviews were held via Zoom, which proved to be a viable tool for producing qualitative data as it provided a sense of safeness in relation to sanitary hazards linked to the pandemic. Also, Zoom proved to be a convenient tool in terms of access, time and cost effectiveness, allowing us to interview medical practitioners living outside the metropolitan region (Archibald et al., 2019).

Initially, public and private voucher schools from the city of Santiago were contacted and presented with the research. Participation required schools to open their doors so we could carry out interviews with the Special Education Needs teams during the first year and develop ethnographic observation during the second. Three schools agreed to participate, but with the onset of the Covid-19 pandemic, two of them requested not to continue. As for the third school, access was granted after interviewing its headmistress, who then acted as gatekeeper and vouched for our research to the non-profit foundation financing the school. Researchers had to adapt to the new conditions for physical distancing and capacity required by the Ministry of Health and the Ministry of Education.

The school, which we will call 'Saint Peter', is a private state-subsidised institution located in a semi-rural borough of the metropolitan region of Chile. Although the school did not have a PIE programme, it did have an Inclusion Unit which mirrored PIE procedures, aims and goals. Their pupils include vulnerable children from close-by slums and neighbourhoods. The school's educational model seeks to provide excellence in education to children living in vulnerable conditions. In addition to academic excellence, values that are identified with Catholicism are promoted. Their expectation is that by delivering this educational model, children will have better tools to face life and improve their material conditions.

The invitation to participate in the research, consent forms and thematic script used for the interviews were reviewed and approved by the funding body and the sponsoring university. These forms and documents underwent the highest levels of scrutiny to gain ethical approval. These institutions deemed this research 'high risk' since it involved children diagnosed with a mental health diagnosis, so additional protocols had to be fulfilled to gain approval. Additionally, and following ethical regulations dictated by these institutions, data were collected only from people who consented to participate. Pseudonyms replaced all names of persons and places. The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions. Finally, data were coded and analysed with the help of NVivo qualitative software.

ADHD DIAGNOSIS AS AN AMBIVALENT WAY OF CARING: WHY DIAGNOSE?

> Sometimes, I think that we search to diagnose whatever fits with the Integration Programme so you can grant the child access to it, and help them. I really don't believe that people do that with, like, a Machiavellian purpose [of performing mental health diagnoses to secure additional funding]. Or... maybe, it can be that as well, because that's what is terrible about this system: it links diagnoses to money.
>
> (Gaspar, Child Psychiatrist, interview, 23 April 2021)

ADHD is, presently, a controversial diagnosis. Its legitimacy has been constantly questioned by experts in education and the social sciences, who claim that the lack of relievable biomarkers for this condition is proof of its sociocultural rather than biological nature. For its part, those arguing in favour of the biological existence of the diagnosis claim that this restless questioning of ADHD as a medical entity deeply troubles those affected by it, increasing stigma and misconceptions about the true nature and extent of this condition (Faraone et al., 2021). We are not attempting to solve these polemics, but to move beyond them. Our interest lies not in joining the debates about the true nature of this condition, but in understanding what the diagnosis produces (Rojas Navarro & Rojas, 2019), and in revealing the rationalities traversed by clinicians to opt for diagnosing a child with ADHD. As we discuss in this section, clinicians' narratives show how diagnosing can be considered as an ambivalent way of caring.

Scholars in STS and feminist theory have emphasised that care is not a straightforward process. As a concept and practice, care is filled with ambivalence and contradictions. In the name of care many things can go wrong. Yet, it is not possible to think about the continuity of everyday life without care. While traditional narratives of care, revolving around the ideas of 'caring for' and 'caring about', account for different modes and elements involved in the process of caring, we argue that they are insufficient to grasp the full complexities linked to care. We agree with them that care is intrinsically interdependent and necessary for sustaining life, yet we urge to push care beyond its traditionally humanistic assumptions. Interdependence operates by bringing together a vast array of more-than-human actors, objects and spaces. Care is open-ended and in constant reconfiguration. As Martin et al. (2015) argue, acts of care are intrinsically embroiled with everyday politics, making some things noticeable and worthy of affection and attention while excluding others, as care is also a policy of knowledge (Puig de la Bellacasa, 2017). Data produced with our interviewees show how care 'organizes, classifies, and disciplines bodies' and can become 'a means of governance' (p. 3), while at the same being central for attending to the needs of those who risk being neglected, and upholding life. This ambivalence can be noted in the words of Carolina, a child psychiatrist, who argues:

> The main issue is, what use do you give to it [the diagnosis] after you perform it? The idea is not that it is used to pigeonhole them [the diagnosed children], or to say "children with ADHD are...", you know? This is infrequent nowadays, but before things like that used to happen, things like someone saying "ok, everyone that has to take a pill come to this or that room". So yeah, in situations like that with those difficulties that are not necessarily connected with the process of diagnosing, but are rather linked with whether that diagnosis is turned afterwards into practices that meet what that child needs. That is what is more complicated. To me, in general terms, if there is a child that truly shows signs of ADHD, or that I think could benefit

from having medication... to me that is not as complicated a decision as not knowing where that diagnosis is going to land, you know?

(Carolina, Child Psychiatrist, 28 October 2021)

Carolina's worries match what has been theorised by Annemarie Mol (2008), when arguing about the importance of distinguishing in health-related practices between caring *for* and caring *about* someone. To Mol, clinical practice invokes an institutionalised mode of caring, distinguishable for its goal-oriented practices aimed at improving the needs of patients. However, one can care for somebody without caring about her. This means that one could do what it takes for someone to feel better, without actually having a particular affective disposition towards her. However, both modes of care can coexist, and caring about someone can lead to specific actions to ensure that the person is being cared for. The interviewees tend to agree on this point. The diagnostic practice is a way to care for the child, but is not enough to care about her. This needs to translate into actions, some of which escape their control and professional jurisdiction. As Carolina mentions, the crafting of the diagnosis can be performed with best intentions, it can be deemed as a mode of 'response-ability' towards the needs of others, a way to compose worlds together and to mind other's needs (Haraway, 2016). But as relational phenomena, diagnoses can also become hazardous non-human actors. And although their crafting can come from a process of ethical and affective encounters with another, they can become entangled in other kinds of arrangements.

What does it do [performing the diagnosis]? Well, it produces many things. First, it allows us to organise reality in a certain way that allows us to push interventions that could help the child. I mean, for instance, if she has certain problems, and she is assigned to a diagnostic category, hopefully this goes along with a wider understanding of her problems. I mean, the diagnosis is aimed at producing a deeper understanding of her discontents.

(Javier, Child Psychiatrist, 9 December 2021)

Well, basically, the diagnosis is performed to help the child, to name whatever is happening. And often it helps to externalise the symptoms so you don't frame it like "this kid is manipulative", or "she is lazy", but rather to acknowledge that she really is facing an obstacle and that we are going to work on that. And with some disorders, it helps to bring all of us together, including the family, against what is wrong (...) and it also helps to guide school' interventions.

(Paola, Child Psychiatrist, 3 May 2021)

As seen in the excerpts, psychiatrists think about the diagnosis as an ethically oriented practice that is directed at imbuing a new sense of agency to the diagnosed child. For them, the diagnosis grants the child the possibility to be different in a way that avoids classifications that might relegate them to positions that risk neglect and punishment. It is a way to recognise a struggle and offer potential support to overcome it. Yet, this has been a matter of debate in some approaches working on Disability Studies, where it is argued that by accepting the biomedical framing proposed by the medical model, the one being cared for is relegated to a position of dependence and passivity. As Wynance (2010) mentions, from such a standpoint, the diagnosis can be considered as a mode of coercion, involving a loss of independence and control. But such rationale only stands if one thinks about dependence and autonomy in absolute terms, as though

one has to be totally autonomous and free, or face total dependence and control. From the standpoint of the interviewees, the ADHD diagnosis does not operate like that. It resembles more what Gomart (2002) has called a 'generous constraint'. For Gomart, to care can entail a loss of freedom, however absolute freedom is not the highest good, but part of a constellation of elements that are in constant accommodation and rearrangement. As such, no one is totally dependent or independent, but carers and the one being cared for exhibit varying and shifting forms of engagement and (in)dependence while working together, constantly reassembling their interactions. As Gomart argues, agency is not the capacity to act alone but to 'deploy skillfully and cunningly the right conditions in order to allow action to arrive; to act because one was generously constrained' (p. 546). Following such understanding, the diagnosis can be reframed to think about disabilities not from the liberal notion of individuality and ableness, but in terms of multi-faceted relationalities that are in continuous rearrangement and constantly unfolding (Goodley et al., 2014).

Undoubtedly, diagnoses can also be used to objectify individuals, fostering dependence by the one who is being cared for. However, they can also become a form of intensifying care practices, promoting new arrangements responding to needs and struggles that previously have been met carelessly or not met at all. As constraints, diagnoses are not always generous, and that is part of the ambivalence that psychiatrists must face and manage when dwelling on performing a diagnosis or not. It is possible to see how the diagnostic process operates on two simultaneous levels from a care perspective. On a micropolitical level, they can produce ethico-affective encounters. On a broader dimension, they can participate in more comprehensive political arrangements.

Regarding its micropolitical dimension, diagnoses have the potential to unfold care as part of an intimate encounter between the child and the psychiatrist. Intimate, inasmuch as the techno-scientific framing advanced by the biomedical model does not forcefully imply the child's alienation to the objectifying and cold gaze of biomedicine. As Latimer and López-Gómez (2019) argue, 'technoscientific world-makings are not just socio-material practices, but affective and embodied processes, filled to the brim with moments of "being moved" and "moving"' (p. 252). In this case, the diagnosis is not an automatic decision solely born out of a bureaucratic rationale but rather an ethical action oriented by a caring purpose. It is a form of minding the child, as argued by Gaspar, one of our interviewees:

> Yes... What I search for in order to perform a diagnosis like that [ADHD] is that the diagnosis has some kind of connection with the worries or motivations that parents or the child have when coming for my help. Normally I search for that coherence between their motivations, you know? What the school thinks, and this is my personal approach, I mostly take it off the table. I think about it more like an informant than someone that I have to account to with my diagnosis. Because, from my point of view, a diagnosis has to answer to the worries and concerns of the one asking for help (...) So, in certain diagnoses, like ADHD, I only enunciate it when it allows me to do something about it. I mean, when it is causing problems, and when I'm doing something like a treatment or an intervention, you know what I mean? Otherwise... I mean, the diagnosis has to serve the purpose of helping and caring for someone, of clarifying doubts and concerns and proposing a way to help, don't you think?
>
> (Gaspar, Child Psychiatrist, 23 April 2021)

Gaspar's words show how, in the intimacy of the clinical encounter, biomedical knowledge does not act as a top–bottom imposition on disabled children, simply overwriting their bodies and selves, aiming to achieve normative ideas about normalcy, capacity, agency and ableism

(Curran et al., 2018). It is rather set into motion as a way to translate uneasiness, discontent and worries into a different grammar, one provided by care, opening for them the potentiality of transformation, and providing a new set of practices, discourses and techniques to engage with them (Tironi & Rodríguez-Giralt, 2017). In that sense, the diagnosis is a non-human actant whose materialisation is bound to modify the scene and that, in principle and according to our interviewees, should be oriented by a caring purpose, allowing care to emerge as a form to mind the child, and also as a material practice to be set into motion. We will further explore this point in the following section.

Yet, diagnoses can also act on another level. While they can be invoked and enacted in (un) caring ways in the micropolitical dimension of the clinical encounter and the school, they can also be enrolled in the production and functioning of wider political engagements. Scholars have flagged how ADHD can take different shapes and traverse different paths, making it difficult to reduce its existence to the pristine version displayed by international classification arising from global north countries (Bergey et al., 2018). In Chile, educational policies have instrumentalised mental health diagnoses in ways in which their caring potential risks becoming detrimental, being used for exclusion and profit in the name of care, failing to serve the purpose that the interviewees think they should, as they are incorporated with neoliberal principles of competition and accountability pervading the current educational system. Interviewees recognise this threat: how biomedical knowledge can be exploited to serve purposes that drift away from immediate caring, and can be used otherwise:

> If one doesn't provide what the school wants [the diagnosis to enter the PIE and secure funding], they probably won't ask for your evaluation again. But if your indication doesn't match what the school thinks, they just say to the parents: "go visit another clinician". This has happened to me before. Schools don't say "Ok, perfect, so this is what the clinician thinks". They say "I don't buy it. Go visit a different clinician". This really happens. They point out who they want parents to visit, a neurologist or a psychiatrist, because they sort of already have a preconception of what they want to hear. So, one has to do something. I know many colleagues do this, and I do it too. You have to define what's the focus of your intervention, right? I mean, who are our efforts aimed at, to fit the necessities of the child, or the necessities of the school? I'm very honest about this with them [schools], and I don't think this makes me a bad clinician or anything alike.
>
> (Matías, Child Psychiatrist, 20 October 2020)

> You can see that schools without PIE often have a better sensibility and attunement to find out exactly what to do about this child [with an ADHD diagnosis]. When you have PIE, as I mentioned before, you have kind of a crooked incentive, because you have this "let's put a diagnosis on this kid" rationale, so they can enter PIE and get resources, but that doesn't necessarily mean they care more, and they can make no difference in their daily life. If the same child could attend a school with or without PIE, maybe in the one without PIE they could get better results…
>
> (Pedro, Child Psychiatrist, 20 November 2020)

The erosion of the care capacities of different elements in everyday life because of engulfing liberal policies has been extensively debated by scholars who have addressed this problem (The Care Collective, 2020), and who have called for the need to unsettle these arrangements

while imagining alternatives to heal and preserve different forms of existence (Povinelli, 2011). Aligned with this, interviewees feel the need to be mindful about how biotechnology and its byproduct circulate and become entangled in different articulations composed by different human and non-human actors, politics and affects. Care is inter-relational and interdependent, and therefore cannot be considered as an inner property of the capacity of any technology, object or individual. It is something that emerges, an affective disposition and a material practice arising from entanglements that are oriented to care.

Importantly, care is not an absolute value, and there is no single, correct way to care. It requires tinkering and amendments, compromises and constant revision as particular ways of caring can quickly go wrong, becoming conservative and paralysed, and settling in ways that foster exclusion and normalcy (Duclos & Sánchez Criado, 2019). This highlights an idea central to the reflection of thinkers such as Maria Puig de la Bellacasa (2017), namely, that caring for these technologies and knowledge is an ethico-political standpoint. Therefore, we should care for things, objects and individuals that care for us. In that sense, as a technology, diagnoses need constant revision to prevent them from losing their capacity to mobilise care and preventing them from becoming lost to power relations that use them for control and dependency, or for the stigmatisation, segregation, exploitation and capitalisation of those who are different (Puar, 2017).

FROM CLINIC TO SCHOOL: THE REENACTMENT OF CARE ENTANGLEMENTS THROUGH THE ADHD DIAGNOSIS

As a material practice, care can be enacted differently according to the entanglements produced in the particular time and place where it is happening, and in relation to the different human and non-human actors that get involved in the process. Schools provide a significant location to understand how the ADHD diagnosis is understood and put into practice. Schools play a crucial role in identifying children exhibiting conduct and emotions that could raise the question about the existence of a potential mental health condition or disability, and are also in a privileged position to put diagnoses into practice, either for caring purposes or not. As Matus (2019) has argued, schools are ideal places to see how normalcy and difference are co-constituted amidst social practices that shape some children's bodies and identities as normal, and others as deviant, amidst power relations characterised for their surreptitiousness, cloaking practices of intolerance, marginalisation and discrimination. However, no one school is identical to another and it is precisely the micropolitical level of everyday practices where the possibility of different entanglements around the ADHD diagnosis opens up.

The entangled composition of everyday life has been a commonplace theme in social sciences during the last decades, pushing forward the notion that it is impossible to think about humans as entirely autonomous beings. Rather, thinking in terms of entanglements underscores how it is through relations and by becoming bound with others that different individuals—but also other phenomena—manage to temporarily come into existence (Giraud, 2019). This implies a processual, relational and dynamic notion of how life and things unfold. Also, it hints at how we should approach and explore entities whose identities are not fixed but in constant reenactment, such as diagnoses, and carefully consider the conditions for their emergence, and what they can do (Locock et al., 2016).

In exploring how the ADHD diagnosis can be enacted in the school setting for caring purposes, we offer a vignette of our fieldwork that helps to illustrate how the concerns and motivations shared by clinicians in the previous section find their way to schools, helping to convey caring

entanglements aimed at involving the child in classroom dynamics and activities, so they do not drift apart from the everyday life of the class. As one of the interviewees mentioned, the diagnosis has the 'potential to be a key that unlocks new doors'. Although true, this statement must be carefully weighed in relation to a context where not only are resources scarce, but also ideas of inclusion and disability are inspired by discussions happening in the global north and have little consideration of the social, cultural and economic particularities of countries of the global south (Singal & Muthukrishna, 2016).

In Chile, inclusion practices inspired by northern countries are promoted, but the human and material realities under which these systems will be operationalised are not considered. In practice, this entails that the clinicians making diagnoses for educational purposes conform to international guidelines defining ADHD. Yet, they also understand that sometimes the diagnosis can mask other confluent social realities that require attending to but cannot be carefully met without the extra resources mobilised by the diagnostic category since the implementation of the educational policies previously mentioned.

The following vignette does not attempt to represent how diagnosis unfolds every time in schools, but to reveal how the everyday can be presented under specific circumstances, allowing re-enactment of the affective and practical qualities of specific moments (Atkinson-Graham et al., 2015). In addition, it allows sustaining, in an empirical manner, how other possibilities could happen (Savransky et al., 2017) if we think about other, more careful entanglements of the diagnosis and the school setting.

> Just as the teacher mentioned to me earlier that day, after lunch it is debate time. Pablo, who is already acquainted with my presence in the classroom, greets me and we start talking about his morning. I have noticed that he is a little more restless when he is just arriving at school, more talkative and impulsive. The class starts, and Pablo and his group manage to give an excellent presentation. The teacher congratulates him and his group. Pablo sits down for a while, and then stands up and exits the classroom. I see him through the windows, as he starts wandering through the hallways, but always near the classroom so the teacher and his classmates can still see him. Finally, he lies against the windows, and from outside the room he watches the presentations of his classmates. The teacher asks him one, two, three times to come back inside and sit down, but Pablo ignores this. The teacher does not insist on that point. Pablo spends the whole debate time entering and exiting the classroom but, despite his wandering, he seems attentive to what is happening in the classroom. He frequently turns his eyes to where the whiteboard is, and makes comments about the presentations while he walks around.

> Valentin arrives late to the debate. He is walked in by Amanda, the chief of the Integration Programme. He realises that he was not chosen to be part of their debate team, so he has to do his presentation alone. He looks uncomfortable, and shy, but nevertheless agrees to participate in this activity. He slowly walks to the front of the classroom, and sits down facing his classmates. Amanda quietly follows him and sits down in the first row, just in front of him. I can hear her encouraging him. As he talks, she keeps motivating him. When the presentation is over, she asks some additional questions that Valentin needs to answer but, when he struggles to order his ideas, she lends him a hand. I can see how the teacher and Amanda focus their attention and support on Valentin. When the scene is over, they cheer him up, praising his

ideas and motivating him to continue developing them. "That was great Valentin, simply spectacular. Let me congratulate you for your thoughts and your arguments, and the visual aids you brought along. Look! all your classmates are paying attention to you!" Just now Valentin finds the courage to look at his classmates, and smiles. "See? See how happy you are? Again, congratulations, that was magnifique, you did it!", adds the teacher, as the bell sounds, announcing the end of the class.

(Field notes, 17 November 2021, Spanish Class)

This vignette introduces us to two children, one of whom is diagnosed with ADHD. While Pablo conducts himself in ways that could be challenging to Saint Peter's school's educational staff members and his peers, his teachers do not feel that his behaviour escapes what they can manage. Of course, it might be troublesome for teachers to involve Pablo in classroom dynamics, as they constantly have to be aware that his actions might disrupt the learning process of others. Nevertheless, teachers in this school do not expect student behaviour to be flawless. This does not mean that academic performance is disregarded as irrelevant. Good grades and behaviour are commonly reflected upon as signs foretelling the potential to change the social and economic condition in which these children live. For teachers, education can encourage social mobility. But, in catholic schools, these aims and goals can co-exist with religious principles that push specific moral values, providing an alternative framing for what is considered troublesome and diagnosable in children (Rojas Navarro & Vrecko, 2017). As Mariana, one of the teachers, argues, *'I do not expect for them to be perfect, or that they have to be silent and still the whole class'.* Although schools are institutions where constant examination occurs, not all examining falls under the pursuit of flawless behaviour or outstanding grades. Instead, Mariana mentions that her attentiveness aims at scanning those who are academically or socially struggling. It is supposed to raise awareness of those left behind: *'I do try to scan if they can achieve some basic things (…). But, one cannot expect all of them to be good at something. Of course, they are all different, and each one is going to achieve different things'.*

Acknowledging that children are different, and therefore have diverse potentialities and limitations, was an idea shared by the teachers we interviewed. For the same reason, actions and dynamics aimed at homogenising their qualities or identities were not the only ways in which diagnoses materialised in the classroom. The main problem comes with reflecting on how to foster each child's capacities while upholding their differences amidst scarce resources, and, frequently overpopulated classrooms attended by children living in conditions of vulnerability, precariousness and neglect. For children like Pablo, this entails being more flexible with norms and codes of behaviour such as staying in the classroom. To thrive, he needs a teacher to provide more room for him to dwell, think and inhabit that space. Teachers tolerate this as they understand that, as long as this does not expand further, both Pablo can learn and the class is not compromised. It just takes an additional effort from them, and they are willing to do it, although this might entail clashing with an educational system that is not designed to care for differences (Araneda & Infante, 2020). As Alejandra, the English teacher, summarises: *'(…) the [educational] system does not support it [different forms of learning and inhabiting the classroom]. It just does not invite all children to learn in the way they should learn'.* But, in some cases, a teacher's goodwill does not suffice. Their intentions and skills are insufficient to foster the learning process or to address the child in a way that makes a difference and, as a result, they feel helpless and lost.

My first reaction when encountering children like that [diagnosed with a mental health disorder] was asking myself "what do I do?" Because it is hard. Every kid

has their own needs. So, it is hard to get to know the full spectrum of needs for one specific child. So, when you have so many children in the classroom… It is difficult to give yourself time to know exactly what it is that one child needs. And it is so complex […] so yeah, I feel like teachers end up without the proper tools to help.

(Alejandra, English Teacher, 31 May 2021)

Such is the case of Valentin, the child diagnosed with ADHD from the previous vignette. Unlike Pablo, teachers feel that their abilities are not enough to help him thrive. A different affective and material disposition is required to create the conditions for Valentin to perform in a way that he feels confident around others. In such a way, the ADHD diagnosis distinguishes him as someone who requires an alternative entanglement to happen, as it implies a different form of biocultural make-up (Frost, 2016). Jutel and Nettleton (2011) have argued that once enacted, the diagnosis produces an actualisation of the individual, generating modifications both on the identity of the one diagnosed, and in the social setting that she inhabits. In this case, the ADHD diagnosis allows for the involvement of new actors and materialities aimed not at erasing differences, but at caring for non-standardised individualities. It is a form of alterbiopolitics (Puig de la Bellacasa, 2017), an attempt to carefully allow for the flourishing of different modes of existence. However, as mentioned earlier, we must avoid the mistake of thinking in binary terms—all or nothing—when it comes to thinking about agency, ableness and difference.

What is interesting about the case provided by 'Saint Peter' school is that, as the institution is not part of the PIE programme, suspicions about seeking child diagnoses to secure additional funding are inconsequential. What animates this search seems to be something different. It is a way to reach out to other professionals—clinicians and mental health experts—that can aid staff members in better responding to the child's needs and struggles. As such, it offers an explanation expected to remove the children from a position in which they could be criticised or judged. It emphasises that despite efforts, traditional learning entanglements do not necessarily resonate with them as expected, and therefore require a different intertwining with the classroom setting. Specifically, this requires for the school to be 'response-able', and schools—as relational phenomena—can unfold to meet these requirements, or not. In the case of this school, interviewees constantly signal that their openness and attentiveness towards these needs and struggles are commanded by the orientation provided by the headmistress. In her role, she has prompted the reorganisation of the school so that it can develop the capacity to respond and engage with these demands in an ethical and political way (Kenney, 2019), opening to different possibilities and forms of everyday engagement with those diagnosed.

DISCUSSION

In this article, we have argued that given the rational and processual characteristics of the social world we inhabit, we should carefully reexamine the role played by mental health diagnoses in the everyday life of diagnosed children. As discussed throughout this article, the role and understanding of ADHD diagnosis is not fixed, and therefore can be put into practice in manifold ways, including as conveners of care. Undoubtedly, biomedical categories can and have been used by educational and social policies in ways that are condemnable. This has been critically noted by a vast body of work that has highlighted how biomedical rationality can be used for the exclusion and marginalisation of those who are different when compared to the able-bodied, white, middle-class, male individual that historically has set the standard of what we should

be (Braidotti, 2013; Puar, 2017; Roberts, 1997). Nevertheless, as mentioned, there is more to diagnosis than that. As we show in our discussion, care entanglements can also arise as part of modes of encounter between diagnosis, the child and the classroom setting, as revealed by our interviewees.

However, care entanglements are not the only acts that can arise from such recognition. Chile presents a scarcity of human and non-human resources to properly care for children in schools belonging to public education. Furthermore, schools compete amongst each other for funding and resources. Additionally, since the promulgation of PIE programmes, funds for inclusion strategies can only be granted once a diagnosis is performed, and those who do not receive a diagnosis are left in the dark, waiting on the goodwill and tinkering care that can be cast by other means. Because of the abovementioned, uncareful entanglements can take place in relation to the diagnosis. By this, we refer to when the diagnosis is performed for the purpose of securing funding, but without the consequent transformation of the material and semiotic landscape inhabited by the child. When this happens, the child gets trapped in a diagnosis without the deployment of care practices that could allow for the child to navigate the educational system, adapt to the social and intellectual environment of the classroom or tailor the classroom setting to the child's needs, which requires an additional effort which—as our interviewees mentioned—some schools are prone to neglect.

In this sense, the biomedical framing provided by using mental health diagnoses such as ADHD offers both limitations and potentialities. Amongst the latter, this way of recognising differences enables the emergence of new sets of special arrangements to benefit the diagnosed child (Anastasiou & Kauffman, 2013). After all, this novel kind of biological framing comes in replacement of more traditional educational techniques that have treated the same conduct and behaviours as the sign of 'wicked' or 'lawless' personalities that must be corrected with rigorous discipline and punishment (Lange et al., 2010). As expressed by both the clinicians and educational staff interviewed during our fieldwork, diagnosis is expected to be animated and sustained as part of a scenario where, by recognising the child's differences, it can be reorganised to encompass new human and non-human actors and foster alternative dynamics that could grant the child a novel sense of wellbeing.

To claim that mental health diagnosis can be used to produce care entanglements does not disavow the risks attached to their overuse, or the detrimental effects linked to their engulfment by neoliberal policies that reduce their action to the labelling and classification of individuals exhibiting different traits and characteristics. But this characterisation and sorting does not necessarily imply discrimination, segregation and other kinds of practices that come attached with the idea that difference is a value-laden arrangement of the social world. Rather, we have sought to problematise what alternative outcomes can arise from the recognition of these forms of alterity, avoiding a somewhat naive conceptualisation that dismisses the potential of difference, rather than attending to it in a careful way.

The ambivalence in how care can act as part of ADHD diagnosis reminds us that, just as care entanglements can take place thanks to the diagnosis, things can also go the other way. During diagnosis, when caring about someone's being and becoming, things can go wrong. But also, even though diagnoses can be used for marginalisation, they can also be used to promote better entanglements and make a better life for the diagnosed child. This ambivalence is not only a reflection of the entangled nature of everyday phenomena but also a constant warning that care needs to be constantly revisited and unsettled when its potential to convey practices and affects aimed at making a difference in diagnosed children's everyday lives becomes hindered. Caring is always local and situated, tailored and tinkered according to specific needs. Yet, it holds the potential

to sustain different modes of existence. As such, our argument is that we should not abandon knowledge that has the potential to mobilise and convey care (Puig de la Bellecasa, 2017). As Duclos and Sanchez-Criado (2019) argue, we should care for such knowledge, and dispute it from the power relations that might turn it into a mere exercise of palliation or maintenance of a world that need to become more attentive to difference.

AUTHOR CONTRIBUTIONS
Sebastian Rojas-Navarro: conceptualisation (lead); data curation (lead); formal analysis (lead); funding acquisition (lead); investigation (lead); methodology (lead); project administration (lead); resources (lead); software (equal); supervision (lead); validation (lead); writing—original draft (lead); writing—review and editing (lead). **Samanta Alarcón-Arcos**: conceptualisation (supporting); data curation (supporting); formal analysis (supporting); investigation (supporting); methodology (supporting); software (supporting); writing—original draft (supporting); writing—review and editing (supporting). **Ismael Tabilo-Prieto**: conceptualisation (supporting); data curation (supporting); formal analysis (supporting); investigation (supporting); methodology (supporting); writing—original draft (supporting); writing—review and editing (supporting).

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DATA AVAILABILITY STATEMENT
In accordance with ethical regulations dictated by the funding body and by the university sponsoring this research, data were collected only from people who consented to participate. To assure anonymity, all names of persons and places were replaced by pseudonyms. The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions. Finally, data were coded and analysed with the help of NVivo qualitative software.

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