



# Citing conduct, individualizing symptoms: Accomplishing autism diagnosis in clinical case conferences



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## ABSTRACT

In this paper, I examine how clinicians at a clinic for developmental disabilities in the United States determine whether children being evaluated for autism spectrum disorder (ASD) showed symptoms of that condition. Drawing on a convenience sample of 61 audio and video recorded case conferences from two time periods (1985 and 2011–15), and combining Conversation Analysis with insights from Actor Network Theory, I find that clinicians describe (via a representational practice called “citation”) children’s conduct in ways that advance diagnostic claims. More specifically, they portray key actants in the assessment process in patterned ways: the test instrument is represented as a neutral tool of measurement, the clinician as administrator and instructor; and the child as the focal figure whose conduct is made to appear independent of the other participants and suggestive of diagnostic symptoms. These tacit representational conventions conform to and reproduce the assumptions of standardized testing, according to which clinicians and tests are to be neutral arbiters of the child’s abilities, and thereby provide for objective, warrantable findings. At the same time, however, by designing representations around the child’s symptomatic conduct in this way, clinicians may minimize or elide their own contributions, and those of the test instrument, to the child’s performance, and thereby make the child alone appear responsible for what are, in fact, interactionally-occasioned behaviors.

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## 1. Introduction

The prevalence of autism has risen dramatically in the past two decades. A recent estimate by the Centers for Disease Control (CDC, 2015) puts the rate for American children at 1 in 68, and the trend shows no signs of abating. One of the most challenging aspects of diagnosing autism is that the disorder has no clear biomarkers. While most researchers agree that the condition has a genetic component (Bumiller, 2009), there is at present no firm knowledge of its genotypic correlates. Thus, when evaluating a child for autism, clinicians rely on a combination of standardized tests, interviews with caretakers, and clinical observation to determine a diagnosis.

Much of the data on which clinicians base their conclusions is generated in the course of clinical assessments. This data must be ordered, interpreted, and translated into determinate findings before a diagnosis can be made. As clinicians do this interpretive work, they provide *citations* to instances where the child showed

(or failed to show) symptoms of the disorder in question. These *citation practices*, which mark specific features of a perceptual or discursive field as salient, are an integral part of the “professional vision” (Goodwin, 1994: 606) of clinicians, and serve a loosely analogous function to a practice Goodwin (1994) calls “highlighting.” However, whereas highlighting denotes a generic practice for demarcating particular aspects of an object or field, citation practices differ in that they are specifically probative (and adumbrative) of diagnosis. In that respect, they are more akin to what Maynard (2004) terms “citing the evidence,” a set of practices by which clinicians formulate clinical signs that may indicate symptoms and implicate a diagnosis prior to asserting it.

In this paper I examine how, in case conferences about children being evaluated for autism, clinicians use citation practices to index symptoms of that disorder, specifically in the course of describing for colleagues how the child behaved while they assessed him. In so doing, I build upon insights from Actor Network Theory (hereafter ANT; see Latour, 2005), which broadens traditional conceptions of agency to incorporate non-human actors (“actants”). Accordingly,

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along with children, and the clinicians themselves, I also attend to how standardized test instruments are represented in clinicians' discourse. Specifically, I show that clinicians represent their interactions with children in ways that foreground (via citation) the child's conduct, while minimizing the contributions of other actants (i.e. clinician and instrument) to the child's performance. Thus, clinicians are portrayed as facilitating and/or reacting to children's actions, while test instruments are treated as neutral, autonomous tools of measurement that record data for assessment, rather than contributing to such data.

Clinicians' representational practices accord with an overall orientation to standardized test administration. In order for the results to be valid and reliable, tests must be administered in accordance with procedural rules codified in official manuals and guidebooks. These rules are designed to minimize interference by the clinician, and other extraneous factors, with what the test measures—i.e. specific abilities and traits of the examinee. In the ideal test situation, the clinician in no way contributes to the child's responses. Similarly, the test provides objective measurements of target constructs, without influencing their display (see [Maynard and Marlaire, 1992](#)). Thus, by portraying themselves in officially prescribed roles—those of facilitator-administrator and instructor—and the instrument as a largely passive recording device, and by foregrounding the child's conduct, clinicians represent test situations in ways fitted to the protocol of standardized testing. The key actants all behave as expected if the results are to be warrantable and accountable. This is not to say that such talk deliberately misrepresents or distorts the reality it depicts. Rather, as with other representational practices, such as patient records, "Since the creation of the representation involves the active work of ordering... it is in fact involved in the very event it represents" ([Berg, 1996: 500](#)). Hence, clinical representations of events constitute those events *as* ones with diagnostic significance that were occasioned in standardized ways. As such, they do not merely record or affirm the achievement of standardization, but provide for its accomplishment and ratification as a practical matter.

Accordingly, muting the contributions of other actants to the child's behavior is a feature of demonstrating standardization. However, an important (though easily overlooked) consequence of this practice is to elide the interactional context in which the behavior occurred. Abstracted from its setting, the behavior then appears as a personal characteristic of the child, which effectively individualizes his symptoms. That is, the symptoms are located inside the child alone, rather than at the intersection of child and environment. This reflects a broader individualistic bias within modern biomedicine ([Kleinman, 1988](#)), and encourages interventions targeted primarily at the patient, rather than the environment in which s/he is embedded. This may be especially problematic for conditions like autism, which are defined precisely in terms of maladaptation to one's environment. Accordingly, the way a child's conduct is represented can matter a great deal for diagnosis and treatment. I elaborate on these matters in the Discussion section of the paper.

## 2. Literature review

The questions addressed in this paper are located at the intersection of the sociology of medicine—particularly the emerging subfield known as the sociology of diagnosis (see [Jutel and Nettleton, 2011](#))—and science. More specifically, my analysis is informed by scholarship that incorporates concepts and methods from ANT into studies of the diagnostic process (see [Gardner et al., 2011](#); [Mol, 2002](#); [Timmermans and Buchbinder, 2013](#)) as well

ethnomethodological and conversation analytic studies of science ([Lynch, 1993](#)) and medicine ([Heritage and Maynard, 2006](#)).

A growing number of studies incorporate ANT into analyses of diagnosis. Though they investigate disparate topics, these studies share an emphasis on how human and non-human actants concertedly enact medical objects. These objects represent more or less stable webs of relations among actants, and include treatment devices and regimens, such as metered dose inhalers ([Prout, 1996](#)); diagnoses, such as atherosclerosis ([Mol, 2002](#)) and cardiac disease ([Gardner et al., 2011](#)) that may be realized and enacted across multiple sites (e.g. labs, doctor's offices, therapists' clinics, etc.); screening technologies, including genetic testing for newborns ([Timmermans and Buchbinder, 2013](#); see also [Timmermans and Berg, 2003](#)); and patient records, which selectively represent (and constitute) certain aspects of patients' case histories while eliding or marginalizing others ([Berg, 1996](#)). The present paper builds on this research by explicating how work done by an association of actants (see [Latour, 2005](#))—clinicians, children, and test instruments—is stabilized (in the context of a clinical evaluation) into a linear narrative about the child's symptoms at a particular juncture in the diagnostic process. More precisely, the paper examines representational practices, particularly citation, whereby certain features of this actor-network are selectively emphasized while others are minimized or muted. These practices constitute a procedural mechanism, specified in terms of members' methods ([Garfinkel, 1967](#)), for converting clinical actor-networks into particular kinds of evidence. In explicating these practices, then, the paper provides an account of *how* representations articulate actants, and with what consequences (i.e. individualizing symptoms). That is, it shows precisely how they are assembled in real time, rather than taking them as ready-made or given; and how that assemblage matters for the patient.

My analysis is also informed by conversation analytic (and cognate) scholarship on interaction in medical settings, or "medical CA" (see [Gill and Roberts, 2013](#)), and contributes to micro-interactional understandings of medical practice. With regard to case conferences (the focus of this paper) in particular, [Atkinson \(1995\)](#), building on the work of [Anspach \(1988\)](#), identifies some of the discursive practices doctors use to manage uncertainty, resolve discrepancies, and make diagnoses. Relatedly, [White \(2002\)](#) analyzes how child health services workers narrate cases in ways that propose the child's problems are either strictly medical or (also) psychosocial; that is, caseworkers' narratives tacitly imply causes for children's symptoms, which may include parental neglect. More recently, [Turowetz \(2015\)](#) shows how clinicians, in evaluating a child for infantile autism, use storytelling (in a case conference) to portray an ambiguous action—the child asks the clinician "can you drink" from a picture of a cup, which, in its context, is interpretable either as an attempt at imaginary play or the confusion of an image with a real object—as evidence of possible cognitive delay, which they later reinterpret (in conversation with the parents), again by way of storytelling, as an instance of problem solving, proposing that the child was physically manipulating the picture to answer a test question. The present study advances this literature by expounding tacit conventions clinicians exhibit in their representations of children, and how these facilitate the production of warrantable, objective accounts of children's symptoms.

## 3. Data and methods

The data for this paper consist of audio and video recordings of children being evaluated for developmental disorders at a large

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