Makeover Nation

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THIS CHAPTER picks up the dual themes of managing and selling makeovers that were introduced in the analysis of the psy-function and youth. It focuses on the nexus of education and pharmacology, specifically controversies about Attention Deficit Hyperactivity Disorder (ADHD) and Ritalin, an amphetamine-related pill that has been prescribed over three decades for children diagnosed with the disorder. ADHD and Ritalin offer a means of identifying, naming, curtailing, and channeling unproductive, uncontrolled, disruptive exuberance, such that “troubled” young people lead disciplined lives, making them over without allocating vast human resources to monitor and direct them.

Many thanks to Marie Leger, with whom I wrote a paper that formed the basis for much of this chapter.
In 1999, almost 2.98 million pharmaceutical prescriptions were written for US adolescents—over eleven thousand new scripts each weekday—and in 2000, 37% of US residents aged 15 to 24 were diagnosed as mentally ill (Waters 2000; Berman et al. 2000). So just as young people are identified as problems in ever more sophisticated ways, so they are more and more likely to be treated via consumption, in the shape of a pill. Thanks to such medical interventions, classroom conduct and scholastic results are made over by an invisible and inexpensive device; Ritalin is, as per the wider designer-drug phenomenon, central to US upward-mobility fantasies of transcendence through purchase. It is a sign of how commodified forms of generational transcendence characterize the United States and its niche fetish—identity for sale.

I do not argue that ADHD is arbitrarily “made up,” even though it was a politically correct construction by pharmaceutical corporations to replace the less palatable “minimal brain damage” (Gottlieb 2000). Nor do I negate the necessity of social formations decreeing certain forms of conduct (and suffering) unacceptable. I acknowledge the efficacy and legitimacy of democratically derived and policed norms of life. But to regard definitions (for example, of what is mad or sane) as timeless, spaceless, absolute accounts of interiority that explain and match exteriority is to miss the temporal and spatial contingency and discursive and institutional politics of the occasions when suffering becomes illness (Halasz et al. 2002: 1). So rather than endorsing or debunking ADHD, or promoting or condemning Ritalin, I suggest that the moral panic associated with them is a routine, generic event that emanates from today’s risk society via a political economy and political technology of personhood that invest contradictorily in the national makeover.

### Attention Deficit Hyperactivity Disorder

Within the last few years scientific studies have shown . . . that ADHD probably is not primarily a disorder of paying attention but one of self-regulation; how the self comes to manage itself within the larger realm of social behavior.

—Russell A. Barkley (1995: viii)

Initially intended for classroom use, the MotivAider ($90.00 retail cost) is a pocket-sized, battery-operated device that can be set to provide a gentle vibration at determined intervals for the ADHD child and/or parent. The ADD Warehouse on-line catalog states, “The MotivAider sees to it that a child receives enough of the right reminders to make a specific improvement in behavior.”

—Adam Rafavolich (2001: 380)
The first quotation above comes not from some loopy Foucauldian, social constructionist, or risk sociologist, but a pro-Ritalin clinician. Yet despite his insight, Barkley and others still desire scientific correlations between conduct they are keen to control and a somatic problem. ADHD provides the psy-function with reasons to make Ritalin “the cornerstone of therapy” (Steinberg 1999: 223). And treatment is acceptable only as part of medicalization. There must be a physiological underpinning to these disorders, lest they be dismissed as malingering by patients; as quick and easy explanations for parents, teachers, and doctors; or as self-interest on the part of the psy-function and the pharmaceutical and educational establishments (Conrad 1975). The American Medical Association asserts that each year, $77 billion of national income is lost due to educational underattainment caused by ADHD (2004), and the American Academy of Pediatrics (2005) has no doubt that the disorder exists. In 1990, an NIMH study included colorful pictures of brain scans, suggesting that a number of adults with a history of ADHD in childhood had decreased brain metabolism. These images circulated widely in the media, and the research was used to assert a biological basis for the disorder: brain lesions that affected dopamine (Breggin 1998; Steven Rose 2006: 261). In the words of prominent academic Harold Koplewicz, “It is not that your mother got divorces, or that your father didn’t wipe you the right way. . . . It really is DNA roulette” (quoted in Waters 2000). In 2003, a study funded by the NIH suggesting that people with ADHD had small brains led to debate over whether brain size was a function of the disorder or of its treatment; the author declined to make underlying data freely available. Not surprisingly, many mothers welcomed medical diagnoses and drugs for dealing with their children in order to elude the patriarchal blame of psychoanalytic explanations and the intrusive child-guidance movement—a classic case of competing forms of rent-seeking within the psy-function, with neurology and pharmacology triumphing over the talking cure. True believers were delighted when the diagnosis globalized in the 21st century, as the globalization was taken to prove that ADHD was not the creature of pharmacological hubris, medical gullibility, or national specificity—though it was subaltern white-settler colonies that fell most fully into line (AKA Canada and Australia) (Singh 2002; Lenzer 2006; Oak 2004; Carey 2006b; Herman 2001: 307; Anwar 2007; Scheffler et al. 2007).

ADHD adherents express alarm at “a discipline known as the sociology of medicine,” claiming that its “ politicization of neuropsychopharmacology undercuts everything for which evidence-based medicine stands”
via “a recurring wave of anti-medication hysteria” (Accardo and Blondis 2001). The “International Consensus Statement on ADHD” rails at “media reports” relying on “wholly unscientific . . . social critics” whose concerns are “tantamount to declaring the earth flat, the laws of gravity debatable, and the periodic table in chemistry a fraud” (2002: 89–90; also see Carey and Diller 2001 and Ginther 1996). But should these self-anointed successors to Galileo, Newton, and Mendeleyev be so confident? The “International Consensus Statement on ADHD” drew sturdy repudiation from authors of equivalent eminence—but without equivalent ties to pharma-funding (Timimi et al. 2004).

The medical literature on ADHD displays a strong preference for what is described, almost in base-superstructure terms, as “underlying physiology.” Yet even subscribers lament the weak correlation of “brain damage with attentional dysfunction” (Lock and Bender 2000: 30–31), and many admit that “definitions of learning disabilities are astoundingly plastic,” depending on “one’s choice of boundaries” (Hinshaw 2000: xv). This dilemma is euphemized as “the heterogeneity of ADHD,” a function of combining “a cluster of several behavioral deficits, each with a specific physiologic substrate” (Sieg 2000: 111). There seems to be a rather puzzled search in physicians’ offices, laboratories, classrooms, and recreational facilities for a singular truth about ADHD that either coheres logically, or corresponds to empirical observation. The Journal of Attention Disorders has dedicated a decade to it (Messinger 1978: 67; Sandberg and Garralda 1996: 281–82; Tait 2005).

Five attempts have been mounted to provide a biological basis to the disorder:

- The first takes the efficacy of treatment as proof of the existence of disease: since Ritalin works like a neurotransmitter, reducing disruptive conduct and increasing concentration, there must have been a problem with neurotransmission in the first place. This reasoning neglects the fact that Ritalin used by “healthy” children also leads to greater obedience and focus.
- The second removes the blame from neurotransmitters and places it on pregnancy and birth. Prenatal and perinatal traumas are held responsible for early behavioral difficulties. Research validates such claims only up to the age of three years, so they are rarely used to justify Ritalin prescription.
- The third turns to retarded maturation, “soft signs” of neurolog-
ical function; but again, they are encountered in normal children as well.

- The fourth looks in the direction of physical abnormalities, but there are weak correlations between these difficulties and hyperactivity.

- Last, the inevitable appeal to genetics has produced no absolute proof; concordance of ADHD among monozygotic twins is only 51%, compared to 100% concordance of eye color, which suggests only a partial genetic link, although an ADHD Molecular Genetics Network continues the hunt.


These five forms of thought offer less than compelling evidence that ADHD exists independently of its diagnosis and treatment. The credulous New York Times Magazine is reduced to arguing that at the end of the day, “doctors know it when they see it” (Belkin 2004). When and where have they seen it? The American Academy of Pediatrics’ treatment guidelines for children aged 6 to 12 emphasize that symptoms may not be apparent during an appointment, so doctors should ask parents, caregivers, and teachers about conduct at home and at school. The symptoms must be present for six months in at least two of the child’s social settings (for example, home and school), and other conditions should be ruled out (or diagnosed as coexisting disorders); it can get crowded in those brains. Endless studies that find children are hyperactive at home but not at school, or at summer camp (where 40% of the population was on chronic prescription drugs in 2006) but not in clinicians’ rooms, do serious disservice to biological claims. The NIH Consensus Conference has not established any basis for ADHD in brain functioning. So when parents, encouraged by television commercials that warn of youth violence and/or educational failure absent psy-intervention (Welch et al. 2007; Glassner 1999: 78), present professionals with such queries as “Do you test for ADD [Attention Deficit Disorder]?” they are reifying a cluster of symptoms and signs into a biological-neurological condition (Diller 1998: 3). Perhaps there is no “objectively discoverable pathogen” and “ADHD is a purely hypothetical construct” that lacks an incontrovertible clinical test, relying instead on symptomatology (Schubert et al. 2005: 151, 155). In the words of the British Journal of Psychiatry, it may be “best understood as . . . cultural” (Timimi and Taylor 2004).
But that is not the hegemonic account: both therapy and drugs are recommended forms of treatment once extensive surveillance has done its work. This is no surprise, given that clinical discussion of unruly conduct amongst children has a long history: mania and melancholy were identified as distractions two millennia years go. The NIMH (which, like the American Psychiatric Association, is unable to spell the word “principal” or correctly parse “well-qualified” in its publication on ADHD, a document full of imprecations and incantations to do with “impulsivity” that nevertheless appear not to have constrained its rush to publish) dates discovery of the disorder from 1845, when Heinrich Hoffman (1999) wrote “The Story of Fidgety Philip” for children. George Still, who had been “collecting observations . . . of defective moral control as a morbid condition . . . in association with idiocy or imbecility” for some time, described ADHD-like symptoms in 1902. He attributed them to an inherited neurological disorder that produced “defects of inhibitory volition” leading to an “abnormal defect of moral control” via theft, sex, violence, mendacity, hyperactivity, and an “abnormal incapacity for sustained attention” (Hall 2000; “New” 2001; Accardo and Blondis 2000b: 4–5; Porter 2002: 48; Breggin 1998: 179; National Institute of Mental Health 2006: 2; Ozarin and McMillan 2003; Still 1902 and quoted in Lakoff 2000: 149–50).

It took the 1917–18 encephalitis epidemic to stimulate this discourse more thoroughly. Clinicians were presented with numerous young patients who behaved oddly, which suggested a link between lively but unfocused conduct and brain damage or disease. Hyperactivity was first declared in the late 1950s by European researchers. The 1960s witnessed a grand Atlantic bifurcation over the disorder(s). European clinicians began, and have largely continued, to define the problem narrowly, in terms of “excessive motor activity,” probably caused by damage to the brain. In the United States, by contrast, hyperactivity has been viewed as part of the problem, with brain damage part of the cause. Things shifted in 2003, when a review of research that alleged correlations between ADHD and brain damage revealed that these studies had not disclosed that their subjects had been using a variety of drugs prior to the brain images, which may have produced the injuries depicted (Sandberg and Barton 1996: 2–3, 8; O’Meara 2003).

As per these key differences of opinion over defining the disorder, its diagnosis has remained controversial and may even appear ludicrous to the non-initiate. The very word “disorder” is preferred DSM nomenclature, “code for a vision of the world that ought to be orderly” (Hacking 1995: 17). Successive DSMs differ radically in their definitions of ADHD: DSM-
II offers hyperactivity, impulsiveness, and inattention as three cores, supposedly diminishing in adolescence; *DSM-III* divides these cores into their own groups, with minimal disorders within each one to qualify (it rapidly doubled US diagnoses); and *DSM-IV* clusters the cores into one multifaceted problem while criticizing previous rules of inclusion and exclusion. This version requires a minimum of six forms of inattention/hyperactivity in order for children to be diagnosed as sufferers, and it offers some rather sinister-sounding variations, such as “Conduct Disorder” and “Oppositional Defiant Disorder.” The latter comes complete with the splendid acronym “ODD.” It is applied to children who “argue with adults or refuse to obey,” in the approving words of the NIMH, and is often diagnosed among gay adolescents. Hmm. And the Brown Scale urges parents to watch over their charges lest they “act smart,” a sure sign of the condition. The text revision of *DSM-IV-TR* devotes eight pages to ADHD, compared to eight lines three decades earlier, with the disorder now divided between problems with “executive functions” versus “selective attention.” The one thing not in doubt is ADHD and its treatment. No surprise here, when a cool 62% of the 2006 *DSM* panel concerned with the disorder have ties to pharmacorps (McBurnett et al. 2000: 229–31; Perring 1997: 230–31; National Institute of Mental Health 2006: 17; Albright 2006: 186; Conrad and Potter 2000: 564; Glassner 1999: 79; “The Role” 2006; Hari 2007; Aldhous 2006).2

The casual reader of the *DSM*’s list of ADHD signifiers may be inclined to identify with such “symptoms” as: easily distracted, clumsy, impatient, explosive, always on the go, fidgety, talking loudly, moving a lot during sleep, immature, and a loner. I plead interpellated, and I am not alone. The power of the Protestant work ethic to require productivity and erase failure is clearly evident in the NIMH’s concern that ADHD sufferers “impulsively choose to do things that have an immediate but small payoff rather than engage in activities that may take more effort yet provide much greater but delayed rewards” (Hacking 1995: 145; National Institute of Mental Health 2006: 4). *New York Times* columnist Maureen Dowd (2003) went on-line to self-administer “Dr. Grohol’s PsychCentral Adult A.D.D. Quiz” and immediately found herself hailed by the available signage and symptomatology. Edward M. Hallowell and John J. Ratey’s Random House–published, auto-diagnostic questionnaire of one hundred tests for ADHD asks whether potential adult sufferers “laugh a lot” or “love to travel” (quoted in Eberstadt 1999) (surely reminiscent in its “craziness” of Vico’s other-worldly distinctions between plane geometry versus algebra’s impact on children’s fitness for work). The questionnaire gained legitimacy because Hallowell
and Ratey are psychiatrists who have decreed themselves to be ADHD sufferers, although neither is a researcher in the field and self-diagnosis is highly dubious. The Adult ADHD Self-Report Scale encourages participants to note any tendencies to “fidget or squirm” when undertaking dull tasks or confronted by background noise; to misplace objects; or to finish others’ sentences. Right. For those especially keen to be the fourth man or first woman in Jerome K. Jerome’s boat, TV commercials encourage viewers to consult http://www.adhd.com/adults/adults.jsp, and Vogue magazine directs readers to the World Health Organization’s 2003 instrument for screening adult ADHD, to help sufferers avoid speeding tickets, multiple sexual partners, alcohol, recreational drugs, and philandering scoundrels. There is also advice for those who might be able to achieve the diagnosis of “executive dysfunction,” a related problem identifiable through compulsive emailing. To help recruit patients/consumers, drug companies use a variety of techniques: Strattera (Eli Lilly) offers the Self-Report Scale on its site; Lilly has purchased http://adhd.com/index.jsp; and Shire (maker of Vyvanse) dispatches an ADHD Progress Kit from http://www.vyvanse.com. Time magazine suggests that prominent sufferers include Bill Clinton, Benjamin Franklin, Albert Einstein, and Winston Churchill (Lee 2003: 316, 318; Conrad and Potter 2000: 566–67; “Are You Living?” 2006).

No wonder the disorder was the most-diagnosed psychiatric problem for US children by the mid-1970s (Conrad and Potter 2000: 563). The rush to identify it becomes rather sinister (and anthropometric) when physiological forms of diagnosis extend to associating a “double posterior hair whorl,” an “anterior cow lick,” or “electric hair” with a proclivity toward ADHD (Accardo and Blondis 2000a: 153). Such articulations connect to a long history of attributing deviance to anatomy. Take, for example, Cesare Lombroso’s examinations of prostitutes in late-19th-century Italy for signs of physical “degeneracy,” or the sex-variance study carried out in New York City between 1935 and 1941, in which Robert Dickinson compared the genitals of women traced on a glass plate covering their vulvas to differentiate lesbians from nonlesbians. Such research became a model for understanding delinquent conduct as hereditary, sometimes alongside and sometimes in competition with schools of thought that focused on feeblemindedness (Terry 1998; Horn 1995; Griffin 1993: 17; Getis 1998: 24; Gray 2003: 37).

Foucault usefully identifies three key qualities of the psy-function that can guide us through this conceptual thicket: “the power to determine, directly or indirectly, a decision of justice that ultimately concerns
a person’s freedom or detention”; “discourses with a scientific status”; and “discourses of truth that provoke laughter” (2003b: 6). This remarkable amalgam of state power, academic legitimacy, and popular whimsy sees an almost unprecedented blend of control, authority, and pleasure. When Dowd or Vogue link concerns with conduct and status to humor, the sense of ADHD as something that can be normalized becomes all the stronger. The very epistemological weaknesses of the psy-function allow it to serve as a “switch point” between government, commerce, and jocularity (Foucault 2003b: 33).

Once more, children are both at risk, and are themselves risks, with popular culture a folk devil. Parents are urged by the psy-function to control children’s interaction with television and computer games, lest they become dupes at the console. TV is blamed for making them unable “to sit still,” leading to ADHD. Researchers probing the minds of people aged between one and three decree that watching television produces ADHD at seven, because it encourages impulsiveness. The American Academy of Pediatrics recommends no “screen time” for this group, and just an hour or two a day of “quality television and video” for older preteens, as ADHD is articulated to the fast pace of Rugrats, The Wiggles, and Sesame Street, with Disney’s Baby Einstein products a supposed corrective (Malacrida 2002: 369; Malacrida 2003; Malkki and Martin 2003: 219; Rafavolich 2001: 388; Gillam 2004; Christakis et al. 2004; Jane Healy 2004; Melissa Healy 2004). ADHD and its prescription drug of choice are crucial in juvenation. The psy-function has rarely had such success circling the young.

The “true” prevalence of ADHD across gender, geographic, class, and racial lines has generated many conflicting opinions, yet certain groups of people are more frequently circled than others. Boys are four times more likely than girls to receive a diagnosis of ADHD and be prescribed stimulant medication (Woodworth 2000). Based on US Census data and other studies, it has been proposed that in 1994, 5.8% of boys and 1.5% of girls aged between 5 and 17 had ADHD. DSM-IV suggests that 6.8% to 7.5% of children are sufferers. In the UK, the gender ratio is three to one. Epidemiological studies vary in reported prevalence between 0.5% and 26% of all children, and the NIMH estimates from 3% to 5% of, or 2 million, US residents. Gender differences have been explained as an outcome of the less violent ways of girls, which lead to fewer referrals than the attention-getting conduct of bratty boys and to the assumption that boys are more unruly, so they are more closely evaluated. Only in the area of sex do girls draw an equivalent gaze of the medical police: twenty-five years ago, the National Association of Private Psychiatric Hospitals recommended
“immediate acute-care hospitalization” for girls who embark on “sexual promiscuity” (quoted in Glassner 1999: 79). Recent feminist scholarship and activism, such as Australia’s ADDventurous Women electronic community, regard the association of males with ADHD as largely mythic, proposing that the clinical imbalance derives from underdiagnosis amongst girls and older women, such that there is said to be a “hidden epidemic.” But the tendency equally originates in the 1970 Isle of Wight studies and some behavioral checklists, which divide disorders between those of conduct, among boys, and emotion, among girls. This bifurcation, as per the Platonic/Kantian binary mentioned in the previous chapter, informs the DSM and the International Classification of Diseases. It constructs children as “miniature adults” open to adult syndromes, even as their specific disorders may achieve mature onset or recognition (Quinn and Nadeau 2000: 216–17; “Really Desperate” 2006; Timimi and Taylor 2004; Steele et al. 2006: 1893; National Institute of Mental Health 2006: 1; Rogers 2001; Staller and Faraone 2006; Timimi 2002: 34–35).

ADHD is mostly found amongst upper-middle-class white people living in the suburban Northeast, South, and West of the United States. African-American families use Ritalin at one-half to one-quarter the rate of their white socioeconomic equals, while the drug’s uptake is virtually zero amongst Asian Americans. Black Yanqui communities are flooded with antipsychiatric materials alleging every manner of conspiracy—for example, that ADHD and Ritalin form a “genocidal plot.” This may account for the low prevalence/credulity/uptake among African Americans, along with a tendency to incarcerate African Americans or diagnose them as in need of remediation as part of racist moral panics. There is conflicting evidence about the impact of class and family background on ADHD diagnoses. Some studies propose a link between disadvantaged families; some do not. There has been little sustained research into this disparity. Outside the United States, as well as within, ADHD is less prevalent in rural areas, while in Canada there is a relationship between poverty and diagnosis. Certain findings suggest that cultural differences have zero impact on the problem once the diagnosis is in play, though this claim has caused controversy among medical and educational anthropologists. By 2004, it was suggested that 8 million US adults had the disorder, putting it second only to depression in prevalence (Diller 2000; Sandberg and Garralda 1996: 283–84; Williams 2003; Barry 2002; Bender 2006; Diller 1998: 35–36; Hestintall and Taylor 1996: 330; Luk 1996: 358; Cantwell 1999: 4; Brownell et al. 2006; Brewis et al. 2000; Brewis 2002; Calderaro 2002; Jacobson 2002; Belkin 2004). Diagnosis continues. And once a diagnosis is secured, it
generally leads to one outcome—prescription drugs, classically Ritalin, an education/fun/social-control makeover rolled into one.

Ritalin

How has it come to pass that in fin-de-siècle America, where every child from preschool onward can recite the “anti-drug” catechism by heart, millions of middle- and upper-middle class children are being legally drugged with a substance so similar to cocaine that, as one journalist accurately summarized the science, “it takes a chemist to tell the difference”?

—Mary Eberstadt (1999)

7-year old Douglas Castellano’s unbridled energy and creativity are no longer a problem thanks to Ritalin. . . . “After years of failed attempts to stop Douglas’ uncontrollable bouts of self-expression, we have finally found success with Ritalin,” Dr. Irwin Schraeger said.

—The Onion (“Ritalin Cures Next Picasso” 1999)

Ritalin is related to amphetamines, a class of chemicals first synthesized in the 1880s that replicates neurotransmitters to arouse the nervous system. Since the 1920s, their capacity to stimulate activity has been widely appreciated as a source of both recreational pleasure and occupational effectiveness, with the first recorded prescription against hyperactivity in 1937 and later use by fighter pilots and JFK. Children diagnosed as educational underachievers participated in clinical trials from 1930, with Benzedrine tested as a counter to nerves and wildness and a stimulus to academic success. As of 1970, fifteen different pharmaceutical corporations manufactured over thirty kinds, amounting to 12 billion pills annually. Under the chemical name of methylphenidate, Ritalin is within this group. Methylphenidate was created in 1944 as part of a search for a nonaddictive stimulant. Ten years later, it was endorsed by the FDA to treat narcolepsy, depression, and lethargy. Reborn as Ritalin in the early 1960s by the pharmaceutical company Ciba-Geigy (later called Novartis following a merger with Sandoz) as a memory aid for seniors and treatment for chronic fatigue syndrome after tests on the wife of a researcher named Rita (who said it improved her tennis), the drug was soon redisposed yet again, for use on children (Petrina 2006: 521; Jenkins 1999: 30–31; Perring 1997: 231; President’s Council on Bioethics 2002b; Steinberg 1999: 225; Breggin 1998: 180; Diller 1998: 21–22, 25; DeGrandpre 2006: 4; Blech 2006: 65).

Ritalin has been enormously popular since its introduction. By the mid-1960s, it was the drug of choice for treating performance and behavioral
issues in US children—perhaps an early sign that psychoanalysis was on the wane. In 1970, 150,000 children were using it, increasing to 900,000 in 1990. Across the 1990s, the number of US children and adults diagnosed with ADD/ADHD rose, with most patients taking Ritalin and some using Dexedrine. Between 1990 and 2005, methylphenidate production increased seventeenfold, and amphetamine production thirtyfold. Sales went from $109 million in 1992 to $336 million four years later. Eleven million prescriptions are now written in the United States each year. These figures are astonishing for controlled substances (Sandberg and Barton 1996: 11–12; Marshall 2000; Healy 2006; Russell 1997).

Studies suggest that Ritalin increases adherence to polite, restrained social norms and encourages strong academic performance, calm conduct in class, pacific public behavior, intersubjective pleasure, and participation in organized sports (Trapani 2000: 201; Powers 2000: 486; Cantwell 1999: 16). Such effects register the ideal makeover, encouraging government at a distance via consumption that transforms the self. We might translate these correlations between Ritalin and conduct by a few degrees, such that they are viewed as preparation for a conservative role in the labor pool, via the suppression of disgruntled responses to oppressive institutions and norms and via the diversion of energy into recreational pastimes rather than politics. A healthier, fitter, more polite population reduces the cost of public health and guarantees a functioning and pliable workforce. It even helps tourism by delivering a ready supply of happy, smiling people ready to welcome strangers and their money.

Just as ADHD has its skeptics, so does its treatment. Peter Breggin, one of the most visible contemporary critics of pharmacological psychiatry, stigmatizes Ritalin as an “Iatrogenic Drug Epidemic” that generates mindless obedience, suppresses emotions and ideas, and diminishes self-esteem (1994: 303–5, 309). Other medical professionals/populist authors who dissent from the mainstream cast doubt on the drug’s long-term safety, its role in facilitating or obstructing long-term cures for ADHD, and its capacity to treat-without-understanding—changing behavior by masking biological, familial, or institutional problems (Diller 1998: 13). Richard DeGrandpre (1999) does not question the existence of the disorder. He takes reports of its increasing incidence literally but claims that ADHD is prompted by a speedy society in which rapid-fire culture, rather than abnormal biology, produces addictions to newness and change. DeGrandpre uses the amount of money poured into pop-culture moments—such as Titanic (1997)—to advance this hypothesis. His recommendation is not medication—providing stimulants to sensory addicts just compounds the problem, he
says—but slowing society down to a “natural speed and rhythm” to challenge “the dominant paradigm of work work work . . . [and] overcome cynicism through hope and action” (DeGrandpre 1999; also see Rafavolich 2001: 387–88). Psychiatrist Paul Steinberg (2006) believes ADHD to be just one of many disorders that are artifacts of a knowledge economy. There are clear ties in such analyses to prayer-and-care communitarian anxieties about the impact of neoliberalism on atomized social relations, and the Margaret Mead school of anthropology, which argued that the United States imposed quite specific stresses on young people (Maira and Soep 2004: 249). For his part, Ratey argues that contemporary office life creates problems for executives because they lack secretaries to maintain their calendars and expense accounts (cited in Belkin 2004). Put another way, he is referring, in distinctly gendered terms, to the impact of self-governing and multiskilling on the middle class.

Some critics suggest that the psychologization and therapization of teaching have produced the rush to Ritalin, because schools, now viewed as mental-health institutions, often threaten parents with removal of their children from classes absent medication. The right attributes this trend to egalitarian educational philosophy, alleging that it makes teachers responsible for students’ performance against a presumed tabula rasa of equal innate ability. Such conservatives contend that this tendency, along with pharmacology’s displacement of old-style physical sanctions as a means of disciplining children, has encouraged educators to put their charges on Ritalin. Alternatively, it has been suggested that the introduction of “high-stakes” testing into many states—with funds allocated to school districts on the basis of improved student test scores—has compelled counselors, teachers, and principals to recommend Ritalin to parents to heighten students’ performance. Indeed, property values, jobs, and salaries can depend upon grades. Meanwhile, critics accuse the federal government of exacerbating the trend by creating incentives to define pupils as disabled, via special-education programs that support low-income parents and schools once children are diagnosed with ADHD. This becomes a concern of progressives, too, as they note the medicalization of education and the advent of “Teachers as Sickness Brokers for ADHD” via a formal role allotted by DSM-IV, something duly exploited by pharmacorps’ assiduous use of Web sites to promote products in ways that masquerade as disinterested informational clearinghouses. It can be excruciatingly difficult for parents from non-psy backgrounds to master and counter the discourse of such environments. The Ohio State Board of Pharmacy worries that these programs heighten stimulant prescriptions, while both CBS’s Eye on America
and the Drug Enforcement Administration (DEA) disparage Ritalin as “the fourth R in schools” (Diller 2000; Livingstone 1997; Sax 2000; Mur- lowe 1997; Phillips 2006; Tait 2001; McHoul and Rapley 2005b: 442–44; McHoul and Rapley 2005a; House of Representatives, Subcommittee 2000: 11; Woodworth 2000). Would that such critics had it within them to tie these concerns to the way contemporary capitalism devalues equity and social justice in comparison with efficiency and effectiveness—to see that Ritalin is the risk-society additive par excellence, as evidenced in the moral panics which ensue when its proliferation attains levels that trouble ideas of nature and godliness.

Bush Minor’s Council on Bioethics has conducted far-reaching discussions on drugs as cures to illness versus aids to performance (2002a, 2003). One key point is the ethical distinction between “therapeutic” and “enhancement” uses of Ritalin. Broadly put, many people and institutions, most importantly Health Maintenance Organizations (HMOs), accept the former but reject the latter. They endorse medical intervention to enable people to achieve a potential that has been diminished by some disability, but abjure attempts to excel beyond the norm through biochemical intervention—so mad people may control themselves with lithium, but athletes should not use stimulants to improve their performance; treating pupils’ “severe hyperactivity” is acceptable, but improving “the concentration of Ivy League test-takers” is out of order. Medicine should enable factor endowments to flourish in the face of obstacles, but equalizing the distribution of endowments reduces self-esteem, with subsequent achievements devalued as “cosmetic enhancements.” This is “fitting in” versus “fitting in too well” (President’s Council on Bioethics 2002a; Kass 2003; Elliott 2003b: xv). It is equally a meeting point of neoliberalism, Social Darwinism, and religiosity.

The distinction between therapy and enhancement becomes difficult to sustain, with ADHD’s classroom impairment and Ritalin’s classroom improvement mutually defining one another, in ways described by staff of the Council on Bioethics as “subjective” and “fuzzy.” And the entire diagnostic and biochemical setting is colored by contradiction and capital. Such topics became a matter of legal redress when some US medical students who failed their National Board of Medical Examiners tests claimed their failure was due to ADHD and sued the board, asking for additional exam time—unsuccessfully, because the Courts found that their completion of medical school indicated they could perform above-average intellectually. Many litigants have used the Americans with Disabilities Act (ADA) against dismissal for poor work performance caused by ADHD, but
they have lost virtually every court case. The National Collegiate Athletic Association, on the other hand, allows athletes with proof of ADHD to take stimulants. In other words, the distinction is cultural: when medicalized, these drugs are legitimate; when claimed as pathways to transcendence (or eugenics), they are not. Meanwhile, colleges across the United States ponder the statistics estimating that anywhere between 65,000 and 650,000 students have ADHD; the Federal Rehabilitation Act that prima facie requires them to offer special services to sufferers, so they often seek exemption from it; and the evidence that more and more co-eds are using prescription drugs as study aids (President's Council on Bioethics 2002b; Elliott 2003b: xvi–xvii; Belkin 2004; Farrell 2003; Nichols 2004).

In 1999, the Colorado Board of Education resolved to discourage teachers from recommending Ritalin. In 2000, a five-year, $6 million federal government study of its effects began. That same year, the drug's manufacturer, Novartis, the 20,000-strong parents' rights group Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD), and the American Psychiatric Association faced class-action lawsuits in Florida, New Jersey, California, and Texas, charging that they conspired to drive up demand for Ritalin and did not publicize warnings about its risks to the nervous and cardiovascular systems. The lawsuits were all subsequently dismissed or withdrawn (Leibowitz 2000; Diller 2000; Layton and Washburn 2000; Wilce 2000; Rogers 2001; "Doctors, Lawyers" 2001; Hausman 2002).

Part of this panic derived from a challenge to the psy-function. Pediatricians and family practitioners write most prescriptions for Ritalin in the United States, thus removing it from the exclusive clutches of psychiatrists, the traditional gatekeepers of mind-altering drugs, who argue that the ability of pediatricians and psychiatrists to prescribe the drug leads to over-prescription. Of adolescents treated for depression in Oregon in 1998, 60% were prescribed drugs not by psychiatrists but by pediatricians; in North Carolina in 1999, the figure was 72%. It comes as no surprise that old conflicts over credentialism are raging anew, with psychologists seeking the right to prescribe medication, and psychiatrists seeking to discredit them. While the AMA and the American Psychiatric Association ban members from participating in US torture, the APA does not, on the advice of its Task Force on Psychological Ethics and National Security. For much of the 1990s, the military had granted psychologists the right to prescribe medication, and they hope to have this right renewed by participating in interrogations. The American Psychiatric Association lobbies with all its might against this dispensation. These conflicts are occurring in a context where
HMOs have undermined previously hegemonic power brokers through a discourse of bureaucratic-managerial commodification. Insurance-company support for family therapy has rapidly declined since the mid-1990s advent of wholesale managed care versus fee-for-service. HMOs want to erase symptoms and reduce long-term, face-to-face, and in-patient treatment. They will fund only four to six therapeutic visits before the use of pharmacology, paying psychiatrists much more for follow-up visits to evaluate the impact of drugs than to meet a child’s family. Lance Clawson, a Fellow at the American Academy of Child and Adolescent Psychiatry, suggested on C-SPAN in 2003 that the refusal of HMOs to fund sufficient meetings with physicians encouraged the early prescription of Ritalin. The drug has had its own makeover as a cost-cutting policy technology, a substitution effect for what had become an annual hospital cost to insurance firms of $30 billion for children (Schachar et al. 1996: 435–36; “Doctors, Lawyers” 2001; Gaus 2007: 28; Kory 2007; Shorter 1997: 295; Waters 2000; Hyman 2000; Woodworth 2000; Daly 2006).

Meanwhile, alternative ADHD therapies are also being governmentalized and commodified via support groups, counseling, biofeedback, and vitamin supplements (“nutraceuticals”). In many cases, this “alternative” (but equally corporate) discourse blames mothers for causing their children’s mental problems, notably through breast-feeding (Scheid 2000; Waters 2000; President’s Council on Bioethics 2002b; Glassner 1999: 78, 80; “Nutraceuticals” 2003; Malacrida 2002: 373, 379). Here we see deregulatory health-care policies and alternative health movements generating new forms of consumerism and self-government that both criticize and mirror prescription drugs.

Apart from questions of prevalence, and in whose hands prescription lies, some important issues surround the ethics and the physiological impact of Ritalin. True believers argue that moral panics over the drug are driven by illegitimate anxieties about the number and rate of diagnoses. They point to its high therapeutic safety index, a figure derived from dividing a toxic dose by a therapeutic one. But Ritalin may produce anorexia; “intermittent drug holidays” are recommended to ensure normal growth; and there are concerns over its role in the etiology of tics and Tourette Syndrome. Long-term use (beyond fourteen months) has not been studied, as the pharmaceutical industry is primarily interested in the short-term effects of medications. In the period between 1990 and 2004, of the 2,353 drugs that the FDA approved and required pharmacorps to study via postsales research, just 6% were scheduled for further study (Powers 2000: 477, 483, 489–90; Hyman 2000; Chen 2007).
Conflict-of-interest concerns have also caused controversy for the disorder and its drug. In reaction to organic, bottom-up patient groups that have been successful in goading and criticizing medical capital, big pharma has established and sponsored pseudo-civil-society arms of their publicity campaigns (Rose 2007: 142). CHADD is one of many front organizations masquerading as organic consumer groups that lobby on behalf of their key substructural base—in this case the pharmaceutical sector—by claiming to deliver “science-based, evidence-based information” (Children and Adults with Attention Deficit/Hyperactivity Disorder 2005). In the words of the British Medical Journal, the reality is that entities “ostensibly engaged in raising public awareness about underdiagnosed and under-treated problems” are really part of corporate marketing and surveillance campaigns, creating comprehensive media platforms of experts, victims, and advocates. The United Nations International Narcotics Board has issued a warning about CHADD’s responsibility for the rate of Ritalin consumption (Moynihan et al. 2002: 886; also see Conrad and Potter 2000: 560; Singh 2002: 593).

In the 1990s, pharmacorps gave CHADD 9% of its annual revenue. Despite adverse publicity and a stern reprimand from the DEA, the organization continued to secure funding from the industry: for the period 2002–3, 17% of its operating funds; in 2005, 22%; and in 2006, 28%, from such friends as Pfizer, Shire, New River, UCB Pharma, Cephalon, McNeil, Novartis, and Lilly. In 2005, CHADD activists and staffers appeared on almost nine hundred radio shows to spread the word. CHADD’s arresting magazine Attention! has a print run of 141,000—with 65,000 copies bought by Shire and UCB Pharma for product placement in doctors’ waiting rooms. The glossy ADDitude magazine comes out six times a year. Featuring inspiring stories of social, educational, and financial success, ADDitude is underwritten by advertising drug regimes and financial programs that guarantee a profitable life for sufferers, and it offers information on academic scholarships thoughtfully provided by drug companies. For customers who want their diagnostic acronyms personalized or credentialed, CHADD offers its own Visa card, and one can study on-line at the ADD Coach Academy, where $3,695 for nine months of instruction qualifies graduates to charge $400 an hour for listening to adult sufferers on the telephone. Astonishingly, CHADD was attacked by Republican Congressman Dan Burton on the grounds that this constituted a conflict of interest—staggering hypocrisy from a US political party, but in keeping with its denizens’ terror in the face of ungodly mental intervention. More typical was the double-declutching of Representative James Greenwood, who shifted
directly from chairing a House subcommittee charged with monitoring pharmaceuticals to running the Biotechnology Industry Organization, a lobby group for firms he had supposedly just been interrogating, such as Pfizer, Bristol-Myers Squibb, Eli Lilly and Company, and GlaxoSmithKline (Russell 1997; House of Representatives, Subcommittee 2000: 43; Children and Adults with Attention Deficit/Hyperactivity Disorder 2005; Children and Adults with Attention Deficit/Hyperactivity Disorder 2006; Hearn 2004; Hansen et al. 2003: 51; Phillips 2006; Belkin 2004; Montero 2002; Gettelman 2004). For patients interested in a more organic site of shared experience, http://www.adhdnews.com provides many hair-raising as well as reassuring stories of medical competence and incompetence and what it is like taking this stuff.

Pediatrician Michael Ruff has found the use of stimulant medications “a blessing” in his practice but is appalled by the hidden financial/pharma self-interest that underwrites much ADHD research. Here is his account of going through the morning mail:

Almost everything I received had something to do with ADHD. There was a magazine entitled “The ADHD Podium” (sponsored by Shire and Adderall), which contained an article on how to use the DSM IV criteria to diagnose and treat children with ADHD. Next was a brochure and video-tape from the University of Florida and Lilly (Straterra) on how to diagnose ADD in adults. Additionally, there were several faxes and letters offering to teach me more about the genetics, neurochemistry, and pharmacotherapeutics of ADD via dinner meetings and telephone conferences.

Finally, there were 3 magazines of different genres for my waiting room; all of which contained cover ads for Straterra, boldly proclaiming “Welcome to Ordinary” (via medication). (2005: 557)

In addition to this overdetermined political economy, Ritalin is also liable to induce moral apoplexy. It works similarly to cocaine, though more slowly because it is a pill. A link has been established between its medical applications and recreational drug use, starting in 1960s Sweden. The drug was subsequently removed from distribution there. The DEA designates it as a Schedule II substance, a categorization that stigmatizes drugs as liable to lead to abuse. In 1995, when CHADD, the American Academy of Pediatrics, and others petitioned the DEA to lower regulatory controls, on the grounds that Ritalin had minimal recreational potential, the DEA refused, aware of the drug’s capacity to suppress appetite, induce wakefulness, and make people happy (Vastag 2001; Poulin 2001; Diller 1998: 348n86;

Street names for Ritalin include some clever coinages: Vitamin R, Skippy, the smart drug, R-ball, JIF, and MPH. Dealers in the United Kingdom call it “kiddie coke.” In 1994, a national high-school survey found that 1% of all seniors had taken it the year before without a prescription, and five years later the figure was 3%. In 1990, there were 271 emergency-room reports of Ritalin overdoses, and 1,727 in 1998. By 2005, the figure was 3,212. From January 1990 to May 1995, methylphenidate ranked in the top-ten controlled drugs stolen from Registrants, and about seven hundred thousand dosage units were reported to the DEA’s drug-theft database in 1996 and 1997. One in ten US teens reported recreational use of Ritalin and its kind in 2005. School nurses, “teachers of the year,” and principals are among those found “liberating” Ritalin from school coffers (Lynette Scavo in Desperate Housewives uses her son’s supply). Use of Ritalin was banned from the professional golf tour in 2008 (“Generation Rx” 2005; “Behave” 2004; Kolek 2006; Jarboe 2006; Leinwand 2007; Teter et al. 2006; Bonk 2007). DEA and UN evidence presents grim findings on prescription/use (see figures 1–3).

All of this has, of course, attracted major media attention as part of an emergent moral panic, contradictorily tied to neoliberal media marketing struggles over youth that parallel Ritalin’s chronology: for by the late 1960s and early ’70s, popular magazines were locked in a contest with color tele-

![Figure 1. Aggregate production quota (in kilograms), DEA data](Source: Woodworth [2000]).
Figure 2. United Nations data, methylphenidate consumption (defined daily dose in millions) (Source: Woodworth [2000])

Figure 3. Amphetamine and methylphenidate prescriptions, IMS Health, National Prescription Audit Plus (Source: Woodworth [2000])
vision for audiences. They reacted by addressing young people both as readers (through stories on popular culture) and as problems (through generational stereotyping). This practice continued as the cultural industries promoted the existence of catchy-sounding generational cohorts to advertisers (“the Greatest Generation,” “Baby Boomers,” “Generation X,” “Generation Y,” and “Generation Rx”) with supposedly universal tendencies and failings. When the Partnership for a Drug-Free America (free of recreational drugs, not corporate ones) released a report on teens in 2005, the bourgeois media leaped at the neologism “Generation Rx” as part of an emergent moral panic over prescription abuse—without noting this was just the second occasion such substances had been included in the national survey (Kitch 2003b: 188; Shreve 1997; “Generation Rx” 2005; Szalavitz 2005).

Recognizing the media’s power, Ciba-Geigy spreads the gospel of brain disorders as the key to depression and other abnormalities wherever possible—for example, by financing Public Television’s series The Brain (Breggin 1994: 122) during Bush the Elder’s celebration of the brain, when ADHD became known as the “diagnosis of the decade.” Media attention has since been “unprecedented” in terms of “national magazine covers, science features in daily newspapers, broadcast television highlights, talk radio topics, and local-news spots” (Hinshaw 2000: xiii). Positive popular literature about the phenomenon also appeared around this time, via a flurry of populist parental and adult-sufferer guidebooks, many written by clinicians and academics. Notable examples include Barbara Ingersoll’s Your Hyperactive Child (1988); Hallowell and Ratey’s Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood to Adulthood (1994); Barkley’s Taking Charge of ADHD (1995); Colleen Alexander-Robert’s ADHD and Teens (1995); Grad L. Flick’s Power Parenting for Children with ADD/ADHD (1996); Edward H. Jacobs’ Fathering the ADHD Child (1998); and Paul Weingartner’s ADHD Handbook for Families (1999). There was a veritable explosion of stories, mostly credulous, in popular periodicals during the 1990s, from Better Homes and Gardens to Seventeen. As well as favoring biological and genetic explanations for ADHD and providing tips on diagnosis and treatment, such texts function as behavioral guides, offering recommendations on managing children so they learn to govern themselves through token economies and other rewards and punishments (Eberstadt 1999; Rafavolich 2001: 375; Schmitz et al. 2003).
At the same time, popular culture has picked up on anxieties from the antipsychiatry movement, represented by the tragic heroics of Jack Nicholson’s character in *One Flew Over the Cuckoo’s Nest* (1976), to embark on such pop-psy-function denunciations of Ritalin as *The Myth of the Hyperactive Child, and Other Means of Child Control* by Peter Schrag; Diane Divoky and Gerald Coles’ *The Learning Mystique* (1987); and Scientology founder and science-fiction writer L. Ron Hubbard’s repeated attacks (Diller 1998: 31). In the wake of Prozac’s popularization and associated debates about antidepressants, the genre drew new strength in the 1990s via Breggin’s *Toxic Psychiatry* (first published in 1991) and *Ritalin Nation* (1998); Lawrence Diller’s *Running on Ritalin* (1998); Thomas Armstrong’s *The Myth of the ADD Child* (1995); and DeGrandpre’s *Ritalin Nation* (1999). The debate has trickled into popular literature as well through Robin Cook’s 1994 novel *Acceptable Risk* (Stookey 1996: 163, 172–73, 75, 18n1).

Not surprisingly, from the 1970s, horror stories about Ritalin began appearing in the bourgeois US press as part of its drive to identify appealing topics unrelated to old definitions of news. In the late 1980s, articles critical of ADHD and Ritalin were published in the *New York Times*, the *Wall Street Journal*, the *Washington Post*, and the *Los Angeles Times*; and a segment was aired on ABC’s *Nightline* (Singh 2002: 579; Breggin 1998: 180, 183). *Good Housekeeping* magazine queried “the rush to Ritalin,” dubbing it “kiddie cocaine” and suggesting that “at the slightest sign of trouble—a child keeps running back and forth to the water fountain, has an unruly week pushing other kids on the playground, or plays drums on his desk with pencils—parents are circled by the school’s teachers, psychologists, and even principals, all pushing Ritalin” (Russell 1997). Activist Jim Hightower referred to “Babies on Drugs” (2001). Other critics called it the “chemical cosh” or “a cane-for-the-brain” (Midgley 2003; Hari 2007). The “War on Drugs’ slogan” was accused of transmogrifying into “not medicating your child is unethical” (Schubert et al. 2005: 152). And *Newsweek* went from an unfortunately worded endorsement of Ritalin as “one of the raving successes in psychiatry” to warning that it “may be causing some hidden havoc . . . in an impatient culture” (quoted in Schmitz et al. 2003: 394).

The first Congressional report on behavior-modification drugs and children was inspired by Ritalin as far back as 1970, while hearings were prompted in 2000 by a story in the *Washington Post* entitled “Omaha Pupils Given ‘Behavior’ Drugs,” which raised the specter of mind control and merged with popular concerns about diet to suggest a more “natural” treatment. Over the next three years, Ritalin made guest appearances on
Dateline NBC; CNN’s Larry King Live (featuring Bush Minor’s dyslexic brother and ADHD-diagnosed nephew explaining why Ritalin must be abjured); 48 Hours and Eye on America from CBS; and Cleveland’s WKYC-TV. These programs screened investigative reports and idiot punditry on Ivy League Ritalin abuse and drug dealing, emergency-room visits, and school complicity. PBS and A&E ran documentaries, with “journalist” Bill Kurtis intoning that Ritalin was challenging “the very essence of childhood itself” (Singh 2002: 579; Leo 2002: 58; House of Representatives, Subcommittee 2000: 14; Kurtis quoted in McDonald 2001). The New York Post headlined CHADD as a “Ritalin Pusher” and the New York Times noted the panic (Diller 1998: 30–31; Sandberg and Barton 1996: 3, 18–19; Montero 2002; Zernike and Petersen 2001). The House of Representatives Subcommittee on Early Childhood, Youth and Families, Committee on Education and the Workforce (2000: 7) queried whether the problems of accurate diagnosis meant that “youthful rambunctiousness” or “serious stressors like divorce or neglect” saw Ritalin erroneously prescribed. Congressman Bill Goodling said, “Ritalin may be the biggest drug problem we have in the country, and it drives me up the wall to see little children get hooked so early” (House of Representatives, Subcommittee 2000: 9).

The biggest flurry of media attention devoted to children and Ritalin was set off in 2000 by a study stating that in the previous decade, the prescription of stimulants as treatment of ADHD in US children aged 5 to 14 had increased dramatically, with use by those aged 2 to 4 growing three-fold between 1991 and 1995. These findings were confirmed by subsequent research (Zito et al. 2000; Goode 2003). The NIMH reacted strongly, rejecting prescription to large numbers of preschoolers (which the DEA had never approved) and funding a large research project to evaluate that group. Skeptics argued that their findings would eventually legitimate the practice. Major media attention was also paid to state intervention against parents who took their children off Ritalin. In one New York case, a local school district informed the Child Protective Services Unit, which accused some parents of child abuse—a charge that was not sustained in court and led to eleven states insisting teachers not mention Ritalin or ADHD to families. Then the House’s Government Reform Committee heard testimony from Lisa Marie Presley on behalf of Scientology that children were being “drugged” and ADHD was an invention that obscured the real problems of allergies, lead exposure, hearing, and eyesight. It was, in the words of the church’s Citizens Commission on Human Rights, “psychiatry’s cash cow diagnosis” and had helped to kill Kurt Cobain. In 2003, the House Committee on Education and Labor introduced a Child Medica-
tion Safety Act to protect parents from schools requiring them to have their children medicated. It was sponsored by several leading Republicans, including then-Speaker Dennis Hastert. All this was much to the chagrin of true believers in Ritalin (“Scandal!” 2000; Leo 2002: 53; Leibowitz 2000; President’s Council on Bioethics 2002b; Citizens Commission on Human Rights 2003; Titus 2004; Barkley et al. 2003).

USA Today proposed a national debate on the growing gender gap in educational attainment, under the headline “Girls Get Extra Help While Boys Get Ritalin” (2003), blaming the decline in male scholastic performance on the preponderance of female teachers, the absence of “advocates,” and the easy availability of Ritalin as opposed to holistic, pedagogical answers to their difficulties. This was part of a clever reversal of arguments for gender equity, a standard move by the right to reassert patriarchy by deconstructive sleight of hand and a return to long-standing anxieties about the impact of female role models on young men. At the same time, the science in support of therapeutic rather than pharmacological interventions was gathering strength—with the APA and the American Academy of Child and Adolescent Psychiatry favoring behavior modification as first steps in 2006 and clinicians blaming “permissive or uncertain child-rearing” for ADHD (Kimmel 1997; Carey 2006b).

Meanwhile, Neil Bush, the officially intellectually disabled Bush brother, appeared on ABC’s modestly named Good Morning America in 2002, blaming dull textbooks and a lack of engagement in school for ADHD, while thoughtfully taking the opportunity to promote his investment in pedagogic courseware—but this conflict of interest was not noted by the network or by fellow Republicans. By 2006, Neil’s big brother’s No Child Left Behind Act had provided a means of profit for his Ignite Learning firm. Partly owned by their parents, the company’s product is purchased through uncompetitive bidding by school districts utilizing federal, Saudi, and Moonie funds, despite widely variant evaluations of its value. Their mother, Barbara, made purchase of it a condition of her “charity” to school districts after Hurricane Katrina (Roche 2006). Perhaps this was familial synergy, not sharp practice. Sometimes it’s hard to tell them apart.

**Conclusion**

Upon reflection, I think a combination of prayer and Ritalin could eliminate her excess energy.

—Head priest at Catholic school to a mother
How dare you! You may call her hyperactive, but if the good Lord gave her excess energy then by God no one is taking it from her.
—Mother (Superstar 1999)

The increasing number of children diagnosed with ADHD is deemed objectionable because the public is worried about harm done to the young in a hyperspeedy age of hypercompetitive parents, and because the diagnosis pathologizes children who were previously viewed as normal or mischievous. Critiques of Ritalin evoke nostalgia for a less technological era when “boys were boys” and that was all there was to say about the topic. Today’s fuzzy boundaries differentiating the feisty child from the ill one are viewed as problematic; they help explain fervent searches for signs of ADHD displayed on the body, in the hope such signs may clearly distinguish children who need treatment from those who do not. Hair, toes, and brains are categorized and evaluated in the expectation that they will lead to a concrete, unitary diagnosis acceptable to scholars, clinicians, parents, teachers, and the public. But the absence of incontrovertibly objectifiable signs linked to an underlying cause remains matched by symptoms that are always liable to redefinition. The twin objectives of the applied sciences—to understand causes and to master interventions—are only partially met. Any notion of “pure” medicine is compromised by forces of management, education, government, and capital (Hacking 1995: 12). Drugs answer the question of the disorder’s “realness” by sidestepping it. Who can identify authenticity or distinguish illness from factor endowments when pills make people comport themselves differently from before they were ingested? In the process, pharmacology partially lifts psychiatry out of its ascientific mire (Reznik 1998: 214, 220) and advances makeovers through government at a distance. A pill is a commodity and governmental form par excellence—truly “consumed,” genuinely material and measurable, utterly standard, and infinitely repeatable. It adheres to bureaucratic norms of reliability, efficiency, and substitutability, thus enabling the actuarialization and financialization of the sick mind—perfect Yanqui-makeover material.

For therapists, the pharmacological threat to talking cures has encouraged collective action to preserve analysis (Lerner 2000). For pharmaceutical corporations, it has encouraged competition. Shire, the extraordinary new company that is a developer and marketer of drugs rather than their researcher and manufacturer, expanded at unprecedented pace in the new century via Adderall. Long a weight-loss pill and now an alternative to Ritalin, it offers three kinds of amphetamine instead of one, and it lasts longer. Shire bought the rights to Adderall in 1997 and “repositioned” it
from anti-obesity to anti-ADHD. The company also purchased data on the 180,000 US doctors who had prescribed drugs for the disorder; then it mapped national sales strategies around the areas with the highest numbers of prescribers. Adderall rapidly attained 36% of the US market, with $758 million in US sales by 2000. Compared in its effects and toxicity to the demonized Ecstasy, the drug is banned in Europe and was abruptly outlawed in Canada in 2005 after links were drawn to twenty deaths and its use led to the acquittal of a man who killed his daughter because the drug made him psychotic. In the United States, it is approved for three-year-olds. Meanwhile, Shire developed a patch, Daytrana, to disseminate a generic form of Ritalin that would supposedly avoid abuse. It was approved by the FDA in 2006, even as the administration issued a strong warning about Ritalin’s potentially fatal impact on the heart and its hallucinatory side effects. Other “new” treatments (almost generics, they are known as “me-too drugs”) include Concerta, based on methylphenidrate; Atomoxetine, which is marketed as Strattera (a nonstimulant); Dexamphetamine; Cylert (which is toxic to the liver); Ritalex, Novartis’s kinder, gentler Ritalin; and Modafinil, sold as Alertec and Provigil as a nonaddictive alternative and used illegally by US athletes and legally by high-altitude bombers. The fact that Strattera targets noradrenaline, not dopamine, compromises the claim that ADHD is all about brain lesions affecting dopamine, but this fact is rarely, if ever, commented on (Clark 2000a; Clark 2000b; Zernike and Petersen 2001; Cox et al. 2003; Phalen 2000; Oliver 2000; “Shire” 2003; “Drug Withdrawal” 2005; Steven Rose 2006: 260–61; Hearn 2005; President’s Council on Bioethics 2002b; Spatros 2001; Gardiner Harris 2005; Gardiner Harris 2006; National Institute of Mental Health 2006: 22; Krauskopf 2001; Heavey 2006; Wallis 2006; “Supercharging” 2004; Eccleston 2006).

When sales of Ritalin slumped in 2002 in the face of longer-acting rivals, Novartis sought to strike back via extended-release Ritalin LA, which supposedly lasted the length of a school day. The one drawback was that the comparative advantage that the corporation claimed over competitors had no research to support it. WPP’s subsidiary Intramed commissioned faculty to author a paper filling that gap. Intramed wrote it and the professors signed it, based on the guarantee that the piece would be “quick, down and dirty.” A ghostwriter with a doctorate in anatomy and a dozen years of experience in penning such deceits was hired to produce the required outcome. It was approved by Novartis and published in a journal (Moffatt and Elliott 2007; Petersen 2002). The next task of these unscrupulous cash-register intellectuals would be to deal with a 2007 government order requiring
ADHD drug producers to tell patients about adverse cardiovascular and psychiatric responses to their medicines (“FDA Directs” 2007).

The *New York Times Magazine* had a large, glossy series of “articles” and advertisements in 2002, paid for and produced by pharma-corporations, entitled *From Cause to Cure: Mental Health and Nervous System Conditions*. It offered a “case study” of an adult ADHD sufferer who, once diagnosed and treated, increased his salary by $10,000. Thus shall we know them. There is no shame: after September 11, 2001, promotions for Zoloft associated the drug with firefighters, flags, and the corporation’s relief fund, noting its sorrow, “We wish we could make a medicine that could take away the heartache.” Lilly lined up to market Strattera to what it hoped were 8 million adults across the United States, and Concerta appeared in commercials on A&E and the Discovery Channel. Meanwhile, the FDA warned Shire that its advertising claims were unsubstantiated. But while most people believed that the administration approved all such texts prior to their going to air, its capacity to do so had been undermined by Minor. Physicians are beginning to depart the picture, just as psychoanalysts had done, eclipsed by the drugs they broker. Next, it will be the turn of the FDA to disappear as an independent watchdog—its Center for Drug Evaluation and Research is now virtually half-funded by corporations, in order to hasten approval of new medications (Jaramillo 2006: 277; Pfizer quoted in Rubin 2004: 377; Rosenthal et al. 2003; Zarembo 2005; Zernike and Petersen 2001; Diller 2001). All this direct-to-consumer advertising had clear effects on treatment, as patients and their caregivers read misleading claims for the curative powers of medications through slogans such as “an idea that a kid with ADHD can believe in,” “the science behind ADHD and self-esteem,” and “life stopped being about ADHD and started to be about staying in the game” (quoted in Goldstein 2006). Children are important targets for Novartis, which has produced a picture book about Hippihopp, an octopus who is “everywhere and nowhere,” suffering the trials and tribulations of adult scolds until a turtle medico diagnoses him with ADHD and proffers the cure: “a small white tablet” (Blech 2006: 64).

By 2004, ADHD medication sales added up to over $2.7 billion, with more than 33 million prescriptions. Sales rose to $3 billion in 2006. Novartis might assert that Ritalin holds only 20% of the US market in methylphenidate, but prescriptions for those aged between 20 and 44 rose by 139% in the five years to 2005 (Jarboe 2006; “Really Desperate” 2006; Barry 2002). And the drug’s name represents more than sales; it stands for recalibrating a new generation—the triumph of psy-drug treatments. For example, the Riddlin’ Kids (2002), a postpunk Texas band with a homonym
to avoid legal action and a debut album entitled *Hurry Up and Wait*, were promoted as “fired-up energy balls” with a “hyped-up stage antic.” They featured in *Orange County* (2002) and the video game *ATV Offroad Fury 2*. The Ritalin Reading Series on New York City’s Lower East Side restricted writers to four-minute performances, while the founder of JetBlue Airways boasted that staying off medication enabled “his” ADD to differentiate him from ordinary workers, and Novartis referred to the disorder as “a life-long loyal companion.” The Cyberathlete Professional League decided to test participants in e-sports for use of Ritalin. True believers estimated that as many as 25% of US children suffered from “communication disorders.” Perhaps this made Bush Minor more legitimately representative of the nation than was often thought. And as more and more pharma drugs were blamed for violence, GlaxoSmithKline, Pfizer, and Lilly provided prosecutors with information and even special manuals for use against defense teams whose clients claimed they were driven to kill by a pill—a somewhat more sinister outcome than baptizing a parakeet (Tavernise 2004; Belkin 2004; Accardo and Blondis 2001; Blech 2006: 64; “CPL to Test” 2006; Waters 2004). Product placement had migrated from doctors’ offices to prosecutors’ briefs.

In late 2007, the Multimodal Treatment Study of Children found that Ritalin and Concerta were effective in the short term; but over three years, they had no discernible impact on conduct and could diminish physical growth. The NIMH advised that those diagnosed with ADHD simply “grew out of it” and caught up with their age group academically. At that moment, 4.4 million school pupils across the country were deemed to be sufferers, with half of them prescribed stimulants. But have no fear—providential new territory had been unveiled. Bipolar disorder, long assumed not to exist amongst children, was announced as a sleeper, with a fortyfold increase in diagnoses over the previous decade—though the NIMH was skeptical (Stratton 2007; Gellene 2007; Healy 2007).

New best-selling drugs used on hundreds of thousands of children in the United States to counter “behavior problems” have often not been approved or adequately tested for these populations. These “atypicals” are frequently prescribed by doctors who receive direct financial inducements from pharmaceutical companies. Minnesota, the one state that requires disclosure of such arrangements, reports that such graft increased sixfold in the five years to 2005, a period during which Medicaid prescriptions of atypicals to children increased by a factor of nine, with a dramatic correlation between psychiatrists receiving money from companies and urging patients to spend it on related brands (Harris et al. 2007). Along the way,
a grand project of bringing the mentally ill out into the light of day was accomplished, and a new way of seeing the world modeled upon, and in turn modeling, makeover citizens. The moral panics over ADHD and Ritalin veer in “diametrically opposed directions”—one finds overtreatment, the other discerns undertreatment; one disavows ADHD as an invention, the other demonizes its critics as unscientific (Lewis 2006: 85). Perhaps the panics about Ritalin will die off once it is recognized as one more cosmopolitan investment in human capital, in a risk society that wagers its future on the very people about whom it is most worried. As pharmaceutical companies market their wares more and more effectively to parents, doctors, and teachers—and forces mount in opposition—all participants must make peace with the tension between promises of new applications and fears of doping the future. The moral panic may become as hidden as the disease and the drug that birthed it.

Young people are a canvas for painting contradictory images of social life. As the noted pharmacological researcher Julie Zito asks, “How do you even know who the kid is anymore?” when multiple prescriptions expose children to “a potpourri of target symptoms and side effects” (quoted in Carey 2006a). Onto their bodies are projected the foibles of adulthood and the mythologies of the makeover, from all sides. The latest jag for pharma is paying doctors to talk up the likelihood of bipolar disorder amongst children—a bold untapped market/diagnosis. At the same time, the Child Medication Safety Act of 2003 is meant to “protect children and their parents from being coerced into administering a controlled substance” (Harris et al. 2007; Act quoted in Petrina 2006: 531n42). Can there ever be a sphere for discussing these topics from beyond diagnosis and prescription, outside the DSM’s reach (Harwood 2006: 144)?

So swallow and blink—then talk. As you do so, recall the words of David Healy, a former Secretary of the Royal College of Psychiatry: the pills on your tongue “lie midway between magic bullets and snake oil” (1997: 4). And note that the culture-jamming group Adbusters sells sugar placebos as antidepressants, given their favorable results in clinical trials (Greenberg 2005)! Concerns about mental health, educational success, drug use, and corporate commodification have joined left and right in a bipartisan panic culture, all orchestrated around a little pill and its impact on turning little people into big citizens. Unless the nature of corporate-state relations is fundamentally questioned as part of the debate about the disorder and its treatment, this panic will prove unproductive.