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A Very Childish Moral Panic: Ritalin

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This paper examines some of the moral panics around hyperactive children, the construction of Attention Deficit-Hyperactivity Disorder, and the lure of Ritalin in turning kids identified as "at risk" into successful, productive individuals. Through a historicization of the child as a psychiatric subject, we try to demonstrate Ritalin's part in the uneven development of modern trends towards the pathologization of everyday life, a developing continuum between normality and abnormality, and an emphasis on the malleability of children and the importance of environment in their upbringing. We conclude that Ritalin is a part of modernity's project of turning people into individuals—in this case, a kind of US transcendence fantasy—which, along with discourses and institutions, promises to transform young subjects and biocosmetically alter their futures.

KEY WORDS: Ritalin; modernity; Attention Deficit-Hyperactivity Disorder; children; everyday life; productive; psychiatric subject.

INTRODUCTION

For years it has been a nostrum of the cultural left to attack the psy-complexes—psychoanalysis, psychology, psychotherapy, psychiatry, and psychopharmacology. These complexes are easy marks for accusations that they generate and sustain false consciousness, bourgeois individualism, racism, and sexism, as well as implicating folks in the policing apparatus of medicine, therapy, and thought control. The taste for the psy-complexes is seen as a luxury unavailable to those preoccupied with subsistence, a manifestation of middle-class guilt at

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the ravages of capitalism. It is also a reminder of the "Red Scare" of 1919, when the United States government was assured that psychotherapy could defuse the appeal of Marxism to the urban poor, and the later rise of behaviorism, a model of person-as-machine that promised to manage individual conduct in the interests of capital. Critics on the left further argue that the pathologization of young people distracts attention from structural inequalities by psychologizing issues of social order and disorder. For the right, the psy-complexes are suspect because they suggest personal weakness, threaten a lack of productivity, and may imply the use of public resources for personal "development." Each side revels in denouncing the solipsistic absorption and selfish individualism of those derided by Bill Clinton as "the worried well." For their part, corporations promote fast, efficient solutions to life's problems—stop talking and start swallowing. Reactions against the psy-complexes have taken a variety of forms: the anti-psychiatry movement of R.D. Laing and others; critiques of Freudianism; denial of public funds for therapy; critical press about both counseling and psycho-pharmacology; and battles within the psy-complexes between therapeutic and drug treatments. The practical philosophy movement in the United States stands in opposition to pharmacology under the slogan "More Plato, Less Prozac" (Marinoff, 2000).

Each of the psy-complexes has been subject at one time or another to "moral panics." This term was coined within critical British criminology in the early 1970s to describe media messages announcing an increase in the crime rate, and the subsequent establishment of specialist police units to deal with this alleged problem (Thompson, 1998, p. 7; Erich Goode, 2000). Moral panics were initially theorized as short-lived spasms with a standard trajectory: exaggeration, prediction, symbolization, and then conclusion. Next, they were thought of as a series of waves that spoke of wider ideological contradictions about economic inequality (Barker, 1999). So we might say that a moral panic is a sudden, brief, but seemingly thoroughgoing anxiety or condemnation concerning particular human subjects or practices. Often generated by the state or the media and picked up by interest groups and social movements, its verve is generally disproportionate to the extent of the "problem" it brings into being, such that the panic's life is determined by the practices of its intellectual progenitors rather than its material outcomes (Jenkins, 1999, pp. 4–5). The literature on moral panics suggests that they function synecdochally: part of society is used to represent (or perhaps distort) a wider problem—youth violence is a suitable case for panic, whereas systemic class inequality is not; adolescent behavior is addressed, but capitalist degeneracy is not (P. Cohen, 1999, pp. 192–193; S. Cohen, 1973, pp. 9–13). Moral panics often take the form of crusades, sustained over a certain period by activists ("moral entrepreneurs") seeking to protect a majority they see as feckless and vulnerable. A "turncoat," a rejected or dissident former insider, is a crucial component of a prominent panic, but the perfect deconstructionist is the professional "expert" (Thompson, 1998, pp. 3, 12, 91).

The dual role of experts and media critics in the constitution of moral panics sees the former testifying to their existence, and the latter sensationalizing and diurnalizing them—making the risk attributed to the particular panic seem like a new, terrifying part of everyday life. The cumulative impact of this alliance between specialist and popular knowledge is a heightened yet curiously normalized sense of risk (Wagner, 1997, p. 46). Particular kinds of individuals are labeled as dangerous for social well-being because of their "deviance" from agreed-upon norms of the general good. Once identified in this way, their life-practices are interpreted from membership of this group. Critics of the moral-panic process propose that we should ask not "Why do people behave like this?," but "Why is this conduct deemed 'deviant,' and whose interest does that serve?" (S. Cohen, 1973, pp. 12–13).

Moral panics are part of today's "risk society," a world characterized by "institutions of monitoring and protection" that seek to protect people from "social, political, economic and individual risks" in the service of the time-discipline required by capitalism. Rather than risk being occasional, it is now a constitutive component of being and social organization (Beck, Giddens, & Lash, 1994, p. 5). Advanced industrial/postindustrial societies induce massively increased feelings of risk in their populations by admitting and even promoting the irrationality of the economy. Simultaneously, environmental despoliation, cycles of recession, the decline of life-long employment, massive international migration, changed gender relations, developments in communication technology, and the rolling back of the welfare state, alongside income redistribution towards the wealthy, have left people in postindustrial societies factoring cost and benefit into the everyday as never before, even as their sense of being able to determine their future through choice is diminished. Put another way, whereas early modernization was primarily concerned with the establishment of national power and the accumulation and distribution of wealth, developed modernity produces new risks for its members beyond those of the nation and affluence. Moral panics become means of dealing with these risks via appeals to "values," a displacement from acknowledging the systemic nature of socioeconomic crises and fissures (Thompson, 1998, pp. 22–23, 62, 88, 140). They both contribute to and are symptomatic of the risk society.

Youth occupy a privileged position in moral panics. Positioned between birth and adulthood, holding both the promise of the future and the key to its potential corruption, youth are both "at risk" and "a source of risk." They must be protected from harm by the family, society, and educational institutions because they embody a threat to order and stability, as provided by those same institutions. From characterizations of youth's hedonistic consumption, to their association with subcultures and resistance—in the form of anti-war movements, global popular culture, and alternatives to traditional lifestyles—panics about youth and youth safety are also panics about moral and social order (Thompson, 1998, p. 1).

The idea of the moral panic is unusual as a sociological concept in that it is freely used and accepted in the mainstream UK media (Barker, 1999)—although

the *British Medical Journal* has attacked applying the idea to science (Daniels, 1998). In this paper, we examine the moral panic surrounding Ritalin, an amphetamine-related pill that has been medically prescribed for use by children diagnosed with attention deficit hyperactivity disorder (ADHD) in the United States for over three decades and is now the object of great controversy both here and in other countries.

Our intent here is not to debunk Ritalin, but to follow the agnosticism of Michel Foucault. He was careful to avoid arguing that madness did not exist, or was a product of medicine: "That people are suffering, that people make trouble in society or in their families, that is a reality." He sought to uncover how mental conditions were identified and rendered as problems in need of treatment, with the aim of explaining how these forms of problematization function as techniques, economies, social relations, and knowledges (1994, p. 123). Similarly, we are not arguing here that ADHD is "made-up," nor do we negate the value of decisions made within particular social formations that decree certain forms of conduct (and suffering) to be unacceptable or deny the efficacy and legitimacy of democratically-derived and -policed norms. But to regard definitions (for example, as to what is mad or sane) as timeless, spaceless, absolute accounts is to miss the temporal and spatial contingency of the knowledges that are applied to generate social norms. Rather than promoting or condemning Ritalin itself, we suggest that the moral panic associated with it is a routine, generic event that emanates from today's risk society and its political economy and political technology of personhood. Using theoretical insights derived from social constructionism, the history of thought, and the sociology of risk, we examine the human sciences' discourse of personhood, the history of American psy-complexes and the policing of children, and these complexes at work on ADHD and Ritalin. We find new ways to explain the panic, if not to adjudicate on it, and conclude that Ritalin is, as per the wider designer-drug phenomenon, the latest path to the United States upward-mobility fantasy of transcendence, a combination of the pleasure and self-development sides of United States popular culture.

THE PSY-COMPLEXES

The human subject is generally known via three modes of subjectification: the speaking subject (defined by linguistics); the working subject (from economics); and the living subject (as per the natural sciences, especially biology). These modes define subjects as internally split or separated from others, nominating the sane versus the mad, the well-behaved versus the criminal, and the healthy versus the sick. Such categories are produced through the decisions and apparatuses of institutions that are driven by forms of scientific knowledge. Of course, self-directed techniques also turn a person into a subject: gay versus straight, private versus public, and learn*ed* versus learn*ing*. Struggles for power take

place over:

> the status of the individual: on the one hand, they assert the right to be different, and they underline everything that makes individuals truly individual. On the other hand, they attack everything which separates the individual, breaks his links with others, splits up community life, forces the individual back on himself and ties him to his own identity in a constraining way. (Foucault, 1982, pp. 781, 777–778)

The raw stuff of human beings, then, is *not* individuals: people *become* individuals through the discourses and institutions of modernity. Over time, rites of passage from traditional societies are increasingly displaced, supplemented, or made purely symbolic by scientific accounts of personhood: status and ancestry join measurement and confession, as ritualistic shame meets inner guilt and state authority. Epistemology shifts, with facts and interpretations deriving from experimentation rather than individual authority. But even as this looser model of power appears, so too do hospitals and psychologists (Foucault calls them "professionals of discipline, normality and subjection"). They utilize the new forms of knowledge to multiply and intensify the expression of power over bodies. For example, adults who lack the ability to narrate their feelings and struggles to the satisfaction of psychologists are incarcerated for failing the duty of disclosure that is the corollary of Enlightenment freedoms (Foucault, 1979, pp. 193, 224, 296; Foucault, 1987, p. 23; Albee, 1977, p. 152).

Crucially, at the beginning of the nineteenth century, psychiatry intervened in the legal field, establishing its right to define individuals as sane or insane through the concept of the dangerous individual and the homicidal maniac, thus claiming a role in the allocation of justice and punishment. By the end of the nineteenth century, however, psychiatry was no longer only interested in the criminal, but had established that there was no qualitative difference between heinous crimes and minor delinquencies—that these were varying degrees of the same thing! Since that time, the concept of the dangerous individual has emerged, an extension of the boy who runs around looking up little girls' skirts, stealing stop signs, or in our case, acting up in class. The model poses several scientific puzzles: Are there individuals who are intrinsically dangerous? By what signs can they be recognized? How should one react to their presence? These quandaries relate to forms of punishment. In the course of the past century, penal law has enlarged, organized, and codified the suspicion and the identification of dangerous individuals, from the rare and monstrous figure of the monomaniac to the common everyday figure of the degenerate, the pervert, the constitutionally unbalanced, and the immature (Foucault, 2000).

Enlightenment knowledges invented collectives as well as individuals. The populace became the province of statistics, bounded not by the direct exertion of juridical influence or domestic authority, but by forms of knowledge that granted "the people" a life that could not be divined from the model of the family (Foucault, 1991a, pp. 98–99). Even as Revolutionary France was embarking on a regime

of slaughter, public-health campaigns were underway—an ongoing Janus-faced "game between death and life" (Foucault, 1991b, p. 4). Out of that came the following prospect: "Maybe what is really important for our modernity—that is, for our present—is not so much the étatisation of society, as the governmentalization of the state" (Foucault, 1991a, p. 103). Cholera, sanitation, and prostitution were figured as problems for government to address in the modern era, through "the emergence of the health and physical well-being of the population in general as one of the essential objectives of political power." The entire "social body" was assayed and treated for its insufficiencies. Since that time, governing people has meant, most centrally and critically, obeying the "imperative of health: at once the duty of each and the objective of all" (Foucault, 1991b, p. 277). Science and government combined in new environmental-legal relations, under the signs of civic management and economic productivity. In 1855, Achille Guillard invented "demography," merging "political arithmetic" and "political and natural observations," which had been on the rise since the first population inquiries in seventeenth-century Britain. The new knowledge codified five projects: reproduction, aging, migration, public health, and ecology (Fogel, 1993, pp. 312–313). It has been determinate in articulating productivity to fitness since then. These forces coalesce in the psy-complexes, which have attained their most developed form in the United States.

United States psychiatry has twice announced breakthroughs that appeared to guarantee its stature, during the nineteenth century and again in the 1960s. First, moral treatment and the "talking cure" (named by Bertha von Pappenheim) then pharmacology and community care (JFK's promise of two thousand Community Mental Health Centers and the American Psychiatric Association's in-house 1963 declaration that the profession was ready to "inherit the earth") were thought to offer deliverance. There has been a shift—winding, incomplete, and frequently circular—from religious judgment and confessional technique to medicalized chemical intervention and deinstitutionalized help, from carceral buildings and elongated couches to pill-dispensing hospitals and returns to the social (Musto, 1995; Shattuc, 1997, p. 114). Today, more money is spent promoting the new "wonder drugs" in the United States than on all medical school and residency training put together—in 1998, Eli Lilly spent in the United States $95 million to promote Prozac (Maslin, 2000; Bloom, 2000). How did these "breakthroughs" happen?

The key enabling moment for the psy-complexes in the United States is the period after the Second World War. During this period, the Federal Government invented new laws, agencies, and programs that encouraged the development of mental health as an industry. The popularity of Freudian psychoanalysis peaked during this time (between 1940 and 1965), after demonstrating efficacy with soldiers during World War II, although many "cures" may have been more attributable to the war ending than to psychoanalysis (Hale, 1995, p. 382).

Additionally, in 1954, the first psychoactive drug came onto the market. Chlorpromazine (sold as Thorazine) combined with new governmental employment of therapists to reverse the institutional removal of the mentally ill from public life. Two years later, the number of mental-hospital patients declined for the first time since the previous century. Patients were not the only ones to come out. Whereas almost all psychiatrists worked in hospitals in 1940, by 1957 over 80 percent did not. With the advent of Medicare and Medicaid as part of the "Great Society" reforms of the next decade, public hospitals lost more patients. State governments utilized new forms of funding to shift them into non-traditional institutions like private nursing homes, halfway houses, and outpatient care, which were simultaneously ideologized as democratic by the emergent community-care movement (Herman, 1996, pp. 257–259).

The importance of diagnosis became eminently clear with the introduction of psychoactive therapeutic drugs in the 1950s. The availability of effective medicine made diagnosis particularly important, although in psychiatry the effect of a medicine itself often created the diagnostic category of the disease it was "designed" to alleviate. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders I (DSM)*, which catalogues mental disorders for the field, was created in 1952 and encompassed an expansionist project, in which broad labels were used for diagnosis with the aim of encompassing the whole of society. *DSM II* was published in 1968, and embodied a psychoanalytic approach to psychiatry.

The status of psychoanalysis began to decline after 1965, however, because of doubts about its scientific validity, its links to the establishment rather than with progressive reform, a renewed interest in genetic/biological causes of mental illness (particularly after the advent of psychotherapeutic drugs in the mid-'50s) and the rising popularity of alternative models. The *DSM III*, published in 1980, was a response to biopsychiatry, and focused on symptoms and description rather than etiology or theory. The purported reason for not focusing on etiology was to avoid controversy about causes amongst different camps of psychiatry, but in actuality, this model was directly opposed to the psychoanalytic perspective and also to the social psychiatry models that had been emerging in the 1960s. The shift from *DSM II* to *DSM III* marked an important moment in the history of psychiatry, as the biopsychiatric model of diagnosis came to dominate over the psychoanalytic model (Cooksey & Brown, 1998, pp. 529–530).

Although the supposed aim of the new diagnostics was to avoid the expansionist tendencies in the 1950s and '60s when there was a greater social and economic attention to mental illness, this counter-tendency is itself expansionist, in the name of biopsychiatry. Nosology as applied to conduct now depends on entirely distinct practices being collocated by clinicians in order to define them as amounting to psychopathology. The result fixes these forms of life as immovable diagnostic things via reification, reductionism, and synecdoche (part of one's

"behavior" stands for the totality of one's personality). This has been identified as a danger associated with attention deficit disorder and its relatives (Santostefano, 1999, pp. 322–323).

In 1990, President George Bush the Elder declared the commencement of the "Decade of the Brain." This represented the triumph of the "New Psychiatry," which had mobilized psychosurgery and drug treatments from the 1960s to the point where they were dominant. Identifying the brain as the etiological site of educational, social, personal, and even political problems, psychiatrists have comprehensively medicalized misery, to the point where ideas of early-childhood trauma are deemed outmoded and there are moves to erase psychotherapy from psychiatric education. Pharmaceutical corporations and their prescribing delegates have become the new hospital administrators and therapists, under the slogan "You can't talk to disease" (Breggin, 1994, pp. 11–13, 17, 23, 122). Prior to addressing this topic with reference to ADHD, we need to historicize one more item—the child and its psyche.

POLICING THE CHILD

Based on his studies of France, Jacques Donzelot (1979) states that child psychiatry was not originally concerned with psychiatric particularities common to children, *per se.* The early physicians who directed mental asylums, and the alienists and the neurologists who restricted their expertise to a small group composed of the severely insane, were interested in childhood insanity as it was linked to the future health of the adult.

For example, the vagabond became the focus of psychiatric attention in the last decade of the nineteenth century, and problematic children were seen as potential future vagabonds. This attention to children was intended to "preselect and to pretreat," separating troubled children from the normal population (Donzelot, 1979, p. 131). The school became a site for observing the signs of disorders for which children were to be treated, and the family was seen as the originary site of mental illness. Juvenile law at this time was shifting its focus from punishment and repression to education and prevention, and psychiatry played a major role. By the middle of the twentieth century, the damning diagnosis "pervert" became less common, and the shift away from permanent diagnosis and towards "educability" continued.

But child psychiatry became more and more concerned with the proclivities of everyday children. By the early decades of the twentieth century, there was a shift in focus—the "predelinquent" child emerged as a subject of child guidance, and psychiatry grew increasingly interested in the everyday "normal" child, which included all ages and classes (Jones, 1999, p. 9). The asylums of the nineteenth century were replaced by or converted into hospitals, psychiatrists developed an

interest in everyday problems and patients—not just the criminally insane—and psychiatry increasingly focused on the normal (Lunbeck, 1994, pp. 22–24).

An early twentieth-century concentration on deviant children emerged in the United States via the juvenile courts, which were founded in 1899. These courts, which mostly dealt with the poor, were based on the premise that adult courts were too harsh, doling out sentences that were too final and not therapeutic-minded enough for children. The Juvenile Courts linked up to psychiatry early on; in 1909, the Juvenile Psychopathic Institute (JPI) was founded in Chicago. It aimed to improve the juvenile court, while the courts were to seek psychiatric evaluation of perplexing cases. With this union of child law and child psychiatry, progressives hoped to rely on scientific research into the causes of juvenile crimes to eradicate juvenile delinquency. And the turn of the century was an auspicious time to garner public support for this movement, as the mass media were filled with reports of rising crime, justifying immediate social action. The JPI suggested that delinquents were "normal" children, not feebleminded or psychopathic, and its findings were praised by welfare and prison reformers. This inspired a national child-guidance movement, which created more court-affiliated clinics (Jones, 1999, pp. 15, 37–38, 43, 56–57). In 1910, the National Committee for Mental Hygiene (NCMH) was founded in the United States, supported with grants from the Rockefeller Foundation and the Commonwealth Fund. The prevention of mental illness and delinquency was its aim, to be achieved through children. In 1922, the NCMH provided seed money to establish child-guidance clinics, and by 1936 there were 235 such clinics nation-wide (Hale, 1995, p. 87; Jones, 1999, pp. 58–60).

Many current attitudes about children took root in the child-guidance movement during the first half of the twentieth century in the United States (Jones, 1999, p. 4). There was a shift at that time from a focus on heredity as a cause of deviance to the impact of environment on character, the influence of the home, family, and parents on children's development, mother-blaming, the continuum drawn between normal and abnormal children, the negative effects of severe repression on children, and childhood sexuality (Hale, 1995, p. 85). The child-guidance clinic's first patients were young delinquents and their parents, mostly from immigrant families and low socioeconomic groups, but throughout the next few decades, this clientele grew to encompass middle-class children brought by mothers concerned with educational performance and sexual behavior (Hale, 1995, pp. 7, 87). By the 1920s and '30s, child guidance had begun to take an interest in the "problem child," who was "normal" in comparison with nineteenth-century psychiatric subjects, but deviant with respect to authority—for example the family or the school. This problem child could come from any social class (Jones, 1999, p. 7).

After World War II, child psychiatrists associated more with the medical community than with social workers and liberal reformers. In 1952, the American Academy of Child Psychiatry was founded. It restricted membership to medically trained persons who were part of the American Psychiatric Association, and in

1959 child psychiatry became a formal medical sub-specialty. Social-structural factors were not completely eschewed; in 1970, the Joint Commission on Mental Health of Children denounced the nation for ignoring socioeconomic factors that related to the well-being of children (Jones, 1999, pp. 217–218).

Coterminous with this history, we have seen the intense differentiation of United States children from adults. In the hundred years to 1950, the school displaced the factory as the site for disciplining children, parents in the evolving nuclear family were held responsible for their children's welfare and punishable by the state for failing to be responsible adults, and child psychologists emerged to theorize and treat children in terms of "natural" forms and stages of development into adulthood. Protection in the form of policing was an established norm by the 1950s (Steinberg & Kincheloe, 1997, pp. 1–2). In 1958, the National Defense Education Act invented the school-guidance counselor, funding 60,000 jobs. Almost overnight, children were subject to external testing and self-monitoring against norms of scholastic and occupational achievement derived from the psy-professions (Herman, 1996, pp. 257–259).

By this time, the "privatized nuclear household with its male breadwinner, female homemaker, and dependent children" had shifted from an "insurgent ideal" of the white middle class during the nineteenth century to a tentatively achieved but ideologically naturalized norm (Reeves & Campbell, 1994, p. 186). In the 1950s, 80 percent of children lived with their married, biological parents. But that was true of just 12 percent of children by the end of the 1980s. Seven percent of children lived with an employed father and "home-duties" mother (Reeves & Campbell, 1994, pp. 186–189). This is but one of the statistical changes that have generated concerns about youth and their well-being: as suicide rates fell across the population, they rose among young people—the suicide rate among 15–19 year-olds quadrupled between 1950 and 1995, notably among males. Key social measures of unhappiness correlate with youth today in a way that they did not even up to the mid-1970s, and young people report greater distress than before, beyond what old people experience (Putnam, 2000, pp. 261–263). These indices contribute to heightened concern about the welfare of youth; this is coterminous with increased contact with the psy-complexes, which simultaneously functions to protect youth and generate statistics that add to the concern: in the year 2000, 37 percent of US residents aged 15 to 24 were diagnosed as mentally ill (Berman, Strauss, & Verhage, 2000). In 1999, almost 2.98 million prescriptions were written for United States adolescents—over 11,000 new scripts each weekday (Waters, 2000).

The media have also come to take a critical role in the creation of childhood. The proliferation of new media technologies has seen a vast increase in the amount, degree, and speed of textual content experienced by children and young people, with much more of the latter's diurnal experience produced by entertainment corporations and much less by parents. The brief moment of parental dominance in the 1950s was itself clouded by the media—congressional hearings into juvenile

delinquency heard again and again from social scientists, police, parents, and others that the emergent mass media were standing between parents and their children, diverting offspring from their parents' values (Gilbert, 1986, p. 3). This trend has continued. Ideologies, institutions, and policies predicated and structured on "tradition" are inadequate in the face of such major social change. On the one hand, children experience the extended working hours and diminished spending power of harried, often single parents. On the other, children are interpellated by the corporate advertising and entertainment as competent, knowledgeable consumers who should not be cowed into submission by authoritarian parental and educational will (Steinberg & Kincheloe, 1997, pp. 2–3, 16–17).

ATTENTION DEFICIT-HYPERACTIVITY DISORDER

ADHD and hyperkinetic disorder provide the psy-complexes with their reason for prescribing Ritalin, since stimulants like it are "the cornerstone of therapy" for the disorder (Steinberg, 1999, p. 223). This use of treatment only works, of course, as part of medicalization—there must be a physiological underpinning to these disorders, lest they be dismissed as malingering by sufferers, quick remedies for parents, teachers, or doctors, or self-interest on the part of the psychiatric and pharmaceutical establishments. Five distinct attempts have been mounted to provide a biological basis to the disorders. The first takes the efficacy of treatment as proof of the existence of disease—Ritalin works like a neurotransmitter, repairing concentration and disruptive conduct, so there must have been a problem with neurotransmission in the first place. This neglects the fact that use of Ritalin on "healthy" children also leads to greater obedience and focus. The second removes the blame from neurotransmitters and places it on pregnancy and birth, where prenatal and perinatal traumas are held responsible for early behavioral difficulties. The research only validates such claims up to the age of three years, so it is rarely used to justify Ritalin prescription. The third turns to retarded maturation, "soft signs" of neurological function; but again, these signs 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. Lastly, the inevitable appeal to genetics has produced no absolute proof. Concordance of ADHD among monozygotic twins is only 51 percent, compared to 100 percent concordance with eye color, which suggests only a partial genetic link (Rubinstein, Scrimshaw, & Morrissey, 2000, pp. 42–43; Livingstone, 1997).

Taken together, these five forms of thought offer less than compelling evidence that ADHD "exists" independently of its diagnosis and treatment. They have been described as "highly subjective" even though they are presented as quite the opposite (Messinger, 1978, p. 67). Endless studies that find children are hyperactive at home but not at school or *vice versa*, or hyperactive at both but not at summer camp or in clinicians' rooms, do serious disservice to biological claims

(Sandberg & Garralda, 1996, pp. 281–282). The United States National Institutes of Health Consensus Conference has not established any basis for ADHD in brain functioning. So when patients or their significant others present professionals with such queries as "do you test for ADD?," they are reifying a cluster of symptoms and signs into a biological-neurological issue (Diller, 1998, p. 3). Where did such queries, with this earnest backdrop, derive from?

Hyperactivity was first declared in the late 1950s by Europeans, despite its contemporary status as an American disorder. But clinical discussion of unruly conduct amongst children has a much longer history. In its earliest manifestations, such disorders were attributed to moral defects in dealing with authority and self-discipline, evidenced in unruly bodily motions and inattentiveness. This analysis derived from a Social Darwinism employed to explain class difference (Sandberg & Barton, 1996, pp. 1, 5–6). Moral and medical discourses blurred on their way past one another, with each affected by the transaction, as "behavior" came to displace "morality." But the latter heavily coded the former, if in a scientistic manner that treated norms as necessary for social cohesion and individual advancement on a secular rather than a God-given basis.

Even before identification of hyperactivity in Europe, George Still identified ADHD-like symptoms in 1902, attributing them to an inherited neurological disorder (Breggin, 1998, p. 179). However, it took the 1917–18 encephalitis epidemic to stimulate this discourse more thoroughly. Clinicians were presented with numerous young patients who behaved oddly, and this served to confirm the diagnosis of unusually lively but unfocused conduct on brain damage or disease. The 1960s witnessed a grand Atlantic bifurcation over the disorder(s). European clinicians began, and have largely continued, to define the problem narrowly and specifically, in terms of "excessive motor activity" probably caused by damage to the brain. In the United States, by contrast, hyperactivity was viewed as part of the problem and brain damage part of the cause, as attention deficits were categorized and counted (Sandberg & Barton, 1996, pp. 2–3, 8).

As per these key differences of opinion over defining ADHD, its diagnosis has remained controversial and at times even appeared ludicrous to the non-initiate. Successive *DSMs* have radically differed in their definitions of ADHD. *DSM-II* offers hyperactivity, impulsiveness, and inattention as three cores; *DSM-III* divides the three into their own groups, with minimal disorders required within each one; and *DSM-IV* clusters them into one multifaceted problem whilst criticizing previous rules of inclusion and exclusion. This version requires a minimum of six forms of inattention/hyperactivity in order for children to qualify (McBurnett, Pfiffner, & Ottolini, 2000, pp. 229–231).

The casual reader of the *DSM* list may be inclined to diagnose him or herself, identifying with such "symptoms" as being easily distractible, clumsy, impatient, explosive, always on the go, fidgety, talking loudly, moving a lot during sleep, immature, and a loner (Accardo & Blondis, 2000b, pp. 4–5). Some of this becomes

rather sinister when forms of diagnosis extend to identifying a "double posterior hair whorl," "anterior cow lick," or "electric hair" with a proclivity towards ADHD (Accardo & Blondis, 2000a, p. 153). There is a long history of attributing deviance to physiology. Take, for example, the sex-variant study carried out in New York City between 1935 and 1941, in which Robert Dickinson traced the genitals of New York women on a plate of glass placed over their vulvas to differentiate lesbians from non-lesbians, or the studies of the criminal anthropologist, Cesare Lombroso, undertaken in Italy in the late nineteenth century, in which prostitutes were examined for signs of physical "degeneracy" (Terry, 1998; Horn, 1995). Today, such signs are also visible from within the body. In 1990, a National Institute of Mental Health (NIMH) study included colorful pictures of PET scans, suggesting that a number of adults with a history of ADHD in childhood had decreased brain metabolism. These images were produced and circulated widely in the media. The study was used to assert a biological basis for ADHD (Breggin, 1998): "It is not that your mother got divorced, or that your father didn't wipe you the right way . . . It really is DNA roulette" (Harold Koplewicz quoted in Waters, 2000).

Still, this "roulette" requires interpretation. There is a strong preference in the medical literature on ADHD for knowing and attending to what is described, almost in base-superstructure terms, as "underlying physiology." Yet even these true believers lament the weak correlation of "brain damage with attentional dysfunction" (Lock & Bender, 2000, pp. 30–31), and many admit that "definitions of learning disabilities are astoundingly plastic" and depend on "one's choice of boundaries" (Hinshaw, 2000, p. xv). This dilemma is positively spun as "the heterogeneity of ADHD," a function of its collecting together "a cluster of several behavioral deficits, each with a specific physiologic substrate" (Sieg, 2000, p. 111).

The "true" prevalence of ADHD across gender, geographic, and class lines is a topic that has generated many conflicting opinions, yet certain groups of people are more likely to be diagnosed 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 census data and other studies, it has been proposed that of children aged between 5 and 17, 5.8 percent of boys and 1.5 percent of girls had ADHD in 1994. However, the ratio was 3.5:1 two years later, while in 1995, 25 percent of Ritalin use was by adults. Clinical numbers suggest males outnumber females 9:1, while the epidemiological ratio is 4:1. In the UK, the figures are 3:1. The gender differences have been explained away as an outcome of the less-violent ways of girls, which lead to fewer referrals than the attention-getting conduct of bratty boys. Recent scholarship regards the association of males with ADHD as largely mythic, proposing that the clinical imbalance derives from under-diagnosis amongst girls and a similar failure to identify ADHD in older women (Quinn & Nadeau, 2000, pp. 216–217). Geographically, ADHD is mostly found in the South and West of the United States amongst upper-middle-class whites living in the suburbs. Outside the United States as well as within, Ritalin is more prevalent in poor urban rather

than rural areas (Diller, 1998, pp. 35–36; Hepstintall & Taylor, 1996, p. 330; Luk, 1996, p. 358; Cantwell, 1999, p. 4). African-American families deploy the drug at half to a quarter the rate of their white socioeconomic equals, while use is virtually zero amongst Asian Americans (Diller, 2000). There is conflicting evidence on the impact of class and family background on ADHD diagnoses. Some studies propose a link between disadvantaged families, and others do not. There is a much stronger correlation with attention deficit diagnoses (Sandberg & Garralda, 1996, pp. 283–284).

Responding to the threat to its legitimacy posed by this sociological variety, the American Academy of Pediatrics issued its first detailed guidelines for ADHD diagnosis in 2000. The group is also writing treatment guidelines for children aged 6–12 to emphasize that symptoms may not be apparent in a doctor's office, so doctors should ask parents, caregivers, and teachers about conduct at home and school. The symptoms must be present for six months in at least two of the child's social settings (i.e., home and school) and other conditions should be ruled out (or diagnosed as co-existing conditions) (Hall, 2000). And so, although controversial, diagnosis continues, and once the diagnosis is attained, it generally leads to one outcome—the prescription of Ritalin.

RITALIN

Ritalin is related to amphetamines, a class of chemicals that replicates the function of neurotransmitters in arousing the nervous system. Amphetamines were first synthesized in the 1880s, and since the 1920s, their capacities to stimulate activity have been widely appreciated. By 1970, fifteen different pharmaceutical corporations manufactured over thirty kinds, amounting to 12 billion pills annually. Ritalin, with the chemical name methylphenidate, is within this group (Jenkins, 1999, pp. 30–31; Steinberg, 1999, p. 225). Methylphenidate was first synthesized in 1944 as part of a search for a non-addictive stimulant, and used in the United States ten years later, when it was endorsed by the FDA to treat narcolepsy, depression, and lethargy. Researchers recommended the drug for controlling children's behavior in 1963 (Breggin, 1998, p. 180). It was reborn as Ritalin by the pharmaceutical company Ciba-Giegy in the early 1960s as a memory aid for seniors, before being redisposed yet again for use on children (Diller, 1998, pp. 21–22, 25).

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 United States children, perhaps an early sign that psychoanalysis was on the wane (Sandberg & Barton, 1996, pp. 11–12). In 1970, 150,000 children were on the drug, increasing to 900,000 in 1990. Across the 1990s, the number of United States children and adults diagnosed with ADD/ADHD rose, to 2 million in 1993 and 3.5 million by 1997, with most patients taking Ritalin and some using Dexedrine.

During that period, the amount of Ritalin produced increased by 700 percent, an astonishing figure for a controlled substance. Eleven million prescriptions are written in the United States each year and sales went from United States $109 million in 1992 to United States $336 million in four years (Marshall, 2000; Russell, 1997).

Early studies suggested Ritalin increased adherence to norms of polite, restrained conduct, but subsequent research proposes strong correlations with improved academic performance (Trapani, 2000, p. 201; Powers, 2000, p. 486). The drug has latterly been positively linked to more manageable conduct in class, better scholastic results, diminished violence, greater intersubjective pleasure and calm, and higher rates of participation in organized sport (Cantwell, 1999, p. 16). Here lies the point of suspicion for critics on the left. We might translate these correlations a few degrees such that they are viewed as social conformity, preparedness for a conservative role in the work force, suppression of disgruntlement that is a rational response to oppressive institutions and norms, or diversion of energy into reactionary pastimes. A healthier, fitter, more polite population reduces the cost of public health, guarantees a functioning and pliable workforce, and even helps tourism. This longstanding criminological obsession deems familially-based and institutional activities to be worthy, integrative norms, whilst informal leisure is demonized as a danger that should be pacified and redirected into an appropriate sphere—literally, national fitness.

Pediatricians and family practitioners write most prescriptions for Ritalin in the United States—this removes it from the clutches of the traditional gatekeepers of psychiatric drugs, the psychiatrists (Schachar, Tannock, & Cunningham, 1996, pp. 435–436). Of adolescents treated for depression in Oregon in 1998, 60 percent were prescribed drugs not by psychiatrists, but pediatricians. In North Carolina in 1999, the figure was 72 percent (Waters, 2000; Hyman, 2000; Woodworth, 2000). Health Maintenance Organizations (HMOs) have added to this trend of undermining power-broking professionals through the discourse of bureaucratic-managerial commodification: "deprofessionalization is one of the outcomes of the new managerialism" (Scheid, 2000). There has been a rapid decline of insurance-company support for family therapy since the advent of wholesale managed care versus fee-for-service, in the mid-1990s. HMOs will only fund four to six visits before the use of drugs (Waters, 2000).

But apart from questions of prevalence and in whose hands prescription lies, some important issues surround the ethics and physiological impact of the drug. True believers argue that Ritalin is safe and effective, that the moral panics surrounding it are driven by illegitimate anxieties about the number and rate of diagnoses. It has a very high rating on the therapeutic safety index, a figure derived from dividing a toxic by a therapeutic dose (Powers, 2000, pp. 477, 483). However, Ritalin can produce anorexia, which is said to end once use is discontinued, while "intermittent drug holidays" are also recommended to ensure normal growth. There

is also dispute over its role in the etiology of tics and Tourette's Syndrome (Powers, 2000, pp. 489–490). Long-term use (beyond 14 months) has not been studied, as the pharmaceutical industry is mostly interested in measuring short-term effects of medication, and is ill-disposed to perform long-term studies of the type desired by parents (Hyman, 2000).

Additionally, the "abuse" of Ritalin, characterized as its recreational use, has proved troubling. The Drug Enforcement Administration (DEA) designates it as a Schedule II substance, a categorization that stigmatizes drugs as liable to lead to abuse.[4] In 1995, the supposedly independent patient-rights' group Children & Adults with Attention Deficit Disorders (CHADD) and the American Academy of Neurology submitted an unsuccessful petition to the DEA to lower regulatory controls. The Administration declined, for safety reasons (Diller, 1998, p. 348 n. 86). There have been many reports of Ritalin abuse, starting with 1960s in Sweden. A statement issued by the DEA in 1996 noted that Ritalin abuse had increased significantly since 1990; in 1994, a national high-school survey found that 1 percent of all seniors had taken Ritalin the year before without a prescription. In 1999, the survey found that 3 percent had. In 1990, there were about 271 emergency room reports of Ritalin and 1727 in 1998. From January 1990 to May 1995, methylphenidate ranked in the top ten most frequently reported controlled drugs stolen from Registrants; about 700,000 dosage units of stolen methylphenidate were reported to the DEA's drug-theft database between January 1996 and December 1997. School nurses, "teachers of the year," and principals have been among those found stealing Ritalin from school coffers. In May 2000, the House Education and Workforce Committee held hearings on the recreational use of Ritalin, in which testimony was given stating that one in five college students use Ritalin illegally (Sax, 2000). Responding to concerns about the illicit use of Ritalin by both students and adults in public schools, the United States government launched a study of "Ritalin abuse" in November 2000 (Woodworth, 2000; Thomas, 2000).

Conflict of interest concerns have also caused controversy; in the 1990s, the manufacturer gave CHADD 9 percent of its annual revenue (Russell, 1997).

MEDIA CONCERN

All of this has, of course, attracted major media attention—Ritalin receives both good and bad press. Recognizing the media's power, Ciba-Giegy (now called Novartis following a merger with Sandoz), the manufacturer of Ritalin, spread the gospel of brain disorders as the key to depression and other abnormalities by financing public television's series *The Brain* (Breggin, 1994, p. 122). But from

[4]The DEA designation guarantees good data on levels of prescription, as the state sets an annual quota on the production of Schedule II substances in response to pharmaceutical industry requests and the amount of sales by pharmacies (Diller, 1998, p. 27).

the 1970s, several horror stories about Ritalin appeared in the *bourgeois* United States press. Congressional hearings were prompted 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" form of treatment (Diller, 1998, pp. 30–31; Sandberg & Barton, 1996, pp. 3, 18–19). These concerns coalesced with the anti-psychiatry movement of the time, represented by the tragic heroics of Jack Nicholson's character in the film version of Ken Kesey's novel, *One Flew Over the Cuckoo's Nest.* The decade also produced the first pop-psy-complex denunciations of Ritalin, with the publication of *The Myth of the Hyperactive Child, and Other Means of Child Control*, by Peter Schrag and Diane Divoky, and Gerald Coles' *The Learning Mystique* (1987), while Scientology founder and science-fiction writer L. Ron Hubbard also denounced Ritalin (Diller, 1998, p. 31). In the late 1980s there was another round of media attention, with articles appearing in the *New York Times*, the *Wall Street Journal*, the *Washington Post*, and the *Los Angeles Times*, and a segment on Ted Koppel's *Nightline* (Breggin, 1998, pp. 180, 183). Popular literature also appeared favoring the phenomenon around this time, notably Barbara Ingersoll's *Your Hyperactive Child* (1988) and Edward M. Hallowell and John J. Ratey's *Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood to Adulthood* (1994) (Eberstadt, 1999). This genre of popular critique drew new strength in the 1990s, in the wake of Prozac's popularization and associated debates about it and other mind-altering antidepressants, via Peter Breggin's *Toxic Psychiatry* (first published in 1991) and *Ritalin Nation* (1998) plus Lawrence Diller's *Running on Ritalin* (1998), Thomas Armstrong's *The Myth of the ADD Child* (1995), and Richard DeGrandpre's *Ritalin Nation* (1999). The debate has trickled into popular literature as well, via Robin Cook's 1994 novel *Acceptable Risk* (Stookey, 1996, pp. 163, 172–173, 175, 180 n. 1).

In the first Bush's decade of the brain, ADHD came to be referred to as the "diagnosis of the decade." Media attention has been "unprecedented" since in terms of "national magazine covers, sciene [*sic*] features in daily newspapers, broadcast television highlights, talk radio topics, and local-news spots" (Hinshaw, 2000, p. xiii). In 1997, *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, plays drums on his desk with pencils—parents are circled by the school's teachers, psychologists, and even principals, all pushing Ritalin" (Russell, 1997).

Breggin, one of the most visible contemporary critics of pharmacological psychiatry, stigmatizes Ritalin as "an iatrogenic drug epidemic." He charges it with generating a mindless obedience that suppresses emotions and ideas, diminishes self-esteem, and takes away from a sense of self while questioning the very existence of ADHD (1994, pp. 303–305, 309). Other medical professionals/populist authors who dissent from the mainstream pose questions about 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 a hidden problem, whether biological, familial, or institutional (Diller, 1998, p. 13). 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 rather than abnormal biology. Rapid-fire culture is culpable for producing sensory addicts, addicted to newness and change. DeGrandpre uses the amount of money poured into fleeting pop-culture moments—such as *The Titanic*—to advance this hypothesis. His prescription for the problems is not medication—providing stimulants to sensory addicts just compounds the problem, he says—but to slow society down, to return to a "natural speed and rhythm," to "challenge the dominant paradigm of work work work," and to "overcome cynicism through hope and action" (DeGrandpre, 1999).

A very recent flurry of media attention devoted to children and Ritalin was set off by a study published in the *Journal of the American Medical Association (JAMA)* by Julie Zito and her colleagues. They state that in the last decade, the prescription of stimulants in the treatment of ADHD in United States children aged 5–14 has dramatically increased, and use by those aged 2–4 grew threefold between 1991 and 1995 (Zito, Safer, dos Reis, Gardner, Boles, & Lynch, 2000). The NIMH reacted strongly to these findings, rejecting prescriptions to large numbers of preschoolers, and funding a large research project to evaluate that group (Scandal!, 2000). This round of moral panic continues previous decades' skepticism of psychiatry. It highlights the increasing frequency of prescription of Ritalin, its abuse by "normal" children, and the potential nature of ADHD as a sociocultural phenomenon, which should not be treated with drugs. Major media attention was also paid to the bizarre summer 2000 instances of state intervention against parents who took their children off Ritalin. In one New York case, the local school district informed the Child Protective Services Unit, which accused the parents of child abuse, a charge upheld in court (Leibowitz, 2000). More and more public schools threaten parents with removal of their children from conventional classes absent medication (Diller, 2000).

CONCLUSION

Some suggest that the psychologization and therapization of teaching have produced the Ritalin trend. They have turned educators towards diagnostics, such that schools are viewed as mental-health institutions. The right derides egalitarianism in progressive educational philosophy for making teachers responsible for students' performance against a presumed *tabula rasa* of equal innate ability. Such conservatives contend that this philosophy, along with a pharamacological replacement of old-style physical sanctions as means of disciplining children, have

encouraged educators to put their charges on Ritalin (Livingstone, 1997). Alternatively, it has been suggested that with the introduction of "high stakes" testing into many states—in which funds are allocated to school districts based upon improvements in students' test scores—counselors, teachers, and principals may be more inclined to recommend Ritalin to parents, in a desperate attempt to improve performance; indeed, local property values, jobs, and salaries can depend upon these scores (Sax, 2000).

In the light of these concerns, attempts have been made to study, understand, and reverse the Ritalin trend. In 1999, the Colorado Board of Education resolved to discourage teachers from recommending Ritalin. The following spring, the Federal Government funded a five-year United States $6 million study of the drug's effects (Leibowitz, 2000). Novartis, CHADD, and the American Psychiatric Association now face class-action lawsuits in New Jersey, California, and Texas that they conspired to drive up demand for Ritalin and did not publicize warnings about the nervous and cardiovascular systems. Breggin is a star witness (Diller, 2000; Layton & Washburn, 2000).

Although the United States produces and consumes about 85 percent of all Ritalin, panics surrounding its increased use are not restricted to American children (Woodworth, 2000). While containing many of the same concerns exhibited in the United States, these panics are also about modernity and power in a global economy. The *Independent* of London warns of increased Ritalin consumption in England, noting that as the latter is customarily 10–30 years behind the United States, it could look forward to an ADHD epidemic, treated with Ritalin; a warning is already in place, as prescriptions in Britain tripled across the 1990s (Lacey, 1996). Just as in the United States, these concerns are not always met with uniform policy responses. In the fall of 2000, Ritalin was banned for preschoolers in the United Kingdom, just weeks before the National Institute for Clinical Excellence advocated *more* prescriptions for children, setting off a flurry of debate (Hinsliff, 2000; Orr, 2000). Within this framework, the under-prescription of Ritalin—whether characterized as the absence of sick children or the absence of pill-happy doctors and parents—can sometimes be as problematic as its over-prescription, signifying non-modernity. For example, one Israeli woman's dissertation, while granting that Ritalin may be over-prescribed in the United States, states that Israel is "behind the United States in knowledge and awareness," that many ADHD children in Israel go undiagnosed (Mason, 1999).

The increasing number of children diagnosed with ADHD is deemed objectionable because the public is worried about real harm done to children in a hyper-speedy age of hyper-competitive 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, one in which "boys would be boys" and that was all there was to say about the topic. Today's fuzzy boundaries that differentiate the normal feisty child from the ill are viewed as problematic.

This helps account for the fervent searches conducted for signs of ADHD displayed physically on the body, in the hope that this will clearly distinguish those who need treatment from those who do not. Hair patterns, odd toes, and brain scans are evaluated and categorized with the expectation that they will lead to a concrete and unitary diagnosis, waiting to be read by experts and accepted by parents, teachers, and the public.

"The most important epidemiological question in psychiatry is the following: When is a person malingering? It is the difficulty of answering this question that shakes the very foundation of psychiatry" (Reznek, 1998, p. 214). The absence of objectifiable signs via an underlying cause is matched by a set of symptoms that are always liable to redefinition. Drugs answer the question by sidestepping it—they can make people comport themselves differently, and in the process, lift psychiatry out of its ascientific mire (Reznek, 1998, pp. 214, 220). The pill is a commodity form *par excellence*—truly "consumed," genuinely material and measurable, utterly standard, and infinitely repeatable. It also adheres to bureaucratic norms of reliability and efficiency and infinite substitutability. This amounts to the actuarialization and financialization of the sick mind. For therapists, this threat has encouraged collective action to preserve analysis (Lerner, 2000). For pharmaceutical corporations, it has encouraged competition. Shire, the extraordinary new company that is simply a developer and marketer rather than a researcher and manufacturer or drugs, expanded at unprecedented pace in 2000 on the back of Adderall, a dynamic new alternative to Ritalin that offers three kinds of amphetamine instead of just one and lasts longer. It attained 36 percent of the United States market virtually overnight and led to the acquittal of a man who killed his daughter because it was determined the drug made him psychotic. It is banned in Europe (Clark, 2000a and 2000b; Phalen, 2000). That again forwards the question of United States *avant-gardisme*.

Americans are world-renowned (and much laughed-at) for (i) putting certain things *in* their mouths (cigarettes, sugar drinks, and fast food); (ii) making words come *out* of their mouths to condemn these very activities; and (iii) exporting this combination of customs to other peoples. Now, Americans' capacities to seek more and more artificial substances to put in their mouths include the promise to make themselves into completely different people. The promise and the risk are, quite literally, to take this American oral fetish and transform it into the ultimate American dream: self-invention. The sense of ethical incompleteness inscribed in Americanness, courtesy of being the underclass of Europe, then inventing personal self-criticism as an invitation to consumerism and a means of surviving and thriving in a risk society, is today producing what Erik Davis diagnoses as "the posthuman self." No wonder the UN finds Europeans prefer downers and United States citizens opt for uppers (Cappella & Boseley, 1999)!

The nineteenth-century's dangerous individual has become younger, whiter, and middle class in the United States, where people are increasingly "on

drugs—SSRIs, hormones, brain boosters, neurotransmitters." Instead of old-style recreational objects that Americans liked to put in their mouths (alcohol, tobacco, coffee, and illegal substances) which had instantaneous joy and release as promises, tied in some cases to the threat of death, disability, or pain, the new, legal, but controlled substances, offer a permanent overhaul (Davis, 2000). No huddling outside the office building, no stains on the paperwork or keyboard, no obvious need to be like others. No quick pleasure, no hangover, no snoring or morning cough driving those around you to distraction, no staggering to the bathroom to be ill, no breathlessness walking up two flights of stairs, no emanations from the mouth, hair, or clothes to mark one out. Instead, the personal side to risk is made manageable via a quiet daily insurance that backs up the gains made the day before within one's not-so-hard drive of a body. In this sense, the new drugs are designed for upwardly mobile people who have decided to abandon former existences. For they make us anew, via a form of secular, even scientific transcendence that markets in pill form the grand promise of the United States: that what you were born as will not define you ever more. And once the decision has been made to take these reformatting technologies, they "melt invisibly into the texture of the everyday" (Davis, 2000). Rather than forming relationships with others through the shared experience of ingestion, the new drugs forge a new relationship with the self that is nearly invisible to others and oneself after a time. As such, they fulfill the peripatetic individual's *ur*-dream—to learn the code, to crack the means of making oneself anew, to be other than what one came with—and to do so in a seamless way that does not draw attention to itself. No wonder that thirty-eight million people in the United States have tried Prozac and 10.3 million new prescriptions were written for it in 1999 (Erica Goode, 2000).

In the process, the grand project of bringing the mentally ill out into the bright lights of narcissistic day has been accomplished, their new way of seeing the world modeled upon and in turn modeling the behavior of a new citizen, one whose change is invisible, thanks to pharmacology. Perhaps the moral 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 most panics. As pharmaceutical companies market their wares more and more effectively to parents, doctors, and teachers, and forces mount in opposition to this new era of swallowing, both sides must make peace with the tension between promises of new applications and fears of doping the future.

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