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On the Other Side of Hyperactivity: An Anthropology of ADHD

by

Marc Andrew Goodwin

A dissertation submitted in partial satisfaction of the

requirements for the degree of

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in

Anthropology

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Graduate Division

of the

University of California, Berkeley

Committee in Charge:

Professor Lawrence Cohen, Chair

Professor Xin Liu

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Professor Vincanne Adams (UCSF)

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Abstract

On the Other Side of Hyperactivity: An Anthropology of ADHD

by

Marc Andrew Goodwin

Doctor of Philosophy in Anthropology

University of California, Berkeley

Professor Lawrence Cohen, Chair

This dissertation, *On the Other Side of Hyperactivity: an Anthropology of ADHD*, provides a meta-historical and cultural perspective on the emergence and proliferation of Attention Deficit Hyperactivity Disorder (ADHD) in the United States over the last three decades. Through in-depth multi-sited ethnography (15 months in the San Francisco Bay Area) with doctors, educators, parents, and children as well as detailed archival research into the disorder's antecedents, my research explores how ADHD operates as both a psychiatric category and social imaginary that links together in its operation the domains of education, biomedicine, and family life in the late twentieth and early twenty-first centuries. More broadly, by examining the relationship between consumption and time, my analysis pushes the study of ADHD into new territory showing how ADHD's symptoms—hyperactivity and impulsivity—operate both through the body and its exterior milieu creating a new architecture of experience in contemporary American life.

Toward this end, my analysis here develops a renewed concept of hyperactivity that differs from the term's everyday use. Hyperactivity comes from the Greek ὑπέρ-, "over, beyond, above" and the Latin *activus* related to the noun *actus*, a "driving" or "impulse." In both its broadest sense as a concept and its specific meanings as a medical category, hyperactivity as a condition marks a threshold. On the one hand, the challenge of this dissertation is to locate this threshold by attending both ethnographically and historically to the ways that hyperactivity has been marked as a significant problem in the world: for example, when and where does hyperactivity emerge as a target of psychiatric intervention? Why does its diagnosis and treatment remain controversial today? How do scientific and medical approaches to hyperactivity challenge commonsense ideas about personal responsibility and accountability? More importantly, the challenge is to think life on the other side of this threshold, on the other side of hyperactivity. This means thinking hyperactivity not simply as a medical category or oppressive label, but as an active and dynamic force. It also means thinking hyperactivity not only in the negative sense of the limits it sets on life—how do the categories, labels, modes of treatment and diagnosis of the condition constrain and confine, etc.—but also in the positive powers of creativity, novelty, and difference. Therefore the task, I argue, and what my dissertation attempts to do, is to show through sustained empirical attention and conceptual reflection the singular way hyperactivity articulates things like neurological deficit, rituals of self-stimulation, habits of consumption, and modes of identification and belonging that before had no direct connection, and thus to appreciate what is new and different about hyperactivity in the world today.

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Chapter One: On the Other Side of Hyperactivity

The idea for this dissertation began back in 2004, during the oppressive heat of summer, and in a moment of intangible distraction. I was in a classroom in the Haidan district of Beijing, China, staring out the window, admiring the central courtyard on what was an unusually overcast day. And then I heard a voice from the front of the class, calling my name: “顧萌, 您跟上我講的了嗎?” “Marc, are you with me?” I snapped back and fumbled through the text to find an answer to what I thought was the right question, but judging by everyone’s laughter I realized my attempts to gracefully save myself were futile. Teacher Liu sighed and shook his head, “您的世界和我的世界,不一樣。” “Your world and my world are not the same.” Everyone laughed. I had to laugh too, and yet I couldn’t believe it. Here I was, at age twenty-three, and on the other side of the globe and I still couldn’t outrun the most stubborn fact of my life: their world and my world were not the same. A week earlier I was in the cafeteria eating lunch with Teacher Liu and several other students. “How come you never pay attention in class but you always do well on the tests?,” he asked me in all niceness and sincerity. I shrugged. “I don’t know, I guess I’m easily distracted.” I could have told him, in embarrassment, that I had been diagnosed at age ten with a very “American” disorder that supposedly makes it difficult for me to sit still or pay attention. But I decided not to; his world and my world were not the same, I reasoned.

But what would it mean to inhabit a different world? This dissertation on the topic of Attention Deficit Hyperactivity Disorder (ADHD) takes up this question, though in an admittedly different sense than the experiential or phenomenological framing of the question might imply. Instead it starts with a hypothetical situation and a world of questions and possibilities: if one were to write an ethnography of ADHD that wasn’t about whether the disorder was real or culturally constructed, what would it look like? If one were to write a history of hyperactivity, could one do so without drawing a straight line between the discovery of symptoms to today’s hyperactive children? Can one write an anthropological analysis that takes the materiality of ADHD seriously without assuming the disorder begins and ends in the brain? And for that matter, can one write a critically engaged anthropology of ADHD that doesn’t attempt to situate or “contextualize” the disorder within totalities like culture? What if instead of thinking about ADHD in terms of space and identity, one thought about it in terms of time and becoming? I don’t intend these questions to imply a dismissal these previous ways of grappling with the problem of ADHD—and indeed I follow every one of these approaches at some point in this dissertation. I do however believe that we stand to gain a lot by attempting to think the problem of ADHD differently.

This hypothetical world would be very different from our own that treats ADHD as a controversy about overdiagnosis and overtreatment and that tries to understand the disorder as a problem of suffering bodies and politically responsible subjects. Still, my dissertation, *On the Other Side of Hyperactivity: an Anthropology of ADHD*, tries to take the questions I posed above seriously. On the one hand, in a more traditional sense, it provides a meta-historical and cultural perspective on the emergence and proliferation of Attention Deficit Hyperactivity Disorder (ADHD) in the United States over the last three decades. Through in-depth multi-sited ethnography (15 months in the San Francisco Bay Area) with doctors, educators, parents, and children as well as detailed archival research into the disorder’s antecedents my research here explores how ADHD operates as both a psychiatric category and social imaginary that links together in its operation the domains of education, biomedicine, and family life in the late twentieth and early twenty-first centuries.

More broadly, though, my dissertation seeks to push the study of ADHD into new territory, by examining hyperactivity itself as a condition of life that takes diverse forms.

Toward this end, my analysis here develops a renewed concept of hyperactivity that differs from or everyday use of the term. Hyperactivity comes from the Greek ὑπέρ-, “over, beyond, above” and the Latin *āctīvus* related to the noun *āctus*, a “driving” or “impulse.” In both its broadest sense as a concept and its specific meanings as a medical category, hyperactivity as a condition marks a threshold. On the one hand, the challenge of this dissertation is to locate this threshold by attending both ethnographically and historically to the ways that hyperactivity gets marked as a significant problem in the world: for example, when and where does hyperactivity emerge as a target of psychiatric intervention? Why does its diagnosis and treatment remain controversial today? How do scientific and medical approaches to hyperactivity challenge commonsense ideas about personal responsibility and accountability, and so on. More importantly, though, on the other hand, the challenge is to think life on the other side of this threshold, on the other side of hyperactivity. This means thinking hyperactivity not simply as a medical category or oppressive label, but as an active and dynamic force. It also means thinking hyperactivity not only in the negative sense of the limits it sets on life—how do the categories, labels, modes of treatment and diagnosis of the condition constrain and confine, etc.—but also in the positive powers of creativity, novelty, and difference.¹ Therefore the task, I argue, and what my dissertation attempts to do, is to show through sustained empirical attention and conceptual reflection the singular way hyperactivity articulates things like neurological deficit, rituals of self-stimulation, habits of consumption, and modes of identification and belonging that before had no direct connection, and thus to appreciate what is truly new and different about hyperactivity in the world today.

This introduction attempts to set into clearer relief the approaches I take in my dissertation and has four parts. In the first part, I very briefly outline ADHD’s diagnostic criteria and its epidemiological profile. I assume the reader has little or no prior familiarity with ADHD, and this brief sketch provides background information, which, while not essential, is nevertheless helpful in reading through some of the discussions in later chapters. In the second part, I consider the question “Is ADHD Real or Constructed?” which covers much of the anthropological and sociological literature on the subject of ADHD. While there is other interesting work on ADHD and similar topics from the fields of anthropology and medical sociology, I treat them at length elsewhere in this dissertation. In part three, I cover the sites and subjects that comprised my field research. Finally, in part four, I outline the three chapters of this dissertation and conclude with a discussion of the concept of hyperactivity and make a case for its necessity in understanding ADHD in the contemporary United States.

What is ADHD?

The main challenge ADHD poses for anthropological analysis is that it is not a single thing, but rather it refers to a multiplicity of symptoms, bodies, practices, forms of knowledge, modes of intervention, subjectivities, and so on: what some anthropologist’s would call an assemblage (Ong and Collier 2004; Marcus and Saka 2006). That ADHD as both a linguistic referent and an analytical concept names all of these heterogeneous elements only fuels its controversies. At the same time, it is precisely this confusion, and the capacity

¹ The obvious debt here is to the work of Gilles Deleuze and Alfred North Whitehead. I attempt to provide the reader with additional background on their work when appropriate.

of the term to exceed our ways of thinking it comprehensively, that makes ADHD such a fascinating topic to study.

In 1980, the American Psychiatric Association added “ADD (Attention Deficit Disorder) with or without Hyperactivity” to the third edition of their Diagnostic and Statistical Manual of Mental Disorders. In doing so, they ushered into existence, without much fanfare, what would become not only the most common disorder of childhood, but also arguably the most visible disorder of childhood, for at least the next two decades.² According to the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), the “essential feature” of ADHD is:

a persistent pattern of inattention and/or hyperactivity-impulsivity that is *more frequent and severe than is typically observed in individuals at a comparable level of development* (Criterion A). Some hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before seven years, although many individuals are diagnosed after the symptoms have been present for a number of years (Criterion B). Some impairment from the symptoms must be present in at least two settings (e.g. at home and at school or work) (Criterion C). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning (Criterion D). The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychic Disorder and is not better accounted for by another mental disorder (e.g. a Mood Disorder, Anxiety Disorder, Dissociative Disorder, or Personality Disorder (Criterion E) (American Psychiatric Association 2000).

ADHD currently has three sub-types: predominantly inattentive type (ADHD-I); predominantly hyperactive-impulsive type (ADHD-HI); and a combined type (ADHD-C) that includes symptoms of both inattention and hyperactivity-impulsivity. Although the combined subtype is common, there is growing speculation that ADHD-I and ADHD-HI are “distinct and unrelated disorders” (Milich, Balentine, and Lynam 2001). There is also a special designation “ADHD, Not Otherwise Specified” to encapsulate “disorders with prominent symptoms of inattention or hyperactivity that do not meet criteria” for ADHD (American Psychiatric Association 2000). As can be seen in Table 1, the diagnostic criteria for ADHD tend to reflect children’s activities, and one of the several proposed changes for the next version of the DSM, is to lower the number of required criteria for a diagnosis of Adult ADHD given that findings suggest the number of symptoms decline with age even if the overall impairment persists throughout adulthood.³

Table 1. DSM-IV Criteria for ADHD (American Psychiatric Association 2000)
A. Either (1) or (2): (1) Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level: Inattention (a) often fails to give close attention to details (a) or makes careless mistakes in schoolwork, work, or other activities (b) often has difficulty sustaining attention in tasks or play activities

² I cover this history in chapter three. See also (Lakoff 2000).

³ See “DSM-5: Options Being Considered for ADHD” on <http://www.dsm5.org/Pages/Default.aspx> (accessed May 2010).

- (c) often does not seem to listen when spoken to directly
- (d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- (e) often has difficulty organizing tasks and activities
- (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- (g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- (h) is often easily distracted by extraneous stimuli
- (i) is often forgetful in daily activities

(2) Six (or more) of the following symptoms of **hyperactivity–impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

- (a) often fidgets with hands or feet or squirms in seat
- (b) often leaves seat in classroom or in other situations in which remaining seated is expected
- (c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- (d) often has difficulty playing or engaging in leisure activities quietly
- (e) is often “on the go” or often acts as if “driven by a motor”
- (f) often talks excessively

Impulsivity

- (g) often blurts out answers before the questions have been completed
- (h) often has difficulty awaiting turn
- (i) often interrupts or intrudes on others (e.g., butts into conversations or games)

The exact causes of ADHD remain unclear, but there are likely multiple causal pathways involved (Nigg 2006; Nigg et al. 2005; Castellanos and Tannock 2002). Research indicates that ADHD has a genetic component and has a high degree of heritability (J. M. Swanson et al. 2000; Durston n.d.; Bobb et al. 2006; Elia and Devoto 2007). Experiential risk factors include low birth weight, maternal smoking, lead poisoning, fetal alcohol problems, and other pre- and perinatal insults (Knopik et al. 2005; Coles et al. 1997; Lou 1996; Nicolescu et al. n.d.; Nigg 2006). Although “bad” parenting is likely not a cause of the disorder, parenting can have an impact on both the trajectory of the disorder within a child as well as affect treatment outcomes for ADHD (Nigg and Hinshaw 1998; Kaiser, Hinshaw, and Piffner 2010; Karen C. Wells et al. 2000; Knopik et al. 2005).

Critics of ADHD—both within professional medicine and beyond—have pointed to the disorder’s “fuzzy” and “hopelessly murky” diagnostic criteria, arguing that the DSM’s checklist includes symptoms that nearly everyone experiences from time to time (Timimi 2004; Timimi and Leo 2009; Degrandpre 2000; Breggin 2001; Diller 1999; Lerner 2004). In my conversations with psychiatrists, however, I found that the mere presence of symptoms is not in itself enough for a diagnosis. Rather, what is important they argued, are the severity of these symptoms. Furthermore how one interprets the phrase “than is typically observed in individuals at a comparable level of development,” has an impact on who gets diagnosed. There are, however, differing opinions amongst medical practitioners about what constitutes “typical.” One psychologist seemed to this situations well when he told me: “if you think only 2 percent of kids should actually have ADD or should be diagnosed, then ADD is overdiagnosed, if you think a figure like 8 or 10 is more representative, then it is underdiagnosed...it’s that simple.”

Epidemiological Profile

Although the exact rate of diagnosis and treatment for ADHD has been the source of debate in the past, the most recent data from a comprehensive study conducted by the Centers for Disease Control, suggests that 8.4 percent of school-aged children in the United States have been diagnosed with ADHD. This figure is larger than the often-quoted rate of three to seven percent, however the percentage of children receiving psychotropic medication for ADHD is still (just) under five percent (Pastor and Reuben 2008; Daniel J. Safer and Zito 1999). Diagnosis for the disorder varies demographically according to geographic region, level or type of insurance, ethnicity, and gender (Nigg 2006; Pastor and Reuben 2008). Currently boys are diagnosed by a ratio of 3:1, although the ratio varies from 2:1 to 10:1 depending on the subtype of ADHD—girls are more likely to be diagnosed with ADHD-I than ADHD-HI—and setting—boys are overrepresented in clinical samples (Biederman et al. 2002; Pastor and Reuben 2008). Research indicates, however, that the rate of girls being diagnosed with the disorder is rising faster than the rate for boys (Robison L.M.[1] et al. 2002). Furthermore, while it was once thought to exist only in children, the past decade, in particular, has seen the proliferation of a new category of “Adult ADHD,” with sampling data suggesting a prevalence rate among adults in the United States of roughly 4 to 5 percent (Kessler et al. 2006; Faraone and Biederman 2005).

As the number of children and adults diagnosed with ADHD has grown over the last three decades, so has the cost to treat the disorder. Recent estimates put the excess cost of ADHD to the United States economy at over thirty billion dollars annually (Birnbaum et al. 2005). According to a National Institutes of Health report, by the mid-nineteen nineties, national public school expenditures on behalf of students with ADHD already exceeded three billion dollars annually (National Institutes of Health 1998). ADHD is often considered an academic problem (it’s often referred to as a “learning disorder”) and the proliferation of the category has had a significant impact on education in the last three decades. For children with ADHD, academic impairment is usually evident within the first few years of schooling (Lahey et al. 1998). One study even found basic (pre)academic deficits in preschoolers (DuPaul et al. 2001). Because hyperactive children require, or demand, more teacher attention, they are often seen as a strain on classroom resources. At the same time, students with the inattentive subtype of ADHD are often ignored by teachers because they are less likely to participate in classroom activities (Hinshaw 1998).

There is also growing concern that the kind of symptoms that are associated with ADHD (e.g. impulsivity and hyperactivity) are indicative of other behavioral problems. Recent research indicates that people with ADHD or ADHD symptoms are more susceptible to addiction and substance abuse (see, for example, Kollins 2005). It is also believed that people with ADHD are significantly over-represented in prison populations (Curran and Fitzgerald 1999; Rasmussen, Almvik, and Levander 2001; Rösler et al. 2004). For these reasons, ADHD is seen as creating life impairments serious enough to justify the its continued existence in the DSM (Barkley 2002).

The Problem of ADHD's Reality.

In his introduction to *Marking Time*, Paul Rabinow, following John Dewey, insists that “[i]nquiry begins in an indeterminate situation.” It starts “midstream,” “always already imbedded in a situation” that is “both settled and unsettled” (Rabinow 2008:8). Upon beginning my research on ADHD I found myself in such an indeterminate situation that was at once settled, unsettled, and from my perspective, unsettling. In particular was the notion

that ADHD is, as I suggested in my opening vignette, a largely “American disorder.” There is good reason for this suggestion. Although diagnosed across the world where biomedicine is prevalent, the United States makes up a disproportionate percentage of diagnoses of the disorder and disproportionately consumes medication for treating ADHD (Kewley 1998; Berbatis, Sunderland, and Bulsara 2002; Ghodse 1999). According to the United Nations, the United States produces and consumes about eighty-five percent of stimulant drugs used to treat ADHD, like Ritalin (Scheffler et al. 2007). Furthermore, according to some researchers, if one were to apply DSM-IV or ICD-10 criteria, ADHD or HKD exists at similar rates across the ‘developed world’ (Faraone, Biederman, and Friedman 2000; Nigg 2006; Spencer et al. 2002).⁴ If ADHD is a product of a particular biomedical and psychiatric rationality, practiced in a variety of settings throughout the globe, how can we explain this uneven deployment of diagnoses and treatment?

There are, no doubt, several factors that help explain the proliferation of ADHD as a viable category in the United States over the last three decades. To begin with, an explosion of research and knowledge-production in the fields of medicine, psychology, and public health has led to a “demystification” of the disorder, and hence, higher rates of diagnosis (a point that was made by many of the psychiatrists and psychologists I talked to). Another important factor is the aggressive marketing of pharmaceuticals in the United States and abroad (Critser 2005; Barsky and Borus 1995). Others suggest that ADHD is a form of social control that has emerged in response to, among other things, compulsory education (Conrad 2006a).

Pharmaceutical marketing is certainly an operative factor in understanding why ADHD is so prevalent in the United States, but as a hypothesis, it is probably more useful in explaining the *proliferation* of the category of ADHD (an increase of diagnosis) *within* the United States than it is in explaining different rates of diagnosis and treatment *between* the United States and other countries. The medication of ADHD has an interesting history. Between 1981 and 1987, Ritalin use doubled, but then leveled-out because of public campaigns by groups like the Church of Scientology, who spread fears about the potential effects, both long and short-term, of medicating children with stimulants (Safer and Krager 1992). Then starting in the early 1990s and continuing throughout the decade, the use of all stimulant medications, including Ritalin, increased significantly (Jensen and James R. Cooper 2002). While the increase in stimulant medication use for children is noteworthy, it is also interesting to note that there were roughly similar rates of *for all* prescription medications for children during that same period (Zito et al. 2003). Such findings help may help explain or illustrate the medicalization of ADHD, but they don’t explain its peculiarity. Furthermore, the United States has lower per capita expenditures on pharmaceuticals than countries like France and Japan which have comparatively lower rates of diagnosis and treatment for ADHD (US Dept. HHS 2000). We might also ask, if ADHD is merely a psychiatric label to isolate and control deviant children who don’t sit still in school, why isn’t it diagnosed at similar rates everywhere compulsory education exists, as some doctors, using standardized diagnostic criteria, suggest it should be (Spencer et. al 2002)?

In arguably the most cogent and thorough treatment to date of ADHD and its controversies, Joel Nigg, a clinical psychologist and professor, specializing in the disorder candidly addresses many of the most fundamental questions facing ADHD today. In particular, he argues that although the etiology of the disorder is not yet clear, ADHD

⁴ ICD-10 is the International Classification of Diseases, of the World Health Organization. HKD stands for Hyperkinetic Disorder, the closest equivalent to ADHD.

nonetheless has clinical validity: it's symptoms hang-together, and it can be seen as a legitimate disorder to the extent that it produces significant impairment across multiple domains of life. At the same time, he notes, ADHD remains controversial because of the different rates of diagnosis between social groups, because it challenges basic ideas of personal responsibility, and because the medications used to treat it are feared as dangerous (Nigg 2006:3-49). The unevenness of diagnosis and treatment for the disorder not only between the United States, and the rest of the world, but also within the U.S. itself, suggests that much work remains to be done on the topic of ADHD, not only in psychiatry and neuropsychology (e.g. in refining operational criteria and isolating the etiology of the disorder), but also in the social sciences more broadly, and anthropology in particular, in providing contextualization for the emergence of the medical category of ADHD.

Perhaps driven in part by the uneven diagnosis of the disorder, one question I encountered frequently when describing my research to friends, acquaintances, and even some informants in the field was "do you think ADHD is real?" As many times as I received the question I never developed a completely adequate answer. In typical anthropological fashion, I often stressed that to the extent that symptoms of ADHD are perceived as sufficiently "real" and impairing for sufferers, and to the extent that the category has gained widespread legitimacy among both medical practitioners and the lay public, that we ought to consider it a "social fact." This answer, while necessary, is not of course sufficient for understanding ADHD in the United States today. In particular, ADHD is held by many to be a "bogus" disorder because of its inexact diagnostic criteria, the centrality of psychostimulants for its treatment, and the fact that ADHD is diagnosed more in the United States than elsewhere in the world. Indeed, one question that I encountered frequently, especially among more senior anthropologists and sociologists, was whether ADHD is a "culture-bound syndrome" (Rose 2006).

The literature on culture bound syndromes has a long history. Since at least the nineteenth century, colonial doctors and observant field missionaries took note of mental disorders that had no equivalent in the West. Examples include: *koro*, reported most frequently in South East Asia and in China, a condition in which the victim feels as if his penis is shrinking and may retract into the abdomen; *latah*, hypersensitivity to sudden fright, which occurs throughout the world, but mainly in South East Asia; *amok*, a dissociative episode of violent behavior; *susto*, "fright" or "soul loss" in Mexico, Central, and South America; *nervios*, a condition in Latin America that describes sickness or emotional distress brought about by difficult life circumstances, etc. (See Appendix I, DSM-IV). An early cultural psychiatrist from Hong Kong, P.M. Yap (1951) grouped together these otherwise incongruent phenomenon under the title "Mental diseases peculiar to certain cultures" thus setting into motion the concept of culturally-specific psychopathology (Tseng 2006). Even still, western psychiatry tended to view these examples as idiosyncratic, albeit highly interesting ones, and tended to reinforce the fundamental distinction between medical 'knowledge' and culturally-specific "beliefs" (Good 1994). Since then, there has been an abundant literature on cultural-bound syndromes—some from anthropology, most from ethno- or cultural psychiatry (Simons and Charles Campbell Hughes 1985; Tseng 2006).

A symptomatic reading of the literature on culture-bound syndromes, however reveals some challenges. The defining problematic for these scholars is the relationship between local knowledge and universal biology. The challenge with this literature is that, by it's own framing of the problem, it must attempt to refract and situate illness in relationship to a series of, what it poses as, implicitly or otherwise, confining binary oppositions: culture

vs. biology and local vs. universal (Cohen 1999). This duality creates something of an intellectual dilemma; a dilemma that exists, *a posteriori*, at the level of analysis, not at the level of observation. Historian of medicine and the body, Shigehisa Kuriyama, has suggested the term “local diseases,” as way of moving beyond the idea of culture bound syndromes while still capturing the multi-dimensionality of difference. As a concept, “local diseases” does three kinds of simultaneous work. First, it takes seriously the idea of the locality in the sense that people tend to think of culture as geographically bounded, or at least situated. Secondly, and as a refinement of the first point, it brings history into the analysis, thus moving past implicitly functionalist models of culture as a closed system of representations, beliefs, and practices. Therefore, thinking about local diseases, helps us think not only about “why here (or there)?” but also “why now?” For example, in his study of Katakori, a Japanese condition which is glossed in English and German as ‘stiff shoulders’ and “Schulterspannung” respectively, Kuriyama (1999) examines the relationship between pre- and post- Meiji era discourses of the body. Although Katakori was unheard of before Meiji times, Kuriyama examines a similar ailment “kenpeki” during the Edo period, a time when there was extensive literature about the art of massage. Thus, “what began in the nineteenth century as an ailment that was known and treated by the hand, has become, at the end of the twentieth century, a syndrome with no objective anchoring, a psychosomatic disorder associated with depression, insomnia, and chronic fatigue” (Kuriyama 1999: 18). This kind of historical method and attention can help us better understand the ways that a disorder/disease/distress is not simply the product of a template of cultural meanings about illness, but also a history of these meanings in formation. While it can be argued that many scholars working within the “culture-bound” or “culturally-specific” disorders framework employ some form of historical methodology, Kuriyama and his colleagues take this charge more seriously. Finally, the idea of locality, according to Kuriyama, also implies embodiment, to “recast the enigma of diversity as a problem not merely about alternative ways of describing the body, but about different ways of being bodies” (Kuriyama 1999: xi).

Much of the sociological and anthropological literature on ADHD equates the disorder’s culture arguing, in particular, that the diagnostic category is part and parcel of a larger process of medicalization in North America in the late twentieth and early twenty-first centuries. Implicit in these accounts is a bifurcation between the child, as something real, demanding our ethical attention, and *childhood*, as the set of representations, beliefs, and practices, about children, i.e. something “constructed.” Thus for these critics, the child is oppressed or repressed by a particular conception of childhood in late modernity that seeks to limit its behavior—primarily through stimulant medication—into what is considered normative or acceptable (Timimi and Leo 2009; Timimi 2004; Rafalovich 2004, 2001, 2001). The most notable figure in this medicalization scholarship is Peter Conrad, a sociologist and pioneer in the social study of ADHD, who began writing about the medicalization of hyperactivity back in the 1970s before the concepts ADD or ADHD had achieved official medical status in the DSM. Originally published in 1976, Conrad’s book “Identifying Hyperactive Children: the Medicalization of Deviant Behavior” provided not only sociological critique of hyperactivity, but also a rich, detailed study of a disorder that—while still relatively unknown to the public—was quickly exploding in both diagnosis and treatment (a topic I give much closer attention in chapter three) (Conrad 2006b). Since then, Conrad has published widely on the topic of the medicalization of ADHD (Conrad and

Potter 2000; Conrad 1992, 2005, 1975; Thomas et al. 2006).⁵ Ethnographers of ADHD have also attempted to give voice to parents', and in particular mothers', struggles to manage the daily ins and outs of their children's conditions against the background of a culture of medicalization (Garro and Yarris 2009; Carpenter-Song 2009; Singh 2004, 2005; Malacrida 2004, 2003, 2001). These studies by Conrad, and more recently by ethnographers like Carpenter-Song, Singh, and Malacrida provide us with both the analytical tools and ethnographic richness to show how mothers and children become "marginalized" or "vulnerable" in the process of diagnosis and treatment of ADHD. As I argue in chapter 4 though, by sticking closely to the dimension of common sense (which

⁵ Medicalization, in its widest sociological sense, describes and analyses the trend, particularly in western societies, of how social and behavioral phenomenon comes to be understood, organized, and treated under the purview of medicine. This social phenomenon could often be viewed as problematic, e.g. alcoholism (Robins 1980) or child abuse (Pfohl 1977), not only in the sense of being bad or deviant, but also more broadly, in the sense of acquiring cultural attention, and therefore could include 'natural life processes' like birth (Davis-Floyd 1992) or menstruation (Martin 1987). Early critiques of medicalization (Szasz 1961, Laing 1960) focused on the problem of trapping complex psychological and social distress in the estranging geometries of medical and biological models. Within professional psychiatry, this trend could be seen with the increasing professional alienation of Freud's legacy, and the rise of operationalizable diagnostic criteria, for example, the creation of the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952. The offshoot of this medicalization critique within psychiatry reached its most articulate and potent form with the anti-, or democratic-psychiatry movement of Franco Basaglia (Scheper-Hughes and Lovell 1986).

According to Conrad, medicalization occurs on three separate, but functionally interactive, levels: the conceptual, the institutional, and the interactive. At the conceptual level, problems—however they are defined, cast, or come into being—are organized through a medical vocabulary and given shape through concepts and models (e.g. hyperactivity, ADHD). At the institutional level, organizations (e.g. mental institutions) employ medical approaches to solve problems they are socially sanctioned to deal with. Finally, on an interactional level, doctors diagnose patients using medical models and prescribe medical forms of treatment (1992: 211).

Recent work on the topic of biomedicalization pushes medicalization theory, on both the thematic and conceptual level, into the twenty first century. Adele Clarke, et al. see what they term as 'biomedicalization' as an enduring shift within American medicine, culture, and society. The "bio" in biomedicalization points to does important work. To begin with, biomedicalization accounts for transformations as a result of new technologies and concomitant forms of knowledge like genomics, biotechnologies, molecular biology, and the life sciences, more broadly, which take as their object *bios*, rather than simply sickness or illness (Rabinow 1996, etc). Secondly, the authors point to the reorganization of infrastructures of health and biomedicine through the redistribution of medical knowledge and the rise of medical information technologies, networks, insurance care, etc. Although this shift has taken place over the past few decades it has now reached a "critical infrastructural mass" (2003: 162). This redistribution of health management and infrastructures also corresponds to the emergence of biomedicine as an increasingly important political and economic sector within the United States. Health has become a commodity, a fact apparent in the aggressive rise of pharmaceutical marketing, as well as the rise of per capita health expenditures. With ADHD this can be seen in the aggressive marketing of stimulant and non-stimulant medications that promised increased attention and impulse control. Toward this end of inquiry there has been a growing literature on the anthropology of pharmaceuticals and pharmaceutical marketing (Lakoff 2005; Petryna, Lakoff, and Kleinman 2006), as well attention to the growing trend within psychiatry of privileging pharmaceutical interventions over psychoanalytic theory (Luhmann 2001)

makes a distinction between the facticity and normativity of ADHD) this kind of scholarship can engage with both the popular and medical literature of the disorder on its own grounds, but in doing so it reduces what ADHD is to the problem of medicine, mothering, childhood, and culture.

But how can we take the idea of contingency seriously without reducing ADHD to an effect of something else like ideology, culture, or power? Offering a more nuanced analytic, anthropologists and historians of science and medicine have sought to show that a disorder is not simply a set of symptoms that can then be medicalized at one location in space and time and not other (in other words there is not “behavior” that then becomes deviant and subsequently medicalized). Instead, often through a close symptomatic reading of the contemporary literature they attempt to show symptoms are singular and emergent artifacts of a cultural sensibility. These scholars, like Allan Young, Ian Hacking, and Emily Martin, take the question “real or constructed” to be vexed and constraining. As Young notes in his book on Post-Traumatic Stress Disorder: “[m]y job as an ethnographer of PTSD is not to deny its reality but to explain how it and its traumatic memory have been *made* real, to describe the mechanisms through which these phenomenon penetrate people’s life worlds, acquire facticity, and shape-self knowledge of patients, clinicians, and researchers” (Young 1997a:5-6). To do this, Young attends to the problem of memory, and specifically traumatic memory, showing how PTSD is an entanglement of practices of memory, modes of diagnosis and medical intervention, and modes of self-narrative and identification. Likewise, Ian Hacking took a similar approach in his study of Multiple Personality Disorder, and has pushed this perspective further to describe ADHD (albeit in cursory fashion) in his more recent book in *The Social Construction of What?* (Hacking 2000, 1998). Hyperactive children, Hacking believes, are not simply social kinds, but are what he calls (playing with the term hyperactive), “interactive kinds.” Indeed, what is at stake with a complex phenomenon like ADHD is not merely that it labels or provides subjects for social control, but that it brings together social interventions (disciplinary mechanisms in schools, parenting styles, medical treatments), with a semiotic or cultural terrain of identity, thus linking emergent interventions with new social “kinds” in ways that weren’t previously possible.

In her brilliant account of bipolar disorder, Emily Martin takes up these historical approaches, to address a problem that I frequently encountered in conversations with informants: Martin found puzzling in her research how bipolar was linked unproblematically to past states and historical figures as if one could assume that the mere presence of symptoms implies the same disorder of bipolar and its experience. Echoing Young, she argues that people like Van Gough “could not have experienced their lives as manic depressives because the cultural work that eventually created the linguistic and social category of manic depression had not yet come into being” (Martin 2009:231). I take up the question of ADHD’s historicity in chapter three, but more broadly, as I discuss in chapter four, the question of ADHD’s reality acts as a significant presence in the publicity of the disorder despite attempts by prominent researchers and clinicians in the field of ADHD studies to depoliticize the disorder by presenting the science as settled (Barkley 2002; Timimi and Eric Taylor 2004; Timimi 2004).

Sites and Subjects

Four years ago, when I embarked on developing a research problem and design on the topic of Attention Deficit Hyperactivity Disorder in the United States, I was immediately bombarded with all kinds of useful questions from my faculty advisors and fellow graduate

students, questions that friends, informants, and acquaintances interested in my research still ask me today: What does it mean to study ADHD? Do I think ADHD is a valid diagnostic category? Would I be focusing my efforts specifically on children or adults? Why is ADHD an ‘anthropological’ topic? These questions raised a number of tricky conceptual and methodological concerns that I had not originally foreseen; though as I have discovered, they are concerns that shoot to the core of my project. For example, although I intended to study both adults *and* children, I wasn’t yet clear on how I would articulate the differences between the two? My training as a graduate student encouraged me to think carefully about the relationship between categories of observation and categories of analysis, or between what Clifford Geertz distinguished as “experience near” and “experience distant” concepts (Geertz 1983). Although my informants used the distinction between adults and children largely unselfconsciously I was wisely cautioned by my advisors not to reinscribe a medicalized vocabulary of “doctors,” “parents,” and “patients,” into my conversations and interviews with informants.

I formally began my research in July 2008 after receiving human subjects clearance from my home institution (the University of California Berkeley). Using contacts I had gained through a pilot project conducted in from September 2005 to February 2006, I started fieldwork by integrating myself into the learning disabilities community. ADHD is considered a learning disorder not a “disability.” Even still, people with other learning disabilities are often diagnosed with ADHD as well—recent CDC data indicates that just under four percent of all school-aged children have both ADHD and another learning disability (Pastor and Reuben 2008).⁶ In the beginning, I worked primarily with three groups: the East Bay Learning Disabilities Association, CHADD of Northern California, and a local support group run by a teacher with a learning disability in San Francisco. In the LD community I found myself working with a mix of learning specialists, Psy.D.s, parent advocates, and adults with ADHD and LD. In these groups I volunteered with the organizations, attended administrative and support meetings, and participated in organized social events. In doing so, I built up a group of informants with whom I gained a closer relationship. This closeness also stemmed in part from the fact that I was diagnosed with ADHD at age ten and so people saw me as more than simply a researcher.⁷ Although people involved in these groups came from a variety of ethnic and racial backgrounds, most of my informants from these venues were middle to upper middle class and white, a fact that accorded with my initial observations in my pilot project.

My sampling methods posed both special challenges and special opportunities for addressing some of the pressing issues about ADHD (is it overdiagnosed? Is there unequal access to treatment and diagnosis?, etc.) One challenge in working with advocacy organizations and self-help groups is that ADHD is overrepresented not simply in terms of numbers, but also in terms of attitudes and outlooks about the disorder. In a sense, these enclaves of professionals, advocates, and self-identifying subjects constituted what one might call “hyperzones” of ADHD. As I discuss more depth in chapter four, in these venues

⁶ Combining ADHD and LD into one community brings a larger turnout to events and meetings. The grouping also makes practical sense given that people with these conditions face many of the same life challenges like job discrimination, perceived deficits in social skills, and trouble managing time and money. By grouping ADHD and LD these organizations also increase their membership base and income from donations and membership dues.

⁷ In fact, I found that although (much to my surprise) these organizations, had been studied before by social science and public health researchers, participants took a keen interest both in my research and me personally.

and associations I was witness to the ways that ADHD serves as both a platform for identity politics and also a site of biosociality (Taussig, Rayna Rapp, and Heath 2005; R. Rapp 2001; Rabinow 1996; Rose and Novas 2005; Rose 2006; Dumit 2000). While my research sites did not allow me to solve the question of unequal diagnosis by viewing diagnosis in its absence, I could study it in its presence. In other words, I believe my research afforded me a better understanding of multiple pathways of diagnosis that people with ADHD get diagnosed and treated for the disorder, and while this may not itself explain why others do not seek or receive such care, it nonetheless can help set other data and observations into clearer relief.

Meanwhile, as my research progressed I found myself, mostly for practical reasons, falling back onto a kind of familiar vocabulary surrounding “child” and “childhood.” This in part stemmed from the requirements of sampling methods as dictated by my human subjects protocol: first I met with parents and adults, and then with their permission and usually in their presence, I interviewed children. I also felt justified in treating children separately because both popular and medical literature tends to distinguish between ADHD, which is seen largely as a problem of childhood, and what is now called “adult ADD”—ADHD that although present in childhood brings its own set of challenges and modes of treatment as children with ADHD reach adulthood. As is the case for both many ethnographies of childhood, as well as studies of ADHD, the need to treat children and childhood as somehow unique seemed a practical necessity. Most children I interviewed for in my research were between the ages of 11-17 (n=13), but I did interview a few younger children under 10 (n=4). Interviews lasted anywhere from 15 minutes to one hour. Interviews with parents (mothers n=18; fathers n=7) typically lasted from 30 minutes to one and one-half hours and were conducted in a place of their choosing (either at one of the LD venues, in their home, or at a local café).⁸ Several of these interviews with high school students occurred as group interviews, much like a focus group, though (in order to maintain privacy) these group discussions only occurred when they preceded or followed events where these students would have been together anyhow. These interviews with families, but most especially with middle school and high school aged students were a source of incredibly rich data, and it is my regret that much of the topic of these discussions (particularly on prescription medication, school routines, self-perception, etc.) did not make it into this dissertation, but will likely be used for an upcoming article on the use of ADHD medication in schools. I also had conversations with many adults with ADHD at support group functions.

Psychiatrists (n=10), psychologists (n=8), and Psy.D.s (n=2), also played a crucial role in my research. Not only were most doctors I spoke to candid about both their opinions and attitudes about ADHD and child psychopathology, but they also were foundational in my thinking about the science of ADHD and its publicity. In particular, as I discuss in further detail in chapter four, ADHD remains a controversial topic in the United States partly due to what is considered to be its scientific and medical controversy. Thus doctors and other scientists played a key role in my research which sought to better understand this controversy. Toward this end I also interviewed a handful of clinical researchers (n=6), who helped clarify technical questions I had about ADHD, and who offered their insights into topics ranging from etiology and research on the disorder to drug treatments and pharmaceutical marketing. On this last topic I also had multiple interviews

⁸ The number of mothers is higher than the number of children because I interviewed a number of mothers who were involved in advocacy work but not their children.

with four pharmaceutical representatives (two current employees, and two former employees who now have other jobs) who represented three different pharmaceutical companies. These interviews provided a wealth of fascinating data, interesting observations, and colorful stories about the making and marketing of drugs. In being remarkably candid, these informants also helped me better sort through attitudes and opinions about pharmaceutical marketing I encountered in conversations with other informants and that circulated in the popular press. Although much of this data on pharmaceuticals did not make it into this dissertation, I found it helpful for an upcoming project I am working on related to the social life of amphetamines.

One final area of my dissertation research was in the field of education. My work here included classroom observations at a local public high school in Berkeley, California, and informal interviews with students and teachers. As part of my work with advocacy organizations, I had extensive conversations with learning specialists and educational consultants who occupied an important part of the diagnostic apparatus of ADHD that I wished to study. Finally, during the writing of this dissertation I worked as a research assistant coding interview data and writing narratives for a study on ADHD in adults age sixty years and older. On top of these sites and subjects, I also had many informal encounters dealing with ADHD at places like conferences and in everyday life. Taken individually, my work with different groups of informants was not sufficient enough to provide any statistically significant data. Taken as a whole, however, my fieldwork provided me with a rich source of data and afforded a broader perspective that I would argue only a fieldwork-based approach can provide.

I would therefore argue that my “field” consisted not of individuals per se, nor of a “culture,” but rather of the *diagnostic apparatus* of ADHD. This research, as I had hoped, provided a clearer picture of the pathways of diagnosis and treatment for both children and adults with ADHD. The term “diagnostic apparatus” that I have been using sounds ominous and perhaps conjures ideas of an encompassing whole like Eisenhower’s “military industrial complex.” In point of fact though, this apparatus consists of a loosely grouped network of institutions, actors, and practices that both enable and constrain certain kinds of care and treatment outcomes, as well as shape ADHD’s publicity. Indeed, taking this idea of “networks” seriously, one could follow Bruno Latour, John Law, and other “actor network theorists” (no doubt the label, as Latour illustrates in his most recent book *Assembling the Social* is both telling and misleading) in seeking to identify the actants (both human and non-human—children, doctors, Ritalin, etc.) and their shifting relations, as they “make and re-make” ADHD as a technical, scientific, and political “thing” (Latour 2007). Although this dissertation does not reflect this approach per se, the knowledge gained from my fieldwork and such a framing of the problem have been invaluable. Without them the observations in this dissertation would not have been possible.

Approaches and Concepts

Both Gregory Bateson and his first ethnography *Naven* (1936), hold an important, if ambivalent, relationship to the mainstream of anthropological thought and history.⁹ That Bateson himself considered the text something of a failure speaks to the way that his analysis sought to raise and answer questions absolutely fundamental to the discipline. For

⁹ *Naven* is an ethnographic analysis of a set of rituals and ceremonies among the Iatmul of New Guinea that mark important occasions between the mother’s brother, *wau*, and sister’s child, *laua*. More broadly it seeks to critically engage concepts, theories, and methods that separated American and British Anthropology by the early to mid twentieth century.

Bateson, “The writing of [*Naven* was] an experiment, or rather a series of experiments, in methods of thinking about anthropological material” (Bateson 1958:257) Experiment, comes from the French *expérience*, and on the one hand, it means “to put to the test”; on the other, it means “to have experience of; to feel.”¹⁰ Not coincidentally, these two meanings correspond exactly to the basic methodological distinction in *Naven* between the scientific and affective approaches to studying culture as outlined in Radcliffe-Brown and Ruth Benedict. Method, it is worth mentioning, comes from the Greek *hodos*, meaning “way” or “path.” Thus, in one sentence, Bateson articulates three concepts that are absolutely central to *Naven*. First, that there are two main approaches to understanding the naven and secondly, that each of these approaches represents a specific way or path *into the broader problem of culture*.

In the subtitle to *Naven*, Bateson calls his book “A Survey of the Problems suggested by a composite Picture of the Culture of a New Guinea Tribe Drawn from Three Points of View.” These three points of view—structural, ethological, and sociological—can themselves, Bateson suggests, be grasped through either “scientific” or “artistic” techniques. When Bateson seeks to engage culture in this way he is not suggesting simply that structural functionalism illuminates one side of culture (its structure, etc.) and that affective or aesthetic approaches provide illuminate the other (its ethos) as if culture has two sides like a coin. Rather, culture is an open and expressive “whole,” “an elaborate reticulum of cause and effect” and the only way into this whole is through “some arbitrarily chosen point.” Thus part of coming to terms with the irreducible problem of culture in itself means developing specific methods, paths, or ways into this problem. It means, as Bateson mentioned, experimenting.

Like Bateson’s concept of culture, I see the problem of ADHD as “an elaborate reticulum of cause and effect” which cannot be adequately grasped in its entirety (this would assume a position of exteriority), but can only be understood by delving into its midst. Also as Bateson did in *Naven*, I have tried in this dissertation to take an experimental approach to the problem of ADHD, not because I see this dissertation as “avant garde” but because I see it as a “putting to the test” of different approaches to the topic that I think would benefit from more thought and empirical attention. These approaches may not be what one might have traditionally expected from anthropology or what one might have expected given the topic, but it is my hope that I have given them enough ethnographic, historical, and conceptual attention to make them vibrant and compelling approaches in themselves. The dissertation, like Bateson’s *Naven*, is told from three points of view and thus has three additional chapters.

Chapter Two: A New Architecture: Hyperactivity, Consumption, Time

Chapter two begins with the story of a nine-year old running out of time on a classroom activity. But under what conditions is it possible to be “out of time” on the other side of hyperactivity? And if, as Derrida once argued, “[t]ime...gives nothing to see,” that “[i]t itself withdraws itself from visibility,” and that “[o]ne can only be blind to time,” then how can we make time present as a meaningful, or at least, productive concept in our study of hyperactivity (Derrida 1992:6)? To answer this question, the second chapter explores a new architecture of experience that has emerged in the last three decades that links neurological deficit, rituals of self-stimulation, and modes of postmodern consumption. In particular, drawing upon ethnographic material from my fieldwork with hyperactive children

¹⁰ See *Oxford English Dictionary*.

and adults as well as a reading of the literature on the neuropsychology of attention, I consider stereotyped, self-stimulating, behaviors typically associated with ADHD—like rocking—as a way of inhabiting a body, and more broadly the world, in, or out of, time. Toward this end, this chapter takes up Georges Bataille’s concept of sovereignty as a way of thinking through the relationship between hyperactivity, consumption, and time. “What is sovereign in fact,” Bataille tells us, “is to enjoy the present time without having anything else in view but this present time” (Bataille 1991a:199).

In part two of the chapter, I use Christine Rosen’s notion of “egocasting”—the idea that technologies of control and selection have allowed us to create our own individual environments of self-entertainment—as a way of thinking about the relationship between media consumption, hyperactivity, and time. To develop this idea I draw upon recent theorizing in neurophilosophy as well as Deleuzian and post-Deleuzian scholarship on experience and sensation to outline a concept of “architecture” as an activity of giving form to experience. Working through examples from my ethnographic encounters, I consider how the relationship between neurological deficit and consumption is captured on the one hand by an extensive, entropic, architecture that is becoming dopaminergic (meaning that the entire system has the overall effect of increasing dopamine in the brain), and on the other by an intensive unfolding of events, that is becoming hyperactive. My point, I argue, is not that media consumption causes the symptoms of ADHD—hyperactivity, impulsivity, or inattention (although contemporary neuropsychology leaves this possibility open), but rather that these behaviors share with egocasting an affective regime of “becoming the moment”—what one leading clinical psychologist on the topic of ADHD sees as the defining feature of the disorder. To become the moment, to run out of time, means to inhabit time without concern for the future (the main criterion of impulsivity), and thus to live differently in the present.

Chapter Three: Writing the History of Hyperactivity

This chapter explores what is at stake in writing the history of hyperactivity after Ritalin. In their popular self-help book on Attention Deficit Hyperactivity Disorder, *Driven to Distraction* (1995), psychiatrists Ned Hallowell and John Ratey tell a new history, what would become, *the* history of ADHD. Their narrative draws a line that starts with a nineteenth century children’s story “The Story of Figety Philip” about a restless boy who ruins his family’s dinner, and ends with Alan Zemetkin’s studies of ADHD brains using positron emission tomography imaging, PET scans. This history reads the past, and all its preoccupations with “defects of moral control” and maladjusted children, through the lens of naturalism and posits an eternal figure of the hyperactive child, who has “existed throughout the centuries,” such that its symptoms and neurological markers can be read like a transparent film against the sheer unindividuated backdrop of history (Hallowell and Ratey: 271). The essential tropological features of this story—of progressive scientific discovery and subsequent redemption of the affected body—underscore the ways in which doctors, operating in a so-called “New Era” of professional psychiatry, invoke a philosophy of history that locates ADHD in particular, and pathology in general, in a material dimension prior, and exterior, to discourse and signification. Operating against this logic are sociological and anthropological critiques of the medicalization of ADHD which view both hyperactive children, and mothers of hyperactive children, as figures trapped within a culture that blames the victim. In these approaches, mother and child are always seen as mediated through things like language, culture, and ideology. The popular history of hyperactivity and medicalization critiques conceptualize history in different ways, but both stabilize history

and put it to work by connecting it to stable eternal objects like material conditions or everyday categories like children, mothers, ideology, and culture.

My chapter here thinks the history of hyperactivity differently. Rather than starting by tracing the emergence of the medical category of ADHD per se, my analysis looks at how the problem we know as ADHD has been assembled from similar configurations in the recent and not-so-recent past. What is unique about ADHD, I argue, is the singular way it links together in its operation the domains of school, home, and clinic. To see where these elements are first articulated in a significant way my chapter gives special attention to the mental hygiene and child guidance movements in the early twentieth century. These movements are significant with respect to ADHD for two reasons. First, operating against popular eugenicist ideas of their time, they sought to disarticulate deviancy from heredity, and drew upon a growing science of behaviorism to provide a framework for conceptualizing child pathology. These sciences played an important role in rethinking the relationship between heredity and environment, between seed and soil, and nature and culture, that served as a horizon of intelligibility for human behavior in the early twentieth century. Second, it was from these sciences that the “everyday child” emerged as a significant object of clinical attention. Contrary to previous scholarship on this subject I argue that the everyday child was not a way of labeling or confining deviancy to a particular body. The everyday child rather was a kind of virtual condition. It shifted the locus of attribution for behavioral problems outside the individual. In doing so the concept of the everyday child implicated both the family, particularly the middle class family, and the school as important milieus where the child was in-formation.

The second section of my paper picks up with a story in a Canadian newspaper in 1979 about a family and their hyperactive child. 1979 is an important moment for thinking the history of hyperactivity because it exists at the verge where hyperactivity is becoming Attention Deficit Disorder. My analysis here gives closer attention transformations in professional psychiatry over the previous decade culminating the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* in 1980. The rise of neuropsychiatry along with the symptoms-based approach of the DSM-III allowed psychiatrists and psychologists to rethink hyperactivity as cognitive lack, thus interiorizing a disorder which mental hygiene had for so many decades conceptualized as a problem of environment. At the same time hyperactivity was conceptualized as a problem that manifests itself in schools and at home, not a problem that begins there. Therefore the configuration of school, home, clinic that was first articulated with the child guidance movement in the early twentieth century was left intact but was invested with a new set of logics.

Chapter Four: The American Scene

Chapter four, the longest of the chapters, begins with an opinion editorial by Allen Frances—chairman of the last edition of the DSM task-force—in which he argues that the upcoming version of the DSM is too inclusive and will make almost any behavior susceptible to being pathologized. In particular Frances argues that the last DSM led to the “epidemic” of ADHD in children, and that the new version will probably create a similar epidemic in adults. I use Frances’ op-ed as a point of entry into ADHD’s controversies. Drawing upon ethnographic material in my conversations with psychiatrists and psychologists, as well as a culling of material from popular media representations of ADHD, I show how the notion of controversy—as it is with “global warming” a psychiatrist informant notes—is often upheld through the practice of false balancing in journalism—the

practice of making two sides to an issue or story and given each roughly equal weight—as well as through appeals to common sense. The second part of the chapter takes up one of ADHD’s more pressing controversies, the seeming unequal diagnosis and treatment of ADHD across racial and class categories in the United States. Here I examine the sentiment I often heard expressed in conversations with informants, that ADHD is “affirmative action” for wealthy whites. To better understand these beliefs, I give a close reading of journalism on the subject of special accommodations for ADHD and Learning Disabilities, and show how fears about “gaming the system” are closely tied to a politics of resentment around education, race, and entitlement in the post-welfare United States.

In part three of the chapter, I compare and contrast one of Ronald Reagan’s campaign speeches on the problem of “welfare queens” with former Boston University President Jon Westling’s rant against a fictional learning disabled student, to show how the impersonal politics of resentment that I outlined above collapses around, often stereotypical, identities. I argue this is how blame operates in the United States. By developing a concept of blame as an act of fixing responsibility, I show how debates in the United States about ADHD are really debates about who or what is to blame for the disorder. Thus, if we seek to better understand what ADHD is beyond simply a medical category or social identity, we should pay attention to the pure operation of blame which connects seemingly distant figures like the welfare queen to hyperactive children, or pushy, achievement-obsessed parents.

Finally, I conclude the chapter and dissertation, with a call for a new kind of critique. I follow Bruno Latour in arguing that critique as we know it in the social sciences and humanities, which attempts to unmask the uncertainty in science, often has the effect of reducing the complexity of scientific issues that we study. It does so by reducing what Latour calls “matters of fact” to other matters of fact. In the case of ADHD, for example, medicalization theorists share much in common with Scientologists and evangelical Christians in their skepticism towards science, and hold many similar views on the topic of the medical legitimacy of ADHD and stimulant drugs used to treat the disorder. This affinity stems from reducing matters of fact—e.g. the number of children being prescribed Ritalin—to other matters of fact—e.g. culture, ideology, power, etc. Tying the multiple threads from the chapter together, I argue that what common sense, critique, and the politics of blaming share is a subtractive logic that reduces what ADHD is rather than multiplying what it can do or can be. I conclude with an observation of Henry James published just over one-hundred years ago in his text “The American Scene” about the centrifugal motion that seems to capture this American malaise around ADHD.

Conclusion: On the Other Side of Hyperactivity

In *Bipolar Expeditions*—which was published during my fieldwork (and which I eagerly anticipated)—Emily Martin urges us to treat bipolar not as a social construction, but to think with its *symptoms*. She opens her book noting that “American culture today has a strong affinity with manic behavior;” an affinity she sees everywhere: in the “irrationality” of markets, with frenetic figures like Robin Williams, in advertising, in the language of love (Martin 2009:1). What Martin makes possible, I argue, is a way of taking culture seriously without reducing a disorder to its constraining elements. As someone who was diagnosed with bipolar herself, Martin the anthropologist and ethnographer doesn’t see bipolar as merely a confining label or a way to sell more drugs, but as a condition that operates in both culture and in the afflicted individual. The job of anthropology as she sees it, following Wittgenstein, is to connect the “private interiority of the mind [with] the space of social

interaction” (Martin 2009:232). The important point though is more than the observation that the relationship between mania and American culture is analogous. American culture *is* manic. Economic markets work on a logic of excess and surplus just like love. And just like with bipolar’s “intense emotion like states”, there is an unsteady swinging movement from high to low, which can be seen in the ethnographer’s self-disclosure and in her informants’ coming to grips with their own condition.

Michelle Rosaldo attends to the same concept of culture as an emotive field in *Knowledge and Passion*, her study of Ilongot sociality. Ilongots, she argues, divide life between *liget* and *beya*, that is between knowledge and passion. *Liget* is a kind of “energy,” the “source of motions in the heart.” “Without *liget* to move our hearts,” informants told her, “there would be no human life” (Rosaldo 1980:47). It is seen as a creative and productive force or energy. *Liget* is an intensity where the heart “goes beyond its limits” and expresses itself in envy, anger, rage, chaos, or even focus and concentration (Rosaldo 1980:46-47). In Ilongot society, knowledge, *beya*, on the other hand, “gives form, sense—and consequence—to the motions of the heart” (Rosaldo 1980:38). Because the heart can go “beyond its limits” as Rosaldo’s friend and informant put it, these motions of the heart are not trapped within what we might think of as a self; instead knowledge and passion are *co-extensive throughout* Ilongot society. As a result, Ilongots “conceptualize ‘inner states’ and ‘objective happenings’ in terms that equate and interlink events we tend to see as independent” (Rosaldo 1980:48). Whereas we tend to think of emotion as private and its expression public, Ilongots do not make such a distinction, rather “Ilongots see continuities, casting social life as a sort of ‘actualization’ of the emotions, and viewing difference and division as the product of affective processes that are at once invigorating and stressful, ever disruptive of the ideal state of balance and equality which, at the same time, they sustain.” The upshot of this is that, “[f]or Ilongots, one might suggest, there is neither ‘individual’ nor ‘social structure,’ but rather *certain processes working equally in nature, social groups, and human consciousness*” (Rosaldo 1980:223). Therefore, in Rosaldo’s ethnography, Ilongot culture is not a sieve or template for thought and action. It is a “net of senses” where emotion is always being captured and redeployed.

We can see this kind of emotive field at work in Martin’s ethnography. Markets “require emotions,” she insists; “not flattened but *intense* emotions” (Martin 2009:53). “Experiences of mania, once considered a sign of fearful and disordered irrationality, have come to epitomize the vital energy—found in the psyche rather than the laboring body—which the market needs to keep expanding.” “Markets are not human, but they are vital—‘alive’ and with ‘animal spirits’—at the same time this vital energy is being drained out of actual living people” (Martin 2009:54). But Martin steps back from the precipice, noting—just as she did at the start of her book—that this vitality “is the heart of the *affinity* between cotemporary American culture and the characteristics of manic depression” (Martin 2009:54). Martin’s analysis, therefore, brings us right to the *limit of vitality’s legibility*. It can only be read or grasped as it collapses back into minds, culture, and markets.

In this dissertation, I have used the admittedly awkward and clunky phrase “anthropic dimension” to refer to this limit of intelligibility. I find this term useful in my own work because I found throughout my fieldwork and my subsequent thinking about it, that debates about ADHD tended to cling stubbornly to the dimension of human subjectivity and sociality. This was frustrating to me, especially with respect to ADHD, because everything that could possibly be exciting or interesting about the disorder and what it does in the world immediately got collapsed back onto pre-existing problematics. Isn’t it interesting, for example, that college campuses are becoming dopaminergic through the

increasing use of amphetamines in both leisure and work settings? Is there something like Adderall operating on college campuses or in the families of children with ADHD that is a process in itself? Isn't family life in ADHD households shot through with the action of drugs like Ritalin and Adderall—euphoria, emotional lability, emotional blunting, etc.? Of course the more important question to critics is are drugs being abused on college campuses today for competitive gain? Are children really safe from drugs that are like “cocaine”? These are not questions to dismiss outright, and I don't want to suggest that these questions shouldn't be asked. But in bringing everything back to bodies, identities, ethics, and culture serves to keep our perspective trapped within or on an anthropic dimension. ADHD as it currently is serves as a point of *vitiatio*n, and we need concepts that will allow us to appreciate what ADHD can be when it is not anthropic.

This is what is at stake, I would argue, with the concept of hyperactivity. As I mentioned at the outset, hyperactivity comes from the Greek ὑπέρ-, “over, beyond, above” and the Latin *āctīvus*, related to the noun *āctus*, a “driving” or “impulse.”¹¹ Thus hyperactivity, as I am using it here is an impulse beyond a limit; the question is what constitutes this limit. Since hyperactivity is a concept, it follows that this question is purely conceptual. At the same time, it is important for my analysis throughout this dissertation. In “A New Architecture,” for example, I argue that rituals of self-stimulation like body-rocking are places where a body—that accrues time as a penalty in the form of understimulation, and that perceives this time as a burden—can become the moment. “Becoming the moment,” which is also a key marker of impulsivity, is an act of sovereignty where one, if only for a very brief moment, connects with the outside again. This outside, I would argue, is the realm of hyperactivity. In “The American Scene” I argue, following Andrew Barry, that the political becomes politics through the act of indexing, and in particular, assigning blame onto political and ethical subjects. But like Barry, I argue that political events like the riots following the Oscar Grant shooting, can operate beyond politics proper and make the political visible through the act of political misrecognition; that is, these events are political precisely because aren't intelligible through our preconceived ways of defining politics.¹² Here again, the affect of politics crosses the limit of hyperactivity. Although less present in my chapter on the history of hyperactivity, there is nonetheless this limit that marks the intelligible from the unintelligible that manifests itself in debates about life and pathology in early twentieth century discussions of misbehaving children. The act of locating child behavior is limited by two degrees of freedom: seed and soil, nature and nurture, heredity and environment. Nearly every text of the day on the topic of child behavioral issues is confined by this limit.

What I am calling hyperactivity here corresponds to Deleuze's concept of the virtual. Throughout his writings, Deleuze makes the fundamental distinction between the actual and virtual, which are both manifestations of the real. Broadly, and in synthetic fashion, we might say that for Deleuze the virtual is the realm of “incorporeal events” and transformations on the “plane of immanence,” and that the actual is the “mixture of bodies” and “states of affairs” in our extensive world. There is often confusion about what Deleuze means by this distinction, which he no doubt exacerbates by using different terms throughout his writing, but what is of critical importance is the assertion that the actual world—that is, the world of extended things, everyday ideas and the representations we

¹¹ See *Oxford English Dictionary* for etymology, and also *Oxford Latin Dictionary*.

¹² As I discuss further in chapter four, Oscar Grant was a young man who was shot and killed by a white police officer in January 2009.

have for them (this is a hyperactive child, that is a normal one; this is science over and against culture)—is not all there is to the real (Deleuze and Parnet 2007:142-152). Rather there is a potential in life to become otherwise that we can appreciate if we attend—as I have tried to do in this dissertation—to moments and events beyond an anthropic dimension. For example, what happens when instead of treating ADHD as a category that then becomes contested, we instead look only at contestation in itself? What would the symptoms of hyperactivity look like if we saw what they did when they are not just in the brain or body, but becoming events in the world, like children body-rocking or playing videogames? *Thus the point of this dissertation is to show through sustained empirical attention and conceptual reflection how hyperactivity's domain of effectuality exceeds our current ways of perceiving it, which are tied to the anthropic concept of ADHD.*

This may not seem like the domain of anthropology. But as I hope I have made clear in my discussions of the works of Bateson, Rosaldo, and (in “A New Architecture” and “The American Scene”) Radcliffe-Brown and Evans-Pritchard, there are plenty of moments when anthropology delves into the virtual and the realm of the potential. My goal in this dissertation has been to make this project explicit.

But what kind of anthropology is this? If, as Marcus and Fischer noted over twenty years ago in *Anthropology as Cultural Critique*, the defining anthropological trope is irony, this dissertation instead attempts to think not through irony as sophistication and contradiction but through the sublime. By the sublime, I mean moments—like Andrew listening to Beethoven, seeing “one-hundred television screens blinking in their own distracted language” at 35,000 feet, or Henry James’ comparisons of America to india-rubber—where observations become not merely just another example to represent the subject matter (although I have included plenty of those in this dissertation as well), but rather moments of rupture that enable us, or force us really, to intuit something *new* that doesn’t correspond to our otherwise settled way of viewing the world.¹³ Then, if only for a moment, we can appreciate what life is like on the other side of hyperactivity.

¹³ For more on this point see (Colebrook 2006:151).

Chapter Two

A New Architecture: Hyperactivity, Consumption, and Time in the “Age of Egocasting”

When I first met Andrew on a Sunday afternoon in the last days of Summer, he was rocking back and forth on an oversized couch. He was nine and with his arms by his sides and his toes just touching the floor he could manage, without much effort, to bounce his back off the top cushions like a spring. He would do this for hours listening to his iPod (a portable music device), sometimes playing and replaying the same song over and over. He would rock in the car too; so much that his mother had to constantly adjust the passenger seat in her Volvo. He would rock in bed at night before he fell asleep with the radio playing. He even showed me how, lying down on the floor on his side with his knees bent.

“Don’t you get dizzy?” I asked.

“No.”

“That’s cool, I get dizzy just looking at you.”

Almost thirty years after Sony released its first Walkman, and Attention Deficit Disorder was added to the DSM-III, Andrew-rocking has become a visible expression of a new architecture of experience that functionally links neurological deficit, self-stimulation, and consumption of electronic media, in what Christine Rosen has cleverly dubbed the “Age of Egocasting.” Over the course of my fieldwork I had come to recognize what I had somehow already known intuitively, but had never really been able to see until now; namely, that the symptoms of ADHD—hyperactivity, impulsivity, and inattention—are themselves vital elements that make the world work in new ways. But it took Andrew rocking to show me how.

Andrew and his family make their home in the settled geometries of asphalt, ryegrass, and young vegetation that mark the tracks of new development on the other side of the hills dividing Berkeley and Oakland from the rest of the East Bay. On the way to his house, if you are traveling South on a particular overpass, and if you bother to take your eyes off the road ahead, for a brief moment you can see the neatly pressed rows and curves of double story houses; red Spanish style roofs set in an oasis of improbable green, surrounded browning hills on all sides. Part of my fieldwork was coming to grips with the ways that the American Suburb as a social form and style of consumption is implicated with hyperactivity as a condition of modern life. I spent the first seventeen years of my life trying to escape the suburbs and now I felt like I was coming back to a familiar habit.

Andrew’s mother, Amy, is an attractive thirty-two, and judging by the size of her ring, extremely married. She ended up with an eight year-old son last year when she married Andrew’s father who is nine years her senior. We talk in the kitchen exchanging niceties: I like your house how long have you lived here? Oh right, you are a new addition to the family, I forgot. How is my research going? Well, thank you. Of course, I would love to tell you about it but I never have the right words.

Amy is from Tennessee. Her accent has gone elsewhere but you can still hear the South in the way the rising tones pile up at the ends of her sentences. We talk for a while about ADHD, medication, school life. I look nervously at my notebook fishing for a question without actually reading.

“He takes after his father.”

“What do you mean?” I ask, pretending not to know.

“You should meet Brian. He’d be good for your study. Sometimes I don’t know who’s more of a spaz, Andrew or his dad.”

I ask her about the rocking. According to her husband Brian, Andrew started rolling himself to sleep in bed when he was four. Andrew's biological mother, was plagued by self-doubt, and took this as a failure of herself as a mother. Brian chalked the rocking up to being a kid. "There comes a time, though" Amy reasoned, "when you realize, 'My kid isn't normal.'" This happened just before Brian and his first wife, by some small irony also named Amy, divorced. I wonder what kind of stress Andrew's rocking causes Amy number two.

"I've grown used to it. He just has a lot of extra energy."

"Besides listening to music, what do you think he thinks about when he's rocking?"

"I have no idea, he just zones out. I'm sure he has a good imagination, he likes to write stories." Would I like to see them?

Amy takes me to Andrew who is now in his room drawing. It smells of folded clothes; like an unfamiliar soap. Pieces of his life are strewn over the floor: paper, two worn socks, a notebook. There is something about this messy room that elicits an uncanny feeling of being out place. Andrew has bunk beds that form an L where two walls meet; but he shares the room with only himself.

"Nice bunk beds," I say, fumbling for something to elicit a response. Nothing. Maybe he thinks I'm talking to mom.

"Hey Drew, show Marc your stories." He seems at first not to listen, but then, almost in one motion, swings his chair around and launches onto the bottom bunk to retrieve his notebook.

"Which ones do you want to see?"

"I don't know. Which is your favorite?"

He thumbs to a story he wrote for class, "THE GREAT ESCAPE," scrawled in capital letters. Written in the first person, it is about a boy in fourth grade who hates school. One day, a "rainy day," he drops his pencil on the floor, but when he gets out of his chair to retrieve it, the pencil rolls into a black hole under the table, which, as Andrew explains, was big enough for three of his other classmates thus concealing the hole. The boy looks into the hole and realizes it is some kind of time tunnel and falls in. He feels himself aging to fifteen; he is stronger now; he is the same person and yet he is somehow smarter. Then, almost instantly, he is transported "to the other side of the universe," which at age nine probably seems as far away as fifteen. There he is greeted by friendly aliens in some kind of "mansion" that is hosting a Christmas party. The boy is now wearing a red sweater and talking to other people he strangely knows but has never met before. He goes down a staircase and into an empty room. A vase falls off a high dresser and breaks on the floor—even though the floor is carpeted. The boy searches for a broom and dustpan when he is suddenly transported back in time and space to the classroom. "'Where the *heck* have you been?!' the teacher screamed." The boy starts to answer "'you will never believe me...'" Neither the boy nor the story finishes the sentence.

"What happened?" I ask.

"I ran out of time," he answers matter of factly, shifting my question to a different register. With that he jumps off the bottom bunk, doing his best attempt at a karate kick. His landing leaves a lot to be desired; a kind of half stunt roll that ends when his desk chair doesn't move out of the way.

"Owww." Andrew's eyes roll back as he feigns passing out. Amy's not impressed. "God, Drew, be careful!" You can tell she's said that phrase so many times that its edge has worn off. Then she turns to me, "are the other of the kids you interview like this?"

I shrug. She looks older to me now.

When I left their house that evening, the sun looked somehow familiar and I had the sad epiphany that last time I had felt this way the sun was basically the same age, and I was now twenty-seven. Amy was thirty-two with a nine year old kid. Time was running out on us too as the sun watched with a warm, brilliant, indifference. It seemed unfair. As Andrew himself once told me, “I wish I was born in the future.”

As I got to know Andrew better, I came to realize that he, and others like him, are always running “out of time.” First, time is something they seem to have less of than others. They don’t finish assignments, they hand in homework late if at all, they show up late for class, they take longer to pick up social cues. This is why the most common academic accommodation for children with ADHD is “extra time.” Secondly, they are out of time in the sense that the main symptomatic markers of ADHD—hyperactivity, impulsivity, and inattention—all imply a different kind of relationship to time; a disordered time, wherein these criteria are themselves operationalized as problems of time. Professional psychiatry equates the temporality of ADHD with that of the present moment, of the “now.” Thus for Russell Barkley, a psychologist and leading authority on ADHD, if parents want to understand their ADHD children, they need to train themselves to see the world within a different frame of time; they need to “become the moment.”

But under what conditions is it possible to be “out of time” on the other side of hyperactivity? To answer this question, this chapter explores a new architecture of experience that has emerged in the last three decades that links neurological deficit, rituals of self-stimulation, and modes of postmodern consumption. In particular, drawing upon ethnographic material from my fieldwork with hyperactive children and adults as well as a reading of the literature on the neuropsychology of attention, I consider stereotyped, self-stimulating, behaviors typically associated with ADHD—like rocking—as a way of inhabiting a body, and more broadly the world, in, or out of, time. Toward this end, this chapter takes up Georges Bataille’s concept of sovereignty as a way of thinking through the relationship between hyperactivity, consumption, and time. “What is sovereign in fact,” Bataille tells us, “is to enjoy the present time without having anything else in view but this present time” (Bataille 1991a:199).

In part two of this paper, I use Christine Rosen’s notion of “egocasting”—the idea that technologies of control and selection have allowed us to create our own individual environments of self-entertainment—as a way of thinking about the relationship between media consumption, hyperactivity, and time. To develop this idea I draw upon on recent theorizing in neurophilosophy as well as Deleuzian and post-Deleuzian scholarship on experience and sensation, to outline a concept of “architecture” as an activity of giving form to experience. Working through examples from my ethnographic encounters, I consider how the relationship between neurological deficit and consumption is captured on the one hand by an extensive, entropic, architecture that is becoming dopaminergic (meaning that they entire system has the overall effect of increasing dopamine in the brain), and on the other by an intensive unfolding of events, that is becoming hyperactive. My point, I argue, is not that media consumption causes the symptoms of ADHD—hyperactivity, impulsivity, or inattention (although contemporary neuropsychology leaves this possibility open), but rather that these behaviors share with egocasting an affective regime of becoming the moment. To become the moment, to run out of time, means to inhabit time without concern for the future (the main criterion of impulsivity), and thus to live differently in the present.

ADHD and Time

In 1997 Russell Barkley, then a professor of psychiatry at State University of New York, Syracuse, published his first edition of *ADHD and the Nature of Self Control*. In part because the prose was accessible, and in part because the disorder was still less than twenty years old and there were only a handful of comprehensive accounts of the condition, the book became something of an authoritative guide on the subject of ADHD. As the title might suggest, Barkley's main contribution was to re-theorize ADHD not as a problem of inattention or hyperactivity per se, but as a problem of self-regulation. His text fulfilled a need for thinking about the disorder that bridged advances in basic science on neurology and behavior with a more practical focus on clinical outcomes. Perhaps most importantly, it equipped clinicians with a new vocabulary and explanatory framework for conceptualizing and treating child behavioral problems of and relating to ADHD.¹⁴ I want to give closer attention to Barkley's model because it proposes a very specific relationship between time and the subject that helps us better understand the relationship between ADHD and self-stimulating behaviors.

Barkley's so-called "Unifying Theory of ADHD" constructs a "hybrid" model that conceptualizes the disorder as implicating four neuropsychological functions: working memory; self-regulation of affect, motivation, and arousal; the internalization of speech; and reconstitution. Drawing upon several decades of research in the neuropsychology of attention, Barkley suggests that all four processes depend on behavioral inhibition for "effective execution." He isolates three kinds of behavioral inhibition necessary for these other executive functions: 1) inhibiting a prepotent response to an event; 2) ceasing ongoing responses, "thereby permitting a delay in the in the decision to respond or continue responding"; and 3) what's called interference control: "protecting this period of delay and the self-directed responses that occur within it from disruption by competing events and responses" (Barkley 1997:47-48). As Barkley notes, "This is *not* to say that behavioral inhibition directly causes these executive or self-directed actions to occur in any primary or immediately proximal sense of causation. But it does set the occasion for their performance by providing the delay necessary for them to occur" (Barkley 1997:51).¹⁵ In other words, because of delayed or stunted development in several key regions of the brain, especially the prefrontal cortex, children with ADHD have trouble with inhibition. Without this critical "delay" other important executive functions don't have the time to operate. The final result, Barkley argues, is the symptoms we see with ADHD.¹⁶

¹⁴ At this time, Barkley is one of a handful of recognized authorities on the subject of ADHD that are well-known in both scientific and lay circles. In private conversations, many psychologists and psychiatrists I spoke to, especially those engaged in basic research on ADHD, expressed their misgivings with the speculative nature of Barkley's reasoning. In particular, they felt that the data and studies he uses to support his hybrid model could just as easily lend support to other theories (sometimes conveniently their own). As one clinical psychologist put it to me, in "good science, the data should lead necessarily to the conclusions." At the same time, most felt that, on a practical level, Barkley's model worked as an approximation, and that his insights into ADHD as a problem self-regulation were helpful in providing therapeutic guidance to parents, teachers, and practicing psychologists.

¹⁵ Emphasis original.

¹⁶ Note that for Barkley this delay is temporal, compared to post-phenomenological positions like Foucault and Derrida who seek to spatialize time and auto-affectation. For more on this point see Leonardo Lawlor's insightful essay "Life: An Essay on the Overcoming of Metaphysics" (Lawlor 2007).

If ADHD is a problem of self-control, what constitutes this “self”? Without getting lost in a metaphysical labyrinth, Barkeley tries to answer this question by revisiting an older discussion on the topics of “will” and “volition.” He thus poses the question: “Who or what decides in what service the executive functions and self-regulation will be put, and for what purpose” (Barkley 1997:202)? He admits that this question points to thorny problems that plague discussions of consciousness and cognition, like the homunculus within the brain or the endless embedding of centers of decision, calculation, and experience often likened to Russian Dolls. At the same time he brackets these concerns by appealing to the enduring problem of the “central executive” and its continuing presence in contemporary neuropsychology. Posing the question another way, he asks: “what process is it that determines which goals will be selected, which plans, rules, and other sources of information will be considered in support of them, and what forms of private self-directed actions are necessary to generate that information” (Barkley 1997:201)? In other words, is there a something that itself presides, controls, or influences in some way, all of the executive functions of the brain?

Despite his best efforts to avoid metaphysics, Barkley rather ambitiously suggests that “if such an entity must be specified...it is time.” “Or,” stating it otherwise, it is “*the individual’s sense of the future, [that] is ultimately the central executive*”(Barkley 1997:202).¹⁷ Though it is not clear exactly what Barkley means by “time”—a point that I give more consideration below—this is truly a radical notion. If contemporary neuroscience has attempted to locate, or at the very least has made it safe to conceivably locate, will or volition within the brain itself, suggesting that time is the central executive means suggesting that volition and will both *precedes* and *exceeds* the brain. This is a point I would like to return to later in my discussion of an architecture of experience. First, however, we need to clarify what Barkley means by “time” and also what place time has in theorizing ADHD.¹⁸

Not surprisingly, Barkley draws the familiar distinction between time as a physical reality, that is, a pre-personal, objective time, and time as it is perceived by human beings.¹⁹ For Barkley, time is a physical fact that we either perceive or fail to perceive based not upon culture as a sieve or template, but rather the brain as a sensitive instrument: “[t]his makes the prefrontal cortex of the human brain, in a sense, a *time machine*” (Barkley 2005: 206, emphasis added). Here he appeals to Einstein and Minkowski’s notion that time is not

¹⁷ Emphasis original

¹⁸ I should note that my aim isn’t to get Barkley “right” as it were, but rather to extend his ideas to their logical limit, and to see what difference they make for thinking hyperactivity anthropologically.

¹⁹ The British Philosopher, J.M.E. McTaggart makes famous this distinction in his foundational article “The Unreality of Time” (McTaggart 1908). For McTaggart “A-series” time is closest to the time perceived by human beings. This time has a “past,” “present,” and “future.” “B-series” time is closer to what Barkley would call “real” time in the sense that it suggests that events are ordered in relation to one another. McTaggart’s contribution was to suggest that time was an illusion. This is because on it’s own B-series time does not imply change. This is what is now called “tenseless” time. A-series time is illogical because any event is at some point in the future, at some point present, and at some point past. It is illogical for some event to be present past and future because they are by definition mutually exclusive. Alfred Gell takes up this same distinction in “The Anthropology of Time” (Gell 1996). For Gell there is a “real” physical time corresponding to B-series time, an untensed time, but phenomenologically humans experience a-series time (Hodges 2008). Whereas Gell as an anthropologist shows how A-series time is informed by both perceptual structure and human sociality (e.g. cultural representations, beliefs, etc.), neuropsychologists like Barkley tend to maintain the distinction between A- and B-series time, but see the former as structured first and foremost by the perceptual capabilities of the brain and central nervous system.

something added onto three dimensional Euclidean space, but rather is part of the same continuum of space-time. Of course, one might reasonably question what kind of work the notion of space-time does for Barkley given that, as Einstein's thought experiments and Minkowski's many caveats suggest, space-time as a unified concept only takes on mathematical, or for that matter perceptual, significance when one deals either with cosmological distances and/or speeds approaching that of light (Einstein 2006). Nevertheless, animating Barkley's assertion is the idea that time is a reality that we can be more or less attune to based upon the sensitivity of our neural equipment. This is what Barkley means by the seemingly cryptic statement "[t]ime, or the individual's sense of the future, is ultimately the central executive." The main crux of the argument is that people with ADHD have brains that remain underdeveloped in key regions, especially the prefrontal cortices, and as a result they do not perceive time in the same way as people with "normal" brains. This "time blindness," or "temporal myopia," as Barkley calls it, explains why people with ADHD, like Andrew, are always running "out of time."

Though this theory sounds fanciful, there has been a growing mound of research to buttress it. The idea that temporal processing is implicated in attentional problems is decades old but has only recently received closer empirical attention. It should be noted at the outset that the experimental set-up used to test temporal processing in those with ADHD focuses mainly on the perception of duration, and not time as an abstract concept. In most cases research subjects are asked to reproduce a fixed or variable duration of time by pressing a mouse-like device. Overall, studies have shown that people (especially children) diagnosed with ADHD show a statistically significant difference in their ability to correctly estimate and reproduce time compared to their "normal" counterparts (K Rubia et al. 1999; Sonuga-Barke, Saxton, and Hall 1998; Barkley et al. 1997).²⁰ In particular, children with ADHD are likely to underestimate time. For example, when asked to press a button on a timing switch after twelve seconds (below a threshold of five seconds or less there doesn't seem to be any significant difference), children with ADHD are more likely to press the button earlier. This would suggest aversion to delay and problems with motivation and sustained attention rather than the inability to perceive time itself.

One study, however, took a different approach. Researchers ran an experiment wherein they flashed two colored discs on a computer screen sequentially to a sample of ADHD children and a control group. They showed one disk for 1000 milliseconds, then they showed the other disk for 1300 milliseconds (though the order is random for each iteration). Children were then asked to select the disk that appeared longer. This was repeated many times for each child. Researchers found that children with ADHD had significantly more difficulty judging which disk appeared for a longer duration. Whereas in previous studies the differences only became significant after longer durations (at least five seconds), the perceptual difference here is remarkably small—on the order of a few hundred milliseconds. This finding, however, suggested something new about ADHD and time. In the previous studies involving longer durations, the underestimation of time was theorized to be a function of impulsivity, aversion to delay, and poor motivation. But in this study, researchers concluded that the discrepancy between the two groups suggests that

²⁰ One reasonable explanation for this discrepancy might be that people with ADHD struggle with motor control which would impact performance on time tasks. But even though, motor control is seen as an impairment of ADHD, there is a growing consensus that problems with temporal processing, are at the very least coincident with these issues with motor control, and more likely are prior to motor control problems and not the reverse (Nigg 2006:165).

children with ADHD have deficits in perceiving *time itself*. Drawing on other research in this area, the authors suggested that this perceptual deficit could impact on other functions relating to language and motor timing (Anna Smith et al. 2002). Therefore, while it is perhaps a stretch to imply, as Barkley does, that people with ADHD are “blind” to time, evidence does at the very least suggest that with ADHD, time is disordered and in two ways: first, there is an underestimation of time related to impulsivity; and secondly, there is perceptual deficit of time itself.

As I argue later, whereas for much of its history hyperactivity was considered to be too much activity, now it is seen as too little. Even before ADD was added to the DSM-III in 1980, the notion of hyperactivity was already conceptualized through a model of neurological deficit. Neuroimaging studies—which not surprisingly have been on the forefront of ADHD research of the last twenty years—have identified four key regions of the brain that are likely implicated in ADHD: the prefrontal cortices, the basal ganglia the cerebellum, and the corpus callosum (Nigg 2006:56). It is theorized, and recent research suggests, that problems with temporal regulation implicate the prefrontal cortices and cerebellum in particular (Nigg 2006:56). Using neuroimaging studies, the notion of “deficit” implies decreased brain activity, and even volume, in key regions of the brain, as well as a deficiency of certain neurotransmitters like dopamine and norepinephrine. I attend to the logic of neurological deficit in more detail later in this dissertation. For now, I’d simply like to note that in this theorization of ADHD as neurological deficit, children with ADHD underestimate time because they are understimulated and have difficulty tolerating delay. In this model people with ADHD *feel time* in a different way. In my fieldwork, the two most common emotions expressed by my informants were “frustration” and “boredom.” Time is a burden. People with ADHD, I argue, are constantly trying to escape time, and because impulsivity is by its nature pre-personal, “and without consideration of future consequences,” as the authors of the aforementioned study of time perception put it, these acts of escape often occur without conscious planning or recognition (Anna Smith et al. 2002:529).

Taking the T.O.V.A.

This affective triangle between time, impulsivity, and frustration itself finds its way into the diagnosis of ADHD. There is no better example of this than the Test of Variables of Attention—more commonly referred to by its bite-sized acronym, TOVA—which holds a privileged position within the diagnostic apparatus of ADHD. Although the test has competitors, it is seen as the “gold-standard” of Continuous Performance Tasks—tests that require a subject to respond to an ongoing task and that are used to measure impulsivity and attention. The TOVA was the test doctors, parents, and children referenced the most in my fieldwork (though for the most part only clinicians referred to it by name). When people say they take a “computer test” for ADHD, they usually mean the TOVA. The test was developed over the course of several decades by Lawrence Greenberg, a now retired professor of psychiatry at the University of Minnesota, but was only commercially available since the late 1980s.

For privacy reasons, and to maintain proper testing conditions, I did not personally sit in on a TOVA being administered during my fieldwork. I did, however, take the TOVA myself at age ten in January of 1992 (when it was still relatively new), and in the meantime I have had extensive conversations both with people who have administered the test, and with people who have taken it. Because the TOVA nicely illustrates the relationship between time, impulsivity, and frustration in ADHD, and because this relationship is itself

essential for understanding the relationship between hyperactivity, consumption, and time, I'd like to briefly provide you with something of a composite sketch of the TOVA and its administration.

Imagine yourself sitting in a room, likely a psychologist or psychiatrist's office, which itself is likely part of a suite in a multi-story office complex built sometime between 1970 and 2000 (whether the building is part of an "office park" or other such buildings boasting generous parking and just enough greenery to take the edge off depends on whether you call your home suburban or urban—if you are rural you likely traveled the better part of an hour to such an office park). There is carpet on the floor, probably Berber; it hides stains well and also cuts down on echo, though this is something of a non-issue given the drop-ceiling is lined with sound absorbing melamine tiles. Maybe there is a Ficus tree or other office-friendly shrubbery in need of attention and you wonder why it isn't on the other side of the room to receive sunlight from the adjacent wall of continuous windows. This is the third time you've been to the office and you've likely completed several hours of other neuropsychological tests—including the standard intelligence test called the WISC-III—over the course of several visits. These visits were likely paid for by your parents and hopefully at least partially covered by insurance, after a several hundred dollar deductible. You were fortunate enough to get out of school for these visits, or unfortunate enough if they were scheduled over weekends, holidays, or your summer break.

It is between nine A.M. and noon. This is to ensure that the TOVA is taken under similar conditions by everyone, to avoid "diurnal variations," and so that you aren't yet fatigued by the other tests you will be taking later today. TOVA is administered on a computer—specifically a PC running Windows (the TOVA isn't currently available for Mac). The next thing you should know, but the attending psychologist won't tell you, is that the makers of TOVA pride themselves on having designed a "boring" test. It's over twenty-two minutes long, and consists of two sections roughly eleven minutes each. The only operation you have to complete for the test—and to complete again, again, and again—is to click a button on a "microswitch," designed to be accurate within one millisecond (as compared to twenty-eight milliseconds on a regular mouse or keyboard whose margin of error is outside the acceptable range). When you see one kind of target (a black square near the upper border of a white square) you will click the button, but you will refrain from clicking the button when you see the other kind of target (a black square near the lower border of a white square). These geometric targets are monochromatic and designed to be as "culturally neutral" as possible. Because you will be presented with one of these two targets every two seconds, for a duration of one-hundred milliseconds, you are effectively getting this "question" nearly seven-hundred times in a row. For the first section of the test the "target infrequent" half, you will see the target for which you will need to click the microswitch only one time for every three and a half times you see the other target (for which you should not press the microswitch). The idea here is to make the test as boring as possible, and as a result you might miss targets because you aren't paying close enough attention (these are called errors of omission and they are taken as a sign of inattention). Then for the second section of the test, the "target frequent" half, you will get three and a half "yes" targets for every one "no" target. Hopefully by the time this second section starts you are bored and fatigued from staring at a screen without blinking for over ten minutes. As the test switches to this highly demanding situation, you are more likely to press the microswitch when you shouldn't (these are called errors of commission and are taken as a sign of impulsivity).

"This test measures your ability to pay attention," your psychologist notes, as you are

sitting in the chair in front of the computer. Before the official test begins you are given a practice test lasting three minutes during which time the person proctoring the test (technically, the test is administered by the computer) will show you how to hold the microswitch and press the button. The practice test is straightforward enough. So the psychologist continues: "OK, now we are going to do the test for about twenty minutes. Do the best job you can. Also, you should know that your eyes are probably going to get a little tired. Even so, try and do the best job you can... press the button as quickly as you can but only for the square with the hole in the top. I'll be staying here while you do the test, but I can't talk to you once the test starts. Do you have any questions before we begin?" "Ready, here we go...start watching the screen" (Lawrence Greenberg et al. 2007:68). A solid dot appears in the middle of the screen, then a countdown, 3...2...1...

The first target you get is a hit, it lasts for only a tenth of a second, and you press the microswitch.²¹ Less than two seconds after pressing the switch, you get another target, which again is gone before you can give it much thought. This time the little square is on the bottom; no go. Then you get another target with a square near the bottom of the bigger square and you again refrain from pressing the button. The next target again is a 'no.' So is the next, and the next, and the next, and the next, and the next, and the next, and the next (each flashing only a fraction of a second). Twenty seconds has elapsed since the first target when you get your next hit. Then a 'no,' followed by three consecutive hits. This is jarring because you have no idea how frequently to expect the 'yes' targets.

Three-hundred, twenty-two targets and roughly ten minutes later, the test shifts, unbeknownst to you, to the "target frequent" portion. Eight out of the next ten targets are hits, and you are beginning to wonder if the test hasn't shifted a gear. After a couple of minutes more your mind starts to go blank, but then you realize you have pressed the button even though the square was at the bottom, expecting a 'yes' target. This gets your attention so you are more vigilant but after a few more targets you over-correct and press the microswitch when you shouldn't. After another couple of minutes, if you are the impulsive type (which you likely are given that you came to this office in the first place), you are beginning to grow resentful; resentful of the test, of the computer, and of the psychologist behind you watching calmly. This growing frustration manifests itself in a number of ways. You might, for example, as is common, vocalize your displeasure by exhaling loudly in exasperation as you miss targets. Or you might, as I did, try to break the microswitch by pressing the button as hard as you can and holding it down as targets continue to come and go on the screen. But the psychologist doesn't like this as a replacement microswitch probably costs the better part of one-hundred dollars, plus shipping, and won't arrive in time for the next scheduled test, so he reprimands you, reminding you with a firm tone to press the button quickly and only once. Now you feel guilty and make an effort to try harder. Fortunately, you have only 262 targets and less than nine minutes remaining, after which the tests ends and the computer saves your results.

During the test, the psychologist was standing behind you observing several things very carefully. First, she or he looked for compliance by listening carefully to ensure you pressed the microswitch quickly, consistently, and only once per target. Secondly, the psychologist was judging your mood, and in particular whether you were exhibiting any signs of frustration, fatigue, impulsivity, or anger. Finally, she or he monitored for

²¹ The algorithm used in the TOVA to generate the sequence of targets is proprietary and a closely guarded secret, but using the criteria outlined above and random number generating software, I've come up with a hypothetical TOVA target sequence.

attentiveness and distractibility. The psychologist now notes these behaviors on a “behavioral observation form.” The “qualitative data” recorded by the attending psychologist is considered essential for contextualizing the quantitative data recorded by the computer. As such the TOVA isn’t just a computer test. It is a diagnostic tool that renders the symptoms of ADHD visible as both numbers and affective responses. It should be noted that in itself the TOVA is not used to diagnose ADHD. Rather it is used as part of a comprehensive approach that includes family histories, teacher and parent reports, and other relevant data so forth. But what the TOVA can do is operationalize impulsivity within time in and against time.

Before transitioning to a discussion about the anthropological import of thinking hyperactivity as a process in time, it is worth emphasizing several points. First, picking up on a theme I address at length in the fourth chapter of this dissertation, contemporary discourse in the United States tends to conceptualize ADHD as a problem that happens to children as material bodies and political and ethical subjects. The attempt over the last four decades, however, to locate hyperactivity in particular, and pathology in general, within the brain—while often being grafted onto preconceived notions of a pre-given normative subject (as the notion of neurological ‘deficit’ would suggest)—also provides a point of departure for thinking hyperactivity in new ways. Secondly, and in particular, although the details of the etiology of ADHD remain murky, recent research in the neuropsychology of the disorder has provided greater clarity about specific neurological pathways and mechanisms responsible for the symptoms associated with ADHD—namely hyperactivity, impulsivity, and inattention. Third, because the theory of neurological deficit operationalizes these symptoms as neurological events, symptoms now become intelligible as processes that both precede and exceed the subject in time. Therefore, finally, the challenge for a critical analysis of ADHD is to treat these processes as things in themselves with their own anthropological importance, to push them to do new kinds of conceptual work, and therefore to see what difference they can make for thinking hyperactivity today.

Hyperactivity, Consumption, and Time

This chapter began with Andrew-rocking less as an illustration of what ADHD is, in the representative sense of the term, and more as a way of framing ethnographically the relationship between hyperactivity, consumption, and time. After Andrew, I began to see rocking as a way of inhabiting a body both in, and as his story and neuropsychology might suggest, out of time. And I began to see it everywhere. Although stereotyped behaviors like body rocking are more commonly associated with autism and other developmental disorders (most notably mental retardation), I found that many of my informants engaged in body-rocking on regular basis, and many did so for considerable amounts of time each day. Given the stigmatizing nature of stereotyped movements, most informants I talked to had kept their body-rocking a secret until I had asked; and when I had asked it was often as if I had, without warning, uncovered in them a strange and uncanny self-knowledge. Many had never before connected their body-rocking with ADHD.

Andrew’s step-mother Amy’s reasonable explanation that her son “just has a lot of extra energy,” invokes the commonsense notion of hyperactivity as surplus. As hinted at earlier though, thinking hyperactivity as neurological deficit allows us to understand the relationship between hyperactivity and rocking differently. There are currently several theories for understanding both the presence of stereotyped behaviors, as well as their frequency, persistence, and intensity. One theory conceptualizes stereotypy as a coping mechanism for overstimulation in overwhelming environments. This would help account for

the presence of stereotyped behavior in people with autism whom, it is believed, have difficulty modulating sensory input (Kuhn 1991:14). Another theory is that people engage in stereotyped behavior because they are understimulated, and actions like body-rocking and hand-waving/flapping provide vestibular-proprioceptive, and visual stimulation (Bonadonna 1981; Gershon Berkson, Andriacchi, and Sherman 2001; Lovaas, Newsom, and Hickman 1987). This theory would support the notion of “self-stimming,” particularly as seen in people with autism, but could also explain both body-rocking in particular, and “fidgeting” more generally, in people with ADHD. Stereotyped behaviors also occur in cases where the dopamine pathways of the brain become overloaded, and thus are often exhibited in conjunction with high doses of cocaine, amphetamine, or methamphetamine in both laboratory animals and humans (Asher and Aghajanian 1974; Wallach and Gershon 1972; Budygin 2007; M H Lewis, Baumeister, and Mailman 1987).

As the abundance of contexts for stereotypic behaviors suggests, there is likely not one single cause of stereotypy. At the very least though, excluding drug-induced stereotypy, research in the neurobiology of stereotypy suggests these behaviors might be linked to deficits in the prefrontal cortices and the basal ganglia, which could be caused by a number of factors including early neglect (Cooper and Dourish 1990; M H Lewis et al. 1987; M H Lewis et al. 2005). For our purposes here, it’s worth noting that stereotyped behavior is not necessarily self-stimulatory, and that not all self-stimulatory behavior is considered stereotyped.

Body-rocking, though, fulfills both criteria. It is stereotyped insofar that it is persistent and repetitive. And it is often, though by no means always, self-stimulatory. Self-stimulatory behaviors are frequent among infants and toddlers, but this behavior usually decreases with age (Tan, Salgado, and Fahn 1997; Lovaas et al. 1987). Despite research on the subject, it is difficult to know with any certainty how common or prevalent body-rocking is among adults and children. Two studies by Gershon Berkson and colleagues found that, although the estimated rate of body-rocking among children of preschool age is around five percent, this rate may increase to reach fifteen percent of college-aged adults; though they found a rate between three and twenty-five percent depending on the method and restrictiveness of criteria (Gershon Berkson and Andriacchi; G Berkson, Rafaeli-Mor, and Tarnovsky 1999). Among people with mental retardation, the rate of body-rocking has been measured at forty-four percent (Rojahn 1986). Given that the rates of body-rocking in Berkson’s studies were self-reported, and given that college students received course credit for their participation, a figure like fifteen percent of college students in general seems high. Again this may be the inclusiveness of the criteria used to define “body-rocking.” Although the behavior can be exhibited in a number of ways, for many of my informants body-rocking was not simply a passive habit like biting one’s nails; rather, for at least a handful, it was something that they engaged in on an almost daily basis, and would sometimes do for hours a day. Furthermore, while many of my informants engaged in body-rocking while doing other activities—like reading, using the internet, watching television, or even eating—as Andrew’s case illustrates, rocking is something that can be an activity in itself even if it is accompanied with other activities. In other words, the rocking becomes primary.

But what relationship might body-rocking have with hyperactivity, and why body rocking? Surely, less than one third of people I talked to who had been diagnosed with ADHD engaged in this behavior on a continuing basis (at least after I started asking), meaning it wasn’t simply something they did as a child but is something they continue to do (although many had dropped the habit during certain periods of their lives only to start

again later). So of course, I am not suggesting that all people diagnosed with ADHD body-rock, and neither is the reverse true: that all people who body rock are ADHD. But I do think body-rocking draws our attention to three things: first, that it is something that people often feel compelled to do, even against their “will.” Secondly, body-rocking holds a special relationship to time; in particular, it is seen as time consuming, and indeed the relationship between body-rocking and time can be thought through the idiom and logic of consumption. Finally, body-rocking becomes, for some of my informants anyway—and something which accords with my review of online blogs—a mode of escaping the world both as a particular kind of time and as a social effect.

This is well illustrated in a conversation I had with an informant Eric—who had been active in one of the support groups I was attending—about the oppressiveness of time. Eric is divorced, a man of forty-one, and way too interesting for his oversized navy sweater—the nineties kind with a lonely double stripe running across the front that says ‘I’m bored.’ His face has just enough wrinkles for his age, and there is some kind of texture in his voice that comes from more than just smoking.

“I can’t tell you how much fucking time I waste doing *this...*” [imitating a rocking back and forth].

“So then why do you do it?,” I ask, though I immediately regret the question’s bravado. Eric paused for a second as if he were actually thinking.

“I don’t know. Because I can’t stop. I can’t *not* rock. I can feel it, you know...” he arched his back, sticking his chest out. “Like this one time, I was at a play with my ex-wife of the time—you know the theater, I don’t even remember what the fuck it was called, this was like eight or ten years ago—but I was sitting there and I felt like I was going to break into a million pieces, like I was...I was just going to crack into pieces, all over the floor. Like I’m imagining it now in my head and my skull cracks open and falls backwards, and my right arm crumbles off and shit...that’s what it felt like.”

I try to interject with a question but he beats me to the chase. “That was...I could feel it all night. Actually the first act was okay, and then in the second act, or part two or whatever, I just became restless.”

“What do you mean by restless?”

“Well restless is a bad word for it, because it sounds like it’s no big deal, like ‘sit the fuck still.’ But I told my wife later, ‘God, that was unbearable for me’ and she was like ‘Yeah, what was your problem, you couldn’t sit still.’ And I couldn’t. All I could think about was breaking apart, like I was in withdrawal or something, and I’m sitting there,” he breaks seamlessly into character, mocking himself “‘well I can’t move now I just moved, people are going to look at me like ‘what the fuck, why won’t that guy sit still?’ I just wanted to break out of my suit. I wanted...You know what?” He paused for what seemed like a long time and smiled, shaking his head.

“I realize this just now talking to you, but I realize why I rock.” He nods his head, “I rock because I feel like my body is always going in a million different directions, and I need to move. When I rock I feel like I’m moving, I hate being still...you know? I hate being still.”

Here we have the three aforementioned elements of body-rocking with respect to hyperactivity:

1. Compulsion/impulsion

First, it’s a compulsion or impulsion. “Because I can’t stop. I can’t *not* rock.” It is something that seems to originate not from volition, but something prior to volition that tests the limits and solvency of volition. But what is so compelling about rocking? If we take rocking to be

a response to understimulation, which as his story about feeling trapped in the theater might suggest (an interesting venue given he himself felt on display), then how might rocking allow one to cope with this understimulation? To answer this question, we need to think about rocking not simply as an activity but as a causal process.

Body-rocking is considered a form of self-stimulation because it stimulates the vestibular system. Vestibular stimulation initiated through rhythmic motions like rocking and swaying has been used not only to soothe crying infants, but also to treat stereotypic movement disorders (Pederson and Vrugt 1973; Sandler and Coren 1981; Lower 2000; Bonadonna 1981; Esther Thelen and Donna Fisher Thompson 2009). Body rocking and hyperactivity can be conceptualized in a purely functional way. On the one hand, there is the “problem” of understimulation which, as you’ll remember, is theorized through a model of neurological deficit. In particular, “people with ADHD” (remember that I always employ that phrase here with full knowledge of the way it tautologically connects the truth of the disorder with its symptoms), are thought to have deficiencies in brain systems associated with reward, motivation, and arousal. This is why, it is believed, people with ADHD respond well to psychostimulants, which increase levels of dopamine and norepinephrine in the brain. On the other hand, there is the “solution” that links repetitive rhythmical movements with neurological “gratification.” But what are the details of how this solution might unfold?

Body-rocking can take several forms but generally involves a repetitive rhythmic action whereby the trunk of the body acts as a lever or motion arm, usually by it being bounced off the back of a chair, or cushion, which is used like a spring. This action in turn causes a linear motion of the head forwards and backwards, or more precisely, parallel to the Sagittal plane and perpendicular to the Coronal plane. This motion in turn causes the fluid in the anterior and posterior semi-circular canals—which form part of the vestibular labyrinth of the inner ear—to slosh around. At the base of the semi-circle canals are ampullae, as well as two organs called the utricle and saccule, all of which contain hair cells embedded in a gelatinous membrane which is itself covered by a fibrous structure composed of calcium carbonate crystals. This structure, the Otoconia, is heavier than the membrane and fluids surrounding it and thus conserves more momentum during the forward and backward movement of the rocking motion. The displacement of this structure relative to the base of the membrane causes a distortion of the membrane itself, which displaces the hair bundles embedded in the membrane. These bundles consist of anywhere from a few dozen to a few hundred stereocilia, and one kinocilium (which is the tallest structure of the hair bundle). Movement of the stereocilia toward the kinocilium causes potassium channels to open, thus depolarizing the hair cell and causing the release of neurotransmitters (particularly glutamate and acetylcholine). Movement in the opposite direction closes the channels and hyperpolarizes the hair cell (Purves 2008:315-333). Although a number of neurotransmitters are involved in this process, it seems likely that of particular importance is acetylcholine, which connects with cholinergic receptors in the brain that in turn induce the release of dopamine, which produces feelings of pleasure and satisfaction (Horii et al. 1994).²²

Although I have outlined how body-rocking can be thought of as self-stimulation through vestibular stimulation, the specific details of this process are not so essential in themselves for thinking about body-rocking’s relationship to time. One could conceivably

²² It is worth noting that nicotine activates cholinergic receptors by “mimicking” acetylcholine and as such I find interesting the way Eric’s story invokes the affect of withdrawal.

make the same point while drawing a box around the details, so long as there is an “input,” labeled “understimulation,” and an “output,” labeled “stimulation.” At the same time, in attending to vestibular stimulation in its specificity, I hope to convey the extent to which anthropology can *think with* neuropsychology, by conceptualizing hyperactivity and impulsivity as a series of events in themselves, beyond their popular representation as socially marked symptoms. Thus rather than trying to reduce rocking to its neurochemical effects as its fundamental truth, I would like to orient the reader to the idea that hyperactivity and impulsivity do not begin and end in bodies themselves but are processes that link bodily states, outward behaviors, styles of consumption, etc. This is a point that I return to in the next section of the paper.

2. Time and Consumption

Secondly, activities like body rocking hold a special relationship to time: “I can’t tell you how much time I waste doing *this*...” Here body-rocking *consumes* time; and for some, like Andrew, hours of a day. I want to work through the idiom of consumption because I think it nicely captures the way self-stimulatory behavior is conceived through a social time marked by relations of value. I found in my fieldwork that wasted time became a progressive burden in the form of accumulated debt. This was particularly evident in a study I was involved in during the writing phase of the dissertation, which focused on ADHD in the elderly (people over the age of 60 who had been diagnosed with ADHD). Many informants felt that the symptoms of ADHD had a significant impact on their financial lives, and many felt unable to retire because of a lifetime of being in debt. Perhaps this is because in contemporary American capitalism, time assumes value, not only as a venue to create value, but also as something that always has the potential to become value itself: time as a commodity. But how is this so? Three ways of thinking the relationship between time, value, and consumption seem relevant here: Time-Discipline in Industrial Capitalism, Disciplinary Time, and finally Postmodern Time.

The social historian, E.P. Thompson, traces the emergence of this configuration in his now classic analysis “Time, Work-Discipline, and Industrial Capitalism.” Thompson highlights an important shift in the relationship between time and labor taking place by the eighteenth century in industrial Europe. In agricultural systems of production, labor is task-oriented, and there is less of a distinction made between “work” and “life” (Thompson 1967:60). With the rise of industrial capitalism, there was a shift from task-orientation to timed labor. “Those who are employed” in this system, Thompson argues, “experience a distinction between their employer’s time and their ‘own’ time. And the employer must *use* the time of his labor, and see it is not wasted: not the task but the value of time when reduced to money is dominant. Time is now currency: it is not passed but spent” (Thompson 1967:61). Here he draws upon Henri Lefebvre’s observation that agricultural societies follow cyclical time and industrial time emphasizes linear time (Thompson 1967:60, 15n). As a social historian, par excellence, Thompson locates the emergence of what he calls “time-discipline” within the context of systems of labor in the seventeenth through nineteenth century Great Britain. Therefore, the “synchronization of labor” corresponds not only to the advent of relatively affordable time-pieces like the pocket watch, but more broadly to the creative effects of “large-scale machine powered industry” (Thompson 1967:71).

In *Discipline and Punish* Michel Foucault takes up the relationship between time and productivity in early Industrial Europe but recasts it not as a product of Capitalism or industry per se, but rather as part of a new “general formula” of discipline that he sees

emerging by the seventeenth century—and that becomes fully visible in and by the eighteenth century. In “the body of the condemned,” which serves as the introduction to his text, Foucault recounts, with grizzly detail, the public torture and execution of the regicide Dameins, in Paris, 1757. Here the exercise of the right to decide life and death is a reminder of the sovereign’s power. It is both spectacular and excessive, but it is also discontinuous. By this time though, a new mode of power—what Foucault calls “disciplinary power”—was already emerging. To help illustrate this point, Foucault contrasts the body of the condemned with that of the soldier or student. Whereas through torture power is exercised discontinuously, excessively, and publicly, disciplinary power operates continuously and quietly through a “microphysics” of power that targets the body in both its individuality and its multiplicity as the “social body” (these two “bodies” correspond to the two poles of what Foucault would later, in his first volume of *The History of Sexuality*, call “biopower”) (Foucault 1990).

In particular, Foucault shows how the time table, an “old inheritance” from monastic life, takes on new functions in the schools and factories of seventeenth century France. He argues that the refinements became more exacting as the time table was applied to the demands of wage labor (Foucault 1977:150). One of the central purposes of the time table was to ensure a “totally useful time”: “Time measured and paid must also be a time without impurities of defects; a time of good quality, throughout which the body is constantly applied to its exercise” (Foucault 1977:150-151). By closely articulating gestures of the body with time—as in military drills and exercises, for example—discipline defines an “anatomy-chronological schema of behavior” wherein “time penetrates the body” (Foucault 1977:152). One of the central features that distinguishes the function of the time table in this new disciplinary regime is time’s “exhaustive use” (Foucault 1977:154). Whereas traditionally the principle of the time table was “essentially negative”—meaning it was a technology used to avoid wasting time through idle behavior—the new principle of the time table is positive; “it is a question of extracting, from time, ever more available moments and, from each moment, ever more useful forces” (Foucault 1977:154). By positing the organic body “the seat of duration,” by dividing this duration into ever smaller durations—a process he calls the “seriation” of time—and by making the body accountable to these durations through exercise and examination, power comes to be “articulated onto time” itself (Foucault 1977:160). Thus in sum, discipline becomes not only “an art of distributing bodies,” but also a way of “extracting time from them and accumulating it” (Foucault 1977:164).²³

As Paul Rabinow has noted, Foucault’s “history of the present” extends only until the nineteenth century and, although this history is used as a diagnostic of contemporary problems, we should be careful in assuming that these historical conditions remain with us today (Rabinow 2003:107-108). Therefore, while—as I argue throughout this dissertation, especially in chapters three and four—discipline as a modality of power remains evident in the way ADHD as a technology links together in its operation the domains of school, home, and clinic, the neuropsychology of ADHD introduces not only time but a new temporality into the thinking of ADHD. This new temporality—of the “now” or of the “moment”—has raised questions, many of them alarmist, about the relationship between ADHD and the temporalities of contemporary consumption, or more broadly, postmodern time

²³ Though Foucault also argues that discipline goes beyond this principle and more broadly becomes a way “of composing forces in order to obtain” what he calls “an efficient machine” (Foucault 1977:164).

(Degrandpre 2000). In particular, one question that remains open, is what is the relationship, if any, between consumption of media in an age of postmodernity and the symptoms of ADHD?

“Doesn’t [television/video-games/hip-hop...insert some aspect of contemporary life] cause ADHD?” I was frequently asked, particularly by baby-boomers and the generations before them. I came to recognize the question as a rhetorical one. When I responded, as I usually did, that it was an interesting idea but that I didn’t know of any research that suggested a causal link one way or another, my caution was usually met with skepticism. “I’ve heard that MTV has changed the way we watch TV,” one fifty-something businessman told me at a cruising altitude of 35,000 feet, suggesting, sincerely and without any arrogance, that maybe I should check into it. “Everything’s faster now,” he continued, “and if you don’t like what’s on one channel you can just switch over to the next.” “Now even the news is that way, we don’t have news anymore, just a bunch of soundbites and ‘infotainment.’” After all, he reasoned, “hasn’t the whole world become hyperactive?” Maybe. But later, on my way back from the rear lavatory, I pressed through rows of bored and under-oxygenated passengers, with one-hundred television screens each blinking in its own distracted language, and I realized I couldn’t really say “no.”

But what would it mean that the whole world has become hyperactive besides the vague idea that the world is somehow “faster” today. David Harvey, who thinks claims about the hyperreality of postmodernity are “exaggerated” nevertheless urges us to take seriously the idea that the transition from Fordist to post-Fordist production and the rise of flexible accumulation has brought with it a perceptive compression of time and space. Not only has modern telecommunications and aviation made the globe perceptively smaller, but “new technologies of electronic control” along with vertical disintegration of the means of production led to an acceleration of production itself (Harvey 1989:284). This in turn has accelerated exchange and consumption. “Improved systems of communication and information flow, coupled with rationalization in techniques of distribution (packaging, inventory control, containerization, market feed-back, etc.), made it possible to circulate commodities through the market system with greater speed”; now “twenty-four hours is a long time” (Harvey 1989:285). The result, he argues, borrowing a phrase from Alvin Toffler, is a “‘throwaway’ society” that operates on the logic of “instantaneity” and “disposability” (Harvey 1989:286).

I want to avoid the seduction of attempting to characterize the “essence” of our age (though I’m certainly not suggesting that Thompson, Foucault, or Harvey are doing this), especially because, as I noted from the outset, I consider this dissertation to be an attempt to think hyperactivity in itself without mooring it to the “context” of some fundamental ground or horizon of intelligibility like “culture,” “political economy,” or even the “suffering body,” as we might think of it in medical anthropology. But even without making epochal claims it seems at the very least reasonable to suggest that with Capitalism, late or otherwise, time becomes marked by relations of production and consumption. If Max Weber was correct in showing how the logic of production and accumulation mapped onto the logic of salvation in Protestantism, then we might suggest that impulsivity, which as you’ll remember is “without consideration of future consequences,” works blindly in the other direction through expenditure and consumption (Weber 2001). As the rich literature on consumption from Marx to Harvey indicates, we tend to think of consumption as driven by systems of production and exchange. But Andrew-rocking challenges us to consider consumption as something in itself; something that, on the one hand, is embedded within these systems (Andrew’s iPod is playing music downloaded from iTunes, for example), but

that, on the other, is something that has the capacity to exceed production and exchange. But how can we think consumption in this way?

3. Sovereignty and Becoming the Moment

In his three volumes of *The Accursed Share*, though particularly in his first, George Bataille attempts a new reading of consumption through the concept of the “accursed share” (Bataille 1991b). For Bataille, the accursed share is the remainder and excess inherent in *all life*, and this remainder becomes expenditure and waste when it crosses the limits and thresholds that life sets for itself. One of Bataille’s main contributions here is to think consumption and expenditure as problems of a “generalized economy” rather than simply Capitalism per se. He appeals, in a very French way, to the notion of potlatch in primitive society as an example of unproductive expenditure, and argues this idea of excess haunts even productive consumption of twentieth century capitalism, as can be seen in the notion of “luxury.”

Is self-stimulation consumption? And if so, what kind of consumption is it? To answer this question requires us to, like Bataille, develop consumption as a concept beyond its fixed everyday meanings, and in this case anthropological meanings, which reduce consumption to an essentially economic, political, and social activity. Consumption comes from the Latin *consumere*, which carries most of the same meanings as the English verb “to consume,” namely to destroy, to kill, to use up, to waste, squander, or spend. But I would also like to suggest another way we might think of consumption, which derives from its Latin etymology *con+sumere*; namely, “to take or appropriate *entirely* as one’s own.”²⁴ It is in this sense that consumption best captures what Andrew is doing when he is rocking and listening to music: By immersing himself, impulsively, into a world he himself controls, he is taking time, and at least momentarily, making it entirely his own.

This definition of consumption pushes us toward what Bataille called “sovereignty.” Sovereignty, Bataille argues, is “Life *beyond utility*.” “What is sovereign in fact is to enjoy the present time without having anything else in view but the present time” (Bataille 1991a:198-199). This is what Barkley means when he suggests to parents, that if they want to understand, connect, and even control their hyperactive children, they need to “become part of that moment” (Barkley 2000:146). This is how we might best understand the relationship between ADHD postmodern consumption. We should not assume we can draw a straight line between consumption of frenetic media and the symptoms of ADHD (though we cannot rule out this kind of causal relationship). Rather, I would contend that what rituals of self-stimulation and consumption of contemporary media share with impulsivity and hyperactivity is an affective regime of, what we might call following Barkley, “becoming the moment.” It is the opposite of the “servile” relationship to productive consumption that puts “duration first,” and employs “the *present time* for the sake of the future”(Bataille 1991a:198).

In thinking about the relationship between ADHD and volition, Barkley echoes this point, recasting Freud’s distinction between the pleasure principle and reality principle as a problem of time: “As any self-respecting, self-regulating adult comes to realize with age, we progressively become a slave to time. The controller of our decisions, the determiner of the object of self-regulation is time” (Barkley 1997:205). This is why, he argues, time is “a burden to bear.” Andrew’s story, “THE GREAT ESCAPE,” and Eric’s experience at the theater both point to a desire to “break out” of time, to escape it by going elsewhere,

²⁴ As consulted in the *Oxford English Dictionary*, and Chambers and Murray *Latin-English Dictionary*.

whether it be the “other side of the universe,” or out of one’s own suffering body. Eric’s story, in particular, shows how the oppressive weight of time is never “empty,” but rather manifests itself in the symptomology of “withdrawal.” One sixteen year-old I talked to echoed this point when she put it this way: “Spanish class after lunch is unbearable. The other day I forget my medicine, and I wanted to die...I couldn’t hear anything the teacher was saying...but I could actually hear the clock ticking.” Death here is hyperbolic but, again it underscores the ways that time is felt a presence that penetrates the physical body through the symptoms of restlessness. In these kinds of understimulating situations rituals of self-stimulation, often coupled with a second activity like watching television, playing video games, but overwhelmingly, listening to music, provide “the *miraculous* sensation of having the world at [one’s] disposal,” even if just for “a brief moment” (Bataille 1991a:199). Furthermore, like impulsivity, although we are conscious of it, the sovereign moment “remains outside, short of or beyond, all knowledge”(Bataille 1991a:202).

Consumption as sovereignty, though, remains transitive as both a word and as a concept. In other words, it requires time to be an object that is separate from subjects that use it. In the last section of this chapter, using insights from Deleuze and Guattari and Alfred North Whitehead as well as ethnographic material on video games, music, and the American suburb, I explore how we might break impulsivity and hyperactivity from this perspective by attending to them in their pure effectuality. Toward this end, I develop a concept of architecture to how show the aforementioned elements of neurological deficit, self-stimulation, and consumption of electronic media link together in their operation to create a vibrant world extended in space, and also how we can think this architecture in its intension, as a multiplicity of events in time. Doing so allows us, I argue, to appreciate how impulsivity and hyperactivity are themselves vital creative elements that operate well beyond what we think of as ADHD.

Egocasting

We are living in a world, argues Christine Rosen, “where we exercise an unparalleled degree of control over what we watch and what we hear”; “a world where the individual’s control over the content, style, and timing of what he consumes is nearly absolute” (Rosen 2005:67, 51). Or in other words, we are living in what she calls (and what surely has to be one of the more ingenious phrases of our time), “The Age of Egocasting.” For Rosen, egocasting, “the thoroughly personalized and extremely narrow pursuit of one’s personal taste,” is not simply an activity that we engage in, but rather a social and technical milieu; a persistent situation that we find ourselves in that is as objective as the weather (Rosen 2005:52). Rosen’s article on the subject, aptly titled “The Age of Egocasting,” consists of two basic arguments. First, that this new age is made possible by the advent of new technologies like TiVo and the iPod, which like the Walkman and remote control before them, have encouraged a new level of “selective avoidance,” and secondly, that by allowing us to remain in bubbles of entertainment that we ourselves create, these technologies shelter us from the difficult but necessary emotional and social labor of interacting with other human beings and challenging ourselves with ideas, styles of thinking, and aesthetic programs that we might not otherwise agree with.

Though highly suggestive and engaging, neither argument is particularly novel in itself, and indeed, in typical journalistic fashion, Rosen generously allows others to make these points for her. But, in its own way, Rosen’s article is truly unique and in my mind is interesting for at least two reasons. First, it nicely illustrates the ways that critiques of new media technologies tend to treat choice as both an exciting possibility and a potential

problem. In stressing the ego of egocasting, Rosen presumes already a very specific kind of subject, what we might call, for lack of a better term, a neoliberal subject—it maximizes its benefits, and to the extent that it does so in the name of free choice and market reason, it makes excuses to no one. The result of all this choice, she argues, is that we have become “pod people” (referring to the “pod” in iPod). “Those people with white wires dangling from their ears might be enjoying their unique life soundtrack, but they are also practicing ‘absent presence’ in public spaces, paying little or no attention to the world immediately around them” (Rosen 2005:66).²⁵ A second result of this is choice is that egocasters have become what Rosen calls “shallow critics.” On the one hand, the logic of choice has led to a new critical attitude toward entertainment, and yet, on the other, because technologies of personalization have isolated listeners and viewers from challenging ideas, today’s techno-citizens lack the perspective and faculties of aesthetic judgment to be able to criticize popular art on its own grounds. The main thrust of her argument here comes explicitly from Theodor Adorno’s aesthetic theories, especially on music, which make the distinction between art and artificiality, and art and entertainment. “The convenience of iPod and its ability to facilitate easy listening is undeniable; but we should not let its convenience discourage us from seeking the distinct pleasure of hearing music made, not merely replayed. And we should be careful that our desire for convenient music does not make all music simply convenient” (Rosen 2005:67). Rosen also draws perceptively on Walter Benjamin’s essay “The Work of Art in the Age of Mechanical Reproduction,” in order to trace the emergence of a new kind relationship between art, its technical production, and mass consumption. In doing so she pushes Benjamin’s insights beyond their confines to consider what they might mean for artistic criticism in a world where entertainment is “on demand,” as the slogan has it (one can almost hear Adorno dismissively highlighting the phrase in English).²⁶

In some ways Andrew’s media consumption is Adorno’s worst nightmare and nicely captures Rosen’s notion of egocasting as both choice and escapism. During the time of my fieldwork Andrew was obsessed with Beethoven’s ninth symphony, which it must be said, is a mature thing for a nine year old to be listening to. I asked him once why he liked Beethoven so much. “Because he was a genius,” he said. But, as Adorno might have feared, Andrew listened to the Ninth like one might listen to popular music. First, he didn’t listen to the whole symphony, just the fourth movement, which he downloaded from the Internet after he learned about “Ode to Joy”—the chorus in fourth movement of the symphony that is arguably the most recognizable piece of music in the world—in his music class. Secondly, he would listen to the Ninth like a song, often singing along while rocking.

²⁵ Here, Rosen seems to be echoing Richard Sennett who makes a similar point three decades earlier in his book *The Fall of Public Man*, which has become something of a minor classic in political theory (Sennett 1992). Ten years ago, Harvard Sociologist Robert Putnam generated considerable attention when he suggested in his book, *Bowling Alone*, that civic engagement in America was in decline, as was evident in the decreased attendance at civic organizations like the Kiwanis Club or Girl Scouts. Even though more people were bowling than ever, they were increasingly bowling alone. While his data did suggest that participation in civic organizations has steadily declined for the past several decades, many of Putnam’s critics took him to task for failing to take the internet seriously as a legitimate space where new forms of sociality were taking the place of face to face interactions (Putnam 2001).

²⁶ That Rosen would draw upon the likes of Adorno and Benjamin is all the more remarkable given that her piece appeared in *The New Atlantis*, a journal that has acquired something of a reputation for neo-conservative social criticism (Leon Kass and William Kristol are among its contributors).

Third, he would repeat it over and over, as a kind of instant gratification (he needed only press the left side of the flywheel on his iPod). And, fourth, as I mentioned earlier, he would do this for long stretches at a time, thus cutting into time he could presumably use to interact with friends. And yet, for all the time Andrew spent rocking, he was definitely outgoing, and seemed to have many friends. He also participated activities like Karate, which his parents thought helped him with concentration and discipline.

It remains to be seen whether the proliferation of technologies of personalization is leading, or will lead, to the kind of isolation and social fragmentation, or degradation of art that Rosen foresees. Not surprisingly, Rosen anticipates this point, noting that “[q]uestions about the erosion of cultural standards inevitably prompt charges that the critics are unduly pessimistic or merely hectoring” (Rosen 2005:68). But I’ve highlighted Rosen’s essay because on the one hand, it shows how questions about the subject and technology have been framed in popular journalism as also having social, ethical, and political implications worth more carefully considering. And, on the other, by conceptualizing the relationship between the subject and new technologies as one of personalization, choice, and egocasting, Rosen’s essay underscores the ways that contemporary thinking about machines and human life tends to reassert the primacy of the human over and against the machine (although the margin of difference is appreciated as growing smaller).

This is hardly surprising given that conventional wisdom insists that humans—as both natural bodies and moral beings—are different from the material elements that make up an increasingly technologized life. Cell phones, computers, video games, iPods are things used to augment human life but they don’t constitute this life, the logic goes. This attitude is perhaps most visible in television and film, which taken as a whole, paints an ambivalent picture of machinery becoming intelligent: from the ambiguously-limbic HAL-9000 computer in Stanley Kubrick’s *2001: A Space Odyssey*, “I’m sorry Dave, this conversation can serve no further purpose,” to KITT’s somewhere-between-matter-of-fact-and-emotive exclamations in *Knight Rider*, “Michael, you’ll never believe what I’m picking up on the scanner.” The presumed relationship between human and computer, HAL’s meltdown aside, is still told through the dominant frame of mastery and dependence. But even as—or perhaps more appropriately, precisely when—technologies like iPhones are increasingly seen as becoming part of human subjectivity and sociality, recent theorizing in post-Deleuzian circles has challenged the linear models of “prosthetic coupling,” and cyborg futures that haunt popular, literary, and academic imaginaries (Massumi 2002; S.Rai 2009; Colebrook 2010; Bonta and Protevi 2004; DeLanda 2005). In particular, there has been a turn toward both the concept of affect as well as a growing fascination with scientific fields like dynamical systems theory, in the hopes these new areas of focus will provide vocabularies and frameworks for thinking the relationship between the human figure and its technologies differently.

Machine Life

I remember the first time I saw a Nintendo Entertainment System: it was in Matt Williams’ basement in 1987, and it seemed that with over thirty levels we would never get tired of Super Mario Bros. Then one day, we watched in astonishment as our friend Eric’s older, and more dexterous, brother beat the last level by throwing the switch on the drawbridge and sending Bowser into a pixelated sea of lava. Twenty years later I’m with Sebastian, who’s fourteen and walking me through *Halo 3*, a popular “first-person shooter” based on the premise of an interstellar war hundreds of years in the future. Our squadron mission begins as we snake our way through a ravine on a lush earthlike planet almost Technicolor

in its fantasy. But as fighting erupts I quickly lose myself in the complexity of the game play. I don't last very long before my half of the screen turns red from blood.

"Don't worry, you have another life; I'll cover you." Sebastian tells me.

Being raised without videogames, and being predisposed to follow the older model of play—"shoot anything that moves"—I unleash a flurry of bullets at the next thing that ambles into my simulated field of vision.

"Um, you're shooting me now," Sebastian announces calmly.

"You're kidding me. Was Halo 2 or 1 this complicated?"

My sense of out-of-placeness in response to the speed and complexity of play convinces me, at least momentarily, in the truth of glib pronouncements that generations are accelerating apart. But at this distance, and from this perspective, I can see Halo 3 as a kind of glorified Continuous Performance Task. Like the TOVA, its setup requires the subject to discriminate between targets and non-targets within a time-sensitive environment by pressing a button or series of buttons on something like a microswitch. And like the second half of the TOVA—the "target frequent" half—it operates on the logic of overstimulation. I'm overwhelmed, but Sebastian is completely engrossed. Whereas the TOVA prides itself on boredom, Halo 3 is a continuous unfolding of digital stimuli. There's fantasy and violence. Even the controller provides kinesthetic stimulation as it vibrates to simulate the recoil of machine-gun fire. When we started playing there was enough late evening sun that we didn't think to turn on a lamp. Now when I look over at Sebastian he is bathed in a blue-grey light from the television. His face is completely expressionless but you can see the movement of a video dream reflected against the lenses of his glasses. I am beginning to realize we spend our lives as a kind of circuit.

In her article, "Video Poker," Natasha Schüll asks "[w]hat about being a self today do compulsive gamblers wish to escape, and how do slot machines become places of refuge" (Schüll 2008:156)? It is clear that Schüll's informants became attracted to digital gambling for many different reasons, but she outlines four main modes or "forms" of escape: "escape from bodily existence; escape from social exchange; escape from monetary value; escape from chronological time" (Schüll 2008:156). But once addicted—the medicalized vocabulary seems appropriate here (her informants are sampled from Gambler's Anonymous)—their relationship to the machines become singular. Schüll calls this relationship "machine life"; a term she borrows from an informant. This term nicely captures the gambler's predicament in at least two ways. First, since these machines cost two resources—time and money—gamblers lives become increasingly organized around getting back to the machines to gamble and finding the money to do it. They schedule their work, family, social, and even bodily schedules, around gambling, and every aspect of their lives becomes measured in either time or money. Thus the logic and operation of the machines comes to structure their lives almost entirely. Secondly, once in the zone, gambling becomes absolutely effortless, and the psychological line between the self and the machine becomes not only blurred but, in some extreme cases, erased altogether. Some gamblers, for example, will unknowingly vomit or urinate on themselves, and others dress appropriately because they know they will do so. As one of Schüll's informants succinctly describes it, "it's like playing against yourself—you are the machine; the machine is you" (Schüll 2008:159).

Schüll's article provides a useful framework to work through and with when attending to the use of electronic media like iPod and video games. It would be a stretch to compare Sebastian to a compulsive gambler, although video-game dependency is now achieving a similar status to compulsive gambling in self-help and therapy, and compulsive "gamers"

are often prescribed similar drugs as those struggling with gambling (mainly selective serotonin reuptake inhibitors). In 2007, partly in response to public efforts by recovering addicts and other advocates, the American Psychiatric Association even briefly considered including “video game addiction” to the DSM-V, though it soon dropped the idea citing the need for further research (Science Daily 2007). Setting aside medicalized identities, both compulsive gamblers and compulsive video game players (or for that matter internet users) represent one extreme limit of a potential latent in activities that many Americans with access to such technologies engage in: *becoming the moment*.

Perhaps the most striking example of this I came across was a teenage girl, Ashley, who lived through her cell phone. Between 2008 to 2009 during the time of my fieldwork, the use of Short Message Service technology (SMS)—referred to more frequently as “text messaging”—seemed to explode. According to data published by the Cellular Telecommunications Industry Association, by 2009, there were almost 286 million wireless subscriber connections, which represented a “wireless penetration” of 91 percent of the United States population. In 2005, Americans sent a total of total 9.8 billion text messages every month. In less than five years, that number had increased by more than an order of magnitude to over 150 billion text messages a month.²⁷ Text messages, sent mainly from cell phones, are generally 160 characters in length and can be sent relatively cheaply, which explains why SMS had a thriving life in Europe and Asia—where it cost less to send an SMS message than it did to place a regular phone call—before it caught on in the United States. Most of my teen informants were on unlimited texting plans, meaning that, for a flat fee in the tens of dollars a month, they could send unlimited text messages. Ashley would send dozens of messages a day and talk on the phone when she wasn’t sending messages. One month she ran up a cell-phone bill of over one-thousand dollars because she had accrued “overage” charges when she used up all of her allotted minutes for that month. Her parents paid the bill but were flabbergasted when, two months later, she managed to go over her limit again by several hundred dollars. After that, the phone became a privilege tied to an incentive system, rather than a right.

Recently, anthropologist Tanya Luhmann, conducted a survey of 200 undergraduates at Stanford who owned and used an iPhone (Macintosh’s widely popular version of a “smartphone” that includes wireless telephone, internet, and multimedia capabilities). According to the results of the survey, almost one quarter reported that their phone felt like an “extension of [their] brain or body,” and 75 percent reported falling asleep at least once with the device (Carey 2010).²⁸ Even U.S. President Barack Obama has received press coverage for use of his BlackBerry smartphone, which he often keeps clipped to his belt in a leather holster. “For years, like legions of other professionals, Mr. Obama has been all but addicted to his BlackBerry.” *The New York Times* reported shortly after Obama was elected President in November 2008. “The device has rarely been far from his side—on most days, it was fastened to his belt—to provide a singular conduit to the outside world as the bubble around him grew tighter and tighter throughout his campaign” (Zeleny 2008).²⁹ Not surprisingly, *The New York Times* article emphasizes the BlackBerry as a social tool; something that humans like the President can use to connect

²⁷ <http://www.ctia.org/advocacy/research/index.cfm/AID/10323> (accessed May 2010).

²⁸ See also, <https://www.stanford.edu/dept/anthropology/cgi-bin/web/> (accessed May 2010).

²⁹ Although, as the *Times* reported, there was good indication to believe the President would be forced to give up his phone for security reasons once he assumed office, he still wears his BlackBerry on his belt over a year later.

with other humans, even as the world becomes increasingly fragmented. Whereas Rosen sees these technologies as trapping us within bubbles, *The New York Times* sees these technologies as a way to escape them. But I would like to set aside the question of sociality, which, while no doubt a rich topic for anthropological investigation, moves us away from the point I am trying to make here in this chapter about hyperactivity, consumption, and time.

What struck me in my interactions with Ashley, who had been diagnosed with ADHD around age eight and then bipolar disorder around age sixteen, was how the cell-phone had become not so much a convenience, accessory, or even extension, but really an *investment*. Even in our interviews, the phone was a central presence. Between or during responses she would glance down at her phone if it was on the table, or pull it out of her pocket. Sometimes she would keep it in her hand. She would check her phone even when it didn't vibrate to indicate she had received a call or message, as if just to check. She was a classic example of the cruel effectiveness of intermittent reinforcement: in cages at B.F. Skinner's laboratories at Harvard, pigeons would peck a switch to get a food pellet but, following protocol, would only receive them at irregular intervals. But this didn't stop the pigeons from pecking until they sometimes damaged their beaks. In these acts of investment, Ashley's life was becoming, like Sebastian's life (when he's totally engrossed in Halo 3), and like Schüll's informant's life, "machine life."

A New Architecture

Over the past three decades, neuroimaging technologies have helped usher in a new era of brain sciences that have moved from conceptualizing the brain as a structure to conceptualizing it in terms of functions.³⁰ In particular, neuro-plasticity, the idea that the brain is a pliable organ that makes and remakes itself through the remapping of neural networks in adaptive response to learning and experience, has replaced more static models of the brain.³¹ Keeping up with these changes, the of field neurophilosophy—which is partly informed by but not identical to older philosophies of mind—has emerged as one way of taking seriously the ontological and metaphysical demands that these shifts in the brain sciences entail. One area that has attracted recent attention is the problem of "extended cognition." At stake in this theory is whether the brain as an organism is a bounded entity that, although coupled with environment, receives input from the environment to function as a relatively closed system, or whether cognition exceeds the "brain" proper, forming one complex system. In his recent book, *Supersizing the Mind*, for example, Andy Clark takes this later view proposing a model of cognition in which the mind is not simply in the brain itself but also extends into the world, making the mind a series of extended loops that connect and reconnect milieus, like brains, with actions and objects "out there" in the world (Andy Clark 2008). In a similar vein, Anthony Chemero has recently applied insights from non-linear dynamical systems theory coupled with non-representational philosophy to push these ideas of extension to reconcile or solve what he takes to be fundamental problems in the philosophy of mind—an approach he calls "radical embodied cognitive science" (Chemero 2009). These ideas of extending the brain outside its protective space in the body are arguably becoming accepted wisdom, even within the mainstream of the brain sciences where the idea of "brain" has become "a shorthand for all

³⁰ See (Dumit 2003) for an anthropological treatment of these technologies and (Finger 2001) for a longue durée treatment of neuroscience.

³¹ For a philosophical treatment of the concept of plasticity see (Malabou 2008).

of the interdependent interactive processes of a complex dynamical system consisting of the brain, the body, and the outside world" (O'Shea 2003:3).

In her most recent book, *Deleuze and the Meaning of Life*, Clair Colebrook finds this turn toward the brain puzzling, in part because the new approaches in cognitive science and philosophy, like the theories of extended mind that I hinted at above, have the potential shift attention *away* from the brain and cognition rather than toward it. "If it is the case that life is properly understood as relational, distributed, disembodied, dynamic, autopoietic, and only relatively closed" Colebrook asks, "how is it that one specific system—the brain—falls into the illusion of regarding itself as a determining, disembodied, and representing center" (Colebrook 2010:30)? The "affective, vital turn" in these approaches has brought with it also a commitment to the principles of immanence and de-centering; presumably things that Deleuze and Guattari (for whom she is an important interlocutor) valued in their philosophies. But Colebrook sees an important distinction between the work of Deleuze and that of contemporary philosophies of mind and cognition; a distinction that she characterizes as the difference between "active" and "passive" vitalism. Active vitalism is pragmatic, and asserts the primacy of a subject "that infuses and lives through matter" (Clark's extended mind is a good example) As such, the focus is on autopoiesis: how does a system create itself and maintain its boundaries as a stable or semi-stable form? In contrast, Deleuze and Guattari's vitalism is passive and radically essentialist (surely, at first glance, the last two adjectives one would ever think to apply to a Deleuzo-Guattarian philosophy). It is passive, she argues, because their vitalism does not attend to the maintenance of life of an organism (as a self-organized system), and it is radically essentialist because paradoxically, in reversing Platonism, as Deleuze famously seeks to do in *The Logic of Sense*, this vitalism pushes Platonism to its logical extreme. For Deleuze, "what Plato uncovered were pure potentials or powers of individuation that could not be reduced to what can be known, lived, represented or contested within the already actualized range of possibilities" (Colebrook 2010:34). Thus, in creating and using concepts, Deleuze and Guattari's passive vitalism seeks to go beyond the limits of actual systems to appreciate the potential of life beyond our given experience or its actual forms.

These two kinds of vitalism nicely frame what I mean by an architecture of experience. In invoking the concept of *architecture* I am drawing upon a more obscure definition of the term which refers to "the action or process of building" rather than a building or structure itself. In other words, architecture, as I am using the term here, is an *activity* that expresses a form or set of relations. It is something that happens over time, which is why it is a useful concept for thinking the relationship between hyperactivity, consumption, and time. By *experience*, I mean the immanent realm of pure effectuality in and through which all life is effected. This concept no doubt differs fundamentally from experience as it is usually understood in anthropology where experience is something that one person or group has and that it shares with the anthropologist who must then represent this experience in writing.³² For Deleuze, experience is impersonal: there are not

³² The appeal to experience is seen as somewhat naïve today. And one criticism of experience is the way it is bracketed and resistant interrogation. The problem with "the evidence of experience as historian Joan Scott sees it, for example, is that it lends itself to a sort of intellectual and moral quietism, through the inhibition of cultural critique. Indeed, "the project of making experience visible precludes analysis of the workings of the system and of its historicity; instead, it reproduces its terms." Such an endeavor, furthermore, "exposes the existence of repressive mechanisms, but not their inner workings or logics; we know that difference exists, but we don't understand it as relationally constituted" (Joan W. Scott 1994:367).

subjects who experience; rather subjects are effected through experience—they are part of experience itself. This is what Alfred North Whitehead means when he says that “drops of experience” “are the final real things of which the world is made up. There is no going behind [them] to find anything more real” (Whitehead 1979:18).³³ Thus, an architecture of experience connotes a process that gives form to experience. The difference between active and passive vitalism, I would argue, corresponds to whether one takes this process of giving form to experience as *activity* (as function), or *hyperactivity* (as beyond function).

Activity as function: there is no better example of this in anthropology than in the work of A.R. Radcliffe-Brown. In his essay “On the Concept of Function in Social Science” Radcliffe-Brown uses the series process: function: structure as an analytic for understanding social life. “The concept of function as here defined thus involves the notion of a *structure* consisting of a *set of relations* amongst *unit entities*, the *continuity* of the structure being maintained by a *life-process* made up of the *activities* of the constituent units” (Radcliffe-Brown 1965:180, emphasis original). In other words, processes (he lists such examples as punishment of a crime or a funeral ceremony), function so as to maintain social structure. Just as important is his assertion that the “total social structure” has a unity that can only be thought of as functional, and that can only be appreciated or apprehended through its functioning: “social morphology cannot be established independently of a social physiology,” as he puts it (Radcliffe-Brown 1965:181). The organic analogy here, of course, comes most notably from Durkheim and it is of central importance, because it shows what function is where one might locate it. To begin with, function is centrally tied to “activity”: “an organ has an *activity* and that activity has a *function*” (Radcliffe-Brown 1965:179, emphasis original). Secondly, he draws on Durkheim’s definition “that the ‘function’ of a social institution is the correspondence between it and the needs of the social organism” (Radcliffe-Brown 1965:178). In his own schema, Radcliffe-Brown substitutes “necessary conditions of existence” for Durkheim’s “needs” but in either case function has a goal or telos, or—in Aristotelian causality—a final cause. Thus function links activity and final causes. Thus, in Radcliffe-Brown’s anthropology function links activity and final causes and has two meanings: 1) a relationship or set of relationships—function expresses the relationship between processes and structure; and 2) activity—function *does* something, its goals are its effects.

Following Radcliffe-Brown, we can either think of Andrew-rocking as a totality, or we can disaggregate Andrew-rocking into a series of functions, inside of which are nested another set of functions, and so on. These material operations settle into what are called “self-organized criticalities”; a term that was developed by physicists Per Bak, Chao Tang, and Kurt Wiesenfeld, to refer to non-linear, dynamic systems (Bak and Paczuski 1995). These self-organized criticalities apply to systems on multiple scales and have been used to describe everything from cosmology to neuroscience (Adami 1995; R. Chialvo 2004). Manuel DeLanda has recently, and very ambitiously, attempted to bring together Deleuzian ontology with these approaches in the physical and natural sciences, but as Colebrook’s distinction between active and passive vitalism makes clear, we don’t really need such an approach here (DeLanda 2005). In such systems, we wouldn’t need goals, or needs per se as much as attractors, which are sets of conditions that a complex system tends to over time. As I stated earlier, the logic of “deficit” which underpins neurological models of

³³ Whitehead here is using drops of experience as a flourish for his concept of “actual entities.” But his point is sincere and strictly consistent with the rest of his schema.

attention deficit hyperactivity disorder, conceives of impulsivity and hyperactivity as a function (or dysfunction) of dopaminergic circuitry in the brain that underlies reward/response systems (Nigg 2006:142-160). This is why people with ADHD, it is thought, have difficulty with delay, and it also helps explain why people like Andrew, Sebastian, and Ashley, gravitate toward technologies in which stimulation is “on demand.” If we think about Andrew rocking we have several components. First, a set of conditions characterized by neurological “deficit”: the brain as a complex system. Secondly, we have stereotyped behavior which itself is autopoietic. As Lovaas, Newsom, and Hickman note in an article on self-stimulation, the “progressive narrowing of topographies to a final, stereotyped form may be viewed as a self-shaping process in the same sense that, at a more complex level, an athlete or musician engages in successively ‘better’ topographies and discards them until achieving a topography that ‘feels right’ or produces the ‘right sound’” (Lovaas et al. 1987:49). And as I outlined earlier, body-rocking produces vestibular stimulation when the body is used as a pendulum, and when the fluid in the inner ear sloshes around exciting microhairs in membranes at the base of the vestibular labyrinth (which in turn open potassium channels that stimulate the release of neurotransmitters like glutamate and acetylcholine). Third, as part of this assemblage, Andrew uses an iPod—a device that stores musical files as binary code on a small hard disk. When he selects an audio track, a program on the processor reads each frame of the mp3 audio file and translates it into electromagnetic waves that travel into the headphones where a wire coil vibrates a plastic cone that creates transverse sound waves, which in turn replicate the sound information collected on the recording. When Andrew listens to music, in this case, Beethoven, the perception of music—if it is sufficiently intense—stimulates areas of the brain, especially the nucleus accumbens and ventral tegmental area, which are rich in opiate receptors (Blood and Zatorre 2001). And so on and so forth. The details here no doubt seem tedious, and I haven’t done them justice insofar as I have presented these systems as the linear unfolding (and they only scratch the surface). But they nevertheless underscore how this architecture can be understood as a series of self-organized systems. The important thing here is that all these activities are immanent to the field of production, and by attending to these processes in their detail, we can understand the relationship between humans and machines, not as two things that come together, but as a series of functions related in their exteriority.

This is one way of thinking this new architecture of experience. The architecture here isn’t a building, but it is an architecture of entropy itself. In other words, what is actual is the way that work must go into open systems and energy expended in order to keep parts of the system in lower entropy. But what does this system have to do with hyperactivity, consumption, and time? Although there could be a longer answer to this, what is at stake in this new architecture is the way that these material flows are *becoming dopaminergic*. Following Clark and Chemero, these dopaminergic pathways are not just part of the brain as a closed organ, but instead operate through more complex pathways like the ipod, cell-phone or video game. What is dopaminergic about these pathways is the way that reward/response systems are increasingly activated through instant, flexible, consumption of electronic media, making life, as it was for Schüll’s informants, “machine life.”_But in Colebrook’s scheme, this is the active vitalism. What would the passive vitalism look like and what kind of architecture does it create?

In *The Monadology*, that understated piece of deductive logic that begins with “The Monad” and ends with “our happiness,” Leibniz, as if echoing Descartes’ charge to understand the mind and thinking mechanically, proposes the following thought

experiment: “Supposing that there were a machine whose structure produced thought, sensation, and perception, we could conceive of it as increased in size with the same proportions until one was able to enter into its interior, as he would into a mill. Now, on going into it he would find only pieces working upon one another, but never would he find anything to explain Perception. It is accordingly in the simple substance, and not in the composite nor in a machine that the Perception is to be sought. Furthermore, there is nothing besides *perceptions and their changes* to be found in the simple substance. And it is in these alone that all the internal activities of the simple substance can consist” (Leibniz 2008, section 17, emphasis added). Descartes ran into the same problem in *The Treatise of Man*. Despite his extremely detailed (for the time anyway) conception of the materiality of thought, he could only push the mechanics of perception, thought, volition so far with the mechanical model (Descartes 2003). One might object at this point, arguing that Leibniz’s model for a thought machine is mechanical whereas the human mind is many orders of magnitude more complex—brains have something like one-hundred billion nerve cells, and subsequently one hundred trillion interconnections. But we shouldn’t get wrapped up on this point because what is actually important in the Leibniz thought experiment is not perception (at least for my purposes here). What if we asked instead, where does one locate *function* in such a machine? The answer of course is strictly, nowhere, at least as we conventionally think of the term because function is *virtual* rather than actual.

One might object that function is not real but rather an outmoded idea like the infamous “ether” of nineteenth century physics. In other words, we don’t really need it, and. Clearly process is visible through change, but isn’t function pure absence? This is a plausible statement. Consider, for example, the following statements by the philosopher Arthur Prior—appearing in a discussion of tensed and un-tensed conceptions of time:

(3) It is now six years since it was the case that I am falling out of a punt

(4) My falling out of a punt has receded six years into the past (Tooley 2006:23).

Prior continues:

But of course (4) is just a paraphrase of (3), and like (3) is not about any objects except me and that punt—there is no real reason to believe in the existence either now or six years ago of a further object called my “my falling out of a punt” (Tooley 2006:24).

Tooley, the author of the article “Metaphysics of Time,” in which Prior’s comments are reprinted, goes on to point out the fallacy of Prior’s reasoning, arguing that even with the existence of Prior and the punt, statement (3) could still be false if Prior didn’t fall out of the punt or didn’t do so six years ago. “But,” Tooley continues, “neither will it help if one adds the existence of both the relation of falling out of, and the relevant moment of time, since what one needs is those four things, properly interrelated: one needs a certain *state of affairs*, the state of affairs that is Prior’s falling out of the punt at the relevant time (Tooley 2006:24). What is actual here is the state of affairs. What is virtual is the *event*.”

Closer attention to the event is critical for my discussion here, not only because it helps explain why falling out of a punt is real, but also because it shoots to the core of what is at stake with “becoming the moment.”³⁴ Drawing inspiration from the Stoics, Deleuze

³⁴ In anthropological writing, which traditionally has sought to emphasize the endurance of phenomenon—usually by recourse to the ethnographic present—events tend to signify “happenings,” and are closely related to episodes. In “Deep Play: Notes on a Balinese Cockfight” for example, Geertz treats the cockfight not as an event but as a reconstructed set of relations that are more or less stable. What was eventful was “the raid” which Geertz and his wife used as both an

defines events as “incorporeal transformations” that hover over the surface of bodies; they are things that haunt the present as pure potentialities.³⁵ Furthermore, unlike the example I outlined above of a system in equilibrium, events are not the causation itself, they are its effects. “The Stoics saw clearly that the event is subject to a double causality, referring on the one hand to mixtures of bodies which are its cause, and on the other, to other events which are its quasi-cause” (Deleuze 1990:94). Because an event is purely an effect, it is not goal-driven; it has no aim.

For our discussion here, the incorporeality of events is important because they allow us to attend to Andrew-rocking, Ashley-texting, and Sebastian-gaming in a different way. Whereas in our previous architecture of organized material flows, activity was strictly causal, in an analysis that foregrounds events, activity becomes virtual and quasi-causal. This is because, as I suggested, Andrew rocking is an event in itself, and like in our previous architecture, we can think of this event as consisting of many other nested events. Andrew-rocking is a convenient abbreviation for other events like fluid-sloshing, hair-depolarizing, bits-decoding, cone vibrating, and so on. Following Deleuze, we can consider the relations between these events to constitute an intensive multiplicity.³⁶ But whereas in the previous architecture of dynamic systems, the function *is* the activity of the system—as a measure of, for example, entropy—in this virtual architecture, function itself has no specific aim but rather links the events of activity themselves together. In this virtual intensive architecture, function is not active, but rather it is *hyperactive* (cf. Colebrook). As I use the term here hyperactivity refers to its literal definition, which comes from the Greek, ὑπέρ-, “over, beyond, above,” and the Latin, *āctīvus*, related to the noun *āctus*: a “driving” or “impulse.” What hyperactivity becomes then, in such a formulation, is unfolding of an intensive architecture of events, each of which corresponds to its own line of becoming. Here the architecture is a form, but rather than being a rigid organization, it is *the relative activity of time itself*. In such an intensive system, Deleuze argues, “[t]ime itself unfolds...instead of things unfolding within it”; it becomes “a pure *order* of time” (Deleuze 1994:88 emphasis original; see also DeLanda 2005:104-135). Thus to recapitulate, we have on the one hand an extensive, entropic, architecture that is becoming dopaminergic, and on the other, an intensive architecture that is becoming hyperactive.

Impulsivity, Egocasting, and “Becoming the Moment”

While esoteric, the anthropological import of Deleuze’s Stoic return lies in the way he locates states of affairs in the depth of bodies and events on the surface of bodies as a series of effects connected through an affective logic of sensation. With this distinction in mind, it is interesting to note how the concept of neurological deficit locates disorder in the depth of the body, within the interior milieu of the brain, and yet the evidence of this deficit,

opportunity to build report and a rhetorical strategy in the writing of ethnography (Geertz 1973). I’ve have used this “event” throughout this dissertation in a similar way to refer to a point of entry into a problem or persistent situation of ADHD today. In our discussion of time here, though, the term “event” takes on a different meaning.

³⁵ In a way, Deleuze’s events share an affinity with Einstein’s events. In his theory of special relativity, Einstein distinguishes between events and observers. Events are absolute spatio-temporal locations, and observers measure events. Observers here needn’t be anthropomorphized, they merely express a relationship with the event.

³⁶ Brian Massumi took this idea further in his study of affect and the concept of diagram, creating a similar concept he calls the “biogram” (Massumi 2002). See the introduction of this dissertation for a further discussion of the concept of intensive and extensive, virtual and actual, etc.

of its effects, are *perceptible only through events or their effects*: as a functional signature of functional magnetic resonance imaging (fMRI), for example, or through ADHD's symptoms which can be conceptualized as events; as the DSM criteria indicate: the subject "often *fidgets* with hands or feet or *squirms* in seat," often "*runs* or *climbs* excessively in situations which it is inappropriate." He or she "talks excessively," "blurts out answers," "interrupts," "intrudes," etc. Even adults may feel the impersonal affect of "restlessness" (American Psychiatric Association 2000). The intransitivity of ADHD's symptoms, I would argue, underscores the way that disordered bodies can already be thought of as a series of effects and becomings. This is precisely what is at stake with Deleuze's invocation of Spinoza's observation that "[w]e do not know what the body can do..." (Deleuze 1988b:17).

It is this capacity to *do* that serves as a rejoinder to Rosen (and more distantly, Adorno). For Rosen, egocasting is by its nature inward looking. Because technologies of self-selection today have allowed an unparalleled degree of control and choice, and because this choice has led to instant gratification, egocasting is erasing the inherent inequality between desire and consumption in two ways. First, the instantaneity of technologies of egocasting means that desire and consumption are potentially coextensive, such that any surplus of desire is quickly satiated by easy and convenient consumption; and secondly, that in this state consumption no longer becomes a fulfilling or rewarding activity but instead mere distraction. Egocasters have become so accustomed to "on demand" entertainment, Rosen argues, that they increasingly trap themselves in ecologies of media they themselves have created.

My ethnographic work with people with ADHD, though, I would argue, troubles Rosen's assumption that consumption-as-egocasting constitutes an ethics and sociality of confinement or disengagement. Eric's desire to break out of his body, expressed through the symptomology of withdrawal, nicely captures a common theme in my fieldwork: namely, that in the absence of stimulation, time makes its presence felt as a penalty that accumulates on the body and that becomes a progressive burden to bear. This is why Eric was content during the first act of the play, but then felt overwhelmed during the second act. Likewise Kristina, the student I mentioned earlier, who actually had to leave Spanish class that day (despite it being her favorite subject), told me once that "you don't know what it's like to live in this body sometimes." It is clear that at least some of my informants used egocasting and its technologies as a way of escaping their bodies and time, both of which they took to be oppressive.

The title of Andrew's story, "The Great Escape," was probably a coincidence. He told me later that he actually got the idea from a guided imagery activity he did with his therapist, who, it seems likely, wanted to reinsert Andrew back *into* time by having him visualize himself in the future. But I think the idea of escape nicely captures the distinction I would like to make with respect to this new architecture that links neurological deficit and consumption and egocasting. Whereas egocasting suggests escape into the self, as both a citizen and a subject, the kind of "becoming the moment" that I witnessed in my fieldwork, and that Schüll witnessed in her observations of compulsive gamblers is a different kind of escape. Spinoza's question about what a body can do, points to the potential ways that we can conceive of the body during these acts of personalized and technologized consumption. The event of Andrew-rocking, for example, links a time, a disordered body, and a style of consumption. On the one-hand it fulfills the function of self-stimulation through vestibular and aural stimulation. On the other though, the impulsivity driving such behaviors, it is theorized, makes the person resistant to stop even with social sanction

(Lovaas et al. 1987). In other words, as I mentioned above, rocking is a compulsion, and I think it shares with technologies of instant gratification, an affective regime of “becoming the moment.” Becoming the moment, though, in Deleuze’s affirmative ontology, means “becoming imperceptible,” losing track of oneself and connecting with the outside world through the intensive process of sensation. If one of the challenges of having a body is being cut-off from the outside, then reconnecting with the outside is an ethical imperative, Deleuze argues (Deleuze 1988a, 1988b). If we think about impulsivity’s and hyperactivity’s relationship to the event of “becoming the moment” we can see how the two occupy different positions with respect to this limit. Impulsivity, as I mentioned earlier, is “without consideration of future consequences” (Anna Smith et al. 2002:529), and because it is driven by a state of affairs located between the brain—which is conceptualized through deficit—and an appetitive stimuli outside of the brain (image, sound, taste etc.), we can argue that impulsivity is part of the extensive architecture that is conceptualized through extended theories of mind and dynamical systems theory. In other words, it is actual. As such, it can approach the limit of the event, but one can never truly become the event. Bataille is careful to make this point, that the sovereign moment is brief and fleeting. But for that brief fleeting moment we have the sense of the “miraculous.” So impulsivity is becoming the moment, and in doing so becoming the event, but it never counter-effectuates itself through the event, which would mean losing all sense of self. Even compulsive gamblers crash back to earth after machine life. In the other side of this limit, though, as I outlined above, is the realm of pure events, which rather being driven by activity, is marked by hyperactivity. At this limit, Bataille argues, we have no knowledge of the moment because we are so caught up in its experience.

One important caveat I would like to make clear, is that, people with ADHD’s lives are not necessarily marked by more moments of sovereignty than other people’s lives. I used Andrew-rocking, Sebastian playing video games, and Ashley texting because becoming the moment is a potential latent in the kinds of technologies of instant gratification that Rosen talks about in “The Age of Egocasting.” What is important to note though, is that we can see hopefully now that hyperactivity and impulsivity are not simply symptoms trapped in a body, but rather processes that operate transversally across domains. In attending to these processes we can better appreciate the ways that ADHD’s domain of effectuality exceeds our everyday modes of anthropological perception.

The second to last time I saw Andrew, he and Amy took me for a ride around their suburb, which is really a city with incorporated limits made of a jagged grid of single family homes, retail establishments, and light industry, flanked on the north by a eight-lane interstate highway. It also hosts two national laboratories that make nuclear weapons and give its citizens jobs. It is California and the streets are named after trees, saints, and names from Mexico. I have no idea where we are going on our tour, other than we will pass by the newly revitalized downtown, Andrew’s school, and where they buy groceries and go out to eat dinner. As we pull out of Andrew’s subdivision, past a Panda Express, I ask Andrew, who is sitting on the driver’s side in the rear of the car (I’m given the honor of the passenger seat), how many students go to his school. But he’s distracted.

“Hey Amy.”

“Hold on Drew, Marc’s asking you a question.” But this protest only brings the conversation to a halt.

“Sorry. Can we listen to my music?”

“Can’t you use your headphones?” she asks

“They hurt my ears.”

“Hah, you use that thing all hours of the day and *now* your ears hurt?” Amy asks incredulously, prodding him.

“yeah, so...”

And Amy interrupts, “maybe it’s because you have it turned up too loud did you ever think of that?” She seems proud of this remark. That Andrew actually thinks it’s funny is obviously by his cracked smile, but he manages at the same time to mock her by reproducing her barb but in some kind of gargle, which to his credit, is uncannily accurate. Knowing she’ll probably take offense he quickly pleads, “come on, please...”

Amy turns to me, “is it alright with you?”

“Yeah, sure that’s fine.”

She fumbles with an adaptor to plug in his iPod. And when he presses play, the speakers unleash unmistakable angry stabs in D minor: Beethoven, who else?

“God Drew, haven’t you heard this like million times already? Marc doesn’t want to hear this.”

“No, it’s alright,” I assure her. “I like Beethoven.”

It has some while since I have actually “listened” to the Ninth. More than any other of Beethoven’s symphonies it is overplayed, and when given the choice I usually pass over to something else; my right and privilege in an age of egocasting. But this evening I have to listen, and as we wind our way around parks and strip malls, I realize that I had forgotten how sublime the Ninth really is, especially the fourth movement—the phrasing, the judicious use of the secondary dominant that seems to predict Schumann, the lyricism of the chorus that Brahms famously quotes in the last movement of his first symphony written fifty years in its shadow, and the oppressive Fugue that Bruckner tries to outdo in the finale of his epic Fifth, that Mahler could never get his orchestra to play with sufficient weight of tone, and that nearly warps under the brilliance of its own impossible math. And yet Andrew is in the back seat, 200 years later and on the other side of the globe, and conveniently knows none of these things. He is rocking steadily, though not in time, lost in an emotional arabesque listening to the words of a dead German poet. As we turn onto the access road that runs parallel to the highway, Andrew, as if imitating a famous tenor, doubles the final chorus in a language neither German nor English: “*Freu—de, Schön—er....Gött—er—funk—en! Gött—er—funk—en!*” And I can only laugh.

Chapter Three: Writing the History of Hyperactivity

In 1845, Heinrich Hoffmann, a medical doctor from Frankfurt and the son of an architect, anonymously published a series of illustrated macabre children's stories, *Lustige Geschichten und drollige Bilder mit 15 schön kolorierten Tafeln für Kinder von 3-6 Jahren* (Funny Stories and Amusing Pictures with 15 Beautifully Colored Panels for Children Aged 3 to 6). In one story he writes of an ill-behaved child, Zappelphilipp, 'Fidgety Philip', whose uncontrollable behavior ruins his family's supper.³⁷

"Ob der Philipp heute still
Wohl bei Tische sitzen will ?"
Also sprach in ernstem Ton
Der Papa zu seinem Sohn,
Und die Mutter blickte stumm
Auf dem ganzen Tisch herum.
Doch der Philipp hörte nicht,
Was zu ihm der Vater spricht.
Er gaukelt
Und schaukelt,
Er trappelt
Und zappelt
Auf dem Stuhle hin und her.
"Philipp, das mißfällt mir sehr !"

Seht, ihr lieben Kinder, seht,
Wie's dem Philipp weiter geht !
Oben steht es auf dem Bild.
Seht ! Er schaukelt gar zu wild,
Bis der Stuhl nach hinten fällt;
Da ist nichts mehr, was ihn hält;
Nach dem Tischtuch greift er, schreit.
Doch was hilfts ? Zu gleicher Zeit
Fallen Teller, Flasch' und Brot.
Vater ist in großer Not,
Und die Mutter blicket stumm
Auf dem ganzen Tisch herum.

"Let me see if Philip can
Be a little gentleman;
Let me see if he is able
To sit still for once at table."
Thus spoke, in earnest tone,
The father to his son;
And the mother looked very grave
To see Philip so misbehave.
But Philip he did not mind
His father who was so kind.
He wriggled
And giggled,
And then, I declare,
Swung backward and forward
And tilted his chair,
Just like any rocking horse;-
"Philip! I am getting cross!"

See the naughty, restless child,
Growing still more rude and wild,
Till his chair falls over quite.
Philip screams with all his might,
Catches at the cloth, but then
That makes matters worse again.
Down upon the ground they fall,
Glasses, bread, knives forks and all.
How Mamma did fret and frown,
When she saw them tumbling down!
And Papa made such a face!
Philip is in sad disgrace.

³⁷ I have included the original German text because rhyming couples present especially unique challenges in translation, and the English translation provided is not even closely a literal one. Both German and English versions of Hoffmann's *Der Struwwelpeter* can be found online at <http://www.fln.vcu.edu/struwwel/philipp.html> and http://www.fln.vcu.edu/struwwel/philipp_e.html, respectively.

Nun ist der Philipp ganz versteckt,
und der Tisch ist abgedeckt,
Was der Vater essen wollt',
Unten auf der Erde rollt;
Suppe, Brot und alle Bissen,
Alles ist herabgebissen;
Suppenschüssel ist entzwei,
Und die Eltern stehn dabei.
Beide sind gar zornig sehr,
Haben nichts zu essen mehr.

Where is Philip? Where is he?
Fairly cover'd up, you see!
Cloth and all are lying on him;
He has pull'd down all upon him!
What a terrible to-do!
Dishes, glasses, snapt in two!
Here a knife, and there fork!
Philip, this is naughty work
Table all so bare, and ah!
Poor Papa and poor Mamma
Look quite cross, and wonder how
They shall make dinner now.

To many today on the other side of Ritalin, this uncanny tale seems to describe almost too exactly the condition of Attention Deficit Hyperactivity Disorder (ADHD) and the fraught parent/child relationships it frequently engenders. It is not uncommon for parents, advocates, and even psychiatrists to look into the past for the antecedents of ADHD, and to see yesterday's 'problem child' as today's hyperactive child (Burd and Kerbeshian 1988; Hallowell and Ratey 1995:269-271).³⁸ Today, ADHD is the most common psychiatric disorder of childhood in the United States. It is estimated that around eight percent of school-aged children have ADHD, and that between two and two and a half million are treated with stimulant medications like Ritalin and Adderall (Pastor and Reuben 2008). Yet before the 1980s the category of ADHD was virtually unheard of. The rapid emergence and proliferation of the disorder in the United States has ignited considerable debate, much of it in the popular media, about the validity of the category of ADHD (Degrandpre 2000; Breggin 2001; Critser 2005). Clearly, for those suffering with both the symptoms and the label of ADHD, as well as parents, advocates, and the professional apparatus supported by ADHD—doctors, psychologists, psychiatrists, learning specialists, civil rights lawyers, pharmaceutical representatives—have a great deal at stake in the disorder's moral legitimacy in American discourse. The way to give ADHD credibility has been to give it a history. Of course, this raises the fundamental question 'how does one read ADHD into the past when the notion itself did not exist in the first place?'

This paper is a consideration of what is at stake both politically and intellectually in the writing of the history of hyperactivity on the other side of Ritalin. It focuses on two historical moments. The first centers around the mental hygiene and child guidance movements in the early twentieth-century United States, when the behavior of "everyday children" became the targets of psychiatric power. The 'problem child'—also referred to as the 'unadjusted' or 'maladjusted' child—emerges at this time as a rhetorical figure and convenient placeholder for a whole number of medical conditions and social kinds. The problematic behaviors associated with problem children in the early twentieth century often reflect the current symptomatology of ADHD as outlined in the DSM-IVR—hyperactivity, distractibility, impulsivity, and inattentiveness. More often than not, however, problem children showed no ADHD-like symptoms; rather they were bed-wetters, compulsive liars, or had problems with truancy, temper, and stealing. Despite these differences, studying the child guidance movement is helpful in framing ADHD because it involved the same

³⁸ My informants often spontaneously referred to Figety Philip in conversations as proof of ADHD existing in the past.

domains—school, home, and clinic—that figure prominently in the lives of hyperactivity today.

The second section of the paper begins with a story in a Canadian newspaper in 1979 about a family and their hyperactive child. 1979 seems a particularly apt moment because it existed at a threshold where hyperactivity was becoming “Attention Deficit Disorder,” and precisely because it was situated at this verge, it has the potential to bring the past into productive tension with the concerns surrounding hyperactive children today. More broadly, the nineteen-seventies resided at the juncture of several important trends surrounding mental illness and disorders and their diagnosis and treatment: the decline of psychoanalysis and psychodynamic per se in the theorization and treatment of mental illness, the push within professional psychiatry to render diagnostic criteria operationalizable, culminating in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980, and the growth of psychopharmacology and marketing of psychotropic medications, particularly methylphenidate (also known as Ritalin). It was also during the nineteen-seventies that mental illness became explicitly politicized. Not only did mental illness become a site for a politics of recognition—with the birth of political movements and advocacy for those suffering from mental illness and learning disabilities—but there was a corresponding shift in the locus of attribution for these forms of affliction. Psychiatrists and social workers in the fields of mental hygiene and child guidance between the first two world wars blamed deviant and problematic behavior in children on environmental effects like bad parenting. By the nineteen-seventies, however, psychiatry in general, and child psychopathology in particular, tended to theorize the etiology of mental disorder as a problem of neurology. More broadly, this had a profound impact on public attitudes of the problem of hyperactivity, and specifically within medicine and allied fields of research, it led to a novel, very particular, and structurally invariant narrative of how hyperactivity was discovered as a biological problem requiring drug intervention in the early twentieth century. The 1970s then become an important moment in thinking through the problem of Attention Deficit Hyperactivity Disorder because close attention to these enduring shifts within professional psychiatry, education, parenting, and our political culture is critical for understanding how ADHD operates as a medical and social category in our contemporary world.

The Rhetorical Figure of the Problem Child

It is difficult to determine where and when the term “problem child” is first employed. No doubt, wicked, naughty, and ill-behaved children had shown up in literature long before “Fidgety Philip” managed to ruin supper in *Der Struwwelpeter*. But by the early twentieth century, in the United States the problem child emerged as an important figure upon and through which a whole range of anxieties about parenting, family, discipline, and delinquency were articulated.

The focus on the child as an object of psychiatric attention has a longer history that is beyond the scope of this chapter (Laqueur 2004). But the emergence of child guidance clinics that stressed intervention and prevention of problems along with changes in family life and cultural attitudes about childhood brought the child to the foreground as an object of social concern in the early twentieth century. Whereas at the turn of the century, psychiatric focus on children had not yet systematically developed into a sub-discipline, by the early 1920s the child guidance movement had developed and coordinated the professionalization of the psychological study and treatment of the child (Thom 1922).

Although the histories of the mental hygiene and child guidance movements have been written elsewhere and better, the contours, institutions, and underlying philosophies of these movements are worth rehearsing (Richardson 1989; Jones 2002; Horn 1989). Historians of child guidance clinics, and the mental hygiene movement point to shifts in the conceptualization of childhood and changes in family life developing in the early twentieth century United States to help contextualize the emergence of the sciences of childhood. First, there was a general shift in thinking about children that took place in the late nineteenth century. The narrative is a familiar one. Middle-class families were having fewer children, and because of changes in the labor economy, children's economic value was less important. As a result, parent-child relationships became deinstrumentalized, and there was a corresponding shift in the ethic of domestic care (Horn 1989:36-38; Fass 2006:21-56). The aims of 'child savers' who became a popular but loosely grouped movement of activists by the Early Progressive Era reflected this broader "sentimentalization of childhood." In addition to developing welfare institutions for children in order to deal with the pressing problems of urban crowding, poor housing, and poor sanitation, child savers were instrumental in lobbying for the establishment of juvenile courts and prisons (Jones 2002:29-37; Richardson 1989:11-14). From the very beginning of this development, the characterization of child and adult delinquency and criminality was set into centrifugal motion, so that even by the end of the first decade of the twentieth century, separate courts, procedures, and penalties existed for each group. As late Victorians, child savers extolled the Christian virtues of redemption. But the goals behind juvenile justice were twofold: first, *re-educate* current juvenile delinquents, and secondly, *prevent* young offenders from a life of crime.

In his text, *The Mental Hygiene of Childhood*, published in 1919, the psychiatrist William White noted, "it is strangely interesting and confirmatory...that the history of the treatment of the defectives, the insane, and the criminals has been the same sort of history as has been the history of the child" (White 1919:173). By this White not only meant that criminals and the mentally-ill had child-like instincts, but also that the same Christian ethic of care was the impulse for reform in both areas. What we see at this moment is the emergence of a professional apparatus for handling problems of childhood. The mental hygiene movement, founded in 1909 with the establishment of the National Committee for Mental Hygiene (NCMH) by Clifford Beers, William James, and Adolf Meyer set many of the underpinnings of the child savers agenda into theoretical and professional motion. The goal of the mental hygiene movement was to apply principles of human psychology to help reform those suffering from mental illness, and also prevent mental illness, particularly by addressing focus on detecting problems early in childhood. In 1918, by Anna Harkness the heir to vast sum of oil money, founded the Commonwealth Fund, which by 1921 had established two programs: one to promote child health, the other to prevent delinquency (Horn 1989:4; Jones 2002:58-59).³⁹ The establishment of this philanthropic agency marked an important event in the history of child psychiatry. Over the next decade, the Commonwealth Fund established community child guidance and demonstration clinics in major cities across the United States. According to the Fund's annual report in 1922, these clinics had several specific aims:

³⁹ Margot Horn, *Before it's too Late* (Philadelphia: Temple University Press, 1989), p. 4; see also Kathleen Jones, *Taming the Troublesome Child* (Cambridge: Harvard University Press, 1999), pp. 58-59

1. To develop the psychiatric study of difficult, pre-delinquent, and delinquent children in the schools and the juvenile courts; and to develop sound methods based on such study.
2. To develop the work of the visiting teacher whereby the invaluable early contacts which our school systems make possible with every child may be utilized for the understanding and development of the child.
3. To provide courses of training along sound lines for those qualified and desiring to work in this field.
4. To extend by various educational efforts the knowledge and use of those methods (Stevenson and Geddes Smith 1934:20-21).

The establishment of these child guidance clinics was significant in two ways. First, it made psychiatric intervention possible at the community level to both the middle and working classes. Secondly, in doing so, it established an explicit program that in its operation linked together three separate domains—the school, the family, and the clinic—a defining characteristic of the way ADHD operates in the contemporary world. This relationship was essential in creating a new kind of subject distinct from the intractable delinquent or incurable or mentally ill (Horn 1989:40). What emerged was the figure of the everyday ‘problem child’ who was neither normal nor beyond the limits of psychiatric potential.

Defining the Problems of the “Everyday Child”

In the first decades of the twentieth century the ‘problem child’ emerged as a placeholder for a certain kind of normative entity. The following examples serve as illustrations: “an atypical child is one whose social reactions indicate that he is seriously deficient in that which experience shows is essential to social fitness” (Knight 1921:67). “The problem is more or less outside the experiences usual to the child who is in all respects normal and must be examined and diagnosed always with respect to this possibility” (Schmitt 1918:687)⁴⁰ Or, “a problem child is one whose behavior deviates from the norm in some respect which is considered important” (R. Ray Scott 1930:139). Upon closer inspection, however, it is clear that the problem child was an umbrella term for a whole number of problematic behaviors—bed wetters, delinquents, overactive children, liars, misfits, nervous types. What bound these conditions together, however, was the notion of “maladjustment to the social milieu” (R. Ray Scott 1930:139).

The idea of maladjustment, of course, implied a specific ontology of difference—one in which the norm was never fixed in any absolute sense (to biology, for example) but rather was dependent on the social environment. Discourses of race, heredity, eugenics, and criminality in the late nineteenth and early twentieth centuries, in contrast, symbolically encoded deviance onto the somatic body as something fixed and always a danger. Cesare Lombroso’s anthropology of female criminals provides a striking example:

The first, aged 40, killed her husband with reiterated blows of a hatchet, while he was skimming the milk, then threw his body into a recess under the stairs, and during the night fled with the family money and her own trinkets. She was arrested a week later and confessed her crime. This woman was remarkable for the asymmetry of her face; her nose was

⁴⁰ Clara Schmitt, “Developmental Alexia: Congenital Word-Blindness, or Inability to Learn to Read,” *The Elementary School Journal*, 18, 9, 1918, p. 687

hollowed out, her ears projecting, her brows more fully developed than is usual in a woman, her jaw enormous with a lemurian appendix.

No. 2, aged 60. Was constantly ill-treated by her husband, whom she finally joined with her son in strangling, hanging him afterwards so as to favor the idea of suicide.

Here again we have asymmetry of the face, breadth of jaw, enormous frontal sinuses, numerous wrinkles, a hollowed-out nose, a very thin upper lip, with deep set eyes wide apart, and wild in expression.

No. 3, aged 21. Was married against her will, ill-treated by her husband, whom she killed after a night altercation, with a hatchet while he slept.

In her we find only a demi-type. Her ears stand out, she has big jaws and cheek-bones, and very black hair, besides other anomalies which do not show in the photograph, such as gigantic canine teeth and dwarf incisors.

No. 4, aged 44. Strangled her husband by agreement with her lover, and threw him into a ditch. She denied her crime. Hollowed-out nose, black hair, deep set eyes, big jaw. Demi-type.

No. 5, aged 50. A peasant. She killed her brother at supper, so as to inherit from him. She denied her guilt persistently. Was condemned, together with her hired accomplices, to twenty years' penal servitude. She had black hair, gray eyes, diasthema of the teeth, a cleft palate, precocious and profound wrinkles, thin lips, and a crooked face. Demi-type (Lombroso 1909:89-90).⁴¹

Lombroso's typologies of the criminal may serve as an extreme example of widely-held beliefs on the relationship between heredity, mental illness, and criminal behavior, but it nicely illustrates the distinctions between older discourses on criminality and those in the developing fields of mental hygiene and child guidance. Not only did most professionals in the child guidance clinics view the heredity of mental characteristics as scientifically unfounded, such views, they believed, actually were counterproductive to the fundamental project of reforming the individual. "Of all the mistaken ideas that produce unfortunate attitudes toward children on the part of parents," writes Mary Sayles in 1928, a prominent figure and author of child guidance literature, "none are more dangerous than ideas regarding heredity" (Sayles 1928:118). For Sayles, "failure to appreciate the influence regarding heredity to grow into obsessions which paralyze effort and help to bring about the very results feared" (Sayles 1928:119).

Sayles' and Lombroso's texts were written only three decades apart, but there was a clear shift in the *locus of attribution* for deviancy. Whereas earlier sciences of delinquency and criminality, particularly anthropology, focused on the fixedness and inherent-nature of deviancy (whether it was acquired in a Lamarckian fashion and then passed on or inherited in a Mendelian fashion was a point of scholarly debate), the mental hygiene movement treated deviancy as a problem of environment.

What we see emerging then by the 1920s, and something certainly more fully developed in the next two decades, is a general disarticulation of the problems of social

⁴¹ Caesar Lombroso and William Ferro, *The Female Offender* (New York: D. Appleton and Company, 1895), pp. 89-90

deviancy and heredity. Authors of the mental hygiene and child guidance literature demonstrated a marked self-awareness of their discipline's sense of motion. As they saw it, these new fields represented an important point of departure from existing sciences on criminality and delinquency. In these emergent fields, the target of intervention was not the delinquent or criminal, but the pre-delinquent and the pre-criminal (Stevenson and Geddes Smith 1934:30). There were still of course, proponents of eugenic ideas in the mental hygiene movement. And with the Immigration Restriction Act of 1924 and the sterilization programs in the American South, one could argue that the preoccupation with heredity was as strong as ever (Kevles 1995). But as is often the case with ideas there is a considerable 'lag time' between the height of their popularity and subsequent legislation and policy. It seems fair to view these eugenic measures passed in the 1920s as the *terminal effects* of a discourse that was generally losing favor with the scientific elite and funders in philanthropic circles by the 1930s. Thus, the problem child differed in important respects from the dangerous types that haunted the public imagination in the early twentieth century. Problems of child behavior weren't treated as immutable perversions or wild exceptions but as everyday problems requiring parental vigilance.

The semantic development of the category 'problem child' was part of a broader trajectory in which childhood came to be treated as a domain of social attention in the first decades of the twentieth century. The establishment of child guidance clinics in the 1920s, brought psychiatric attention to a new kind of figure—the “everyday child” (Jones 2002:93-97). Consider the following footnote of a text on child guidance clinics, for example:

In the six years 1927-1933, at the Institute for Child Guidance, New York, the conditions most commonly mentioned by applicants as reasons for bringing a child to the clinic (in order of frequency) were as follows:

Disobediance, negativism, stubbornness,	Enuresis
Rebelliousness	School failure
“Nervousness”	Speech Difficulties
Temper	Disturbing behavior in School
Stealing	Fingersucking and Nailbiting
Truancy, home and school	Placement, adoption
Lying	Overactivity
Feeding difficulties	Shyness, withdrawal
“Does not get along with other children”	Sleep disturbances
Retardation in school	Fears
	Excessive phantasy ⁴²

There are several points of interest in this list of symptoms. First, some seem indicative of what we would today call Attention Deficit Hyperactivity Disorder, but most others not. Secondly, is the range of behaviors. Bed wetting seems an unpleasant but relatively minor inconvenience, stealing, on the other hand, already involves a legal sanction. But the point of child guidance was to prevent delinquency, to intervene at an early stage so as to avoid the intensification of problems down the line. Even a symptom like “excessive phantasy,” it was believed, if left unchecked, could manifest itself in abnormal and anti-social behavior.⁴³

The rhetoric and guiding principle behind child guidance was that with the right techniques and attention, troubled children could be reformed and reintegrated into social

⁴² (Stevenson and Geddes Smith 1934:55-56).

⁴³ During the 1924 trial of Richard Loeb and Nathan Leopold, two young men from Chicago accused of kidnapping a young boy, the defendants were portrayed as indulging in abnormal fantasies, which escalated finally to the crime of kidnapping. See (Fass 2006:81-82).

life. For doctors and psychologists in the mental health movement, the most effective method of reintegration was through reforming the negative habits and behavior of both children and their parents. The fundamental ideas behind so-called ‘habit training’ stemmed from the broad appeal of behaviorism in the human sciences in the first decades of the new century (Horn 1989:57-59; Jones 2002:99; Richardson 1989:97).

For many of the behaviorists in the child guidance movement “personality” was essentially the sum repetition of behaviors and actions. In this regard, as it has been mentioned, personality is not the product of heredity. Rather personality could be worked upon, transformed, and reformed; and although immediate results could be obtained, a substantive transformation was thought to be a slow, residual process. Habit training involved a three-fold logic of termination, removal, and substitution (Thom 1924). Psychiatrists, psychologists, and social workers helped isolate negative patterns, but ultimately it was up to the parents to implement these changes. In a leaflet devoted to habit training, parents were constantly asked to reflect upon their contribution the negative behaviors, “Do you worry too much?,” “Do you ‘baby’ and cuddle your child too much?,” “Do you try to satisfy every wish of your child just because ‘he wants it so’?,” “Do you seem *stiff* and *harsh* to your child, repelling his confidences, telling him not to bother you with his nonsense” (Thom 1924, emphasis original) .

Habit training literature reveals ambivalences about middle-class life. On the one hand, it socializes parents and children to behave like normal middle-class entities. On the other hand, it is critical of many of the associated trappings of middle-class lifestyle. Since the nineteenth century, modern moralists were concerned with the over-indulgence of the middle-class, and what this indulgence meant for the socialization of children (Jones 2002:23-24).

Today’s leading figures in the field of ADHD tell parents not to blame themselves for their children’s hyperactive behavior (Hallowell and Ratey 1995; Barkley 2000, 1997). So why then should a historical analysis of ADHD involve a history of parent-blaming? Given that the locus of attribution for child deviancy shifted to the family by the 1920s it might seem strange to start here, especially since one of the fundamental rhetorical functions of situating mental illness in neurology, that has occurred since the 1960s, is to exculpate parents for their children’s conditions. One of Hallowell and Ratey’s techniques in their history of ADHD, conscious or otherwise, is to point to all the lonely scientific discoveries made in isolation in a world of parent-blaming, that posited the biological causes for the disorder. As I’ve suggested this ignores the ways in which institutions fundamentally operating in the social category of ADHD today—schools, families, and psychiatry—were first assembled around a specific social concern—child behavior. In other words, a history of ADHD should not be a history of the discovery of the truth of the disorder, but a history of the things—objects (problem children, parents), techniques (habit training, drugs), and domains (school, home, the clinic) that make it work.

On the Verge of the DSM-III

In the last days of the 1970s, the Toronto newspaper *The Globe and Mail* published an article about a wealthy family whose son had gone from Ritalin to behavioral modification and then back again in hopes of controlling his behavior. I quote it at length because every detail seems uncanny—hyperactivity is becoming ADHD.

For John Smith going home from work to see his children has always been an adventure, although not necessarily a pleasant one.

There was the time when he came home to find his son Paul, who

was 3 at the time, throwing jam around the kitchen. The baby sitter couldn't control him. Or the time a few years later he came home to find the recreation room virtually demolished by Paul, who had spent the afternoon hammering holes in the plaster walls.

Even Paul's sister, Margaret, was the recipient of the boy's inability to channel his energy into more constructive pursuits when Paul held her down and cut her hair off.

Both at home and at school, Paul was uncontrollable. At school he couldn't sit at his desk for more than a few minutes at a time. He would walk aimlessly around the class in the middle of a lesson, jostling other students and knocking their books and pencils off their desks.

"Our child . . . was so difficult to look after and to discipline, we were really lost as to what to do with this child. When you're in that kind of position with a child at the age of 5, you take any advice with open arms," said Paul's mother Mary, her voice reflecting the desperation of coping with her son over the last six years. At the age of 5, Paul (now 11), was diagnosed as being hyperactive.

Dr. Jim Swanson, a doctor at the Hospital for Sick Children involved in studying hyperactivity, said in an interview that hyperactivity affected one to 3 per cent of the school-age population. Dr. Swanson described it as a disorder or syndrome. Doctors don't know what causes hyperactivity, although they theorize that it could be inherited, or caused by brain damage at birth. There have also been a number of treatments developed none of which have been very successful.

While Dr. Swanson was making these observations, children at his clinic were biting their teachers, destroying tables and squirming around on top of desks they were supposed to be working at.

Hyperactive symptoms include overactivity, short attention span, restlessness and impulsiveness. The behavior of a hyperactive child causes tremendous strains on the family, often contributing to marital breakdowns and makes childhood an unhappy experience for all concerned...

"Initially, Paul was put on Ritalin, an amphetamine, which is supposed to increase his ability to concentrate. We didn't like the idea of medication. It frightened me, despite the assurance of the medical people that the medication didn't have any side effects," Mr. Smith said. Doctors believe that Ritalin is non-addictive for hyperactive children.

The Smiths continued to look for a treatment that would help Paul lead a more normal life. As a result of tests conducted by Dr. Swanson and the research team at the Hospital for Sick Children, the Smiths discovered that Paul did not respond well to Ritalin, but was sensitive to the artificial dyes in the food he ate. After the tests, Paul was placed on a diet designed to eliminate artificial colors and flavors. His parents also decided to try a program of behavior

modification. Paul was also placed on a different drug called Dexedrine, also an amphetamine.

When Paul took Ritalin, you would see a lull come over him and he would be still. He would look drugged. That would last for an hour. And in that hour you could accomplish all kinds of things with him, but he was not the animated kid he usually was. On Ritalin there was a time when we thought this kid was a zombie and over-drugged, but he wasn't really, it was just his reaction to the drug. "The first half hour was nothing and the last half hour was nothing. We had an hour in between when he was O.K.," Mrs. Smith said.

Paul didn't like the drug either. His parents aren't sure whether Dexedrine is having any effect or not, but they do know that Paul doesn't like any of the drugs. "Now we're trying behavior modification. I have more hope for behavior modification than anything else," Mrs. Smith said.

Again I have quoted the article here because it nicely illustrates what the problem child had become in the late-twentieth century. Specifically, it inaugurates a new kind of public figure—the hyperactive child. The account is uncanny in ways that "The Story of Fidgety Philipp" is not, in that we are witness to ADHD in the process of becoming. Yet the article never mentions ADHD by name (it did not officially exist until a year later when the DSM-III was published). Still, Paul and his family's situation are familiar to us. These narratives of child hyperactivity and parental suffering became commonplace in the 1990s when diagnoses of ADHD exploded (Danforth and Navarro 2001). Indeed such stories of switching reluctantly from drug to drug, hypervigilantly monitoring every symptom and behavior, were common in discussions I had with parents, especially ones whose children were seen as occupying the high end of the spectrum for ADHD.

From the perspective of the child guidance movement, there are several changes worth noting here. First, hyperactivity becomes not only a problematic symptom, but also a social and medical category. Hyperactive children are problem children in the colloquial sense of the term, but the maladjusted child, the problem child, etc. are terms that no longer carry any clinical significance. Secondly, the mode of treatment has shifted from psychodynamic therapy to a multimodal treatment of stimulant medication, diet, and cognitive behavioral therapy.

During the 1970s the American psychiatric profession was undergoing a transformation in the way that it conceptualized and classified mental illness. The period following the Second World War was something of a golden era for American psychiatry (Mayes and Horwitz 2005:252). Not only did the profession itself enjoy immense public prestige, but research programs in psychiatry were well-funded by universities and foundations. By the 1970s however, this public esteem had eroded. This erosion was triggered by factors both internal and external to psychiatry itself. First, and most publicly, were attacks on psychiatry as a form of social control. Early critiques of medicalization, e.g. Thomas Szasz's *The Myth of Mental Illness*, published in 1961 and R. D. Laing's *The Divided Self*, published in 1960, focused on the problem of trapping complex psychological and social distress in the estranging geometries of medical and biological models (Szasz 1984; Laing 1965). The offshoot of this medicalization critique within psychiatry reached its most articulate and potent form with the anti-, or democratic-psychiatry movement of Franco Basaglia (Scheper-Hughes and Lovell 1986).

Secondly, the psychiatric profession struggled to police its boundaries and moral and professional legitimacy against the encroachment of psychologists and social workers. Psychodynamic theory did not entail medicine itself, and therefore those professionals without a degree in medicine but with training in talk therapy could provide services for cheaper than psychiatrists. This proved financially damaging for psychiatrists as it became increasingly difficult for government agencies and health insurance providers to justify covering the more expensive fees charged by psychiatrists when cheaper resources were available (Mayes and Horwitz 2005:256-258). Therefore, one of the main points of legitimacy for psychiatrists was their authority to prescribe medication for their patients. There was a serious disconnect, however, between existing psychodynamic theories of mental disorders, which posited the etiology of mental illness as a complex of intrapsychic forces, and popularly prescribed medications which treated symptoms not causes. Furthermore, at the same time, the merits psychoanalysis were cast into some doubt because of the practices limited success in treating seriously mentally ill patients (Mayes and Horwitz 2005:255).

By the 1970s the field of psychiatry was a “crisis of legitimacy.” In 1974, Robert Spitzer, a professor of psychiatry at Columbia University, and an influential agent in the American Psychiatric Association’s decision in the previous year to strike ‘homosexuality’ from the DSM-II, was asked to head the APA’s Task Force on Nomenclature and Statistics. One of the central responsibilities of the task force was to bring the DSM-II into rough congruence with the International Classification of Diseases (ICD), which was in the process of being revised by the World Health Organization (M Wilson 1993). Spitzer has become something of a totem in the field psychiatry for his involvement in transforming modern psychiatric theory and practice (Spiegel 2005). As a task force consultant he was a central participant in the construction of the DSM-II in 1968 (M Wilson 1993:404).

The first edition of the Diagnostic and Statistical Manual of Mental Disorders was published in 1952. The DSM-I reflected the psychiatric profession’s need following the Second World War to provide a system of classification for mental disorders that could provide some semblance of continuity in diagnosis. This early edition mirrored the contemporary focus on psychodynamic and psychoanalytic approaches and divided mental disorders into two groups—the first group included mental disorders precipitated by impaired brain function; the second group involved disorders stemming from the patient’s inability to successfully adjust to his or her environment (Grob 1991:428). In 1968, the APA published the second edition of the DSM. This edition was significant for two reasons. First, it involved significant changes to the organization of diagnoses. Secondly, it saw the addition of many new diagnoses not included in the DSM-I. Among these additions was a new section on “Behavior Disorders of Childhood and Adolescence” which described disorders “occurring in childhood and adolescence that are more stable, internalized, and resistant to treatment than transient situational disturbances, but less so than psychoses, neuroses, and personality disorders” (Robert Spitzer and Paul Wilson 1968:1628) This new section included Hyperkinetic reaction, Withdrawing reaction, Overanxious reaction, Runaway reaction, Unsocialized Aggressive reaction, and Group Delinquent reaction. In many ways these disorders were an umbrella for many of the behaviors treated in child guidance clinics in the first half of the twentieth century. At the same time, their addition hinted at the recalcitrant nature of child behavioral problems to traditional modes of treatment like behavior modification and psychodynamic approaches.

As is evident in the newspaper article about Paul, by late 1970s there was a focus, at least with respect to hyperactivity, to treat the symptoms, not the causes. Paul was

given medication to mitigate his uncontrollable behavior, was put on a special diet that cut-out food additives thought to amplify the effects of hyperactivity (the now discredited Feingold diet), and he received behavior modification to provide structure and guidance. Paul may have also been receiving psychodynamic therapy, the article does not specify, but if so it would have been co-extensive with these new regimes of treatment, not an integral part of them. What we are witnessing then by the 1970s is a professional coalescence around the treatment of the symptoms of hyperactivity rather than their underlying causes. This is precisely the shift captured by the DSM-III. When Spitzer and his colleagues set out to revise the DSM-II in the mid-1970s, psychodynamic approaches were well past their prime in psychiatric theory and practice. The long-term efficacy of psychoanalysis was cast into serious doubt, and there was a push within the profession to create measurable, standardized diagnostic criteria (Mayes and Horwitz 2005:251). This symptoms-based approach, which became the basis for the DSM-III, was envisioned by its architects to be the prototype for a new psychiatry; it would re-legitimize the field by giving it a clinical design and edge (Feighner 1979:1173-1174).

It might be tempting to dismiss the history of the changes of the DSM as a “history of ideas,” aloof, and out of touch with actual changes in clinical practice. But the DSM-III marks a critical event that articulates, and brings together, a set of shifts in psychiatry in the 1970s, and makes possible a set of fundamental transformations to the conceptualization and treatment of mental disorders in general, and of hyperactivity in particular, in the last decades of the twentieth century. When questioned by friends, informants, and colleagues, about the emergence and proliferation of ADHD in the 1980s and 1990s, I frequently point to the addition of “Attention Deficit Disorder” to the DSM-III in 1980. But this invocation provokes an understandable skepticism, “so what’s in a name?” In other words, if both the labels for ADHD, e.g. minimal brain dysfunction, and hyperkinetic reaction of childhood, as well as its stimulant treatments, e.g. Ritalin, existed for decades beforehand, why should adding “ADD” to the DSM-III have any effect on the frequency of diagnosis and treatment of the disorder. But the DSM-III did three things. First, by providing a detailed symptoms-based approach, it enabled psychiatrists a kind of objective standard for diagnosing patients. Critics, particularly from outside psychiatry, have questioned the supposed ‘objectivity’ of these measures. What does “driven by a motor” mean, what counts as “easily distracted,” don’t most children avoid “tasks that require sustained mental effort”? The argument follows that ADD has exploded because its diagnostic boundaries are too fuzzy, or more strongly, that the DSM-III and subsequent revisions have legitimated drugging children for meaningless criteria (Jacobson 2002). But from the perspective of the emergence and proliferation of the disorder the validity of these criteria are secondary to the fact that their existence enables a particular kind of normative subject, the hyperactive and inattentive child, that is rendered available for certain modes of treatment, most especially, through stimulant medication. Secondly, this symptoms-based approach allowed a new way of justifying clinical research, as researches, particularly those applying for federal funding, could increasingly justify their programs with recourse to standard measurable diagnostic criteria. During the Reagan years following the publication of the DSM-III, even as social services for those diagnosed with mental illness were cut, the research budget for National Institutes for Mental Health (NIMH) grew by eighty-four percent (Mayes and Horwitz 2005:263-264). Finally, and perhaps most significantly, making symptoms, not underlying causes, the criteria around which to base a diagnosis gave pharmaceutical companies things to treat so that these symptoms became the targets of drug therapies. As such, the DSM-III effectively “realigned the incentives of a great many

stakeholders—clinicians, insurers, the government, pharmaceutical companies,” a move that was part-and-parcel of a broader reorganization of infrastructures of health and biomedicine in post-Welfare United States.⁴⁴ The turn to a symptoms-based approach involved narrowing the clinical gaze—with psychoanalysis the truth of the disorder was complex and hidden, hence the need for a lot of expensive therapy—but this restriction made it easier for pharmaceutical companies to focus research on specific targets (M Wilson 1993:399). In the case of Attention Deficit Disorder, stimulant medications have become *the* predominant mode of treatment, and three decades after the DSM-III, between two and two and a half million children are now treated with these drugs.⁴⁵

Ritalin and History

In 1979, the same year the article “What Makes Paul Run?” appeared in *The Globe and Mail*, *Newsweek* published an article titled “Drugs and Psychiatry: A New Era” hinting that the profession whose hospitals reeked from “100 years of urine,” was in the process of a much-welcomed transformation. Specifically, in this “new era” the brain represented a kind of frontier, partially charted though still open to possibility.

Psychiatrists today are less likely to blame serious mental illness on psychic trauma like unresolved anger at a mother or father. Now, they are increasingly conscious of the role of “neurotransmitters” and “receptors”—the chemicals that transmit impulses from cell to cell in the brain, and the nerve sites in the brain that receive the messages. Many mental disorders, a growing number of doctors believe, result from mix-ups in the infinitely complex interplay of brain chemicals... [D]rugs seem to stimulate the activity of brain neurotransmitters. The tricyclic compounds (Elavil, Tofranil, Sinequan, Vivactil, Aventyl) appear to affect two neurotransmitters: some increase levels of norepinephrine, others the action of serotonin. The MAO inhibitors (Marplan, Nardil, Parnate) block an enzyme that breaks down various neurotransmitters, including norepinephrine, improving their effectiveness in the brain (Matt Clark et al. 1979).⁴⁶

The details of these neurotransmitters may seem tedious and banal; more important is how this logic creates a triangulation between drugs, the brain, and the self. Although the use of pharmaceuticals in the United States has a long history, I would argue that this particular configuration is a relatively recent one and has much to do with the reorganization of professional psychiatry in the 1970s, and the kinds of relationships it created between doctors, patients, and pharmaceutical companies. The crisis of legitimacy that plagued psychiatry made the field particularly receptive to advances in the neurological sciences. Whereas with psychodynamic theory, the truth of the subject resided in the murky play of intrapsychic forces, neuropsychiatry operationalized subjectivity, so that the

⁴⁴ quoted from *Ibid*, p. 258; for a discussion of this redistribution see, (Clarke et al. 2003).

⁴⁵ (Pastor and Reuben 2008). This, of course, raises a whole set of challenging historical questions. What was the relationship between the emergence of the category of ADD in the DSM-III and the explosion of methylphenidate consumption in the United States in the 1980s and 1990s—epiphenomenal, directly causal, symptomatic? Did the success of Ritalin stem from aggressive marketing on the part of pharmaceutical companies or were these companies enabled by new norms of psychiatric diagnosis? Did supply drive demand or the other way around? The answers to these questions are important but outside the scope of this chapter. Andy Lakoff asks similar questions in his ethnography of “pharmaceutical reason” in Argentina (Lakoff 2005).

⁴⁶ Refers to online edition without corresponding page numbers.

“stuff” of older vocabularies— affect, reason, insanity, emotion— could be measured or at least conceptualized as a series of neurological events.

Specifically the emergence of methylphenidate, or Ritalin, as a psychopharmacological intervention for hyperactivity represents an important event in the way we think about ADHD, such that the two have become almost synonymous in public discourse. Indeed, much of the public debate about the validity of the disorder is itself shot-through with the ambivalences about, and sometimes even outright hostility toward, drugging children (Breggin 2001; Timimi and Leo 2009; Timimi and Eric Taylor 2004). Ritalin was first developed by Ciba Pharmaceuticals (today known as the drug company Novartis) in 1955, initially as a treatment for lethargy and narcolepsy. The early advertisements for Ritalin “Ritalin Sparks Energy” seems rather ironic given that today parents, as was also the case in Paul’s family, complain that the drug turns their kids into “zombies.”

When Ritalin came onto the market in the late 1950s and early 1960s it faced intense competition in a booming pharmaceutical market. However Ciba’s shrewd combination of marketing and promotion of research played an important part in the drug’s success (Singh 2002:592). By the 1960s Ritalin was being used to treat children with ‘minimal brain dysfunction’ and other behavioral issues. The 1960s saw the increased prescription of Ritalin, and by the end of the decade between 150,000 and 200,000 children in the United States were being treated with the drug (roughly .002 percent of the child-aged population) (Mayes and Rafalovich 2007:449). In the early 1970s, there was a brief moment of public concern about the drug following a 1970 *Washington Post* article that claimed, inaccurately, that five to ten percent of school children in Omaha, Nebraska were receiving the drug (in fact the figure was five to ten percent of children in special education were receiving treatment). Following this concern and public debate, the Drug Enforcement Agency classified methylphenidate as a schedule II narcotic, meaning that there were restrictions on production, and heavier controls on prescription and supply of the drug (Mayes and Rafalovich 2007:450). The real explosion of the use of Ritalin came in the 1980s and 1990s when use of the drug in the United States increased by five-hundred percent (Daniel J. Safer and Zito 1999; Zito et al. 2003).

I want to conclude this paper by shifting away from the history of Ritalin itself and instead focus on how Ritalin has changed how we think of the history of child behavioral problems.⁴⁷ Ritalin in this sense serves both as a category of analysis and as a category of observation. On the one hand, as a category of analysis it is a rhetorical convenience, standing-in for the various ways pharmaceuticals have reconfigured the conditions of life in the past four decades. On the other hand, as a category of observation, Ritalin, as-a-thing-in-itself figures prominently in the public imaginary surrounding issues of hyperactivity and drugs. It has acquired loaded meanings in contemporary discourse on issues surrounding parenting, education, and medicine, and carries with it a set of ambivalences about the possibilities and limits of pharmaceutical intervention and psychiatric reason.

I opened the paper with the “Story of Fidgety Philip” because it has become an important artifact in the debates framing the legitimacy of ADHD and its pharmaceutical treatments. Specifically, it has been invoked in a structurally invariant narrative of ADHD that looks for today’s symptoms of hyperactivity and inattention in yesterday’s problem children. I am not certain where this narrative first emerged, but it’s sheer repetition (in both print and electronic forms—in self help books, on websites, online encyclopedias, etc.) has

⁴⁷ There are actually few histories of Ritalin per se. The best I’ve come across is Mayes and Rafalovich, “Suffer the Restless Children,” 2007.

made it a kind of “official history.” I suspect its popularity has much to do with two psychiatrists, Ned Hallowell and John Ratey, who included this narrative of ADHD in their bestselling book, *Driven to Distraction*, which was first published in 1994 and, according to the publishers website, has since sold more than one-million copies. In condensed and paraphrased form the story goes as follows. In 1904 *The Lancet* publishes Hoffman’s the story of Fidgety Philip, thus bringing medical attention to a behavioral problem. Two years before, in 1902, George Still “described a group of twenty children who were defiant, excessively emotional, passionate, lawless, spiteful, and had little inhibitory volition. This group consisted of three boys for every girl, and their troubling behaviors all had appeared before the age of eight. What was most striking to Still was that this group of kids had been raised in benign environments, with ‘good enough’ parenting” (Hallowell and Ratey 1995:269-271). Still’s observations supported theories by William James, the American psychologist, that lack of inhibitions in control, volition, and attention are all related and have a neurological basis. In 1934 two physicians, Eugene Kahn and Louis Cohen, published an article in the *New England Journal of Medicine* that argued that the symptoms of what we now call ADHD were a function of brain damage caused by the encephalitis epidemic of 1917-1918. Then, in 1937, Charles Bradley, discovered, quite by chance, that “behaviorally disordered” children respond well to the stimulant Bazedrine. By the 1950s, “this population of children would be labeled MBD—minimal brain dysfunction—and treated with Ritalin and Cylert.” In 1957 the label “hyperkinetic syndrome” was used to refer to a condition of hyperactivity and was tied to a specific structure of the midbrain, the thalamus—though the connection was never proved. Hallowell and Ratey then go on to provide a history of the discovery of specific neurotransmitters involved in ADHD. They concluded with the now infamous, Alan Zametkin’s study which uses PET scans to track differences between ‘normal’ and ADHD brains (Hallowell and Ratey 1995:271-278).

The logic of this narrative is linear and it reads the past—and all its preoccupations with “defects of moral control” and maladjusted children—through the lens of naturalism and posits an eternal figure of ADHD (from Fidgety Philip to Dennis the Menace in Hallowell and Ratey’s narrative) prior to discourse and signification, so that the symptoms of ADHD can be read retrospectively with accumulated knowledge; such is the language and rhetoric of medical progress. In this regard, Hallowell and Ratey’s history of ADHD serves as a nice illustration of Georges Canguilhem’s assertion that in the history of science previously peripheral moments and dialogues become meaningful with regards to a new discovery or breakthrough (Canguilhem 1991). George Still’s research in the first decade of the twentieth century on ‘normal’ children with behavioral problems only became important years afterwards when neuropsychology ‘located’ the origin of disorders in the brain rather than in parenting. Likewise, as a symptomatic reading of the literature on methylphenidate in the 1970s indicates, Charles Bradley’s experiments with Bazedrine in the 1930s, had acquired a new significance as the drug found a market for hyperactive children in the 1960s and 1970s.

This perspective, of course, has the explicit political function of using the moral legitimacy of science to tell a story—about a misunderstood condition in the past that we understand now today—to a general public in the United States that remains, as much as ever, highly ambivalent about both the category of ADHD and the stimulant medications used to treat it (Danforth and Navarro 2001). As I hope the *Newsweek* article “Drugs and the Psychiatry: A New Era” made clear, by the 1970s there was a shift in the locus of attribution for pathology from the family (and especially parents) to the brain. This corresponded to the growth of public interest groups for mental illness, most notably the

National Alliance for Mental Illness, which was first formed in 1979, and today has over 200,000 members.⁴⁸ Today groups like Children and Adults with ADD (CHADD) are central figures in spreading awareness of ADHD and its stigma, lobbying for better legal accommodations for learning disabled students, and organizing research into pharmaceutical and non-pharmaceutical treatments.

My efforts here can be seen as an engagement with ADHD and the stakes of telling its history. In this paper I have attempted to position myself between two seductive modes of engaging the problem of hyperactivity over the last few decades.⁴⁹ On the one hand, unlike the critiques of the medicalization of hyperactivity, throughout this dissertation I have taken the materiality of ADHD more or less for granted (which in part stems from my conversations with clinical psychologists on the subject, and also from an earnest attempt familiarize myself with the corresponding literature) while still trying to be attentive to the ways that its ontological status and moral legitimacy have been in motion in various moments of history. This position seems a valuable one because critiques of the medicalization of child behavior and its treatment through stimulant drugs invoke the popular, and often unchallenged, belief in our contemporary world that medicine and its concomitant forms of knowledge and practice are somehow a less authentic way of marking our bodies and selves.⁵⁰ On the other hand, it seems necessary to engage with the limits of the standard narrative of ADHD—the story of misbehaved children, like Fidgety Philip, who have been redeemed by uncovering of the truth of hyperactivity in the late twentieth century. In doing so I have sought to contextualize hyperactivity as one among many culturally significant instantiations of the broader rhetorical figure of the ‘problem child’; a figure that became a convenient figure of speech in the early twentieth century, but remains with us even today.

My recourse to history here also doesn’t invoke historicism, which seeks to understand the past on its own terms, nor a kind of scientific history—the quest to detail history “as it actually happened,” to employ Leopold von Ranke’s oft-quoted dictum. Rather, by focusing on how child behavior in general, hyperactivity in particular, had

⁴⁸ www.nami.org

⁴⁹ One challenge with this paper, as is the challenge with many histories of diagnostic categories, is that I treat hyperactivity as both a real and constructed entity, and there is often an unintentional slippage between the two meanings. See, for example, Iliina Singh, “Bad Boys, Good Mothers, and the ‘Miracle’ of Ritalin,” *Science in Context*, 15, 4, 2002, p. 599; and Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton, NJ: Princeton University Press, 1995).

⁵⁰ The critiques of medicalization do not necessarily preclude the ‘reality’ of diagnostic entities, but because they frame the practice of diagnosis as a problem of authenticity, it necessarily creates a tension between the social and biological ontology of the diagnosed thing. The same can be said for debates on ‘culture-bound syndromes.’ For medicalization critiques of ADHD see especially, Peter Conrad, “The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behavior,” *Social Problems*, 23, 1975, pp. 12-21; Idem, “Medicalization and Social Control,” *Annual Review of Sociology*, 18, 1992, pp. 209-232; Idem, *Identifying Hyperactive Children: the Medicalization of Deviant Behavior* (Burlington, VT: Ashgate, 2006); Peter Conrad and Deborah Potter, “From Hyperactive Children to ADHD Adults: Observations on the Expansion of Medical Categories,” *Social Problems*, 47, 4, 2000, pp. 559-582. For a thoughtful critique of the literature on culture-bound syndromes see, Lawrence Cohen, “The History of Semen: Notes on a Culture-Bound Syndrome,” in *Medicine and the History of the Body: Proceedings of the 20th, 21st and 22nd International Symposium on the Comparative History of Medicine*, Shigehisa Kuriyama, ed. (Tokyo, Japan: Ishiyaku EuroAmerica, Inc.: 1999), pp. 113-38.

become objects of concern and intervention at different moments, my efforts here can be seen as a kind of “effectual history”—a genealogy of the objects, techniques, and rationalities, that make up the problem of ADHD today (Foucault 2003; cf. Gadamer 1989:300-302). The key to thinking through ADHD historically is not by rendering it transparent like a film and reading its symptoms and neurological markers against the sheer unindividuated backdrop of history, but rather by giving special attention to the ways the problems and moral spaces of our contemporary world have been assembled and reworked from similar configurations in the in the recent and not-so-recent past.

Chapter Four: The American Scene

America is a history littered with regret. In a recent opinion editorial “It’s not too late to save ‘normal’: Psychiatry’s latest DSM goes too far in creating new mental disorders” (March 1, 2010), Allen Frances, the former chairman of the DSM-IV’s so-called “task force” warns that we are all becoming pathological.⁵¹ Or at least pathologized. The new “recklessly expansive” additions, Frances cautions, will “extend the reach of psychiatry dramatically deeper in the ever-shrinking domain of the normal,” thus creating “innocent bystanders” out of people who would be better off “never entering the mental health system” in the first place (Frances 2010). His own regret is that despite “conservative and careful” consideration by himself and the panel he chaired for the previous version of the DSM, the changes he helped institute nevertheless initiated “three false ‘epidemics’—attention deficit disorder, autism, and childhood bipolar disorder” (ibid). He goes onto list a litany of seemingly absurd neologisms—almost Orwellian in their pretense—that presumably make the previous three look tame: “minor neurocognitive disorder,” “mixed anxiety depression,” “psychosis risk syndrome.” Others are even more troubling. “‘Paraphilic coercive disorder’,” he laments, “introduces the novel and dangerous idea that rapists merit a diagnosis of mental disorder if they get special sexual arousal from raping.” Frances also cautions that existing diagnostic categories will balloon and with unintended consequences: “‘Autistic Spectrum Disorder’ probably would expand to include every eccentricity,” and “‘attention deficit disorder’ would become much more prevalent in adults, encouraging the already rampant use of stimulants for performance enhancement.”

That the op-ed was published in the *Los Angeles Times*—the paper of a city built on illusion, artifice, and its own fair share of enhancement—seems something of an irony. Before L.A. the United States was largely divided between vertical cities and the rural spaces of rolling farmlands. But the country followed L.A.’s lead in growing horizontally, eschewing the vertical logic of the city for the artificial convenience and measured comforts of the suburb. It is interesting to note how Frances’ polemic amounts to something of a critique of diagnostic sprawl; a critique of the ways that the proliferation of new diagnostic categories and expansion of older ones is crowding out “the ever-shrinking domain of the normal”—what Alistair Donald has called, in another context, “the Wal-Marting of American Psychiatry” (Donald 2001). One can only imagine a populace, dysmorphic in its self-image, awakening to a sobering voice from the east warning that the rest of the county is becoming like them, a shallow fashion. Fortunately, for well-tanned and over-medicated Angeleños, the weather that day was perfect: clear, sunny, and with a high of 71 degrees.⁵² They say that living well is the best revenge.

Medical anthropologist Emily Martin recently revisited Michel Foucault’s prediction that there may one day be an end to madness when either pharmacology finds a way to intervene on every symptom of mental life, and/or with the “rigorous definition of behavioral deviations accompanied by methods of neutralization” (Martin 2009:278). For Foucault this will happen when madness is brought into the realm of reason. But in “it’s not too late to save ‘normal’,” Frances also fears the opposite: He worries not simply that all madness is brought into the realm of reason, but also that by changing diagnostic categories and criteria to “encompass every eccentricity,” that reason is being brought into the realm of

⁵¹ DSM stands for Diagnostic and Statistical Manual of Mental Disorders. It is published by the American Psychiatric Association and is used as a reference to classify mental disorders.

⁵² According to weather reports for that day, supplied by the L.A. Times.

madness; that there will no longer be any normal. It is as if, paradoxically, that through its expansion, reason threatens to spread itself to a slow negentropic death.

My juxtaposition here is no doubt too easy and exploits the simple fiction of L.A. as a series of palm-lined freeways, movie studios, and practices of bodily enhancement, but I think it captures the fear—popular among many people I’ve talked to—that psychiatry is slowly transforming itself from a medical profession into a lifestyle industry.⁵³ Frances’ op-ed also nicely underscores the ways that ADHD, in particular, and mental-illness in general, gets framed as a technical problem that spills out beyond its borders to become a “societal issue that transcends psychiatry,” as he puts it. This is because, “where the DSM-versus-normality boundary is drawn also influences insurance coverage, eligibility for disability and services, and legal status—to say nothing of stigma and the individual’s sense of *personal control and responsibility*.”⁵⁴ One of the central arguments in this chapter is that responsibility remains central for appreciating ADHD’s controversies in the United States today.

To be sure, Frances’ contributions to the DSM, and his emeritus status as Professor and former Chair of the department of Psychiatry at Duke University, attest to his expertise as well as his historical perspective on the problems of diagnosis in twentieth and twenty-first century psychiatry. Nevertheless, or perhaps for precisely this reason, he seems to slip into a kind of hyperbolic language common in popular discussions of ADHD that many of my informants in psychology and psychiatry generally find troubling. For example, when he suggests, as you’ll remember, that the new category paraphilic coercive disorder “introduces the novel and dangerous idea that rapists merit a diagnosis of mental disorder if they get special sexual arousal from raping,” mightn’t one reasonably retort: “as opposed to the “normal,” run-of-the-mill, kind of sexual excitement from raping?” And if Autistic Spectrum Disorder “would expand to include every eccentricity,” would that then mean that one’s aforementioned special sexual arousal from raping would get one labeled as “paraphilic coercive” *and* autistic? These snide critiques are perhaps unearned but they nonetheless highlight the extent to which discussions of the diagnostic integrity and validity of newer disorders like ADHD frequently devolve into an exaggerated rhetoric that forecloses any possibility of, what one might naively call, reasonable debate.

This chapter is about, among other things, this act of foreclosure. Why after three decades since it was added to the DSM-III, and despite an ever-growing mountain of evidence to suggest both the clinical and etiological validity of the disorder, does ADHD remain mired in controversy? But the more important and untimely question, is not why is this so, but *how* this is so. In exploring this distinction, this chapter is comprised of five parts. In the first part, I draw on both encounters and observations from my ethnographic fieldwork, as well as material from popular modes of circulation (e.g. television, film, and print media) in order to illustrate how the uncertainty surrounding ADHD plays out as a public problem. In particular, I show how the skepticism about both the disorder and the drugs used to treat it take the form of either populist critiques that employ “common sense” as a counterweight to scientific expertise (as can be seen in the Christian Right’s opposition, which mirrors the Right’s hostility to the notion of global warming), or of critiques that target psychiatry in particular as a form of social control (as can be seen in the Church of Scientology’s anti-psychiatry stance or academic critiques of medicalization). In

⁵³ See, for example, Carl Elliott’s book, *Better than Well: American Medicine Meets the American Dream*, (Elliott 2003).

⁵⁴ Emphasis added.

effect, I argue that ADHD remains controversial not because of the uncertainty of “science”, but because of the certainty of “common sense.” In the second part of this chapter, I consider the relationship between the uncertainty of ADHD and its politics, and explore how other literatures both on the topic of ADHD and in medical sociology and anthropology more broadly have addressed this issue. In particular, drawing from the work of E.E. Schattschneider and Andrew Barry, I outline a concept of the political that is intensive, public, and that operates through the act of indexing. In part three, I use the question about racial and class disparities in the treatment and diagnosis of ADHD as one pathway in the politics of the disorder. Whereas other studies have studied disparities themselves, my approach here explores the relationship between race and ADHD by examining more closely the popular belief that ADHD is, in the words of one prominent critic, “affirmative action for spoiled, rich, white kids.” Toward this end, I explore discourses of race, merit, and entitlement in the post-welfare United State by comparing prominent stereotypes about learning disabled students and the figure of the welfare queen, which are both accused of “gaming the system.” I also show how these fears have fueled the controversy surrounding ADHD. In the next section, “Toward an Analytics of Blame,” I develop a *concept* of blame that helps explain not why ADHD is politicized, but rather *how* this is so. As a fixing of responsibility, blame takes the impersonal realm of difference and collapses it around individual identity which are seen as the cause and origin of politics, and which can be held accountable as subjects. In particular, by combining ethnographic work with a reading of the literature on ADHD and parenting, I show how, as subjects interpellated by blame for the disorder, mothers are central to ADHD as a social imaginary. Finally, in the last section of this paper, I draw together the themes of politics, blame, and common sense by demonstrating the role “critique” plays in maintaining ADHD’s controversies, and why critique is an inappropriate and inadequate response to the anthropological problem of ADHD today. Here I follow Bruno Latour, who in his essay, “Why has critique run out of steam?,” argues that by attempting to reduce the reality of “matters of fact” to other matters of fact,” critique subtracts reality from itself rather than adding or multiplying it. Here I show how medicalization and common sense critiques of ADHD both employ this same subtractive logic through contextualization and blame. While these approaches attempt to locate the truth of ADHD, critique would be better off asking instead: what is truly new about ADHD and what difference does it make today?⁵⁵

Setting the Scene for Research

In June of 2005, when I was still a young graduate student at Berkeley thinking about studying ADHD, a rather minor scandal occurred when the popular film actor Tom Cruise appeared on NBC’s *The Today Show* to promote his upcoming movie *War of the Worlds*, a film adaptation of H.G. Wells’ classic science fiction novel. Cruise’s interview with host Matt Lauer quickly turned into a tense affair when Lauer brought up Cruise’s criticisms of friend

⁵⁵ In this chapter I do not examine at any serious length what factors might explain the emergence and proliferation of ADHD in the United States over the last three decades. I cover this topic in the introduction to this dissertation, and there are other excellent treatments of the subject, most notably Joel Nigg’s comprehensive and balanced account in *What Causes ADHD?* (Nigg 2006). Instead, I examine the controversy surrounding ADHD in the United States, and ask, why thirty years after it was added to the DSM-III, does ADHD remain mired in controversy? What is now Attention Deficit Hyperactivity Disorder, was called Attention Deficit Disorder (ADD) in the DSM-III. Many people refer to ADHD as ADD in everyday speech today.

and actress Brooke Shields. At that time, Cruise had been critical of Shields for going into psychotherapy and taking anti-depressants for post-partum depression.

“Matt, you have to understand this. Here we are today where I talk out against drugs and psychiatric abuses of electric shocking people, okay, against their will, of drugging children with them not knowing the effects of these drugs. Do you know what Adderall is? Do you know Ritalin? Do you know now that Ritalin is a street drug? Do you understand that?” Awkward pause.

“The difference is...this was not against her [Brooke Shields’] will though.” Lauer gets three words into his sentence before being interrupted by Cruise.

“No, no, Matt, no, Matt, Matt, Matt, Matt, I’m asking you a question...Matt, I’m asking you a question.”

Lauer purses his lips. “I understand there’s abuse of *all* of these things.” He’s interrupted again by Cruise.

“Here’s the problem, you don’t know the history of psychiatry. *I* do.”

“Aren’t there examples, and might not Brooke Shields be an example of someone who’s *benefited*, from one of those drugs?”

“All it does is mask the problem, Matt. And if you understand the history of it, it *masks* the problem...that’s what it does. That’s all it does. You’re not getting to the reason why. There is no such thing as a chemical imbalance.”

“So post-partum depression to you is...a little psychiatric goobly-gook”

“Matt...don’t...Matt, no, no I did not say that.

“I’m just asking what would you call it...”

“Matt, that is abs..Post-, now you’re talking about two different things.”

“But that’s what she went on the anti-depressant for.”

Cruise reiterates that drugs only mask symptoms. He admits that Shields’ symptoms are “real,” and that Lauer’s characterization of “psychiatric goobly-gook” is “an alteration” of his point of view. The conversation, if one can call it that, continues down this uncomfortable path with Lauer trying to find a middle ground. “I’m only asking, isn’t there a possibility that...do you examine the possibility that these things do work for some people? That yes, there are abuses. And yes, maybe they’ve gone too far in certain areas. Maybe there are too many kids on Ritalin...”

“Too many kids on Ritalin?” Cruise at this point has a painful look of bewilderment on his face. Lauer tries to interject a question but is quickly hushed. “Matt, Matt, Matt, Matt,” each Matt gets softer than the next. “You don’t even...you’re glib. You don’t even know what Ritalin *is*. If you start talking about [a] chemical imbalance you have to evaluate and read the research papers on how they came up with these theories, Matt. Okay, that’s what I’ve done. And you go and say, where’s the medical test, where’s the blood test that says how much Ritalin you are supposed to get.”

The host again, tries to smooth things over: “...it’s very impressive to listen to you. Because clearly, you’ve done the homework...and you know the subject.”

But Cruise is not to be consoled. “*And you should*...and you should do that also,” he reprimands. “Because just knowing people who are on Ritalin isn’t enough. You should be a little bit more responsible in knowing really...”

The interview gets more uncomfortable before it winds to a close, with Lauer suggesting that Cruise knows “zero” about his friends’ experiences with psychiatry, and with Cruise complaining that Lauer is being too “reasonable” about the subject.

Cruise’s interview on the Today Show occurred when I was in the very early stages of putting together a feasible research project on the topic of ADHD. At that time I was still

thinking through the dominant approaches that medical sociology and anthropology had taken with respect to the field of psychiatry—ethnopsychiatry, culture bound syndromes, medicalization and biomedicalization, labeling theory, Science and Technology Studies, anthropology of knowledge, governmentality studies, and so on. At that time, it seemed that those approaches, or my limited understanding of them anyway, weren't adequate to the task of thinking productively through this event. In particular, I was interested in the ways that Cruise kept trying to pin down Lauer on his "responsibility," or lack thereof, for knowing more about the dangers of psychostimulants like Ritalin. The logical anthropological question would have been "responsibility to *whom*?" thus trying to locate the social conditions for such an enunciation. To ask this question though would be to collapse it into an issue of identity and belonging, which seemed to be precisely the way that ADHD operated as a political category in contemporary American discourse. After all, identity politics fit nicely with the literature on neoliberal governmentality, biosociality, and biological citizenship that held currency within my discipline. At the same time, I suspected that there was something more going on here, and that responsibility as a concept could work in such a way that it exceeded the capacity to be a "responsibility to whom?". In other words, could there be such a thing as responsibility in itself, as a pure operation. But at the time, I didn't know how or where else to take this line of reasoning. One thing was clear to me, however: this act of fixing responsibility was doing very important work. Something was happening here that could potentially be useful in thinking about ADHD; I just wasn't sure what.

Needless to say, the public response following the Tom Cruise/Matt Lauer interview followed a predictable, but entertaining, plot line that avoided the substance of the interview. Lauer, a Today Show veteran of eight years, was praised for his poise and integrity. Cruise was criticized for attempting to bully Lauer (who he claimed was his friend), and for his seemingly unstable public behavior. It should be noted, that just one month before, as part of his aforementioned publicity tour, Cruise made an equally bizarre appearance on the Oprah Winfrey show, jumping up and down on Oprah's guest couch, and punching the floor in a fit blind euphoria—he was, he said, in love (Waxman 2005). Critics also questioned the appropriateness of trying to sell Scientology to the public on both television and on filming locations. Tom Cruise, it seemed, was himself becoming psychotic.

The Church of Scientology would seem a distant secondary player in the debate about ADHD, but in fact, the religion (some call it a cult) has played an important role in shaping the trajectory of ADHD in the United States. As I outline in more detail in chapter five, the Church ran a very public, and by most accounts, successful, campaign against Ritalin in the late 1980s—although following a brief lull, the prescription of psychostimulants took off again in the 1990s (D J Safer and Krager 1992). But I've highlighted this event not simply because it was watched by so many viewers (owing to the significant airtime the interview received as a piece of entertainment news itself), but also because it illustrates how ADHD is politicized through the act of protest and blame—by testifying about the truth of ADHD and fixing its responsibility.

Controversy and Common Sense

In an address given to the House Committee on Government Reform in 2002, director of the National Institute of Mental Health, Dr. Richard Nakamura, addressed the widely held

belief, popular among the lay public and even many medical practitioners, that ADHD is a bogus disorder.⁵⁶

We cannot overemphasize the point that, as a matter of science, the notion that ADHD does not exist is simply wrong. All of the major medical associations and governmental agencies recognize ADHD as a genuine disorder because the scientific evidence indicating it is so is overwhelming....The central psychological deficits in those with ADHD have now been linked through numerous studies using various scientific methods to several specific brain regions (the frontal lobe, its connections to the basal ganglia, and their relationship to the central aspects of the cerebellum). Most neurological studies find that as a group those with ADHD have less brain electrical activity and show less reactivity to stimulation in one or more of these regions. And neuro-imaging studies of groups of those with ADHD also demonstrate relatively smaller areas of brain matter and less metabolic activity of this brain matter than is the case in control groups used in these studies.

In the above excerpt, Nakamura was reading from an open letter published by over seventy scientists working on ADHD in the United States and internationally (Barkley 2002). Nakamura's words suggest, on the one hand, that neuroimaging research carries significant truth value, as a collection of scientific facts, and that neuroimaging research represents, as it were, the "state of the art," of ADHD research (Dumit 2003, 2000). On the other, they also reveal an impatience, a resentment even, with the what many scientists I have talked to, have called a "gap" between the scientific "truth" of the disorder and what they believe are "outdated" misconceptions about ADHD that circulate within the "general public." The scientists who contributed to the "International Consensus Statement on ADHD" from which Nakamura was reading, open the statement, noting that they are "deeply concerned about the periodic inaccurate portrayal of attention deficit hyperactivity disorder (ADHD) in media reports." "We fear," they continue, "that inaccurate stories rendering ADHD as myth, fraud, or benign condition may cause thousands of sufferers not to seek treatment for their disorder." They also note concern that ADHD's controversy "leaves the public with a general sense that this disorder is not valid or real or consists of a rather trivial affliction" (Barkley 2002:89). The scientists then point to the common criticism that ADHD's controversies stem from, the journalistic practice of false balancing:

Occasional coverage of the disorder casts the story in the form of a sporting event with evenly matched competitors. The views of a handful of nonexpert doctors that ADHD does not exist are contrasted against mainstream scientific views that it does, as if both views had equal merit. Such attempts at balance give the public the impression that there is substantial scientific disagreement over whether ADHD is a real medical condition. In fact, there is no such disagreement—at least no more so than there is over whether smoking causes cancer, for example, or whether a virus causes HIV/AIDS (Barkley 2002).

Not surprisingly, the statement received a hero's welcome among advocates for ADHD (if one runs an internet search on the consensus statement one finds links from dozens of advocacy organizations to the document). The consensus statement also perhaps

⁵⁶ <http://www.nimh.nih.gov/science-news/2002/attention-deficit-hyperactivity-disorders-are-children-being-overmedicated.shtml> (accessed May 2010).

overstates ADHD's "consensus." Two years later, Sami Timimi, a prominent critic of ADHD, published "A Critique of the International Consensus Statement on ADHD" in the same journal that included thirty-three co-signatories (though very few come from "Research 1" universities like most of the signatories on the original consensus statement).⁵⁷ Timimi rightly points out that neuroimaging studies of ADHD haven't been as universally accepted as the consensus statement might lead one to believe. Nevertheless, the consensus statement underscores the ways that the scientific uncertainty of ADHD is exaggerated, and at the very least, it suggests that many of the leading scientists on the disorder find the persistence of ADHD's controversies to be a problem worth publicly addressing. The opinions in the consensus statement also accord well with many of the observations that scientists I talked to offered about ADHD's public controversy.

"The problem is twofold" Mia, one late thirty-something clinical researcher told me. "Journalism likes to sensationalize the pharmaceutical aspect of things. Not that there isn't some truth to it. Of course pharmaceuticals care about their bottom line that's their job...or at least one of their jobs...but that's irrespective of ADHD's scientific profile. Another thing is that it's probably over-diagnosed in some cases, and again that's nothing to sneeze at, and there are probably cases...or I should say, there *are* cases, where kids are being overmedicated, but again that's a social or a professional issue for psychiatrists, its not a question of the science."

Another psychiatrist, Dr. G., a native of Southern California who has been practicing for over four decades put it this way: "It's like with climate change. There are a lot of skeptics out there...Sarah Palin is one...but there are others. Is climate change a threat? I can't say for sure, but I also know I'm not in a position to attack the idea because I'm not an expert in that field. The same goes for criticisms about psychiatry; a lot of people say attention deficit disorder or depression isn't real. They used to say that about schizophrenia too, by the way...But most of these people aren't doctors and they aren't familiar with the science or, for that matter, with the medication. "

The reference to Sarah Palin—the Republican Vice Presidential candidate in the 2008 election who has famously challenged the notion that evidence of climate change can be attributed a human cause—may seem, at first glance, like a detail worth eliding in an ethnographic text, but as it might indicate, my discussions with informants about the contested nature of ADHD took place at a time when a similar kind of debate about the use and limits of expert knowledge was playing itself out in a very public way over the question of "global warming," and I came to increasingly appreciate the ways the two situations, or debates, were structurally similar. Palin's affable "aw, shuck's" persona, self-branded image as a "hockey mom," and now famous, or some might say, infamous, references to characters like "Joe six-pack" captured, intentionally or otherwise, a populist sentiment, or *re-sentiment*, about the perceived encroachment of the arrogance of Washington and expert knowledge on common sense and individual liberty. This distrust can be traced back maybe too generously to the Jeffersonian ideal of civic republicanism embodied by the yeoman farmer, or less generously to a secessionist politics of states rights or Nixon's "silent majority." Dr. G's comparison of psychiatrists and climate scientists works in the other direction by highlighting what he sees as the ignorance and hypocrisy that such a position entails.

⁵⁷ R-1, refers to the Carnegie Classification scale that is used by the organization to determine funding. R-1 indicates a top-tier research university. I pointed to the fact that most of the co-signatories of the critique did not come from R-1 universities not to dismiss the statement but rather to give the reader a better understanding of how opinion might be divided on the issue.

Although most of my formal fieldwork was conducted in what I have called in the introduction to my dissertation, “hyperzones of ADHD”—figurative spaces where ADHD was an accepted and even celebrated diagnosis—many of my discussions outside of these spaces were with people who often evoked a commonsense critique of both ADHD and its drug treatments. Tom, for example, is a former Army Ranger and now works for the Department of Homeland Security. He drives a Harley, hails from the great state of Texas, and is “part Cherokee.” I when I first started fieldwork I would run into him more often than not on Tuesday nights at a local pub where my friend Adam and I would play darts. He is a friendly outgoing person and one evening our conversation inevitably turns to my research. I tell him I study Attention Deficit Hyperactivity Disorder. “You mean like hyperactive kids?” he says in his always-playful way. Given his strong personality, Tom inevitably controls the conversation. “You want to know what I think?” he asks. Given his tone of voice, I already have a good idea of what his opinion might be, but as usual, I am open to listening.

“Sure, what’s your opinion?”

“Quite frankly, I think it’s bullshit” he tells me. Then he turns away and aims his dart. “Most of these kids don’t even have ADD.” Dart.

“What makes you think they don’t have ADD?” I ask.

“Because it’s made up anyway.”

“You mean you think ADHD is made up or people make up the fact that they have it?”

He glances up and to the right trying to digest my question and then shrugs his shoulders, shakes his head, and winces, as if the answer were self-evident. “Both.”

Then he turns to the board and throws another dart. “I mean I’m not saying they make it up, ‘cause it’s the parents anyway. So the kid may be hyper but it doesn’t mean they have a condition.” He tells a story of his nephew who was suspected of having ADHD. “He’s a good kid, he’s a spaz, but all he needed were some rules and he was fine.”

Tom’s skepticism of ADHD only goes so far. It’s not that he doesn’t believe in ADHD *per se*; he’s just never met anyone who he thinks has *actually* suffered from a genuine case of it. Skeptics, I found, usually employed this logic of deferral. After thirty years, there is something of a begrudging acceptance of ADHD as at least a stubborn possibility. The “commonsense” approach to child behavioral problems, though, conceptualizes the symptoms of ADHD, like hyperactivity, as having a commonsense etiology, like bad diet, bad parenting, or a vague disposition: “boys will be boys.” This kind of antagonistic relationship to scientific expertise is perhaps strongest on the political Right in United States, and particularly, the Pentecostal Christian Right, which has, for example, waged largely unsuccessful battles in some states and districts to thwart the teaching of evolutionary biology in public schools.⁵⁸ During research on popular non-prescription treatments for ADHD I came across a great example of this skepticism, in a *700 Club* segment, that had aired sometime in the previous year, on the advantages of using a particular herbal supplement, L-theanine, to treat ADHD. The *700 Club* is a television program broadcast on the Christian Broadcasting Network. According to the CBN’s website, the show, which is “is a mix of news and commentary, interviews, feature stories, and Christian ministry” is broadcast in 95 percent of the U.S. television market, and is one of the longest running shows on television.⁵⁹ Pat Robertson, the show’s creator and host, had an unsuccessful candidacy in the Republican primaries of the 1988 Presidential election, and has made television his home before and since.

⁵⁸ See, for example, (Mckinley 2009).

⁵⁹ <http://www.cbn.com/700club/ShowInfo/About/about700club.aspx> (accessed, April 2010).

The segment on L-theanine is begins with an angelic C-major chord of synthesized strings. Maybe it's the lighting, or perhaps the filter, but Robertson is looking radiant in his sand stone suit and gold tie. "Have you heard 'Attention Deficit Disorder'?" he asks in his always-folksy aspirated voice, and in a way that makes it sound like the world is rushing by too quickly. "Now they've got a double, 'Attention Deficit Hyperac-tivity Disorder'; they lump 'em to-gether," he says, squinting, and emphasizing the last word in a Southern Baptist whisper. Robertson has a habit of gently shaking his head whenever he talks, as if things don't quite add-up. "This is a complex problem that takes skilled medical diagnosis. And yet health workers in schools, who are not carefully trained are 'wily nilly' diagnosing active children as having AH..." he shakes his head and fumbles for his notes "...ugh, you know D, hyperactivity. And [here is] something that was given to me earlier" he says, waving a memo for the camera. "For example, *mold*, can cause this problem. *Red dye* can cause this problem. *Poor diet* can cause this problem. *Genetic dis-orders*...And there're *many doctors* in America who are beginning to speak out, and they are saying ADHD is over di-ag-nosed. And it's over diagnosed by people who really aren't qualified. And as a result *many children* in our nation are being over-medicated...it may be some of your children or grandchildren. So is there a better way to treat kids with attention problems? Medical reporter Galen Tetherow has the story on a *natural* alternative that worked for one family."

The camera cuts from Robertson to an aerial view of Vancouver, Canada, home to a married couple with two hyperactive twin sons, Scott and Spencer, who were diagnosed with ADHD at age 6. We get the typical story of hyperactive boys, failing grades, repeated phone calls from the schools, and stressed-out parents. Then the narrator, Tetherow announces that "about 5 percent of Canadian kids are diagnosed with ADHD; 8 percent in the U.S." "The numbers really jump in the number of drugs prescribed for the disorder. In the U.S. alone that number has doubled in the last ten years." "So is there something wrong with these kids brains?" Tetherow asks in an incredulous tone.

The segment cuts to a psychologist in her office that is decorated with books and a green frosted lamp.

"It looks like, in those children, that minority of children who really have the disorder, that there probably is some neurological underpinning to it. But again, that's a small fraction of the children who actually carry that diagnosis and get treated for the condition." The psychologist, Gretchen LeFever, is introduced as a "child development expert" who believes that "ADHD is both overdiagnosed and overmedicated." The graphic on the screen tells us she's a psychologist at Regent University (where Pat Robertson is founder and Chancellor). "Those professionals who continue to say that ADHD is widely underdiagnosed or that only about three percent of children in this country receive ADHD drug treatment are simply wrong. The data do not support it."

"But what's the downside of diagnosing and treating lot's of kids?" Tetherow asks as the camera pans over a classroom of children.

"The bottom line is we simply have not looked at the long term—over the long haul years of drug treatment—effectiveness or consequences," says LeFever.

The segment shifts to the family's struggle with medicating their sons. "So they put Scott and Spencer on Ritalin. A drug they said turned the boys into 'zombies'." Then they switched to Dexedrine, but found it unhelpful. The rest of the segment touts the benefits of L-theanine, a green tea extract, that supposedly aids in concentration, and that is being tested now by a medical doctor. Scott and Spencer participated in a study by the doctor and their grades and performance in hockey improved. The family has also switched to a

healthier diet. We are privy to the two boys getting hugs from their father for their good grades, and the segment ends with the twins on the ice playing hockey. “With renewed hope [Scott and Spencer] take to the ice with Olympic Gold in their dreams.”

We cut back to Robertson in the CBN studio. “Thank you Galen. You know, I may sound like a broken record, but the same thing is causing many other problems, and that thing is *too much sugar*, too much salt, too much white bread, too much sweets...too much candy...too much stimulant like Cokes...and caffeine. Not enough, fruits, vegetables, protein rich food that are not fried...and low sodium and exercise.” His younger female co-anchor, who joined him after the video segment, nods along in agreement. “I mean it’s just a no brainer,” he continues in exasperation. “But you know they have these manifestations in kids; their brains *need to be fed*. They’re starving, they’re growing and they need to be nourished.” His co-anchor chimes in. “You’re right Pat. Just to kind of concur, it’s *amazing* the effect of food and [how] what we eat has an effect on our behavior and attitude and our outward and inward appearance.” Robertson agrees totally. Now it’s his turn to talk again. “Don’t medicate unless you absolutely have to. Some of these things are controlled substances. They, you know” he starts laughing, “they’d be on a level of cocaine. And they’re drugs; they’re bad for people. They don’t do you any good...they merely suppress a problem and the problem may be the kid is growing and he’ll grow out of it by the time he gets to puberty...he’ll be okay.” At this point his palms are facing upwards as if in prayer, but he drops them and sighs. “Let’s change the way we’re thinking here in this country in relation to Ritalin. I just can’t stand what’s being done.”

Although I’ve positioned Robertson as a Pentecostal Christian, there is nothing here to mark him as such other than the venue. Never once in either the video segment or Robertson’s commentary are there any gestures towards the divine of the kind that usually dominate Robertson’s often eschatological commentaries. He offers us nothing here if not common sense. “It’s just a no brainer.” Hyperactivity is caused by “too much sweets.” Drugs are “bad for people.” “He’ll grow out of it.”

In a fascinating article, “Hyper Talk: Sampling the Social Construction of ADHD in Everyday Language,” Scot Danforth and Virginia Navarro examine 224 “language events” relating to ADHD gathered from a variety of venues and domains in American social life and include both interview data and material culled from media sources. The authors seek to understand how specific cultural tropes are deployed in discussions of ADHD by sampling what they call “everyday discourse”: “By using the term *everyday discourse*,” they argue, “we are pointing to those conversations occurring between family members, friends, acquaintances, or even strangers in which the specific, “common sense” practicalities of the social situation at hand are paramount” (Danforth and Navarro 2001:173). They believe that this focus on common sense can make a useful addition to understanding ADHD as a social category because everyday discourse “is mundane yet powerful in the way it produces, reproduces, and contests the production of social identities through the linguistic framing of particular life situations” (Danforth and Navarro 2001:173).

In many ways their work gives sustained empirical attention to a realm that constituted the “outside” to my field; namely, the space that envelops the “hyperzones” of ADHD that I came to view as akin to oases. Their data is drawn from interactions of the kind that I had with Tom, who I mentioned earlier. Danforth and Navarro’s careful attention to the linguistic detail of speech acts surrounding, what they describe as the “social construction of ADHD,” reveals, not surprisingly, a deep ambivalence about both the medical category of ADHD and its pharmacological treatments. In particular, they show how people who resist the notion of ADHD draw on commonsense notions of parenting

and self-discipline as “extrascientific evidence” that reframes ADHD symptomology as moral problems (Danforth and Navarro 2001:182).

I certainly don’t want to imply that doctors all agree on the validity of ADHD or the benefits of certain treatment modalities like psychostimulants. Some for example, felt that ADHD was too broad a category and that with future research it was likely to be disaggregated into separate diagnoses. In particular, ADHD-C or ADHD-H, often present different symptoms than the predominantly inattentive type of ADHD (ADHD-I). However, as was pointed out to me, this is not likely to change any time soon given how infrequently changes are made to the DSM. As of this moment, the DSM-V is being finalized and is scheduled to be published in May 2013.⁶⁰ Several psychiatrists I spoke to were also reluctant to prescribe psychostimulants to young children, like pre-teens, except in cases where medication was clearly necessary. Most psychiatrists I spoke to preferred to use several different modes of treatment concurrently, like combining medication with behavioral therapy.

In my discussions with psychiatrists, it seems that the validity of ADHD was less important in deciding who was diagnosed and what treatment they received, than was the doctor’s approach to medicine. Some doctors I spoke to were reluctant to diagnose ADHD without a clear history of symptoms that were persistent and significantly impairing since childhood. Others seemed more comfortable prescribing medication than others. One forty-something psychiatrist, who is open about the benefits of medication, articulated this position well. “I’m of the mindset that if you know something works, why change. I only prescribe what I’m comfortable with based on the literature that’s available and my own experience with patients. So I won’t prescribe something that I don’t think has a clear record of efficacy and safety. I also know that medication does work...Obviously, when deciding what’s right for a patient you weigh the costs and benefits.” “I always start at low doses and I never go higher than a recommended therapeutic dose. So I ask my patients, first, you know ‘how are the symptoms now with the medication?’ And if there’s still room for improvement than I’ll up the dosage as long as they’re tolerating the side effects. Because the idea is to treat *all* of the symptoms if possible. If a patient isn’t tolerating a medication well,...again I start at a low dose, but if there are side effects, as long as they’re minor, I usually have them stick with it for a few weeks because often it takes the body time to adjust a new treatment. If the side effects are troublesome then we can lower the dosage, or stop the medication all together. It just depends on the patient.” He went on to reason that the safety of psychostimulants makes them suitable as a long-term treatment for ADHD: “Now [with] some medications...you eventually want to come off of them gradually. With the stimulants like Ritalin, Concerta...they generally have a good track record in terms of long term use, so as long as the patient is tolerating it, and it’s *working*, then why switch?”

Contrasting common sense and expert knowledge, as I’ve done here, seems like a naïve distinction. After all, hasn’t anthropology played an important role in showing how these divisions are artificially maintained? Isn’t there danger in treating “science” as an autonomous realm that proceeds through the slow, arduous, accumulation of facts, over and against a random and capricious society? This outmoded view of science has been largely done away with in humanistic anthropology thanks to the efforts of people like Foucault, Kuhn, Feyerabend, and more recently Latour and his colleagues in Science and

⁶⁰ <http://www.dsm5.org> (accessed April 2010). I outline proposed changes to ADHD in the DSM-V in the introduction.

Technology Studies. As a result, I would argue, this is no longer our danger today. Rather the danger is in not taking science seriously enough or in seeking to contextualize it as an effect of power, ideology, or metaphor. And again, although, some doctors I spoke to felt ADHD was overdiagnosed, and although much work remains to be done in clearly identifying etiologies of the disorder (Nigg 2006), I would suggest, much like the scientists in the international consensus statement did, that ADHD's scientific uncertainty and controversy is exaggerated. Even before I began my fieldwork I found troubling how closely sociological and anthropological critiques of ADHD resembled popular ones that one could find on Public Television, in trade press books, or on talk radio, most of which lament how behavior and achievement were being medicalized and overtreated with stimulants. Thus I follow Bruno Latour in asking, "why has critique run out of steam"? a question I return to in the conclusion of this chapter. What we need is a new kind of critique specific to ADHD that doesn't rely on common sense as a foundation. What I'd like to develop in this chapter is an awareness of how ADHD's controversies are closely bound to common sense. As Clifford Geertz has argued in *Local Knowledge*, common sense is not simply charming and folksy, or even *savior faire*; it is an orientation toward Truth. "Religion rests its case on revelation, science on method, ideology on moral passion; but common sense rests its on the assertion that it is not a case at all, just life in a nutshell. The world is its authority" (Geertz 1983:75).

ADHD remains a controversy for two reasons: first, as Danforth and Navarro's study indicates, appeals to common sense are frequent in contesting ADHD, and these appeals are successful insofar as they render the diagnosis and treatment of ADHD as a problem. Bad parents, lazy, misbehaving children, bad teachers, doctors, pharmaceutical companies can all have ulterior motives for accepting or promoting ADHD, but what motives can opponents of ADHD possibly have? The fact that common sense is accountable only to itself makes it resistant to reflexive interrogation. Secondly, common sense demands to know the truth *behind* ADHD. What *really* causes ADHD? What *is* ADHD: is it really a disorder, a way to control kids, an opportunity structure, a set of symptoms, a convenient excuse, a way to market drugs, etc.? Is it nature or nurture? Is ADHD real or constructed? I was asked these questions all the time, and they are perfectly reasonable, and even important questions to be asking at times. I mention these questions here not to demean them or the people who ask them, but rather to highlight the ways that common sense holds ADHD accountable. There is no truth of ADHD, but the need to find it, and to *represent it* as both scientific fact and moral identity is how ADHD becomes political in the United States.

ADHD as a Political Problem: Approaches and Methods

Originally, when I began my fieldwork my goal was to explore the controversies surrounding ADHD as not just scientific or medical problems but as problems that linked science and medicine to other political and social forms. Not surprisingly given my interest in critical medical anthropology, Michel Foucault's empirical work on madness, the clinic, the prison, and sexuality were not only scholarly points of interest, but also obligatory passage points. In particular, Foucault's work on discipline was especially relevant given that both ADHD and its treatments could, without much of a stretch of the imagination, be viewed as disciplinary mechanisms to create "mute and docile bodies." At the time, I was also trying to conceptualize the relationship between ADHD and biopower. According to Foucault's schema, biopower is a mode of power that operates simultaneously at two poles. The first pole, an "*anatomo-politics of the human body*" centers on the "body as

machine” and works to create mute and docile bodies through discipline which can be integrated into explicit functioning systems and programs—the technologies of discipline Foucault outlines in *Discipline and Punish* serve as a good examples here (Foucault 1990:139). Operating at the second pole is a “*biopolitics of the population*” which aims at maintaining the life of the species body through a series of regulatory technologies (ibid). Therefore, biopower is at once and the same time “anatomic and biological, individualizing and specifying, directed toward the performances of the body, with attention to the processes of life” (ibid). Whether ADHD concerns life per se is debatable (and I mean debatable not in the sense of doubtfully, but rather in the open sense of a question). Also, it was less clear to me at the time that ADHD was operating within a mode of governance that operated at the level of the population per se. If there is some kind of multiplicity that isn’t population what might it be? What does biopolitics look like in the United States today, and where are its effects evident?

In his book, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*, sociologist Nikolas Rose provides a magisterial account of the ways that transformations in the fields of neurology, psychopharmacology, and the molecular sciences are forging new links between government, life, and politics in contemporary wealthy democracies. The relationship between government and “life itself” was first outlined, of course, by Michel Foucault in his 1975-1976 lectures at the College de France, and then later in the first volume of *The History of Sexuality* (Foucault 1990, 2003). According to Foucault life itself comes under the explicit realm of calculation with the emergence of the “arts of government” starting in the seventeenth century.

In *The Politics of Life Itself*, Rose argues that Foucault’s biopower and biopolitics are undergoing several critical mutations that correspond to new “forms of life.” Unlike the “histories of the present” that Foucault conducted in studying the prison, sexuality, etc., which sought to “destabilize the present,” Rose’s method of inquiry, what he calls a “cartography of the present,” seeks to destabilize the future, by creating a map of “an emergent form of life, and a draft of the potential futures it embodies” (Rose 2006:5). This involves, among other things, tracing what he sees as five new “pathways” or “mutations” that he sees biopolitics taking in the twenty-first century. First, Rose looks at the “molecularization” of the gaze of the human sciences and what this new way of seeing makes possible. Secondly, he attends to the process of “optimization,” which augments life, perfects it even, beyond “the poles of health and illness” through technologies of enhancement. Third, he charts a new kind of “subjectivation,” that connects identity and sociality to the conditions of life itself. Fourth, Rose explores the rise of new kinds of “somatic expertise” that link life and modes of governance in novel ways (Rose 2006:5-6). Finally, Rose examines what he calls “economies of vitality” that link markets, science, and domains of production like pharmaceuticals: what Kaushik Sunder-Rajan calls “Biocapital” (Sunder-Rajan 2006). In all fairness, Rose didn’t so much invent these ideas as much as thoughtfully trace the relationship between them with careful empirical attention to events and happenings in the sciences and politics. Whereas Rose sees these five ideas as “mutations,” I am more inclined to treat them, less ambitiously, as lines of inquiry or subjects of empirical attention. In particular, I give the subjects of molecularization (Chapters 2, 4, 5), optimization (5), and somatic expertise (4) more attention elsewhere in my dissertation. For now, I’d like to draw a closer connection between subjectivation and governance in the contemporary United States as it relates to ADHD.

One thing that was clear to me even before I began my fieldwork was that American Liberalism provided ripe conditions for the politicization of ADHD. As an

undergraduate I had spent a couple of summers as an activist and intern on Capitol Hill, and I returned after my senior year with a research grant to study environmental activism. These experiences gave me a greater appreciation of the ways that political movements and interest groups could mobilize both scientific expertise and appeals to identity as lobbying tools. This political landscape has conceived considerable attention from other fields like political science and political sociology, which set these observations into clearer relief. In his much-acclaimed book, *Bowling Alone: The Collapse and Revival of American Community*, for example, political sociologist Robert Putnam argues that the glory days of associationalism in America are gone. Not only has the traditional family unit eroded, but membership in the kinds of civic organizations that were once popular in the 1950s and 1960s, e.g. the Rotary Club, the Kiwanis Club, the NAACP, has dwindled. Today Americans civic engagement is largely confined to organizations whose “only act of membership consists in writing a check” to an address somewhere around “14th and Streets” NW, D.C. (Putnam 2001:52). In terms of participatory democracy, this has entailed the decline of party “mobilization” and the rise of a politics of “activation,” to use Steven Schier’s language. Whereas before voters chose one political party or the other to make a whole range of political decisions for them, new technologies like the internet and targeted media campaigns have emerged, which activate informed citizens around narrow issues and hot-button topics, e.g. gun control, women’s reproductive choice, transit development, school choice, etc. (Schier 2000). Of course, in the mid-twentieth century, pluralists like John Kenneth Galbraith considered politics to be a clash of special interests, and C. Wright Mills saw a “power elite” organized of just a few well-educated, well-connected, and engaged people, driving political action in the U.S. (Judis 2001:3-32). So what is different about politics in the United States today?

Since the signing of the Civil Rights Act in 1964, when Democratic President Lyndon B. Johnson was said to have remarked “There goes the South for a generation,” the United States has undergone its most significant shift in electoral politics since the New Deal Realignment (Sundquist 1983). These shifts correspond also to the rise of neo-conservatism in the United States, which both pre-dated and outlasted Ronald Reagan’s presidency. In an essay titled “Governing ‘advanced’ liberal democracies,” Nikolas Rose suggests that changes in politics are not due to neo-conservatism per se, but rather to the rise of what he calls “advanced liberal governmentality.” Rose outlines three fundamental shifts. First, “a new relation between expertise and government” has emerged that can be seen in new regimes of accounting and financial management, and which take several forms—marketization, monetarization, and audit (Rose 1996:54).⁶¹ Secondly, advanced liberalism involves “a new pluralization of ‘social’ technologies” (Rose 1996:56). Many of central institutions of the welfare state have been decoupled from one another and a whole range of new social technologies have taken their stead. What has replaced the apparatus of the social is a loosely affiliated network of autonomous actors that are linked through their relation to some kind of problem.⁶² This can be seen in the decline of the

⁶¹ In the United States, for example, the “No Child Left Behind Act”, a piece of federal legislation passed in 2001 with the aim of improving performance in primary and secondary education, creates, in theory, a system of accountability by instituting a new series of standardized tests and giving parents more choice in the schools their children attend.

⁶² For example, in her study of Cambodian refugees in the San Francisco Bay Area, Aihwa Ong shows how problems like domestic abuse are being addressed through new social technologies like self help groups, and how these groups play an important role in the re-organization of traditional technologies of government like the welfare office and the legal system. Furthermore, for recent

welfare state (or more broadly what Gilles Deleuze and Paul Rabinow have called “the social”), and the rise of other organizations that have taken its stead, like self-help groups, or even the internet (Deleuze 1997; Rabinow 1995). Finally, advanced liberalism entails “a new specification of the subject of government” one that is actively responsible in his/her own governance, one that is expected to be an “expert of themselves” (Rose 1996:59).

This notion of self-expertise is well captured by the concept of “biological citizenship,” which was developed, as many good ideas are, seemingly independently with respect to two different empirical circumstances. In an article, aptly titled “Biological Citizenship,” Nikolas Rose and Carlos Novas claim that “citizenship in the contemporary age of biomedicine is manifested in a range of struggles over individual identities, forms of collectivization, demands for recognition, access to knowledge, and claims to expertise” (Rose and Novas 2005:442). This “politics of embodied or somatic individuals,” they argue, is “creating new spaces” and “generating new objects of contestation, not least those concerning the respective powers and responsibilities of public bodies, private corporations, health providers and insurers, and individuals themselves” (Rose and Novas 2005:442).

Rose and Carlos Novas call this kind of neo-liberal ethical terrain around conditions like disability, “the political economy of hope.” To illustrate this point they examine the practices of recovery surrounding depression. Recovery from depression in today’s era of biological citizenship requires enlisting “a whole range of techniques of the self: practicing self-discovery, liking yourself, being kind to oneself, reducing stress, engaging in physical exercise, eating well, writing lists and keeping diaries, building one’s self-esteem, joining a support group, or reading the Prozac.com newsletter” (Rose and Novas 2005:447). Central to this understanding of biological citizenship is the “self-expertise” of the subject in producing truth about one’s own body; but this truth is hooked up to a whole array of technologies of neo-liberal governmentality.

Adriana Petryna develops this concept concurrently in her book *Life Exposed: Biological Citizens After Chernobyl*, which examines through the ways in which those suffering from the effects of the reactor meltdown at Chernobyl must fight for recognition of illness in order to receive welfare benefits from the state (Petryna 2002). Petryna calls this complex negotiation “biological citizenship” because life itself becomes implicated in state belonging. This kind of political struggle for recognition exists in the United States with respect to learning disorders and disabilities like ADHD. Patients and their caretakers, often lobby hard for special accommodations—e.g. performance enhancing medication in the form of stimulants, extra test time, smaller classrooms, individualized attention). These accommodations have even been protected through legal routes like the Individuals with Disabilities Education Act, Individualized Education Plans (IEPs), and Section 504, etc.—a point I return to later in this chapter.

Biological citizenship, as the essay by Rose and Novas indicates, takes on particular forms in contemporary North Atlantic and European democracies. In an essay

immigrants, “a variety of agents—the state, the corporation, the local authorities—can distribute different kinds of social goods in a complementary fashion that secures overlapping webs of support and sustenance” (Ong 2003:286). As Rose states, “The reconfiguration of political power involved here cannot usefully be understood in terms of the opposition of State and market: shaped and programmed by political authorities, new mechanisms are utilized to link the calculations and actions of a heterogeneous array of organizations into political objectives, governing them ‘at a distance’ through the instrumentalization of a regulated autonomy” (Rose 1996:57).

entitled “Multiculturalism and ‘The Politics of Recognition,’” Charles Taylor argues that contemporary (neo)- liberal societies like Canada and the United States are marked by a discourse of equality and universal dignity (Charles Taylor and Gutmann 1992). This “politics of recognition” has played itself out in western liberal democracy through identity politics, multiculturalism, and the political recognition of previously marginalized groups. Disability constitutes part of this neo-liberal terrain of governmentality insofar as the conditions of life around the category of disability have become politicized over the past three decades. One way of understanding this general condition of recognition, and of biological citizenship, is to examine how ethico-political identities assemble around conditions of life itself, what Paul Rabinow calls *biosociality*. “In the future,” Rabinow argues “the new genetics will cease to be a biological metaphor for modern society and will become instead a circulation network of identity terms and restriction loci, around which and through which a truly new type of autoproduction will emerge” (Rabinow 1996:99).

In a preface to a special issue of *Critical Inquiry* called “Intimacy” Lauren Berlant suggests that these new sites of auto-production are also sites of intimacy; but it is an intimacy that is *becoming public* (Berlant 1998). This kind of intimacy, which often occurs in self-help and patient rights groups settings, can also occur through technologies like the internet and television—“talk shows, on-line disability support groups, Web sites, and so on”—what Rayna Rapp and Faye Ginsburg call “mediated kinship” (R. Rapp 2001; Taussig et al. 2005). Kinship may seem an inappropriate term for such a public form of engagement, but as Veena Das and Renu Addlakha argue “[t]he domestic sphere...is always on the verge of becoming the political” (Das and Addlakha 2001:512). In their article on disability and forms of stigma in India, Das and Addlakha employ the “admittedly awkward” phrase “domestic citizenship” in an attempt “to show that the domestic, once displaced from its conventionally assumed reference to the private, becomes a sphere in which a different kind of citizenship may be enacted—a citizenship based not on the formation of associational communities, but on notions of *publics* constituted through *voice*” (Das and Addlakha 2001:512). Although Das and Addlakha’s ethnographic account focuses on the ways disability and stigma are encapsulated in narrative and voice, their insights help shed light onto the ways that disability becomes inflected by kinship and the ways that kinship is tested, tried, and put into action through disability’s sheer existence and marginality.

Joe Dumit’s work on what he calls “New Sociomedical Disorders” pushes this kind of work on biosociality and citizenship in productive new directions by exploring specifically how disorder, disability, and conditions of life are politicized not only through their publicity but also the public life of knowledge surrounding these conditions. These New Sociomedical Disorders include such contested medical conditions as ADHD, Chronic Fatigue Syndrome, Post Traumatic Stress Disorder (PTSD), Multiple Chemical Sensitivity (MCS), and Gulf War Syndrome (Dumit 2000). There are several criteria of a New Sociomedical Disorder: “1) they are ‘biomental’: their nature and existence are contested as to whether they are primarily mental, psychiatric, or biological. 2) They are causally undetermined: their etiology is likewise contested as to social, genetic, toxic and individual responsibilities. 3) They are ‘biosocial’: persons having these conditions are organized, coordinated, and feel a kinship based on their shared experience.”⁶³ These three elements

⁶³ Dumit’s concept of new sociomedical disorder also helps contextualize or retheorize Alan Young’s findings on the polythetic classification of Post Traumatic Stress Disorder in *The Harmony of Illusions* (Young 1997).

of new sociomedical disorders nicely capture ADHD's political profile in the United States today, and help explain, at least in the general sense, how ADHD is in fact never one thing but rather a multiplicity that operates simultaneously across domains that we take for granted—science, medicine, society, the family, and so on.

ADHD and the Political

But what does it mean, as I have suggested, that ADHD is a politicized category? How does ADHD become political or politicized? In his book *Political Machines: Governing a Technological Society*, sociologist Andrew Barry provides a way of thinking politics beyond our commonsense notions, by distinguishing between “politics” and “the political.”

By politics I mean a way of codifying particular forms of contestation—particularly associated with the activities of political parties and the state. Politics, in this sense, refers to the conventional forms in which the term is used. These political forms are themselves objects of contestation. The boundaries of what we call politics are the objects of political action. This sense of politics can be contrasted with a notion of the *political* which I take here to be an index of the space of contestation. Thus an action is political in this latter sense to the degree to which it opens up new sites and objects of contestation. And it is *anti-political* to the extent that it closes down the space of contestation (Barry 2001:194).

There are four things worth noting here. First, Barry's notion of the anti-political as the closing down of the space of contestation brings to mind E.E. Schattschneider's, now canonical, observations in *The Semisovereign People* that politics is waged on a strategy of expanding or narrowing the scope of conflict. This is because, for Schattschneider, politics is a fight—a “contestation” to use Barry's language—and it has two elements: the participants, and the audience. The audience largely determines what the outcome of the fight will be. “*This is the basic pattern of all politics*,” Schattschneider says (Schattschneider 1975:2). Thus in politics, the underdog(s) seek to expand the scope of conflict by inciting the audience to action. This is because the effects of audience participation in a conflict are unlikely to be equal, and as the underdog one hasn't much to lose in expanding the conflict, especially if the audience seems favorable. This model is by anthropological standards too neat. As the subtitle of Schattschneider's text indicates, this is a “realist's view” of politics, which gives it something of a pragmatic applicability. As an approximation it works nicely as a preliminary heuristic for thinking through ADHD-as-politics.

The examples I provided above—Frances's op-ed, Cruise's rant on *The Today Show*, and Robertson's grandfatherly caution—all illustrate, in their own way, examples of politicizing ADHD by expanding the scope of conflict through involving the audience. “Defining the elusive line between mental disorder and normality is not simply a scientific question that can be left in the hands of the experts,” Frances warns. “This is a societal issue that transcends psychiatry.” When Lauer attempts to placate Cruise by complimenting him on having done his “homework” on Ritalin and ADHD, Cruise responds, “*And you should...and you should do that also...Because just knowing people who are on Ritalin isn't enough. You should be a little bit more responsible in knowing really.*” Here we have Cruise, attempting transform Lauer from a passive apologist for Ritalin to an active participant in the contest over Ritalin's public legitimacy. When Lauer responds that he's not prescribing Ritalin and is not encouraging anyone else to, Cruise suggests that this view is naïve because Lauer is a public figure and his silence on the subject is irresponsible. This is why he chastises Lauer for being “reasonable” about the issue. And how else should

we interpret Robertson's disheartened plea to his *700 Club* viewers if not as a call to action?: "Let's change the way we're thinking here in this country in relation to Ritalin. I just can't stand what's being done."

Secondly, and related to the first point, ADHD becomes political by becoming public. In each of these cases the venue is as important as the message—to use a variation of Marshall McLuhan's oft-quoted dictum. The *Los Angeles Times* has a daily circulation of just under one million readers, NBC's *The Today Show* is the number one morning news program with an average viewership of just under six million viewers, and the *700 Club* averages one million viewers a day.⁶⁴ I chose these three examples not simply because they were somehow the most representative of the resistance to ADHD (although the fact that each is illustrative in its own way is no doubt helpful), rather I chose them because they show moments when and where ADHD is becoming a political discourse, where ADHD is becoming public, and where it moves from a technical question debated by experts to a popular one debated by non-experts. After all, as Michael Warner reasons in his book *Publics and Counterpublics*, "expert knowledge is in an important way nonpublic: its authority is external to the discussion. It can be challenged only by other experts, not within the discourse of the public itself" (Warner 2002:145). Frances is no doubt an expert but he is addressing a non-expert public. And although Cruise framed himself as an expert on the subject of Ritalin, his public persona is that of a celebrity and actor; a persona that no doubt influenced Lauer's demeanor in the interview—would Lauer have challenged a medical doctor?—and also the spin following the show that focused on Cruise's erratic behavior rather than the substance of his critiques.

As a related proposition we might add that in becoming public, politics becomes *protest*. It is not coincidence, I would argue, that Barry chooses protest as a paradigmatic political form. Protest comes from the Latin *protestari*, which means "to testify publicly or bear witness to."⁶⁵ Although the examples I have provided above do not constitute a kind of protest that fits the popular imagination, I nonetheless would suggest that they fit the concept of protest that I am outlining here. It is to testify publicly, to bear witness. If, as I suggested earlier, there was no appeal to the divine in his segment on ADHD, Robertson nonetheless politicizes ADHD through the Christian modality of *bearing witness*.

Third, in opening up a space of contestation, the political for Barry is a point of rupture that makes the difference of politics visible (and this is why he focuses on events like demonstrations). He draws here from Giorgio Agamben's analysis of the Tiananmen uprisings in June 1989, in his book *The Coming Community*. "For Agamben what makes Tiananmen a political event is the way that it manages to escape the logic of the existing ways of organizing and codifying antagonism. The actions of Tiananmen demonstrate a political collectivity not by expressing an identity which pre-exists the action, but by forging an association marked by difference" (Barry 2001:195). This is what makes political action "subversive." I would argue that the politics of ADHD works in the other direction. What we see with ADHD are attempts to reduce the difference of hyperactivity back to a fundamental ground of identity, which is why the concepts of the politics of recognition, biosociality, and biological citizenship are helpful for understanding ADHD as a political category in the contemporary United States. This identity politics is not simply something

⁶⁴ *The LA Times*, *The Today Show*; and *700 Club* circulation numbers are available at the following websites http://www.latimes.com/extras/ads/circ_02.html; http://www.stateofthemediamedia.org/2008/narrative_networktv_audience.php?cat=2&media=6; <http://www.cbn.com/700club/showinfo/about/about700club.aspx>, (accessed April 2010)

⁶⁵ See Oxford English Dictionary, and Oxford Latin Dictionary.

that is practiced by advocates of ADHD. People who object to the labels of hyperactive or learning disabled are not opposed to identity per se, they oppose the potential adverse effects of what they perceive to be the negative labels that these categories impose. Remember Frances' warning about the effects of diagnostic sprawl on "stigma and the individual's sense of personal control and responsibility."

Fourth, the political and anti-political are "an index of the degree to which a problem or object is open to contestation" (Barry 2001:268). There are two things worth noting here: a) that politics is by this definition, a matter of "degree," or what Deleuze would call the *intensive*: it is virtual but real; and can only be measured indirectly through its actual effects. b) What is an index? It is something that points to something else, for example "a piece of wood, metal, or the like, which serves as a pointer; *esp.* in scientific instruments, a pointer which moves along a graduated scale (or which is itself fixed while a graduated scale moves across its extremity) so as to indicate movements or measurements."⁶⁶ To index, is "to indicate", "to point out." One way of rendering the difference of politics actual is to reduce this difference to some fundamental ground—a point that Nietzsche and Deleuze have made elsewhere and that I return to later. In the case of ADHD, I would argue this occurs through the act of indexing, of pointing to toward abstract entities like the market, power, genes, or to individual and group identities as the origin of ADHD. This act of indexing thus takes the form of a fixing of responsibility; of blaming. Therefore, if one wishes to better appreciate what is truly "political" about ADHD in the United States, one might start by looking at the "blame game" that surrounds the disorder. Assigning blame, is by nature public or social because, as an act it addresses itself to the community or entity that one is responsible to: to be responsible one must be responsible toward someone or something: like God, society, humanity, oneself, etc.

So to recap, what can we say thus far about ADHD and politics? ADHD, I would argue, is made political in three ways. First, as can be seen in the examples of the Frances op-ed, the Tom Cruise/Matt Lauer interview, and the *700 Club* segment, there is a classic Schattschneiderian expanding of the scope of conflict. This is achieved by taking a technical subject, that normally operates in the domains of professional psychiatry, and making it a point of *public* attention, which is done by calling into question the validity of ADHD usually by recourse to common sense. Working against this politics, is the anti-political work (in Barry's schema) by Nakamura and other scientists, who seek to make ADHD a purely scientific and apolitical subject; a question of expertise that is nonpublic⁶⁷.

Secondly, we have ADHD as a biosocial category as can be seen with advocacy groups like Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD), who lobby on behalf of people with the disorder. These groups play an important role in providing a network of support and political action, and can be understood, using literature in political science and sociology, as constituting a kind of politics that activates a small segment of the population around very narrow issues—a politics of "activation." This kind of politics is also nicely captured by the existing literature on the subjects of biosociality and biological citizenship. This scholarship is essential to understanding how ADHD is a political category in the United States, but it does not tell us everything. It is necessary, but by itself, not sufficient for appreciating the complexity of ADHD in American political life. I have chosen in this chapter to focus on other events, situations, and states of affairs, not because I think these previous approaches are flawed—indeed I could spend a dissertation

⁶⁶ Oxford English Dictionary.

⁶⁷ See, for example, (Dumit 2000).

“illustrating” the validity of these approaches through ethnographic examples—but rather because I see this literature as sufficiently robust on its own, and think I can make a greater contribution by focusing on other areas and ways that ADHD inhabits the political.

Third, ADHD becomes political when it collapses around identities or abstract entities like parents, children, brains, genes, markets, etc. This takes the form of a fixing of responsibility, or blaming. It is this last point that I would like to give closer attention to in the remainder of this chapter. In particular, I show how ADHD is a political problem in the United States not simply because its etiology is unclear, but because the problem of ADHD implicates questions of work, merit, and who or what is deserving of special resources because of social, political, or economic disadvantage. Thus I argue, the politics of ADHD take a particularly “American” form because of the way the blame game surrounding ADHD bears a striking resemblance to the blame game surrounding race and entitlement in the post-welfare United States.

Disparities in Diagnosis and Treatment of ADHD in the United States

One nagging question about the diagnosis of ADHD—a question that has no doubt helped fuel ADHD’s controversies—is not simply “why did it explode,” but also “why has this proliferation been so uneven”? I received many different answers to this question. It is a fairly well known fact that boys are more likely than girls to be diagnosed with ADHD, but many people were troubled by the idea that ADHD seems to remain a disorder diagnosed and treated primarily for white children. If depictions in popular media and advertising are any indication, the paradigmatic hyperactive child is a white, 10-year old boy. Epidemiological studies indicate that although the symptoms of ADHD (e.g. impulsivity, hyperactivity, and distractibility) as outlined by standardized diagnostic measures, like the DSM-IV, and ICD-10, appear even across populations, minorities like Latinos and African Americans are much less likely to get diagnosed with ADHD and even less likely to receive psychotropic medication for the disorder than whites (Regina Bussing et al. 2003; R Bussing et al. 1998; R Bussing, Schoenberg, and Perwien 1998; Leslie et al. 2007; Zito et al. 2005; Coker et al. 2009). Furthermore, because ADHD has been proven to negatively affect academic performance, the disparities in lack of treatment and accommodation for the disorder would seem to contribute to already existing inequalities in educational opportunities between whites and minorities (Mandell et al. 2008; R Bussing et al. 1998; Regina Bussing et al. 2003).

To date, because of the implications of these disparities and of the prevalence and importance of ADHD to the realms of education, child development, and health policy, there has been considerable focus on what kinds of factors (e.g. parental involvement, health insurance, cultural beliefs about medical intervention and education, etc.) help or hinder diagnosis and treatment of the disorder (Leslie et al. 2007; R Bussing et al. 1998; R Bussing et al. 1998; Kataoka, Zhang, and Kenneth B. Wells 2002). Zito and colleagues (Zito et al. 2005), for example, have suggested that racial disparities in prescription of psychotropic medicine for ADHD is significantly impacted by Medicaid eligibility categories. Similarly, Stevens, Harman, and Kelleher (Stevens, Harman, and Kelleher 2005) explore how insurance is proportionally related to levels of care and treatment. Through use of survey data, they found that African American and Latino parents are less likely to self-

report their child as ADHD, and that African American children were less likely to seek stimulant medication treatment than white American children.⁶⁸

These studies raise a number of important questions about the social life of ADHD and point to a new way that the disorder is being politicized. Parents, doctors, and teachers I spoke to in discussions on the subject tended to frame the uneven diagnosis of ADHD in one of two ways. First, as the literature above might indicate, many people saw the uneven diagnosis of ADHD, as an effect of a number of factors including access to health care and parental attitudes about the efficacy of psychopharmacological intervention on their child's behavior. Others however, believed that ADHD was over-diagnosed among some groups, particularly African American boys, in clinical settings, suggesting that perhaps this was a way of pathologizing black masculinity. Ann Ferguson hints at this possibility in her study *Bad Boys: Public Schools in the Making of Black Masculinity*, an ethnographic study of discipline at a racially diverse middle school in Berkeley, California (Ferguson 2001). Ferguson suggests that the disciplinary challenges young African American boys face at school stem in part from the ways black masculinity is an embodied, habitual response to social inequalities; a set of strategies that get young boys into trouble, especially with, but not always, white school administrators. She sees a troubling erasure of the social etiology of defiance in psychiatric categories like Oppositional Defiance Disorder (ODD) (in the DSM-IV), which the American Psychiatric Association insists applies only to within-child mechanisms. Although Ferguson doesn't demonstrate this has led to the pathologization of black masculinity per se, her careful analysis of the relationship between race, masculinity, and discipline nonetheless points to this troubling possibility. Just as important for our purposes here, Ferguson also shows how school administrators constantly frame success as an individual choice; something I also witnessed in my observations of ESL students in a learning environment saturated with messages of uplift and empowerment.⁶⁹ Again, the theme of "personal responsibility"—a hallmark certainly of neo-conservative politics, and perhaps even advanced liberal governmentality—is at work not simply where the apparatus of the social is in retreat, but even in the heart of what remains perhaps the single most "social" technology in the United States: public education.

To speak here of "racial disparities" in the diagnosis and treatment of ADHD, may seem to follow the trend of epidemiology in reifying what are in fact very contested, and to some extent, fluid social categories—ones as anthropologists we would seek to open up

⁶⁸ While these data are plentiful and indeed helpful in positing interesting, and in some cases even statistically significant, conclusions about the effects of these variables on racial and class disparities of diagnosis and treatment, much of this data has been gathered through insurance data, surveys, and brief interviews. As a result there has been surprisingly little ethnographic work to date on how children get diagnosed with ADHD and the relationship of these specific patterns of diagnosis to larger anthropological concerns—e.g. how are knowledge and practices, like child psychiatry and medical diagnosis, produced and legitimated, and how is this process shot-through with unspoken assumptions about socially marked categories like race and class? Consequently, the connection between the emergence and uneven diagnosis and treatment of ADHD and broader historical and cultural trends has remained largely speculative, and there is need for empirical work that can bridge 'on-the-ground' ethnographic observations of the patterns of treatment and diagnosis of ADHD with broader anthropological theorizing and contextualization. Elizabeth Carpenter-Song helps address this gap in her ethnographic study of children with ADHD and bipolar and their parents in Cleveland, Ohio (Carpenter-Song 2009).

⁶⁹ ESL is the common abbreviation for English as a Second Language programs in public schools.

through more careful ethnographic attention. As I indicated earlier, aside from Elizabeth Carpenter Song's work on this subject, much remains to be done on this front, and one potential criticism of my ethnography on the subject of ADHD is that I didn't take this responsibility more seriously in the design and execution of my field research. At the same time, race is not simply a category or identity, but also a field of difference, and my research on the topic of ADHD tries to think through the relationship between race and ADHD by attending to movements within this field. The effects of race in the United States are no doubt grossly unequal but, as critical race theorists have suggested, the upshot of this is that race can be appreciated as not something that just happens to particular bodies, but as something that produces social difference everywhere. One way that we can better appreciate not only how ADHD is politicized but also its connection to the operation of race in the United States, is to examine moments where "whiteness" gets interpellated as a racial category through the politicization of ADHD.

To help investigate this possibility, I spent some time in a public high school in California trying to better understand the ways that public schools serve as "sorters" and what effect this might have on the unequal treatment and diagnosis of ADHD. One day, I find myself sitting in a classroom with 26 students from various nationalities, all of them assembled there in straight rows because English is not their primary language. In stark contrast to this rigid spatialization of bodies comes an uncomfortably loud, almost hypnotic drone over the public address system: "*Slow ride, take it easy...*" This mantra echoes for what seems like too long, but is soon interrupted by a young male voice, over-trebled, and confident: "Today is Friday, June 8th, 2007. For you graduating seniors, the last Friday you will ever spend at Park High." Then a female compatriot starts talking but bursts into laughter; I can only sense that something is going on out view, because we can hear his laughter too picked up by the painfully sensitive PA microphone that sounds like if it were to be dropped would go off like a bomb. The ambition, vitality, enthusiasm, and even knowing cynicism that mark the voices of the two young student announcers represent one limit of the possibilities of freedom and opportunity at Park High.⁷⁰ By the looks on the faces of the students around me, I felt like I was sitting with the other end.

The English as a Second Language (ESL) class is run by Ms. M, who starts them on the day's assignment. "You've picked a bad day to observe the class," she tells me. "They're just revising their folktales." She hands me a pile of folktales written by her other class she teaches later in the day. The idea of the assignment is to have students write a fable from the perspective of their home country, except in English. I look through the pile. The first fable is about a family of pigs in Mexico. Another, "Three Little Chickens," is set in "a small village in China called ChingKwan." It is the story of Diao, Bao, and Gao, who head to the river to play. An eagle, Maohei, wants to kill them, but a hunter shoots and kills it. The boys thank the hunter and continue to play together. According to the student the moral of the story is "A bad way has a bad end." At the bottom next to the moral, is a note from Ms. M scrawled in red ink, "I don't see this."

I get bored reading and glance around the classroom, which is plastered with reminders, and messages of empowerment and uplift. Over the whiteboard in the front of the class is a banner with the words of Benito Juárez "El Respeto al Derecho Ajeno Es la Paz."⁷¹ Next to a picture of Martin Luther King Jr. on the adjacent wall is a poster ostensibly written by students in the class:

⁷⁰ Park High is a pseudonym

⁷¹ Respect for the Rights of Others is Peace.

PROBLEMS/ROAD-BLOCKS TO OUR PURPOSES

- Bad friends pushing us to skip class
- Using drugs, alcohol, cigarettes, etc.
- Fighting with friends or problem with other people or family
- Problem with English make everything harder
- Having to go back to my country for serious reason or problem
- Having to move to another state.

I go back to reading the folktales. "Tomorrow is Another Day," is about a girl raised by her grandmother in rural China. "Tomorrow is for people who are ready," the student writes.

When the class ends, I stay after to talk to Ms. M., who is frazzled and at first seems irritated with my questions. I ask Ms. M if she knows of any kids who have been diagnosed with ADHD here. "I don't know, not in my class. Are you kidding? Most of these kids' parents don't even speak English. You know how much of a problem that is? One of my students, Luz, you know him, he's the one who I had to threaten to take his phone away...he's a sweet kid, he really is, but I had to call home because he was coming in everyday and he'd never have the homework done. But his parents don't speak English so he had to translate. For them!" She laughs incredulously, "I mean, this is ridiculous, here I am telling him to tell his parents that he needs to do his homework? Did he tell them, I have no idea."

This has lightened the mood a bit.

"Well, whatever, anyway, I mean it's a good question it's just that most of these kids' goal is to graduate high school, and I'm here to help make sure they do that. If there are problems, you never know, maybe they have ADD, maybe they were actually good students before, but now they change schools and they have problems."

I nod.

"Like this one student, Adel, he's Irani. Really smart; just doesn't care. Is that ADD? I don't know, I'm not a doctor."

Ms. M's reluctance to see ADHD everywhere seems to contradict popular fears that overworked teachers are encouraging children to be tested with ADHD to help with classroom management. Instead, her comments suggest that parental involvement is critical for the diagnosis of learning disorders. But parental involvement was generally something she found in short supply in her experiences as an ESL teacher at Park High (she also told me of another situation where a brother and sister, both in the same class, had missed class for several weeks, but their parents were just as surprised to discover this because they were busy working multiple jobs). Her suggestion that there is no ADHD in her ESL classroom points to another possibility that I heard frequently in my discussions about the proliferation of ADHD in the United States: that what is in fact driving the diagnosis of ADHD is, as the literature on biological citizenship might suggest, is parental activism. But "activism" puts perhaps too positive of a spin on what is viewed more frequently as a kind of opportunism. More bluntly, it is often suggested that over-privileged whites are using ADHD as an excuse for special accommodations like extra time on standardized tests, and for access to performance enhancing drugs like Ritalin and Adderall. The concomitant assumption is that these children do not have ADHD, or that ADHD and Learning Disabilities are generally meaningless labels in the first place. These attitudes help explain the popular notion that ADHD is a kind of "affirmative action for white people."

ADHD, Whiteness, and Entitlement

In April 2001, when I was a sophomore in college, columnist David Brooks wrote a piece for *The Atlantic Monthly*—back when it still carried that name—called “The Organization Kid.” The cover that month featured a girl, of maybe sixteen years, with a button nose, pert lips slightly glossed, perfectly manicured brows, and hair pulled back into a pony-tail. More importantly though she is surrounded by all the accoutrement of the overachiever: books, a violin, a soccer ball, even an outrageously un-mobile cellular telephone. She has headphones around her neck, a watch on one wrist, one finger in a book, and a violin bow slung over her right shoulder. And what else screams over-entitled WASP more than having the scene as a painted portrait, set in a study of deep restrained mahogany? “The Next Ruling Class” the cover announces in understated serified font, and below in italics: “Meet the Organization Kid.” The Organization Kid cuts a striking figure: she’s ostensibly not a sex symbol, at least not the way she is painted, but there is something nonetheless intimidating about her stoic look. Like Brooks’ article, her portrait is vaguely ambivalent; it is not clear whether we are supposed to feel threatened or sorry for her.

Brooks’ essay might as well be anthropology the way he sets himself up as a naïve fish out of water. “A few months ago I went to Princeton University to see what the young people who are going to be running our country in a few decades are like.” This generational divide is the main organizational device for the essay. Brooks came of age as a conservative just after an era defined by the “narcissism and nihilism” of the baby boomer generation, but walking around places like Princeton or even any American mall, he is struck by the “upbeat 1962 pre-assassination innocence.” “At the schools and colleges where the next leadership class is being bred, one finds not angry revolutionaries, despondent slackers, or dark cynics but the Organization Kid.” On the one hand, Brooks’ essay is about how much life has changed about elite campus culture, but more broadly it is about what Brooks calls “the meritocratic elite” which seems, at least on the surface, something of an oxymoron. What he finds striking is the way that people who came of age after the fall of the Berlin Wall during the boom years of the Clinton Presidency are completely achievement oriented. “I asked several students to describe their daily schedules, and their replies sounded like a session of Future Workaholics of America: crew practice at dawn, classes in the morning, resident-advisor duty, lunch, study groups, classes in the afternoon, tutoring disadvantaged kids in Trenton, a cappella practice, dinner, study, science lab, prayer session, hit the StairMaster, study a few hours more.”⁷²

Although Brooks attributes much of this kind of work ethic and embrace of authority to the boom years of the 1990s—“if your experience consisted entirely of being privileged, pampered, and recurrently rewarded in the greatest period of wealth creation in human history, you’d be upbeat too. You’d defer to authority. You’d think that the universe is benign and human nature is fundamentally wonderful”—he nonetheless ultimately sees parenting as the root of this worldview. “If [the meritocratic elite] are group-oriented, deferential to authority, and achievement-obsessed, it is because we achievement-besotted adults have trained them to be. We have devoted our prodigious energies to imposing a sort of order and responsibility on our kids’ lives that we never experienced ourselves.” Brooks goes on to paint a picture of obsessed upper-middle class and affluent parents who will buy every last Baby Mozart compact disc to ensure their child’s

⁷² (Brooks 2001). Brooks’ essay is available online at <http://www.theatlantic.com/magazine/archive/2001/04/the-organization-kid/2164/> (accessed April 2010). I refer here to the online version and therefore do not include page numbers.

neurological development. “The pressure is on” he observes without a whiff of judgment.

The Organization Kid was educated in what Brooks dubs “the big-backpack era,” a period that he estimates began sometime in the mid-1980s. Although bigger backpacks meant more homework, a presumably neutral result, Brooks sees a another disturbing trend in education: “increasingly, and in surprising numbers, kids whose behavior subverts efficient learning are medicated so that they and their classmates can keep pace.” He cites the statistic that the United States consumes ninety percent of the world’s Ritalin. “Far from all that Ritalin goes to elementary school kids,” Brooks concedes, “but the Ritalin that does is prescribed most frequently in upper-middle-class suburban districts—where, one suspects, the achievement ethos is strongest.”⁷³ Given the essay appeared in a popular journal, Brooks doesn’t cite his sources. The figures he gives for the consumption of Ritalin in the United States are readily available, but his assertion that Ritalin is consumed at higher rates in wealthy suburban areas is less well studied and it would be interesting to see from where Brooks drew that conclusion. At the very least though, it serves the rhetorical purpose of the drawing the link between wealth, elitism, privilege, and the focus on achievement and success. Brooks notes that although the meritocratic elite that populate campuses like Princeton are perhaps not exactly representative of young Americans taken as a whole, they are nonetheless “the logical extreme of America’s increasingly efficient and demanding sorting-out process, which uses a complex set of incentives and conditions to channel and shape and rank our children throughout their young lives.”

The merits of Brooks argument are, of course, debatable. At the time, *The Atlantic Monthly*, was deluged by letters to the editor; some readers praised Brooks for articulating what they saw as an unhealthy focus on achievement dumped upon children by their parents, whereas others, current Princeton students in particular, felt his observations were overblown, and were extrapolated from a few lunch encounters with the most achievement obsessed students. I’ve cited Brooks’ essay here not so much to make the point that there is something like a meritocratic elite, but rather because it serves as an illustration of the ways that the relationship between Ritalin, ADHD, and parenting hold a privileged position in popular accounts of the limits of meritocracy, and to show that the problems of merit and achievement are objections of sustained reflection in contemporary print journalism.

In my fieldwork on ADHD, I encountered three main objections to the disorder. First, that the diagnostic criteria for ADHD are so vague that they could include any and every normal child, and indeed every normal child exhibits these behaviors. This view generally stemmed either from a common-sense rejection of the need for the diagnostic category or a fear or cynicism that the label was being used to control children. Secondly, that psychostimulant drugs like Ritalin and Adderall, are dangerous (“they are similar to cocaine” the common critique goes) and they drug children into submission, turning them into “zombies”, and suppressing their natural behaviors. Like the previous objection, this view tends to stem from either a commonsense idea that psychoactive drugs are by their nature “bad” because they alter one’s state of mind (as Robertson articulated), or from a view that drugs like Ritalin are a form of social control; a kind of “chemical straitjacket” as the

⁷³ Indeed, reporting in a piece called “Why Ritalin Rules,” which appeared in 1999 the journal *Policy Review*, which is published by the Heritage Foundation, Mary Eberstadt, echoes this commonly held assumption when she quotes from *The Myth of the ADD Child*, noting that “Many middle and upper-middle class parents...see Ritalin and related drugs almost as ‘cognitive steroids’ that can be used to help their kids focus on their schoolwork better than the next kid” (Eberstadt 1999:3). (Note that the pages in Eberstadt refer to a pdf version of the piece, which may not correspond to the page numbers in the original version in the *Policy Review*). See also, (Armstrong 1997).

Scientists like to call it. The third main objection to ADHD is more germane to our discussion here: namely that, regardless of its validity as a medical disorder, ADHD is abused by opportunistic parents who want to use the accommodations afforded for learning disabled and disordered students to give their child or children an unfair advantage on measures like standardized tests. "It is a way for rich white kids to create a minority niche for themselves," said the founder of Princeton Review California, in a 2000 *Los Angeles Times* article. "I don't see many kids from Compton getting these kinds of luxurious diagnoses" (Weiss 2000b).

During the mid-1990s, to early 2000s, a number of articles and essays appeared in newspapers and magazines chronicling the potential abuse of special accommodations for learning disabilities by wealthy white suburbanites; what critics call "gaming the system." One of the first and more notable pieces was an essay by Ruth Shalit, "Defining Disability Down" which appeared in the *New Republic* in 1997. Shalit paints a picture of abuse by parents and students who wish to cheat the system: "clinics swarm with hordes of pushy parents and catatonic collegians, all hankering for a diagnosis of intractable infirmity," to be labeled with what she calls "boutique diagnoses." She also suggests that what drives this push is the fear of mediocrity, which the middle-class rationalizes as the fault of an underlying disability. "This is the new frontier," Shalit writes "the learning disability as an opportunistic tautology." In this climate, "the learning-disabled are now eligible for a lifelong buffet of perks, special breaks and procedural protections, a web of entitlement that extends from cradle to grave" (Shalit 1997).⁷⁴ Shalit and others were particularly bothered by what they perceived to be the persistent pursuit of a medical diagnosis for special gain; a practice commonly referred to as "diagnosis-shopping": the idea that wealthy (mainly white, and mainly suburban) parents go to psychiatrist to psychiatrist, learning specialist to learning specialist, looking to obtain a diagnosis of a learning disability (often shortened to LD) or testing that will help obtain such a diagnosis (Gross 2002).⁷⁵

Another common point of view is that learning disabilities and disorders are not worthy of disability status except in exceptional cases. It is like my aforementioned experiences with Tom, who did not oppose the idea of ADHD per se, but had never, in his opinion or experiences, come across a genuine case of it. Similarly, in an article published in the *Vanderbilt Law Review*, "'Accommodations' for the Learning Disabled: A Level Playing Field or Affirmative Action for Elites?," Craig Lerner argues that learning disabilities are in most cases not "real" disabilities, at least not by legal standards because they do not present a significant impairment in terms of functioning. As a result, he argues that except on rare occasions, people with learning disabilities should not be afforded special accommodations in academic settings. "An entire industry has arisen dedicated to the diagnosis and medication of any student falling short of Einsteinian mental prowess combined with Gandhian spiritual calmness," Lerner observes wryly. "And needless to say, there are the armies of lawyers who are prepared to do battle on behalf of the 'learning disabled,' and who have likened such efforts to earlier struggles for equality on behalf of disadvantaged groups such as African Americans, women, gays and lesbians,

⁷⁴ This source is available online on The New Republic's website and does not have corresponding page numbers. All citations refer to the Online Edition.

⁷⁵ When the College Board—the organization in charge of the SAT, which is the main standardized test used in college admissions—announced that it would discontinue "flagging" tests taken under non-standard conditions (e.g. taken with extra time), there was a fear that the number of requests for special accommodations would increase, but the College Board also instituted a stricter auditing system to offset the potential for abuse.

and the elderly” (Lerner 2004:1045). Critics like Lerner charge, and this is a common complaint, that the only real beneficiaries of labels of ADHD and their accommodations are wealthy white parents and students, and disability rights lawyers—Shalit suggests that any public resistance to disability rights law is “effectively vanquished by televised testimony from sobbing children in wheelchairs.” Lerner also suggests that “recent studies have demonstrated that students requesting an LD diagnosis are disproportionately from affluent communities” (Lerner 2004:1108), one of his main and underlying assertions. But it is not clear which studies he is referring to other than two newspaper articles that he cites—the aforementioned LA Times article, and an article in the *Hartford Courant*. The second article doesn’t measure “students requesting an LD diagnosis” but rather how LD diagnoses are distributed within the state of Connecticut school system. The article also suggests the possibility that this distribution could be due to which school districts have sufficiently robust budgets and adequate special education programs to support people with learning disabilities (Green 1998).

After the aforementioned article in the LA Times of January 2000, California State Senator Richard Alarcon, requested an audit of special accommodations provided by the College Board on the SAT in the state of California. Kenneth Weiss, the author of the previous article, quoted the audit, suggesting that “[s]ome undeserving students may have received extra time on standardized tests, possibly giving these students an unfair advantage over other students taking the same test” (Weiss 2000a). Particularly troubling were the disparities between affluent and less affluent areas in the number of students receiving special accommodations. Replying to the Weiss editorial, Gaston Caperton, then president of the College Board, wrote a letter to the editor two weeks later, countering that while he found abuse troubling and objectionable, the cases of abuse made up a minority of cases of people asking for special accommodations, and that they likely accounted for only one fifth of one percent, or one in five-hundred, of SAT test takers (Caperton 2000). Even in his previous article, Weiss argued that “47,000 SAT exams were given accommodations,” in the previous year and that “[t]he vast majority [were] not controversial” (Weiss 2000b). The audit also found that less than two percent of test takers received extra time or other accommodations; a number that is significantly lower than the percentage of LD students in the state. This would suggest that not all students with LD are taking advantage of accommodations, and or that only a percentage of students with LD end up taking the SAT. Since 2002, as was previously mentioned, the College Board has introduced a stricter auditing system. Caperton, echoing disability rights advocates, argued that the class disparities of those receiving special accommodations was troubling, but that the real solution was to provide outreach and spread awareness to address the problem of unequal access rather than to endorse “a solution that can only make it more difficult for deserving students to take advantage of a legitimate accommodation” (Caperton 2000).

In my own fieldwork, I discovered just how dependent the economic apparatus surrounding ADHD is on this culture of meritocracy. Many of my informants, for example, worked in the fields of educational consulting and educational psychology. Some worked in special education or in school administration working on behalf of, what they perceived to be, a student’s well-being and best interests often *against* a parent’s skepticism or hostility towards diagnosis. But most made their living as entrepreneurs and relied heavily on parental initiative in getting their child tested for ADHD. I found that even among these entrepreneurs, there was, what one might call, a healthy amount of skepticism about the intentions of many of their clients. “You’d never believe some of these parents,” one

learning specialist Alice confides. We are at an event organized and sponsored by a local chapter of a learning disabilities organization that we both volunteer in, which is being held at a public library in an affluent neighborhood in the hills of Oakland. The purpose of the event is to educate parents on how to navigate the legal challenges in obtaining special accommodations for children with learning disorders and disabilities and also to serve as a social event for people living with learning disabilities. These events are usually attended by three kinds of people: children with LD, their parents, and professionals like disability and civil rights lawyers and people in the fields of education, psychology and social work. Alice is just starting out as an educational specialist, and is trying to build up a client base made up of new clients and referrals. “Some of these parents are so hell-bent on getting their kids tested.” She tells me of one mother—and in these kinds of stories, mothers are often portrayed as the main offenders—who needs to get her eight-year old daughter tested so she can get into a private gifted and talented school in Colorado. “So how much do you think a test like that costs?” Alice asks me pointedly.

“How much? I don’t know it depends on the test. A thousand dollars?” I respond, trying my best to make it sound like a declaration rather than a guess.

She doesn’t say anything, but shakes her head. “I was going to charge her twelve-hundred. But then she says, ‘Well I heard I can get it done somewhere else for six-hundred.’ So I have no choice to do it for six-hundred or lose her business.” “But can you imagine paying that much to get your kid tested so they can get into a school that you have to pay another thirty-thousand or however many dollars a year in tuition?” Then she expands the discussion to talk about the “pressures” that parents place on their children today, relaying a story about a friend of hers whose six-year daughter participates in “10-20 hours of gymnastics a week.” “And who is it who’s always talking about how she needs to please her parents?” she asks in a sarcastic tone.

The seeming lack of connection between the two threads of the conversation illustrates, I would argue, the way the politics of blame operate with respect to ADHD. The main figure of scorn is a parent of an Organization Kid. They are wealthy, probably, though not always, white. They are almost always the mother, and they are, as Alice put it “hell-bent” on their child succeeding. What also is interesting about Alice’s story is the way she brings the two stories together to the point where they become ethically contiguous. For what it is worth, over the course of my fieldwork, I attended a dozen or so of these events on the subject of special accommodations, and never once did I meet a child there who didn’t seem to struggle with a learning disorder or disability that wasn’t marked. Many, for example, had by their own disclosure, multiple learning disorders, and cases of ADHD were often accompanied by problems like dyslexia, auditory processing disorders, or even Asperger’s and high functioning autism, most of which have symptoms that plainly manifest themselves in even basic social encounters.

This isn’t to suggest that people aren’t “gaming the system,” as it were, but based upon my ethnographic experiences and conversations with Psy.D.’s, learning specialists, and neuropsychologists—the professionals who administer the tests often needed for proof of ADHD or other learning disabilities—these fears are exaggerated. Like many exaggerated fears these concerns aren’t easily dismissed, and many informants, as Alice’s comments might suggest, have certainly come across “pushy” parents. At the same time, professionals expressed an ability to make informed judgments about whether or not to diagnose, or to recommend a diagnosis of, ADHD or LD. I also interviewed teachers and administrators working in special education in California public school systems. Although they all have horror stories in dealing with parents—due to the fact that parents often want

what is best for their child but aren't familiar with the limits of the system—most school administrators noted that obtaining special accommodations can be such a lengthy, involved, and frequently expensive, process—for both the school system and for parents—that “gaming the system” is not something that one can just do “on a whim.” Parents of children with LD and ADHD also expressed frustration, often to the point of tears, in dealing with schools. Even with evidence of ADHD or a learning disability, the process to obtain a 504 plan or an individual education plan (IEP) can take months or drag on for over a year.⁷⁶ These costs and barriers, I would argue, might go a long way in explaining why there are such discrepancies in who receives special accommodations.

If these fears about cheating the system are real but exaggerated, it raises the more anthropological question: why are accommodations for learning disabilities and disorders like ADHD framed as an important social and political issue? Is it because it points to class and racial inequality and unequal educational opportunities? For example, one might cynically point to the irony in the founder of Princeton Review in California criticizing “luxurious diagnoses” when his company charges on average more than one-thousand dollars for SAT test preparation. Is he really worried about “kids from Compton”? Why not frame the problem as indicative of broader more systemic educational inequality?

Fears of rich, white, suburban, parents and children “gaming the system” illustrate, I would argue, how a politics of resentment operate today in the post-welfare United States. Perhaps in an age of meritocracy, the “Organization Kid” has become, in a perversely ironic way, the new “welfare queen.” This may seem an irreverent comparison (one I develop more later in the chapter), but consider the fear that fraudulent acquisition of special accommodations by a few students makes more likely the possibility that others will in turn do the same. Indeed, Lerner presents such a “slippery slope” arguing that:

people are apt in such circumstances [where one student is aware that another is receiving special accommodations] to overstate the number of “cheaters.” In other words, even if the number of people gaming the system rises from 1 to 5 percent, there will be an impression that the total numbers of cheaters has soared well beyond that. The felt pressure to cheat, or otherwise risk falling behind, will become acute. Indeed, one can easily see how a cascading effect could quickly transform a wealthy suburban school from one in which only 2 percent obtain extra time to one in which a third do so (Lerner 2004:1110).

There is nothing particularly flawed with Lerner's reasoning here except that it is purely hypothetical. It is also counterfactual, given that—if one takes the aforementioned College Board audit as anything of a guidepost—well less than one percent of test takers are actually “gaming the system.” Although Lerner's statistics may be hypothetical, the

⁷⁶ According to the Department of Health and Human Services, Office of Civil Rights “Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to employers and organizations that receive financial assistance from any Federal department or agency, including the U.S. Department of Health and Human Services (DHHS). These organizations and employers include many hospitals, nursing homes, mental health centers and human service programs. Section 504 forbids organizations and employers from excluding or denying individuals with disabilities an equal opportunity to receive program benefits and services. It defines the rights of individuals with disabilities to participate in, and have access to, program benefits and services.” See www.hhs.gov/ocr/504.html (accessed April 2010).

concerns he articulates are not.

In 1995, something of a minor scandal erupted when the provost of Boston University, Jon Westling, announced that he would be taking charge of deciding who received special accommodations for learning disabilities at BU, and that the university's Office of Learning Disabilities Support Services (LDSS) would now need to implement stricter standards for students seeking accommodations, including new neuropsychological testing. This caused significant concern among LD students, and led to the directors of the LDSS resigning in protest (Elswit, Geetter, and Goldberg 1999:293). Shortly before the announcement, in July of that year, Westling delivered a speech in Melbourne, Australia, called "Disabling Education: The Culture Wars Go to School," in which he criticized the uses and abuses of special accommodations for the learning disabled in higher education. Westling told the audience a story about a girl he called "Somnolent Samantha," who had approached him on the first day of class with a letter about her special needs. Westling outlined to his audience the seemingly selfish demands the student made:

The letter explained that Samantha had a learning disability "in the area of auditory processing" and would need the following accommodations: "time and one-half, on all quizzes, tests, and examinations;" double-time on any mid-term or final examination; examinations in a room separate from other students; copies of my lecture notes; and a seat at the front of the class. Samantha, I was also informed, might fall asleep in my class, and I should be particularly concerned to fill her in on any material she missed while dozing (Blank 1998:3).⁷⁷

In 1996, after Westling had become president of Boston University, a number of learning disabled students, including at least one with ADHD, filed a class action lawsuit against the University. The case, *Guckenberger v. Boston University*, has since become a landmark decision concerning learning disabilities. During the trial, under questioning by the judge, Patti B. Saris, Westling revealed that the character of "Somnolent Samantha" was, in fact, a fabrication, a point that no doubt made the case a national news headline: "Fictitious Learning-Disabled Student Is at Center of Lawsuit Against College" read the title of a *New York Times* article (Lewin 1997). Furthermore, it was also discovered that despite Westling's public insinuations, there had been no documented examples of students cheating the system by fabricating documentation for special accommodations. By "[r]elying only on popular press accounts that suggested learning disabilities were being unfairly exaggerated and misdiagnosed," the judge noted Westling had in fact, "provided no concrete evidence that any BU student faked a learning disability to get out of a course requirement" (Blank 1998:44). Judge Seris also noted that Westling's proposed changes to the University policies on learning disabilities were based only on his "unfounded belief that learning disabled students...were unmotivated (like 'Somnolent Samantha') or disingenuous" (Blank 1998:44). The court ruled in favor of the plaintiffs, finding that the University had violated the rights of the students as outlined under the American with Disabilities Act of 1990, a decision that was seen as a major victory for students across the country with learning disabilities.

Guckenberger v. Boston University serves as a nice illustration, I would argue, of three important points relating to the politicization of learning disorders and disabilities like ADHD. First, it shows that much of the hostility toward categories like ADHD stems from the belief that ADHD, learning disabilities more broadly, are of dubious medical and

⁷⁷ Westling quoted in (Blank 1998).

scientific credibility and, furthermore, that if there are genuine cases, they are exceedingly rare, with most people presenting symptoms that are not worthy of medical or legal recognition. Robertson, Lerner, Shalit, and Westling all make this argument. But what “evidence” do they provide for the assertion that ADHD is not a valid medical category? How do their critiques operate rhetorically? Again, in most cases popular critiques of ADHD appeal to the “common sense” notion that ADHD is, at its core, a bogus category rather than appealing to statistical evidence that would suggest its overdiagnosis. It is important to note, that these critiques—with the exception of Cruise’s Scientologist perspective that Psychiatry as a whole is “suppressive”—are not opposed to science or psychiatry per se, they simply charge that ADHD is bad science. Shalit’s polemic here serves as a good example. She writes: “[n]o one would deny that an individual who is unfortunate enough to be afflicted with one of the classically defined mental disorders—schizophrenia, paranoia, manic depression, and so on—suffers from a clearly defined and clearly recognizable infirmity, one that is likely to impair significantly her educational achievements and career prospects” (Shalit 1997:2). However, she goes on to suggest that “[t]he diagnosis of a learning disability, in contrast, is a far more subjective matter” (Shalit 1997). If the three “classically defined” disorders that she cites are indeed so objective, one wonders why they are no longer listed in such terms in the DSM-IV-R. Secondly, one might ask, how Shalit can be so confident in separating learning disorders from other psychiatric conditions that require a level of “subjective” judgment on the part of psychiatrists. To illustrate the seeming looseness and absurdity of diagnostic criteria for LD, Shalit observes that “[a]ny hypochondriac can test himself” for learning disorders. “[I]n a recent booklet, the American Council on Education supplies a checklist of symptoms for adults who suspect they may be learning disabled. Some of us will be disturbed to recognize in the checklist possible symptoms of our own.” She goes on to list several examples: “‘a short attention span,’ impulsivity, ‘difficulty telling or understanding jokes,’ ‘difficulty following a schedule, being on time, or meeting deadlines’ and ‘trouble reading maps’” (Shalit 1997:5). Of course, one might counter that a “hypochondriac can test himself” for any condition including what she listed before as “classically defined” disorders. The symptoms she lists above are ostensibly banal and tedious: who hasn’t at one time or another missed a deadline?; haven’t we all misunderstood jokes before?; are maps ever really that easy to read? She goes on to imply that “lousy grammar” is taken, by LD advocates, as a sign of dysgraphia. Shalit’s reasoning here closely resembles Frances’ warnings, in his op-ed “It’s not too late to save ‘normal,’” of the “recklessly expansive” tendency to over-diagnose mental illness. But her seeming dismissal of the legitimacy of learning disabilities through an appeal to common sense fails to engage with the voluminous literature on LD in any substantive way.

Lerner takes a similar approach in his attack on ADHD and LD. For example, he suggests that “there is a great degree of overlap—estimated at anywhere from 10 percent to 100 percent, or roughly the level of precision one comes to expect in this field of study” of ADHD and other learning disabilities (Lerner 2004:1076). But this lack of “precision” stems primarily from Lerner’s own misunderstanding of the subject matter. To what do the figures 10 to 100 percent refer? His footnote gives evidence only for a discrepancy of 12 to 90 percent, and even this discrepancy, which is admittedly gross, stems from the fact that Lerner is drawing from vastly different contexts and situations. Thus, the discrepancy between the two figures of 12 percent and 90 percent points to the fact that ADHD is more often co-morbid with some learning disabilities than with others. It does not suggest, however, as Lerner would have us believe, that the difference between these two numbers stems from an overall lack of rigor in the fields of psychology and medicine.

Again, like Shalit, Lerner doesn't dismiss psychiatry as a whole, but like Shalit and Frances, he is troubled by what he sees as the watering down of psychiatry and the concomitant legal protections of disability attached to psychiatric and medical conditions. As he states: "what constitutes a learning disability is so hopelessly murky that it is conceivable that most students receiving accommodations genuinely think that they have, and could be diagnosed as suffering from, a learning disability" (Lerner 2004:1107). As a result, "[t]he original idea of learning disability—a *substantial* discrepancy in academic performance and tested mental aptitude—is now in tatters, and virtually any American student whose academic performance falls short of his own or his parents' bloated expectations can demand and receive accommodations" (Lerner 2004:1109). But what evidence substantiates this claim?

Stressing the overdiagnosis and over-treatment of ADHD, I would argue, is not simply limited to a few conservative columnists. Rather it is a consequence of the journalistic practice of "false balancing": the idea that there are two sides to every story and that each side should receive roughly equal treatment and coverage. Lerner, Shalit, and even Robertson appeal to expertise as a way of challenging the legitimacy of ADHD, and while the sources they cite are credible—Lawrence Diller and Peter Breggin are perhaps the most outspoken critics—and while they raise concerns that many psychiatrists that I talked to share about over-diagnosing and over-treating ADHD, their views do not constitute the center of gravity of scientific thinking on ADHD; a situation which no doubt makes them seem like maverick doctors speaking truth to power. I've reiterated these points not because I see it as anthropology's place to intervene in these discussions, but rather because it seems like anthropology's role to attend to the ways in which the idea of controversy as a journalistic frame plays a central role in the publicity and politicization of ADHD, in much the same way that global warming remains such a public issue (a point I return to in the conclusion of this chapter).

Secondly, *Gluckenberger v. Boston University*, as both a court case and public event, illustrates how concerns about the emergence and proliferation of categories like ADHD, are not simply concerns about overmedication or mental health per se, but also about fears of the erosion of personal responsibility and the danger of providing "entitlements" to those undeserving of such benefits. This is why, I would argue, that ADHD is seen as "affirmative action for white people," and indeed I heard this claim frequently throughout my fieldwork in conversations about special accommodations—not only from those who opposed special accommodations (a sentiment that was often expressed in casual conversations with strangers or acquaintances interested in my project), but also from parents who felt themselves the objects of other parents' scorn.

In my discussions with informants as well as my reading of the relevant literature there are several fears about special accommodations for learning disabilities that seem to echo fears of affirmative action. Consider Yale Professor David Gelertner's opinion-editorial "No more cheating for a good cause" (July 22, 2005 *Los Angeles Times*) which makes the case that while Affirmative Action was once necessary and maybe even beneficial—he cites Justice Sandra Day O'Connor as an example—the program is now outdated and counterproductive:

Affirmative action has turned the United States into an aristocracy. British aristocrats have enjoyed their own kind of "reverse discrimination" for a thousand years. America's affirmative-action aristocrats were only created a generation ago; until then, they were targets of bigotry themselves. So what? No aristocracy is acceptable in the U.S. (Gelertner 2005).

Gelertner's concern about aristocracy seems to evoke the common criticism that Affirmative Action benefits (often wealthy) minorities at the expense of (often poor) whites. Like Lerner and Shalit—who argue that that people with learning disabilities, with rare exception, aren't *really* disabled—Gelertner assumes that those who benefit from affirmative action, like British Aristocrats, aren't really in need of special advantages, which is perhaps why he likens affirmative action to “cheating.” This sentiment is echoed by Washington University of St. Louis Professor of Physics Jonathan Katz—who in 1998 nearly lost his job when he refused to grant students with documented learning disabilities special accommodations as outlined by the University's disabilities resource program (Rajaram 2006). In an opinion piece posted on his website, he argues that: “extra time is cheating because it gives the recipient an advantage over other students. No one respects those who they think are entitled to cheat, and I only have contempt for those who tell them they are entitled to cheat.”⁷⁸ For Katz, such measures amount to “affirmative action for spoiled rich white kids.”⁷⁹ In another piece, also posted on his website called “Nature cannot be fooled”—an allusion to Nobel Prize winning physicist Richard Feynman's oft-quoted observation about the inevitable causality culminating in the solid rocket booster failure and explosion of the Space Shuttle *Challenger* in 1986—Katz elaborates on this notion of cheating: “What harm is done?” he asks:

The integrity of the grading process is corrupted, and the grades earned by other students in honest competition are devalued. Weak students get grades they have not earned, and may build a career on them. Would you want to be treated by a doctor who was admitted to medical school only because he received double time on examinations?

Perhaps the greatest harm is to the principles of fairness and honesty. Bending the rules for the “disabled” establishes the idea that rewards go to those who manipulate the system, not to those whose accomplishments are earned through honest effort, evaluated fairly. And it encourages everyone to lie about reality when it does not satisfy our desires. That is the path to the Challenger disaster, and much worse.⁸⁰

Taken as a whole, Katz's comments reveal the kinds of hostilities directed at both accommodations for learning disabled students and for affirmative action (for what it is worth, Katz also has posted a piece on his webpage critical of affirmative action, and interestingly enough, the idea that global warming is a problem). First, we have the assumption that people who are receiving these accommodations “manipulate the system” giving them an unfair advantage. As Katz's assertion that accommodations for LD amount to “affirmative action for spoiled, rich, white kids” might suggest, there is also the insinuation that these benefits are going to those who don't deserve them. One might, of course, counter that by taking such a position Katz and others hijack the serious problem of privilege, and in particular white privilege, and wield it as a weapon against already disadvantaged groups. Secondly, Katz's belief that special accommodations amount to unequal treatment and logically results in tragedies like the Challenger disaster, “and much worse,” illustrates the often recited fear that accommodating learning disabilities and disorders will lead to an inevitable decline in standards when less deserving people are given preference over more deserving people in the name of “political correctness” (a

⁷⁸ <http://wuphys.wustl.edu/~katz/LD.html> (accessed April 2010).

⁷⁹ Ibid.

⁸⁰ <http://wuphys.wustl.edu/~katz/naturefooled.html> (accessed April 2010).

phrase that Katz recites with seeming vitriol).⁸¹

Third, these concerns highlight the ways that questions of work, merit, personal responsibility, and fears about “gaming the system” haunt discussions of both accommodations for learning disabilities and affirmative action. In Danforth and Navarro’s aforementioned article on ADHD in “everyday discourse,” the authors found that special accommodations are often seen as disrupting fundamental beliefs about fairness and equity in education and everyday life. “I don’t really believe most of these children have ADD. [It] gives them a good excuse for not paying attention or doing work,” said one of their informants. “The only disability in life is a bad attitude” argued another (Danforth and Navarro 2001:182). These responses seem to invoke what Harvard Law Professor Alan Dershowitz frequently refers to as the “abuse excuse”; or what the other-half of the title his book calls: “Cop-outs, Sob Stories, and Evasions of Responsibility.” Dershowitz’s observations apply specifically to the law, in particular the practice of defendants claiming prior abuse, mental illness or social marginalization and victimization as a defense strategy, but one can see the critique of this kind of logic at work in the arguments of Lerner and Katz: “ADHD as an Evasion of Responsibility” (Dershowitz 2000).⁸²

The notion of ADHD as an “evasion of responsibility” brings to mind the work of Talcott Parsons in *The Social System*, a classic work in Sociology in which he outlines, among other things, his concept of the “sick role” (Parsons 1991). According to Parsons, sick people have two major rights and two major duties. The first right is the legitimate freedom from the normal responsibilities and obligations of healthy persons in society. The second right is exemption from responsibility for his or her condition, as it is beyond his or her control. These rights bring with them the responsibility of acknowledging one’s sick and undesirable nature, and secondly the responsibility to get well so as relinquish the sick role and return as a normally functioning member of the social system. In doing so, the sick person must call upon expert help (e.g. a medical physician) and submit to this person’s or institution’s expertise and authority. The problems ADHD poses to such a social system are obvious. Whereas, for example, sufferers from radiation sickness from the Chernobyl disaster (to draw from Adriana Petryna’s aforementioned ethnography) experience debilitating life-long illness, ADHD is seen as a disorder that presents significant impairments in some contexts or situations, but not others. People with ADHD are thus stuck in a semi-permanent sick-role for which they receive special exemptions, and yet with these exemptions they are still afforded all of the benefits of a non-sick person. In other words, the challenge of ADHD for such a system, is that suffers of ADHD receive benefits but without the same responsibilities. The same logic applies to affirmative action as a remedy. One can be “sick” as it were, but by the logic of the system one shouldn’t be able to participate in the benefits of the system. This is what upsets Lerner. Learning disabilities to him should only be disabilities when they exclude an individual from being able to participate in normal life. Therefore, one cannot be both learning disabled *and* a successful student. Success as a student is evidence that one is not really learning disabled. Individuals with learning disabilities must adopt the sick role, which absolves one of responsibility, but also excludes one from the benefits of participation in the social system.

⁸¹ See also Walter Olson’s “Standard Accommodations: The Road to Universal Disability,” (Olson 1999).

⁸² Indeed, it is interesting to note that Dershowitz includes ADHD in his “Glossary of Abuse Excuses” noting that it was invoked in the much publicized Michael Fay case—involving an American teenager convicted of vandalism and theft in Singapore in 1994—as a way to avoid the punishment of caning (Dershowitz 2000:322).

Thus the implicit charge against ADHD and LD is that one “can’t have it both ways,” as it were.

Finally, *Gluckenberger v. Boston University* shows the extent to which the politicization of ADHD involves collapsing the impersonal difference of politics the around representative identities. Tamar Lewin captures this point well in his *New York Times* article on the case (April 8, 1997), when he notes that, “[e]ven though [Somnolent] Samantha is fictional, she and her inventor are at the heart of an academic debate over how much help, and what academic adjustments, learning-disabled college students are entitled to.” It is not so much though, I would argue, that Samantha and Westling are at the center of the debate, but rather as points of visibility, they come to stand in for the debate, they are *representative* of the debate. If Westling was convinced that learning disabilities were over-diagnosed and over-accommodated, where did this belief come from? Why make up a character? In a June 1997 column in *The Nation*, “Straw Women, Fragile Men,” Patricia Williams, who was at the time a Professor of Law and prominent contributor to debates in Critical Race Theory, argued that “the trouble with Samantha-as-representative was that she was a stereotype. Like any insulting stereotype, Samantha’s persuasiveness was based on disguising the worst-case scenario as normative, thus lending power to those, like Westling, who would ambush the ‘reality’ of her excesses (Patricia Williams 1997:10).

Take as a comparison with Somnolent Samantha the following excerpt from a February 15, 1976 article in *The New York Times*, chronicling Ronald Reagan’s use of the “welfare queen” as a talking point in that year’s Republican Presidential primary:

“‘There’s a woman in Chicago,’ the Republican candidate said recently to an audience in Gilford, N.H., during his free-swinging attack on welfare abuses. ‘She has 80 names, 30 addresses, 12 social security cards and is collecting veterans’ benefits on four nonexistent deceased husbands.’ He added: ‘And she’s collecting Social Security on her cards. She’s got Medicaid, [is] getting food stamps and she is collecting welfare under each of her names. Her tax-free income alone is over \$150,000.’”

...“After first noting that his audience is composed of ‘hard working people’ who pay their bills and put up with high taxes, Mr. Reagan frequently tells them about Taino Towers, a four-building subsidized housing project in New York City. ‘If you are a slum dweller,’ Mr. Reagan says, ‘ you can get an apartment with 11-foot ceilings, with a 20-foot balcony, a swimming pool and gymnasium, laundry room and play room and the rent begins at \$113.20 and that includes utilities’” (The New York Times 1976).

The article goes on to point out the discrepancies in Reagan’s account of the so-called welfare queen. Linda Taylor, the person in question was actually charged with using four names, not 80, and illegally acquiring 8,000 dollars not 150,000 dollars. The article also shows that Reagan seriously mischaracterizes the apartments of Taino Towers, noting that the apartments he referred to are the largest in the complex and are meant to be shared by a family of six. “There is no way,” the article asserts after talking to the project manager, “that anyone could get such an apartment for \$113.20” (The New York Times 1976).

Reagan was, of course, known for embellishing the truth, although there is little doubt he actually believed what he said.⁸³ In a way this is irrelevant. If Linda Taylor had actually

⁸³ For more on this point, see Alan Spitzer’s *Historical Truth and Lies About the Past: Reflections on Dewey, Dreyfus, de Man, and Reagan*. In his treatment of Reagan’s speech at the military cemetery at Bitburg, Germany (the final resting place of a number of member of the SS), George Schultz, Secretary of State under Reagan, is quoted as saying, “[Reagan] would go over the ‘script’ of an

embezzled 150,000 dollars using eighty names, and if an apartment at Taino Towers with eleven foot ceiling actually cost 113 dollars a month, what difference does it make? Somnolent Samantha was not real, but for Westling, she came to stand in for a real problem. There is no point in attempting to access the intentionality of such speech, because this would, I think, fall into the trap of treating these remarks as simply personal opinions or prejudices. Reagan used both Taylor and Taino Towers as a way of mobilizing white fears of African Americans cheating the system, just as Westling used the character of Samantha as a way of mobilizing fears that people claiming learning disabilities are cheating the system. What is more important, I would argue, is how Linda Taylor and Somnolent Samantha are held responsible, not simply for themselves as persons, but for a general problem. I am not arguing that the welfare queen and Samantha are simply analogous; rather I believe they are both visible articulations of the same problem of *personal responsibility* that is a problem, not simply of welfare or disability rights, but of the post-welfare United States more generally.

In 1996, a Republican Congress passed, and Clinton signed into law, the ‘Personal Responsibility and Work Opportunity and Reconciliation Act’, which phased out Aid to Families with Dependent Children (AFDC), and replaced it with Temporary Assistance for Needy Families (TANF)—a program that set time limits for benefits and required recipients to look for work.⁸⁴ One could argue that this rhetoric of personal responsibility is a hallmark of neo-conservatism and not indicative of a general political problem. But Nikolas Rose argues otherwise: “[t]he power of the governmentalities of the Right over the past two decades lies in the fact that it is the Right, rather than the Left, that has managed to articulate a rationality of government consonant with this new regime of the self, to develop programs that translate difficulties such as those in the housing market, or in relation to health, and to invent the technical forms that promise to give effect to it” (Rose 1996:60). What Rose allows us to see here is how personal responsibility becomes a particular kind of response—what he calls a “new regime of the self”—to the decline of the welfare state. If we take this idea seriously, we might suggest that ADHD has become a political issue in the United States precisely because it points to the problem of personal responsibility. This, again, helps explain Frances’ point that I’ve raised a couple of times now, that “where the DSM-versus-normality boundary is drawn” influences an “individual’s sense of personal control and responsibility.” I would like now, though, very briefly, to develop the idea of responsibility not simply as a historical fact or context (we care more about responsibility today than we did yesterday, or here rather than there), but also as part of a *concept of blame*, that can help better articulate the relationship between ADHD, identity, and politics.

Toward an Analytics of Blame

On January 1, 2009, shortly after two A.M., a young unarmed black male was shot by an armed, white, and also young, Bay Area Rapid Transit police officer while supposedly resisting arrest on a subway platform in Oakland, California. He died the next morning. The incident was captured on cell-phone cameras, and video of the incident quickly circulated on television and the internet. One week later, a public demonstration was held in Oakland

event, past or present, in his mind, and once that script was mastered, that was the truth—no fact, no argument, no plea for reconsideration, could change his mind. So what Reagan said to the American people was true to him, although it was not the reality” (Alan Barrie Spitzer 1996:108).

⁸⁴ For a thorough treatment of the legislative battles on welfare reform and on the freshman class of Republicans of the 104th Congress, see (Killian 1998). For a broader history of welfare in the United States and Great Britain, see (King 1995).

to protest the excess use of force by the white officer, and to demand his arrest. The peaceful protest turned violent, however, when a crowd of several hundred protesters began breaking storefront windows and vandalizing automobiles. Subsequently, news of both the shooting and riot became a national headline.⁸⁵ At the time of the riots, I was in the second half of my field research, much of which took place in the city of Oakland. I was immediately struck by how—at least in the local and cable news—the incident quickly became a question of who was to blame. Was the officer defending himself from what he perceived to be a weapon? Was he motivated by race? Did the young man resist arrest? Was the shooting an accident? Did the officer actually mean to fire his taser instead? Although on a much different scale, the events brought to mind the 1992 Los Angeles Riots following the acquittal of the four white officers who savagely beat Rodney King after a high-speed pursuit. I was only ten years old at the time, but I remember vividly the scenes of Reginald Denny being dragged from his semi-truck and beaten by a crowd of young men while news anchors and pundits, hundreds of miles away in climate controlled studios, could only watch the scene captured by helicopter cameras on their studio monitors, and denounce the incident as sheer barbarity. As with the shooting of Oscar Grant in Oakland, 2009, the beating of Rodney King and the subsequent riots were framed in accusations of blame. Who or what was to blame for the beating of Rodney King: was it the four white police officers? Was it a wider institutional problem of the Los Angeles Police Department? Did King resist arrest? Was it a broader social problem of racism and mistrust in the United States? And who or what was to blame for the riots: was it, again, the egregious actions of the four white police officers? The mainly white jury that acquitted them? Tensions caused by Korean store owners setting up convenience stores in all black neighborhoods? Was it, as then Vice President Dan Quayle suggested, a result of a culture of poverty and broken households?

The two events were separated by over sixteen years and three hundred miles, and yet the similarity of the two sets of events is striking. Setting aside the obvious similarities—both involved white-on-black police brutality and subsequent rioting—it is interesting to note how, if the public response to the issue was any indication, the only way to make these incidents intelligible was through *fixing responsibility*. This realization was a turning point for my project; not so much in how I conducted my research but in how I was beginning to think ADHD-as-concept as a set of relations marked by the making-public of ADHD, rather than ADHD as simply a medical category or social label. When I reflect back on my “fieldwork,” I realize now that my “field” was the differential field of blame in which ADHD was embedded, but—as the Oscar Grant incident demonstrates—could not be reduced to ADHD itself.

Debates about ADHD in the United States today are debates about who or what is to blame for ADHD: What explains the disorder’s presence and its exploding rate of diagnosis and treatment over the last three decades: is it bad genes, too much television, video games, lazy children, deficient brains, pushy parents, overworked teachers, greedy pharmaceutical companies, over-accommodating doctors? Thus far, in every example I’ve provided, blame is assigned to someone or something. Allen Frances argues, for example, that diagnostic sprawl stems from what he calls “therapeutic zeal”: “[e]xperts have an almost universal tendency to expand their favorite disorders: not, as alleged, because of conflicts of interest—for example, to help drug companies, create new customers or increase research funding—but rather from a genuine desire to avoid missing suitable patients who

⁸⁵ For a timeline of the incident see (Kuruwila, Burress, and Bulwa 2009).

might benefit.” Politics works two ways here. As Joe Dumit shows in his essay “When Explanations Rest” expert testimony, like Frances’, can be understood as truth claims which do important kinds of work like expanding or narrowing the scope of conflict around disorders whose etiology remains unclear or contested (Dumit 2000). This contestation, according to Barry and Schattschneider, makes politics political. By this same logic non-politics can be political, as Cruise’s Today Show appearance makes clear. Likewise as Barry notes, politics proper can be non-political to the extent that “politics” closes down the space of contestation.⁸⁶

At the same time what makes these acts political, I would argue, is the way they fix responsibility. Implicit in the critiques I’ve presented above, is the Habermasian distinction between facticity and normativity (Habermas 1998). For Frances, there is the objective fact that the categories and criteria in the DSM are too inclusive, thus leading to the expansion of diagnosis and over-treatment. At the same time the locus of blame is on doctors, who he says that in their “zeal” to help patients are pulling too many people into the mental health system. ADHD cannot be political if it is purely a question of facticity, in which case politics would be completely settled. It is by assigning blame, and fixing responsibility to a social ground or identity, that ADHD becomes political. This is the political project of *representation* (Deleuze 1994). For Agamben, you’ll remember, “what makes Tiananmen a political event is the way that it manages to escape the logic of existing ways of organizing and codifying political antagonism” (Barry 2001:195). In particular, the protests at Tiananmen were truly political “not by expressing an identity which pre-exists the action, but by forging an association marked by difference” (Barry 2001:195). But I would argue, and I suppose this is a purely terminological distinction, that what is, in fact, political is the work that collapses this difference that exceeds politics back to the ground of identity.

This makes the political act of blaming anthropic: for Robertson, ADHD is caused by “too much sweets” but really it is doctors who are “willy-nilly” diagnosing children who are to blame. For Cruise the Scientologist, Ritalin may be “masking the problem” but it is psychiatry as a form of social control, and psychiatrists as “suppressive persons” who are responsible. My informant Tom believes that his nephew’s ADHD is caused by a lack of discipline, structure, and rules, and it is parents who are responsible for providing it. Parents generally, but mothers in particular, are held accountable for their child’s ADHD, and as such are the constant targets of the blame. In Shalit’s article, for example, she quotes Dr. Lawrence Diller, author of *Running on Ritalin*, who notes that, “[i]n the space of twenty years, American psychiatry has gone from blaming Johnny’s mother to blaming Johnny’s brain” (Shalit 1997). This is an ostensibly neutral statement, but Shalit’s insinuation is that such a move does the work of absolving mothers of guilt. Shalit proceeds to suggest that the evidence for ADHD as a neurological disorder is questionable and that what is really driving parents is the fear of their child being “average.”

There is no better example of the anthropic operation of blame than in the way “mothers” get interpellated as responsible subjects for their child’s disorder. Mothers are the central figures in ADHD’s “blame game.” In my fieldwork I found that mothers were generally plagued by more self-doubt about whether they were doing “the right thing” for their child than were fathers. And if one looks at the literature on ADHD—that for the sake of convenience one might divide up into three kinds: popular, applied social science, and

⁸⁶ Michel Foucault illustrated a similar point when he showed that problems that are cast as technical problems requiring technical solutions are often seen as outside the realm of politics and thus beyond power; though in fact, this act of disguise is one of the central ways that power legitimates its operation in modern life (Foucault 1990).

critical approaches—one finds that mothers dominate the discussion of ADHD; more so than perhaps even than children. For example, popular literature on ADHD and parenting—which can often be found in the self-help/psychology section of major bookstores, or online on websites like CHADD.org—offers practical advice, and connects to readers through appeals to experience, either in the form of personal vignettes or clinical observations, and through the credibility of expertise (Rafalovich 2001). While the vast majority of these books are written by psychiatrists and psychologists, there is growing sub-genre of personal narratives and memoirs.⁸⁷ On the one hand this literature frequently targets mothers specifically, although more often than not ‘parenting’ is taken to be gender neutral. But on the other, the question is, “who reads these books?”. In conversations with parents, for example, I found the vast majority of the time that women, not men, referenced popular books on ADHD. This observation is buttressed by feedback on popular online booksellers like Amazon.com, where reviewers—with the notable exception of doctors, psychologists, etc.—are overwhelmingly female.⁸⁸ One could turn pop-psychology back on itself and speculate that this difference possibly stems from gendered communicative practices where men generally take appeals to personal experience less seriously than women, valuing instead appeals to authority and so-called fact (Tannen 1987). More important though is the observation that while ostensibly gender neutral, popular self-help literature on ADHD and parenting finds its way into the hands of women more than men, which would suggest that mothers are more often taken as the targets of responsibility for their child’s ADHD (a point I discuss at further length in chapter four, on the history of the “everyday problem child”).

The second genre of literature on ADHD and mothers is in applied social science, especially in the fields of psychology, sociology, public health policy, and social work. These studies tend to focus on three things. First, what if any effect does parenting, and specifically mothering have on the emergence and trajectory of the disorder (Chi and Hinshaw 2002; Johnston et al. 2002; Hinshaw et al. 2000; Johnston 1996; Najman et al. 2000). Secondly, how do parents cope with the strain of their children’s disorder, not only in dealing with the child’s own behavior, but also the social ramifications of being seen as either a good or bad parent (Baker 1994; Harborne, Wolpert, and Clare 2004; Norvilitis, Scime, and Lee 2002; Podolski and Nigg 2001). And third, how can fields in the applied health sciences do a better job at understanding the cultural, financial, social, and practical barriers that parents face in seeking and receiving care and counseling for ADHD and other learning disorders and disabilities (R Bussing et al. 1998; Regina Bussing et al. 2003; Zito et al. 2005). Again, ‘parenting’ is ostensibly gender neutral in these studies, but often mothers are used as a convenient place-holder or stand in for parents plural. In his highly influential longitudinal studies of the effects of parenting styles on ADHD outcomes, Stephen Hinshaw and his colleagues rely almost exclusively on mothers to generate their research conclusions. This is in part to avoid introducing statistical bias but the fact that the study contains only mothers is not considered in itself problematic speaks to the ways that parenting and mothering are frequently collapsed into one another. In one study on the stigma surrounding ADHD, for example, the investigators note that, “although the study was not seeking mothers only, all 51 parents were mothers” (Norvilitis et al. 2002:62). This was despite their best efforts at gender-neutral sampling methods. A review of this literature reveals both a hetero-normative assumption about family structure (I have thus far

⁸⁷ See, for example, (Blake E. S. Taylor 2008).

⁸⁸ Women and mothers often self identify themselves.

not encountered any discussion of ADHD in families with same-sex parents, although there is discussion on popular websites), and an often taken for granted assumption that mothers are the primary figure responsible for the child's well-being.

Finally, mothers receive disproportionate attention in sociological and anthropological scholarship on ADHD.⁸⁹ Ethnographers have attempted to walk a fine line between taking seriously, and one might even say, giving voice to parents', and in particular mothers', struggles to manage the daily ins and outs of their children's conditions while at the same time showing how these struggles are structured in part by discourses of performance and authenticity within which parents themselves are implicated. Recently, Elizabeth Carpenter-Song works through what she calls the "lived experiences" of families' attitudes towards the medicalization of behavioral problems like ADHD and pediatric bipolar disorder (Carpenter-Song 2009). Her study of "Euro-American" and African American families in Cleveland, Ohio, gives special attention—if not intentionally, at least through its sustained engagement—to mothers' experiences in negotiating and evaluating the diagnosis and treatment of ADHD. In particular she captures the ways that mothers attempt to evaluate biomedical explanations and treatments for child hyperactivity against more everyday understandings of their child and parenting (Garro and Yarris 2009).

This kind of ethical stance toward mothers, both critical yet sympathetic, stems in large part from a common stance in the literature that views mothers as complicit but "marginalized" and "vulnerable". In her comparative study of 34 mothers in Canada and Great Britain, for example, Claudia Malacrida explores the ethical space opened up in the interactions between professional discourse and maternal resistance (Malacrida 2004, 2003, 2001). Mothers, she asserts, are "objects of surveillance" and "bearers of blame" for their children's underperformance and bad behavior (Malacrida 2001:142). She acknowledges that although changing attitudes about parenting make it more acceptable now for men to participate in the emotional work of caring for children with an ADHD diagnosis, she decided to study only mothers because, "even when there are actual shifts in gendered parenting practices, women continue to mother within a persistent culture of mother-blame" (Malacrida 2001:145). Iina Singh echoes this logic in her own qualitative studies of parents and ADHD. Singh argues that mothers often lobby for an ADHD diagnosis because it locates the disorder in the brain, what she calls the "brain-blame narrative", thus absolving themselves of the guilt for their children's condition (Singh 2004).⁹⁰ At the same time, mother-blame finds its way back when mothers are accused of bad parenting for allowing their children to take Ritalin by those skeptical of the diagnosis. Mothers also feel a sense of guilt for chastising their children for bad behavior, when, as the brain-blame narrative puts it, it is not the child's fault. Although ADHD and Ritalin displace guilt from mothers, this absolution, as she puts it is "simply seductive rhetoric" (Singh 2004:1204). Singh's insights push us to appreciate the ways that mothers cannot be blameless so long as ADHD remains politicized as a disorder of parenting because their ethical subjectivity is constituted through a series of investments of blame and responsibility.

But what evidence is there that parents generally, and mothers in particular, are

⁸⁹ It is interesting, though perhaps not surprising, that ethnographic studies of ADHD have chosen to work almost exclusively with families and schools rather than in, for example, the clinic. As I argue in my next chapter on the history of hyperactivity, problems like hyperactivity linked for the first time the three domains of school, home, and clinic. These domains remain critical for understanding ADHD today.

⁹⁰ See also Singh's related work on the subject: (Singh 2005, 2003, 2002).

blamed? Thus far, I have made the case that blame takes the form of fixing responsibility—one definition of the English word “blame.” I offered the example of Tom earlier, as someone who actually did blame parents specifically: “‘cause it’s the parents anyway,” as he put it. But more frequently, like Iina Singh, I encountered not blame per se, as in Tom’s statement, but rather a general resistance or resentment of what some took to be parents trying to absolve themselves of guilt and avoid responsibility. “Ugh, I can’t stand it” one grandmother told me. “Now kids are all on Ritalin. It’s like fast food today. Parents feed their kids mac-n-cheese and chicken nuggets all the time because no one takes the time to cook anymore.” Elsewhere, at the orchestra, I am chatting with a member of the first violins after the concert and I mention my interest in ADHD. “I don’t know, but I suspect it’s like with television,” he tells me. “Parents just plop their kids down in front of the TV because they are too busy to actually engage with them.” I encountered these statements often over the course of my fieldwork and more broadly in discussions with casual acquaintances. In the beginning it was easy to dismiss them as the voice of another generation lamenting how the world is no longer as good as it was yesterday (remember Robertson’s monologue on the *700 Club*?). But after hearing so many of these statements they began to blend into one kind of stubborn idea and I had to admit that maybe Edmund Leach was right when he compared myth to a radio transmission; how many different ways can language express the same set of relationships (Leach 1970)?

The centrality of mothers to ADHD’s publicity underscores the considerable extent to which ADHD can be thought of as a history of being blamed and becoming blameless. It is this double movement, I would argue, that constitutes the politics of ADHD. In his book *AIDS and Accusation: Haiti and the Geography of Blame*, Paul Farmer likewise demonstrates how three “logics” of accusation—accusations in sorcery in Haitian villages, North American accusations of Haiti having spread HIV/AIDS to the United States, and Haitian counter accusations that explain AIDS as a conspiracy of the United States—create a “dense network of associations” and impute the origin and spread of HIV/AIDS to human agency (Farmer 1993). Farmer’s concept of a geography of blame serves as a useful analytic for appreciating how blame functions in the politicization of ADHD. Blame is something that mothers do to themselves—an activity—and also a mode of perception—the internalization of other peoples’ perception of mothers as mothers. And as I found in my conversations with parents, blame is a kind of game—“the blame game”; a struggle with their children about their children’s behavior. Children blame mothers as a way of externalizing behavior. “It’s not my fault! I forgot my homework at home, you never put it back in my bag after you checked it!” The blame game also happens between partners who disagree who and what is responsible for their children’s behavior and wellbeing. Blame is exchanged between parents and school administrators. Parents blame the schools for dragging their feet in filing out the mandatory paperwork for Individualized Education Plans (IEPs) and for not following through on the details of these IEPs. Teachers blame parents when they feel students are bright but not trying hard enough, or when they feel that parents aren’t forcing students to do their homework. They also blame parents when recommendations for neuropsychological testing are not taken seriously.

Blame in this sense is a “fixing of responsibility” for the causality of *past* actions, events, or states of affairs. But part of this topography of blame, as I hope I showed in the first part of the paper, is a fixing of responsibility that not only blames people for past actions but holds them accountable as ethical and political subjects in the present and future. The controversy surrounding special accommodations, for example, shows how ADHD poses special challenges to the concept of disability when someone is

disadvantaged in one context and not another. The backlash against accommodations highlights what is perceived to be the ethical irresponsibility of parents, children, and even doctors, in “cheating the system.” With respect to parenting, advertising for medication like Ritalin and Adderall in magazines like *Women’s Day* and *Good Housekeeping* has the overt function of getting mothers to suggest different drugs to their doctor, but the very juxtaposition of mother and child in these advertisements also interpellates mothers as ethical subjects responsible for their child’s treatment.

But whether this fixing of responsibility points to the past, present, or future, its critical function is pointing. The political for Barry, is “an *index* of the *degree* to which a problem or object is open to contestation” (Barry 2001:268, emphasis added). By fixing responsibility onto particular identities, blame serves as this index of the political. In the case of welfare and ADHD, we see politics with mother blame or the figure of the welfare queen. If as the feminist saying has it, “the personal is political”, then we might also say that the political becomes personal through politics, through the act of assigning blame. Reagan was, of course a master at this. He took the impersonal affect of disgust and collapsed it around the figure of the welfare queen.⁹¹ Lee Atwater, campaign advisor to George H.W. Bush did the same during the 1988 presidential campaign when he mobilized white fears and associations of criminality and blackness by using a series of targeted ad campaigns referencing Willy Horton (an African American convict who raped a white woman and stabbed her boyfriend while on furlough from prison). Although Jon Westling’s persistent references to Somnolent Samantha were no doubt much less egregious or pernicious as Atwater’s references to Horton or Reagan’s references to Linda Taylor, they nevertheless used the same tactic of mobilizing impersonal fears, or in this case resentment, through the tactic of personification. The intent here is at some level irrelevant; more important is the operation of blame itself.

As I hinted at earlier, the operation of blame is necessarily *anthropic*. By anthropic, I mean that concerns about ADHD tend to begin and end with human subjectivity and sociality. This is most obvious when individuals bear the burden of blame (as was the case when Alice blamed one of her friends for being overbearing parent). These acts of blaming are directed, of course, to those who are either diagnosed with ADHD or those who care for people diagnosed with ADHD (parents, teachers, doctors, etc). Secondly, responsibility is often fixed onto personalities who come to stand in for general problems rather than specific actions or attributes. Somnolent Samantha, is a good example, even though she was a fictive character. Other names have been held up as prime examples of what is wrong with learning disabilities and disorders. For instance, Walter Olson and Ruth Shalit use Marilyn Bartlett, a graduate of Vermont Law School, as an example of how accommodations for learning disabilities will lead to a decline in standards. Bartlett failed the New York bar exam on multiple occasions and sued the state’s Board of Law Examiners, when her petition for special accommodations for a reading disorder were denied. Both Olson and Shalit lamented now Supreme Court Justice Sonia Sotomayor’s decision in favor of Bartlett: a person who has trouble reading is likely not fit to be a lawyer, they reasoned.

In his article on special accommodations for LD, Lerner cites Blair Hornstine—a disabled student who sued to be sole valedictorian of her high school in New Jersey and subsequently became the recipient of death threats—as an example of someone trying to

⁹¹ For a sustained discussion of the “politics of disgust” and the figure of the welfare queen see (Hancock 2004).

game the system. Hornstine was scheduled to matriculate at Harvard the Fall following her high school graduation. But following the lawsuit, a number of students at Harvard circulated a petition requesting her admission be withdrawn, which Harvard did in fact do, when a number of students trawling the internet for any incriminating evidence found instances where Hornstine had plagiarized work for her school's newspaper (Lerner 2004:1106-1107). Although, as the death threats would suggest, there was outright hostility was directed toward Hornstine herself, accusations of blame abounded following Hornstine's rejection from Harvard. Much of this blame was directed at her father, who was a federal judge and was believed to have initiated the lawsuit. News of the event even reached across the Atlantic. John Sutherland, writing for London's *Guardian* opined: "A clever girl is destroyed. Why? Because her parents pushed her; her school pushed her; the whole educational system pushed her. They call it the quest for excellence. I call it child abuse" (Sutherland 2003).

There are also impersonal figures of blame, like mothers in general (rather than particular ones). This impersonal blame may also be affixed to ostensibly non-human entities like schools, pharmaceutical companies, the field of psychiatry, or even—as Richard Degrandpre does in *Ritalin Nation*, or Ilna Singh does in her work on parenting and ADHD—"culture" (Degrandpre 2000). Although the bearers of blame may not always be human, the act of blaming itself is anthropic. This is the case for two reasons. First, even institutions like psychiatry or nebulous concepts like culture are personified or invested with anthropic qualities. This is because ADHD as a political problem clings stubbornly, indeed can only be thought, in terms of older moral vocabularies. Of course, as I outline in my chapters *A New Architecture* and *on Adderall*, I encountered plenty of situations in my fieldwork where ADHD was becoming non-anthropic, but in doing so it was becoming hyperactivity itself and ceased to inhabit the political problem of ADHD. When most people complain about pharmaceutical companies driving the explosion of methylphenidate consumption, they aren't talking about an impersonal method of accumulating wealth. Indeed what is at stake is the essence of a corporation—which itself is a rights bearing entity. "I don't trust drug companies to make what's right for my daughter," Janice, a mother who took her daughter off of ADHD medications after months of experimentation, told me, "I trust them to make what will help their bottom line...that's not the same thing." That's a phrase I heard a lot, the "bottom line." It's a perfect example of indexing ADHD to an exact location. This is not, of course, to suggest that Janice and others are wrong, but merely to highlight how even when talking about non-human entities, the discussion about ADHD remains grounded in moral and ethical terms.

Secondly, just like the 1992 Los Angeles Riots or the death of Oscar Grant, ADHD is rendered intelligible by either locating symptoms on a suffering body and or by fixing responsibility onto a political subject that is accountable to itself and others, and that may be influenced by power, ideology, etc. But what about the ability of new technologies and forms of knowledge to fundamentally reshape the human figure? One of the reasons I've attempted in this dissertation to think *with* science rather than against it, as is often the case in critical studies of science, is that by thinking ADHD and its symptoms as operational criteria, scientific approaches to the study of attention offer one way of moving beyond the anthropic dimension. This is not because "science" itself is disinterested or inhuman, but because, as Deleuze and Guattari argue in *What is Philosophy?*, by conceptualizing problems in terms of functions, science thinks life impersonally (Deleuze and Félix Guattari 1996). But making these emergent sciences the object of analysis does not in itself do this work. Paul Rabinow's concept of biosociality, for example—which I

mentioned before, and which has been taken up by others like Rose, Dumit, and Rapp—shows how the conditions of life (like ADHD symptoms, or T-cell counts) become sites of identification and belonging. But as the name of the concept suggests, sociality remains a constitutive element of this phenomenon. I attended many self-help meetings for ADHD and LD, classic sites of biosociality. And while people used science as a way of reframing their problems—people talked a lot about their “brains”—they nevertheless did so to reaffirm themselves as human subjects with thoughts, feelings, emotions, and values, and to help give meaning to their actions for which others held them accountable.

Of course, one could rightfully point out that throughout this chapter my approach and orientation has been resolutely anthropic. In particular, I’ve piled one name on top of another as “examples” or “illustrations” of what makes ADHD political.⁹² But my challenge has been to use these “examples” also as *events* or entries into the problem ADHD in the United States over the last several decades. This distinction points to two ways we might use the concept of blame: First, as a *dye* that *traces* a topography or set of connections and connectivities. Farmer uses blame this way in *AIDS and Accusation* by allowing blame to *highlight* a set of relationships—between Haitians, Americans, doctors, etc.—that are at their heart, political. Using blame as a dye to analyze ADHD casts light onto a dense network of blame. In so doing, we can tell not only who is included or excluded in this network, but also where the main nodes are, and who bears a disproportionate amount of blame (e.g. mothers or pharmaceutical companies), thus revealing not only what entities are involved in the blame game, but also where the responsibility for ADHD is fixed. This is helpful because ADHD is not a single thing; it is a multiplicity of symptoms, bodies, practices, forms of knowledge, modes of intervention, subjectivities, and so on: what some anthropologist’s, following Deleuze and Guattari, would call an assemblage (Ong and Collier 2004; Marcus and Saka 2006).

One challenge that ADHD poses to anthropology is that, as both a linguistic referent and as an analytical concept, it names all of these aforementioned heterogeneous elements; a situation that regrettably leads to confusion when trying to parse out the ways the term is used. That people often use ADHD to refer to different situations, environments, and things only fuels ADHD’s controversies. At the same time, it is precisely this confusion and the capacity of the term to exceed our ways of thinking the topic comprehensively, that makes ADHD such a fascinating topic to study. With blame, for example, we can show how ADHD is not something separate from the world that then gets debated or accepted but instead is a technology that links together in its operation disparate elements like teachers, pundits, presidential candidates, brain scans, amphetamines, mothers, scientists, doctors, children, pharmaceutical corporations. Blame shows how these things are linked very intimately to concerns that are ostensibly unrelated to medicine like discourses of race and entitlement. The concept of blame allows us to bend the world into new shapes, connecting wealthy whites with disadvantaged blacks, to see the connection between a fictive college student with a learning disability, and the figure of the welfare queen.

While illuminating there are limits to this approach. As Deleuze and Guattari insist in *A Thousand Plateaus*, the act of “tracing” is rooted in the project of representation. There is on the one hand the thing being traced, and then on the other its image or representation (Deleuze and Felix Guattari 1987:12-15). Tracing in this case is ultimately judged not on its powers of creation or what it can do, but rather on its accuracy: “tracing always involves an

⁹² This has been to some extent unavoidable because, as the *Writing Culture* generation made clear, anthropology is a project of representation.

alleged ‘competence’,” they write (Deleuze and Felix Guattari 1987:13). Thus there is a danger in using blame as a concept, blame-as-dye, if we think we are tracing something *actual* in the world. This would fall into the trap of common sense, which assumes there is something called ADHD that actually refers to a stable thing or set of relationships that precede our ways of thinking or talking about them. Why else would scientists like Barkley and his esteemed colleagues feel the need to free ADHD from controversy if they didn’t believe that ADHD was a stable referent? The other challenge with using blame this way is that blame is already necessarily anthropic because the things blaming and being blamed have prior identities. Mothers are a good example here. To be sure part of their subjectivity is constituted through the act of blaming and being blamed but their subjectivity exceeds these events. The trap here is thinking that blame is an assemblage that connects already formed things (for example, to recite the list above: teachers, pundits, presidential candidates, brain scans, amphetamines, mothers, scientists, doctors, children, pharmaceutical corporations). As I outlined in the introduction, and as I hopefully demonstrated in the previous chapter, one challenge for an anthropology of hyperactivity, is to think hyperactivity beyond ADHD. To do this though requires thinking ADHD not simply as an actual extensive multiplicity inhabited by objects that correspond to our everyday associations (this is a mother, that is a pill), but an intensive virtual multiplicity that attends to the becoming of life beyond our ways of representing it (what Deleuze and Guattari call “desiring production”, and I’ve called, for reasons I outlined in the introduction, “hyperactivity”)

To help move us in this direction, we might develop a concept of blame as an *event*. I mentioned earlier how in his book *Political Machines*, Andrew Barry defines the political as the index of the degree to which a space, problem or object is open to contestation (Barry 2001:194). In particular, he develops a concept of “demonstration” as both a tactic to gain visibility (one of the purposes of protest), and as a pointing toward something (as to get one’s attention not simply for its own sake but to direct it toward an object or issue). In this chapter, I’ve suggested that blame performs a similar function. Like a demonstration it is a protest—it testifies and bears witness in a public way (indeed Barry sees witnessing as an important ethical technology for political actors). But also, like demonstrations it points to something, not as demonstrations might do, to get one’s attention toward a topic (like immigration reform, or global warming) but rather to fix responsibility. Following Agamben, Barry sees the radical potential in demonstration because as an *event* it can point to something outside the horizon of political intelligibility. As you’ll recall “what makes Tiananmen a political event is the way that it manages to escape the logic of the existing ways of organizing and codifying political antagonism” (Barry 2001:195). What differentiates blame from Barry’s concept of demonstration, is that while the latter can serve as a point of political rupture, blame as an event, redirects attention back onto existing political logics: pharmaceutical companies are greedy, mothers of children with ADHD are just looking for an excuse, doctors are overzealous, achievement oriented students are looking for a competitive advantage. Blame is a poor substitute for genuine political engagement—at least as Barry and Agamben understand the term “political engagement”—because it is itself a *moral judgment*.

As I suggested earlier, blame as an event is tied to what Deleuze calls the project of representation. In *Difference and Repetition*, Deleuze sees representation as an operation that reduces the difference of life (and for Deleuze all life is pure difference) to the ground of identity (Deleuze 1994). A closer reading of Deleuze’s concept of representation is beyond the scope of the analysis here, but it suffices to say that blame as I am using the term here

constitutes a particular kind of representation. As I suggested with Reagan's attacks on welfare and Westling's attacks on learning disabilities, blame takes impersonal affects—disgust, resentment, anger, disappointment—and fixes them to the ground of identity. And it does this in a very particular way: by fixing responsibility. In other words, blame does the work of connecting causality with the moral realm of identity. So for example, in a politics of blame, hyperactivity—rather than being a virtual process that can operate through all life (as I demonstrated in the last chapter)—is a *symptom*. And these symptoms are blamed on someone or something—a child might be blamed for her or his laziness, or parents might be blamed for poorly socializing their children, or “bad genes” may be blamed. This is why I suggested at the outset of this chapter that blame is an act of “foreclosure.” Not only does it foreclose any possibility of reasonable discussion about what ADHD is (leaving us with a “controversy”) but also blame forecloses what hyperactivity can be by pinning activity to an origin of identity. In thinking blame as an event rather than a dye we don't necessarily see who or what gets effectuated by blame. But it allows us to better appreciate how blame is *purely operational*, and how, as an act of representation, it clings stubbornly to an anthropic dimension that governed by the moral vocabulary of responsibility.

This chapter began with an opinion editorial, wound through discussions of common sense, politics, responsibility, and blame, and has no doubt seemed unnecessarily long. But I want to suggest the following: the sections above are not merely “related” insofar as they all deal with ADHD in the United States. Although drawing together the interconnections between these subjects would be a useful contribution in itself to the scholarly literature on attention deficit hyperactivity disorder this has not been justification for keeping the reader's attention for so long. Rather the point I would like to make is this: on the subject of ADHD, common sense, fixing responsibility, and blame are not merely related, they are equivalent, all three perform the same operation. Thus we might subsume the three under an equivalency principle. Einstein did this with acceleration and gravity, which allowed him to deduce the theory of general relativity (Einstein 2006:60-66). My purpose here, of course, is of comparatively zero ambition, but in the last section of this chapter, drawing on the observations of Bruno Latour, I would like to extend this idea of equivalence to show how blame, fixing responsibility, and critique (both academic and common sense) all work by the same subtractive logic, and as a result are not adequate responses to the problem that ADHD poses for anthropology today.

On Disappointment and Matters of Concern

In a recent filmed lecture with Alain Badiou titled “Democracy and Disappointment,” Simon Critchley suggests that for the Ancient Greeks, philosophy began in wonder, but for us today, and certainly for him, philosophy now begins in disappointment (Walker 1999; Degrandpre 2000). Perhaps this is our curse, Critchley suggests, on the other side of Marx and Nietzsche. Indeed, this chapter began, and was driven by, if not disappointment, at the very least, a dissatisfaction with the ways ADHD remains mired in controversy, and how this controversy becomes *the* central way of thinking and talking about ADHD in the United States today. This controversy means that ADHD gets reduced to a blame game, with everyone pointing to what they think is responsible for ADHD, as if there were some hidden truth that needs to be exposed: we are being controlled by “big pharma”; kids need a convenient excuse for their bad behavior; teachers are overworked; achievement obsessed parents want to cheat the system. But this chapter now concludes with another disappointment that I hinted at earlier: namely, that in starting with controversy, critique thus far has been inadequate in appreciating the problem that ADHD poses for

anthropology today. Aren't there other ways of thinking ADHD that don't involve suffering bodies or political subjects that bear rights and responsibilities? Isn't critique's predominant move of contextualization—the project of locating or pointing to the reasons or conditions for ADHD and its controversies—strikingly similar to common sense critiques of ADHD which all fix responsibility onto someone or something? In other words, isn't contextualization like the political act of indexing?

I began with Allen Frances' critique of diagnostic sprawl, in part because of what I see as a tension or contradiction running through ADHD in America that is at its heart actually quite Nietzschean. On the one hand, the responsible ADHD, the ADHD of what psychiatry and Frances want it to be is a category that works on, what I was calling an East-Coast, vertical logic, which reduces symptoms to easily identifiable identities. These identities correspond to Parsonian social roles and to medical and juridical categories like "learning disabled." This kind of ADHD operates on and through the logic of representation: ADHD corresponds to observable symptoms on the bodies that themselves constitute social and political identities. On the other hand, we have what ADHD is likely becoming—Frances' nightmare—and this is the ADHD of diagnostic sprawl; an ADHD that is politically irresponsible and foregrounds convenience, and quality of life, over and against political, social, and even epistemological representation. It is the horizontal ADHD, and like Nietzsche's horizontal thought, it is beyond good and evil; or in other words to appreciate its operation one cannot appeal to older moral vocabularies of good and evil. This is largely what troubles Frances. If diagnostic categories continue expand, multiply, and consume every symptom, then there will no longer be any way of holding people responsible for their own actions—as in the case of the philanderer or the rapist. As a result, everyone becomes a new kind of person, and special categories like "disability" lose their bite. I don't want to reduce Frances' editorial to only this concern, or to the concern that psychiatry will subsequently lose its professional credibility, especially after it worked so hard to earn it back over the last several decades. Just as important to Frances, it seems, is the risk of over-, or "unnecessary," treatment for millions of Americans who don't need to assume this extra "risk." But clearly part of what troubles Frances is the way American psychiatry is spreading itself too thin.

I also began the chapter with Frances' op-ed because it seemed as good an example as any of the ways that ADHD remains a "contested" thing—category, disorder, topic, issue, etc.—in contemporary American discourse. And I found as both an anthropologist, and as someone who was diagnosed with the disorder and continues to receive treatment for it, that both popular media like journalism, and critical social science, are not adequate to the task of engaging with ADHD in a way that appreciate what ADHD could be other than a contested diagnosis. In particular, I was dissatisfied with the facile critiques that ADHD is simply, or *primarily*, a label to control deviant children, a way to sell more pharmaceuticals, or a way to obtain special accommodations in schools. In other words, I objected to the need to find the essence of ADHD, or what it is "really about." Moreover, this chapter begins in disappointment with the ways that journalism continues to inflate the scientific uncertainty around diagnosing and medicating children for ADHD in the name of sensationalism or false balancing, and with the fact that the critical social sciences and humanities continue to make the controversy of ADHD their central point of entry into engaging the subject. It also strikes me as troubling that medicalization critiques of ADHD follow the same kind of hermeneutics of suspicion that commonsense critiques of ADHD employ. In emphasizing this point, my engagement here with ADHD in the American Scene

has tried to make space for a new kind of critique that doesn't begin in suspicion or uncertainty, or even the idea that culture, capitalism, or politics is primary.

These concerns may seem purely academic, but it is interesting to see how critique travels between the social sciences and journalism. In May of 2000, a few months after Kenneth Weiss' L.A. Times exposé on rich white kids "working the system" and around the time David Brooks was wandering around Princeton talking to well-groomed, over-scheduled, and over-deferential undergraduates, *Reason*—a magazine devoted to "free markets and free minds"—ran a piece by Jason Sholl that nicely captures the malaise of ADHD in an era trapped between the pre-9/11 optimism of economic boom and the lingering paranoia of Y2K. Called "Dangerous Distraction," it was a book review of two books overtly critical of ADHD and its convenient treatments: *The Hyperactivity Hoax* and *Ritalin Nation*.⁹³ ADHD's scientific validity, if the article is any indication, is hotly disputed. "In fact, about the only thing a decade of research on the disorder has established beyond doubt" (the ambiguity of "beyond" here is clever) "is that Ritalin does help children concentrate" (Sholl 2000a).⁹⁴ But "[i]t was never the strength of the science," Sholl argues, "that carried the day for the biomedical view" of ADHD. Rather he points to a number of complicating factors: "[a]ll of a sudden there was a legitimate medical diagnosis that explained away uncooperative children, eased parental guilt, relieved teachers' anxiety, and lined the pockets of pharmaceutical companies and HMOs." "Is it any wonder," Sholl asks rhetorically, "that this diagnosis caught on"? In the review that follows, Sholl nicely illustrates the ways that critique gets reappropriated, reenacted, and redeployed through what Theodor Adorno might have lamented as the "hollow," "objective" language in critique as commodity:

A 1998 conference on Attention Deficit/Hyperactivity Disorder (ADHD) sponsored by the National Institutes of Health concluded that "after years of clinical research and experience with ADHD, our knowledge about the cause or causes of the disorder re-mains speculative." The uncertainty hasn't stopped any number of researchers, journalists, and pundits from commenting on everything from the tricky ethics of diagnosing the disorder to the dangers of treating it with Ritalin. The debate over ADHD—biological reality or social construction, legitimate learning disability or cultural artifact—is one of the most heated in science and education today. And while the appearance of two new books on the subject doesn't promise answers to any of these thorny controversies, it does mark an opportune moment to sift through a decade's worth of information on ADHD and ask what, if anything, we have learned from the national experiment that has made this term a household word (Sholl 2000a).

Sholl never actually "sifts through" this information, but it is nonetheless interesting to note how his piece uses uncertainty or controversy as its central organizing device. This frame is so pervasive that when I began thinking about ADHD as a viable research topic, it was unthinkable to approach ADHD as anything other than a controversy. "I hope you are going to be critical about this whole thing" one faculty member, not on my committee, told me. "It's ridiculous how people want extra time on tests now because they can't pay attention. People want a label for everything." On the one hand, the comment might suggest that as anthropologists we aren't so sheltered from common sense ourselves. On the other hand, I

⁹³ (Walker 1999; Degrandpre 2000).

⁹⁴ All citations to this piece refer to the online version which does not include page numbers.

would suggest that this comment also underscores the ways that anthropological critique as a project of contextualization shares with common sense critique a hermeneutics of suspicion. Although most anthropologists would likely find Sholl's dilemma "biological reality or social construction" unsatisfying, the skepticism within humanistic anthropology and sociology toward the reductivist imperative in the natural sciences and medicine, goes a long way in explaining why controversy remains central even within what I would consider sophisticated accounts of ADHD in anthropology and sociology today.⁹⁵

Foregrounding controversy and uncertainty, of course, means that alternative explanations for ADHD remain obligatory talking points in popular critiques. Sholl, not surprisingly turns to medicalization as a possible explanation for ADHD's alarming proliferation. "During the past few decades, unpleasant aspects of human experience—everything from grief to shyness to anxiety—have increasingly fallen under the heading of mental illness." As a result, he suggests, "[h]yperactivity may be yet another example of a disagreeable personality trait that has been medicalized" (Sholl 2000a). Once medicalization becomes the predominant mode of critique, then one has to wonder what kind of critical purchase or analytical promise the approach holds for a critical anthropology today.

Throughout this chapter, I have argued that we should take seriously the dangers that common sense poses in attempting to think ADHD critically. But just as troubling is how *critique has become common sense*. The notion that hyperactivity, depression, or for that matter, erectile dysfunction or restless leg syndrome are part of the growing net of professional medicine and pharmaceutical marketing has become ubiquitous in the rhetoric of popular critiques of ADHD to the point that we take it for granted.

But if anthropological critiques like medicalization have become common sense, it seems that common sense has become anthropological. Indeed in Sholl's article the anthropologist arrives to uphold the wisdom of common sense. "After all, aren't all kids 'easily distracted' some of the time?," Sholl asks. "Isn't a certain amount of hyperactivity a *natural part of childhood?*"⁹⁶ "While such questions seem obvious," he observes, "for years researchers have been reluctant to take them seriously, not least because so many in the field are already heavily invested in a biomedical view of the disorder." "In a rare exception," however, "University of Massachusetts anthropologist Ken Jacobson completed the first behavioral study of ADHD involving a population of 'normal' children." For details of the study, Sholl draws upon an interview he conducted with Jacobson, which appeared in abbreviated form, and in more subdued language, a few months earlier in *Lingua Franca*. Jacobson notes that both ADHD and non-ADHD children he observed displayed "concentration, alertness, and control at certain moments, and restlessness, inattention and defiance at others." Thus, he concludes that, "[i]f you're predisposed to label *any* child as ADHD, the distracted troublemaker or the model student, you'll find a way to observe these behaviors. And if you're predisposed not to find it, then you'll find ways of overlooking these behaviors." Beneath the earlier version of Sholl's piece in *Lingua Franca* is a telling irony; an advertisement for a book called "The Sound Bite Society": "brilliant," one reviewer glows, "explores the various consequences of television's inherent propensity to simplify complex ideas" (Sholl 2000b:15).⁹⁷

⁹⁵ Nikolas Rose's *The Politics of Life Itself*, and Joe Dumit's "When Explanations Rest" serve as good examples here. I do not wish to suggest that Dumit or Rose are opposed to reductivism in the sciences, but I would argue that any discussion on ADHD must take controversy as its starting point because a general skepticism towards reductivism in the humanities.

⁹⁶ Emphasis added.

⁹⁷ See also (Jacobson 2002).

Then consider the following neat bookend to a smart and thoughtful magazine review from a local columnist, Seth Rogovoy, in the December 1999 edition of the *Berkshire Eagle*, that cuts from Michael Tilson Thomas, to Nirvana, to Fenway Park, to Gandhi, to and then to ADHD.

In the January issue of *Lingua Franca*, which calls itself "the Review of Academic Life," Jason Sholl reads some recent studies and asks some pointed questions about attention deficit/hyperactivity disorder (ADHD) and the promiscuous use of the drug Ritalin.

According a recent study by Ken Jacobson, a doctoral candidate in anthropology at the nearby University of Massachusetts at Amherst, there are *no detectable differences in behavior between "normal" children and ADHD-labeled children.*

Rather, ADHD is a culturally-determined syndrome. In England, for example, diagnoses of ADHD are much fewer than in the U.S., because the British "have a more liberal definition of 'normal' than do Americans." *A lot of what gets medicalized as ADHD here in the U.S. would be considered disciplinary cases in the U.K.*

Perhaps even more telling is the disparity in the treatment afforded learning-disabled minorities—who are "usually warehoused in Special Ed programs"—and the children of wealthier parents, who "parlay ADHD diagnoses into the obtaining of special amenities for their children"—amenities, Sholl emphasizes, that would benefit any and all mediocre students, learning-disabled or not. "Affirmative action for affluent white people" is what one critic calls special treatment for children with ADHD (Rogovoy 1999).⁹⁸

With only a slight change in wording from the *Lingua Franca* piece (which stated that Jacobson "found no significant differences whatsoever"), now there are "no detectable differences in behavior" between kids with ADHD and "normal" ones, leading one to wonder, of course, how these children would have been labeled in the first place. I mean this neither as a criticism of Jacobson per se, whose comments were likely taken out of context, nor of Rogovoy, who it must be said, found the time to read *Lingua Franca* and write an interesting review. But I do find interesting, in both the Sholl piece and the Rogovoy redux, how anthropology comes to stand in for critique. And yet this critique—at least as it is presented here—is nothing more than common sense.

My argument is not that the diffusion of critique takes us further away from the truth of ADHD, as if each rendering—from Jacobson, to Sholl, to Rogovoy—is like a photocopy of the previous photocopy, each becoming increasingly blurry and loosing detail until it is unrecognizable from the Master-copy. For this to be true, then one would have to think highly of the original critique, which as I've indicated, is no longer truly critique. Rather my point has been all along that there is no truth of ADHD, and that the need to find the truth of ADHD, to fix the responsibility for ADHD on someone or something, is a project of representation—in both the political and epistemological sense of the word. This is a project that plays itself out in a variety of venues and domains from the clinical laboratory, to the classroom, to the editorial page. The task of a truly critical anthropology of ADHD is to think ADHD beyond representation, or in other words, to move from what ADHD is or is

⁹⁸ Emphasis added.

not, to what ADHD can be and is always becoming. As Rogovoy optimistically asks in his aforementioned review, “what better time to begin than now?”

But what kind of critique would this be and what would it look like? A few years back, Bruno Latour raised the question “why has critique run out of steam?” The occasion for this question came from reading an editorial in *The New York Times*, where Republican strategist Frank Luntz argued that although “the scientific debate [about global warming] is closing around us [Republicans]” there is still a chance to keep the debate open, but only if one can “continue to make the *lack of scientific certainty* a primary issue” (Latour 2004:226, *emphais original*). As my previous conversation with Dr. G indicates, isn’t this what critics of ADHD have done, just as Sarah Palin has done with global warming? Isn’t this precisely what Schattschneider meant by expanding the scope of conflict, or what Barry meant by the political? Latour found Luntz’s suggestion troubling in part because this was ostensibly what science studies had been doing for decades and what graduate students in the humanities are being trained to do even today. “While we spent years trying to detect the real prejudices hidden behind the appearance of objective statements, do we now have to reveal the real objective and incontrovertible facts hidden behind the *illusion* of prejudices?,” Latour asks only half-jokingly (Latour 2004:227). Is there not, to use Latour’s words, “something troublingly similar in the structure of the explanation” between, for example, Scientology’s paranoid rejection of psychiatry and drugs like Ritalin as a form of social control, and the medicalization and quasi-Foucauldian critiques of ADHD as a way of controlling deviant behaviors and disciplining bodies through labels and medication (Latour 2004:229; Rafalovich 2001)

Latour suggests that in the face of these disturbing similarities, we need to rethink what critique is and what it should do. He argues that:

the critical mind, if it is to renew itself and be relevant again, is to be found in the cultivation of a *stubbornly realist attitude*—to speak like William James—but a realism dealing with what I will call *matters of concern*, not *matters of fact*. The mistake we made...was to believe that there was no efficient way to criticize matters of fact except by moving *away* from them and directing one’s attention *toward* the conditions that made them possible. But this meant accepting too much uncritically what matters of fact were (Latour 2004:231-232).

Latour traces this tendency to the influence of Kant. But rather than attending to what makes thought possible (as Kant does), Latour thinks critique should bring us closer to reality itself. “Reality is not defined by matters of fact” (Latour 2004:232). Or perhaps a better way of putting this is that reality cannot be reduced to matters of fact; reality *exceeds* matters of fact, and, as such, “[m]atters of fact are not all that is given in experience” (Latour 2004:232). “Matters of fact are only very partial and, I would argue, very polemical, very political renderings of matters of concern and only a subset of what could also be called, *states of affairs*” (Latour 2004:232). “It is this second empiricism, this return to the realist attitude, that I’d like to offer as the next task for the critically minded” (Latour 2004:232).

But what does Latour mean here by matters of fact and matters of concern, and what is this new “realist attitude”? The “same word *thing* designates matters of fact and matters of concern,” he says (Latour 2004:233). Here he turns to Heidegger’s bifurcation between *Gegenstand* (object) and *Thing*. “What would happen,” Latour wonders, “if we tried to talk about the object of science and technology, the *Gegenstand*, as if it had the rich and complicated qualities of the celebrated *Thing*” (Latour 2004:233). He offers the

Space Shuttle *Columbia*, which disintegrated upon re-entry into earth's lower atmosphere, as an example of both a scientific object (a matter of fact), and a set of things (matters of concern). Like *Challenger* before it, the event of the *Columbia* disaster rendered visible how the Shuttle, as a taken for granted object, also constituted a set of relations that exceeded its sheer facticity.

The problem with critique, part of what Latour calls its "critical barbarity," is that "no matter what we do, when we try to reconnect scientific objects with their aura, their crown, their web of associations, when we accompany them back to their gathering, we always appear to *weaken* them, not to *strengthen* their claim to reality" (Latour 2004:237). This is because, in the act of critique, we seek to show how matters of fact are effects of other matters of fact like ideology, power, politics, class, inequality, gender, and so on. In doing so, critique *subtracts* reality from itself rather than *adding* reality. Both blame and medicalization critiques of ADHD, I would argue, work by the same subtractive logic. And this is why this chapter began in disappointment; a disappointment not so much with what ADHD is as a matter of fact, but a disappointment because both blame and sociological critiques of ADHD work by the same logic of subtraction, that reduce ADHD to matters of fact only. This is because discussions about ADHD, as the Frances op-ed might indicate, tend to be framed within the Habermasian duality of facticity versus normativity. Scientists I talked to tended to frame ADHD in these terms as a way of closing down the space of contestation: there are matters of fact about ADHD over and against the normative judgments of these facts, they reason. Critics of ADHD also rely on this duality as a way of expanding the scope of conflict by arguing that the facticity of ADHD is subservient to its normativity, which is itself a matter of fact. This happens when, for example, we suggest that the diagnostic criteria of ADHD are, *in reality*, nothing more reflections of norms about what constitutes appropriate behavior, or when we say that ADHD is an outcome or effect of the process of rationalization and the medicalization of deviant behavior. This confuses reality with what is *actual*. It seeks to locate the truth of ADHD within some matter of fact—culture, capitalism, modernity, power (and power for critics of ADHD, despite any allusions to Foucault, is usually subtractive and repressive, rather than additive and productive as in Foucault. Richard Rorty, once observed, following Vincent Descombes, that, "the American Foucault is Foucault with most of the Nietzscheanism drained away" (Rorty 1991:193)). This is what Latour means when he says that in trying to get us closer to reality critique actually takes us further away, which is why, as I suggested in the introduction to this dissertation, contextualization alone—situating ADHD within other matters of fact—is not an adequate or appropriate response to the *problem of ADHD*.

As Latour insists, "matters of fact are a poor *proxy* of experience and of experimentation." Instead they are "a confusing bundle of polemics, of epistemology, of modernist politics that can in no way claim to represent what is requested by a realist attitude" (Latour 2004:245). As an antidote to the problem of stale critique that always subtracts reality, Latour offers the thought of Alfred North Whitehead, who "instead of taking the path of critique and directing his attention away from facts," "tried to get *closer* to them, or, more exactly, to see through them the reality that requested a new respectful realist attitude" (Latour 2004:244). But Whitehead does not do this through contextualization; as he argues in *Process and Reality*, "there is no going behind actual entities to find anything more real" (Whitehead 1979:18). Rather he opens up what reality

can be by moving from, what is in Latour's schema, matters of fact to matters of concern.⁹⁹

But what's at stake in this distinction? In *Witchcraft, Oracles, and Magic Among the Azande*, for example, Evans-Pritchard notes that when an old man dies, those unrelated to the man attribute the death to old age, but never in the presence of kinsmen who complain that witchcraft is to blame (1937: 77). As an anthropologist, Evans-Pritchard does not concern himself about who is really to blame: is it witchcraft, old age, something else? These matters of fact are none of his concern. He does not avoid this problem by simply contextualizing the event in terms of representations, beliefs, and practices; he also develops an analytics of cause and effect, and thinks Magic conceptually, to show not simply that Magic is a belief, but how Magic is always virtual, how it effectuates kinship, social structure, relations between humans and animals, nature and culture, etc. By weighing in on who or what is to blame (culture, medicalization, discipline, etc.), contextualist critiques of ADHD, in contrast, can only engage with blame in a first-order kind of way. They can weigh in on who or what is to blame for ADHD and its controversies: for Conrad it's medicalization, for Jacobson it's cultural attitudes about labeling and what is normal, for Ralfalovich its discipline. This pointing to what explains ADHD is the equivalent, I would suggest, of arguing who or what is responsible for the old man's death.

But "[w]hat would critique do," Latour asks, "if it could be associated with *more*, not with *less*, with *multiplication*, not *subtraction*" (Latour 2004:248). Here he applies Allan Turing's question, "Can a machine be made to be super-critical?" to critique itself. What would a super-critical critique be? To the extent that "critical" implies a limit or threshold, then being "super-critical" would mean going beyond this limit, going beyond our previous limits of critique; it would mean critique would multiply what reality is and can be, rather than reducing it to matters of fact. With regards to politics and ADHD this means going beyond common sense and going beyond the blame game. It requires instead, as Latour suggests, experimentation; creating concepts that allow us to appreciate what is new and different with ADHD today, rather than reducing it to what we already know.

The American Scene

Less than two decades ago, I sat in my friend Jon Morse's living room watching the television as Republicans swept the House and Senate in midterm elections on a platform of "personal responsibility." They cared so much about accountability that they called their promises for reform the "Contract with America." If the uproar over ADHD and its accommodations is any indication, their concern is still ours today. Indeed, in his account of our new age of "neurochemical selves," Nikolas Rose makes a persuasive case that "the blurring of the boundaries between treatment, recovery, manipulation, and enhancement" of life is at the same time "intimately entwined with the obligations" of the neoliberal subject in the age of biological citizenship (Rose 2006:215). But if American psychiatry, as the long list of pundits in this chapter have cautioned, is transforming itself into a commercial mall, where pushy parents can shop for a diagnosis and purchase a ready-made excuse for

⁹⁹ Matters of concern, says Latour, are what Whitehead calls "actual occasions," and we might productively think of them, I would argue, as events or the set of virtual relationships given in matters of fact. Latour argues that another way of thinking of actual occasions is with Whitehead's concept of societies, but I think this is mistaken. Societies are a kind of nexus, and correspond more to what Whitehead called Enduring Objects. Latour's conflation of the two, I would argue, likely stems from his tendency to think matters of fact through what he calls "things" rather than as events or processes.

everything and for everything a ready-made excuse, then Americans are losing one important way that they hold themselves and others accountable. As Allen Frances suggests, with each iteration of the DSM, psychiatry spreads itself thinner. In doing so, it pulls apart the criteria we have for distinguishing between the normal and the sick, and between those who are responsible for their actions and those who might be exempt from responsibility.

Just over one-hundred years ago, still at the beginning of a new century, Henry James was writing *The American Scene*—a collection of observations like stops on a railway: New York: Social Notes, The Sense of Newport, Boston, Philadelphia, Baltimore. Along this route James is witness to the American family remaking itself. For him, the division is not between East and West, but between Europe and America, between the “vertical” and the “horizontal.” If the identity of the family in Europe “resides more especially in its *perpendicular* [development],...it’s ascent and descent of the long ladder of time, so it develops in the United States by its *lateral* spread” (James 1907:313, emphasis added). And this motion is American social life taken as a whole. Traveling from city to city, he can feel its “absolute centrifugal motion,” “where the American material is elastic, where it affects one, as a whole, in the manner of some huge india-rubber cloth fashioned for ‘field’ use and warranted to bear inordinate stretching.” “One becomes aware,” James writes, “wherever one turns, both of the tension and of the resistance; everything and everyone, all objects and elements, all systems, arrangements, institutions, functions, persons, reputations, give the sense of their pulling hard at the india-rubber: almost always, wonderfully, without breaking it off, yet never quite with the effect of causing it to lie thick” (James 1907:309). America’s “thinness” over and against a Europe of “superimposed densities, a thousand thicknesses of tradition” (James 1907:309).

America, it would seem, is still made of india-rubber today: on the one hand an “absolute centrifugal motion” and on the other a pulling back in exasperation. “We are a lazy, spoiled, ADHD culture—soft and uninterested in thinking for ourselves,” bellows Rush Limbaugh, after Congress passes a comprehensive health care reform bill in late March 2010. On his website, next to these words in the transcript, we see Limbaugh against a backdrop of the American flag and a super-sized Constitution.¹⁰⁰ He is pointing right into the camera with a scowl, fixing responsibility; but on whom? As I’ve tried to make clear, this is the challenge with ADHD. ADHD seems to include, as James would put it, all manner of objects, elements, systems, arrangements, institutions, functions, persons, and reputations. What links these all of these heterogeneous elements together is not simply matters of fact like changes in professional medicine, the production and consumption of pharmaceuticals, parenting styles, or cultural attitudes toward education. What links them, what makes them intelligible as a public and political problem, are matters of concern: the operation of blame. What else can connect organization kids and welfare queens, intergalactic churches in Hollywood and televised Baptist grace? Or, if you still believe in American exceptionalism in the twenty-first century, what better place to find it than in ADHD today?

¹⁰⁰ Rush Limbaugh, “Is it Conservatism’s Finest Hour?” (April 5, 2010) http://www.rushlimbaugh.com/home/daily/site_040510/content/01125110.guest.html (accessed May 2010).

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