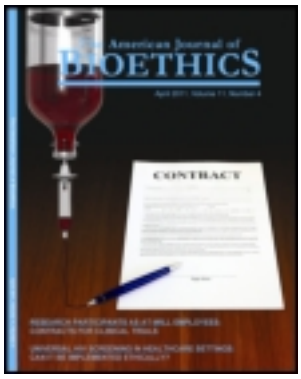

The American Journal of Bioethics
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/uajb20

Will the "Real Boy" Please Behave: Dosing Dilemmas for Parents of Boys with ADHD

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Available online: 20 Aug 2006

To cite this article: Ilina Singh (2005): Will the "Real Boy" Please Behave: Dosing Dilemmas for Parents of Boys with ADHD, The American Journal of Bioethics, 5:3, 34-47

To link to this article: http://dx.doi.org/10.1080/15265160590945129

Target Article

Will the "Real Boy" Please Behave: Dosing Dilemmas for Parents of Boys with ADHD

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The use of Ritalin and other stimulant drug treatments for attention-deficit hyperactivity disorder (ADHD) raises distinctive moral dilemmas for parents; these moral dilemmas have not been adequately addressed in the bioethics literature. This paper draws upon data from a qualitative empirical study to investigate parents' use of the moral ideal of authenticity as part of their narrative justifications for dosing decisions and actions. I show that therapeutic decisions and actions are embedded in valued cultural ideals about masculinity, self-actualization and success, as well as in moral conceptions of authenticity and personal freedom. I argue that this investigation of parents' moral justifications and dosing dilemmas raises questions about the validity of authenticity as a transcendent moral principle. Moreover, this study demonstrates that in order to be relevant, bioethical analysis of neurocognitive enhancement must engage with ground-up studies of moral principles and decision-making in context.

Keywords

attention-deficit hyperactivity disorder (ADHD)

Ritalin

neuroethics

enhancement

authenticity

boys' psychology

Open Peer Commentaries

Debates over the implications of psychopharmacology for authenticity and personhood were originally sparked by Peter Kramer's influential book, *Listening to Prozac* (1993). In a series of case analyses, Kramer suggested that Prozac was doing more than treating depression or low mood in his patients. Some of his patients on Prozac felt as though they had been transformed into new and improved persons; they reported feeling "better than well." Kramer questioned whether such transformation was a threat to an authentic (undrugged, unenhanced) self and wondered about the ethics of prescribing drugs that might somehow change a person's core self. At the same time, Kramer provided several justifications for "cosmetic psychopharmacology"—the use of Prozac for purposes of enhancement of the person, versus treatment of disorder.

The enhancement-treatment distinction, originally made in the context of gene therapy, was meant to distinguish between what Sabin and Daniels have called "departures from species-typical normal functional organization or functioning" and improvement upon normal functioning (1994, 6). The term "enhancement technologies" has been used to describe those treatments that improve human performance, appearance, and/or behavior where such improvement is not medically warranted (or financially justified given limited resources). In light of this distinction, legitimate medical intervention is viewed as morally justified and necessary, while enhancement treatments are viewed as excessive, artificial, and morally suspect.

While there is plenty of discussion, particularly among bioethicists, about the limitations of the treatment-enhancement distinction in theory and in practice, the distinction has been an important analytic tool for the assessment of a variety of present and promised psychotropic drugs. Drugs often included in discussions about enhancement include Ritalin (methylphenidate), Prozac (fluoxetine) and Paxil (paroxetine), used to treat attention-deficit hyperactivity disorder (ADHD), depression and social anxiety disorder, respectively. The status of these "disorders" is contested, both within and outside the medical community, given ambiguous diagnostic criteria and reports that persons without appropriate diagnoses and mild or non-existent "symptoms" can benefit from the use of these drugs (Kramer 1993; Rapoport et al. 1978). Cosmetic use of these drugs is therefore not only possible, but probable, raising concerns about the implications of drug use for what Taylor (1991) has called an "ethics of authenticity"—the self's sense of its own uniqueness and individuality, and the desire to be true to this self (Abbey 2000).

The American Journal of Bioethics, 5(3): 34–47, 2005

ISSN: 1526-5161 print / 1536-0075 online
DOI: 10.1080/15265160590945129

Within the bioethics literature, Ritalin[1] is positioned as one of several examples that explicate larger arguments related to the ethics of these drugs for enhancement purposes, the implications of psychotropic drugs for the authentic self, and the rights of parents to shape the capacities of their children. For example, Brock (1998) has suggested that Ritalin use among children raises concerns about respect for the child's personal autonomy; he argues that as a unique individual, the child's "character, capacities and life history should be permitted to unfold according to its own nature" (1998, 62). Brock is also concerned about the implications of Ritalin treatment for a child's "self-creation and individuality," fearing that Ritalin may negatively impact a child's ability to take responsibility, make choices, and take control over who he becomes. Fukuyama (2002) has argued that Ritalin is being used out of self-interest by parents and teachers who want to make lives easier for themselves with a "medical shortcut" (49); others have noted that Ritalin can be used to confer a competitive advantage on a child (Parens 1998), leading to similar concerns about parents fulfilling their own objectives through Ritalin use rather than acting in the best interests of the child.

These compelling concerns have inspired not only bioethical debate but have also sparked public and media discussions about the ethics of Ritalin use. However, bioethical analysis has to a large extent remained detached from real-life Ritalin use and decision-making processes around Ritalin treatment. Arguments tend to depend on fictional cases which are inevitably reductive and authored in such a way as to construct a particular kind of moral problem and resolution (Elliott 1999). Moreover, the discussion of Ritalin has not been specific or substantive; arguments rarely contain a focus on any one drug, or the behaviors treated. It is not unusual, therefore, to read articles that substantially blur the distinctions among a variety of very different drugs, and very different problematic conditions, such that one might conclude that the ethical considerations around the use of psychotropic drugs are not also contingent on the type of drug, the particular behaviors being treated, and the population under treatment. The lack of attention to the singular issues surrounding particular drugs, behaviors, and disorders has meant that concerns about authenticity and selfhood, improvement and enhancement have remained largely abstracted from the lived realities in which behaviors are viewed as problematic, help is sought, and treatment decisions are made.

In addition, bioethical discussion of authenticity and personhood in relation to psychotropic drug use has remained largely isolated from other disciplinary perspectives on these concepts. Consequently, there has been little discussion of the ontological status of "the self" and the relationship of ontology to moral concept. Investigations into self and identity within cognitive and social psychology, sociology, neurology and anthropology have illustrated how fragile, fragmented and embedded these concepts are, to the extent that some researchers increasingly question the existence of an authentic self.[2] Yet much of the bioethical argument appears to assume an actual, authentic self. Concerns that psychotropic drugs may diminish a "real" self, or transform the self, are founded upon the assumption of a self that is identifiable, coherent, and stable. The individualist emphasis in bioethics can encourage an essentialized vision of this self, as when Brock appears to assume that children have a "natural" character (1998, 62). However, as Elliott (1999) has argued, notions of authenticity do not necessarily map onto a *real* core identity; rather the language of authenticity may more accurately reflect the desire to provide a moral justification for particular medical decisions. The need or desire to provide such moral justification signals the communal and relational importance of moral and ethical languages; indeed, such discourse can be seen as a resource for "playing the games and participating in the dances of cultural life" (Gergen 1994, 104).

Recently, social scientists and bioethicists have called for an infusion of social science approaches and investigations into bioethics in order to

1. I use Ritalin representatively here, as there are other stimulant drug treatments on the market for ADHD. These are discussed later in the paper.

2. This listing is far from comprehensive and is meant to give just a sense of the variety of approaches and arguments on the general topic of mental illness, identity and selfhood. In anthropology see Low's (1994) work on the self/body relationship in the experience of "nerves"; also Estroff's (1985) work on selfhood among schizophrenic patients. In psychology see work on self-concept in children by Harter (1999), and work on self as a construct by Gergen (1991). In sociology see the classic work on labelling and stigma by Goffman (1961) and by Scheff (1966). Cognitive neuroscientist Steven Pinker (2002) has argued that there is no neurological evidence for the self, calling the self a "ghost in the machine"; Varella et al. (1991) have applied Buddhist principles to a neurological analysis of the self and have arrived at a similar conclusion.

construct an informed bioethics that is attentive to lived experience and local situations. In his outline of how social science and bioethics could benefit from a mutually supportive relationship, Hoffmaster (2001) argues that the justificatory approach of traditional bioethics "disregards the extent to which moral concepts and norms derive their meaning and their force from the social and cultural surroundings in which they are embedded" (2). In this paper I locate conceptions of authenticity within parents' moral dilemmas in relation to Ritalin treatment for their sons with ADHD. These conceptions of the authentic self are grounded in the complexities of time, culture, space and lives; understanding this complexity, and the particularity of local situations, helps us understand the contextual significance of moral concepts and suggests the limitations of an ethical analysis that is abstracted from an understanding and analysis of context.

In keeping with the emphasis on the lived-reality of ethical decision-making, this paper focuses not only on the big decision—whether or not to choose medication for the child—but also on the smaller, repeated daily decisions surrounding each dose of Ritalin. Through a qualitative analysis of parents' narratives, I illustrate how decision-making processes around Ritalin doses employ shifting evaluations of the relationships among self, authenticity and disorder, and contradictory conceptions of the "authentic" self. I argue that for parents, the authentic self is part of a strategic construction that has practical import: it informs and justifies decisions about medication use. Parents' strategic narratives are embedded in the larger cultural setting, as they draw on a set of culturally valued norms of male development. Because these narratives encode widely held beliefs and attitudes, they present a strong argument for a particular resolution to the moral dilemma of whether or not to give the child a dose of Ritalin. As this discussion unfolds, I hope to illustrate the reciprocal shaping dynamics of gender, context and moral concept, and to underline the integral role such dynamics play in structuring the moral dilemmas parents face when making dosing decisions.

BACKGROUND TO THE STUDY

The grounded theory method of qualitative research and analysis was used to collect and analyze data for this study (Glaser 1978; Strauss and Corbin 1990). Grounded theory is increasingly used in psychology and in qualitative medical research (Henwood and Pidgeon 2003). At the outset of the study, the method emphasizes broad research questions and a series of methodological steps that ensure active integration of emerging hypotheses, data collection, and data analysis. In this study, the initial research focus was on mothers' and fathers' experiences with ADHD diagnosis and methylphenidate treatment. "Theoretical sensitivity"—the researcher's ability to understand subtleties and nuances in the data—was developed through historical research, extensive literature review, participation in a variety of ADHD-related forums (including clinical, educational, and Web-based communities), and teaching in a K–12 school. A small community of coders worked together during the initial coding phase—known as "open coding"—to explore key themes and categories in the data. This collaborative phase of data analysis and interpretation provided feedback about the structure and progress of the interview itself, and helped to establish the validity of important categories and codes.

Data Collection and Analysis

In the grounded theory approach, higher order descriptive and conceptual categories are developed systematically through several analytical devices, including the method of "constant comparison" and theoretical memoranda. Data collection and analysis occur simultaneously, so that data analysis can inform further data collection. Emerging hypotheses are further tested and developed through additional sampling and data analysis in a process known as "theoretical sampling." Sampling new data on theoretical grounds extends the richness and scope of the emerging theory and diversifies the data set (Strauss and Corbin 1990).

The initial sample for this study was drawn from a pediatric neurodevelopmental clinic within a university hospital in Rhode Island where I worked as a participant-observer/researcher for several years. I interviewed 22 mothers and 12 fathers of boys in the clinic. Since the clinic environment might constrain the diversity of parents' experiences and also of their reports, further sampling in this study reflected an effort to understand whether key concepts and developing hypotheses would be relevant in a non-clinic-based sample. An additional 17 mothers and 10 fathers of boys with ADHD were interviewed; participants were recruited from educational conferences for ADHD, online support groups for ADHD, and local schools. While experiences of diagnosis varied between the clinic and the community samples, all children in the study met diagnostic criteria on the Connors Rating Scales (for

parents and teachers). The main inclusion criterion for all interviews was that parents' sons had been taking medication for a diagnosis of ADHD for at least three months but not longer than one year. This time frame allowed for medication effects to be established in children, and allowed parents to have relatively fresh memories of their parenting experiences prior to diagnosis. Participants were White and lower-middle to middle class. Appropriate ethical consent was obtained from all participants, and institutional review board approval was obtained for research with clinic families.

Interviews

Grounded theory supports the use of creative questions and methods that allow researchers and participants to open up new ways of thinking and seeing a problem (Strauss and Corbin 1990). In this study, open-ended, formal interviews were conducted using pictures chosen by participants from a standardized set of popular weekly and monthly magazines. The set of magazines included *People, Self, Sports Illustrated, Woman's Day*, and *Newsweek.* Picture-oriented interviewing has been used in medical research and in clinical work in order to help participants feel in control of the interview's subject matter, to talk about difficult emotions and experiences, and to enrich verbal narratives (Clark 1998; Gerace 1989; Weiser 1993). At the beginning of the interview, participants were asked to collect up to 10 pictures from the magazines in response to a broad question: *How do you think and feel about methylphenidate (or other psychostimulant) treatment?* The interview was then organized around the pictures, beginning with the participant's explanation of how the picture was relevant to the key question. As data collection progressed, interviews became increasingly focused on exploring representative concepts and developing hypotheses. Mothers and most fathers readily engaged with the various steps of the interview process, and they were encouraged to discuss additional thoughts and concerns that had not been covered during the interviews.

ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD)

ADHD is the most common childhood psychiatric illness in America. Core symptoms include inattention, hyperactivity and impulsiveness. Estimates of prevalence are difficult to assess and vary widely. Depending on diagnostic definition, estimates can range from 1–2% of school-age children to 10–20% of school-age children (Schachar and Tannock 2002; Cooper 2001; Swanson et al. 1993); approximately 75% of those diagnosed are boys. Methylphenidate is a stimulant drug which is currently considered to be the most effective treatment for the symptoms of ADHD (MTA Cooperative Group 1999). For many years, a short-acting form of methylphenidate marketed under the brand name Ritalin (Novartis Pharmaceuticals) was the market leader in treatments for ADHD. However in the past five years, clinicians and families have begun to favor longer-acting forms of methylphenidate (particularly Concerta, by McNeil), and a amphetamine salts, dextroamphetamine and Dexedrine composition (Adderall and Adderall XR by Shire). The newest treatment for ADHD to emerge is a non-stimulant drug called Strattera, by Eli Lilly. According to one estimate, approximately 3% of American school-age children take some form of stimulant drug for a diagnosis of ADHD (Cooper 2001). However prescription numbers and sales figures must also be treated with skepticism. What is clear is that American use of methylphenidate is out of proportion with that of other countries, although global use of the drug is growing. In 1999, the U.S. used 85% of the world's methylphenidate for medical purposes (United Nations International Narcotics Control Board 1999).[3]

Various forms of the ADHD diagnosis and stimulant drug treatments have existed for much of the past century (Singh 2002); however there is still a great deal of public and scientific disagreement over the validity of the diagnosis and concern over rapidly escalating use of Ritalin and other drug treatments for ADHD. The American Academy of Pediatricians released diagnostic guidelines for ADHD in 2000 and in 2001 (see www.aap.org/policy/adhd). These guidelines encourage more rigorous diagnoses of ADHD; however there remains an inherent ambiguity around core diagnostic symptoms. Referrals for ADHD often coincide with children's first year of schooling when behaviors such as fidgeting, inattention, impulsiveness and high activity are widespread—and arguably normal. Parents and teachers have been accused of using Ritalin as a "quick fix" to relieve pressures and problems that are rooted in the environment, not the child. Most clinicians will admit that the symptoms of ADHD are likely to arise out of a combination of biological and social factors;

3. Methylphenidate is not generally used to treat conditions other than ADHD; however it is also indicated for the treatment of narcolepsy.

however a multi-modal approach to treatment is time-consuming and expensive, and pharmacological intervention is often the only treatment provided to the child and the family. Ritalin is not a pharmacological scalpel—that is, effective treatment outcomes cannot be said to prove the validity of the diagnosis (Kramer 1993). In a series of studies performed in the 1970s Rapoport et al. (1978) showed that stimulant treatment improves attention and focus in "normal" as well as in "ADHD" boys. Ritalin's effectiveness in the general population makes it even more difficult to judge whether the drug is being used to enhance performance or to treat disorder.

RITALIN WORK

Bioethical analyses of selfhood and authenticity in relation to Ritalin use are characterized by an over-reliance on Kramer's original analysis of Prozac, personhood and enhancement. Ritalin and related stimulant treatments for ADHD tend to be theorized as equivalent to Prozac in terms of the enhancement issues they raise (e.g., Fukuyama 2002), but Ritalin use is structurally and practically so different from Prozac use that arguments which model concerns about Ritalin on analyses of Prozac can draw only very global conclusions. For one, the population of users of Prozac and Ritalin differs significantly. The fact that the majority of Ritalin users are children between the ages of 7 and 12, and the majority of Prozac users are adults surely suggests the need for distinct analyses of selfhood and authenticity within these user populations.

Another key difference between Prozac and Ritalin is the way in which these drugs work. As a stimulant, Ritalin is an entirely different kind of drug than Prozac. Prozac is taken once a day, and it takes approximately 3–4 weeks to build up an effect in a person's system. Once the desired effects have been achieved, a daily dose of Prozac is sufficient to maintain those effects because a certain level of the drug remains in the system. Ritalin, on the other hand, is effective within 30 minutes to 1 hour of ingestion, and remains in the system for only 3–4 hours. Therefore Ritalin and other short-acting stimulant treatments for ADHD must generally be taken several times a day. Children on Ritalin usually receive three doses, one in the morning, one at lunchtime, and one in the afternoon. Sustained-release (SR) forms of methylphenidate are taken just once a day; however, over the course of an 8–12 hour period, these long-acting drugs should also wash entirely out of the system such that the drug no longer has perceptible effects on behavior. Dose titration is much more difficult with the SR version of methylphenidate, and some parents find it necessary to add a short-acting dose in the afternoons in order to sustain medication effects through the homework period. This additional dose must be weighed against the potential side-effects on the child's sleep and appetite. In my experience, clinicians sometimes prefer to start children—especially the younger ones—on short-acting Ritalin in order to have more control over dosing and to more effectively track drug effects. Later, these children may be put on a long-acting form of methylphenidate.

Most of the children whose parents participated in the study presented here were taking Ritalin. There are several important implications of the necessity for multiple daily doses of Ritalin—and these implications have moral dimensions specific to Ritalin use. The first implication is that Ritalin can be used for what has been called "event-specific" purposes (Diller 1997). In other words, one might anticipate a particular event such as an exam, a party, or an athletic activity in which additional focus and concentration might be beneficial to the child. If the drug were not already active in the system one could take a dose an hour or so beforehand to prepare specifically for this activity. The use of Ritalin for such targeted purposes is not limited to children diagnosed with ADHD. The widespread (and illegal) use of Ritalin as a study and exam aid among American university students is one example of such use outside the ADHD population.

Families of children taking Ritalin for ADHD struggle with a related implication of the need for multiple daily doses: when is it *not* necessary to give a child a dose of Ritalin? The best examples of such times are weekends and school holidays, when many American parents limit or stop Ritalin doses entirely. Parents of children on the SR version of methylphenidate may give a reduced dose or omit the daily dose. This may be partly due to a lack of guidance from clinicians: During the week, clinicians tend to stress Ritalin as a tool to promote educational achievement and success; on weekends and holidays they generally tell parents to use their own judgment as to when to use medication (Diller 1997). In cases where the child's appetite, sleep, or growth are problematic, a clinician may instruct parents to use weekends and vacations as drug holidays.

Here we arrive at another moral problem that is specific to Ritalin use: The person taking the drug is frequently not the person who decides when or

if the drug should be taken. One might argue that this is partly true also for the person whose therapist recommends Prozac. The patient's acceptance of a recommended treatment is mediated by various coercive sociocultural forces, in particular the power of the clinician and the medico-scientific enterprise (Goffman 1961). However, the average adult patient contributes actively to the decision regarding Prozac treatment; in contrast, children who are recommended Ritalin for reatment of ADHD very rarely have a say in the decision over treatment. Generally, parents decide whether or not to accept Ritalin treatment for the child.

An additional and important complicating factor in parents' decisions to accept methylphenidate treatment is that they need to (re)evaluate the decision at least every day. Arguably every dose of methylphenidate parents give a child represents an evaluation of the child's behavioral abilities and limitations in relation to the challenges of that day's particular activities. While some of these doses require little conscious decision-making—such as routine doses on school-day mornings and/or lunchtimes—other doses require more active decision-making, such as whether or not to dose on weekends, or which particular holiday events might warrant a dose and which might not.

Parents who must make ongoing decisions about whether or not to give a child a dose of Ritalin at a particular time enact the role of therapist or clinician. This is especially true when clinical guidance is lacking, such as on weekends and school holidays. Elliott (1999) has suggested that the scientific role of medical practitioner—to observe, diagnose and treat symptoms—is particularly difficult to maintain in psychiatry, where a mechanistic approach to the body belies the complicated cognitive and emotional accompaniments to behavioral disorder. Parents, of course, cannot be asked to achieve an objectivity that even psychiatrists find difficult to maintain, and so their narrative resolutions to the moral dilemma of Ritalin dosing necessarily involve a multitude of reactions, emotions, and personal history.

Kleinman (1988) has argued that such narratives make up part of patients' "explanatory models" that "enable the sick to . . . negotiate, using the specific terms of those models, an acceptable therapeutic approach" (49). Mattingly (1998) builds on this treatment of narrative to understand the therapeutic approaches of those who care for chronically ill patients. In her ethnography of occupational therapists, Mattingly finds her informants "continually engaged in deciphering the actions of [patients] . . . they are constantly reading the actions of others . . . trying to discern what motivates the behavior they can outwardly see. They try to 'find the story' which makes sense of what they observe" (1998, 45–46). Mattingly names the process of discovering the story within experience or action "emplotment." In the following sections of this paper I discuss the ways in which parents emplot their sons' actions in particular stories which function strategically to offer a resolution to the moral dilemma of whether or not to give a child Ritalin in a particular context.

MOTHERS: SUCCESS VERSUS FREEDOM

So far in this discussion I have been referring to "parents" of "children" with ADHD, when in fact a contextualized discussion of parents' moral dilemmas around Ritalin use must be more specific in terms of both parental gender and child gender. Gender of both the observer and the observed matter to the perception of ADHD behaviors, and to the evaluation of those behaviors as representative of underlying pathology (Singh 2003, 2004). Mothers and fathers of boys with ADHD make meaning of the relations among self, disorder, and behavior in markedly different ways; they emplot their sons' actions in different narratives, and they have different resolutions to the moral dilemma of whether or not to use Ritalin in particular contexts.

Locating the Self

Following ADHD diagnosis and Ritalin treatment most mothers interviewed tended to accept key aspects of a biomedical explanation that attributed boys' problematic behaviors to biological and genetic dysfunction. However mothers were far less clear about the extent to which these biologically based dysfunctions and Ritalin treatment affected their sons *themselves* (as opposed to their behavior). While mothers saw the extent to which Ritalin treatment made a difference to their sons' behaviors, they were often unwilling to go the next step and propose an all-encompassing relationship between neurochemistry and personhood (Kramer 1993). More often, mothers posed ADHD behaviors as *part of* who their sons were, and saw Ritalin treatment as opening their sons up to the possibility of better understanding this aspect of themselves. As Delores explains:[4]

4. All names have been changed and individual narratives are composites.

> *I hope he* [her son Gregory] *will be able to understand who he is as a person and what his limitations are, and how he has to find a balance that lets him be on his own. He needs to be aware that he can be pretty impulsive and what he can do if he can't control himself. Ritalin will help him with that, but he needs to understand that he will probably have to take it even when he's older. These are the things he needs to learn about himself, so that he is able to function and be happy.*

Disorder, limitations, and symptoms are part of who Gregory is; he must learn to understand himself in these terms. In this version of the biomedical explanatory model, Ritalin is a lifetime companion, helping Gregory cope with an inherent (chronic) part of himself. Delores may appear to merge Gregory with his disordered behaviors, but note that there is another part of Gregory that is aware of the disordered Gregory and capable of learning from him. It is as though two entities exist within Gregory. One is in control of the other — but Ritalin will always be necessary to maintain this control.

Authenticity

Mothers' descriptions of a struggle between these two entities tend to depict ADHD behaviors as an unwanted, limited part of their sons. The entity that learns to control this undesirable behavior is cast as what might be called an authentic self. Josie describes her son Joseph:

> *I feel so happy for Joseph that he is finding his way and can feel better about himself. I think now he feels good about what he can do. . . . He has friends and has self-esteem. . . . He understands himself better. . . . Now he's comfortable with himself and comfortable with the world around him. . . . The real Joseph is the one on medication. That's the real one. I know that because he doesn't like what he is not on medication. So that can't be the real one. The real one is the one he is most comfortable being. Where he just feels best about himself.*

In this version of the biomedical explanatory model, Ritalin is more than a companion—it is a freedom fighter, releasing Joseph from undesirable, unvalued symptoms into a self that feels "comfortable" and good. Ritalin allows the best version of Joseph to emerge, and this version is who Joseph really is—his authentic self.

There is a clear moral imperative of Ritalin work inherent in the idea of conquering an undesired and undesirable aspect of the self to allow a "real" self to emerge. Josie even calls Joseph by a different name when Joseph is acting up. She calls him "Jason" after a troublesome relative. This signals to Joseph that Jason has temporarily taken over. The temporary nature of the takeover is important to mothers. Most seem to believe that what is real in their children is part of an essential core that remains intact despite a child's behavior—and despite chemical intervention into the child's behavior. When I asked mothers how they reconciled giving their sons a drug that changed them, most mothers very quickly told me that they did not believe Ritalin changed a child in any deep way, because it was only working on "behavior." As one mother said, *"It just changes his behavior, not who he is."*

This distinction between a boy's behavior and his real or essential self has deep moral implications. It justifies the need for medication as a moral imperative to free the real self, and it justifies the use of medication as a relatively superficial intervention that does not in fact penetrate to the child's real self. This kind of reasoning maps on to the frequently echoed similes for Ritalin work in the popular and clinical literature on ADHD. Ritalin is likened to insulin for diabetes, or to glasses for myopia (e.g., Hallowell and Ratey 1994). In interviews mothers used both these similes to justify Ritalin treatment for their sons. But for these similes to mean something, mothers have to hold to a logic in which a child's behavior is a disrupted or disordered part of the body, that is at the same time not part of the child's real self. The similes move behavior disorder into the body of the child, thereby separating body as the (amoral) locus of disorder, from the self, which remains buried, but intact. Medical intervention then restores the integrity of the disordered body, but only impacts the real self in so far as it allows it to re-emerge.

This very fine moral tuning is a legacy of a scientific paradigm that elides moral questions inherent in medical intervention by locating disorder in an allegedly non-moral site—the body. However, modern psychiatric illnesses present a more complicated problem because the locus of illness is generally thought to be the brain. All mothers interviewed identified the primary bodily site of Ritalin work as the brain—which is also commonly understood to be the site of the self. When asked to help me visualize the relationship between self, drug and behavior in the brain, some mothers either verbally described or drew pictures of a brain that contained two separate entities, "bad behavior" and "self." In all these descriptions the work of the drug was contained within the "bad behavior" sphere. Some mothers drew before and after drug pictures. The before pictures showed overlapping

"bad behavior" and "self" spheres, indicating the extent to which the bad behavior was overshadowing the self. The after pictures showed an independent "self" sphere and a shrunken or non-existent "bad behavior" sphere.

Real Boys and Male Success Stories

The notion of a freed, authentic self is the focal point of a particular therapeutic narrative oft-repeated by mothers. I think of this narrative as a "success narrative." The success narrative emplots the actions of the freed authentic self in a culturally valued story of male development, thereby providing an even stronger moral impetus to the use of Ritalin.

Fiona articulates a success narrative:

> *Ritalin opened a doorway* [for Jimmy]. *It gave him away to go. It gave him a way to focus and . . . gave him a direction. . . . I think he feels better about himself. That's the key. To everything. Everything he will do from now on in his life. I want him to know that he is successful. I don't want him to keep hitting walls and feel like he is a failure and that he can't accomplish this or that, or you know, that he is so different. Well, he is different, but so is everybody. He has a value and he can do it, he just needed to realize that. . . . Now the door is open and he can go anywhere.*

Mattingly (1998) suggests that therapeutic actions are given significance through their connections to "life plots, the extent to which they open onto much broader narrative vistas which lead far beyond therapy" (70). The connection between Ritalin treatment and a broader life narrative is fully evident as Fiona describes her hopes for Jimmy's future. As Fiona describes it this "narrative vista" is characterized by freedom—"open doors"—and choice—"he can go anywhere." But Jimmy's direction is not random; his life possibilities are not open-ended. A key feature of his future horizon is "success."

Fiona's vision of Jimmy's successes are part of what Mattingly calls a "space of desire created by the distance between where the protagonist is and where she wants to be" (70). In mothers' therapeutic plots this "space of desire" held a particular understanding of the tools necessary to boys' future successes. The most important element of this model is goal-oriented movement or action. Without Ritalin, Jimmy was stalled—"hitting walls"—going nowhere. With Ritalin, Jimmy is able to focus his actions, thereby regaining footing on a forward-moving developmental track. He gains "value"; he has "found direction"; doors are opening to him. Another key aspect of a successful boy is self-esteem. Jimmy no longer feels like a failure; he experiences "accomplishments"; his differences can be seen as positive and valuable.

For mothers, achievement along the success narrative plot lines signals a positive response to Ritalin treatment. However, a growing literature in boys' psychology cautions against this model of healthy boys' development. The psychologist William Pollack (1998) cites high incidences of depression and ADHD in boys as evidence that ADHD behaviors may be masking boys' reactions to a "culture of masculinity" that requires boys from an early age to be accomplished, independent and self-reliant, thereby emulating cultural models of successful men. Other boys' psychologists argue that Ritalin treatment cheats American boys of their childhood. American parents want their sons to focus on "the seriousness of building a future rather than the frivolous pursuits of the afternoon" (Kindlon and Thompson 1999, 44).

From this perspective, the therapeutic success narrative illuminates the extent to which Ritalin treatment engages gender stereotypes and embeds a potentially harmful developmental model. Fiona's emplotment of Jimmy's 'new' behaviors in a success narrative highlights the importance of these culturally valued aspects of masculinity to perceptions of successful Ritalin treatment. Fiona believes Ritalin treatment is successful in large part because Jimmy "feels better about himself." Later she will say that she believes this is the real Jimmy—*Jimmy likes himself better, so that must be the real Jimmy.* But clearly Jimmy's self-esteem, and his authenticity, are linked to his successes along the developmental track. Fiona's recognition of the "real" Jimmy is inseparable from her perception of Jimmy's cultural value and his ability to achieve a set of gendered goals.

Of course Fiona is not solely responsible for her deployment of these culturally valued images to justify Ritalin use. All mothers I spoke to emphasized a success-oriented path when talking about Ritalin intervention; this is also the path often emphasized by clinicians when providing a rationale for Ritalin treatment. The path of success has key components: self-esteem, friends, direction, opportunity, value, and accomplishments. This conglomerate made up so many mothers' sense of the benefits of Ritalin that I have come to think of it as the "Ritalin track." The track is not only relevant to boys on Ritalin; it

probably exists in most mothers' minds as an orientation toward the future. But when a boy is not a "problem" boy, the pressures to be on the track may not be felt as deeply, or as early. For mothers of boys with ADHD-type behaviors, the track is illuminated the moment the boys fall by the wayside, and mothers are forced to confront a cultural authority that normally remains hidden from view. This cultural authority penetrates to the development of the child in so far as it dictates the particular signposts along a 'normal' developmental pathway. Ritalin helps close the gap between boys with ADHD behaviors and "normal" boys. In fact, the work of Ritalin is sometimes so closely aligned with "normal" development that mothers and clinicians often admitted to me that they could not tell whether changes in boys with medication were due to a normal maturation process or to Ritalin.

Weekend Dosing Dilemmas

If Ritalin frees a boy's authentic self and allows him to be a successful, happy child, there should be little concern over the use of medication on weekends. The use of Ritalin at all times would appear to be a logical, morally, and medically legitimate practice. The frequent analogies to insulin for diabetes, or eyeglasses for myopia, should serve to further legitimize Ritalin as an ongoing treatment. Insulin and eyeglasses are not discontinued on weekends and holidays because the disorders they treat do not go away.

And yet, all mothers I interviewed faced a dilemma over whether or not to give their sons medication on weekends and holidays.[5] Their reasons for keeping their sons off medication included a lack of structured activities, a dislike of having a child constantly on medication, and a desire to allow their sons to "be themselves."

The authentic self was therefore an operative theme in what might be called an anti-therapeutic narrative offered by mothers to resolve the dilemma of whether or not to give a dose of Ritalin. In the anti-therapeutic narrative, the moral dilemma is resolved by withholding Ritalin. As Beth says about her son Stuart:

> *Why should we drug him on the weekend? That's who Stuart is. If he wants to be off the walls, why not? Sometimes the question* [whether or not to use medication on weekends] *drives me nuts, drives me crazy, drives me nuts! . . . Is ADHD really a diagnosis? Are you nuts to think Ritalin works? Is it just that you want it to work? . . . I know half of me wants him to be successful and and do well and blah, blah, but the other half of me is like, who the heck am I pleasing here? He's fine the way he is. It's the weekend for god's sake. He doesn't have to be successful now.*

The anti-therapeutic narrative subverts several key aspects of the therapeutic-success narrative: it questions the legitimacy of the medical model of behavior and treatment; it questions the value of success as a therapeutic goal; and it questions whether Ritalin really works. Most important, the anti-therapeutic narrative proposes a different understanding of authenticity; in this account, the real Stuart is the unmedicated Stuart—"that's who he is." Beth's desire to let Stuart be who he is, and her valuation of his unmedicated self as "fine," lead her to arrive at the opposite solution to the moral dilemma of whether or not to give Stuart a dose of Ritalin. Similarly, other mothers justified withholding medication on the weekends by saying they wanted their sons to be themselves, or to know who they really were.

Mothers' dosing dilemmas on the weekends revolve centrally around a dialectic of authenticity and personal freedom: Who is the real boy really? Can he be free to be who he really is, when he must be chemically controlled in order to be free? On weekends, the answer is often "no." The authentic self is now defined in opposition to the artifice of the medicated self: the unmedicated authentic self is free of restraints, free of the need to be successful. Thus on weekends, a boy's behavior *is* part of who he really is— Stuart *is*"off the walls"—and to deny or restrain that part of him through medication is to subject him to a suspect and confining medical explanatory model.

In the course of a three hour interview, the same mothers produced both therapeutic and anti-therapeutic narratives to justify their giving/withholding medication to their sons, and provided contradictory understandings of their sons' authentic selves in relation to ADHD diagnosis and medication. These contradictions, and mothers' lack of awareness of them, illuminate the moral struggle parents undergo when they must make their own decisions about whether or not to medicate their sons. As Kleinman (1998) has noted, such contradictions are part of illness experience:

5. Three boys were on medication consistently over weekends and holidays. However their mothers also questioned the wisdom of such continuous dosing and experimented with drug holidays.

> [E]xplanatory models are inchoate . . . statements frequently contain contradictions, and they change in content over time as different situations arise. . . . Explanatory models are not merely cognitive representations; they are deeply rooted in the emotional turmoil that accompanies illness. (240)

In the case of ADHD and Ritalin, these contradictory narratives also serve a *strategic* purpose. Dosing decisions are emplotted in moral narratives that present a particular set of relations among authenticity, boy, disorder and medication. How these relations are presented shifts according to different situations not only because of "emotional turmoil," but also because a particular explanatory model is more useful in certain situations than in others. For example, as we have seen, mothers are more likely to use a medical model to explain their sons' need for medication in relation to future success—a notion which is more relevant during the week in a school setting than it is on the weekends. A medical explanatory model also serves a strategic function within a school setting in that it justifies not only the use of medication but also the need for additional support from the school. As Delores explains:

> *I advocate* [for son Gregory] *at school. I have to. He has a problem. They have to help him. He can't help himself. They have to understand that he needs special treatment and that they can't expect him to behave well, the way others do. The medication helps him in school. . . . And the teachers know it; they see the difference too.*

Delores pushes the school to accept a medical explanatory model for Gregory's difficulties, and she points to medication effects as material proof of the legitimacy of this model. In her advocacy for Gregory, Delores encourages the school to emplot its actions viz. Gregory in a therapeutic narrative that provides a strong moral rationale for the various interventions, medical and educational, that Gregory requires. Delores constructs Gregory as helpless and overwhelmed by disorder in order to justify this "special treatment." And yet, during a different part of the interview, Delores tells me that off Ritalin, Gregory is able to control some of his behaviors when he makes the effort, and that she expects such efforts from him at home.

Thus mothers' moral narratives construct a set of strategic relations among behavior, authenticity and drug treatment in order to provide moral justification for their therapeutic actions and decisions. These moral justifications draw upon valued cultural and gendered ideals about self-development and success, as well as moral conceptions of personal freedom and responsibility. Mothers' decision-making occurs in the context of a moral framework (Taylor 1991) that contains contradictory moral, cultural and gendered ideals related to boys, success, self-development and freedom. Mothers' conceptions of "the real boy" are the flexible, malleable center around which to justify their contradictory dosing decisions.

FATHERS: AN ALTERNATIVE VIEW OF MALE AUTHENTICITY

I suggested earlier that gender of the observed *and* the observer matter to the perception of behavior as pathology and to treatment decisions for a child with ADHD. Mothers' struggles to satisfy cultural ideals of successful boys are supported and complicated by their struggles to satisfy cultural ideals of good mothers (Singh 2004). There are tensions and contradictions inherent in these two sets of ideals, leading mothers to experience some Ritalin dosing decisions as moral dilemmas in which conceptions of a boy's authentic self figure centrally, and carry justificatory weight. Fathers also experienced moral dilemmas around some Ritalin dosing decisions, and their narratives about these dilemmas highlight the extent to which conceptions of child authenticity and ideals of self-development—and ultimately dosing decisions—are inherently relational, and contingent upon the gender of both the child and the parent.

Fathers' experiences of Ritalin dosing dilemmas revolved even more overtly than mothers' around gendered norms and ideals related to authentic male behavior. Fathers experienced these norms and ideals through their own boyhood histories and in their role as fathers. Thus they struggled to define, resist, and satisfy ideals of masculine behavior for their sons and for themselves.

Unlike mothers, many fathers I spoke to did not see their sons' behaviors as evidence of underlying pathology. They provided a different explanatory model for problem behaviors: "boys will be boys." Their sons' "wound up," "crazy" behaviors were evidence of their authentic boy-ness; as one father said, *my boys are all boy*. Thus fathers emplotted their sons' actions in an anti-therapeutic narrative, one that ascribed meaning and value to stereotypic gendered behaviors and rejected the notion that these behaviors were inherently problematic. An important element of fathers' anti-therapeutic narrative was that fathers themselves often connected to their sons through their sons' boy-ness. Fathers repeatedly told

me, *I was just like that when I was a boy*; or, *I did crazy things as a kid.* In other words, fathers identified with their sons' "problem" behaviors through memories of their own boyhood, thereby further affirming the validity of an explanatory model that read "problem" behaviors as authentic "boy" behaviors. Elsewhere I have suggested that fathers' anti-therapeutic narrative has a strategic function in so far as it allows fathers to continue to see their own boyhood behaviors as normal rather than pathological. While medical diagnosis and drug treatment of their sons tended to quiet fathers' open resistance to medical explanation, many remained skeptical of the legitimacy of diagnosis and the use of medication (Singh 2003).

Ritalin for Sports

Most fathers who faced a moral dilemma over Ritalin dosing experienced this dilemma in the context of their sons' athletic activities. Sporting activities tended to complicate fathers' interpretations of "problem" behaviors as authentic boy behaviors because many of the behaviors that fathers insisted were "normal" in their sons, such as impulsiveness, hyperactivity, and poor listening, interfered with the sons' ability to perform well in sports. As Pollack (1998) and others have noted, boys' athletic ability and participation are highly culturally valued, and sports is viewed as part of an authentic American boyhood. Therefore sports presented a context in which fathers were led to re-evaluate a definition of authenticity that justified these "problem" behaviors.

Many fathers I spoke to appeared to have a bigger stake in their sons' athletic successes than in their educational successes. This may be in part because fathers' own boyhood histories and athletic prowess were implicated in their sons' performances. As one father put it:

> *It's hard to watch him out there* [during a game]. *He's kind of different than the other boys. He can't play a simple game without messing up. . . . Sometimes I'm embarrassed watching him play; he's pretty bad. . . . You know, I was not athletically inclined; two left hands, two left feet. I was a very big disappointment to my father.*

The sports context motivates fathers to emplot their sons' behaviors and actions in a narrative that is not so clearly anti-therapeutic as the boys-will-be-boys narrative. These narratives illuminate a "space of desire" that connects fathers' own experiences to the behavioral predicament of their sons. Behaviors that were read as authentic boy behaviors are now seen as interfering with culturally valued authentic boyhood activities. Impulsiveness and hyperactivity no longer signal gender-membership; rather they isolate the boy from the group, marking him as "different" from the others, an "embarrassment." Fathers' moral dilemmas around Ritalin dosing therefore also raise a set of contradictory relations among authenticity, behavior, and drug treatment. On the one hand, Ritalin dosing is seen as a violation of authenticity, an attempt to subdue authentic boy behaviors. On the other hand, Ritalin dosing brings a boy closer to a masculine ideal: A real boy is good at (and enjoys) sports.

Interestingly, fathers were far less able than mothers to separate and compartmentalize this play of contradictions, and to resolve their dosing dilemmas. For fathers, the issue of their sons' authenticity was mired in cultural and personal attitudes about normative gendered behaviors and concerns about status. The medical explanation that mothers used strategically to advocate for their sons was deeply problematic for fathers. Ritalin for a baseball game might help tame a boy's wild throws on the field and make him a more acceptable, competitive player; however, these positive effects of Ritalin also reinforced the boy's need for a crutch and set him apart from the other boys. Fathers worried that ADHD diagnosis and drug treatment marked their sons as inherently "different" or "weak."

Thus fathers were caught in a conundrum: The very strategy (medication) that might strengthen a boy's individual and group status also threatened his status by marking him as weak, or other. They could see the potential benefits of medication for such events, but this in itself did not provide sufficient justification for the use of medication. For fathers, the medical explanatory model could not provide a strong resolution to the moral dilemma of medication use because for fathers biology is not a morally neutral zone. Biology can be weak and flawed and, in so far as it is inherited, it implicates fathers.

In an effort to resolve the dosing dilemma, some fathers presented a kind of psychological explanation that saw boys' poor performances resulting from poor motivation. This explanation allowed fathers to view their sons as *potentially* in control of their behaviors, and suggested that non-medical responses might be adequate to change these boys' behaviors. As one father said:

If he needs the medication, he needs it. I guess I just wonder whether he couldn't play better without it? It could just be a problem of him not wanting to do it. Why should a boy need medication to play a game?

But the psychological explanation also does not provide a clear moral resolution to the dilemma of whether or not to medicate specifically for the sports event, leaving fathers still unsure of what to do. In many cases, fathers opted to leave dosing decisions—even for athletic events—to their wives.

CONCLUSION

To date, bioethical analyses of Ritalin use have failed to address the distinctive moral dilemmas that Ritalin treatment raises for parents and children. In this paper I have tried to illustrate that these dilemmas are fundamentally tied to the structure of Ritalin dosing, gendered relational dynamics, and gendered ideologies of child development and parenting. Parents may draw upon "predictable" (Elliott 2003) moral concepts and language to justify their dosing decisions—the language of self-transformation and authenticity—but the substance of these moral concepts, and parents' moral resolutions to dosing dilemmas, are anything but predictable; rather they are inconsistent, contradictory, strategic and incomplete. Parents' definitions of authenticity shift according to what parents value in particular contexts. Their shifting conceptions of "the real child" across different contexts are embedded in cultural and gendered norms and ideals about behavior, development, success, the self, mothering, and fathering. Moreover, parents' personal histories shape the ways in which they understand, confront and engage with these ideals and norms and how they translate them into parenting practices and dosing decisions.

The present argument highlights the importance of a sensitivity to context as part of a normative approach to ethical questions related to the use of psychotropic drugs and issues of neurocognitive enhancement. While authenticity is regarded as a positive ideal in western culture, it should not, in this context, be viewed as a static norm that expresses integrity or a transcendence of cultural whims.[6] Indeed, parents' justifications for Ritalin doses suggest that authenticity as a moral concept is grounded in basic cultural values about gendered behaviors, child development and child success—values which are constructed and defined in a contemporary, local setting. Identity, or notions of the self, similarly emerge as flexible, creative and contingent understandings that are fundamentally embedded in cultural and relational practices, structures, and institutions.

In a widely-cited recent article entitled "Neurocognitive Enhancement: what can we do and what should we do?" a group of scientists, cognitive psychologists and bioethicists outline an approach toward clarification of the ethical issues related to neuroenhancement (Farah et al. 2004). They write:

In the ethics of neurocognitive enhancement we are still feeling our way towards the relevant principles and we still have much to learn about the relevant facts . . . Until we have disentangled the a priori from the empirical claims, and evaluated the empirical claims more thoroughly, we are at risk of making wrong choices. (424)

Who is the *we* that will disentangle *moral principle and empirical fact* (2004, 424)? Throughout the article, the authors appear to make the assumption that answers to the challenges of neurocognitive enhancement will emerge from a dialogue between ethicists (who will discover and represent the *moral principles*) and scientists (who will discover and represent *the facts*). As the search for the "right" choices develops, through fervent dialogue and debate under the media-branded banner of "neuroethics," who will be paying attention to what is happening on the ground, where moral life is playing out?

There are indeed consequences to neglecting a ground-up perspective on neuro-ethical decision-making. Howard Gardner, one of the authors of the above-mentioned paper, argues for a "proactive approach" to ethical issues around neurocognitive enhancement: "By the time that we are aware of it, it will be too late" (quoted in Butcher 2003, 133). In the case of Ritalin, it is in one respect already almost too late. A window onto the actual, local, particular and peculiar decision-making processes surrounding the cognitive and behavioral enhancement of children is closing. The pharmaceutical industry (the penultimate social psychologist) has long understood that the necessity of multiple daily doses of methylphenidate lessens the desirability of the drug. A less effective long-acting form of Ritalin was unsuccessfully marketed by Ciba (now Novartis) in the mid-1980s. As more effective treatments have emerged, an increasing number of children diagnosed with ADHD are maintained on a once-daily treatment regimen. This change in medication regimen supports a further normalizing of drug treatment. Inevitably, parents

6. Thanks to Tim Lewens for this insight.

find that ADHD medication is less practically and morally disruptive; they face less socially-situated debate because they do not need to involve others (such as school personnel) in dosing their children, and they experience less internal struggle around dosing decisions, both because they are less frequently faced with the need to dose their child, and because the child him/herself experiences less of the social stigma that can accompany drug treatment for ADHD. As a consequence, parents are likely to become less aware of and less articulate about their own decision-making processes around drug doses. While there are many positive implications of long-acting forms of methylphenidate treatment for children with ADHD and their parents, this shift in drug technology may confirm Gardner's forecast that developments in neurotechnology will cause incremental changes in society that require close, and proactive, scrutiny (Butcher 2003).

The psychologist Kenneth Gergen has argued that a moral life "is not an issue of individual sentiment or rationality but a form of communal participation" (1994, 103). It is true that the communal ground is messy; we have seen that parents' decision-making processes around Ritalin doses involve a daunting array of social, psychological, ethical and cultural resources. But such complexity more adequately represents the moral framework within which parents will make current and future decisions about neuro-enhancing drugs for their children. Empirical social science can provide the substantive moral ground on which to locate ethical analysis of neurocognitive treatments and their use in children. Can applications of moral theory to the problems of neuro-enhancement be relevant without an appreciation of the meaning and significance of behavior, context and moral concepts for those making treatment decisions? The failure of bioethical analyses to properly grasp and grapple with the moral dilemmas of Ritalin treatment for parents of children with ADHD suggests not.

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