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# Children, ADHD, and Citizenship

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*The diagnosis of attention-deficit hyperactivity disorder is a subject of controversy, for a host of reasons. This paper seeks to explore the manner in which children's interests may be subsumed to those of parents, teachers, and society as a whole in the course of diagnosis, treatment, and labeling, utilizing a framework for children's citizenship proposed by Elizabeth Cohen. Additionally, the paper explores aspects of discipline associated with the diagnosis, as well as distributional pathologies resulting from the application of the diagnosis in potentially biased ways.*

***Keywords:*** *ADHD, mental health, political theory*

## I. INTRODUCTION

Children therefore, whether they be brought up and preserved by the father, or by the mother, or by whomsoever, are in most absolute subjection to him or her, that so bringeth them up, or preserveth them. And they may alienate them, that is, assign his or her dominion, by selling or giving them in adoption or servitude to others; or may pawn them for hostages, kill them for rebellion, or sacrifice them for peace, by the law of nature, when he or she, in his or her conscience, think it to be necessary. Thomas Hobbes, from Elements of Law (Chap. 23, Section 8)

Embedded in the idea of children's citizenship are two contradictory notions. On the one hand, children serve as objects onto which others ideas of autonomy can be projected in order to prepare them for adulthood. On the other hand, children are a class of individuals with interests that exist in the

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present and that affect the autonomous adults they become. It is challenging to make decisions about children's interests and the right of children to define and represent their own interests, particularly while also mediating between conflicting assertions of authority by parents and the state.

The diagnosis and treatment of attention-deficit/hyperactivity disorder (ADHD) provides a rich case study for discussing and evaluating these conflicts. Diagnosing ADHD in a child amounts to making an ontological claim about that person. This is evident in the arguments of the medical establishment, educators, and parents, all of which take up the crucial question of who is entitled to the authority to specify and represent children's interests. Three factors make the staking and substance of this ontological claim complicated. The first lies in the fact that multiple actors compete for authority to determine the interests of children. Parents, the state, and children themselves can all legitimately claim the authority to determine what defines and serves the ontological interests of a child. Second, it is unclear what the implications of denying children the authority to make decisions about this aspect of their ontology are for their future, more fully developed, ontological selves. Third, behavioral diagnoses can themselves be specious and have very powerful consequences for children. In this paper, we consider these competing claims in light of prioritizing the personhood of the child over other actors and interests who enter the dialogue. We begin by previewing the justifications for concern over how authority over children is exercised. Next, we take up the complications inherent in making diagnoses of ADHD in children. We then situate the political interests of the child within the complex of actors claiming the authority to specify and represent children's interests. We discuss the bifurcation of those interests into present and future-oriented classes. Following upon this, we take up how children's interests interact with behavioral diagnoses. In light of these concerns, we then address the special attributes of the case of ADHD with special attention to examining what the present and future interests of children may be in nondiagnosis/treatment as well as the various adult interests in these same decisions may be. We conclude with an approach to making ADHD diagnoses from a difference-centered view of children' present and future interests.

## II. AUTHORITY OVER CHILDREN

Governing children presents a thorny problem for the liberal democratic state, inasmuch as a fundamental basis of classical liberalism is the autonomy of the individual to conceive and execute a plan of life. The individual child is constrained and "dependent in many ways—economically, emotionally, and, often, physically" (Fineman, 2003)—and is generally conceived as not possessed of the capacity for full autonomy of the sort that liberal philosophers claim grounds political rights (Rawls, 1996). Political authority over the

child citizen could be characterized by either paternalism on the part of parents and the state or "minorism" in which the child becomes a vehicle for the interests of parents or the state:

> Paternalism allows adults ownership of children's higher level interests and ultimately segregates children, confining them to the private realm of the family and excluding them from public affairs. The minor view of children treats children as means to achieve adult ends. In so doing children's own interests are often obscured or elided with those of adult society. The paternal and the minor views each contributes a distinct set of pathologies to the governance of children while also reinforcing the strength and apparent validity of the other. (Cohen, 2005)

At the other end of the spectrum, libertarian notions of full citizenship for the child ignore "the traits that make children exceptional" and "the ways in which children need an exceptional political status." Under these schema, the child becomes at best an object serving the values and aims of adults; at worst, the child is relegated entirely to the private realm and the potential domination and oppression often delivered upon the powerless within. In this condition, the child is left with few rights, few concomitant obligations, and is at the mercy of parental beneficence.

This unsatisfying set of options has led to calls for "difference-centered" approaches to children' citizenship, in which the child is treated as a protected group with specifically assigned rights (Moosa-Mitha, 2005). Moosa-Mitha advocates a difference-centered citizenship in the case of children, contrasting the assumptions made by contractual and social liberals, who tend to view a capacity for citizenship as an absolute, exercised by assumedly "equal" individuals in specific public activities, with a concept of citizenship that takes into account the entire daily life experience and context in which individuals, of various races, genders, backgrounds, and ages, approach in a host of ways. Moosa-Mitha argues for an acknowledgement that children are present in the relationships that govern their lives and demonstrates that children do, in fact, have the capacity to engage in critical analysis of their circumstances and relationships. The case of diagnosing and treating ADHD, explored below, offers a unique opportunity to test the need for, and strengths of, a difference-centered approach to governing children.

## III. DEFINING, DIAGNOSING, AND TREATING ADHD

> Highly active, inattentive, and impulsive youngsters will find themselves far less able than their peers to cope successfully with these developmental progressions toward self-regulation, time, and the future. They will often experience the harsh judgments, punishments, moral denigration, and social rejection and ostracism reserved for those society views as reckless, impulsive, lazy, unmotivated, selfish, thoughtless, immature, and irresponsible. For society holds widespread and deeply seated beliefs about the nature of self-control and moral conduct. (Barkley, 1997)

Several controversies complicate any normative case one might launch regarding the authority to diagnose and treat ADHD. These include both mild and serious side effects of medication, differences in how ADHD is diagnosed and treated among different races, classes, ethnicities, and regions, and how reliably the diagnosis is made in actual medical practice despite the existence of rigorous guidelines. In order to convincingly demonstrate where authority for ADHD ought to be located, these factors must be taken into consideration. Below we describe the circumstances under which decisions about treatment are made, thus paving the way for considering how those decisions can best be understood.

## Definition and Diagnosis

The US Centers for Disease Control recently reported prevalence and other data for ADHD in the United States (Visser and Lesesne, 2005). As of 2003, approximately 7.8% of the U.S. population aged 4–17 years had ever been diagnosed with ADHD, and approximately 56% of those diagnosed with ADHD were on medication related to this diagnosis. These percentages amount to 4.4 million and 2.5 million U.S. children, respectively, and are generally based upon household self-report that a juvenile living with the adult respondent had ever been diagnosed. The manner and reasons for diagnosis, however, are not explained by these survey results. Although formal diagnostic procedures call for evaluation of both symptoms of ADHD, as well as for impairment in multiple settings, often it is the symptom report from the school system, ideally with concurrence from a parent, that leads to a quick diagnosis in a primary care clinic, leaving questions regarding both actual impairment, as well as the wishes of the child, ignored or minimally considered. An analysis by Gordon et al. (2006) found that symptoms account for less than 10% of variance in impairment and convincingly demonstrated that symptoms may not necessarily be intimately tied to actual impairment in functional realms, such as the classroom. This presents a serious challenge to the trend toward a reductionist, *Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition* (*DSM-IV*) symptom-based diagnostic process for ADHD. In a potentially related issue, child reports of impairment or suffering are often not included in the diagnostic process, which relies greatly upon parent and teacher report. In fact, child self-report is often excluded from ADHD research protocols in children under 12 years.[1] The exclusion of self-reporting may do a disservice to the child since at least one instrument has been demonstrably effective at eliciting reports of impairment directly from children (Klimkeit et al., 2006). Before proceeding into a discussion of unintended or sociopolitically pathological consequences that may result from a low emphasis upon impairment or children's wishes in the ADHD diagnostic process, it is useful to review the clinical case.

As defined in the current version of the *DSM-IV* (American Psychological Association, 1994), ADHD[2] is diagnosed by a combination of poor attention, hyperactivity, and impulsivity that is excessive for the child's developmental level and leads to impaired functioning, with predominantly inattentive (exhibit such symptoms as being "easily distracted by external stimuli," will seem not to "listen when spoken to directly," and will often "fail to give close attention to details or makes careless mistakes in schoolwork, work, or other activities," among other items on the *DSM-IV* checklist) and predominantly hyperactive–impulsive subtypes (i.e., a child who will often fidget, leave his or her seat at inappropriate times, blurts out answers, have "difficulty awaiting turn," etc.), as well as a combined type, where both inattentiveness and hyperactivity/impulsiveness are present. In addition to exhibiting such symptoms from one or both categories, a diagnosis of ADHD requires that at least some of the symptoms must have been present before age 7, that there must be evidence of impairment in two or more settings (i.e., school, home, work, etc.), that there be "clear evidence of clinically significant impairment in social, academic, or occupational functioning," and that the symptoms do not occur during the course of a different mental or other disorder. This aspect of the diagnostic process, or Criterion D under the *DSM* classification system, has been identified as crucial since simply meeting a symptoms checklist does not necessarily imply impaired functioning. Also fundamental to the diagnostic process is input from both teachers and parents (American Academy of Pediatrics, Committee on Quality Improvement, and Subcommittee on Attention-Deficit/Hyperactivity Disorder, 2000). A commonly used rating scale used to screen for ADHD and monitor treatment in children is the Connors Rating Scale, of which there are versions for use by teachers (Connors Teachers' Rating Scale [CTRS]) (Conners et al., 1998b) as well as by parents (Connors Parents' Rating Scale [CPRS]) (Conners et al., 1998a). A shortened version of the CTRS asks the teacher to rate a child on a series of behavioral traits, such as temper, impulsivity, attentiveness, and propensity to cry, on a scale ranging from "Not at all True" to "Very Much True." Similarly, the Parent version asks about these categories of behavior, as well as disorganization and obedience. It is important to note that most versions of the CRS, however, emphasize "symptoms" such as inattentiveness or outbursting but tend to ignore questions of impairment. Furthermore, it is not clear that such instruments are regularly used at the point of stimulant or other treatment, which very frequently occurs in a pediatrician's or family physician's office; in fact, both diagnostic and treatment regimens may be quite irregular (Brown et al., 2001; Leslie et al., 2004; Chan et al., 2005; Miller et al., 2005). The American Academy of Pediatrics (AAP) recently acknowledged this fact and has stressed the need to improve quality of care for children presenting in primary care settings (Leslie et al., 2004), and at least one study has found irregularities in ADHD treatment that exist in both pediatric and family medicine practitioners. In a mail survey of 1,374 Michigan primary care physicians

asking about adherence to AAP guidelines, practice patterns related to ADHD, and parent, teacher, and community influences on ADHD diagnosis and treatment, Rushton, Fant, and Clark (2004) found that over three-quarters (77.4%) of primary care physicians knew of the AAP guidelines, and many (61.1%) incorporated them in practice. Perhaps understandably, 91.5% of pediatricians were familiar with the AAP guidelines, whereas only 59.8% of family physicians were similarly familiar. Furthermore, only a quarter of those surveyed fully integrated all diagnostic components recommended, and some continued using outmoded diagnostic procedures. When it came to treatment, most physicians routinely relied upon medicinal intervention, but only slightly more than half reported rigorously following up on treatment, once prescribed. A survey of 303 Minnesota FM physicians found similar results, with only 54% indicating awareness of AAP guidelines (Daly et al., 2006).

Short-term implications for those with ADHD are poor academic performance and disciplinary problems in the classroom and at home, social ostracization, depression, and diminished self esteem. Not surprisingly, teachers are often the first to suggest a diagnosis of ADHD, followed by parents (e.g., see Sax and Kautz, 2003). Over a longer term, ADHD has been associated with an increased propensity for school failure, poor socialization, tobacco use, drug and alcohol abuse, traffic accidents, and occupational issues into adulthood. Although some symptoms may diminish in adulthood, it is becoming more accepted that ADHD will persist in some form into adulthood (Sim, Hulse, and Khong, 2004). However, in cases where the diagnosis is poorly or inaccurately assigned, an alternative set of pathologies become apparent, the first of which is needless exposure to stimulant medication risks. Beyond this, a host of other issues arise. If, for example, the child is diagnosed and medicinally treated with ADHD based upon symptoms which are inconvenient or annoying for parents or teachers, but the same child is not "impaired" in multiple ways (i.e., the child socializes well with peers, is learning and achieving good grades in school, etc.) and does not feel afflicted, it becomes apparent that both the physical body and the personality of the child, at least in the present tense, are assaulted and altered for the sake of interests that are potentially not her own but rather apply to the aesthetic, punitive, or authoritative judgments made by the adults around them. It is therefore necessary to consider the present and future interests of the child (or her personhood, as described by Moosa-Mitha and others [Moosa-Mitha, 2005]), as well as the effects of the authoritative gaze upon the actions and body of the child.

## Treatment

"Treatment" for ADHD may consist of a variety of modalities, including behavioral or psychotherapeutic intervention, modification of the social environment, and medication. However, it is widely acknowledged that although combined therapies tend to be most effective, most treatment occurs through

the use of medication. Both whether and how ADHD is treated raises a series of concerns about how children ought to be governed in ways that acknowledge and protect their existing and future ontological interests. Beginning in the 1930's, therapeutic regimens for hyperkinesis began incorporating stimulant medications, with Ritalin (generic name: methylphenidate) being introduced in 1956. Since that time, Ritalin, or methylphenidate in other forms, as well as other stimulants (especially amphetamine) have been the dominant medicinal treatment for ADHD. Tricyclic antidepressants have been an alternative treatment for several decades as well, and another nonstimulant medication, Strattera, was introduced to market in the past decade.[3] Although generally considered very safe, stimulant medications are not without side effects. Methylphenidate and amphetamine compounds have been associated for decades with small delays in growth (both height and weight) when used in children. The Multimodal Treatment Study of ADHD conducted by the National Institute of Mental Health recently verified this effect (MTA Cooperative Group, 2004) and offered evidence of benefit for the use of "drug holidays" and strategic dosage scheduling to mitigate the deleterious effect on growth of stimulants; drug holidays and dosage timing are also recommended to mitigate the negative effect of stimulants on sleep. More seriously, several stimulant medications have recently come under fire for severe and immediate side effects, including sudden death in children from stroke and other events, leading to the temporary removal of the stimulant Adderall from the Canadian drug market,[4] although Canada has since reversed this decision. Additionally, Strattera (the nonstimulant medication) has, among other side effects, been observed to increase the risk of suicidal ideation. In more extreme cases, newer generation antipsychotic medications, most typically risperidone (Risperdal), are used (Cheng-Shannon et al., 2004), particularly where low IQ, mental retardation, aggressiveness, or other comorbidities are present. There is a long list of both short- and long-term side effects of these compounds, including cardiovascular effects, weight gain, sedation, sialorrhea, extrapyramidal signs, and hyperprolactinemia.

## IV. DIAGNOSTIC DILEMMAS

As has been consistently reported, ADHD diagnoses occur far more frequently in boys, and a recent review of the literature found that diagnosis of ADHD in girls is often affected by reporting bias on the part of both parents and teachers (Staller and Faraone, 2006). It is also more common in non-Hispanic, English-speaking, and insured children. These last points corroborate previous findings of racial discrepancies in how the diagnosis is applied and converge with a separate analysis of another large survey (Pastor and Reuben, 2005)—when asked whether a child in the home had ever been diagnosed with ADHD, white households are more likely to answer affirmatively than nonwhite households. Cultural differences may play a role—at least one

study has found that Latina mothers are more resistant to medicinal intervention for ADHD due to suspicions over addictiveness and other issues (Arcia, Fernandez, and Jaquez, 2004), for example. Others have suggested a more ominous reason for outcomes such as this. In the United States, African-American children were found to be more likely to be rated higher on some factors by teachers, and African-American boys were demonstrably rated higher on antisocial traits (Epstein et al., 1998) on earlier versions of the Connors Teachers Rating Scale. Evans, commenting on a similar discrepancy in the United Kingdom, has described a "mad/bad" paradigm, where white children who exhibited ADHD symptoms are classified as having an illness, whereas black children are simply classified as "bad" (Evans, 2004).

Beyond racial or gender biases in diagnosis, there is a further issue that has recently been raised by Gordon et al. (2006), namely that *DSM-IV* symptoms of ADHD tend to be poorly linked with level of impairment. Their study, in which measures of symptoms from four unrelated ADHD research samples were correlated with level of impairment, found that symptoms do not predict more than 25% of impairment. This presents a serious challenge to the trend toward a reductionist, *DSM-IV* symptom-based diagnostic process for ADHD. In a potentially related issue, child reports of impairment or suffering are often not included in the diagnostic process, which relies greatly upon parent and teacher report. As noted previously, child self-report is often excluded from ADHD research protocols in children under 12 years.

ADHD treatment rates with stimulant medications are quite low, as noted earlier—only about half of those who would potentially benefit from such medication under this rubric are receiving it and many of those do not receive a clinically adequate dosage (Jensen, 2000). Furthermore, stimulant medication may improve performance on specific tasks, and reduce specific behavioral problems, but it is not "curative," in the sense that the underlying issues do not abate following medical treatment. Although medical treatment has been demonstrated to be more effective in improving specific symptoms of ADHD than behavioral therapies and counseling (when considered "head to head"), ultimately behavioral, social, and educational strategies and interventions are needed for some ADHD children (NIH, 2000). Behavioral therapies used in conjunction with stimulants may even allow lower dosages of stimulant medication to be prescribed (Pelham et al., 2005). Unfortunately, the actual practice of treating ADHD is recognized by many as somewhat irregular. The AAP recently acknowledged this fact and has stressed the need to improve quality of care for children presenting in primary care settings (Leslie et al., 2004). Furthermore, the use of a combination of behavioral intervention alongside stimulant or other medication may not be cost effective (Jensen et al., 2005); the implementation of the full raft of medical, behavioral, social, and educational recommendations made by a 2000 consensus statement issued by the National Institutes of Health (NIH, 2000) may be beyond practical under current conditions.

## V. NORMATIVE CONTROVERSIES

Psychiatry is part law and part medicine. It is the psychiatrist's social mandate to function as a double agent: that is, to help voluntary patients cope with their problems in living and to help relatives and society rid themselves of certain unwanted persons, under medical auspices. The latter task requires coercing the denominated patient; the former is rendered impossible by the slightest threat of coercion, much less its actual exercise. (Szasz, 2003)

Why has ADHD become so popular now resulting in spiraling rates of diagnosis of ADHD and prescription of psychostimulants in the Western world? This question requires us to examine the cultural nature of how we construct what we deem to be normal and abnormal childhoods and child rearing methods. Although the immaturity of children is a biological fact, the ways in which this immaturity is understood and made meaningful is a fact of culture …. Differences between cultures and within cultures over time mean that what are considered as desirable practices in one culture are often seen as abusive in another …. Thus the current "epidemic" of ADHD in the West can be understood as a symptom of a profound change in our cultural expectations of children coupled with an unwitting alliance between drug companies and some doctors, that serves to culturally legitimize the practice of dispensing performance enhancing substances in a crude attempt to quell our current anxieties about children's (particularly boys) development … (Timimi et al., 2004)

In the following section, we shall consider how the teacher and the school, both individually and acting as an arm of the state, as well as the family, via parents, each compete for authority over the child and move on to examine the specific paternalist and minorist pathologies that stem from these relationships. Given that the teacher is often the first to suggest a diagnosis of ADHD, we shall begin with an analysis of the role of school in the ADHD paradigm we are developing here. For this, we may turn back to Foucault, not for his genealogical critique of psychiatry but rather for his discourses on discipline and power (e.g., Foucault, 1977).

### The School as an Arm of the State

Foucault (1977) recognized that it is within particular institutions that power works most effectively, by acting not upon broad economic interests, but on the individual, "docile" body, "exercising upon it a subtle correction, of obtaining holds upon it at the level of the mechanism itself—movements, gestures, attitudes, rapidity: an infinitesimal power over the active body" (Foucault, 1977, 137). The point of such control is to create "a useful body and an intelligible body" (Foucault, 1977, 136) that could be understood and directed to a purpose—"A body is docile that may be subjected, used, transformed and improved" (Foucault, 1977). A significant aspect of highly localized power relations acting upon individual bodies is the observation that:

> At the heart of all disciplinary systems functions a small penal mechanism. It enjoys a kind of judicial privilege with its own laws, its specific offences, in particular forms of judgement. The disciplines established an 'infra-penalty'; they partitioned an area that laws had left empty; they defined and repressed a mass of behaviour that the relative indifference of the great systems of punishment had allowed to escape. (Foucault, 1977, 178)

The mechanisms by which this is accomplished are on the one hand archaic and historical in Foucault's discourse. Straining one's theoretical eye only slightly reveals the more subtle actions from the historical schools, prisons, and hospitals of Foucault's description still at play. Although few schools in present western society resemble the despotic example of training of school children in 18th and 19th century France—"few words, no explanation, a total silence interrupted only by signals" (Foucault, 1977, 166)—the mechanisms have taken on a subtler form. For what is the practice of diagnosing and medicating a child with ADHD, if not the action of the examination, surveillance, and normalizing gaze focused and acting upon the individual body? Empirically, we may ultimately see this as the attempt to normalize and correct the movements, the minute actions, and the utterances of a child; the fact that such a diagnosis is frequently suggested and originated in a school setting speaks directly to the point.

We might stop to consider the motivations of the school, broadly conceived. On one level, the school is engaged in a process of producing future citizens, or more precisely, in producing citizens with an ability to participate in society—to increase their citizenship potential to engage in political and civic activity, to be employable and productive, etc. As such, the school has an interest, at least to some extent (and probably to a great extent) in making, creating, and enforcing assumptions about the citizenship potential of the child. In some arenas, the school in the liberal democracy presents some acknowledgement of the individuality of each child, at least superficially. We might conceive of such acknowledgement as "trait matching." For instance, schools in the United States often offer different tracks for completion, with remedial, "standard," and college-preparatory curricula available for students with different aptitudes. In US secondary schools, students have often been offered courses in either home economics or mechanical "shop" classes, with distinctive gender-based distributions of enrollees. Such distinctions are ontological in nature, however, and serve more to predetermine citizenship potential to some extent than to acknowledge or serve individually and independently determined aspects of the individual's citizenship potential. Other systems may have come closer to the recognition of individuality—many European school systems are designed to track the individual student into a vocational track before the completion of secondary education. To a large extent, however, such tracking does less to acknowledge the ability of the individual to determine their own goals and life plan and more to rush the individual toward productive adulthood and away from a societally

counterproductive extended adolescence. In either case, the child, or in fact the adult citizen they will become, is only superficially treated as ends. The extent to which the developed citizen is a legitimate end of the school is mitigated by the fact that the citizen, so developed, is a means toward what is envisioned as an efficiently functioning society. In the process, the child becomes unitized, defined, and treated via the matching of generalized traits to predetermined (or at least predicted) ends.

Viewed from a Foucauldian (or more generally, a critical or postmodern) viewpoint, this might be described in the language of "normalization." Kirschner has summarized the tension in modern liberal democratic societies between normalization and pluralism as follows:

> All societies seek to ensure their legitimacy. That is, they need to ensure that people are willing to submit to the governing authority and to the rule of law. In premodern societies, much of this was accomplished through the threat of punishment—through forms of coercion and constraint that were external to the individual person's will. But in modern liberal democratic societies, legitimacy is ensured by subjugating individuals from within—by inciting individuals to scan themselves (as well as others) for possible signs of deviance, thereby motivating them to try to maintain or re-establish their 'normality'. Such a dynamic, which Foucault (1980) called 'normalization', ensures that subjects will not only act in accord with the social order, but will also experience themselves as endorsing it. It is a process by which 'others' are identified both within and outside the self … Such others serve to more sharply delineate the character and boundaries of the positive, 'normal' self. These others are then marginalized and excluded, or rehabilitated and cured, so that the self comes to experience itself and to be perceived as more closely harmonized with the normal order. (Kirschner, 2006)

The concept of normalization, as described by Foucault (1977, 1980) himself in several texts, is therefore both a social as well as an individual (psychological) process. In the case of behavioral conditions or learning disabilities that a child may be diagnosed, the individual/psychological result may be the creation of a "bad" self-image on the part of the child, and one held at the core of their "authentic" self (Singh, 2007). The Foucauldian process thus plays out—the child is acted upon by the relatively powerful adults around them, who in effect create the discourse of problems associated with the child. The child, in turn, internalizes the discourse and may, in fact, become an endorser of this view.

In the case of the diagnosis and treatment of ADHD, we see a dramatic extension of discipline beyond the surface body, into the very physiology of the child. In the pre-20th century schools and institutions described in Foucault's account, many of the children would have been selected into, or at least not selected out of, the student body. It is likely that the military-style discipline described in those accounts was effective in a more homogenous classroom. In current liberal societies with aims of universal and compulsory education, however, the gates are thrown open. The hyperactive child, the disinterested or distracted soul, the one who "disturbs other children" (or the

teacher) with "fidgeting" and "outbursts," will need to be dealt with in both quicker and more subtle fashion, if they cannot simply be excluded permanently from the room. Where traditional discipline fails, stimulants may lead us to the docile body.

We can easily hypothesize several reasons for this observation that reflect not a "child-as-present-being" but rather the interests of adults. These can be grouped into two general categories: a desire to eliminate a behavior that is disruptive to others or to the immediate environment or a desire to eliminate behaviors that will not allow the child to develop into existing (adult) conceptions of what constitutes a good citizen. In the first instance, the teacher is protecting what might be viewed on a microscopic level as certain negative liberties of those the child comes into contact with—that is, assumed rights of those in the classroom to be free from the specific disruptive behaviors characterized by ADHD. There may, of course, be a secondary benefit for the child if her or his own attentional or hyperactive behaviors are restrained via medication (or in the absence of medication, at least explained or excused by a formal diagnosis), in that the child may avoid or attenuate the harsh judgment and social ostracization from others within their immediate classroom setting. However, to claim that a measure taken to prevent an undesirable behavior is done for the benefit of the subject of the measure is dubious at best. Let us consider an extreme example—propositions to castrate sex offenders. It cannot be seriously maintained that such a measure would be taken primarily for the benefit of the offender or even that any benefit for the offender is under consideration in this case in any real sense (at least not if viewed through fundamental liberal assumptions about individual autonomy). To be clear, the intent here is not to conflate the severity for the victim of sex offense with the impact on inattentiveness and to do so would be ludicrous. Furthermore, medical interventions for ADHD are not nearly as extreme or as permanent. Furthermore, it would also be a sorry state of affairs if we are to deny that there is any benefit intended for the child in many teachers' suggestion of the ADHD diagnosis. However, to the extent that there is an attempt to normalize, even for the medical or social benefit of the child, then there is the attempt to discipline, to bring the physical body of the child under authoritative control.

The goal of the school, of course, is not simply to elicit silent and docile behavior but to teach the child a particular skill set with which she or he may fully participate in society as a full citizen as some future point—to increase citizenship potential, as described above. Perhaps "silent and docile behavior" is a part of that skill set required for full participation in society, in that it may be interpreted as compliant, normalized, and legible to others. However, we are referring here to skills such as reading and literacy separately from behavioral normalization. A general right to such an education may be viewed as a social right or the beginnings of positive liberty. To the extent that a diagnosis of ADHD may lead to the administration of stimulant or other

medication to a child, which may in turn lead to an improvement in the child's ability to learn fundamental skills (i.e., literacy, basic math, etc.) necessary for full participation in society, we are viewing an enhancement of the educational process and a more extensive realization of a social right for the particular child.[5] There is a necessary practical distinction to be made here, however, since stimulant medication generally improves both the behavioral symptoms and testable academic performance in both the ADHD-diagnosed child as well as the unaffected child. The distinction to be made is whether medication improves the child's skills in the requisite areas or merely their ability to test well on medication at a particular time. As such, we are on a slippery slope in defining who is medically impaired and who merely has access to an enhancement of the normal. We are then faced with a distributional issue—the poor and uninsured who truly need a medical intervention may have restricted access to the remedy, whereas those with greater resources may have more opportunity for mere enhancement. Such a distributional problem may logically lead to an increase in the already existing disparity between the well-off and the poor in educational attainment.

Such a normative critique assumes that the ability to test well and to be tracked into greater academic attainment is of great benefit to the child. To the extent that academic attainment is correlated with greater income and improved socioeconomic status, and such, this may be true. However, as the school must teach particular skills to the child, it must demonstrate the extent to which it has been effective at doing so to the child, the parents of the child, to the state, and to itself. The fact that the skills taught are particular and that the teaching of the skills is performed in large motions to groups of children, as opposed to individually, requires that difference be put aside. Different needs and aptitudes are ignored so to promote instruction and a limited, predictable range of outcomes. At the same time as we improve the material prospects of those, we channel into greater academic attainment in a narrow spectrum of measures, we neglect broader educational aims that might be conceived, to assist the discovery and enhancement by the child of their own citizenship potential—we here emphasize the component of citizenship potential that includes the ability to conceive and modify one's own life plan going forward. Of course, it is easily apparent that basic literacy and math skills are needed in this process, and we do not dispute this. It is the extent to which these, along with a basic ability to behave appropriately, become the only metrics by which we measure the success of failure of a child's education that raises concerns about the normalizing, homogenizing tendency of education in contemporary liberal societies. ADHD medicalization in this context is a symptom of such a problem and not the problem itself.

The school, ultimately, may be viewed as an intensively localized arm of the state. This may vary by degree, for example, between federalized or nationalized European educational systems and the US system of predominantly

local control. However, regardless of the technical implementation of the school in contemporary liberal democracies, there is a tendency toward standardization. The child as future citizen is graded on a limited number of skills—reading and math ability, occasionally writing, perhaps a cursory and oft-ignored familiarity with civics or history, and little else. Although the state may require instruction in art, music, health, and physical education and truly superlative artists, musicians, and athletes may find success in society, little attention is paid to these areas, presenting both a paternalistic and a minoristic pathology in relation to the interests of the child. In its authority over the pedagogical ends of the child under a liberal system of universal education, the school and by extension the state maintain "ownership of children's higher level interests" (Cohen, 2005) and ultimately substitute their own ends for those of the child. Furthermore, the tendency to classify and normalize the education of the child, and hence the ontological nature of the future adult, reduces the child as means-to-end resulting from their minor status.

Burtt (2003) has argued that children are "comprehensively needy adult 'works in progress'," and therefore that the concept of an open future for the child is less than compelling, in light of the need to provide for the physical and developmental needs of the growing child (Burtt, 2003). This argument is presented in the context of a parent's right to choose a "fundamentalist" education, defined as "one that takes fundamental truths about the good and right as given and aims to convey these truths intact to the next generation." Burtt clearly was referring to religious, nationalistic, or cultural fundamentalism and justifying its existence within the educational systems of liberal democracies. However, these categories may merely depict the extremes of fundamentalist education; if the opposite of a fundamentalist education is a liberal one that exposes the child to multiple views, options, and life plans, then it is fair to say that most public education systems operating within liberal democracies lie somewhere in the middle. Whereas these systems may not reach, or at least ought to avoid reaching, the extreme of producing "ethically servile" individuals (Callan, 1997) nor do they produce an "open future" for the child (Feinberg, 1980). The push to label and medicate the child who underperforms in specific categories of academic performance and classroom behavior can be viewed as evidence of a normalizing trend within the educational system, as an extension of the state.

## Parents

As noted earlier, after teachers, parents are most likely to suggest the diagnosis of ADHD in a child (albeit in the form of complaints about behavior or impairment as opposed to the direct suggestion of a diagnosis[6]). The reasons for a parent to raise the issue are often similar or in some cases identical to those of the teacher, and again, the negative/positive liberty dichotomy of reasoning may be applied. Again in the first instance, there is the matter of

pure disciplinary control of the body in its immediate circumstance. Although this may have an ominous ring to it, the examples in practice are common: hyperactivity becomes the complaint that a child is "bouncing off the walls"; impulsivity might manifest as interrupting, speaking out of turn, "talking back," or the physical striking of a sibling; inattentiveness may manifest itself in a disconnectedness from conversations—"are you listening to me?"—or in the movement from one toy to the next, letting the previous object of interest wherever it may land. Here we see a fundamental issue at the heart of the ADHD controversy—the examples we have just listed might be applied to any child at particular times. On the one hand, this has been a complaint of medicalization critics. On the other, the broader clinical community does not deny that this is true; rather, the nature of ADHD is that such behaviors are consistent over time and across multiple environments. In either case, the behaviors are disruptive for others, regardless of whether they are intermittent or essentially part of the ontological view of a particular child. In a slightly altered view of the disciplinary nature of the decisions to diagnose and medicate, Singh (2004) has suggested that the suggestion of the ADHD diagnosis by mothers may represent an attempt to avoid culturally assigned blame for the difficulties of the child.[7] Although Singh was focused on the cultural factors that lead to this unfortunate circumstance, we may here consider this another aspect of the medicine-as-discipline concept. Whether the parental decision to seek a diagnosis and medication for behavioral issues is based upon the desire to ameliorate "bad behavior" or simply to shift the blame for it, in each case, we are viewing a paternalistic pathology. In each of these considerations, the needs of the child have been intertwined with the needs of the parent, and under the paternalistic view of child citizenship, it is completely within the parent's right to allow this to proceed as such. The danger for the child as either a present or future autonomous actor is based in the extent to which she or he is disciplined, via diagnosis or otherwise, to satisfy parental needs rather than their own.

But of course, this is not the entire picture of why a parent may pursue a diagnosis of ADHD for their child. As the school is concerned with demonstrating the success of its own educational program via standardized test scores, parents are concerned with their child's grades, both as evidence of their own parenting proficiency as well as for the child's future prospects. The paternalistic issue is apparent and similar to that stated above—the parent's desire for recognition is conflated with the honest goal to see the child succeed, with a similar danger to that presented in the preceding paragraph. However, in the parental consideration of the child's future prospects, there arises a minoristic pathology as well.

The parent's desire to see their child succeed in the present educational system, to be able to satisfy the disciplinary demands of teachers as well as to attain adequate or superlative grades, may be simply accepted as the parent's desire to see the child imparted with the basic tools for full participation

in society. However, if one accepts the account of the school system presented in the previous section, then there is an element of complicity by the parent in the normalization of their child and medicalization of differences that may exist. Although there may be substantial benefit in the desire of the parent to see their child succeed according to current norms, in accepting this prospect, we must also accept the danger of yet another slippery slope. In accepting existing societal norms for the measurement of success, the parent will have a tendency to insert their own interpretations of these norms therein. Again, this is quite apparent and pervasive as we examine our surroundings, perhaps more so in middle- and upper-class households. We might see this as the desire for the child to go into a family trade or business, into the profession of the parent, and into a profession the parent wishes they may have entered and the desire to see a certain socioeconomic status attained by the child, etc. In these instances, the parent substitutes their own ends for those of the child, and the child in fact becomes a means to the parental ends. This phenomenon does not require diagnostics and medication to proceed; however, within such a system, ADHD diagnosis and medication again may be viewed as a tool to achieve either a correction of perceived threats to the achievement of these future aims inserted by the parent, or a potential symptom of the existence of such a dynamic in some cases.

Of course, in practice, this is not the only dynamic that may occur and may be a bit of a caricature of reality (although we suspect it bears more than a passing resemblance to many individual situations). In practice, parents tend to be more ambivalent about administering dosages of ADHD medication to their children (Singh, 2005). In some cases, parents insist that the child is more "authentic" when on medication and where the unfortunate manifestations of the disorder are not clouding the true self. In stretching the "glasses for the sight impaired" analogy, we might describe an individual who truly believes that their true calling would be to fly airplanes, if it were not for a deficiency in their vision. On the other hand, some parents advocate drug holidays (abstention for medication for a period of time, usually when the child is not in school—i.e., summers, weekends, etc.) as an opportunity for the child to be "themselves," and to run, jump, and be as active as they wish. In either case, the idea of "authenticity" proves to be variable and more a construction of the parent's view of their own child as opposed to a metaphysical truth.[8]

## Implications of ADHD Diagnosis and Treatment for Children

Given the propensity for physical and emotional suffering and harm that can beset the individual child as a result of supernormal levels of activity, impulsivity, or inattentiveness, in addition to the deleterious effect of such traits on academic performance and family life, decisions regarding the diagnosis and

treatment of ADHD have broad and deep implications for children who receive them. Regardless of who makes it, a diagnosis of ADHD makes an ontological claim about a child. Treating ADHD can be regarded as conferring advantages and disadvantages, each of which can be understood from the perspective of parents, the state, children-as-present-beings, and the adults these children become. Treatment was discussed above as were inequalities engendered by uneven treatment rates across social groups. Nontreatment raises another set of ontological issues. Jensen and others have proposed that the characteristics described by a diagnosis of ADHD—inattentiveness, hyperactivity, and impulsivity—may each have conferred evolutionary advantages to individuals who possessed them over the course of human history (Jensen et al., 1997).[9] 'Inattentiveness' in a threat rich environment may have conferred an advantage to the possessor of such a trait, by allowing the tracking of several potential threats at once, without fixing upon one and ignoring others. In other words, the identical trait may be described as an attention-shifting propensity that turns out to confer a survival advantage. Likewise, what is hyperactivity in a classroom setting might have been an advantageous ability to perform additional work in some settings. Impulsivity may have conferred another advantage in a threat-rich environment, where slow deliberation over appropriate action may been a clear disadvantage (where, say the likelihood of facing a saber-toothed cat outweighed the likelihood of danger stemming from the inadvertent insult to a clan member).

The treatment of this pathology therefore has ontological implications for that child. Given this fact, we must consider both who is entitled to make decisions about testing, diagnosis, and treatment. This in turn triggers questions about the child's immediate and long-term interests. As posed in the first section of this paper, several actors, including the state, the families, and the school, make such claims for the child under paternalistic and minor-based justifications, each with their own set of consequences for the child. In a paternal framework of authority over children, the interests of the "child-as-present-being may be wiped away in acts that regard the interests of the child through the lens of adults whose own interests may color these lenses. At the same time, the child as a minor exists to develop into a future adult and participating citizen and, hence, considerable "citizenship potential" that is of immense interest and value to the state. We might conceive of citizenship potential as the sum of all factors that might contribute to an individual's ability to participate in society. For any individual, the concept will have a temporal element to it—the temporarily unemployed may have reduced citizenship potential, which might return with better circumstances. The immigrant may have fairly low or high citizenship potential upon arrival, based upon a host of factors like country or culture of origin, language, physical features, education, etc., that might be expected to improve slightly or greatly (depending upon the starting point) with time. The aged

might have a presently reduced citizenship potential, one that will not improve in the future but that may have been higher in the past.

The liberal theorist must take into account the importance of developing the ability for the individual child to participate in society as an autonomous agent. Much of this is well-rehearsed terrain. The development of a child's potential requires the ability to read, write, perform basic arithmetic operations, and understand basic civic procedures, as well as the capacity to develop a "sense of justice" and a "conception of the good" on the child's own terms. In liberal democracies, as in most societies, children tend to be governed primarily as minors, indicating a belief that they are developing toward personhood rather than actual persons in the present. Decisions made for children by adults are therefore inflected with a future orientation, even if they are made prima facie with present concerns in mind. For example, when we discuss the "happy childhood," do we not value it for its worth in the adult it eventually produces?

In the case of medical decisions, however, there is a substantial present-concern almost invariably, and bearing this in mind, the case of ADHD is not entirely concerned with the child's eventual status as adult. This applies as much to the interests that adults may have in the present-being of the child as it does to the child's actual present interests. Without much work, we can easily see a set of "present" concerns that children might offer as a basis for treating ADHD. Children with severe ADHD may face ostracization by peers, which may be both immediately unpleasant as well as developmentally troubling. In a similar fashion, the fidgeting, impulsivity, and inattention that may be exhibited will often be interpreted as "bad behavior" and, consequently, be punished a consequence a reasonable individual will want to avoid. Furthermore, ADHD, or perhaps the consequences of ADHD behavior described above, may lead either directly or secondarily to substance abuse, depression, accidents, and injury. The immediate amelioration of such adverse consequences via medication or other treatment would clearly be in the interest of the reasonable child, and this aspect of the problem becomes less interesting from a normative perspective. On the other hand, there are risks specifically tied to prescription drug use—stimulants, as noted earlier, have long been associated with possibly temporary growth suppression in children, and some medications have led either directly to cardiovascular events and death in very rare cases. The use of antidepressants in children has also been found to possibly increase risk of suicidal ideation, also noted earlier. In general, however, these risks are seen as worthwhile. The growth suppression effect is manageable through the use of drug holidays, and it appears as though medicated children's growth may rebound in adolescence. Cardiovascular and other mortal threats are exceedingly rare, and patients might be screenable for factors that increase risk, as suicidal ideation may be monitored. As medical treatments are often judged by weighing potential risks against potential benefits, the medicinal treatment of ADHD comes out

of most assessments as among the "safer" medical interventions, relatively speaking.

Obviously, there is the potential for overlap between the substance of paternalist and minorist approaches even though they are differently motivated approaches to children's interests. The child may be subject to both paternalistic replacement of interests in the present (i.e., reactions to behavior for the sake of the parent or teacher) as well as minoristic treatment (i.e., reactions to behavior for the sake of the child's ability to learn skills and contribute to society in the future as an adult). Clearly, there is a case to be made for adult intervention in cases where ADHD may manifest, for the immediate aims of the child. However, the risk/benefit equation mentioned in the previous paragraph may become skewed when the supposed medical "benefits" realized through the adult decision to treat are actually not due to the truly extreme case but rather to increasing pressure to normalize the behavior and scholastic work product of the child.

In considering all the above, it is necessary to ask, from a pragmatic perspective, if the theoretical assertions presented do not make the good the enemy of the great. For if we cannot trust parents and teachers to make judgments about the present and future good of the child, who might we substitute? Clearly, the liberal state would be an inadequate proxy; as Scott (1998) points out, since such a substitution would trade the localized knowledge of the parent and teacher, each of whom should know the child intimately to different extents, with a bureaucratic nightmare. At the core of any debate about children's citizenship or political participation is the true ability of the child to play a meaningful civic or political role, and most would acknowledge that children are not prepared for full citizenship. Given these restrictions, we would like to propose how the issues above might be structurally addressed.

## VI. A WIDER VIEW

We have claimed that a diagnosis of ADHD makes an ontological claim about children that pertains to their present and future selves. Although we identify adult interests in these selves, in this article, we seek to refocus attention on children's present and future interest. To this end, it must first be noted that ADHD may contribute to the development of a self that has desirable traits not likely to develop in persons who do not manifest ADHD symptoms. Attention shifting behavior may actually be valuable in occupations that require a similar skill to that of our ancient ancestors (Hartmann and Ratey, 1995; Jensen et al., 1997; Hartmann, 2003). Although what may immediately come to mind may be military vocations, many occupations that require a multifocal view might benefit. Restaurant line cooks, sales people, police, to name a few, may all benefit from the possession of attention-shifting traits.

Hartmann (2003) has postulated a list of ADHD attributes that may be beneficial, leading the ADHD individual to be a natural explorer, inventor, discoverer, or leader. Indeed, Hartmann points to Thomas Edison as an example of an individual who would have been diagnosed with some subtype of ADHD had he lived a century or so later than he did and attributes the positive aspects of ADHD as contributing to Edison's extraordinary inventive genius. Anecdotal and popular accounts of ADHD often point to those so categorized as intuitive, visionary dreamers. Not surprisingly, discovery of research on positive aspects of this or other "disease states" is difficult since most empirical research tends to focus upon amelioration of "negative" or problematic traits. Normalizing or treating away such characteristics, however, is a potential danger under such circumstances under nearly any rubric of thought that posits individuality as either an individual or societal good to be preserved.

Never the less, ADHD is potentially, but not necessarily, threatening to all children and the adults they become. This implies the need to apply a test for diagnosis and treatment that avoids pure paternalism or libertarianism. The threat is not so great that we can justify ignoring children's interests either in their present or their future form. We seek to do so without conflating the present or future interests of adults involved in making and carrying out these decisions. In order to more fully recognize the linkages between "children-as-present-beings" and the adults they become, we return to the difference-centered approach to children's citizenship offered by Moosa-Mitha. In the case of ADHD diagnosis and treatment, a difference-centered construction of citizenship would require that both the evaluation and diagnosis of the child, as well as the administration of any treatment, medicinal, or otherwise, take into account several items beyond observed symptoms or parent/teacher reports:

1. Symptoms must not merely be disruptive, annoying or disappointing to others, or otherwise inconvenient; impairment in some domain must be apparent;
2. Impairment, moreover, would need to be more than a re-expression of disappointment of parental or academic expectations; consideration of the child's concerns, about both the source or causes of the issues presented during an evaluation, about unpleasant effects of medication, or about a desire to gain control of particular symptoms, must be a serious part of the process;
3. Biases, prejudices, haphazard diagnostic procedures, failure to follow-up on initial medicinal administration, financial incentives, or disincentives, and so forth, must not be allowed to disrupt the process.

In short, taking the interests of the child seriously would require several things beyond the paternalistic choices made by those who hold sway over the child's present and future. Recognizing that children have interests that

must be protected clearly requires that they meet requirements for both symptoms and impairment, that their wishes and explanations for behaviors be heard and considered, and that the process, inherently unequal as a power relationship, be administered as fairly and systematically as possible.

This is not to say that, within our current context, the recognition, diagnosis, and treatment of ADHD are not beneficial to individual children. Rather, it may be enormously so. Children undoubtedly suffer, by their own accounts (Kendall et al., 2003), and medication or other treatments may relieve this suffering to some extent. Furthermore, in the absence of monitored and relatively safe administration of medication, many ADHD sufferers will self-medicate anyway, either through the illicit and unmonitored use of prescription stimulants or through the abuse of nicotine or other drugs. However, we must recognize that they are not curative, that the artificial inflation of a test score may not always serve the child's interests, and in fact may serve that of the parent and school instead.

More broadly, the distribution of access to treatment for ADHD may follow a regressive socioeconomic gradient, with those more likely to be better-off, insured, and academically focused, to be the recipients of the most benefit under the current system. As noted earlier, such unequal access to treatment may contribute to disparities in educational outcome, offering the most well-off of society an additional opportunity for performance enhancement in school, without any benefit to the least-well off. If the liberal society has any intention of respecting the citizens children become, such a disparity makes a mockery of the effort.

## VII. CONCLUSIONS

The recommendation stemming from the arguments above is that the case of ADHD medicalization prompts us to formulate ideas about children's interests keeping in mind that justice demands we consider their present and future personhood. A social right to universal health care might alleviate treatment access disparities as well as irregularities in treatment. Such a social right would complement the social right to universal education, and both would serve the developing child in their ability to make full use of future political and civil rights and to meaningfully participate in society as adults.

Beyond universal health care, the case of ADHD serves as a beacon of warning to the current homogenizing trend in United States and other liberal education systems. Although the use of a limited set of metrics to judge school and individual student performance has the advantage of legibility to the state and broader society, such a system may not serve the interest of developing autonomous citizens. Whether true autonomy is possible is debatable, and critics of liberalism may not agree that such a pursuit is worthwhile.

However, we propose here that regardless of whether one wishes to pursue a liberal, a communitarian or some other view of the good society, the maximization of the potential for each individual is a laudable goal. In expanding the purview of the educational system, we might offer the possibility of maximizing the potential of each individual from among a number of possibilities, as opposed to a limited few.

## NOTES

1. Our thanks to Dr. Jud Staller for a view from the front lines—a child psychiatry clinic.

2. Though presented as controversial in media expositions, ADHD, when correctly diagnosed, arguably meets criteria for being a valid medical disorder (Biederman and Faraone, 2005; Faraone, 2005). As noted above, cross-cultural studies are able to identify ADHD cases outside United States, Canada, and the liberal first-world democracies of Europe (Reid et al., 1998; Yang, Schaller, and Parker, 2000; Rohde et al., 2005), and prevalence is similar worldwide (Faraone et al., 2003). Furthermore, although individual patients may respond in various ways to particular medications or dosage levels, this probably speaks more to the overall etiological heterogeneity and complexity of ADHD than to a fundamental issue of validity. In fact, viewed on a large scale, stimulant medication has a fairly predictable affect in reducing hyperactivity, impulsivity, and inattentiveness and is one of the most efficacious classes of medication used in psychiatry. Furthermore, a concern commonly expressed by some ADHD researchers with the use of stimulants is that the dosages prescribed and/or actually administered can be too small to be of therapeutic benefit or that use of medication drops or stops completely over time in individual patients. Although ADHD frequently is comorbid (co-occurs) with other mental illnesses such as conduct disorder, oppositional defiance disorder, bipolar disorder, and generalized learning disabilities, its symptoms are demonstrably separable from these other phenomena (Biederman and Faraone, 2005; Faraone, 2005). Finally, there is a good deal of evidence for a substantial genetic component in the etiology of ADHD (Faraone et al., 2005). Where critics have sought to use discrepancies in epidemiological rates, the lack of any "cognitive, metabolic, or neurological markers for ADHD," cross-cultural discrepancies, comorbidity with other illnesses, and so forth, to question the very existence of a coherent concept of ADHD (Timimi et al., 2004), such issues may merely point to the difficulty in firmly establishing nosological definitions of complex illnesses.

3. A scholarly review of the history of ADHD is available in the introduction and first chapters of Barkley (1996). Additionally, Several brief timelines of the history of ADHD exist on the internet, including http://add.about.com/cs/addthebasics/a/history.htm (Last viewed 02/11/09).

4. See http://www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/_2005/2005_01_e.html for the Canadian announcement (Last viewed 01/10/08).

5. As described by Marshall decades ago, social rights a necessary partner to civil and political rights, in order to allow the individual full access to and utilization of each of these three categories of rights. See Chapter IV in Marshall (1964).

6. Our thanks to Stephen Faraone for this observation.

7. It must be noted that Singh also suggests that the shift from "mother-blame" to a biologically based "brain-blame" backfires for mothers. Ultimately, she suggests that "medicalization of boys' problem behaviors supports and reconstitutes the potential for mother-blame and does little to pierce oppressive cultural mothering ideals" (Singh, 2004).

8. For a full description of this concept, refer to Singh (2005).

9. Jensen's argument may possibly be simply narrowed down to a discussion of "traits," as opposed those a description of a syndrome that combines several traits and resulting in a child who is "are 2 or 3 standard deviations beyond the norm and who can't focus or sit still for more than a minute."

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## REFERENCES

American Academy of Pediatrics, Committee on Quality Improvement, and Subcommittee on Attention-Deficit/Hyperactivity Disorder. 2000. Clinical practice guideline: Diagnosis and evaluation of the child with attention-deficit/hyperactivity disorder. *Pediatrics* 105: 1158–70.

American Psychiatric Association. 2000. Task Force on DSM-IV. *Diagnostic and statistical manual of mental disorders: DSM-IV-TR*. Washington, DC: American Psychiatric Association.

Arcia, E., M. C. Fernandez, and M. Jaquez. 2004. Latina mothers' stances on stimulant medication: Complexity, conflict, and compromise. *Journal of Developmental and Behavioral Pediatrics* 25:311–7.

Barkley, R. A. 1997. *ADHD and the nature of self-control*. NY: The Guildford Press.

Biederman, J., and S. V. Faraone. 2005. Attention-deficit hyperactivity disorder. *Lancet* 366:237–48.

Brown, R. T., W. S. Freeman, J. M. Perrin, M. T. Stein, R. W. Amler, H. M. Feldman, *et al.*, 2001. Prevalence and assessment of attention-deficit/hyperactivity disorder in primary care settings. *Pediatrics* 107:E43.

Burtt, S. 2003. The proper scope of parental authority: Why we don't owe children and "open future. In *Nomos XLIV: Child, family, and state* (pp. 243–72), eds S. Macedo, and I. M. Young. New York: New York University Press.

Callan, E. 1997. *Creating citizens: Political education and liberal democracy*. New York: Clarendon Press.

Chan, E., M. R. Hopkins, J. M. Perrin, C. Herrerias, and C. J. Homer. 2005. Diagnostic practices for attention deficit hyperactivity disorder: A national survey of primary care physicians. *Ambulatory Pediatrics: the Official Journal of the Ambulatory Pediatric Association* 5: 201–8.

Cheng-Shannon, J., J. J. McGough, C. Pataki, and J. T. McCracken. 2004. Second-generation antipsychotic medications in children and adolescents. *Journal of Child and Adolescent Psychopharmacology* 14:372–94.

Cohen, E. F. 2005. Neither seen nor heard: Children's citizenship in contemporary democracies. *Citizenship Studies* 9:221–40.

Conners, C. K., G. Sitarenios, J. D. Parker, and J. N. Epstein. 1998a. The revised Conners' Parent Rating Scale (CPRS-R): Factor structure, reliability, and criterion validity. *Journal of Abnormal Child Psychology* 26:257–68.

———. 1998b. Revision and restandardization of the Conners Teacher Rating Scale (CTRS-R): Factor structure, reliability, and criterion validity. *Journal of Abnormal Child Psychology* 26:279–91.

Daly, M. E., N. H. Rasmussen, D. C. Agerter, and S. S. Cha. 2006. Assessment and diagnosis of attention-deficit/hyperactivity disorder by family physicians. *Minnesota Medicine* 89(3): 40–3.

Epstein, J. N., J. S. March, C. K. Conners, and D. L. Jackson. 1998. Racial differences on the Conners Teacher Rating Scale. *Journal of Abnormal Child Psychology* 26:109–18.

Evans, R. 2004. Ethnic differences in ADHD and the mad/bad debate. *The American Journal of Psychiatry* 161:932; author reply 932.

Faraone, S. V., J. Sergeant, C. Gillberg, and J. Biederman. 2003. The worldwide prevalence of ADHD: Is it an American condition? *World psychiatry: official journal of the World Psychiatric Association (WPA)* 2:104–13.

Faraone, S. V. 2005. The scientific foundation for understanding attention-deficit/hyperactivity disorder as a valid psychiatric disorder. *European Child and Adolescent Psychiatry* 14:1–10.

Faraone, S. V., R. H. Perlis, A. E. Doyle, J. W. Smoller, J. J. Goralnick, M. A. Holmgren, *et al.*, 2005. Molecular genetics of attention-deficit/hyperactivity disorder. *Biological Psychiatry* 57:1313–23.

Feinberg, J. 1980. The child's right to an open future. In *Whose child?: Children's rights, parental authority, and state power*, eds W. Aiken, and H. LaFollette. Totowa, NJ: Rowman and Littlefield.

Fineman, M. L. A. 2003. Taking children's interests seriously. In: *Nomos XLIV: Child, family, and state* (pp. 234–42), eds S. Macedo, and I. M. Young. New York: New York University Press.

Foucault, M. 1977. *Discipline and punishment: The birth of the prison.* New York: Vintage Books.

———. 1980. *The history of sexuality, vol. 1: An Introduction.* New York: Vintage Books.

Gordon, M., K. Antshel, S. Faraone, R. Barkley, L. Lewandowski, J. J. Hudziak, *et al.*, 2006. Symptoms versus impairment: The case for respecting DSM-IV's criterion D. *Journal of Attention Disorders* 9:465–75.

Hartmann, T. 2003. *The Edison gene: ADHD and the gift of the hunter child.* Rochester, VT: Park Street Press.

Hartmann, Thom, and John J. Ratey. 1995. *ADD success stories: A guide to fulfillment for families with attention deficit disorder: Maps, guidebooks, and travelogues for hunters in the farm.* Nevada City, CA: Underwood Books.

Hobbes, Thomas. 2004. *The elements of law natural and politic.* Whiteface, MT: Kessinger Publishing.

Jensen, P. S. 2000. Current concepts and controversies in the diagnosis and treatment of attention deficit hyperactivity disorder. *Current Psychiatry Reports* 2:102–9.

Jensen, P. S., J. A. Garcia, S. Glied, M. Crowe, M. Foster, M. Schlander, S. Hinshaw, *et al.*, 2005. Cost-effectiveness of ADHD treatments: Findings from the multimodal treatment study of children with ADHD. *The American Journal of Psychiatry* 162: 1628–36.

Jensen, P. S., D. Mrazek, P. K. Knapp, L. Steinberg, C. Pfeffer, J. Schowalter, and T. Shapiro. 1997. Evolution and revolution in child psychiatry: ADHD as a disorder of adaptation. *Journal of the American Academy of Child and Adolescent Psychiatry* 36:1672–9; discussion 1679–81.

Kendall, J., D. Hatton, A. Beckett, and M. Leo. 2003. Children's accounts of attention-deficit/hyperactivity disorder. *Advances in Nursing Science* 26:114–30.

Kirschner, S. 2006. 'Good babies' or 'goodness of fit'? Normalizing and pluralizing dimensions of contemporary temperament discourse. *Culture Psychology* 12:5.

Klimkeit, E., C. Graham, P. Lee, M. Morling, D. Russo, and B. Tonge. 2006. Children should be seen and heard: Self-report of feelings and behaviors in primary-school-age children with ADHD. *Journal of Attention Disorders* 10:181–91.

Leslie, L. K., J. Weckerly, D. Plemmons, J. Landsverk, and S. Eastman. 2004. Implementing the American academy of pediatrics attention-deficit/hyperactivity disorder diagnostic guidelines in primary care settings. *Pediatrics* 114:129–40.

Marshall, T. H. 1964. *Class, citizenship, and social development: Essays*. Garden City, NY: Doubleday.

Miller, A. R., C. Johnston, A. F. Klassen, S. Fine, and M. Papsdorf. 2005. Family physicians' involvement and self-reported comfort and skill in care of children with behavioral and emotional problems: A population-based survey. *BMC Family Practice* 6:12.

Moosa-Mitha, M. 2005. A difference-centred alternative to theorization of children's citizenship rights. *Citizenship Studies* 9:369–88.

MTA Cooperative Group. 2004. National institute of mental health multimodal treatment study of ADHD follow-up: Changes in effectiveness and growth after the end of treatment. *Pediatrics* 113:762–9.

National Institute of Health (NIH). 2000. National institutes of health consensus development conference statement: Diagnosis and treatment of attention-deficit/hyperactivity disorder (ADHD). *Journal of the American Academy of Child and Adolescent Psychiatry* 39:182–93.

Pastor, P. N., and C. A. Reuben. 2005. Racial and ethnic differences in ADHD and LD in young school-age children: Parental reports in the national health interview survey. *Public Health Reports (Washington, D.C.: 1974)* 120:383–92.

Pelham, W. E., L. Burrows-Maclean, E. M. Gnagy, G. A. Fabiano, E. K. Coles, K. E. Tresco, A. Chacko, *et al.*, 2005. Transdermal methylphenidate, behavioral, and combined treatment for children with ADHD. *Experimental and Clinical Psychopharmacology* 13:111–26.

Rawls, J. 1996. *Political liberalism*. New York: Columbia University Press.

Reid, R., G. J. DuPaul, T. J. Power, A. D. Anastopoulos, D. Rogers-Adkinson, M. B. Noll, *et al.*, 1998. Assessing culturally different students for attention deficit hyperactivity disorder using behavior rating scales. *Journal of Abnormal Child Psychology* 26:187–98.

Rohde, L. A., C. Szobot, G. Polanczyk, M. Schmitz, S. Martins, and S. Tramontina. 2005. Attention-deficit/hyperactivity disorder in a diverse culture: Do research and clinical findings support the notion of a cultural construct for the disorder? *Biological Psychiatry* 57:1436–41.

Rushton, J. L., K. E. Fant, and S. J. Clark. 2004. Use of practice guidelines in the primary care of children with attention-deficit/hyperactivity disorder. *Pediatrics* 114:23–8.

Sax, L., and K. J. Kautz. 2003. Who first suggests the diagnosis of attention-deficit/hyperactivity disorder? *Annals of Family Medicine* 1:171–4.

Scott, J. C. 1998. *Seeing like a state: How certain schemes to improve the human condition have failed*. New Haven, CT: Yale University Press.

Sim, M. G., G. Hulse, and E. Khong. 2004. When the child with ADHD grows up. *Australian Family Physician* 33:615–8.

Singh, I. 2004. Doing their jobs: Mothering with ritalin in a culture of mother-blame. *Social Science and Medicine* 59:1193–205.

———. 2005. Will the "real boy" please behave: Dosing dilemmas for parents of boys with ADHD. *American Journal of Bioethics* 5:34–47.

———. 2007. Clinical implications of ethical concepts: Moral self-understandings in children taking methylphenidate for ADHD. *Clinical Child Psychology and Psychiatry* 12:167–82.

Staller, J., and S. V. Faraone. 2006. Attention-deficit hyperactivity disorder in girls: Epidemiology and management. *CNS Drugs* 20:107–23.

Szasz, T. 2003. Psychiatry and the control of dangerousness: On the apotropaic function of the term "mental illness". *Journal of Medical Ethics* 29:227–30; discussion 230–2, 237.

Timimi, S., E. Taylor. 2004. ADHD is best understood as a cultural construct. *The British Journal of Psychiatry; The Journal of Mental Science* 184:8–9.

Visser, S. N., and C. A. Lesesne. 2005. Mental health in the United States: Prevalence of diagnosis and medication treatment for attention-deficit/hyperactivity disorder—United States. 2003. *Centers for Disease Control, Morbidity and Mortality Weekly Report* 54:842–7.

Yang, K. N., J. L. Schaller, and R. Parker. 2000. Factor structures of Taiwanese teachers' ratings of ADHD: A comparison with U.S. studies. *Journal of Learning Disabilities* 33:72–82.