

STIMULANTS

Not Just Naughty
50 Years of Stimulant Drug Advertising

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(Re)constructing a history of methylphenidate (Ritalin)

How do we learn about a drug's history? What resources are available to us when we begin to wonder where a particular drug came from, how it entered the marketplace, the clinic, and the domestic realm? One might follow the drug (or its ancestors) through the clinical literature, exploring its emergence on the scene, who was using it, what for, and with what effects. One might write a chemical history, linking the creation of the drug on a molecular level to other drugs in its molecular field, and the men (usually) and the laboratories whose succor brought the drug into being.

It is extraordinary that to date we are lacking in even these more straightforward historical accounts of the stimulant drugs used so widely in contemporary psychiatry.¹ This is not because these drugs are esoteric; rather, they are household names, icons for contemporary Western socio-cultural preoccupations: Ritalin, Concerta, Dexedrine, Adderall. We have a few histories of another group of popular psychiatric drugs, the antidepressants and the minor tranquilizers, but most people still believe that the most famous of these drugs, Ritalin (methylphenidate), is a "new" drug that came onto the market some time in the 1980s along with con-

cerns about hyperactivity in children. As this chapter explains, Ritalin is not a new drug; it first came on the U.S. market in 1957. But experiments involving stimulant drugs and problematic behavior in children have been on-going since at least the 1920s. What is new is the extraordinary worldwide growth in medical use of methylphenidate, predominantly for symptoms of Attention Deficit/Hyperactivity Disorder (ADHD). Consumption of methylphenidate in the United States outpaces all other countries; between 1991 and 1999, domestic sales of the drug had grown by 500%. Significant growth in consumption in this period is also evident in Canada, New Zealand, Australia, and Norway; however, levels of consumption in these countries are still a fraction of U.S. levels.² Approximately 85% of the world's methylphenidate is currently consumed in America.³ U.S. epidemiological estimates for ADHD are problematic and vary widely, from 1% to 10% of the school-age population. By contrast, estimates in other Western countries such as the United Kingdom vary from under 1% to 3% of the school-age population, and in non-Western countries ADHD and Ritalin are only just being discovered.

Clearly, then, there is an important socio-cultural component to the growth of the ADHD diagnosis, Ritalin, and other stimulant drugs. This chapter contributes to reconstructing the socio-cultural story of the stimulant drugs in America, as part of a larger project which explores how stimulant drugs came to be persuasive tools for behavior management and modification in young children. As such, the focus is on methods of persuasion and modes of representation of these drugs and the symptoms they treat. There is an embedded interest in the major actors—both in those who are doing the persuading and in those who are being persuaded: Doctors, of course, occupy both these actor positions, more or less simultaneously. However, other actors in this story have remained shadowy figures, particularly one of the main actors, the pharmaceutical industry. Why so many shadows in this history? A major problem is that the pharmaceutical industry, specifically Novartis (formerly Ciba) has been only marginally helpful to scholars attempting to piece together the history of the most famous stimulant drug, Ritalin.⁴ The lack of industry transparency in relation to drug development, testing, and promotion is endemic; moreover, the sustained critique of Ritalin is likely to support a tendency to be closeted within Novartis. In the existing historical treatments of hyperactivity, the pharmaceutical industry has been villainized for its contribution to the medicalization of children's problem behaviors via various manipulative schemes.⁵ But such arguments have necessarily

relied largely on anonymous industry informants and anecdotal evidence to substantiate their claims.

The Problem of Evidence

Clearly there is a problem of evidence, or documents, for those wanting to write a history of stimulant drugs. While it is difficult to access the pharmaceutical companies behind these drugs, it is possible to access their public documents. Stimulant drug advertisements are public documents, created and sanctioned by the pharmaceutical company. Treating these advertisements as documents contributes to the history of stimulant drugs in the most basic sense that it provides a new archive to access for scholars, who want to deepen and broaden the existing historical understanding of these drugs. Drug advertisements are an important part of a drug company's persuasive arsenal; they are used to educate the doctors and the public about drugs, and they are used to shape attitudes about and awareness of the body, health, and well-being as part of a campaign to create desire for pharmaceutical products. Advertising drugs to doctors may be an effective form of persuasion and marketing. Ads in clinical journals have long been an important source of drug information for doctors; a 1974 FDA survey reported that 50% of doctors reported using journal advertisements for self-educational purposes.⁶ More recent studies have shown that doctors rely on commercial sources of drug information, especially if they had been practicing more than 15 years,⁷ and that doctors are more likely to write prescriptions for drugs they have seen advertised.⁸⁻¹⁰ Direct-to-Consumer drug advertising, which is allowed in the United States and New Zealand but in no other country in the world, is also proving to be an effective means of drug promotion. Doctors are more likely to prescribe drugs when consumers ask for drugs by name, and consumers ask for products they have seen advertised.¹¹

It must also be said, however, that it has been difficult to establish a firm causal link between drug industry promotional activities and doctors' prescribing decisions. The most obvious association found is that doctors who report relying more on promotional material prescribe more drugs, prescribe less rationally, and prescribe newer drugs earlier than other doctors. However, other characteristics of doctors, such as age, academic level and involvement, and clinical experience may be important factors in this association.¹²⁻¹⁴ In what follows, it should be remembered that advertise-

ments in journal articles are part of a larger drug promotion campaign, which included, for Ritalin, educational videos for clinicians, drug representative visits to clinical and public sites, and funding research into child hyperactivity and drug response. Therefore, these advertisements are most usefully viewed as additional historical resources which can help deepen analyses that include work with a variety of relevant documents. Advertisements can be viewed as discursive spaces, the meeting point of a variety of prominent cultural discourses and rhetorical strategies. In particular, these advertisements point to the clinical-cultural tropes the pharmaceutical industry has both (re)constructed and deployed to persuade first the clinic, then the lay public, of the need for these drugs.

There are two overlapping aims in this chapter. The first is simply to present some of the advertisements for stimulant drugs chronologically, from the late 1950s until the present. The visuals are allowed to speak for themselves to a certain extent, alongside a historical and interpretive context against which to “read” the ads and flesh out the history of these drugs. In the course of this chronology, however, there is a second aim: To make the argument that the contemporary phenomenon of rising ADHD diagnoses and stimulant drug use may be explained, in part, by an older association between problem boys and their problematic mothers. Put even more simply, mothers matter to this phenomenon, but how and why they matter cannot be captured by simplistic and biased mother/parent-blaming narratives. This chapter explores the ways in which stimulant drug advertisements capitalize on the association between problem boys and problematic mothers in order to sell disease and drugs to psychiatrists, and later to sell a drug-assisted relationship and lifestyle to mothers.¹⁵

Ritalin: Gentle, Collaborative, Catholic

Ritalin was first marketed in 1955 by Ciba Company for narcolepsy. Early advertisements show tired patients, whose fatigue is associated with a wide range of psychiatric disorders, including chronic fatigue, depression, and dementia. The text and visuals of Ritalin advertisements throughout the 1950s and 1960s suggest an effort to position Ritalin as a drug that in a sense defies diagnosis: It is useful in the treatment of most psychiatric diagnoses. It is also amenable to working alongside other treatments, including more powerful drug treatments and psychotherapy. Two groups of potential Ritalin users are depicted: the middle-aged and the

elderly. Within these groups, Ritalin candidates are male or female, and White. Initially, Ritalin seems to have been marketed more directly for geriatric patients; ads highlight the benefits of Ritalin’s gentle action and mild side effects for this vulnerable group. Toward the end of the 1960s, however, adverts appear that specifically expand the range of candidates for Ritalin. One such advertisement shows the profiled faces of four men, ranging in age from approximately 40 to 80. All of the men have similarly sad expressions on their faces, although their psychiatric diagnoses are different. The text of the advert reads, “All are candidates for Ritalin.” The symptoms depicted in these advertisements are in no way frightening or flagrant; rather, they are familiar depictions of sadness. When pictured alone these men and women look lonely and depressed; they gaze into the distance, rarely meeting the eye of the viewer.¹⁶

While doctors are infrequently pictured in the adverts, they are, of course, suggested in the gaze of the viewer, and indeed, in one advertisement, the reader sees the (female) patient through the eye glasses and spectroscope of the pictured (male) doctor, creating a direct visual bond between the reader-doctor and the imaged doctor. The most prominent visual in this advert is the doctor’s fist which both holds the spectroscope and serves as a forceful barrier between himself, the reader-doctor, and the female patient. Indeed, there is a great deal of authority and power suggested in the tools of the trade (spectroscope) and the doctor’s fist, which both frame the patient and hold/push her back. Having established the authority of the clinician visually, the text of this advert can exhort the clinician to act gently, not to move too quickly to powerful drugs to treat vulnerable middle-class women, but rather to try “a gentle stimulant with few side effects” and to “reserve more potent agents for more serious conditions.” Such advertisements serve to position both Ritalin and the prescribing clinician as gentle, sympathetic entities (while visually affirming medical authority); just as the patient and her symptoms are familiar, so too is the doctor familiar and his practices thoughtful and unthreatening.

Such images can be linked to a project of domestication of psychiatric authority, as represented by doctors, diagnosis, and treatments. While these advertisements encourage the use of drug therapies that have been more traditionally viewed as part of a biological psychiatry, the visuals and text of these advertisements suggest a not-so-subtle interaction with psychoanalytic approaches to “every day” problems of living. This will be discussed further in a later section of this chapter; at this point, it is sufficient to point out that some of the advertising for Ritalin consciously employs a

psychoanalytic trope in its ads, binding Ritalin to a sympathetic male authority that offers a safe haven, and a safe relationship, for a group of middle-class females—the “worried well.”

Should psychoanalytic psychiatrists still have been worried about using psychotropic remedies in patient therapy, there was another set of adverts to speak directly to the collaborative qualities of mild stimulants. Two of these ads appeared in 1958, soon after Ritalin first came on the market, and suggest that drug companies were aware at this point that psychoanalytic models were sufficiently in ascendance during this time, and that marketing drugs specifically as adjuncts to psychotherapy could be efficacious. An advertisement for Dexedrine (which was earlier indicated for compulsive overeating) shows Rorschach-like images and cites a published clinical finding that “Dexedrine may function impressively as a specific adjuvant in psychotherapy.” The ad for Ritalin is an attempt to simultaneously market a novel form of the drug and position Ritalin as a useful adjunct to therapy. The novel form of Ritalin is “new parenteral Ritalin,” a Ritalin injection. The byline reads, “Help psychiatric patients talk.” The ad is largely text, interspersed with images of a male doctor and a male patient; the latter is obviously finding talking effortful at first. Parenteral Ritalin offered doctors the opportunity to make their patients more “verbal” and “cooperative” quickly—the text promised “rapid” action . . . “in as little as five minutes.” (One can only imagine what a shot of amphetamine would do to a patient in the doctor’s office; this form of Ritalin appears to have been taken off the market very quickly, for reasons about which we can only speculate. For one, abuse potential would be high. By doctors or patients or both?)

While early ads for Ritalin and Dexedrine showed adults exclusively, the use of psychotropic drugs for behavior problems in children was clinically well established by the time Ritalin came on the market in 1955. Results of experiments with the stimulant drug Bazedrine were published by Charles Bradley in 1937;¹⁷ in the following decade, subsequent articles by Bradley and others provide evidence of increasing clinical experimentation and refinement.^{18–20} However, the most commonly used drug treatment for children with behavior problems was still the minor tranquilizers. Tranquilizers for use with children were marketed to clinicians in the *American Journal of Psychiatry* in the late 1950s and early 1960s. “Calmativ Nostyn” (1958) was declared “safe for your little patients too” and indicated for use in “hyperactive” as well as “emotionally unstable” children. Prozine (1959) controlled “acute behavior problems”

in children. An Atarax campaign (1962) declares that this is “a widely prescribed tranquilizer in pediatrics.” The benefits of tranquilizing children to improve school performance is indicated in many of these ads; Atarax, for example, “promptly relieves overt anxiety, lengthening the child’s attention span for better schoolwork and easing his relations with teachers, classmates, and parents.”

Constructing the “Problem” Child in Medical Advertisements for Stimulant Drugs

These ads give us several important clues to the clinical landscape in relation to psychotropic drug treatments for children. Anxious children, hyperactive children, and emotionally disturbed children were well established clinical entities by the late 1950s, such that drugs could be marketed directly for use for these diagnoses. The focus on “the hyperactive” child in the late 1950s may reflect growing clinical awareness and definition of hyperactivity as a disorder of childhood.²¹ Emotional disturbance had long been an ambiguous clinical description of a child with a wide variety of behavioral symptoms whose etiology was largely unknown. Symptoms were thought to be secondary to an underlying primary disorder, and treatment of the secondary symptoms was considered vital to the effort of containing this underlying disorder.²²

Why Boys?

Another significant clue to contemporary and clinical perspectives on the use of these drug treatments in children is the fact that, between 1955 and 1998, all children pictured in advertising campaigns for minor tranquilizers and stimulant drugs are boys. If the persuasiveness of advertisements depends in part on the advertiser’s ability to draw upon familiar cultural tropes and patterns of understanding, then this exclusive, and persistent, focus on boys must be seen as meaningful, not incidental. Drug campaigns both rely upon and construct gender ideologies and gendered behaviors.^{23–25} We need to interrogate the gendering of pathological behavior in children in these advertisements, because by doing so we may come to understand something about the remarkable gender skew in psychiatric diagnosis more generally. In the case of stimulant drug advertising for behavior problems in children, we need to ask the question: Why boys?

What is the basis for the series of equations presented by these ads: children who exhibit behavior problems are boys; behavior problems in boys fall under medical purview; psychotropic drugs are appropriate tools for controlling behavior in boys.

These questions are meant to be part motivational rhetoric; it is impossible to do justice to them in a single chapter. We have little substantive understanding of why an increasing number of school-age boys in America, and around the world, are taking stimulant drugs. We have a number of broadly justified analyses that point fingers at a combination of cultural, social, clinical, familial, biological, and genetic factors. But too often these analyses do not provide an understanding of the *sustained* gendering of the school-age population of stimulant drug candidates. In Conrad & Schneider,²⁶ for example, we had a compelling argument about ADHD as the medicalization of delinquent and deviant behavior. While delinquency is also a gendered phenomenon, this argument did not develop a gender analysis. More recently, a new generation of experts in boys' psychology have argued that we are "medicalizing boyhood" with stimulant drugs in a contemporary setting which is so fast paced and competitive that boys are forced to live up to a "culture of masculinity" much before their time.²⁷⁻²⁸ This argument can at times assume an almost idyllic past in which boyhood was imbued with a Rousseau-like innocence and freedom. And yet what we are learning from the developing history of stimulant drugs is that, even half a century ago, quite normal-seeming boys were presented as appropriate candidates for drug intervention. This appropriation of boyhood by medicine and the pharmaceutical industry is an area that requires exploration. So perhaps a useful way into an understanding of "why boys" is to explore the gendering of normality and abnormality in children's behavior, and to ask how this gendering is achieved.

Problem Boys and Problematic Mothers

How are behavioral "normality" and "abnormality" in boys represented in these visual clinical texts? To begin to answer this question, we need to locate the particular gendering of behavior in children represented in these adverts, within our earlier discussion about the subtle referencing of gendered relational dynamics inside the clinic. Because while an advert may only picture one boy, there are at least two other centrally important figures implied in the discursive space of the advertisement. One is, of

course, the (male) clinician. The other is the boy's mother. Representations of the normal and the abnormal in young boys' behaviors are constructed in the context of this relational dynamic.

If one were to take a single volume of the *American Journal of Psychiatry (AJP)* as a whole in the late 1950s, remove all the articles and leave just the adverts, one might begin to view this collection of advertisements as a picture-book. Each page has its own individual visual and verbal narrative, with a particular message. However, each page also references the other pages in the book, such that there is a collective story built about clinical perspectives on mental illness and the characters that best represent the profession's ability to provide expert care and treatment. If this were a volume from the early 1960s, we would learn that middle-class, middle-aged White women were anxious, depressed, and worried. They visited White male psychiatrists who viewed them with fearful longing²⁹ and sent them home with tranquilizers. These women had children, but only boys, who misbehaved. The boys were hyperactive and unstable. If we added in some pages from a later *AJP* volume, in the 1970s, we would begin to get a sense of some narrative connections: The women's anxiety and depression exist alongside the boys' problem behaviors. Women accompany their sons to the doctor's office. Women look a great deal happier following treatment of their sons. We begin to get a sense that the condition of the mother relates to the condition of the son. Indeed, the picture-book is telling us that these conditions refer to each other in some way; the drugs advertised appear less to be treating individual conditions and more to be treating relationships and interactions.

Historically, biological child psychiatry, as viewed through the lens of stimulant drugs, contains a psychoanalytic assumption of an intimate relationship between a problem boy and his problematic mother. It is this cultural trope which in part supports the rise of stimulant drug use in children. Indeed, a degree of integration of biological psychiatry and psychoanalysis in treatment approaches to "the worried well" should now be unquestioned. The clinical literature in pediatrics and child psychology demonstrates this integration throughout the 1940s and 1950s,³⁰⁻³¹ and advertising of stimulant drugs to clinicians in the 1950s and 1960s directly emphasized the interconnections between drug treatments and psychoanalytic approaches. Moreover, a similar point has been illustrated persuasively, and more expansively, in Jonathan Michel Metzl's discussion of advertisements for the minor tranquilizers and antidepressants.³² If Metzl's project is to illumine the "Freud in Prozac," mine has been, more

narrowly, to explore the professional preoccupation with mother in the impulse to medicalize behavior problems in boys. One might say that the object here is to illumine the mother in Ritalin. The following analysis scrutinizes a set of 1970s *AJP* advertisements for Ritalin, in order to support the claim that this triad of mother-son-clinician is the relational ground upon which the understanding of normal/abnormal behavior in boys is constructed.

Ritalin as a Niche Drug for Minimal Brain Dysfunction (MBD)

Until 1971, advertisements for Ritalin in the *AJP* do not depict children. However, in 1960s advertisements, the text does provide dosage information for “children with functional behavior problems,” suggesting that the clinical practice of giving Ritalin to children was reasonably well established during this period. Indeed, by the 1960s, several influential journal articles had documented the superior benefits of methylphenidate over tranquilizers in the treatment of children’s overactive and distracted behaviors.^{33–35} The group of children whose behaviors benefited most from methylphenidate treatment suffered from what the authors called “chronic brain syndromes.”³⁶ Two years later, a variant of such syndromes, Minimal Brain Dysfunction (MBD), reemerged as an important childhood diagnosis through the publication of a U.S. Public Health Service Report. MBD presented Ciba with the opportunity to market Ritalin for children as a niche drug.

The 1966 U.S. Public Health Service publication, “Minimal Brain Dysfunction in Children: Terminology and Identification,” by Samuel Clements, attempted to pull together a large amount of material on MBD and similar disorders, in order to present a definitive diagnostic guide. In Clements’ review of the literature, he found that MBD had been described by at least 38 different terms, including hyperkinesis and hyperactivity syndrome. Thirty years’ worth of clinical evidence suggested that methylphenidate was an effective treatment for this particular cluster of behaviors, and given the ambiguous nature of the diagnosis, it would be difficult not to begin to use the drug as a pharmacological scalpel. Public health officials sought to educate doctors as well as the public about the nature of MBD, distributing booklets, pamphlets, and short films on how to recognize, evaluate, and treat MBD. The popular press cast the newly hot diagnosis into its ever fiery debate on the growth of the drug industry

and medical diagnosis, the use of psychotropic drugs in everyday life, and the use of psychotropic drugs in children.³⁷

It is against this background that Ritalin, the gentle, collaborative drug originally marketed for a tired, elderly population, becomes fundamentally associated with a population of hyperactive youth. The connection between Ritalin and MBD (or hyperactivity) can be seen as part of a project of “branding” a condition, that is, elevating its importance, creating consensus about the condition, and deciding on the best form of treatment.³⁸ However, even as a niche drug, Ritalin had to retain its catholic heart—MBD was after all an umbrella term for at least 38 other diagnostic terms. Its gentle persona served it well in this new niche: A harsh, unkind drug would not hold appeal as a children’s drug. Ritalin was therefore in perfect position to be in a “special” service as an MBD drug.

Educating Clinicians about MBD and Ritalin

Almost all the advertisements for Ritalin in the 1970s volumes of the *AJP* involve positioning Ritalin as *the* treatment for children with MBD. The advertising text declared that Ritalin had a “special role” in the treatment of MBD. The first advertisement in this series appeared in 1971. It was in part an educational advertisement, focusing on the need to legitimize the disorder and to inform clinicians about symptoms and evaluation of MBD. It was also educational in that this was the first advertisement to offer a representative child patient to clinicians. In the before-drug picture, this first Ritalin boy is reminiscent of the Mellaril boy we saw earlier: His behavior seems out of control. His face is angry—his drawn back mouth suggests that he might be shouting. One arm is raised as if to come banging down on the desk, the other hand claws at the closed notebook. The question above the picture on the first page: “medical myth?” contrasts the “reality” of the pathological behavior seen by the viewer; the juxtaposition of text and image challenges the viewer to deny the reality of this pathology—to keep “dismiss[ing]” the behavior as merely “youthful vitality.” Once MBD becomes a “diagnosable disease entity” on the next page, order and calm are restored. The clinician is informed of the boundaries of diagnosis and of an effective treatment; the boy takes his pills and is once again manageable, under control.

This is the only advertisement in this series that shows the boy alone in all picture captions. He is in a school classroom, which provides an important interpretive context for his behavior. In this context, behavior

that interferes with learning cannot be so easily dismissed. While there is no direct reference to boys specifically in this advertisement (all references are to “children”), the gendering of the problematic behavior is already present most clearly, of course, in the fact that the child depicted is a boy. But it is also present in more subtle descriptive ways; the reference to explanations that see this behavior as part of a child’s “spunkiness,” “youthful vitality,” “aggression,” and “mischievous behavior” suggest activities and an activity level that are cultural markers of boyhood. The behavior depicted in the before-treatment image provides an important contrast to these cultural understandings of “normal” boyhood, in that the boy is shown on his own, wrestling with invisible/internal demons that appear not to provide him any joy. The boy’s lonely frustration interrupts cultural expectations of the sociability of normal boyhood vitality. And yet, the after-picture does not depict a “normal” boy either; rather, the emphasis is on the achievement of controlled behavior in the classroom. This controlled, contemplative boy, whose eyes are cast down, whose hands are neatly placed on the desk, whose hair is neat and tidy—he is not a “normal” boy either. The clinical expectation of treatment outcomes was not normalcy; rather, clinical expectation was built around the notion of contrast between behaviors pre- and post-treatment. Treatment did not normalize behaviors so much as it controlled them.

This emphasis on control allowed Ciba to shift the clinician’s attention away from the problematics of evaluating normal/abnormal behavior in little boys, and to focus instead on the concrete possibilities inherent in Ritalin treatment. If earlier Ritalin adverts emphasized the gentle nature of the drug, and by association the prescribing clinician, this advertisement extended the holding ground to the vulnerable clinician himself. The opening text acknowledges him as a member of the community and invites him to join a circle of collective wisdom and expertise: “What medical practitioner has not, at one time or another, been called upon to examine an impulsive, excitable, hyperkinetic child?” The clinician’s mistakes are simultaneously clarified and excused, in sotto third person passive voice: “In the absence of any detectable organic pathology, the conduct of such children was, until a few short years ago, usually dismissed.” But now that the disorder is “readily diagnosed” and approved by an “expert panel,” there need not be any more debate over the pathological etiology of ambiguous problem behaviors in young boys—and clinicians no longer need to worry about making more mistakes. There

was now a means of controlling the behaviors and medical justification for doing so.

In subsequent 1970s adverts, there was more confidence in clinicians’ knowledge of the MBD diagnosis and consequently less focus on the need to bring the clinician into a community of experts who diagnose MBD and prescribe Ritalin. The advert still spoke to the clinician-reader, of course, and the emphasis on controlling and managing behavior in a school context was sustained. What changed quite dramatically in the course of subsequent advertisements was the introduction of a third person into the dynamic between clinician-viewer and representative boy patient. At first, this person’s status was somewhat vague; she could be a teacher; she could be a mother; she might be both. By the mid-1970s, she was definitively mother.

Insertion of the Female Figure

Advertisements from 1973 and 1974 introduced the importance of relationship into the depiction of problem behaviors in children and suggested that the relationship between mother/teacher and boy was an important factor in the representation of successful drug treatment. The sadness of “Wednesday’s Child”—who is “full of woe”—is depicted with a picture of a crying boy who is closely held and comforted by an ambiguous female figure.

Here, Ritalin is a “helping hand”; the bold text closely aligns with the prominent female hand that embraces and shelters the boy, enclosing their relationship in a private space. But if the female hand is a visual barrier between the clinician-viewer and the boy, it also provides a set of metaphoric linkages between the “helping hand” of the drug, the helpful physician whose hand writes the prescription for the drug, and the woman/mother whose hand encloses the boy. All these hands collaborate in “managing Wednesday’s child.” And so, in fact, the impression of an enclosed relational space between woman/mother and boy is false. The advert encourages doctors to enter this space, to join their hands with that of the woman/mother, in order to embody and facilitate the drug’s reach into the boy. Joined together, these actors promise to resolve not only the problem of individual behavior, but also the emotionally complex relational dynamics that accompany this “affliction.”

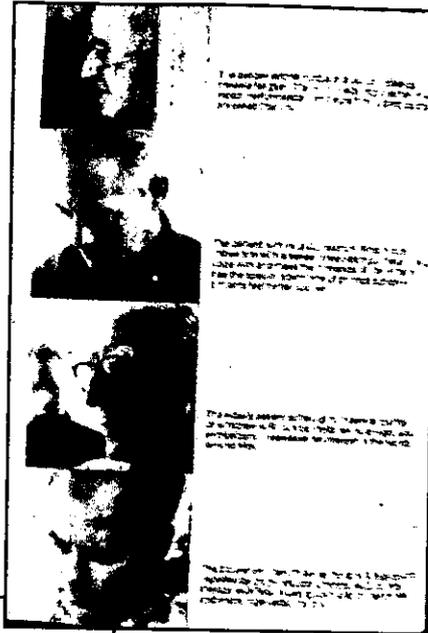
A more straightforward representation of Ritalin’s ability to manage woman/mother/teacher/boy relationships as well as individual behavior

was demonstrated in an advertisement which showed a large picture of a vulnerable-seeming boy listening thoughtfully and carefully to an ambiguous woman who was assisting him with schoolwork. They are both engrossed in what they are doing; their focus isn't broken by the clinician-viewer. However on the ad's second page, the boy kisses the woman in a moment when they are not working (perhaps they have just come in from playing outside—the boy is wearing a hat). His kiss is in profile; his eyes are almost closed and his face is hidden behind her cheek. But her face and her smile are fully exposed, providing the only direct communication between the characters in the advertisement and the clinician-viewer. While the image on this second page is very small, its importance is clearly established in the happy kiss, which releases the focused tension evident on the previous page. That kiss, this relationship—these are key aspects of Ritalin's healing work.

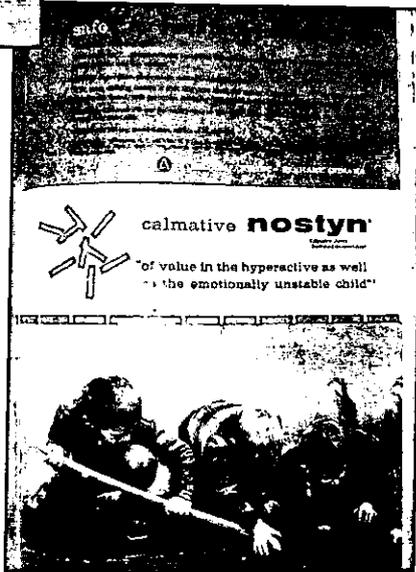
In fact, this relationship is so important in this series of advertisements, that even when the advertisement is ostensibly about something else, a female/maternal presence is powerfully felt. Another 1974 advertisement depicted a doctor doing physical therapy with an MBD boy; the text encouraged the use of Ritalin alongside other treatments for MBD. The physical therapy session is taking place in a classroom, underlining once again the importance of the school context in interpreting and managing boys' behaviors. Apparently only the doctor and the patient are present in the room. However, at their backs, at the far end of the room, hangs a woman's winter coat. It is a curious place for a coat to be hanging, in a classroom, midway up against a window, facing out on a hanger as if to show its details, rather than simply hung on a coat hook behind a door. These curiosities, of course, indicate the importance of the coat's message: it asserts the presence of a woman in the room. Her identity is once again ambiguous.

This sustained ambiguity around the female figure in this series of advertisements may reflect the focus, in this early series of ads with children, on educating physicians about *management and control* of MBD children, rather than *normalization* of MBD children. The former was much more clearly and persuasively a clinical project, while the latter strayed into politically charged territory, where subjective factors endangered medical definition and classification. So the inclusion of women in these ads may at this stage have been carefully nuanced so as to manage the interpretive possibilities. The drug's claims and promises might have extended to the woman-boy relationship, but the contexts in which this

"All Are Candidates for Ritalin" *AJP*, 1968



"So Tired" *AJP*, 1964



"Safe to Play" *AJP*, 1958

MBD...medical myth or diagnosable disease entity

What medical practitioner has not, at one time or another, been called upon to examine an impulsive, uncontrollable hyperkinetic child? A child with difficulty in concentrating. Easily frustrated. Overly aggressive. A classroom rebel.

In the absence of any detectable organic pathology, the conduct of such children was, until a few short years ago, usually dismissed as "a phase," "spontaneous," or evidence of youthful "rizzity." But it is now evident that to many of these children the hyperkinetic reaction syndrome exists as a distinct medical entity. This syndrome—now readily diagnosed through patient history, neurological signs, and psychometric testing—has been classified by an expert panel convened by the United States Department of Health, Education, and Welfare as Minimal Brain Dysfunction, or MBD.



in Minimal Brain Dysfunction... a special role for

Ritalin[®] (methylphenidate)

Hyperactive children will inevitably show a favorable response to the drug. This apparent paradox is underscored by the fact that hyperactive children improve on the medicine.

In past years, Ritalin has gained wide acceptance as an effective and well-tolerated CNS stimulant. In contrast to other CNS stimulants, which induce quality or fat in adolescents only in MBD. Indeed, clinical studies have demonstrated that Ritalin even moderately hyperactive MBD children by controlling hyperactivity. In general, side effects were mild and not as a serious problem and rarely caused discontinuance of therapy, with the usual frequent adverse reactions reported being loss of appetite, sleeplessness, tachycardia, restlessness, headache, and occasional tics. (See Adverse Reaction section of brief prescribing information.)

Not a panacea for all childhood behavior disorders: While documented useful with Ritalin in MBD, the drug has been proven less effective in cases of anxiety, depression, and personality disorders, schizophrenia, epilepsy, and mania. (See Contraindications section.) You should be used in attempting to modify normal peeing papers, which may be characterized by overactivity and/or compulsive behavior.

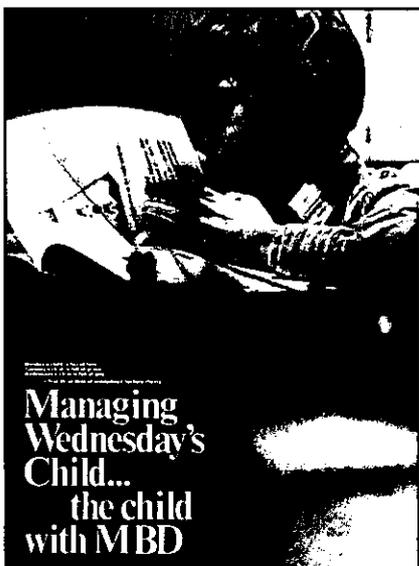
ADVERSE REACTIONS

ADVERSE REACTIONS: In clinical studies, the most common side effects reported in the form of hyperactive behavior in children with MBD were loss of appetite, sleeplessness, tachycardia, restlessness, headache, and occasional tics. In general, side effects were mild and not as a serious problem and rarely caused discontinuance of therapy, with the usual frequent adverse reactions reported being loss of appetite, sleeplessness, tachycardia, restlessness, headache, and occasional tics. (See Adverse Reaction section of brief prescribing information.)

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C I B A

"Myth or Disease?" AJP, 1971



Managing Wednesday's Child... the child with MBD

"Wednesday's child is full of woe"
It need not be this way for the MBD child.
He can learn and adjust if given a helping hand.

Without help the MBD child may be a slow reader and find writing difficult, and adjustment hard to grasp. The way to overcome and the signs are for diagnosis. The result can seriously hamper the educational and social development.

But, properly diagnosed and treated, MBD—Minimal Brain Dysfunction—can be brought under control so that the affected child can develop normally.

And Ritalin can play an important part in the total rehabilitation program of the MBD child, which includes remedial exercises at home and at school to counteract the drug of stress in many MBD children.

While it is well tolerated, it can help control the excessive motor activity of the MBD child and ameliorate behavior and learning problems.

If correct, Ritalin is not indicated for children with personality and behavioral disorders not associated with MBD.

Contraindications
Ritalin is contraindicated in children with personality and behavioral disorders not associated with MBD. It is also contraindicated in children with epilepsy, glaucoma, and severe hypertension. It should be used with caution in children with heart disease, diabetes, and thyroid disease.

Warnings
Ritalin should be used with caution in children with heart disease, diabetes, and thyroid disease. It should be used with caution in children with epilepsy, glaucoma, and severe hypertension. It is also contraindicated in children with personality and behavioral disorders not associated with MBD.

How to Use
Ritalin should be given to children with MBD in the form of tablets or capsules. The dosage should be adjusted to the individual child's needs. It should be given in the morning and in the afternoon, with meals.

Side Effects
The most common side effects of Ritalin in children with MBD are loss of appetite, sleeplessness, tachycardia, restlessness, headache, and occasional tics. These side effects are usually mild and do not require discontinuance of therapy.

Ritalin[®] (methylphenidate)
only when medication is indicated

C I B A

"Wednesday's Child" AJP, 1973



"The Coat in the Room," *AJP*, 1974

1971 ...a difficult child, a distraught mother
 Medical diagnosis: MBD

An MBD child on the road to maturity.

1974 ...a regular fourth-grader,
 accepted at home

Ritalin (methylphenidate)
 to help when medication is indicated

CIBA

"Perfect Pictures" *AJP*, 1975

Things are good on the ADHD front.



Good start.



Good day.



Good tomorrow.

IMPORTANT SAFETY INFORMATION FOR ADDERALL XR

ADDERALL XR is for patients with a confirmed diagnosis of attention-deficit/hyperactivity disorder (ADHD). ADDERALL XR should not be used in children under 6 years of age.

ADDERALL XR should not be used in children:

- Who are overly anxious or agitated
- With glaucoma, or in severe hypertension
- Who are taking or who recently took an MAOI inhibitor

ADDERALL XR has a high potential for abuse. Children at highest risk are patients with a history of drug or alcohol dependence, mental illness, seizures, high blood pressure, or heart conditions.

The most common side effects with ADDERALL XR include decreased appetite, decreased pain, loss of sleep (insomnia), and increased heart rate.

Shire US Inc.
www.adderall.com



If your child is taking ADDERALL XR, your doctor is now in a good time for your child to try NEW ADDERALL XR Extended-Release Capsules.

If you have a child with ADHD, you know how hard school can be. The right medication is a good start in making things easier for your child and your whole family. It helps control some of ADDERALL XR's most common adverse effects of ADHD symptoms throughout the day, including the important ones when many children just begin to wake up. ADDERALL XR helps and helps you to get the most out of your child's day.

Ask your doctor today about the benefits of ADDERALL XR and whether or not your child is a good time to switch to a once-daily medication that can help your child make the most of his or her entire day!

You can also access ADDERALLXR.com or call 1-877-774-9220 for more information.



"Domestic Harmony" People, 2002

FOR PARENTS OF CHILDREN WITH ADHD

Finally!

Schoolwork that matches his intelligence
Friends that ask him to join the group
Family hours that last for hours
A real solution for ADHD

ADDERALL XR*

- Works fast for the start of the school day — with or without food
- Offers all-day ADHD symptom control
- Has a history of safety and tolerability
- Helps improve academic performance

ONE DOSE, ALL DAY
ADDERALL XR
Extended-Release Capsules

IF YOUR CHILD'S CURRENT THERAPY ISN'T MAKING THE DIFFERENCE YOU HOPED FOR, TALK TO YOUR DOCTOR TODAY ABOUT ADDERALL XR.

ADDERALL XR was generally well tolerated in clinical studies. The most common side effects are decreased appetite, stomachache, difficulty falling asleep, and emotional lability.

Tell your doctor if you have a history of high blood pressure or any heart conditions, glaucoma, thyroid problems, emotional instability, mental illness, or a known allergy to the type of capsule. ADDERALL XR may not be right for you. If you are currently or have recently taken a type of antidepressant called a MAOI inhibitor, you should not take ADDERALL XR. There is a potential for worsening of mania or mixed mania and Tourette's syndrome.

*Some of your doctor's other medications may lead to drug interactions. Report any new symptoms to your physician.

There is a low potential for overdose with ADDERALL XR. In case of overdose, call your doctor.

Shire US Inc.
www.adderall.com

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"Finally a Hug"
Good Housekeeping, 2004

relationship was depicted were not domestic contexts, rather they were school or learning-based contexts, in which behavior management was necessary and justified. To a certain extent such an approach to female representation in these adverts also allowed for a minimization of the importance or power of the woman-boy relationship; as long as the clinic defined the nature and context of this relationship, it held greater power over the boy than did the woman.

Focus on Mothers and Sons

It is only once the reluctance to fully depict mothers in Ritalin advertisements was overcome that the distinctions between a project of behavior management and a project of normalization became blurred. And yet in this blurring, there was also a much clearer picture of how the construction of behavior problems in boys was grounded in a set of interconnecting relationships among boy, mother, and clinician. In a 1975 advertisement that brilliantly foreshadowed the direct-to-consumer advertising campaigns that appeared two and a half decades later, these relationships were cast in a drama that acknowledged the interpretive importance of contexts beyond the school and clinic. Within the domestic and social contexts (including school) suggested in this advertisement, Ritalin managed the appearances that accompanied a particular lifestyle.

The before-image is a photograph of a family—or an attempted photograph of a family. There are two gleaming children, and one “difficult child”—the child with MBD. His behavior disrupts both the taking of the photograph and the portrait of an ideal family—bright, attractive, well behaved, in control, White, middle class. But it is not just the image of the boy that disrupts the idyll; it is also the image of the mother wrestling with the boy, an awkward, appealing look on her face. She is trying hard, doing her best to appear competent and attractive, but her position is literally skewed by this difficult son; in contrast to her good children’s straight backs and perfectly positioned hands, she is “distracted,” imbalanced by the aggressive embrace with this boy.

Thus, the before-image—both visually and in the text—makes a direct link between the behavior and appearance of children to the behavior and appearance of the mother and suggests that the clinician’s tool, Ritalin, can help manage all these appearances. It is the first advertisement to specifically claim the domestic space and domestic relationships as a legit-

imate domain of treatment. To intervene in the domestic space, the expert and his tools necessarily confront maternal authority, and in the process of claiming the space must involve a reduction of mother's competence and power. In this advertisement, mother's reduction is affected both via the obvious inability of the mother to handle this boy on her own, and by the subtle insinuation of her role in the boy's problematic behavior. The text of the after-image tells the viewer that with Ritalin treatment, the boy is "a regular fourth-grader, *accepted at home*" (my emphasis). Embedded in the latter treatment result is a quiet reference to the well-established psychiatric literature on the pathologizing influence of rejecting mothering behavior on young boys.³⁹⁻⁴¹ In the mid-1970s, the problem of maternal acceptance of this child most clearly echoed John Bowlby's⁴² widely read work on attachment disorders in children; and Bowlby's work was, of course, indebted to a psychoanalytic tradition that viewed the relationship between mothers and sons as inherently problematic and potentially damaging to the boy.

In this way, the pre- and post-treatment dichotomy depicted by this advertisement represented not only the successful management of the boy's behavior, but also the successful management of the mother's behavior—that is, returning the boy, the mother, and the family to the appearance of normalcy. It is notable that this advertisement does not promise actual normalcy; it promises only the appearance of normalcy—in photographs. The implication is that for the mother, who will be sending the school photographs to friends and family, the appearance of normalcy is highly valued and is possibly sufficient reason for Ritalin treatment. So, while this is the first advertisement to blur the distinction between Ritalin as a tool for managing behavior and Ritalin as a tool for normalizing behavior, there is still an element of self-consciousness, certainly reflexivity, in the use of a photographic metaphor to depict post-treatment normality. This reflexivity disappeared completely once Ciba began to advertise Ritalin directly to consumers.

We should not forget the perspective of the viewer-clinician in the analysis of this advertisement, although it is easier to forget him when viewing an ad that is so apparently devoid of clinical references. But there is a link, of course, between the perspective of the absent father (who is presumably taking the picture of his family) and that of the viewing clinician. Both men are invisibly positioned in an objective, evaluative posture as they gaze upon the mother and the situation. And there is a further link with the distressed mother, whose eyes make contact

with the camera (her husband) and with the clinician-viewer who stands behind it/him.

The Politics of MBD and Drug Advertising

Why would Ciba believe that clinicians would respond well to an advertisement that so clearly focuses on improvement of lifestyle and appearance with Ritalin treatment? A possible answer may lie in the reference in the ad to the passage of time between 1971 and 1974. By the mid-1970s, there was an ever-increasing number of discussions and debates published in the popular media about psychotropic drug use for children's behavior problems. Congress was involved as well, through an investigation into the "Use of Behavior Modification Drugs on Grammar School Children" in Omaha, Nebraska.⁴³ The congressional hearings uncovered problematic and illegal prescribing practices which underlined concerns about the use of stimulant drugs as a form of institutional control of the individual.⁴⁴ Members of the subcommittee warned about the use of drugs to quiet the "bored but bright child." As this congressional committee went about its work, however, another branch of government, the NIH, was funding clinical research into the efficacy of stimulant drug use in children with MBD and other disorders (e.g. Eisenberg, 1964). Results of clinical research appeared alongside the public outcry during these years, with a stable and interconnected group of clinicians (several of them working from NIH grants) contributing to the work on stimulant drugs with children.⁴⁵ As a result, the early 1970s was a period of stabilization of knowledge claims in relation to both the MBD diagnosis and the use of stimulant drugs in children. In 1971, Paul Wender published a definitive text on MBD in children, with a foreword by Leon Eisenberg, who was at the time a prominent proponent of the diagnosis.⁴⁶ By 1974, an academic conference involving notable clinical and academic figures was dedicated to the subject of stimulant drug use in children. The conference resulted in a widely cited book.⁴⁷

Thus, it would seem possible that by 1975, when this advertisement appeared, Ciba felt confident that clinicians would view MBD as a medical reality and would trust Ritalin as an appropriate treatment. Such confidence may have encouraged them to push the boundaries of treatment efficacy into a realm that was, of course, already implicated—Ciba did not create the conflation of the domestic and the clinical realms. The com-

pany's advertising did, however, draw expertly on this conflation, effectively grounding the evaluation and treatment of problem behaviors in boys in the interconnected relationships among mother, son, and clinician. This grounding in turn provided a marketing platform that allowed for the integration of medical tools and expertise into family life. Harmonious relationships could be represented as an important goal of drug therapy for the White middle-class nuclear family. Drugs could be sold on the basis of what they could "buy" in terms of acceptable social and domestic values. Chief among these values was mother, on whose emotional rationality and maternal competence familial and social harmony depended. Now mother could be managed, treated, and potentially transformed through her son's drug therapy. Thus, management of the mother, and by implication management of her relationship with the "problem" son, emerged as a key justification for medical intervention. The mother was indeed deeply implicated in Ritalin treatment.

Strangely enough, the Ritalin advertising trail, in the *AJP* and in other journals, went very quiet after this 1970s ad series. There was a brief and unsuccessful attempt to market a long-acting form of Ritalin in the 1980s, but for the most part, Ciba put its advertising money into antipsychotics. The only drug consistently advertised for ADHD children during this period was Cylert, made by Abbott.⁴⁸ It is difficult to know the reasoning behind the lack of Ritalin advertising in the 1980s, but one might speculate that the drug was well established for ADHD children by this time, and that Ciba needed to concentrate on launching and establishing other drugs. Moreover, ADHD discussion, debate, and possibly diagnosis also went very quiet in the 1980s, and there was a noticeable drop in the number of prescriptions for stimulant drugs during this period.⁴⁹ This lull helps to explain why the contemporary furor over ADHD and stimulant drug use in children seems so contemporary.

The Politics of Advertising Psychotropic Drugs

The 1980s were, however, important years for the pharmaceutical industry lobby. A series of congressional hearings, begun in 1957 by Senator Estes Kefauver, and continuing into the 1970s, had placed restrictions on pharmaceutical industry promotional activities. Psychiatric advertisements in particular had been targeted for providing misleading or insufficient information about both diagnosis and treatment.⁵⁰ During the Reagan years, however, ongoing developments in U.S. Food and Drug Administra-

tion (FDA) regulatory procedures eventually boosted the industry's ability to promote its products. Of particular relevance during this period was the gradual reinterpretation and revision of long-standing FDA policies prohibiting Direct-to-Consumer (DTC) activities for drugs. By the late 1980s, advertising of drugs in newspapers and magazines was finally allowed.⁵¹ In 1997, advertising using broadcast media was allowed, and by 2001, the pharmaceutical industry was spending \$2.7 billion on DTC advertising.⁵² Despite these changes, the industry did not advertise stimulant drugs directly to consumers because of a 1971 United Nations Prohibition on Psychotropic Drug Advertising. While the United States did sign the Prohibition, no laws in line with the Prohibition were ever passed. Despite the fact that stimulant drugs are classified as controlled substances by the U.S. Drug Enforcement Agency (DEA), neither the FDA nor the DEA has the authority to control public advertising for Ritalin or other stimulant drugs for ADHD.⁵³ By 1999, the pharmaceutical industry had decided to act within its rights and launched the first DTC advertising campaigns for stimulant drug treatments for children. Given the historical roots of the preoccupation with mothers and sons both in child psychiatry and in public discourse, it is hardly surprising that this preoccupation continued to feature strongly when stimulant drug advertising came out of the clinical closet and into the mass marketplace.

Contemporary Direct-to-Consumer Advertising of Stimulant Drugs for ADHD

In stark contrast to the medical advertisements discussed thus far, contemporary Direct-to-Consumer ads for stimulant drugs make no visual attempt to educate the viewer about pre- and post-treatment behaviors. What contemporary ads depict is the drug's promise of life post-treatment. There are no symptoms, only solutions. Unsurprisingly, post-treatment images present a highly idealized portrait of a family life, in which everyone is attractive, middle-class, happy, and well behaved. It should be shocking to the viewer that people like this are also consumers of stimulant drugs. But of course, the message of the ad is that psychiatric diagnosis and stimulant drugs are in fact part of normal domestic life. But the life that is depicted is not normal. The journey of stimulant drug advertising into the public domain has taken the claims of the drug maker from control, to a blurring of control and normalization, to a clear vision of

enhancement. Today the advertisements say to the female consumer: This is the kind of son, the kind of family, and the kind of relationships the drug will buy you. *You will shine.*

A majority of DTC advertising of stimulant drugs in the twenty-first century places the relationship between mother and son squarely in the visual and metaphoric center. The drug is positioned as a tool to manage this relationship; in the absence of symptoms, the mother-son relationship is the only suggested “problem” that needs fixing. Mothers who come across these ads, which are frequently placed in women’s and parenting magazines, learn that successful mothers have successful sons, and that drug intervention is a sign of maternal love and care. They learn that stimulant drugs support a normal boyhood. Most important, they learn that harmonious nuclear family relationships—particularly the relationship between mother and son—are assured through drug intervention.

The ads provide a sense of this kind of DTC campaign. There are no symptoms, no pills, no problems pictured whatsoever. The boy never even looks up at the viewer; he is too engrossed in his good behavior or in his relationship with his mother. His focus is, of course, a desirable behavioral outcome of treatment. But the point of drug treatment, as depicted in this ad, is not simply good behavior; the real promise is an enhanced relationship between mother and son. Simple domestic scenes that were once problematic are now idyllic times of domestic harmony and partnership. Mornings, afternoons, and evenings with this boy are tranquil and controlled; the long-acting version of the drug means no more fights about dosing. The boy does what the mother wants him to do all day long; he is the perfect male companion (particularly in the absence of the father). The mother’s dominance in this advertisement may be partially explained by the fact that such ads are targeting women readers. But the analytic interest is not so much that mothers appear in these ads; rather, it is the mode of mother representation that is remarkable. Her knowing, satisfied look out at the viewer (probably also a mother) is almost coy, alluring. It pulls the viewing mother into the frame with the promise that she too can share in the secret of this kind of relationship with a son. Why is the secret compelling to the viewing mother? Why does she want to buy this kind of relationship with her son? The drawing power of this ad is founded upon the reconstruction of a historical trope that links problem boys to problematic mothers.⁵⁴ The advertisers of Adderall appear to understand that this link causes mothers of boys extreme anxiety; they appear to understand that mothers are directly implicated in their sons’ problem behav-

iors. And so they offer the modern mother a way out of this dilemma: a drug that will make the boy’s problems invisible (as they are in this ad) so that mothers can look more like the stereotypical ideal. The trick is that the link between successful boys and successful mothers is just the other side of the link between problem boys and problematic mothers. On this side, the drug makers just make oppression look and feel better.

This link between successful boys and successful mothers is continued in an Adderall advertisement aimed directly at “parents of children with ADHD.” As such, the drug is positioned explicitly as a problem solver for *parents* (read, mothers). Again, we might ask what the mother’s problem is exactly, as depicted in an advertisement that reveals no child symptoms. What has “finally” come to pass post-treatment? What has the drug delivered for *the mother*? The answer is clear in the joyous hug, the connection between mother and son. This is what Adderall promises: Mothers will “finally” be able to hug their sons like “normal” mothers do, they will feel joy and pride instead of anger and resentment, and their sons will feel happy and loved. Note the test paper the boy is holding; he has been given a B+, a decent grade. The prominent red mark is meant to capture the viewer’s attention. It confirms the goodness of the mother, telling us that she is not unreasonable in her desire for her son’s success. She is not a pushy, competitive mother who puts her children on stimulant drugs so that their enhanced performance can feed her own ego. In contrast, she is overjoyed by a B+. This advertisement therefore not only flips the problem boys/problematic mothers equation onto the success side, but it also goes further to nuance the nature of the mother’s engagement in a boy’s success. In doing so, the drug makers may be responding to the cultural critique of the successful boys/successful mothers equation, which sees mothers as fostering their sons’ success with stimulant drugs to meet their own needs. All this flip-flopping from one side of the cultural-historical trope to the other only underlines the reality that neither side of this trope is a safe or a liberating place for mothers to sit. But as long as the performance/pathology of mother is intimately linked to the performance/pathology of sons on a cultural level, this kind of advertising strategy will probably be effective.

This chapter raised a question about the phenomenon of ADHD and stimulant drug use: Why boys? One answer might be: Because mothers. This is put forward as a partial answer; it probably coexists with a number of others, including biogenetic and environmental factors that may be

peculiar to boys. Most important, it is not meant to be a judgment of mothers. It is meant rather as a (re)assertion of the mother in Ritalin—and the psychoanalytic penumbra in biological child psychiatry—which cannot be overlooked if we are to understand how it is that so many mothers today pursue and desire expert intervention in their young boys' behaviors. Advertising plays a reflexive role in our society; it shapes us but it is also shaped by us. Its power lies in its ability to anticipate us—to discover our weaknesses and desires and use these to construct its promises, create more desire, and sell us products. The problematic terrain of young boys' normality and behavior embodies interconnected clinical and maternal anxieties; if we want clinicians and mothers to become more critical of industry promotional representations of stimulant drugs—so that decisions to treat children with these drugs can be made with greater autonomy and reflexivity—we need to continue to illuminate this anxious underbelly.

NOTES

1. David Healy's interviews with Judith Rappoport, Rachel Klein, and Leon Eisenberg make up a small, fascinating body of historical material on clinical experimentation with stimulant drugs. The interview with Judith Rappoport is in Healy, D. (2000). *The Psychopharmacologists vol 3*. London: Arnold, pp. 333–356; the interview with Rachel Klein is in the same volume, pp. 309–332. The interview with Leon Eisenberg (May 1998) is unpublished, but available from David Healy.

2. Rose, N. (2004). Becoming neurochemical selves. In Nico Stehr, ed. *Biotechnology, Commerce and Civil Society*, pp. 89–128. New Brunswick, NJ: Transaction Publishers, 2004.

3. International Narcotics Control Board (INCB). Use of methylphenidate for the treatment of attention deficit disorder. In: Report of the International Narcotics Control Board for 1995. UN Doc. No. E/INCB/1995/1:II.B.4. [<http://www.incb.org/e/ar/1995/menu.htm>]

4. Larry Diller, author of *Running on Ritalin*, was more successful in getting Novartis executives to talk to him. Novartis has not released much information about the development of the drug or about the clinical trials process.

5. Shrag, P. & Divoky, D. (1975). *The myth of the hyperactive child*. New York: Pantheon.

6. Moser, R. (1974). The continuing search: FDA drug information survey. *JAMA*, 229(10) 1336–1338.

7. McCue, J., Hansen, C., Gal, P. (1986). Physicians' opinions of the accuracy, accessibility and frequency of use of ten sources of new drug information. *Southern Medical Journal*, 79(4) 441–443.

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9. Orłowski, J. & Wateska, L. (1992). The effects of pharmaceutical firm enticements on physician prescribing patterns: There's no such thing as a free lunch. *Chest*, 102, 270–273.

10. Goenuel, F., Carter, F., et al. (2001). Promotion of prescription drugs and its impact on physicians' choice behavior. *Journal of Marketing*, 65(3) 79–90.

11. Kravitz, R., Epstein, R., et al. (2005). Influence of patients' requests for direct-to-consumer advertised anti-depressants. *British Medical Journal*, 293(16), 1995–2002.

12. Caudill, T. S., Johnson, M., et al. (1996). Physicians, pharmaceutical sales representatives, and the cost of prescribing. *Archives of Family Medicine*, 5(4) 201–206.

13. Cormack, M. & Howells, E. (1992). Factors linked to the prescribing of benzodiazepines by general practice principals and trainees. *Journal of Family Practice*, 9(4) 466–471.

14. Bower, A. & Burkett, G. (1987). Family physicians and generic drugs: a study of recognition, information sources, prescribing attitudes and practices. *Journal of Family Practice*, 24(6) 612–616.

15. The advertisements in this chapter were discovered through a systematic investigation of *The American Journal of Psychiatry*, from 1955 to 1988. Two additional medical journals, *Psychiatric Annals* and *The American Journal of Pediatrics*, were surveyed nonsystematically in order to discover any major differences in stimulant drug advertising campaigns in these journals. Direct-to-Consumer ads were gathered from American magazines in a nonsystematic manner between 2000 and 2004. Additional historical resources consulted as part of the investigation into the history of ADHD and stimulant drug use have been described in Singh, I. (2002). Bad boys, good mothers and the 'miracle' of Ritalin. *Science in Context*, 15 (4), 577–603.

16. It has not been possible to include a visual of all advertisements discussed in this chapter. Detailed descriptions are given in place of a picture where necessary. Readers who wish to view all the ads discussed in this chapter should please contact the author.

17. Charles Bradley was the Director of the Emma Pendleton Bradley Home in Rhode Island, the nation's first psychiatric home for children. Readers interested in a more extensive discussion of Bradley and the context of the Home are referred to Singh, 2002.

18. Bradley, C. (1937). The behavior of children receiving Benzedrine. *American J. of Psychiatry*, 94, 577–585.

19. Bradley, C. & Bowen, M. (1940). Amphetamine (Benzedrine) therapy of children's behavior disorders. *American J. of Orthopsychiatry*, 11, 92–103.
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21. Lauffer, M. & Denhoff, E. (1957). Hyperkinetic behavior syndrome in children. *Journal of Pediatrics*, 50, 463–475.
22. Singh, 2002.
23. Hall, A.L. (2005). Welcome to ordinary? Marketing better boys. *American J. of Bioethics*, 5(3), 59–60.
24. Metzl, J. (2003). *Prozac on the couch*. Durham, NC: Duke UP.
25. Smith, M. (1991). *A social history of the minor tranquilizers*. Binghamton, NY: Haworth Press.
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28. Pollack, W. (1998). *Real boys: Rescuing our sons from the myths of boyhood*. New York: Random House.
29. Metzl, 2003.
30. Singh, 2002.
31. Romano, S. (1998). A glaring oversight: The use of stimulant medications in child psychiatry without controlled testing. Unpublished paper.
32. Metzl, 2003.
33. Lauffer & Denhoff, 1957.
34. Connors, K. & Eisenberg, L. (1963). The effects of methylphenidate on symptomatology and learning in disabled children. *American J. of Psychiatry*, 120, 458–464.
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36. Eisenberg, 1964. Work cited in this 1964 paper was supported in part by a grant from the National Institutes of Mental Health, suggesting official acknowledgment of the importance of psychotropic drugs in child psychiatry.
37. "Those Mean Little Kids," *Time*, 1968; "Too Many Drugs," *Time*, 1961; "Pep Pills for Students," *Newsweek*, 1970.
38. Moynihan, R. & Cassels, A. (2005). *Selling sickness: How the world's biggest pharmaceutical companies are turning us all into patients*. New York: Norton Books.
39. Watson, J. (1928). *Psychological care of infant and child*. New York: Norton.
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43. Department of Health, Education and Welfare. (1971). "Report on the conference on the use of stimulant drugs in the treatment of behaviorally disturbed young children." Office of Child Development and the Office of the Assistant Secretary for Health and Scientific Affairs (January).
44. Shrag & Divoky, 1975.
45. Connors, C. K. (ed.) (1974). *Clinical use of stimulant drugs in children: Proceedings of a symposium held at Key Biscayne, Florida, 5–8 March 1972 (International Congress Series)*. New York: Elsevier.
46. Wender, P. (1971). *Minimal brain dysfunction in children*. New York: Wiley-Interscience.
47. Connors, 1974.
48. Cylert was never widely used as a treatment for ADHD; it has been taken off the market.
49. Rose, 2004.
50. Smith, 1991.
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