

Doing their jobs: mothering with Ritalin in a culture of mother-blame

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Abstract

In debates over diagnoses of Attention Deficit/Hyperactivity Disorder (ADHD) and use of the drug Ritalin among the American school age population, discussion often centers around who is to blame for rising diagnoses and increasing use of Ritalin. Parents have come under particular scrutiny by critics who associate ADHD behaviors in children with poor parenting and view Ritalin as a “quick-fix” for socially situated problems. Biologically oriented researchers of ADHD, on the other hand have posited organically based dysfunction as the cause of ADHD behaviors. This paper explores the problem of blame in relation to ADHD diagnoses and Ritalin use from the perspective of mothers of boys with ADHD. Qualitative interviews with mothers suggest that medicalization of problematic behaviors in young boys includes an inherent narrative of blame transformation; this transformation can be expressed as a binarism: mother-blame–brain-blame. The first two sections of the paper document mothers’ experiences of blame for their sons’ symptomatic behaviors against the background of a cultural mothering ideology. The third section considers the promise of absolution from mother-blame inherent in the transformative binary structure. I argue that medicalization of boys’ problem behaviors supports and reconstitutes the potential for mother-blame and does little to pierce oppressive cultural mothering ideals. © 2004 Elsevier Ltd. All rights reserved.

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Introduction

In America, the debate over Attention Deficit/Hyperactivity Disorder (ADHD) and methylphenidate drug treatment continues, fuelled in part by a voracious media. ADHD is the most common child psychiatric disorder in America; core symptoms include hyperactivity, inattention and impulsiveness. Ritalin, a form of methylphenidate marketed by Novartis Pharmaceuticals, is the most common treatment for ADHD. While there is no scientific consensus on how methylphenidate acts on the brain to bring about behavioral changes, a major NIMH study recently found methylphenidate to be the most effective treatment for the symptoms of ADHD (MTA Cooperative Group, 1999).

Controversy over ADHD centers around two related concerns: The ambiguous nature of core symptoms—

hyperactivity, inattention and impulsiveness—and the ethics of methylphenidate use. Seven percent of American children between ages 6 and 11 have been diagnosed with ADHD; approximately 75% of these children are boys (CDC Report, 2002). Recent data suggests that approximately 3% of American children take methylphenidate for ADHD (Cooper, 2001). US methylphenidate consumption is at record levels, having increased more than 6-fold in the past decade (UNINCB, 1999). While ADHD diagnoses and methylphenidate use are growing around the world, this is still a peculiarly American phenomenon: In 1999, Americans used 85% of the world’s methylphenidate for medical purposes (down from 90% in 1995) (UNINCB, 1999).

Responses to the ADHD/Ritalin phenomenon often center around the question of blame: Who or what is to blame for rising ADHD diagnoses and Ritalin use? Answers are situated within a web of vigorously pointing fingers. Accusations have been made against cultural forces such as competition, masculinity, stress

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and speed (DeGrandpre, 1999; Pollack, 1998; Kindlon & Thompson, 1999); institutional forces such as schools, pharmaceutical companies, insurance structures, and the clinic (Breggin, 1998; Shrag & Divoky, 1975; Conrad & Schneider, 1992); and organic factors such as the brain and genes (Barkley, 1997). Perhaps the most commonly fingered factor in ADHD diagnoses and Ritalin use is parents. Because parents manage and mediate the exposure of children to genetic, social, medical and educational elements, parents occupy space in most positions within the web of blame. Parent-blame, therefore, is both specific and scattered, both highly visible and diffuse.

Prominent biologically oriented researchers of ADHD argue that the tendency to associate ADHD symptoms in children with poor parenting is not only unfair but also inaccurate. Parents are not the cause of problem behaviors, biologically rooted dysfunctions are; therefore parenting is unlikely to have much effect on the child's behavior (Barkley, 1997; Hallowell & Ratey, 1994). Such arguments for ADHD diagnosis and drug treatment transfer the theoretical causes of problematic behaviors out of the social realm and into the individual brain. In this way a brain-blame narrative has become a primary means of absolution for parents of children with ADHD-type behaviors.

Parents are not a new concern in the arena of child psychopathology, especially in connection with abnormal behaviors in boys. However, the category "parents" often serves as a euphemistic cover for accusations against mothers (Singh, 2002). Historically mother has been implicated in children's disorders as diverse as schizophrenia (the "schizophrenogenic mother"), autism, epilepsy and asthma. Many of these disorders contain a diagnostic bias towards boys. The scientific literature on parenting and ADHD also betrays an intense focus on mothers and sons. In the past three decades, parent-child interaction studies to investigate the significance of parenting behaviors in children's symptomatic behaviors have systematically excluded fathers and girls and have focused on the potential toxicity of mothering behaviors in relation to sons.¹ While mothers and sons have been carefully researched in the ADHD literature, parents and children have not.

¹ See, for example, Barkley (1988). "The effects of methylphenidate on the interactions of preschool ADHD children with their mothers. *Journal of the American Academy of Child and Adolescent Psychiatry*, 27(3), 336–341; Barkley, R., Karlsson, J., Pollard, S., & Murphy, J. (1985). Developmental changes in the mother-child interactions of hyperactive boys: Effects of two dose levels of Ritalin. *Journal of Child Psychology and Psychiatry*, 26(5), 705–715; Barkley, R., Karlsson, J., Strezelecki, E., & Murphy, J. (1984). Effects of age and Ritalin dosage on the mother-child interactions of hyperactive children. *Journal of Consulting and Clinical Psychology*, 52(5), 750–758.

Despite frequent confessions of this limitation at the end of scientific articles, there has been little effort to amend the research design.

As Rich (1976) and other feminist scholars have pointed out, research language and analysis can cover over the pointed concern with *mothers* in discourse around parenting. In the literature on ADHD, I would suggest, *mothers* have often been accused of poor *mothering* in relation to boys with ADHD. *Mothers* stand to benefit most from whatever absolution comes with a medical answer and solution to children's problem behaviors.

In this paper, I explore the covert binarism inherent in the promise of absolution through medical diagnosis of ADHD: Mother-blame-brain-blame. On a rhetorical level the binarism suggests a clean exchange, as though blame might slip silently across the binary divide leaving no lingering residue. On the experiential level, I will argue, blame is not so easily divided and contained by ADHD diagnosis and Ritalin treatment. Medical intervention does not necessarily mean that mothers do not feel real and potential blame for their sons' behaviors—even as they themselves espouse the brain-blame narrative. Indeed, as mothers attempt to translate a biomedical understanding of ADHD into their relational experiences with their sons, mother-blame is reconstituted rather than abolished.

Structurally, this paper reflects the narratives of mothers of boys with ADHD who talked to me about their experiences with diagnosis and Ritalin. Their narratives tended also towards binarism: Almost all mothers began the interview with stories of their experiences prior to diagnosis, and then shifted to post-diagnosis stories. Embedded in this binarism was a story of transformation of blame, from mother to brain. The first two sections of this paper, therefore, explore mothers' narratives of blame for their sons' behaviors prior to diagnosis, both blame that is self-directed and blame that comes from others. In the third section, I look more closely at the promise of mothers' absolution inherent in the transformative binary structure. Here I am especially interested in the implications of such absolution for the thick skin of an essentializing mother ideology. I consider the possibility that mothers' turn to Ritalin involves an act of self-preservation, and I discuss the politics of maternal self-preservation in a culture that valorizes maternal self-sacrifice.

Methodology and analysis

Participants: mothers and fathers

The methodological approach to this study was based in grounded theory (Strauss & Corbin, 1990). This approach requires the researcher to develop "theoretical

sensitivity” in the research area both prior to and during data collection and analysis (Glaser, 1978). Over the past decade, I have developed theoretical sensitivity through participation in numerous ADHD educational and scientific conferences, and in parent support groups (web and community based). I have closely followed popular, scientific and media reports about ADHD and Ritalin. In addition, I have observed and participated in clinical evaluations for ADHD in two settings, one in the US and one in the UK. In these years I have had formal and informal discussions with hundreds of parents, teachers, researchers and doctors about ADHD and Ritalin. I have also spoken to many children about ADHD and Ritalin.

Most of the mothers and fathers described in this paper took part in a series of interviews I performed in a pediatric neurodevelopmental clinic within a university hospital outside Boston. I was a researcher–observer at this clinic for several years during which I observed ADHD evaluations and participated to a small extent in treatment recommendation discussions with families post-evaluation. In this paper, I include only those interviews that took place with mothers and fathers of boys with ADHD. I interviewed 22 mothers and 12 fathers of boys in the clinic.

Initial hypotheses emerging out of the analysis of these interviews were further tested and developed through additional sampling and data analysis, in a process known as “theoretical sampling.” Such sampling provides density, diversity and scope to the data set (Strauss & Corbin, 1990). I interviewed an additional 17 mothers and 10 fathers of boys with ADHD in a variety of non-clinical arenas. Families discussed in this paper were White and largely lower middle and middle class. Boys’ ages ranged from 7–12 years old, and their average length of time on medication was 5 months.

Interviews

I interviewed participants for 2–3 h using an interview technique called “auto-driven interviewing” (Clark, 1998). This technique supports an attempt to address the power imbalance between researcher and participant by affording participants a measure of control over themes and ideas that emerge in discussion. The power imbalance is never completely equalized, however, especially when interviews take place in a clinical setting. The authority of the researcher is itself an important factor in how participants respond, and researchers will ultimately edit and interpret interviews in accordance with a research agenda (Riessman, 1993).

Participants were asked to choose pictures from a standardized set of popular weekly and monthly magazines in response to a key question. Magazines included *People*, *Self*, *Sports Illustrated*, *Woman’s Day* and *Newsweek*. While the set of magazines was

standardized, all pictures were chosen individually and spontaneously by participants. The key question was purposely broad in keeping with the effort to have meaningful themes and hypotheses arise from the data: *How do you think and feel about Ritalin (or other psychostimulant) treatment?* Participants chose up to 10 pictures in response to this question and wrote down thoughts associated with each picture. Interviews were organized around each picture, beginning with the participant’s explication of how the picture was relevant to the key question. Subsequent discussion of pictures focused on important themes in the individual interview and on deepening the understanding of hypotheses and concepts emerging in the data set. Every effort was made to avoid suggesting material to participants for discussion.

Analysis: mothers, blame and ideology

The voices in this paper represent individual women’s experiences; these are circumscribed by a number of factors including gender, ethnicity, class, psychological wellbeing and so forth. DiQuinzio (1999) notes that feminist accounts of mothering should resist the desire to generalize and focus instead on “specific instances of mothering in specific contexts” (1999, p. 28). In this article, I present the unique qualities of individual experience against an ideological backdrop that is part of participants’ shared cultural knowledge. This shared cultural knowledge means that individual experiences resonate within this particular group of participants, and they are likely to be resonant with the experiences of other individuals from similar social and cultural backgrounds.²

Feminist scholars have linked the phenomenon of mother-blame to a pervasive mothering ideology that contains essentialized and idealized notions of mother and mothering behaviors (O’Reilly, 2001; Chase & Rogers, 2001; Ladd-Taylor & Umansky, 1998). Quinn (1992) has argued that cultural ideas about gender and family roles have motivational force because they are expressed in explicit socializing messages that “depend upon cultural assumptions about what is moral and what is natural” (121). To this extent cultural ideas about mothers do not represent simply a possible interpretation of the social world, but a powerful socializing force that begins in childhood and continues throughout adulthood.

²I worked with a small community of coders to construct lists of codes, themes and concepts, and to discuss developing hypotheses and further sampling. This work involved iterative conversations and exploration of the data; I expect that any new constellation of coders would provide new insights into data interpretation and analysis.

Mothering ideology has been viewed as distinctly oppressive, and recent research has focused on reporting mothers' conflicts and ambivalences about mothering in an effort to present a more complex reality to mothering and to engage with the ready potential for cultural judgement of mothers (Nakano-Glenn, 1994). However, DiQuinzio (1999) notes that the feminist critique and analysis of mothering experiences must include an analysis of the extent to which these experiences "are determined by the very ideological formations that feminism means to challenge" (26). Because mothering ideology is often experienced at an unconscious level, where ideals and expectations are simply part of "commonsense" knowledge, such analysis has the potential to surface the relation between mothering ideology and dependent or contingent cultural practices.

In the following discussion, mothers' experiences of self-blame in reaction to their sons' problematic behaviors are located within a broader analysis of the particular socializing agents that reinforce oppressive and stereotypic notions of mothers and also of young boys. In the process, I hope to raise questions about the extent to which a culturally situated mothering ideology constrains the experiences of and options for mothering "problem" boys. One potential problem with my analysis is that it does, finally, reassert the importance of the relationship between mother and son in ADHD diagnoses and Ritalin treatment. I anticipate at the outset that this assertion will, paradoxically, resurrect the potential for mother-blame. My own aim is not to blame mothers but to explain something of their predicament. I will return to a discussion of the problematics of such explanation at the end of the paper.

Mothers' self-blame

In discussing their experiences of boys' problematic behaviors prior to diagnosis, mothers spontaneously talked about their feelings of self-blame and inadequacy. The two topics, boys' behaviors and mothers' inadequacy, were linked organically and seamlessly, such that it was difficult to penetrate the assumptions underlying the linkage itself. Although their sons had already received diagnoses of ADHD and were taking Ritalin, no mothers described their sons' behaviors in the medical language of "symptoms." Rather, mothers' descriptions emphasized the relationships and the relational contexts within which their sons' behaviors were interpreted.

To provide a context for mothers' feelings of inadequacy, it is helpful to know what kinds of problems mothers were experiencing in relation to their sons' symptomatic behaviors. The following categories are not

mutually exclusive in that concerns in one arena likely affected tensions and concerns in another. *Behavioral problems* included boys' ability to listen and follow directions, to organize themselves and their belongings, and to act with care and responsibility. *Family problems* included tensions in the relationships between mother and son, between father and son, and between father and mother. *Social problems* included boys' ability to play sports, to make friends, and to act appropriately in a variety of social settings. *School problems* included school failure, teachers' concerns, and homework.

The good mother

Mothers' talk about blame revolved around a pervasive visual and narrative metaphor: the good mother. Contained within this metaphor was its opposite: the inadequate mother. The good mother was an idealized portrait of mothers and mothering characterized by qualities such as understanding, protection, closeness, wisdom, selflessness and a lack of conflict. The inadequate mother was characterized by her lack of sufficient care, positive emotion, knowledge, insight and action. Figs. 1 and 2 are two images chosen by mothers to illustrate the good mother.

Themes that elaborated the good mother portrait demonstrate the extent to which the idealized image of mother contains within it the potential for accusation of blame for a boy's problem behavior. Three overlapping themes elaborated the good mother: responsibility, connection, and anger. Mothers' narratives illustrate each theme below. To protect participants' anonymity, all names have been changed, and individual narratives are composites.



Fig. 1. "A normal happy family".



Fig. 2. “The perfect afternoon”.

Responsibility

Martina Hubble, mother of Shaun, age 11:

When Shaun’s problems began to grow I was very depressed. I was very confused. I felt very alone. I felt guilty, because something was happening that I didn’t know how to control. I didn’t know what was going wrong. I felt I was contributing to the problem, you know? I wasn’t solving it. That’s what mothers are supposed to do... So what we have here is that the most important job that I could possibly have, being a mother, it just wasn’t happening.

“Responsibility” focused on mother’s ability to solve the problems her son was having. Mothers who could solve their sons’ problems were considered good mothers who were doing their jobs, while mothers who could not solve the problems were not only inadequate but possibly to blame for the problems in the first place.

Martina Hubble views mothering as “a job” at which she is failing. Her job responsibilities as described here center mainly around the ability to solve Shaun’s problems because “that’s what mothers are supposed to do.” She feels frustrated and guilty over her failure to find the proper solution. This failure is further associated with a feeling that her relationship with

Shaun is full of “confrontation” in which she is the “bad guy” always “screaming” at him. Martina believes that her behavior probably “hurt [Shaun]” even more—and this is another source of guilt. Martina’s feeling of responsibility, therefore, has two dimensions: She feels responsible for solving Shaun’s problems and she feels that her inadequate mothering may have been partly responsible for Shaun’s problems. While no mothers I spoke to felt they were responsible for causing all their sons’ problems, they did tend to feel that they were exacerbating problems when they should have been solving them and that their inadequate mothering created new behavioral and relational problems in their sons.

Connection

Paula, mother of Jack, age 8:

It was like being trapped on a runaway train. Like out of control. I didn’t know what was coming next and obviously something was wrong. But nothing I did could reach him; I just couldn’t reach him, you know? I’d ask him, “Why don’t you listen? Why are you acting so crazy?” But he’d just shake his head and not say anything. It made me nuts! I wanted to shake him and hug him and cry all at the same time. I was so frustrated, so upset and angry that I couldn’t do anything for him. I kept thinking that I should be able to do something, you know, something to pull him out of this.

“Connection” focused mainly on the relationship between mother and son. Good mothers had a close, connected relationship with their sons, characterized by positive emotions such as joy, serenity, understanding and support. The relationship between boys and their inadequate mothers was characterized by a lack of closeness and connection as well by as mothers’ negative emotions such as anger, rejection, depression, isolation and confinement.

Lack of connection was closely tied to feelings of self-blame and inadequacy in mothers, along with a sense of fear over what might happen to their sons if mothers failed to re-establish connection. Descriptions of the gulf between mother and son included strong images of boys who were “out of reach,” “lost,” and “inaccessible” to their mothers.

Paula’s narrative illustrates the fear mothers experience when they cannot connect with their sons. Jack’s withdrawal from Paula, combined with his “crazy” behavior elicits a feeling of desperation in Paula. Images of speed and a lack of control are juxtaposed with her efforts to grasp her son, to connect with him and “pull him out” of what Paula views as an extremely dangerous situation. In Paula’s narrative her inability to connect with Jack is potentially life-threatening: She and Jack

are “trapped” on a “runaway train” going “out of control.” Other mothers confirmed this sense that connection with their sons was a matter of life or death. Their boys were “slipping away,” “losing hold,” “drowning.”

Connection and maternal instinct

While mothers felt that their ability to connect with their sons was vital to the boys’ survival, the difficulties involved in gaining that hold were such that mothers often descended into despair or hopelessness. Carla explains:

It was like a riptide coming to pull him under. You can’t let down your guard...I had to hold on to Jackson so that he wouldn’t go under. And no matter what you did, he was going down.

Carla keeps holding on to Jackson despite knowing that whatever she did, “he was going down.” The implication is that she will go down with him rather than abandon him to the waters. Other mothers also spoke of their willingness to give their lives in the effort to save their sons. Tina tells me:

What would you do if your son was drowning? I’ll tell you what you’d do. You’d jump in and swim up to him, you’d drag him up from the bottom of the sea. You’d sell your soul to get that boy back on shore safe and sound.

Tina dramatically illustrates the extent to which the good mother ideology supports a particular notion of what is often called maternal instinct: the willingness to give one’s own life for that of a child. As *Hrды (1999)* has shown, maternal instinct is an essentialized western ideal, part of a modern landscape of childrearing practices and mothering ideology. So pervasive and entrenched is the assumption of maternal instinct that Tina tells me not what *she* would do if her son were drowning, but what *I* would do. Tina “knows” that my maternal instinct is the same as hers, the same as all women’s, and she knows, therefore, that her dramatic vignette will resonate with me; I understand her fear, her desperation and her courage. Similarly, Paula situates maternal instinct alongside maternal responsibility and connection. As she describes her inability to “reach” Jack she says, “I *should* be able to do something, *you know*, to pull him out of this” [my emphases]. Paula sees herself as responsible for saving her son; it is her duty as a mother. She too punctuates this image of responsibility with the phrase, to me, *you know*. She suggests that what she is expressing is obvious to me, part of our shared natural situation as women.

When maternal sacrifice and care are conflated as part of an essentializing mother ideology, mothers’ failures to connect with their sons are viewed as part of a deep and

dangerous maternal inadequacy that could threaten the life of the child. From this perspective, mothers’ desperation to save their sons must be understood as part of an effort to preserve part of their deepest identity as women and mothers.

Anger

Sue tells me:

The smallest thing would make me upset and either drive me to the point of tears or make me start screaming uncontrollably. I’d shut the door to my room and go bang on something. Not a pretty sight.

Mothers’ desperate desires to connect with their sons were at odds with the anger they experienced in their relationships with these sons. But anger did figure centrally in many mothers’ experiences of disconnection with their sons. All mothers linked anger directly to the image of an inadequate mother who could not control her sons’ behaviors or her own. This inadequate mother’s anger made her irrational and ugly. When out of control, mothers mutated into different forms; alien, ugly and sick forms. Their narratives about anger were filled with self-loathing, often self-pathologizing descriptions: *a bitch, a shrew, a psycho, a schizophrenic, a monster*. *Figs. 3 and 4* are images chosen by mothers to depict these unleashed monsters.

Mothers’ anger made them feel deeply ashamed, and deeply guilty, for anger is a neon sign of a bad mother, as well as of a bad woman (*Miller, 1991*). But mothers’ anger was also a form of expression of their desperation and their isolation. The mothers depicted here screamed “uncontrollably” and cried because they were unable to reach their sons and found the burden of that responsibility almost unbearable. They were isolated:



Fig. 3. “I’m so ugly and angry”.



Fig. 4. “Schizo-woman”.

Sue isolates herself in her room to “bang” on something; Paula feels “trapped,” and Martina feels “very alone.” Within the close, intensely negative confines of this mother–son relationship some mothers began to feel that they hated their sons. As Anne tells me:

I really was starting to dread spending time with him because it was so difficult. It was so hard... Whenever he was getting in trouble he'd say, “You hate me.” [Long Pause] (IS: And did you ever think in that moment, yeah, right now I do hate you?) Yeah, oh yeah. It's very hard but it's a reality.

Anne had likely left her son's accusation dangling because she could not bring herself to admit that he was right. In the end I said it for her, in my words; she agreed but did not elaborate or name her hatred. Anne immediately went on to talk about something else. Hatred of one's child goes against every ideal of the good mother. It was confusing to mothers to know simultaneously the life-giving instinct inherent in the good mother ideology and their own hatred of their sons. Telling me about her feelings of hatred for her son, one mother named the conflict succinctly. She said, *How can you feel that way about someone you gave birth to?*

Maternal fitness

Mothers' intense emotional reactions to boys' behaviors can seem out of proportion when compared with clinical descriptors of ADHD behaviors: i.e., “can't sit still,” “answers out of turn,” “poor organizational skills.” But clinical description tends to isolate the

problematic behaviors of individuals. Mothers experience these behaviors through their relationships with their sons. In this relational context mothers are filled with anxiety, desperation and terror because mothers feel they are personally responsible for these boys—for their very survival. And they see no way to perform their mothering duty and solve the problem.

A more critical interpretation of these mothers' responses to their sons' behaviors might question mothers' maternal “fitness,” by which I mean mothers' psychological, behavioral, and/or emotional wellbeing. In clinical settings, evaluations for ADHD routinely assess mothers' psychological and emotional profiles, and these factors are taken into account when assessing probable causes of boys' behaviors.³ However tempting it may be to support these women's views of themselves as less than fit mothers, mothers' anxieties should not be taken simply as evidence of personal or natural neuroses. Such interpretation would obscure the importance of the depths of maternal anxiety itself and would miss the opportunity to ask questions about its broader origins. As I discuss in the next section, mothers' anxious reactions grow in part out of a constellation of social and cultural factors that support the good mother ideology and reinforce mothers' feelings of self-blame and guilt. Such factors further isolate mothers with the burden to “solve the problem” of their sons.

Blame from others

Mothers of boys with ADHD symptoms reported particularly strong reinforcement for their feelings of inadequacy and personal responsibility for their sons' behaviors in certain social and relational interactions. Here I focus on two major sources of reinforcement mentioned by mothers: fathers' attitudes and community settings.

Fathers' attitudes

Fathers I spoke to often had distinctly different understandings of their sons' “symptomatic” behaviors. I put the adjective “symptomatic” in quotation marks to reflect the feelings of some fathers that their sons' behaviors did not warrant medical intervention. Such

³ Research has shown that mothers of boys with diagnosed behavioral disorders such as ADHD and Conduct Disorders have higher rates of stress and depression than mothers of boys without diagnosed disorders (Anastopoulos, Guevremont, Shelton, & DuPaul, 1992; Brown & Pancini, 1989). Fathers of boys with these disorders do not show higher rates of stress and depression. To my knowledge none of these studies has been able to show a causal link between maternal stress and depression and boys' problematic behaviors.

feelings seem to have played a role in the absence of fathers in clinic evaluations of their sons. Several women reported that they had purposely excluded their husbands from the initial consultation at the clinic, fearing a strong negative reaction to the evaluation procedure. Less than one-third of fathers I interviewed had participated in their sons' initial clinic evaluations. Fathers were not only physically absent; in my review of approximately 70 files of clinic cases for possible inclusion in a study, I could ascertain the contribution of only one father to materials sent to the family prior to evaluation. These materials included child behavior checklists and a developmental history of the child. Beyond the clinical setting where these particular interviews took place, fathers were largely absent in actual and virtual support groups for parents of children with ADHD and in educational conferences for parents of children with ADHD in which I participated (Singh, 2003).

A majority of women I interviewed felt that their husbands did not share their concerns over their sons' behaviors. Several mothers said their husbands thought they were inventing problems. As Regina describes, fathers' doubts had implications for mothers' feelings of inadequacy:

He [husband] would tell me that I was crazy to keep thinking there was something wrong. He'd say, "There's nothing wrong!" It really dulled my motherly instincts to have him doubt me that way. I began thinking I really was crazy.

Other husbands hinted that their wives might be encouraging behavioral problems in their sons through overly indulgent mothering. Mary describes her husband's reaction to her concerns:

He [husband] said to me, not in a mean way or anything, that maybe things would get better if I wasn't so soft on [son]. Maybe I was babying him too much and needed to let him grow up some.

Still other husbands left their wives alone to tackle whatever problems their sons were having, thereby reinforcing mothers' sense of failed duty when they could not solve the problem of their sons' behaviors. Mindy describes a scene between her and her husband following their son's tantrum:

Jason [son] had finally calmed down and we sent him out with his sister to play in the yard. And Jim [husband] turns to me and says, "So, what are you going to do about this?" And I thought, oh God, what am I going to do? And only later did I think, hey, he's not just *my* son. But really, it *was* my problem as his mother. [Emphasis in narrative]

Such attitudes among fathers inevitably contributed to mothers' feelings of personal responsibility and self-blame prior to their sons' diagnosis. In these reports of fathers' attitudes there is further reinforcement for mothers' sense of isolation and failure, as well as the tendency to associate problem behaviors in boys with bad mothering. There is also support for the association between maternal inadequacy and maternal pathology. Regina's husband thinks she is "crazy" to see something wrong with their son. His suggestion that Regina is seeing something that does not exist causes Regina to feel she really is crazy. Regina knows something is wrong; she names this knowing "motherly instinct." In this particular struggle between the vision of mother and the vision of father, motherly instinct is at stake. An essentializing image of mother comes complete with the equation of maternal instinct and maternal fitness. Crazyness is both the feeling and the sign of maternal instinct gone awry.

Fathers' absences from evaluations and their doubts about diagnosis suggest that they do not have the same stake in diagnosis. Some fathers even considered the possibility that their sons were not the primary beneficiaries of diagnosis and treatment. Occasionally a father would ask me directly about this, as did one father, casually, while putting on his coat after the interview: *Do the people here, do you, you know is it possible that you would give a kid Ritalin for the mother's sake?*

Community settings

Community settings were a more subtle mechanism for reinforcing mothers' feelings of inadequacy and self-blame for their sons' symptomatic behaviors. In local, every day encounters on the street and in restaurants, church, shopping malls, movie theatres, and supermarkets, mothers reported experiencing reproach and judgment from onlookers witnessing their sons' behavior. As Shirley reports:

I've always been very sensitive to criticism, and I don't know...I would have people in the supermarket, on the street, everywhere, look down on him or say well, you know, you can't keep him in control.

Mothers like Shirley experienced public judgment as a direct criticism of her mothering. Sometimes such experiences led mothers to avoid certain public places, to the extent possible, with their sons. Anna explains why she avoided church with her son:

I'd be in church with him and he just wouldn't sit still; he'd be fidgeting and I couldn't get him to stop at all, and people would just be turning around and looking at me like why couldn't I do something about him. My husband is sitting right there too, but they're looking at me.

Experiences such as Anna's help us understand why mothers might be particularly "emotional" or "sensitive" when it comes to their sons' behaviors, as fathers often suggested to me in their interviews. Anna is the one who feels judged in daily community encounters for her son's behavior, and her husband's presence does not change her experience.

Mothers often commented to me that the judgment or criticism they encountered in public venues emanated from other women and mothers. The notion that other mothers would help to produce a culture of mother-blame exemplifies Foucault's (1975) theoretical construction of community surveillance systems in which every individual is both a subject exercising the disciplinary gaze, and an object of the gaze. Uncertainty as to whether one is subject or object leads the subject to internalize the disciplinary gaze and to continually reproduce a disciplinary power that has no external material center. To this extent it does not matter whether mothers are actually experiencing this judgement or "imagining" it. The point is that even their imagination reflects the internalization of this disciplinary power.

There is a two-fold irony in the public surveillance of mothers by mothers and other women. When women and mothers judge and evaluate other women and mothers by the behavior of their sons, they are further embedding a culture of mother-blame by which they too are judged. And as mothers of boys with ADHD experience the burden of mother-blame in these public venues, their internalized gaze becomes stronger and more severe, so that they come to manage self-disciplining and self-blaming very well on their own.

I would like to be clear that I am not laying blame for the experiences mothers undergo when their sons are deemed to be "a problem" in fathers' attitudes or in community attitudes. Instead, I am trying to illustrate a pattern of beliefs and assumptions embedded in socially situated interactions that contribute to mothers' feelings of inadequacy and personal responsibility for their sons' problems. Many mothers agree to a mothering role that ultimately places them in the vortex of these swirling pressures. The role is satisfying and sustaining for many women who choose it. However, when a boy exhibits problematic behaviors in a culture of mother-blame, mothers experience a disproportionate burden. At this point mother's responsibility for her son can feel less like a choice that grows out of love and more like a duty borne of guilty association. As mothers feel less and less relationally connected to their sons, they are, paradoxically, bound to them ever more intimately, by duty, guilt and blame.

Mothers' absolution?

Absolution from guilt and blame for children's problem behaviors is one of the promises of ADHD

diagnosis and the explanatory medical narrative that comes with it. As Russell Barkley (1997, p. 319), one of the world's foremost researchers of ADHD maintains: "Knowing the [biological and genetic contribution to self-control], we realize that it is absurd to make moral judgments about the worth or character of parents [sic]...". It is tempting indeed to think that medical diagnosis can sweep a culture of mother-blame into "absurdity"; and it is tempting to believe that researchers like Barkley sympathize with mothers' burden of moral judgement. But it would also be naive to think that the medical-scientific enterprise around ADHD and Ritalin, which involves not only research, but also a range of commodities including educational videos, conferences and books, does not depend in part on mothers' low feelings of self-worth and maternal adequacy.

In a preliminary and general way, however, it is important to say that post-diagnosis of ADHD mothers in this study did report feeling relieved of a burden of guilt and blame for causing their sons' problematic behavior. Most mothers I spoke to said that they had become less anxious and felt happier once their sons were taking Ritalin. Mothers reported that their relationships with their sons and with their husbands improved, and they felt more freedom and flexibility in pursuing social and recreational activities in the community with their sons. Once boys were started on Ritalin, school relations tended to improve, with academic progress by the boy and often more understanding and tolerance from the teacher. Whether or not they believed there was anything medically wrong with their sons, most fathers said that once their sons were on Ritalin, their wives became less anxious and family life was more pleasant.

Ritalin wielded enormous power in the construction of an alternative understanding of boys' behaviors. Freed from the burden of responsibility for causing their sons' behaviors, mothers felt they were finally empowered to "do something," and Ritalin was an important aspect of this doing. Medication became part of the daily ritual at home and at school, necessitating discussion, monitoring and repeated dosing. Mothers became advocates for their sons, educating others about their medical needs and treatment procedures. In this process Ritalin served as a material authority, proving the legitimacy of the biological causation narrative through its work in settling a boy's body and focusing his mind.⁴

⁴Rapoport et al. (1978) have shown that Ritalin improves behavior and performance in "normal" children as well as in non-ADHD children. Contemporary ethical standards do not allow replication of such studies, but it is generally accepted that Ritalin has a positive effect on behavior and performance in the "normal" population of children and adults (Diller, 1998).

Blaming the brain

Mothers' talk post-diagnosis about their sons' problems and their causes often centered around the *lack* of assignable blame, and the importance of separating the boy from "the problem." As one mother told me, *It's not his problem, it's his brain's problem*; and another said, echoing a phrase clinicians use to explain ADHD, *"It's his behavior that's the problem, not him."* I call this understanding of causes for boys' behaviors the "no-fault" model of behavior. This model suggests that no one is to blame for disorder; therefore, no one can be held responsible for behaviors that grow out of disorder. Organic causes are not morally accountable. But which behaviors are linked to disorder, and for which behaviors should boys be held responsible? With a diagnosis whose symptoms are as ambiguous as ADHD, an increasing number of problematic behaviors can be ascribed to the disorder and are therefore apparently not the personal responsibility of anyone.

The separation of person and disorder generally, and boy and brain specifically, is part of a no-fault model of behavior that is not only a rhetorical means of legitimizing diagnosis but also functions as a framework for revising behavior. Education into this framework has practical implications for mothers in that they have to make sense of the no-fault model in the context of their interactions with their sons. Mothers must continually monitor their sons' behaviors and decide which problematic behaviors fall into the category "fault" and which fall into the category "no-fault," as it were. Then they must modulate their own reactions to their sons' behaviors in line with this categorization. There is little consistent or clear clinical indication regarding the extent to which Ritalin treatment confers control over particular behaviors. Some mothers felt that Ritalin treatment encouraged them to ask more of their sons in the way of responsibility over behaviors; however, when their sons responded poorly to these demands, mothers felt they had asked too much and had been given a false impression of "normalcy" by the drug's action. In this way, ADHD diagnosis and Ritalin treatment encourage mothers to reconfigure their mothering in line with a biological narrative of behavioral causation and to judge maternal fitness against their ability to embed this narrative in their mothering behaviors.

In interviews, mothers particularly emphasized their efforts to apply the no-fault model of behavior in their one-on-one interactions with their sons. Below I present one mother's application of the no-fault model of behavior during such an interaction. I hope this brief illustration will suggest some of the ways in which the no-fault model maintains a subtle moral index through

which mothering behaviors are carefully monitored and prescribed.

Delores tells me:

Just knowing that Gregory has a medical problem that causes him to act this way really helps...[N]ow I know what is happening to him when he gets to be a problem, and now I know what to do, how to deal with him...So now when he's on the medication it's kind of nice to be able to really talk to him and he loves to play checkers, so he will sit and play and be really into it. I used to feel really bad when things didn't go well when we were together. Sort of disappointed. I really try to be calmer with him, to speak calmly even when he's driving me crazy. If I yell I feel bad. I feel guilt...I feel like he felt bad because I yelled at him, that his mother doesn't care or doesn't know that he has a problem. (IS: What would the consequences be, for Gregory, if he thought you didn't care or didn't know he had a problem?) Well, I guess if it happened all the time he just wouldn't have any self esteem, no confidence, and he'd probably get worse. I need to be there for him, to help him deal with this.

In Delores' narrative it becomes clear that there is ready slippage between causation and prevention in relation to mother's role in her son's behaviors. The no-fault model of behavior shifts emphasis from mother's role in causing behavioral problems to mother's role in preventing further behavioral and psychological problems. In order to prevent Gregory's problems from getting worse, Delores must be vigilant about her mothering behaviors. Ironically, the no-fault medical narrative focuses Delores not on her son but on his problem. A constant and pervasive awareness of Gregory's problem is the standard for a caring mother, as Delores sees it. To lose sight of Gregory's problem during their game is to be uncaring. Delores is scarcely able to talk about what would happen if Gregory felt she was being unsupportive. When I ask her directly about the potential implications of mothering that do not follow the no-fault model, Delores begins to talk about the implications for Gregory's self-esteem and his improvement, but quickly shifts to affirm her support for him and his "problem."

Thus Delores still judges herself by a standard that associates (what she views as) inadequate mothering with inadequate love, and an inability to recognize and solve a child's problems. The emphasis on her role in prevention of further behavioral problems moves her to work harder to be a good, caring mother. The ideology of the good mother is not pierced by ADHD diagnosis and Ritalin treatment; indeed, in Delores' case it has combined with the medical no-fault narrative to structure her mothering. However, Delores is now more

able to achieve status within this ideological framework. Her mothering work in the midst of this game with Gregory, along with her advocacy for him at school, with his father, and with his peers, all represent her as a caring mother who acknowledges her son's problems and works to solve them. Moreover, her mothering is now backed by the authority of medical science. The desire to be a good mother fuels Delores' efforts to follow the recommendations of medical science, and to view her son on its terms.

Delores' narrative suggests a central conundrum inherent in ADHD diagnosis and drug treatment: Diagnosis and medication may help mothers, sons and families feel and function better, while simultaneously reinforcing biased and psychologically damaging assumptions about "good mothers." Mothers may be relieved of guilt and blame for causing boys' behaviors post-diagnosis, but they are not relieved of judgement and the oppressive weight of responsibility that is part of the good mother ideology. Indeed, one could speculate that this ideology prefigures the rampant pursuit of ADHD diagnoses and Ritalin treatment in American culture, and that the success of this ambiguous diagnostic category is in part contingent on the maintenance of the good mother ideology. When mothers have inadequate support systems and enormous pressure to solve the problem of their sons, the promise of absolution and cure through medical science may be especially difficult to ignore.

An instinct for self-preservation

I have been trying to show how ADHD symptoms, diagnosis and Ritalin work engage elements a good mother ideology, particularly maternal instinct and maternal fitness. Maternal instinct and fitness are of course intimately related. For mothers who experience their sons' behaviors as pathological and dangerous, ADHD diagnosis shores up maternal instinct, proves maternal sanity and thereby reaffirms the potential of the good mother. Ritalin treatment provides material evidence to support a brain-blame narrative that is ostensibly opposed to a mother-blame narrative. However, the mother-blame–brain-blame binarism is further undermined by a fresh accusation leveled at mothers post-diagnosis and treatment of their sons. This accusation has to do with irresponsible uses of Ritalin. Against Delores, the accusation might focus on the notion that she appears to benefit personally from Ritalin treatment; as Delores herself says, the times she spends with Gregory are easier and more pleasurable when he is on the drug. Who benefits more from Ritalin treatment, the child or the mother?

While escalating diagnoses of ADHD and Ritalin use may mean that this a valid question (not just about

mothers but also about other adults in a child's life such as teachers), it is also important to note that this accusation launches another cycle of mother-blame, couched again in the moralizing ethos of the good mother ideology. Small wonder that so many mothers I spoke to talked about their maternal instincts in relation to their sons' symptomatic behaviors. They understood on some level, I think, that maternal instinct is at stake in ADHD diagnosis and especially in Ritalin use. When mothers are accused of using Ritalin as a quick-fix to make their own lives easier, they stand accused of violating a cherished ideal of the sacrificing mother: Good mothers sacrifice themselves for their sons, not the other way around.

This dialectic of maternal sacrifice and maternal preservation is an essential factor in the controversy over ADHD and Ritalin. The controversy rages over where the "self" inserts itself. Mothers' self-sacrifice is praiseworthy. Mothers' self-preservation is not. But mothers' and sons' successes may be intimately bound up with each other such that sacrifices that foster boys' successes can result in maternal status and self-preservation. Mothers told me again and again: Your child's success is a reflection of you as a mother. Mothers' instincts to grasp hold of these "drowning" boys and bring them safely to Ritalin's shores is simultaneously self-sacrificing and self-preserving. With Ritalin these boys are, to use the clinician's phrase, "allowed to be successful." And a successful boy means a successful mother.

Recently, a wave of publications on young boys' psychology has challenged a "culture of masculinity" that promotes oppressive ideals of manhood such as independence, emotional stoicism and competitive success. Pollack (1998) has argued that such ideals can foster feelings of isolation and shame in boys who cannot achieve them. Depressed boys are thought to externalize their distress, and so symptoms of depression can look a lot like symptoms of ADHD. Medicating these symptoms covers over their roots in harmful cultural practices and ideals. Pollack (1998, p. 225) writes, "When boys act out...they are looking for empathy and understanding rather than diagnoses and medication."

But if there is something unsavory in this use of psychotropic drugs to promote success and achievement in young boys, it is not mother. Mothering qualifications are framed within a patriarchal discourse which offers medicalization as a tool to enhance the success of both mother and son. The sacrifice of sons, if this is what Ritalin use is about, is a problem of patriarchy, not a problem with mothers. Mothers who turn to Ritalin are being good mothers within a prescriptive cultural formulation of mothering. They are not trying to escape their duties. They are doing their jobs.

Conclusion

There is nothing new about a woman's turn to medicine and a pill to help her improve herself. Similarly, there is nothing very new about a mother's efforts to improve her children, nor is mother's turn to science for help in child behavior management new. What is new is that American mothers now increasingly turn to a pill to improve their sons' behavior and performance. In that process they adopt a brain-blame narrative of their sons' behaviors that ostensibly absolves them of personal blame for these behaviors. Mothers' personal interests in the improved behavior of sons are obscured—and replaced—with a narrative of behavior in which the brain is the main and isolated actor.

I hope this analysis has recovered an important aspect of ADHD diagnosis and Ritalin treatment that has been obscured by the increasing hegemony of the brain-blame narrative: Diagnosis and drug treatment present an opportunity to improve both sons and mothers. The desire for improvement of oneself or one's children is not inherently problematic; indeed, it is often laudable. The problem is that a pill promotes medicalization and an obscuring of the cultural components of both "behavioral disorder" and "good mothering." And so it becomes increasingly difficult to analyze and understand the role of culture in constructing the need for the biotechnological tools we use to improve ourselves and our children.

I believe that Ritalin is an indicator of things to come, as biotechnology delivers more and more tools engineered to help us deal with the problems of everyday living. Such problems often include the struggle to achieve prescriptive cultural ideals of behavior, appearance and performance. As new pills emerge, promising to improve quirks of personality such as shyness, or cognitive areas such as concentration and memory, important ethical questions also emerge about the cultural conditions that support the development and use of such drugs, most especially in children. Mothers are of course not the only, or even the most important, source of support for the use of new biomedical technologies in the life of a developing child. But as Bordo (1998) has argued, women are especially vulnerable to technologies that promise to enhance women's appearance, behavior and performance in line with cultural and social norms. At the moment, the most prominent of these technologies include cosmetic surgery, Prozac—and, as I have tried to show here, Ritalin.

The success of ADHD diagnosis and Ritalin is built on the back of an oppressive cultural ideology of the good mother. Ultimately, I think ADHD diagnosis and Ritalin affirm cultural stereotypes of good mothers and successful boys and give mothers a better chance of

achieving the ideals inherent in those stereotypes. The trick of the binarism mother-blame–brain-blame is that the brain-blame narrative contains, supports and reconstitutes opportunities for mother-blame. Unfortunately for mothers, the binarism is, finally, false, and promises of absolution are simply seductive rhetoric.

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