Johnny was a difficult child, always screaming, running, and rough-housing, much to his parents’ dismay. He could not sit still to watch a single television show or focus on playing with his action figures for more than a few minutes at a time before he was up and about again, being disruptive and, on rare occasions, destroying his toys and other items around the house. When his mother told him to hold her hand while walking across a busy street or to stay close to her cart at the grocery store, Johnny disobeyed. His mother would think to herself, “I guess he’s just a runaround, rowdy kid.” But as he grew into an adolescent, Johnny increasingly found himself in “time outs” or scolded by his parents and teachers. He felt terrible about being a disappointment, and despite his efforts to be good, he continued to misbehave. Eventually the doctors became involved, and Johnny was diagnosed with attention deficit hyperactivity disorder (ADHD). The doctors assured Johnny and his parents that ADHD was not a rare condition: 11% of school aged children—roughly 5 million American children—are diagnosed with ADHD, and about two-thirds receive psychoactive medical treatments such as Ritalin and Adderall stimulants, which alter a child’s brain chemistry in such a way that he becomes more docile and focused (Schwartz 1). This number seems so alarmingly high that many people have begun to question what drives this prevalence of ADHD in our culture. Are there just more Johnnys out there today, or could this incredible rise in diagnoses be the result of something more troubling?

Recently, numerous documentaries and talk shows have raised public awareness of the disorder, and now that ADHD has become more familiar, some might not be alarmed about the high percentage of children diagnosed with ADHD. What, really, is the worst that could happen if a lot of children are “hyperactive”? The title seems harmless, but a medical diagnosis of ADHD becomes a lifelong label. Most children with ADHD continue to take Ritalin or Adderall into adulthood, creating a huge dilemma: if the child were
to stop showing hyperactive symptoms, would doctors be able to know decisively whether the drugs had cured him or if he had simply aged out of his hyperactivity? Our current solutions to ADHD seem quite straightforward: if you have symptoms A, B, and C, take pill X to get better. It is a tangible, logical solution—one that is simple and reasonable considering our limited resources. However, these pills, although shown to make dramatic differences in children’s behavior, are not entirely safe and come with a multitude of known side-effects and many unanswered questions. What are the long term effects on a child’s developing brain? Could we be altering children’s personalities just to make them more manageable?

According to psychiatrist Sami Timimi’s thoughtful but adamant argument in “ADHD is Best Understood as a Social Construct,” the rapid increase in ADHD diagnoses can be partly attributed to the current state of the medical field, with its unreliable “profit-dependent pharmaceutical industry” (8). Marcia Angell digs deeper into the pharmaceutical industry’s ties to mental health care in her essay “The Epidemic of Mental Illness, Why?” Angell assesses arguments offered by three critics—ranging from concerned to outraged—of the pharmaceutical industry, and she sides with their critiques. There is immense bias in the accessible research on mental disorder treatments because “drug companies make very sure that their positive studies are published in medical journals and doctors know about them, while the negative ones often languish unseen within the FDA” (Angell). As a result of flawed studies and misleading or incomplete medical literature, there are many ineffective and possibly dangerous antipsychotic drugs on the market today, some of which have been shown to create long-lasting differences in brain function—such as a compromise of neuronal pathways and shrinkage in the cerebral cortex. With this kind of evidence available, you would think that the rate of medical ADHD interventions would decrease in an effort to protect our children.

With such high stakes, we need a deeper, more sustained investigation of mental disorders and the way we treat them. Timimi advocates for a “cultural perspective” to “explain the recent rise, to epidemic proportions, of rates of diagnosis of ADHD” (8). He theorizes that rather than being an objective mental illness, ADHD is a social construct—a permanent label that we put on individuals who do not meet the societal standards of how a “normal” person thinks and behaves. We give the ADHD label to a “runaround kid” like Johnny, who becomes restless and reckless after sitting in class all day. But what causes Johnny to behave this way in the first place? We all agree that a child’s mental health can be negatively affected by a “loss of extended family
support,” “pressure on schools, a breakdown in the moral authority of adults,” and many more situational aspects of a child’s life, but we do not usually recognize these social problems as legitimate triggers of psychiatric disorders (8). Instead, we use the specific criteria printed in the current United States version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) to establish who does or does not get labeled with ADHD. Also, the DSM’s wording is actually quite different from the guidelines printed in the world-wide manual of disorders, the International Classification of Diseases (ICD). This discrepancy shows that different cultures have different expectations of behavior; so do the doctors—human beings with their own definitions and opinions on how a “normal” child behaves. With all of these varying, circumstantial factors, we are forced to evaluate the validity of an “objective” ADHD diagnosis, or any mental disorder diagnosis for that matter.

This is not to say that ADHD and other psychological disorders are not “real,” or that the suffering of those who are diagnosed is not legitimate. ADHD is complex; the social construct theory may explain one child’s diagnosis, while another’s can be attributed to other factors. We cannot discount the unlimited number of variables in ADHD diagnosis, and we cannot view the increase in ADHD only through the lens of biology. Mental illnesses “cannot be understood without understanding the ideas, habits and predispositions—the idiosyncratic cultural trappings—of the mind that is its host” (Watters). We must not underestimate how much power the human mind has over the human body, or how much culture and personal experiences affect our conception of what is normal and healthy. Johnny’s mental health is affected by the town he grew up in, the parents who raised him, the teachers who taught him, the siblings and peers who played with him, the television shows he watched—the list of factors is nearly infinite.

The mental lens through which we view our world is not fixed: the mind has an immense capacity to alter, complicate, and transform our understanding of the world. It is malleable and ever-changing because we are ever-changing. We are masters of adapting to our social environments, and these changes often happen unconsciously. The subconscious is so strong, has so much of a hold on our physical selves, that it may lead us into delusion and can even begin epidemics. Susan Dominus in her essay “What Happened to the Girls in Le Roy?” employs the term “mass psychogenic illness” to describe the mental phenomenon found in eighteen schoolgirls from Le Roy, New York (293, 291). The outbreak started with Katie Krautwurst, a high school cheerleader and straight-A student who woke up from a nap to discover her chin had begun to twitch uncontrollably. A few weeks later, her best
friend and fellow cheerleader Thera Sanchez began to flail her arms and hit herself so violently that she constantly had bruises all over her body. In the span of a few months, the tics started to spread throughout the high school social hierarchy, from the popular cheerleaders to the lower-status girls. A neurologist located in Buffalo proposed the diagnosis of “conversion disorder,” suggesting that the girls were “subconsciously converting stress into physical symptoms” and spreading these symptoms to their fellow peers (293). This was extremely unsettling to the concerned parents and community of Le Roy; they could not grasp how this invisible, mental process was causing their girls to be so visibly, physically sick: “How could one person’s illness be reflected in another person’s neural pathways, playing a trick on consciousness, convincing the host that it originated in her own body?” (298). Dominus establishes the role of physiological processes in one of the most important capacities that humans have: “empathy” (298). Through a process called the “chameleon effect,” we recognize the emotions and actions of others through the use of “mirror neurons,” which fire both when we observe and when we imitate an action performed by another human (298). Our minds use mirror neurons so effectively that in some cases the behavior of others can unconsciously manifest itself in our own physical functions, as demonstrated by the Le Roy girls’ mental distress and their resulting physical symptoms.

Even when we are presented with evidence, we are still very skeptical of the relationship between our peers and our physiology. As Derek Summerfield observes, the medical literature hardly ever mentions how “Western mental-health discourse” involves “a theory of human nature, a definition of personhood, a sense of time and memory and a source of moral authority”—none of which is “universal” (qtd. in Watters). Whether it is a conscious or unconscious decision, each individual uses his cultural beliefs and expectations to make sense of his situation and to respond with certain behaviors. In his essay “Drinking Games,” Malcolm Gladwell explores different cultural perceptions of alcohol and how they affect people’s physical behaviors. He contrasts the drinking patterns of the Bolivian Camba and the Italians of New Haven with those of the American population at large, stating that the effects of drunkenness, such as aggression and self-inflation, differ from culture to culture. Although the Camba people of Bolivia drink laboratory alcohol every night, there is, according to Dwight Heath, “no social pathology. . . . No arguments, no disputes, no sexual aggression, no verbal aggression”—behaviors that are typically associated with America’s “picture of alcohol” (qtd. in Gladwell 73). Gladwell states that “culture is a more pow-
erful tool in dealing with drinking than medicine, economics, or the law” (76). Instead of a specific gene among the Camba and the Italians allowing them to drink heavily while still behaving non-violently, there are “ideas, habits and predispositions” that produce specific cultural conditions (Watters). These are what influence the Camba to “drink only within the structure of elaborate rituals,” the “heart of Camba community life”; rituals influence the Italians to view alcohol as “food, consumed according to the same quotidian rhythms as pasta or cheese” (Gladwell 72, 74, 76). And American culture influences us to be “loud and rowdy” in a crowded, dim lit bar on a Friday night (74). The chemical effects of the alcohol seem to matter far less than the cultural conventions that surround it.

These social structures are most effective when influential people reinforce them. To explain the influence of the “popular” cheerleaders of the high school in Le Roy, Dominus asserts, “Cheerleaders frequently come up in case histories of mass psychogenic illnesses at schools, partly because psychogenic outbreaks often start with someone of high social status” (298). Katie Krautwurst and Thera Sanchez, two girls at the top of Le Roy High School’s social ladder, first exhibited their symptoms, which then “seemed to flow . . . to those who looked up to them” (302). High school culture is defined by those of lower social status eagerly desiring to identify and belong with the “popular” group. But this social structure, seen and silently acknowledged by the school’s population, lies just under the surface. Another significant and often deeply hidden part of these girls’ environments lies within their family dynamics. Dominus discovered that of the girls with conversion disorder that she interviewed, “none had stable relationships with their biological fathers”; several had very low income levels; and one girl was juggling being a single mother at nineteen, going to school, and cheerleading (301). There was a “commonality of a certain kind of vulnerability,” and these shared, circumstantial factors that combine to form the Le Roy girls’ culture needed to be taken into account in diagnosing their mental disorder (302).

An assessment of social and familial conditions relies heavily on qualitative analysis and subjective interpretation. Afraid of appearing irrational or too abstract, we often neglect the significance of cultural and social contexts in investigating our physical responses to outside stimuli and turn to more concrete and measurable explanations. We search for reasons to be skeptical, and in qualitative analysis there is plenty to be skeptical of, as it offers possibility and probability rather than the certainty of fixed numbers. Unwilling to accept the “psychogenic illness” diagnosis and all the social and familial introspection that such a diagnosis might have demanded, the Le Roy parents
pointed fingers at contaminated water, soil, decades-old toxic waste spills—they wanted test tubes and hard numbers (294). We measure our problems with biology and math, and then let pharmaceutical companies sell us a chemical cure. We may be uncomfortable with how much control our subconscious minds and our cultures have over our bodies, with the idea that pills cannot solve our problems nor ethanol explain our aggression. But denial produces a mindless and possibly dangerous understanding of the world.

As we continue to seek understanding in a complex world, we are most comforted by empirical, “logical,” straightforward evidence because the alternative would be to face the nuanced and uncertain interactions between body, mind, and environment. Our unspoken cultural conventions convince us that it is ridiculous for the Le Roy girls’ minds to have been converting conscious, stressful emotions into subconscious, involuntary, and severely dangerous motor movements. We are uncomfortable with this concept because we do not want to accept that the human subconscious has more power over us than our conscious minds do. In searching for a satisfying explanation of the girls’ disorder, the town of Le Roy discounted its real roots, forfeiting an opportunity to solve some of the genuine problems that faced them. It is all too easy to discard the ideas that we find illogical and absurd, at the expense of the truth; it is all too easy to homogenize the girls in Le Roy and the hyperactive Johnnys of the world. Often we reject the fact that we are products of our environments, wanting to believe that we have total control over who we are and how we act. However, our surroundings, our personal backgrounds, our genetics, and moreover, our cultures define us along with any personal agency and autonomy we may have. Any singular diagnosis that a doctor might give us is but one component in a complex array of variables regarding our health or our identities. Any singular pill that solves the “problem” of a robust and rambunctious child should be considered an incomplete response to a complex problem.

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