# THE MORAL LIFE OF ADDERALL:
HEALTH, EMPOWERMENT, AND RESPONSIBILITY IN THE ERA OF PHARMACEUTICALIZATION

By

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## ABSTRACT

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My dissertation is an ethnographic exploration of how pharmaceutical morality is challenged, negotiated, and reconstructed across the social life of prescription stimulants. It is situated within the modern American university, where students are experimenting with drugs such as Adderall and Vyvanse in an attempt to improve academic performances. Sanctioned for the treatment of Attention Deficit/Hyperactivity Disorder (ADHD), these powerful medications require a doctor's prescription to access legally. However, studies indicate that they are commonly circulated among peers, leading to proscribed consumption rates of up to 43% in some college populations. Existing research focuses primarily on the motivations of the illicit user and describes their pharmaceutical choices according to neoliberal logics. I build on this work by also considering the moral logics that students rely on to rationalize their controversial behaviors. Moreover, I examine how these logics are translated and absorbed as they filter through the economic, medical, and academic landscapes that circumscribe the user experience. This includes questions of safety, fairness, legality, and efficacy posed by pharmaceutical advertisers, heath service providers, and drug dealers – many of whom contribute to definitions of "responsible" stimulant use in the university setting.

Data for this project was based on ethnographic fieldwork conducted from 2012 to 2014 at a large public institution, which I refer to as "American State University." It is centered around semi-structured interviews and participant observations with 45 undergraduates, aimed at explicating the the complex set of values and concerns that are associated with Adderall in the

college environment. I interacted with these individuals over 12 to 24 months in various capacities as they avoided, procured, distributed and consumed stimulants in public and private settings. To provide context for these student-centered experiences, I also conducted a critical discourse analysis of select direct-to-consumer (DTC) pharmaceutical marketing campaigns and interacted with medical and educational professionals on and around campus. In combination, these methods provided key insights into how discourses around responsible stimulant use were constructed and diffused by these various actors during their interactions with students.

My findings suggest that engagements with prescription stimulants have become a fundamental part of how numerous students construct themselves and are constructed by others as healthy, empowered, and responsible individuals. In particular, the flexibility of Adderall as a medication, enhancement, and recreational drug allowed both users and providers to mold its symbolic meaning into a form that would complement or enhance their moral sense of self. However, my data illustrates how flexibility can lead to instability as students struggled to make sense of the social and chemical implications they experienced during circulation and consumption. I argue that this instability triggered what Zigon (2007) describes as "moments of moral breakdown" which were based in concerns over medical non-compliance, malingering, social stigma, drug dealing, academic dishonesty, and addiction. My multi-methodological approach allowed me to document the strategies informants developed to preclude and respond to these moments of moral breakdown, and the multiple functions of Adderall within these rationales. As a result, my research provides ethnographic evidence to better understand how students manage the double-edged flexibility/instability of prescription stimulant use in order to operate unreflectively in an increasingly pharmaceuticalized environment.

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# CHAPTER 1: INTRODUCTION

Last year, I joined a cross-disciplinary writing group at my university for PhD students seeking accountability and support while working on their dissertations. We started the first meeting of the semester by introducing ourselves and describing our projects. When it was my turn, I began to recite my well-rehearsed academic bio: *Hi everyone, my name is Taz Daniels. I am a Ph.D. student in the medical anthropology program. My research looks at how American college students use prescription stimulants like Adderall to improve their academic performance.* As soon as I mentioned the word *Adderall*, I received an almost visceral reaction that I have become accustomed to whenever I describe my research to colleagues. Their eyes lit up, they leaned in closer, and began flooding me with questions. *Wow, do students really do that? Is it safe? Does it really work? Can you bring some Adderall to our meeting next week?* The last question was followed by an eruption of nervous laughter as if to reassure me, and perhaps more importantly, themselves that they would never expect me to actually supply the drug, even if it *could* help us through the treacherous task of writing our dissertations. There is, of course, always a little truth behind every "just kidding."

Adderall is one of several prescription stimulants marketed to treat Attention Deficit/Hyperactivity Disorder (ADHD), a condition diagnosed in approximately 2–9% of college students in the US (Dupaul et al. 2009). In the last decade, it has also become the drug of choice for undiagnosed or healthy students hoping to increase focus, manage time and improve academic performances. The Food and Drug Administration (FDA) classifies these medications as "Schedule IIN": substances that carry a high potential for abuse, which may lead to severe psychological or physical dependence (FDA 2007). Accordingly, they require a formal diagnosis and prescription from a sanctioned medical professional to be obtained legally. Possession of

Adderall without a prescription carries significant fines and the possibility of imprisonment (FDA 2009). Despite these medical and legal risks, studies report rates of illicit use as high as 43% within some US college populations (Advokat et al. 2008).

My experience conducting ethnographic research on this phenomenon from 2012 to 2014 both reflected and embodied the increasing pervasiveness of this practice within a university setting. Since the start of this project, I have had dozens of colleagues, students, and even professors elicit advice on how to convince their doctors to prescribe them Adderall or ask if I could solicit the drug through one of my informants. As more and more people came clean about their desires to medically cope with the rigors of academic life, I too became acutely aware of my personal and professional shortcomings. Every pile of ungraded papers, missed dinner invitation, and dirty dish in my kitchen sink signaled an opportunity for stimulant use. Over time, the moral dilemmas that came with *writing about a drug* that could potentially help me *write about that drug* became almost unbearable. Do I give in and risk my health, safety, and freedom, or abstain and compromise my unrealized productivity? Although I had never used Adderall, I felt as though my identities as a responsible partner, student, instructor, and anthropologist were being filtered and redefined through this tiny pill.

The degree to which prescription stimulant use was simultaneously normalized, glamorized, and demonized within academia continued to shape my research in ways I had not initially anticipated. However, I eventually learned that I could use this struggle to my advantage and connect with my subjects as both an *insider*, a student also dealing with academic pressures, and an *outsider*, someone who had never used the drug. This positionality allowed me to build trust during student interviews and interactions, and to experience the complexities of this drug behavior through their distinct stories and actions. It also enabled me to move past simply

identifying self-reported motivations for Adderall use, as many studies have done before (Low et al. 2002; McCabe et al. 2006; DeSantis et al. 2008), and consider the moral nuances that shaped student experiences of seeking, circulating and consuming stimulants.

I found that, for some students, Adderall use – with or without a prescription – is never acceptable; it is a sign of weakness, evidence that you do not have what it takes to be in academia. For others, Adderall use is absolutely acceptable; it means that you understand the importance of academic success and are willing to leverage the tools available to you. For most students, however, attitudes toward prescription stimulants are not black or white, as they struggled to rationalize their pharmaceutical choices from moment to moment. My research is an ethnographic exploration of this struggle and the processes by which the boundaries between responsible and irresponsible Adderall use are constructed, contested, destabilized, and re-assembled as part of the modern US college experience. Using stimulants as a case study, I also contribute to an anthropological understanding of pharmaceutical morality, and what it means to be a principled and productive student in an increasingly pharmaceuticalized environment.

## 1.1 PHARMACEUTICAL MORALITY

My research sets out to explore the expansive influence of prescription stimulants on moral subjectivities and experiences within the setting of the modern American university. It builds on over a decade of anthropological and sociological work investigating the pervasive process of pharmaceuticalization, in which transformations in health, identity, agency, and social relationships are understood in relation to pharmaceutical use (White 2002; Dumit and Greenslit 2006; Biehl 2007; Williams et al. 2009; Abraham 2010). I argue that an ethnographic study of prescription stimulants is a particularly productive site for exploring pharmaceuticalization

because they intersect multiple domains of American society as commodities, medications, illicit drugs, and performance enhancers. Using a combination of interview and observational methods, I set out to investigate the various cultural ideologies, relationships, subjectivities, and experiences that are produced, mediated, and transformed by these drugs in their multiple capacities.

Throughout this dissertation, I use the term *pharmaceutical morality* to refer to the explicitly moral dimensions of pharmaceuticalization, as well as the influence of this process on conceptions of morality within the US. I argue that focusing on the moral dilemmas associated with access to, and interactions with, prescription stimulants can offer dialectical insights into the increasingly intimate link between morality and pharmaceuticalization in American culture. My exploration of pharmaceutical morality is guided by two underlying questions: how does morality play a role in shaping pharmaceutical subjects, and how do pharmaceuticals play a role in shaping moral subjects? To address these questions, my research links together anthropological theories of morality, as well as literature that both explicitly and implicitly address the moralized nature of prescription drugs and pharmaceutical practices in the US.

### *1.1.1 Anthropology of Morality*

Existing studies from the health and social sciences that examine illicit stimulant use among US college students have largely, and implicitly, described this phenomenon according to neoliberal logics. Specifically, Adderall use has been presented as a conscious, reflexive, and intentional exercise of neoliberal agency aimed at meeting a predefined goal of enhancing academic performance. According to Gershon (2011:539), neoliberal agency is "produced by consciously using a means-ends calculus that balances alliances, responsibility and risk." She

explains,

> A neoliberal perspective presumes that every social analyst on the ground should ideally use market rationality to interpret their social relationships and social strategies. This concept of agency requires a reflexive stance in which people are subjects for themselves—a collection of processes to be managed. There is always already a presumed distance to oneself as an actor. One is never 'in the moment'; rather, one is always faced with one's self as a project that must be consciously steered through various possible alliances and obstacles (539).

In this view, the primary motivation behind pharmaceutical decisions, including the decision to use Adderall, is conscious and intentional self-improvement. These decisions are premeditated, calculated, and part of a larger ongoing project of reflexively managing oneself as a set of processes or skills.

Studies from the social sciences regularly take this type of neoliberal approach to explaining illicit Adderall use, situating it within broader trends in American culture. For example, Loe (2006:3) presents this drug behavior as part of an ongoing cultural "body project" where "students manage the various pressures of college through the use of psychostimulants, by literally constructing medically-disciplined bodies" (2). She defines these as "bodies that are believed to be more focused, and thus closer to the ideal social construction of a college student" (2). Loe argues that "the self-medicating student body makes sense in the context of a culture that promotes medicine as a tool for the construction of an idealized body, and performance as a marker of success" (17). Levinson and McKinney (2013) take a similar approach, suggesting that Adderall use emerged as a logical response to "psy culture" and the implementation in higher education of neoliberal management strategies, which place emphasis on efficiency and outcomes in a corporate university. They use the concept of "psy culture" to refer to the increased focus on self-improvement via psychiatric drugs and services available on college campuses. Accordingly, Adderall use is presented as a normalized form of neoliberal agency that

is both encouraged and facilitated by changes in the modern university environment.

Studies from the neurological sciences also regularly adopt an implicit neoliberal perspective in their analysis of illicit stimulant use. For example, Muller and Schumann (2011) present a neurobiological framework theory to explain the value of drugs like Adderall among US college students. They suggest that, historically, illicit drug use has been regarded by neurobiologists as a maladaptation, especially in populations prone to addiction because of genetic and environmental factors. They suggest that instead, "the large majority of non-addicted humans who consume psychoactive drugs as a normal part of their lives take drugs because the drugs' effects are useful for their personal goals" (295). They call this phenomenon "drug instrumentalization" and describe it as a behavioral process in which individuals seek out and consume psychoactive drugs to achieve a state of mind that allows for better performance. They explain the prevalence of this behavior as a "functional adaptation to modern environments" that encourages goal achievement through modified consummatory behaviors (293). Ultimately, drug instrumentalization theory supports the notion that even as neurobiological beings, humans are now operating under neoliberal logics in which the strategic consumption of stimulants serves a productive and adaptive function.

While these studies offer important insights into the potential motivations of US college students who engage in illicit Adderall use, the neoliberal approach can also be limiting. Gershon (2011:537) argues that "neoliberal agency creates relationships that are morally lacking and overlooks differences in scale—deficiencies that an anthropological imagination would be able to critique effectively." She goes on to explain that "anthropologists have found that their interlocutors on the ground often talk about epistemological differences in terms of morality, that discussing what is moral has become a means for evaluating the new forms of social

relationships people are constantly encountering" (546). This is particularly true in the case of stimulants, where students might enter into new exchanges with the pharmaceutical industry, health service providers, and drug dealers in order to gain access. Thus, while existing studies often explain Adderall use according to *conscious*, *reflexive,* and *calculated* neoliberal logics, my research also takes into consideration the range of *subconscious*, *non-reflexive*, and *responsive* moral logics that can also facilitate pharmaceutical choice.

In this dissertation, I examine the circulation and consumption of Adderall as a set of complex moral experiences that occur across multiple medical, social and academic domains. Kleinman (1999) explains that "moral experience is about local processes (collective, interpersonal, subjective) that realize (enact) values in ordinary living. These processes cross the boundary of the body-self, connecting affect and cognition with cultural meaning, moral norms and collective identity with sense of self" (73–74). I subscribe to his definition of experience as fundamentally intersubjective and as involving a flow of communications, practices, and negotiations that are embodied with social meanings. With this in mind, I set out to identify those experiences in which students expressed themselves as moral subjects through their interactions with other each other, with drug providers, and with prescription stimulants.

Zigon (2007) notes that one of the primary challenges to studying morality anthropologically is being able to distinguish moral experience from other cultural experiences of daily life. He explains, "morality can best be analytically thought of as those bodily dispositions enacted in the world non-intentionally and unreflectively" (135). Zigon describes these dispositions as familiar and shared with others in a social group, and thus hard to distinguish from what anthropologists usually describe as embodied culture, tradition, and power. As a result, he argues that studying these dispositions alone cannot constitute a proper

anthropology of moralities. Alternatively, Zigon suggests,

> An anthropology of moralities should be limited to what I have called moral breakdowns. That is, it should be limited to those social and personal moments when persons or groups of persons are forced to step away from their unreflective everydayness and think through, figure out, work on themselves and respond to certain ethical dilemmas, troubles or problems. These moral breakdowns are characterized by an ethical demand placed on the person or persons experiencing the breakdown, and this demand requires that they find a way or ways to "Keep Going!" and return to the everydayness of the unreflective moral dispositions (140).

I use Zigon's (2007) framework and identify moments that trigger moral breakdowns or ethical dilemmas within the context of prescription stimulant use among US college students. These include *social moments*, such as key historical events or recurring debates over the ethics of prescription stimulant use that are publicized through academic and popular media outlets. These also include *personal moments* experienced by students who consume Adderall while also dealing with the pressures of improving academic performance, avoiding drug dependency, treating mental illness, preserving academic integrity, and maintaining social relationships. While these pressures can be ongoing, I focus on specific moments in which students, because of their experiences with stimulants, are pulled out of their state of unreflective everydayness and forced to consider their moral position.

It is important to note that I do not take neoliberal logics and moral logics to be in direct opposition or mutually exclusive. Rather, I suggest that neoliberal logics are one of many logics that students draw upon, and should be investigated as such. By examining experiences with Adderall through a broader moral lens, I am open to considering these other logics that facilitate stimulant use among college students and return these individuals to an unreflective moral state. My consideration of other logics includes documenting whether or not students believe the pharmaceutical practice in question is safe, legal, ethical, and/or productive, and how they draw on this belief to understand and rationalize their potentially controversial behaviors. Doing so

offers a more comprehensive understanding of how students incorporate neoliberal ideals into larger moral orientations that give meaning to their interactions with prescription stimulants.

### *1.1.2 Anthropology of Pharmaceuticals*

As an intellectual and ethnographic project, pharmaceutical anthropology has evolved from studying prescription drugs as objects that reflect cultural values and ideologies, to objects that can transform them (Nichter and Vuckovic 1994). For example, in their classic piece "The Charm of Medicines: Metaphors and Metonyms," Geest and Whyte (1989) describe how the materiality or "thingness" of pills make them so powerful. They explain that medicines are "widely believed to contain the power of healing in themselves" and that "anyone who gains access to them can apply their power" with or without the assistance of a medical professional (346). While this perceived, self-contained power can be liberating, Whyte et al. (2002) argue that it can also be constraining. They explain,

> Medicines are empowering in that they offer users a means of control. In making this assertion, we place medicines within the lifeworlds of situated actors. But we must distinguish between control in the short term, and longer-term consequences of using medicines to deal with problems. Control may lead to being controlled. Drug dependence is the most obvious form of subjection. Social scientists point to others as well. Defining a problematic situation as transactable through medicines may eventually increase the control of medical professionals and ideology—a process called medicalization. This may leave people feeling dependent on doctors and drugs to understand and deal with their problems (15).

These questions of agency versus dependency are central to the study of stimulants as both chemical and cultural objects. As medicines, they embody the power to quickly and effectively manage the symptoms of ADHD and foster academic success. At the same time, they are known to carry a high potential for addiction and are linked to a contentious history of medicalization in postwar America (Conrad 1975, Conrad 2005).

Abraham (2010) highlights the double-edged nature of prescription drugs in his description of pharmaceuticalization. He argues that the incorporation of pharmaceuticals into daily American life has resulted in a dichotomy between access-oriented collaboration with, and injury-oriented adversity to the pharmaceutical-industrial complex. Patient advocacy groups such as Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) are an example of access-oriented consumers that Abraham argues bolsters the process of pharmaceuticalization. He also also notes that lawsuits, such as those periodically filed against prescription stimulant manufacturers over the last forty years, have acted to raise public doubts about the safety of these medications. Abraham argues that in some instances, these concerns act to reduce the prevalence of prescription drug use, a process he refers to as "de-pharmaceuticalization." Under this bifurcated framework, pharmaceutical choice becomes an exercise of moral agency in which some consumers embrace pharmaceuticalization as a means to social and personal empowerment, whereas others condemn it, opt out of it, and in some cases, reverse it.

In contrast, Dumit and Greenslit (2006), do not see participation in processes of pharmaceuticalization as a choice. Instead, they describe it as "a form of lifeworld colonization or medicalization from some perspectives in which core metaphors of identity, health, illness, life, longevity, and relationships are mutated" (127). They claim that under pharmaceuticalization, dependency on prescription drugs has become the new normal, where "questions of identity, control, and risk are simply no longer formulated as choices for or against drugs in general, but are, rather, always questions of which drugs and in what combinations" (130). Accordingly, they propose that Americans have incorporated the act of consuming prescription drugs into their own moral sense of self. They articulate this as "ethical identity management" and assert that "Americans are constantly asking themselves if they are doing the

right things in order to be the good people they want to be, and they answer those questions with reference to how they 'choose' to manage their drugs" (130).

In many ways, Dumit and Greenslit's (2006) portrayal of an all-encompassing pharmaceuticalization embodies what Zigon (2007) refers to as an unreflective moral state – one where Americans reach for prescription drugs to solve social problems without really questioning it. They argue that the only reflection involved is in choosing the right brand and dosage to meet their individual needs. While Dumit and Greenslit's view on pharmaceutical choice is cannot be applied in every situation, it does speak to larger trends in US culture where the marketing, prescription and consumption of prescription stimulants have in many ways, become unreflective, normalized occurrences of daily life. This view of pharmaceuticalization also produces a particular type of pharmaceutical subject – one who consumes stimulants strategically and without moral question. This conception is in contrast to Abraham's (2010) pharmaceutical subject who has a conscious choice to embrace or reject pharmaceuticalization through their public and private interactions with prescription drugs.

In this dissertation, I consider both Abraham (2010) and Dumit and Greenslits' (2006) descriptions of pharmaceuticalization in my study of US college students who consume prescription stimulants. I am particularly interested in how students view Adderall use as an unreflective moral choice, or one that triggers and/or results from a personal moment of moral breakdown. Zigon (2007:144) notes that during moments of moral breakdown "it may be tempting to act in ways that might be considered immoral by others or by oneself" (144). Thus, I am interested in documenting how students articulate and rationalize their temptations to seek out, circulate, or consume Adderall. These responses are key to understanding how students return to an unreflective moral state after a moment of breakdown and are able to continue

functioning as moral subjects within a pharmaceuticalized environment.

One of the key objectives in this study is to investigate the range of pharmaceutical experiences that shape moral subjectivities, and situate these experiences within broader forces of pharmaceuticalization in the university setting. This is particularly challenging given the dynamic function of stimulants and their ability to traverse social, medical and academic worlds. I deal with this complexity by systematically mapping constructions of pharmaceutical morality as three interconnected parts across contexts: practices, objects, and subjects.

First, I examine the multiple relationships and practices beyond consumption that can produce pharmaceutical subjects, including marketing, treatment, and circulation. While consumption is by far the most intimate form of subjective self-fashioning, these preceding practices are central to the extensive process of pharmaceuticalization. By investigating what constitutes moral drug marketing, treatment, and circulation practices, I also shed light on the role that advertisers, ADHD experts, and even drug dealers play in shaping the responsible Adderall user within the college environment. Specifically, I consider how moral experiences of participating in direct-to-consumer (DTC) drug marketing, getting tested or accommodated for ADHD, and buying/selling prescription stimulants can also trigger personal moments of moral breakdown. I am especially interested in understanding why these practices might trigger moral breakdowns for some individuals but not for others. In the cases where they do, I set out to document the strategies individuals deploy to respond to these breakdowns and return to an unreflective moral state.

Second, I identify the fluid symbolic meaning of Adderall within and across these contexts, and highlight their capacity to produce and mediate the moral subjectivities of both their providers and users. I directly address questions of agency and dependency to consider how

advertisers, ADHD experts and drug dealers attempt to mold the function of stimulants to manage relationships with US college students. I also consider how users themselves strategically assign meaning to Adderall as a way to prevent or respond to moments of moral breakdowns that result from participating in potentially immoral behaviors. By questioning the assumption that individuals can simply *apply the power* of stimulants to meet predefined goals of improving health and performance, my research offers an opportunity to consider the moral dilemmas that come with facilitating or denying access to stimulants. In other words, I consider how drugs, through the process of pharmaceuticalization, can dialectically redefine the expectations and experiences of being a moral subject.

Third, I expand on the types of moral subjectivities that are produced through the process of pharmaceuticalization. A student who takes Adderall can be at different moments a consumer, a patient, a drug dealer, a drug seeker or a drug user. Each subjectivity represents a variable combination of social contexts, relationships, practices, and value systems. They can also entail a diverse set of moral considerations and breakdowns, each stemming from an increased availability of prescription stimulants in the college environment. My research examines how these experiences are negotiated in relation to other stakeholders and to the drugs themselves, and thus offers a more comprehensive understanding of what it means to be a moral pharmaceutical subject operating these contexts.

### *1.1.3 Moral Frameworks*

In their classic piece "American Cultural Values," Arsenberg, Conrad and Niehoff (1975:367) assert that the dominant means of organizing thought in American life is through "two-fold judgments based on principle." They argue that this tradition of looking at the world in

absolute terms also tends to conflate these dichotomies with an overarching ideology of goodness versus badness – a process they call "moralizing." Taking this into consideration, I look how pharmaceuticals, and specifically prescription stimulants, have been moralized as good or bad through various cultural structures and processes. I build on the work of anthropologists who have engaged with a number of categorical frameworks, many of which emerged from prominent scientific and political discourses. The construction and stability of these frameworks are important to consider because they embody key assumptions and values around the appropriate use of prescription drugs in American culture.

In the following sections, I provide an overview of how some anthropologists have adopted and/or critiqued these frameworks and highlight the moral logics these frameworks are tied to. I have organized them into the follows classifications which align with my systematic study of pharmaceutical morality in the university setting: (1) *moral drugs*—those that focus on the moralized qualities of the drugs themselves; (2) *moral drug users*—those that draw distinctions based on the moralized intentions of the user; and (3) *moral drug practices*—those that also explicitly consider the moralized cultural context of the drug behavior. I then offer my own critique on the limitations of these frameworks in capturing the moral complexities of Adderall use among US college students.

#### *1.1.3.1 Moral Drugs*

In her article "The Pharmaceutical Person," Martin (2006:274) uses the Greek term *Pharmakon* to describe the simultaneously productive and destructive public messages that surround pharmaceuticals in the US. She explains that "in the American Pharmakon, pills are split into good and bad parts" where the "the positive meaning sits uneasily with—and is

shadowed by—the negative meaning." Through ethnographic examples, Martin illustrates how the dangerous parts of an object are removed from direct view through "social processes of displacement" such as strategic drug marketing or the differentiation between intended and unintended side effects (247). She argues that this how Americans are able to "keep ambivalence about drugs at bay enough to take them in the massive amounts" despite the fact that they are "bad objects" (247).

Etkin (1995) also considers the complexity of "side effects" and examines the scientific and political processes by which post-consumption symptoms are explained through biomedical paradigms of physiology and addiction. She explains that for a pharmaceutical to qualify as a biomedical treatment, "there must be a primary effect to which all others are subordinated" (100). This distinction between primary effects and side effects must be made in order to move a pharmaceutical from the experimental phase to the marketing phase. At the same time, Etkin illustrates the instability of this dichotomy, as consumers get lost in the distinctions between intended side effects, unintended side effects, negative primary effects, contraindications, allergic reactions, hypersensitivity, and differential drug metabolism. As a result, the negative and positive qualities of a drug remain in flux as they are filtered and assigned meaning through these complex political, scientific, and capitalist processes.

#### *1.1.3.2 Moral Drug Users*

The motivations of drug users have also become an important factor in articulating the moral trade-offs associated with prescription drugs use in the US. A common categorical framework for conceptualizing these motives is the distinction made between medical versus nonmedical drug users. Experts use this dichotomy to classify users into two categories—those

who follow a protocol set forth by a medical doctor and those who deviate from, or completely circumvent, that protocol. For example, in their study of prescription drug use among high school students, McCabe et al. (2007) assessed nonmedical use by asking the following: "Sometimes people use prescription drugs that were meant for other people, even when their own health professional (e.g., doctor, dentist, nurse) has not prescribed it for them. On how many occasions in your lifetime have you used the following types of drugs, not prescribed to you?" Here, although moral intention may play a role, the distinction is made in service of assessing whether or not actual consumption behavior matches the written prescription.

Another common language framework, used by both experts and the general public, is the trichotomy of "drug use/misuse/abuse." This framework embodies a moral hierarchy by attempting to label a prescription drug user's intention to comply with the intended medical protocol. In an interview posted on the FDA website, Michael Klein, staff director of the Substance Control division, offers some examples:

> Let's say that a person knows that he will get a pleasant or euphoric feeling by taking the drug, especially at higher doses than prescribed. That is an example of drug abuse because the person is specifically looking for that euphoric response. In contrast, if a person isn't able to fall asleep after taking a single sleeping pill, they may take another pill an hour later, thinking, "That will do the job." Or a person may offer his headache medication to a friend who is in pain. Those are examples of drug misuse because, even though these people did not follow medical instructions, they were not looking to "get high" from the drugs. They were treating themselves, but not according to the directions of their health care providers (FDA 2010).

In this framework, a person who follows the protocol set by their doctor is engaging in good drug use. Bad drug use behaviors are so labeled when a user either has moral intentions and breaks the protocol (misuse), or when a user has immoral intentions within or outside the boundaries of the protocol (abuse). This framework assumes that the abuser is more concerned with experiencing the side effects of the drug than the primary effect that is intended to treat their medical condition

– and that they can tell the difference between these two intentions.

Although this framework is widely recognized by medical professionals and law enforcement, the stability of this trichotomy both within and outside of expert discourse is questionable. For example, Quintero (2012) provides a number of examples in which both scientific studies and medical reports inappropriately conflate all nonmedical prescription drug behaviors as "drug abuse." He explains,

> All forms of non-medical use, misuse and abuse become indistinguishable by being reduced to two essential features—they are all uses that are not explicitly medically sanctioned and which are consciously directed at achieving pleasure. This conflation is operationalized in a manner that is familiar to any student of critical analyses of drug representations in the media (504).

Quintero suggests that in comparison, prescription drug users do not see their behaviors as logically or morally equivalent to the use of other illicit hard drugs, or see themselves as drug abusers, because their primary motivation is not to get high. In fact, many of the young adults in his study considered their illicit prescription drug use to be a form of harmless self-medication, or saw it as having some other productive function. Thus, while the drug use/misuse/abuse framework is intended to address some of these nuances, the inconsistencies in its definitions and appropriations into popular discourse illustrate its limitations.

#### *1.1.3.3 Moral Drug Practices*

Perhaps the most common categorical framework, one that is used by both experts and the public to assign some sort of generalized morality to prescription stimulant use, is that of medication/enhancement/recreation (Nichter and Quinter 2011). These categories serve to distinguish between good and bad drug behaviors and correlate closely with the level of perceived regulation in the drugs' production, circulation, and use. Accordingly, medication is

regarded as the most ethical form of drug use; enhancement comes in as a controversial second; and recreation is a distant third. At the same time, these categories also serve a necessary function for the range of individual and institutional stakeholders responsible for the production and regulation of these powerful substances. These stakeholders include drug companies, government agencies, medical professionals, insurance companies, lawmakers and law enforcement, educators, parents, and even users themselves. The trichotomy of medication/enhancement/recreation offers a common, yet flexible language that can be used to promote or condemn pharmaceutical practices that are perceived to negatively or positively affect individuals or society at large.

Despite the seeming practicality of this framework, distinctions between categories are based on multiple and often conflicting moral logics. This includes inconsistent assessments of whether given practices are safe, legal, ethical, and/or productive. Stakeholders assign different meanings and values to these logics. As a result, determining how a drug behavior should be classified can lead to contention within and among groups. At the core of these conflicts is the question of jurisdiction. In other words, whose responsibility is it to ensure that only the "good" drugs are being produced, only the "good" users gain access, and only the "good" behaviors are being sanctioned?

Recently, these questions have come to the forefront of many debates, especially as certain drugs are publicly crossing the boundaries between medication/enhancement/recreation. Marijuana, which has long been labeled as a recreational drug heavily regulated by law enforcement has recently been approved for medical purposes in several US states (Cerdá et al. 2012). Similarly, scientists are studying psychedelics like LSD or ayahuasca to determine whether or not they could have cognitive-enhancement effects that could treat mental illness

(Anderson 2012). There are also medications like human growth hormone (HGH) and steroids, that are commonly used for performance enhancement in professional sports (Sjöqvist et al. 2008). Prescription painkillers like OxyContin, which are known to have addictive properties, are often misused and/or abused by patients and by third-party buyers on the black market (Hansen and Skinner 2012). Despite the moral ambiguities of these examples, they are framed in public discourse as clear and intentional repurposing of drugs or practices from one category to another: from medication to enhancement, from recreation to medication, etc. These superficial distinctions allow the public to more easily pass absolute moral judgments on whether they believe that drugs' shifts between classifications can serve the greater good of society.

*1.1.3.4 Incidental Slippages or Unstable Boundaries?*

According to Singer and Page (2013:13), the media regularly describes emergent issues around drugs and drug use in terms of "moral panics," which commonly entail "exaggerated and distorted portrayals of the drugs as having harmful effects, and growing emphasis on the threat to society." They argue that "in this way, drugs are invested with the symbolic power to instigate popular moral indignation while overtly or covertly indicating the need for greater social control to protect society from the emergent danger" (13). In contrast, the illicit use of prescription stimulants among college students is a phenomenon that has, for many reasons, been portrayed in a more morally neutral tone. Media reports often use innocuous terms such as "study aids," "brain boosters," or "candy for college students" for Adderall, which effectively downplays the significant medical and moral implications of its illicit use. Similarly, scholars have described the behavior as "casual misuse" (Gomes et al. 2011) or "pharming" (Kadison 2005) of "biomedical instruments" (Mueller and Schulman 2011) made available as a result of

"pharmaceutical leakage" (Vrecko 2015) through "gray markets" (Loe 2006). Thus, illicit Adderall use does not appear to be a clear, intentional, or morally charged move between boundaries, but rather a series of relatively harmless, incidental "slippage[s] between [boundaries of] enhancement, recreation and self-medication" (Nichter & Quintero 2011).

I propose that these socially and academically constructed boundaries fail to capture the range of conflated and often contradictory moral logics that individuals draw on to evaluate and rationalize prescription stimulant use. As *medications*, stimulants are considered to be necessary treatments to manage the detrimental symptoms of ADHD (Antshel et al. 2011); at the same time, they are demonized as habit-forming, often-ineffective drugs that carry side effects ranging from heart attacks to psychosis (Ross 2006). As *cognitive enhancers*, they are praised as the next logical step toward human evolution and the embodiment of the American Dream (Smith and Farrah 2011); at the same time, they are condemned as form of cheating, whose normalization will eventually lead to social coercion to consume these drugs in order to remain competitive in various fields of professional life (Goodman 2012). As *recreational substances*, individuals turn to stimulants to gain the motivation needed complete the unpleasant yet noble pursuits of studying, cleaning, exercising, or losing weight (Jeffers et al. 2013); at the same time, they are disparaged as addictive substances that get people high, promote co-consumption of alcohol and other drugs, and cause users to lose the willpower to complete tasks on their own volition (Low et al. 2002).

#### *1.1.3.5 Responsible Drug Use*

In this dissertation, I highlight the inherent instabilities of existing moral categorical frameworks used to describe Adderall use and unpack the complex value systems these terms

embody with in the context of the modern college experience. I do this by examining how individuals define and distinguish between responsible and irresponsible Adderall use as a result of and in response to moments of moral breakdown. Responsible drug use is a concept used among drug scholars to describe drug use that maximizes the drug's benefits while reducing its risk of negative impact on the lives of the user and others around him (Rodes et al. 2009). In general, attitudes around responsible drug use fall along two lines. Some believe that all recreational or illicit drug use is irresponsible because of their potential for addiction and the other social and medical side effects – thus, all non-medical use should be actively avoided or prevented (Hathaway 2001). Others suggest that drug use is an activity that can be simultaneously beneficial and risky; these scholars argue that, like alcohol use, sexual activity, or driving a car, drug use can reduce the damage incurred by using common sense (Moore et al. 2003). I adopt the latter position in considering attitudes toward Adderall use, because it does not adhere to a unified criterion and leaves open for analysis the ways in which students grapple with the double-edged nature of these drugs.

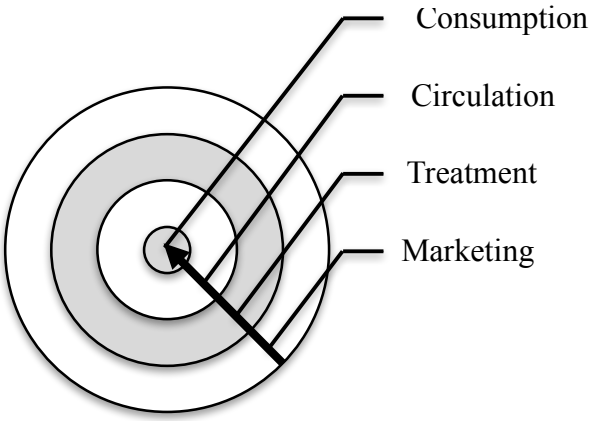
In this study, I consider how the rhetoric of responsibility emerges in response to social or personal moments of moral breakdown or ethical dilemmas experienced by my informants. These moments are always situated in larger cultural trends and debates around the safety, legality, ethics, and efficacy of Adderall use in various contexts. My research is an exploration of how individuals mobilize discourses of responsibility to express their moralized interactions with each other and with prescription stimulants in relation to these concerns. Specifically, I ask, how are responsible drugs, drug users, and drug practices redefined by individuals in response to moments of moral breakdown? I answer this question by offering insights on the heterogeneous experiences of US college students, and contextualizing these experiences across a network of

actors and institutions that contribute to a moral understanding of this drug behavior. In the remainder of this chapter, I describe in detail the methodological approach I used to meet my objectives and map experiences of pharmaceutical morality within the university setting.

## 1.2 THE MORAL LIFE OF ADDERALL

The original intention of this project was to explore the dynamic cultural power of Adderall by documenting the moral experiences of US college students as they sought out, circulated, and consumed the drug. I wanted to know what it was about these small objects and how they moved through the university landscape that enabled them to be so powerful and so contentious. In order to systematically map the moral complexity of Adderall, I based my data collection and organization strategy around Geest, Whyte and Hardon's (1996) biographical approach to studying pharmaceuticals. They propose that pharmaceuticals flow through a life cycle where "each phase has its own particular context, actors, and transactions and is characterized by different sets of values and ideas" (153). While they offer generalized descriptions of these stages that fit most pharmaceutical markets, I looked specifically at the social life of prescription stimulants within the modern university setting across four contexts: marketing, treatment, circulation, and consumption.

**Figure 1. The social life of Adderall**



I examined the drug behaviors or transactions (practices), the perceived function of the drug (objects), and the actors involved (subjects) within and across each of these contexts. My initial approach was to focus on consumption, but to also consider students' self-reported experiences within the peripheral landscapes of marketing, treatment, and circulation. However, as I began my data collection, I was presented with opportunities to interact with individuals who were directly involved in these practices. This included interactions advertisers, medical and educational experts, university administrators, parents and peers. I also began to consider the various moral breakdowns these individuals experienced while facilitating and denying access to prescription stimulants. Although this was not the focus of my study, I also documented how these individuals drew on various moral logics to make their own pharmaceutical decisions and contributed to public and private definitions of responsible Adderall use.

Over the course of the project, I added several critical layers of data collection that allowed me to capture these moments of moral breakdown within and across Adderall's social life. Ultimately, I ended up working backwards from investigating consumption to circulation to treatment and, finally, marketing. This provided insights into how moral discourses around Adderall use were constructed, filtered, and translated across these various contexts. The following sections provide an overview of the layers of my data collection and analytical methods for each stage of Adderall's social life. I include more specific details about these methods and my experience conducting the research in the corresponding data chapters of this dissertation. Table 1 provides an overview of this data collection and organization strategy.

**Table 1. Data collection and organization strategy**

| Context | Marketing | Treatment | Circulation | Consumption |
|---|---|---|---|---|
| **Practices** *Transactions and behaviors* | Direct-to-consumer (DTC) advertising | Diagnosis, prescription, accommodation | Drug dealing | Consuming |
| **Objects** *Adderall as…* | Commodity | Medication | Illicit drug | Study drug |
| **Subjects** *Expert & user* | Pharmaceutical company & consumer | ADHD expert & patient | Adderall dealer & drug seeker | Adderall user |
| **Data** *Sampling, collection, and analysis* | Discourse analysis of selected DTC advertisements | Participation in conferences and classes, informal interactions with professionals | Interviews and observations with 9 Adderall dealers | Interviews and observations with 34 Adderall users with and without prescriptions |

### *1.2.1 Data Collection and Management*

From 2012 to 2014, I conducted fieldwork at and around a large public academic institution that I refer to in this dissertation as "American State University." I chose this pseudonym for two purposes, the first of which was to protect the identity of my subjects and the institution itself; the facilitation of and participation in illicit Adderall use can carry a range of legal, medical, social, and academic implications, including (but not limited to) fines, imprisonment, malpractice, psychosis, expulsion, and stigma. Accordingly, the data collection and data management for this project followed protocols approved by the Institutional Review Board (IRB), which included the use of verbal consent as well as the de-identification of all data related to this project during the collection and analysis phases. Pseudonyms are used throughout this dissertation to increase the confidentiality of all participants while preserving the authenticity of their experiences.

Second, the name used, "American State University," underscores the wide-reaching

cultural dimensions of this drug behavior, which is by no means exclusive to my field site and is at its core an American phenomenon. At the same time, it is important to note that Adderall use is not a homogenous experience for all US college students who choose to either resist or participate in this drug behavior. Thus, the goal of this dissertation is not to provide a representative overview of illicit Adderall use on college campuses. Rather, I set out to document and contextualize individual experiences facilitating, preventing, resisting, and participating in this controversial drug behavior within broader socio-cultural trends in the US.

#### *1.2.1.1 Semi-structured Interviews with Students*

I conducted interviews with a purposive sample of forty-five undergraduates enrolled at American State University. The purpose of these interviews was to solicit narratives from students that would highlight the moral logics that surrounded their pharmaceutical practices. My intention was not to collect from a representative sample, but to interview students who specifically had experiences resisting, avoiding or participating in Adderall use. Informants were initially identified through qualitative sampling, which aims to capture a broad range of major cultural characteristics that are present in a particular social group (Becker 1996). Qualitative sampling assumes that a carefully selected set of individuals within a culture can collectively provide the major core beliefs, knowledge, and information that exist in a larger cultural group (Trotter et al. 2001). One way to gain access to well-informed individuals or information-rich cases for in-depth study is through purposive sampling (Johnson 1990). Research on special or hidden populations, such as drug users, often relies on this type of sampling (Quintero 2006). In order to participate in interviews, each potential participant needed to (1) be an undergraduate, (2) be enrolled full-time at American State University, and (3) have some prior knowledge or

experience with prescription stimulants. Initially, a total of eight participants were recruited through undergraduate research assistants who had connections to students who fit the selection criteria. This intentionally included four females and four males with a range of academic standings and backgrounds, who had varying levels of knowledge and experience with prescription stimulants. I did not specify any criteria for ethnicity or socioeconomic status. Using undergraduate research assistants to recruit these initial participants allowed me to establish a level of trust before the interview took place, which I then built on to recruit additional subjects through convenience snowball sampling.

**Table 2. Select characteristics of total student interview sample**

| Characteristic | Total Sample |
|---|---|
| | No. (%) |
| Gender | |
| Male | 22 (51) |
| Female | 23 (49) |
| Race | |
| White | 40 (89) |
| Non-White | 5 (11) |
| Academic Major | |
| STEM | 21 (47) |
| Non- STEM | 24 (53) |
| Class Standing | |
| Freshman | 8 (18) |
| Sophomore | 10 (22) |
| Junior | 10 (22) |
| Senior | 17 (38) |

Within a week of each interview, the eight original participants put me in contact with acquaintances who would be willing to participate in the interview process. In many cases, these new participants had either bought or sold Adderall from the initial participant, or was someone within their social group who intentionally resisted or avoided Adderall use. In total, I made

contact with forty-eight students who met the criteria for the interview phase of the project, and all forty-eight agreed to participate. However, three of those students were unable to make it to the interview location due to a range of circumstances, and thus are not included in the sample. Table 2 represents selected characteristics of the final forty-five participants during the interview phase, and Table 3 breaks down these characteristics by use type. Note that "STEM" refers individuals in majors related to science, technology, engineering and medicine. "Non-STEM" refers to the social sciences and humanities.

**Table 3. Selected characteristics of student interview sample by use type**

| Characteristic | Users with Prescription | Users without Prescription | Non-Users |
|---|---|---|---|
| | No. (%) | No. (%) | No. (%) |
| Gender | | | |
| Male | 5 (45) | 15 (52) | 2 (40) |
| Female | 6 (55) | 14 (48) | 3 (60) |
| Race | | | |
| White | 10 (91) | 26 (90) | 4 (80) |
| Non-White | 1 (9) | 3 (10) | 1 (20) |
| Major | | | |
| STEM | 2 (18) | 15 (52) | 4 (80) |
| Non- STEM | 9 (82) | 14 (48) | 1 (20) |
| Standing | | | |
| Freshman | 0 (0) | 8 (28) | 0 (0) |
| Sophomore | 3 (27) | 7 (24) | 0 (0) |
| Junior | 3 (27) | 4 (14) | 3 (60) |
| Senior | 5 (45) | 10 (34) | 2 (40) |

According to a recent large-scale survey about illicit Adderall use, which surveyed 2,281 students at a similarly sized university, the demographics of my participants were relatively representative (Vo et al. 2015). They reported that the majority of students who used Adderall without a prescription were white (89%), male (68%) upperclassman (80%) without any significant differences in academic majors. Comparatively, my sample represented an even

number of males and females, who were also 89% white, with a fairly even distribution between STEM and non-STEM majors. Although this exact distribution was not intentional, it allowed access to a variety of experiences across genders and academic majors. Sixty percent of students in my sample were upperclassmen, which was expected given that the likelihood of being exposed to illicit Adderall use increases with undergraduate class standing (DeSantis 2010). Although socioeconomic status (SES) could have provided a key element in contextualizing drug behaviors, data on SES was not formally collected during the interview and thus was not presented in the table. However, the perceived association between SES and drug behaviors was included in the interview protocol and analyzed accordingly.

Audio-recorded interviews took place in a private location on campus and lasted between two and four hours. Following IRB-approved protocols, individuals were informed about the potential risks involved with participating in this project, including the discussion of illegal, unethical and potentially stigmatizing topics. They were also informed that they could skip questions, stop the interview or leave at any time. All participants gave verbal informed consent and were provided with the information for emergency campus mental health services. Students were then asked a combination of semi-structured and open-ended questions about their ideologies and experiences as they related to *medical factors* (ADHD, Adderall, pharmaceuticals, doctors); *social factors* (family, peer groups, socialization, drinking/drug use); and *academic factors* (transitions into college, academic culture, study habits, grades). Each interview followed a similar order, starting with questions about their hometown, family life, experiences in high school, transitions into college, early and current college life, experiences with Adderall and other drugs, and expectations after graduation. This order allowed me to build rapport with students and see how their self-reported values and behaviors evolved over time and were

reflected in their experiences with and around Adderall.

Interviews were transcribed with the help of six undergraduate research assistants and averaged twenty-eight single-spaced pages per transcript. We reviewed transcripts for accuracy and then imported them into NVivo9 software (QSR International Pty Ltd). Initially, we coded the transcripts around three primary contexts: medical, social and academic. As analysis proceeded, we used a grounded theory approach to create increasingly in-depth coding categories based on emergent themes and patterns. Research assistants completed initial coding based on these categories and I later adjusted codes in order to ensure consistency.

#### *1.1.2.2 Participant Observations and Informal Interactions with Students*

During interviews, I built rapport with students and attended a number of private and social gatherings where prescription stimulants were openly discussed, sought after, distributed, and consumed. In general, students were open to talking about Adderall use in front of me, especially when they learned that it was the subject of my research. On multiple occasions, students openly shared their own narratives or stories about a friend or roommate who had a particularly positive or negative experience with the drug. The ease with which I was able to gain access to these moments speaks, in part, to the normalization of this behavior.

By coupling interviews with participant observations, I was able to identify the congruencies and dissonances between how my informants described themselves during interviews—as healthy, empowered and responsible individuals—and their lived experiences as students, friends, patients, drug dealers and drug users. Additionally, during my day-to-day life at American State University, I witnessed conversations and pharmaceutical practices in public spaces frequented by students, such as the library, coffee shops, in classrooms, and in the

cafeteria. I recorded these informal observations as field notes over the twenty-four-month period. However, due to the informality of these interactions, I did not systematically code them into any software program. Key findings from these observations are incorporated into the case studies, which are presented in the corresponding data chapters of this dissertation.

#### *1.1.2.3 Informal Interactions with ADHD Experts*

Initially, my target sample for interviews was limited to students and did not include a protocol to recruit health service providers for formal interviews. However, during my fieldwork, I had a number of opportunities to observe how discourses about ADHD and stimulants were being constructed among experts and eventually disseminated to patients. This included informal interactions with medical experts (clinicians, psychiatrists, psychologists, neurobiologists), educational experts (disabilities services employees, ADHD college program managers) and cultural experts (ADHD coaches, book authors, ADHD advocates). My interactions took place at two ADHD conferences sponsored by Shire Pharmaceuticals, as well as two professional university disabilities services conferences near my field site. These events featured presentations and workshops by leading ADHD experts: clinicians, psychiatrists, ADHD coaches, and university disabilities services employees. Following the public presentations, I informally interacted with professionals one-on-one and was able to build rapport and ask more in-depth, informal questions pertaining to my research. I was also able to attend several ADHD coaching classes via teleconference with a nationally renowned ADHD expert, and learn about other coaches' experiences working with ADHD college students.

Over the course of my fieldwork, I became well acquainted with several individuals involved in ADHD assessment and disabilities resources management at American State

University. As a direct result of these connections, I attended four private group meetings with various health and disabilities services programs at American State, which were followed by informal group and individual discussions regarding the proper management of ADHD students. I maintained regular contact with these individuals and met with them on a number of occasions for coffee or dinner. Additionally, I observed interactions between professionals and patients while accompanying my primary student informants in clinical settings during ongoing participant observations. This included two initial ADHD consultations and eight follow-up doctor's appointments. While these interactions were relatively short (around fifteen minutes) I witnessed a glimpse of the dynamics between students and mental health professionals. During these interactions, I elicited attitudes toward over/under diagnosis of ADHD, over/under-prescription of stimulants, relationships with the pharmaceutical industry, and perceptions of Adderall use among college students. I was interested in how these professionals distinguished between responsible and irresponsible Adderall use, and how they described their responsibility to prevent or facilitate these behaviors. Although I had informal interactions with dozens of professionals over the course of my fieldwork, the case examples from Chapter 3 and Chapter 4 are based on data from the following informants: an ADHD advocate/public speaker, an ADHD coach, a privately-employed psychiatrist, a university-employed psychologist, the director of an academic support program for students with ADHD, and a university-employed disabilities services provider.

#### *1.1.2.4 Critical Discourse Analysis of Pharmaceutical Marketing Campaigns*

In order to illustrate how moral discourses around responsible Adderall use were produced in the marketing context, I conducted a critical discourse analysis (CDA) of selected

direct-to-consumer (DTC) advertisements sponsored by Shire Pharmaceuticals, the makers of blockbuster ADHD drugs Adderall and Vyvanse. This included a thorough review of digital documents, images, and videos related to industry-sponsored contests, scholarships, resources, events, and anti-abuse materials. I focused particularly on those campaigns directed at college students and their parents and present three case examples in Chapter 3. These include (1) The "Own It" Initiative—a set of contests and commercials aimed at adults who believed they outgrew their ADHD; (2) The "U do the Rest" Campaign—a set of contests and resources for adults to use in combination with stimulant treatment; (3) The Michael Yasick ADHD College Scholarship—a financial award sponsored by Shire for students with ADHD that includes ADHD coaching services; and (4) CPAMM—a coalition of medical and educational professionals, funded by Shire, who are addressing the issue of prescription stimulant misuse. My analyses of these campaigns are based on Fairclough's (1989) three-dimensional framework for analyzing the ideological work of advertisements, relations-content-subjects, which is described in detail in Chapter 3.

### *1.2.2 Data Analysis*

As I collected and coded my data, I used a grounded theory approach to capture the range of logics that individuals used to manage the moral flexibility of these drugs and to express themselves as moral pharmaceutical subjects. I began by identifying social and personal moments of moral breakdown across each context, examining how Adderall both triggered and resolved these ethical dilemmas. These moments of moral breakdown fell roughly along two lines: social and personal concerns over preventing responsible Adderall use and/or facilitating irresponsible Adderall use. In this case, social moments of moral breakdown refer to debates

around Adderall use and concerns facing entire industries and institutions. Data about these social moments were collected from both media sources and from informants who voiced their concerns about what responsibility the pharmaceutical industry, medical professionals, and the institution of higher education should bear in facilitating the responsible use of Adderall. Alternatively, personal moments of moral breakdown are those moral experiences in which individuals were consciously responding to and situating themselves within these debates to assert themselves as *responsible* advertisers, ADHD experts, drug dealers, and consumers. Data for these personal moments included informants' self-reported experiences, given during interviews and informal interactions, as well as the moments I witnessed firsthand during participant observations.

To systematically map these moral experiences, I returned to Geest, Whyte, and Hardon's (1989) framework for tracing the social life of pharmaceuticals and identified both social and personal moments of moral breakdown. Specifically, I looked for instances in which actors were pulled out of an unreflective moral state and forced to consciously consider or respond to anxieties of over facilitating, failing to prevent, and/or participating in "irresponsible" Adderall use. I situated these moments within larger public debates around the moral marketing, prescription and circulation of stimulants. By analyzing informants' premeditated and in-the-moment responses to these concerns, I was able to uncover the range of logics that individuals drew upon to assert and preserve their moral subjectivity. These questions are outlined in Table 4 below.

**Table 4. Key analytical questions within each context**

| Context | Marketing | Treatment | Circulation | Use |
|---|---|---|---|---|
| **1. Practices** *Strategic pharmaceutical transactions and practices* | How is the pharmaceutical industry responsibly marketing to consumers? | How are medical experts responsibly treating patients? | How are ADHD students responsibly dealing to drug seekers? | How are students responsibly using drugs? |
| **2. Object** *Adderall* | What is the function of Adderall in this transaction? | What is the function of Adderall in this transaction? | What is the function of Adderall in this transaction? | What is the function of Adderall in this transaction? |
| **3. Subject** *Adderall user* | How is the pharmaceutical industry constructing the responsible consumer? | How are medical experts constructing the responsible ADHD patient? | How are ADHD students constructing the responsible Adderall seeker? | How are students constructing the responsible Adderall user? |

In the first three contexts (marketing, treatment, and circulation), I focus on the ways in which experts are producing discourses of health, empowerment, and responsibility and how they are explicitly defining responsible Adderall use. I examine how these discourses are transmitted and absorbed in each subsequent setting as new experts and stakeholders enter the scene and redefine responsible Adderall use. In the final context (use), I focus on the actual drug user to see how these discourses endure and/or mutate as students actively consume and make sense of their complex experiences with prescription stimulants.

## 1.3 MAPPING MORALITY

In Chapter 2, I provide an overview of the anthropological and sociological literature that examines the cultural role of pharmaceuticals in post-WWII America. Most previous research approaches the topic of prescription stimulants through the lenses of medicalization and, more

recently, biomedicalization. Instead, I foreground my study in the pharmaceuticalization studies literature in order to shed light on the influence of prescription stimulants outside the context of ADHD treatment. As a result, my research demonstrates the limitations of medicalization and biomedicalization theory to fully explain modern pharmaceutical experiences. My dissertation is also informed by recent studies in the health and social sciences that specifically investigate illicit Adderall use among US college students. It also takes into consideration recent popular and academic debates around the neuroethics of prescription stimulant use by the healthy. I provide an overview of this literature and its theoretical frameworks, which I directly engage in the corresponding data chapters of this dissertation.

In Chapter 3, I explore how responsible drug use is defined and facilitated by Shire Pharmaceuticals and its consumers through the DTC marketing of prescription stimulants. I present four case examples that highlight moments in which Shire strategically reacted to allegations that they had irresponsibly promoted unsafe, unfair, or ineffective products to their consumers, and examine the ways that Shire rationalized their new marketing practices, enacted in response to these allegations, as acts of social responsibility. My analyses indicate that there is an ongoing struggle between the pharmaceutical industry and its consumers over the proper definition of ADHD and over the regulation of the responsible use of prescription stimulants. I use these case studies to show how Shire has teamed up with ADHD experts to create new forms of engaged consumerism, founded on the goal of responsible stimulants consumption. In the process, they manufacture Adderall's symbolic meaning, presenting it as an empowerment drug rather than a controversial performance enhancer or a form of medical social control. They have also constructed what appears to be a clear distinction between responsible and irresponsible stimulant use. As a result, Shire has delegated both the benefits and burdens of Adderall use back

to consumers and to the medical professionals charged with prescribing and monitoring Adderall use. I argue that Shire's delegation places upon consumers the responsibility to consume stimulant medications while also promoting others' responsible use of stimulants.

In Chapter 4, I explore how responsible drug use is defined and facilitated by ADHD experts and patients through the diagnosis, treatment, and management of the condition. I present six case examples that highlight moments in which ADHD experts strategically responded to allegations of over-facilitating or preventing access to diagnoses/treatments/accommodations, and examine how these experts rationalized their decisions to either facilitate or deny stimulant use as acts of social responsibility. My analyses indicate that there is an ongoing struggle between ADHD experts and clients to reconcile the compartmentalization of ADHD services across medical and social contexts. I juxtapose vignettes in each context to show how experts rely on their positionality to stimulants, which are framed as un/safe, un/fair, and in/effective treatments, to assert their authority over these facilitations and denials, presenting themselves as responsible service providers in each case. Still, in each of these facilitation/denial exchanges, the symbolic meaning of stimulants as medication destabilizes as both experts and clients unsuccessfully attempt to standardize qualifications for, and fair access to, ADHD services and medications. As a result, clients must strategically assert their congruent identities as patient, consumer, and/or student in order to navigate these multiple contexts and rationalize their desire for ADHD services. I argue that by doing so, both ADHD clients and experts are able to maintain a perceived sense of responsibility to consume stimulants while also promoting the responsible stimulant use of others.

In Chapter 5, I explore how responsible drug use is defined and facilitated by Adderall dealers and seekers during the willful diversion of stimulants, or the "drug deal." I present three

in-depth case examples that highlight moments in which ADHD students strategically resisted or participated in the Adderall market on campus and rationalized their decisions as acts of social responsibility. My analyses indicate that there is an ongoing struggle between ADHD students and Adderall seekers to define and ensure responsible stimulant use during each drug transaction. I use a combination of ethnographic vignettes and interview data to show how ADHD students rely on their positionality to stimulants, which are viewed as as effective, coveted, but potentially dangerous medications, as a way to assert their agency over these exchanges and present themselves as responsible drug stewards. However, with each exchange, the symbolic meaning of stimulants as medications becomes unstable as students struggle to determine which seekers are worthy of their valued medications. As a result, ADHD students must strategically assert their identities as patient, student, or friend in order to navigate these morally ambiguous exchanges and rationalize their decisions to conserve or distribute these powerful drugs. I argue that by doing so, ADHD students are able to maintain their perceived sense of responsibility over the responsible drug use of others.

In Chapter 6, I explore how responsible drug use is defined and facilitated by college students who consume ADHD medications without a legal prescription. I present six case examples that highlight moments in which students interpreted a positive or negative drug experience and subsequently developed strategies to make themselves feel like responsible drug users. My analyses indicate that students experience an ongoing struggle to make sense of and maintain agency over the chemical and symbolic transformation that comes from consuming Adderall. I use a combination of ethnographic vignettes and interview data to show how these students rely on their interpretations, creating strategies that help to mitigate the medical and social side effects of the drug. Yet with each swallowed pill, the symbolic meaning of stimulants

as self-medication, enhancement, and/or recreation becomes completely unstable as students struggle to justify their controversial behaviors. As a result, students must constantly reassert boundaries between their moral selves and the potentially immoral pharmaceutical practices they engage in. I argue that by doing so, these students are able to rationalize their behaviors as a form of responsible, albeit illicit, Adderall use.

In Chapter 7, I provide an overview of key findings from my research and situate them within anthropological theories of pharmaceuticalization and morality. In particular, I present an overview of emergent patterns from across the economic, medical and academic contexts that speak to the management of moral subjectivity in these various capacities. I also reflect on the usefulness of pharmaceutical morality as an analytical tool and the value of ethnography in investigating moral experiences.

# CHAPTER 2: MORAL LANDSCAPES

This chapter provides a historical and theoretical context for understanding the modern medical landscapes that circumscribe prescription stimulant use among college students in the US. It links together selected anthropological and sociological literature that considers the role of prescription stimulants in post-industrial American society. I focus specifically on work that describes the cultural influence of these drugs in relation to attention disorders within academic settings as the *medicalization of deviance* (Conrad 1975) and, more recently, the *biomedicalization of performance* (Conrad and Potter 2005, Clarke et al. 2003). In the first half of this chapter, I explore intersecting trends in morality, pharmaceutical subjectivity and the symbolic meaning of stimulants through the lens of medicalization and biomedicalization. I engage the concept of moral breakdowns to articulate the juncture between these two paradigms in relation to public perceptions of and concerns over prescription stimulants. I contextualize these breakdowns within a number of broader socio-historical factors, including the evolution of attention disorders and the transformation of direct-to-consumer (DTC) prescription stimulant marketing in the last half century. In the second half of this chapter, I offer an overview of key features within the modern DTC stimulant marketing, treatment and circulation landscapes. This overview sets the stage for the following data chapters, which more deeply investigate the ethical dilemmas associated with access to stimulants and how it effects the moral experiences of US college students.

## 2.1 HISTORICAL LANDSCAPES

The cultural meaning of prescription stimulants is deeply entangled with the establishment of psychiatry, and the subsequent medicalization of attention disorders in postwar

American culture. Conrad and Schneider (1980) suggest that after WWII, medicine had replaced religion as the dominant moral ideology and placed health as "a primary value in American society." They argue that this commitment to health served as justification for the treatment and control of undesirable individuals – a process they define as "medicalization." Robbins and Anthony (1982:284) note that "controversies over medicalization tend to involve psycho-emotional problems and the definition of mental health." This psychopathological model of illness was not only effective in redefining deviance as mental illness, but also helped to establish the American psychiatric field in the 1950s (Conrad and Schneider 1980). Accordingly, many issues of social or moral regulation such as gambling, addiction and homelessness had fallen under the medical jurisdiction (see Rosecrans 1985; Schneider 1978; Matheiu 1993). Although this movement was not exclusive to American society, Conrad and Schneider (1980:263) argue that it has "been nowhere more pervasive than in the United States."

Clarke et al. (2003) suggest that in the mid-1980s, American medical culture underwent a second transformation which they define as a movement from medicalization to biomedicalization. They explain,

> Biomedicalization describes the increasingly complex, multisited, multidirectional processes of medicalization, both extended and reconstituted through the new social forms of highly technoscientific biomedicine. The historical shift from medicalization to biomedicalization is one from control over biomedical phenomena to transformations of them (161).

Conrad (2005) also notes that the drivers of medicalization have shifted to include the pharmaceutical industry, insurance companies, and patient groups. However, he critiques the concept of biomedicalization and argues that "medicalization is expanding and, to a degree, changing, but not morphing into a qualitatively different phenomenon" (5). Although I agree in part with Conrad's claim that there is no clear disjuncture between the two paradigms, I adopt

Clarke et al.'s terminology to refer to key shifts in the cultural function of stimulants over the last forty years. In particular, I focus on the re-imagination of prescription stimulants as modes of social *control* in postwar American society to modes of social *transformation* during the turn of the century and into present day. I am particularly interested in how these perceptions have persisted or evolved to inform modern expectations of responsible stimulant use in the US college setting.

Although medicalization and biomedicalization studies offer insights into the cultural significance of prescription stimulants, I use pharmaceuticalization as the primary theoretical lens in this dissertation. Abraham (2010) argues that certain socio-historical aspects of pharmaceutical consumption have features which cannot be properly described by the medicalization framework and the authority of doctors. Instead, he identifies the political economy of the pharmaceutical industry, deregulatory state ideology, and consumerism as key factors that have fostered pharmaceuticalization. He does, however, suggest that medicalization and pharmaceuticalization can be mutually reinforcing processes, especially in the case where medical professionals work with, or for, the pharmaceutical industry to create and redefine disease categories. Abraham describes this as the "medicalization-pharmaceuticalization complex" (608). I consider this concept and the intersections between these processes to understand how prescription stimulants operate within and outside of sanctioned medical settings. I am especially interested in exploring how pharmaceuticalization influences the emergence of illicit prescription stimulant economies and how these drugs become re-engaged and/or detached from their original medical purpose during these illicit exchanges.

In the following sections, I provide a brief history of prescription stimulants in the context of broader socio-historical factors, including the evolution of attention disorders and the

transformation of direct-to-consumer (DTC) prescription stimulant marketing in the last half century. My overview is limited to those factors which directly inform the experience of US college students and does not include insights into other aspects of prescription stimulant history. For example, investigating the modern relationship between prescription stimulant manufacturers and medical professionals, as well as the politics of creating and refining disease categories in the Diagnostic and Statistic Manual (DSM) is beyond the scope of this chapter. I also limit this chapter to sources which I directly engage to analyze the data produced by study of US college students.

### *2.1.1 Ritalin as a Mode of Social Control*

Although attention disorders were not an established psychiatric category in the DSM until the late 1960s, the positive effects of stimulants on children with attention issues was first documented in 1937. Dr. Charles Bradley, the director of a hospital for neurologically impaired children, routinely conducted examinations which caused severe headaches in his patients. He attempted to treat the headaches by administering Benzadrine, one of the most powerful stimulants available at the time. While the treatment did little for the headaches, he observed subsequent improvement in the behavior and school performance of certain children. He later identified those who were most likely to benefit from Benzedrine treatment as characterized by short attention span, dyscalculia, mood lability, hyperactivity, impulsiveness, and poor memory. Although Bradley would go on to publish his findings in a number of medical journals, it would be decades until stimulants would be acknowledged as a viable treatment for children who displayed these characteristics (Lange et al. 2010).

During this time, Bezadrine continued to be a well-recognized treatment for a number of

established medical conditions in adults, ranging from narcolepsy to senility. In 1944, chemist Leandro Pannizon synthesized a safer alternative to Benzadrine called Methylphenidate. It was eventually manufactured as "Ritalin" by Ciba-Geigy Pharmaceuticals in 1954 (Lange et al. 2010). Donohue (2006) notes that the nature of Ritalin marketing was directly influenced by the 1951 FDA amendment of the "Durham-Humphrey Amendment" to the 1938 "Food, Drug, and Cosmetic Act" which significantly broadened the "prescription-only" federal drug classification (Donohue 2006). Tone and Watkins (2007) argue that this act also served to establish doctors as the "expert gatekeepers" to these drugs and pharmaceutical companies as the primary suppliers of prescription medicines. Donohue (2006) explains that although more drugs were now labeled as prescription-only, they did not carry the same level of product information/labeling as OTC drugs. This is because the FDA found some drugs to be so dangerous that they limited information about the drug to prevent any attempts at self-medication. Instead, the labeling was provided to doctors and pharmacists who would relay the appropriate information to patients and facilitate the consumption process. Donohue further notes that this mechanism of drug dispensing also aligned with the American Medical Association's long-held objective to reduce self-medication and increase physician's control over the use of pharmaceuticals. Shortly thereafter, pharmaceutical companies stopped advertising directly to consumers and focused all of their resources towards advertising to doctors.

Conrad (1975) argues that strategic prescription stimulant marketing was a primary driver in the medicalization of children's deviant behavior in the early 1960s. He describes how Ciba-Geigy placed multi-page print ads in medical journals and mailed print ads directly to doctors urging them to diagnose and treat "hyperkinetic" children. They also relied on the efforts of "detail men", or pharmaceutical reps, and funded professional conferences on the disorder in

order to engage with doctors face-to-face. Conrad explains that while most of the promotion was targeted towards the medical sphere, information about diagnosis and treatment of the newly discovered disorder was also directed to the educational sector. He states that drugs like Ritalin had become a mode of "medical social control wielded" by doctors to assert their authority over the deviant behavior of hyperactive children in the postwar America. Accordingly, advertisements produced by the pharmaceutical industry targeting physicians appeared in medical mailers cleverly portraying them through images and camera angles that underscored their clinical authority during the diagnostic and treatment processes (Singh 2007).

Lange et al. (2010) note that the increasing recognition of attention issues in children among the medical community eventually lead to the introduction of attention disorders into the Diagnostic and Statistical Manual (DSM-II) in 1968. The condition was called "Hyperkinetic Reaction of Childhood" and was defined in only two sentences: "The Disorder is characterized by over activity, restlessness, distractibility, and short attention space, especially in young children; the behavior usually diminishes by adolescence" (American Psychiatric Association 1968). This nebulous definition further supported the authority of medical doctors to be able to detect the condition based on their expert training (Conrad 1975). However, Diller (2009) explains that in the 1970s, sensationalized media coverage around Ritalin lead to a series of congressional hearings set to clarify the prevalence and proprietary use of the drug among children. He argues that latent anti-authoritarian trends from the 1960s encouraged non-depressive theories of childhood behavior. This, coupled with anti-industrial trends in organic foods, natural healing, and the rejection of pharmaceuticals, made people wary of potential forms of chemical "mind control" like prescription stimulants.

Lange et al. (2010) explain that in 1980, the disorder was renamed "Attention Deficit

Disorder" or ADD in the DSM-III to reflect findings from current research of the disorder. It was described as manifesting as one of two subtypes: with or without hyperactivity. This conceptualization was a departure from the World Health Organization (WHO)'s definition in the International Classification of Diseases (ICD-9) that focused on hyperactivity as a prominent indicator for the diagnosis of ADD. This iteration of the DSM also included three new symptom lists for inattention, impulsivity and hyperactivity. Further, it added a numerical cut off score for symptoms, guidelines for age of onset and duration of symptoms, as well as the requirement of exclusion of other psychiatric disorders. In 1987, a revision of the DSM-III was released that removed the two subtypes of ADD and renamed the condition "Attention Deficit-Hyperactivity Disorder" or ADHD. Lange et al. (2010) explains that it was argued that the initial creation of subtypes was not based on empirical findings. Instead, the new criteria were derived from rating scales and a field trial - supporting the combination of symptoms for inattention, impulsivity and hyperactivity were into a single list with a single cutoff score.

### *2.1.2 Moral Breakdowns: The Ritalin Wars*

In the 1980s-90s, the concerns over the safety of prescription drugs took a head with wide scale media coverage of the "Ritalin Wars" (Diller 2000). This term referred to a series of lawsuits that were filed by the The Citizens Commission on Human Rights as well as a number of independent plaintiffs against Novartis (formerly Ciba-Ciegy) over the negative effects of Ritalin on children. For example, LaVarne Parker, whose son had been diagnosed with ADHD, filed a $150 million federal lawsuit against an Atlanta area school district, several physicians, and the American Psychiatric Association (APA). She claimed that her son had been medicated with the drug at the insistence of the school district and that it had made him violent and suicidal

(Treadwell 1987). Similar cases were filed in Massachusetts, Minnesota, and California by school districts, doctors, and the American Psychiatric Association and claimed that these groups promoted ADHD as a disease and encouraged Ritalin as the prime treatment for it. Although these suits were eventually dismissed, cases of this nature continued to be filed through the early 2000s (Diller 2000).

The late 1990s also marked the emergence of the consumer's rights and patients' rights movements that demanded increased medical information and involvement in the medical decision making process (Donohue 2006). Abraham (2010) explains that this resulted in politically polarized attitudes towards drugs in the US. Thus, while some consumers focused on promoting the benefits of these technologies, others fought to raise awareness about the dangers they pose to both individual health and society at large. In particular, ADHD advocacy groups like "Children and Adults with Attention-Deficit/Hyperactivity Disorder" (CHADD), founded in 1987, served as the voice of the consumer to demand treatment for this condition. According to their mission statement,

> CHADD emerged in response to the frustration and sense of isolation experienced by parents and their children with ADHD. At that time, one could turn to very few places for support or information. Many people seriously misunderstood ADHD. Many clinicians and educators knew little about the disability, and individuals with ADHD were often mistakenly labeled *a behavior problem*, *unmotivated*, or *not intelligent enough* (CHADD Mission Statement 2016).

These organizations worked closely with doctors and the pharmaceutical industry to advocate for the needs of disempowered children and adults who suffered from attention disorders and required services and accommodations.

While public debates around the social costs and benefits of stimulants continued, Lange et al. (2010) explains that the formal definition of ADHD also continued to evolve through the turn of the century. In the next iteration, DSM-IV (1994), the heterogeneous category of ADHD

was once again divided into three separate subtypes: “predominantly inattentive”, “predominantly hyperactive” and a combined type with presentation of both sets of symptoms. However, the most significant change was that ADHD was no longer conceptualized as an exclusively childhood disorder, but rather a chronic, persistent condition that could continue into adulthood. However, an individual must have shown an onset of symptoms before the age of seven to qualify as ADHD. Conrad and Potter (2005) suggest that the increased recognition and establishment of Adult ADHD, and especially the increase in prescription stimulant use, was due to the effort of a number of scientific research, patient advocacy and the changing landscape of pharmaceutical advertising.

### *2.1.3 Adderall as a Mode of Social Transformation*

Fisher and Ronald (2008) note that the patient’s rights movements in the 1990s emerged alongside a larger shift towards a neoliberal model of healthcare in the US which they refer to as “medical neoliberalism.” They describe this as a system where “healthcare is not a right guaranteed to citizens but is instead composed of products and services to be purchased by those who can afford them” (32). Elliot (2003) explains that this type of commodification reframes health and illness in terms of products and services that can be purchased by engaged consumers. In particular, it promoted the invention of what Applbaum (2006) refers to as the informed medical consumer. He explains that “since, in a consumer society, we see ourselves as individuals and as free agents when we exercise consumer choice, it is not difficult for pharmaceutical companies and other privatized health-care deliverers to convince us that it is empowering to think of ourselves not as patients but as consumers” (446). In 1998, the US FDA changed its guidelines on direct-to-consumer or DTC advertisements to enable widespread

broadcast advertising of prescription drugs (Ronald 2006). Donohue (2006:675) explains, "early DTC campaigns demonstrated the role that patients could play in health care, acting as price-conscious consumers or talking with their physicians about a condition that might otherwise not be detected." Moreover, it gave the industry an opportunity to strategically bypass doctors and promote their products directly to the consumer (Ronald 2006).

It was during this time that Adderall was first introduced on the market by Shire Pharmaceuticals as a treatment for ADHD. The drug was originally approved by the FDA in the 1960s under the name "Obetrol" by Rexar Pharmaceuticals as a weight loss drug. However, in 1994, the company sold the rights to the Obetrol formula to Richwood Pharmaceuticals (now Shire Pharmaceuticals) and in 1996 Adderall was approved for the treatment of ADHD. IMS Health (2000) reports that prescriptions for stimulants and in particular Adderall increased from 1.3 million in 1996 to nearly 6 million in 1999, reflecting, in part, the efficacy of DTC model of drug marketing.

Sigh (2007) notes that the images of Adderall in advertisements from the late 1990s and early 2000s were significantly different that those that appeared for stimulants during the 1950s-1980s. In particular, they made no visual attempt to educate viewers about the behavioral symptoms of ADHD, only the solutions made possible by the drug. Sigh explains, "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" (149). This type of message served to tap into the concerns of patients over the medical negligence of doctors and present medications as a source of empowerment. At the same time, Fisher and Ronald (2008) argue, "what is labeled as empowering can be better thought of as a neoliberal maneuver to make individuals increasingly responsible for their health and well-being through

the consumption of pharmaceutical products" (35).

Dumit (2011) describes the potential for DTC advertising to convert viewers into patients or medical consumers as "pharmaceutical witnessing." He argues that this marketing strategy works by educating viewers about an illness, motivating them to self-diagnose, and convincing them to seek brand-specific treatments. The pharmaceutical industry has historically legitimized such tactics by claiming DTC marketing has an educational function that helps consumers make informed health choices (Conrad 2004; Dumit and Greenslit 2005).

Green (2007) further points out how DTC drug advertising serves to reify disease categories as being drug-centered. He explains, "when pharmaceutical companies define their products' indicated diseases as markets, they bring a logic of brands and commodities into the definition of disease itself" (17). Conrad (2004) notes that this tactic has been particularly effective in markets for medicalized conditions, such as ADHD, where symptoms are ambiguous and stimulants are presented as "lifestyle drugs" that can instantly solve social problems. Singh (2007) argues that over time, drugs like Ritalin and Adderall were re-cast in DTC advertisements as medically sanctioned "performance enhancers" that could benefit children and adults alike. Thus, the decision to seek an ADHD diagnosis and a subsequent prescription for stimulants is framed by DTC marketing as an act of both empowerment and responsibility on the part of the consumer to improve their health and social well-being (Conrad and Potter 2000).

In conjunction with DTC, Conrad (2008) suggests that the medicalization process had shifted towards a consumer-driven model of health where doctors were no longer the ones pushing diagnoses on their patients. By the late 1990s, new players had entered this economy, including parents, educators, insurers, drug companies, and potential patients who could each benefit from an increase in pharmaceutical prescriptions. As the participation and influence of

these parties in the treatment process increase, he argues that doctors must actively renegotiate their relationship to their patients and society at large. Dumit (2012) also discusses the influence of pharmaceuticalization on the doctor-patient relationship in his description of "doctor disempowerment" (14). He suggests that patients are taking advantage of the modern constraints placed on doctors to demand treatment for themselves (and their children). Dumit argues, "Doctors, in turn, because of the multiple pressures of limited patient time, keeping up with rapidly changing information, the constraints of healthcare maintenance organizations and insurance, are quite vulnerable to these demands" (14). Moreover, Howard et al. (2016) shows how the centralized medical authority of primary care physicians has been diffused to team-based models of care. They argue that these "shifts in domains of knowledge involved patient engagement and decision support, patient-focused responsibility or 'ownership' for one's own care, and team-based care" (14).

These observations of diffused medical knowledge resonate with the what Henwood et al. (2003) describe as the rise of the "expert patient" or "informed patient" – a neoliberal subject that was popularized in medical discourse at the turn of the century. They explain that this subject is based on the belief that "the greater availability of health information via the Internet will lead to the emergence of more informed patients who are better able to assess the risks and benefits of different treatments for themselves" (590). However, they argue that this idealized view of an expert patient has many constraints in practice, including the lack of interest or ability for consumers to easily locate reliable information. Moreover, they found that physicians are often unwilling to negotiate with patients, especially when "lay knowledge does not coincide with expert/medical knowledge and where a certain level of compliance with medical opinion is required" (606). Similarly, Fox et al. (2006:1300) suggest that "professionals cling to in their

engagements with patients, controlling information and dismissing efforts by patients to theorize or explain their condition."

These findings are particularly salient when considering the process of diagnosis and treatment of ADHD within college settings. Studies show that there is an especially high potential for malingering, or faking symptoms during diagnosis in order to gain access to prescription stimulants (Rabiner et al 2009). A recent study by Cepeda et al. (2014) also indicates that once diagnosed, some ADHD patients will cross state lines in order to "shop for doctors" who are willing to meet their demand for prescription drugs.

At the same time, Elliot (2010) argues that doctors have not completely shed their relationships with the pharmaceutical industry where drug reps and free drug samples are still common fixtures in clinical settings. Hunt et al. (2012) also describes the influence of "pay for performance" programs that incentivize physicians treating chronic illness to prescribe pills despite the adverse side effects and financial strain it puts on patients. These entanglements and conflicting objectives call into question alliances in the new era of pharmaceuticalization and how drug manufacturers, health service providers and US college students are negotiating moral agency through the sale, prescription and consumption of prescription stimulants.

## 2.2 MODERN LANDSCAPES

In the remainder of this chapter, I examine key features of the modern prescription stimulant landscapes that circumscribe the moral experiences of US college students who engage with these drugs. In particular, I focus on those factors which have significantly altered the landscapes described above and directly inform the data chapters of this dissertation. These sections link together key studies that examine the proliferation of prescription stimulants in

academic settings with broader trends in DTC drug marketing, diagnoses and treatment of ADHD. It also considers public concerns around prescription stimulants that are constructed and circulated in academic and popular media outlets. My goal is to explore the range of ideologies that emerge and evolve in relation to pharmaceuticalization to inform attitudes and expectations around responsible stimulant use across these diverse settings. I am particularly interested in how these expectations differ among various stakeholders who contribute to a moral understanding of this drug behavior in college settings.

### *2.2.1 Modern Marketing Landscapes*

The efficacy of DTC marketing in the last decade has exponentially increased the number of individuals on ADHD medications, but it has also re-stimulated concerns over the safety of these powerful drugs (Diller 2016). This is due in large part to the accessibility to and publicity around data that offers quantitative evidence of the dangers related to prescription stimulant use. For example, a national report from Substance Abuse and Mental Health Services Administration (SAMHSA) indicates a fivefold increase in prescription stimulant-related emergency room visits from 2005-2011 (SAMHSA 2014). This and similar reports are periodically featured in major media outlets and followed by several days of public outrage over the issue at hand. There are also a number of individuals and organizations who attempt to maintain awareness of these issues on a more consistent basis. For example, noted psychiatrist and author David Healy, aims to empower consumers through ongoing projects like Rxisk.com a website where individuals can search for and report drug side effects. Additionally, publicity around young American celebrities like Lindsay Lohan, Jessica Simpson, and Justin Bieber, who have gone to rehab to deal with their Adderall addictions, has brought attention to these issues in

the popular sector.

Along with medical concerns, there are also those who continue to question the chemical efficacy of stimulants to treat ADHD or if ADHD is even a real condition to begin with (Caroll 2014). Some suggest that DTC advertising has served to medicalize underperformance in the classroom and workplace, while others view Adderall as a cognitive enhancer that gives users an unfair advantage over others (Stolz 2012). Others see the drug as a band-aid solution for larger problems within the American education system, including larger classroom sizes, emphasis on grades over learning, as well as the sheer cost of higher education (McMahon 2007). Thus, the decision to consume prescription stimulants comes with both medical and social risks, including the stigma of identifying as ADHD, being called a cheater, and/or continuing to perpetuate the underlying problems with the education system. In these scenarios, Adderall use is not seen as an act of empowerment, but of individual and social irresponsibility.

Despite these widespread critiques, the fact remains that stimulant sales have never been better and the market for ADHD treatments has exponentially grown in the last decade. Today, there are over thirty name brand medications and over twenty generic versions available in the US – the vast majority of which are prescription stimulants (Drugs.com 2015). As a result, companies must continue to find ways to set themselves and their products apart, especially when their medications are more expensive than their competitors. This includes promoting the safety and efficacy of the drug as well as establishing trust in the company itself through strategic brand-centric marketing. For example, in 2014, Shire produced what they call their "Annual Responsibility Review," a 27-page document that outlined progress towards their "four pillars of responsibility" to their patients, people, planet and partners. Such projects included increased transparency in clinical research, increased diversity within their company, eco-

friendly business practices, and partnering with local charities to fund humanitarian projects (Shire 2015).

The rise in ADHD diagnoses coupled with the concern over the safety and stigmas of prescription stimulants has also opened a market for alternative ADHD treatments. Many of these are non-prescription, unapproved capsules and tablets which have capitalized on consumer demands for instant increases in cognitive function without the complications of prescriptions. A web search on Amazon.com for "Adderall", for instance, yields over 70 results, and a search for "cognitive enhancer" yields almost 200 products, with names like "Brain Energy" and "Focus Pep." The neurological reframing of ADHD has also created a market for neurofeedback and biofeedback service providers like "Brain Core" and "Neurocore" who have offices around the country - including two within ten miles of my field site. Advertisements for these programs also pander to parents and adults who want to treat ADHD without the medical side-effects or social stigmas of stimulant medications. Many of these programs are fully covered by health insurance, making them an even more enticing alternative to potentially expensive pharmaceutical treatments.

There has also been an increase in non-medical forms of ADHD management, such as academic and professional coaching. Kubik (2010) explains that coaches are not necessarily psychiatrists or medical professionals, though many may have a background in these areas. Today, there are dozens of certification programs, most of which adhere to the International Coaching Federation's guidelines, yet no formal certification is required to start a coaching practice. The benefit of coaching comes from the focus on "behavioral, emotional, and cognitive outcomes and build[ing] life skills to change negative outcomes and beliefs" (Kubik 2010:1). There is an emphasis on empowering the client to manage the neurological limitation of ADHD,

known as “executive functions” in more personalized way. Cost and breadth of services varies by coach but the drawback is that it can be relatively expensive as it is not covered by most insurance.

This mass increase in both pharmaceutical and non-pharmaceutical treatments for ADHD suggests that the condition has become widely recognized and accepted in mainstream American culture. Conrad (2000) explains that this is in part the result of joint efforts by the pharmaceutical industry and patient advocacy groups such as CHADD and Attention Deficit Disorder Association (ADDA). These alliances have become increasingly fundamental to stimulant sales given the rise in information-based health consumerism and skepticism over information provided directly from the pharmaceutical industry. For example, groups like CHADD and ADDA connect directly with potential and diagnosed patients, intermittently through industry-sponsored conferences, and pervasively through newsletters and social media. In these communications, ADHD is vehemently framed as a genetically-based, neurobiological disorder rather than a temporary psychiatric condition. Thus, “while thirty years ago adult ADHD might have been an oxymoron, today it is deemed a discrete disorder that can be claimed and diagnosed” (Conrad 2000:575). Further, it can also be reclaimed, given that the populations of children initially diagnosed with Attention Disorders in the 1970s-1990s are now adults who may have since stopped taking their medications. Thus, “by redefining ADHD as a lifetime disorder, the potential exists for keeping children and adults on medication indefinitely” (Conrad 2000:568).

The exponential growth in social media in the last decade should also be considered when understanding the modern drug marketing landscape. Sites like Twitter and Facebook allow marketers to engage with consumers on an unprecedented level of frequency and intimacy. This

has created a new generation of consumers who have become more accustomed to the idea of engaging directly with advertisers in order to exercise their consumer rights and improve their buying experience. Thus, although the pharmaceutical industry has not yet found a legal avenue to explicitly advertise medications through social media, it is still leveraging this culture of engaged consumerism through similar strategies. Examples from Shire Pharmaceuticals include sponsoring national contests, giving out awards, and collaborating with consumers in public service projects - all of which signal a significant departure from the one-way discourse of traditional DTC drug advertising of the late 1990s-early 2000s (Shire 2015).

### *2.2.2 Modern Treatment Landscapes*

In 2013, the DSM-5 included a revised set of criteria to assist medical professionals in diagnosing ADHD in adults. This included an extension in the age of onset from age 7 (grade school) to age 12 (middle school) and a reduction in the number of required symptoms from 6 to 5 out of a possible 18. They also rephrased the three subtypes of ADHD - inattentive, hyperactive, and combined - to "presentations," which meant adults could associate with various symptoms over the course of their life. Finally, they suggest that the experience of ADHD could be qualified as mild, moderate, or severe, the distinctions of which are based on how many symptoms a person has and how difficult those symptoms make daily life. The American Psychological Association (ASA) released a statement supporting these changes, stating that they "more accurately characterize the experience of affected adults" and that it "ensures that children with ADHD can continue to get care throughout their lives if needed" (ASA 2013).

However, not all medical professionals agree with these changes and professional critiques of ADHD as a valid and discrete category in the public arena continue to persist. For

example, behavioral neurologist Richard Saul published a controversial book in 2014 titled, "ADHD Does Not Exist: The Truth about Attention Deficit and Hyperactivity Disorder." He argues that ADHD is not a discrete condition, but rather a complex cluster of symptoms stemming from over 20 other conditions and disorders ranging from depression to giftedness to poor eyesight. He asserts that the symptoms of the condition require their own specialized treatments, rather than a blanket prescription stimulant regime. Saul expands on this critique by citing the highly addictive nature of stimulants, their short-term efficacy, and their ultimate detraction from identifying the underlying cause of a patient's symptoms.

Like many psychiatric disorders, there are no objective laboratory or neuropsychological confirmatory tests to diagnose ADHD, nor is there established consensus on the specific cluster of symptoms that constitute the condition (Hallahan and Kaufman 2005). Instead, medical professionals rely on a variety of assessments to determine whether an individual displays the minimum number of symptoms to qualify for an ADHD diagnosis. These assessments include: ADHD symptom checklists, self- or clinician-rated behavior scales, diagnostic interviews, history of past and current functioning and observational input from family members and close associates. While the results of these assessments can provide a basis for, or supplement to a diagnostic interview, ultimately, the diagnosis is based on the medical provider's professional opinion (Hallahan and Kaufman 2005).

As a result, critics argue that increases in ADHD diagnoses are due to the ambivalence of these assessments, allowing anyone to qualify as a candidate for ADHD (Hallahan and Kaufman 2005). Timmi and Leo (2009) explain this in their analysis of DSM criteria/symptoms list for the condition and suggest that ADHD assessments "can only rate a particular adult's perception of a particular [patient] at a particular moment in time. In other words, they are measures of the

subjective perception of the [doctor] filling in the rating scale. What they cannot be is an objective, factual piece of 'hard data' that measures something intrinsic to the [patient]" (5). Rabiner et al. (2009) note that this flexibility has also created an opportunity for college students to deliberately over report symptoms to procure academic accommodations or feign ADHD to obtain a prescription for stimulants for nonmedical purposes.

Another reason ADHD continues to be such a contested disorder is because its diagnosis and treatment is currently compartmentalized across a number of medical and cultural paradigms. As a mental illness, ADHD diagnosis and treatment falls under the purview of psychiatry which often relies on a combination of talk therapy and/or the use of psychotropic drugs to treat symptoms. Experts in this field are certified medical doctors who are able to prescribe stimulants as needed. More recently, ADHD symptoms are explained through the neurobiological approach, which defines it as a genetic disorder possibly affecting genes that produce and regulate Dopamine (Tripp and Wickens 2008). Typically, experts in this field are scientists who are pursuing research trying to find the biological basis of disease. The purpose of stimulants in this context is to correct the imbalance of chemicals in the brain due to the person's genetic makeup. Martin (2007) explains that neurobiological conditions are well received by patients because they provide a scientific explanation and label to a perceived shortcoming. This allows the individuals to escape the burden of being labeled lazy, stupid or crazy (Kelly and Ramundo 2006).

Another framework for understanding ADHD is as a behavioral disorder with additional attention problems. Doctors might diagnose someone with ADHD based on issues in the classroom or in workplace that interfere with their ability to interact with others. In this modality, the purpose of stimulants is to help control, modify, or normalize the behavior of the patient. It

can also be a legitimate explanation for the poor behavior of a person in these environments. ADHD has also been described more specifically as a cognitive disorder or a developmental impairment of executive functions (Barkley 1997). This continues to become a prominent paradigm because, like the neurobiological approach, it explains behavior in terms of the brain. Experts in this field are doctors who have done significant research on ADHD and how it works with and within the brain. The function of stimulants in this modality is to correct the executive functioning problems of the patient. The ADHD patient benefits from this perspective as it is both neurobiological and behavioral. This allows them to explain their behaviors in a biomedical way. This is treated with cognitive behavioral therapy in an attempt to change or fix the disorders (Bramham 2008).

While the science of ADHD continues to evolve, cultural paradigms of ADHD treatment are also important to consider. For example, ADHD has recently been described as Learning Disorder because its symptoms can create difficulties in classroom settings and due to new legislation on disabilities rights. This is due in large part to the the Individuals with Disabilities Education Act (IDEA) of 1999, which classified ADHD a disability and enabled students to receive special education accommodations if they meet qualifying criteria (Vickers 2010). While this modality can provide important benefits to ADHD students, it also charges disabilities service providers are now with translating and accommodating the biomedical symptoms of this behavior. At the same time, information about the condition has become increasingly available to professionals across these paradigms, as well as to the general public. In fact, there are approximately 9,000 books available on Amazon on topics ranging from a beginner's guide to the neurobiology of ADHD to how to treat your own ADHD by changing your diet, to coping with your ADHD child, spouse or loved one. There are also a growing number of ADHD experts

who are known for their work in this field and have a significant impact on public perceptions of the condition - as well as the function/necessity of stimulants treatments.

### *2.2.3 Modern Campus Stimulant Landscape*

As more and more students arrived on campus with ADHD diagnoses and legal access to prescription stimulants, Adderall quickly became the drug of choice for healthy students looking to increase focus, manage time, and enhance academic performances. For example, McCabe et al. (2006) analyzed survey responses from almost 20,000 full time undergraduates at 119 universities regarding the prevalence of illicit use and diversion of four classes of abusable prescription drugs; sleeping medication, sedative /anxiety medication, stimulant medication and pain medication. Their results indicated high rates of illicit use and attempted diversion of these prescription drugs. Among the four classes of prescription drugs, medically prescribed stimulants, such as those used to treat ADHD, were most likely to be approached to divert their medication. In fact, more than half of the undergraduate students with prescriptions were approached by peers without medical prescriptions to acquire their medication. The study also indicated that illicit users are likely to be unaware of a drug's documented contraindications, precautions, or interactions with other drugs.

DeSantis et al. (2008) analyzed 1,811 survey responses and 175 structured interviews from undergraduates at a southeastern university regarding non-medical Adderall use. Their results indicated that 4% of students reported having legal prescriptions for the drug and 34% of the remaining population has used Adderall without a prescription. They report that most of these students reported using Adderall during periods of high stress, and found it to "reduce fatigue while increasing reading comprehension, interest, cognition and memory" (315). They

also report that "most had little information about the drug and found procurement to be both easy and stigma-free" (315). DeSantis et al. (2010) also note that Adderall use was not viewed to be dangerous or immoral among drug seekers, which increased the likelihood of participation in this drug behavior.

The lack of perceived danger stems, in part, to the source of prescription stimulants on college campuses. In their study of Adderall dealers, DeSantis et al. (2013) contend that 30% of students in their sample who took stimulants illegally received them from the 3.4% of students on campus who had legal prescriptions. In other words, Adderall users were seeking drugs from their peers who were themselves ADHD patients - not professional drug dealers. This is important because it illustrates the high demand for illicit drugs compared to a relatively limited supply. Vrecko (2015) agues that many students develop what he calls "scrounging strategies" to obtain Adderall to use on a regular basis. Informants in his study reported feeling uncomfortable asking for Adderall directly because "an explicit request might be perceived as greedy or presumptuous, or might risk putting a friend in the awkward position of having to refuse an appeal for help" (299). Instead, they would wait for friends to offer the drug.

Although there has been a significant amount of research from the health and social science literature regarding illicit drug seekers, few ethnographies focus explicitly on the moral subjectivity of drug dealers, and even fewer attempt to understand what Inciardi et al. (2009) refer to as the "black box of prescription drug diversion." This presents a significant barrier in understanding the moral subjectivity and experiences of ADHD students who do not operate in traditional drug markets or fit the socio-demographic mold of most illicit drug users or dealers. In particular, there are a number of factors that set the circulation of Adderall on college campuses apart from other illicit drug markets. For example, McCabe et al. (2006) conducted a

large scale survey of undergraduates at a large Midwestern University and found that the majority of Adderall dealers on college campuses are white male upperclassmen who are involved in Greek life. In their book *Dorm Room Dealers: Drugs and the Privileges of Race and Class*, Mohamed and Fritsvold (2010) argue that predominantly white, upper-to-middle class demographic of American college students brings with it certain entitlements. They argue that "if a person does not fit the stereotypical drug carrier or drug dealer profile of young urban minority male, regardless of whether levels of actual drug dealing and drug use are on par with or exceed that of the stereotypical dealers, trafficking and illegal drugs becomes a significantly less risky enterprise" (33). It is possible that because of this perceived impunity from the law, college dealers, and especially prescription drug dealers, rarely take legal implications into consideration when dealing their drugs.

This lack of impunity is also due, in part, to the fact that prescription stimulants operate in what Mohamed and Fritsvold call a "closed market" in which dealers only sell to people they personally know and for whom they can vouch. They explain that "closed markets offer both dealers and customers more security and because of the closer interpersonal ties and consistent supply streams, closed markets offer customers some degree of quality assurance over the drugs they buy" (12). McCabe et al. (2006) report that demographics of the typical Adderall dealer mirror those of the typical illicit Adderall user, suggesting that they are part of the same social networks. Moreover, 100% of undergraduates in their survey reported obtaining the drug from a friend or family member.

Another important factor to consider in the productive reputation of prescription stimulants in academic settings. In the last decade, drugs like Adderall have become central to debates on the ethics of pharmaceutical cognitive enhancement or "cosmetic neurology" among

not only academic, but also scientific and medical professionals. Some view pharmaceutical enhancement as an academic or career choice, like other consumer commodities – such as buying a cup of coffee or hiring a math tutor – that may not necessarily be available to everyone (Farrah et al. 2004). Thus, these "enhancements" have the potential to significantly widen existing social inequalities and may lead to coercion of students, employees and even military personnel to take the drugs in order to remain competitive in their fields (Appel 2008).

At the same time, the viability of these drugs to actually enhance brain function remains in question. While there have been several ongoing studies indicating potential increases in reading efficiency and short term memory retention, many argue that there are cognitive trade-offs including a loss of creativity and critical thinking (Chatterjee 2004). These questionable advantages must be further placed in perspective with the cited health risks of ADHD medications. Despite proponents deeming these drugs "safe enough" by the FDA for children and ongoing clinical trials with healthy individuals, negative effects can include cardiovascular problems, potential for abuse and even death (Harris 2009).

## 2.3 CONCLUSION

In this chapter, I offered a brief overview of the emergence of medicalization and biomedicalization in American society and underscored the explicitly moral and neoliberal dimensions of these shifts. The period of postwar medicalization marked the creation of the moral pharmaceutical subject through the conflation of badness and sickness as described by Conrad and Schneider (1975). This process informed and reflected changes in American psychiatry and pharmaceutical culture that made way for the medicalization of deviant childhood behavior as a type of attention disorder. The pharmaceutical industry paralleled these changes as

they pharmaceuticalized this condition and empowered doctors as the gatekeepers of these magic bullet cures, emphasizing their role in promoting ADD as an established category.

The shift towards biomedicalization emerged in relation a significant social moment of moral breakdown in which Americans both desired liberation from the medical imperialism of doctors and more control over their healthcare choices. This played out as a desire for more medical attention and care for ADHD as exemplified by the establishment of CHADD, as well as the rejection of pharmaceuticalization as exemplified by the Ritalin Wars. America evolved in relation to this moment of moral breakdown by turning to neoliberal medicalism, which was presented as patient empowerment by the government as well as the pharmaceutical industry. This turn was a key feature in the shift towards biomedicalization where individuals no longer saw medications as forms of social control, but opportunities for social transformation. Furthermore, the history and promotion of Adderall during this shift in the early 2000s illustrates how the medicine was now being promoted as a lifestyle drug that could instantly fix issues of underperformance. Lastly, biomedicalization and pharmaceuticalization have evolved in the last decade in three spheres: the modern marketing landscape, the modern treatment landscape, and the modern university stimulant landscape.

This chapter serves as a foundation to understanding how changes in these spheres have led to a new set of moral breakdowns associated with the evolution of pharmaceuticalization in the last decade. In the following chapters, I highlight these moments of moral breakdown with each of these contexts in order to understand how advertisers, health service providers, drug dealers and drug users are positioning themselves in these morally convoluted landscapes.

## CHAPTER 3: MARKETING

This chapter explores how responsible stimulant use is defined through the direct-to-consumer (DTC) marketing of prescription stimulants to U.S. college students. Its purpose is to provide insights into how attitudes and opinions around responsible stimulant use are constructed, translated and filtered from the marketing landscapes into the college context. It builds on selected anthropological literature that describes the informed medical consumer, a neoliberal subject who empowers themselves through calculated pharmaceutical consumption. Here, DTC marketing produces a powerful one-way discourse through which drug companies can passively inform consumers about undiagnosed illnesses and potential treatment options. This includes strategies such as personalizing risks, motivating self-diagnosis, and creating branded compliance. Accordingly, it becomes the consumer's responsibility to act upon this information and make a responsible decision about seeking diagnosis and pharmaceutical treatments.

I build on this literature and consider how the DTC marketing of prescription stimulants to US college students has evolved in respect to pharmaceuticalization in the last decade. Increases in prescription stimulant sales have raised public concerns over the intentions and actions of drug companies who irresponsibly promote unsafe, unfair, or ineffective products to their consumers. I use media reports to provide insights into public discourse surrounding this social moment of moral breakdown and highlight the ethical dilemmas faced by the pharmaceutical industry. I situate these dilemmas within the evolving stimulant marketing landscape described in Chapter 2 and illustrate how factors, such as the increasing competition in medical and non-medical treatments and evolving consumer demographics and expectations, have reshaped the producer-consumer relationship.

My goal in this chapter is to examine how drug advertisers have morally positioned themselves, their products, and their consumers in relation to this social moment of moral breakdown. To accomplish this, I conducted a critical discourse analysis (CDA) of selected DTC marketing campaigns sponsored by Shire Pharmaceuticals, that target current and future college students. This included a review of digital documents, images and videos related to industry-sponsored contests, scholarships, resources, events and anti-abuse campaigns. I present four case examples that highlight moments in which Shire positioned themselves in response to public concerns around DTC stimulant marketing and framed their promotion of pharmaceuticals as acts of social responsibility. These case examples are organized around campaigns which both promote the responsible use of stimulants and condemn irresponsible prescription drug behaviors. I present my analyses of these case examples around Fairclough's (1989) framework of relations-objects-subjects to systematically map the moral discourses that surround and are produced through the modern DTC marketing of prescription stimulants. I conclude the chapter with a discussion of how this analysis informs conceptions and expectations of pharmaceutical morality and subjectivity among US college students.

## 3.1 MORAL BREAKDOWN: LOSING CONSUMERS OR SELLING SICKNESS

Over the last decade, annual sales for ADHD medications have skyrocketed from $4.7 billion in 2006 to $12.9 billion in 2015, and is projected to reach $17.5 billion by 2020 (IBIS Health 2015). The number of adults filling these prescriptions has also increased by nearly 50% from 2008 to 2012 (Express Scripts 2014). For ADHD advocates such as Dr. Russell Barkley, the growth in the prescription stimulant market reflects a four-decade long effort to increase awareness for the condition as well as the fulfilled promise of advanced pharmaceutical science

to meet their medical needs (PBS 2001). At the same time, the increase in prescription stimulant sales continues to raise significant public concerns over the legitimacy and social acceptability of traditional DTC marketing and the powerful products they promote. As a result, the pharmaceutical industry is faced with the dilemma of selling ADHD medications without alienating potential consumers.

Media commentaries on these concerns offer key insights into how Americans are responding to the growth of DTC stimulant marketing as a social moment of moral breakdown. For example, in 2013, New York Times journalist Alan Schwarz published a scathing article titled "The Selling of ADHD," which highlighted the dangers of irresponsibly marketing, prescribing, and consuming prescription stimulants. The piece chronicled the pharmaceutical industry's mission to increase sales in the late 1990s by transforming the diagnosis from a temporary psychological condition affecting only children, to a lifelong neurological disorder that goes unrecognized in many adults. Schwarz showed how companies like Shire Pharmaceuticals spent significant resources educating doctors about this new paradigm of ADHD management through online training sites and industry sponsored conferences. While increases in diagnosis rates reflect the efficacy of these strategies, Schwarz quoted several doctors who referred to the phenomenon as a "national disaster of dangerous proportions." These critiques echoed the sentiments of the Institute of Medicine (IOM) who went on record in 2009 to condemn these questionable alliances between medical professionals and the pharmaceutical industry (IOM 2009).

Schwarz further described how companies like Shire relied on DTC marketing through television commercials, print advertisements and online materials to promote their products straight to consumers. Many of these ads encouraged the parents of high school students and

college students who were unsatisfied with their child's academic performance to seek treatment for ADHD. As a result, sales figures for stimulants more than quintupled between 2002-2012. At the same time, Schwarz cited the numerous warning letters Shire and other manufacturers received from the FDA instructing them to withdraw ads for being false, misleading, and/or over exaggerating the effects of their medications. In one letter from 2008, Shire is accused of insinuating that Adderall XR was proven to prevent the consequences of untreated ADHD such as receiving poor grades, being unemployed, or being socially outcast. The FDA letter reports, "while research shows Adderall XR can improve patients' total scores on the ADHD-RS-IV in clinical trials versus placebo, it in no way supports the transformative claims these advertisements suggest" (FDA 2008).

The FDA also accused Shire of omitting critical risk information about contraindications, warnings and precautions associated with the drug in the online advertisement. Schwarz went on to remind the reader of how dangerous and addictive these stimulants can be, especially when their use is not supervised by a responsible medical professional. He quoted Roger Griggs, the pharmaceutical executive who introduced Adderall in the late 1990s, as referring to the medication as "nuclear bombs" that should never have been marketed to consumers in the first place. In contrast, current industry executives hold steadfast to the belief that they are upholding their responsibility to their consumers to educate them about ADHD and its potential treatments. More so, they place responsibility on the consumer to work with his or her medical professionals to make sure ADHD is properly diagnosed, monitored, and treated.

The concerns outlined in Schwarz's article are part of a long-standing public debate over the legitimacy and social acceptability of traditional DTC marketing and the powerful products they promote. It has emerged as the result of a number of factors that shape this new marketing

landscape, including public fears over the safety of stimulants, increasing competition among treatment options, and evolving consumer expectations and demographics. In particular, the expiration of Adderall's patent and the introduction of Vyvanse in 2007-2008 presented an opportunity for the remarketing of ADHD and stimulants to consumers within this context. In this chapter, I examine how Shire Pharmaceuticals has positioned themselves in order to navigate this morally convoluted environment. Specifically, I ask, how is responsible stimulant use defined and facilitated by Shire and its consumers through DTC drug marketing? How do these interactions influence and embody shifting expectations around the responsibility of US college students to facilitate and participate in responsible stimulant use? In the following sections, I explore these questions and investigate how Shire is framing ADHD treatment, the function of stimulants, and the role of the responsible consumer in relation to this social moment of moral breakdown.

## 3.2 CASE EXAMPLES

To better understand this landscape, I examined over a dozen recent marketing campaigns from Shire pharmaceuticals promoting their ADHD medications Adderall and Vyvanse, as well as their company in general. This included a review of television commercials, websites, brochures, reports and other documents associated with domestic and international ADHD awareness and pharmaceutical marketing campaigns targeted towards students and young adults. My analyses of these campaigns are based on Fairclough's (1989) three-dimensional framework for analyzing the ideological work of advertisements: relations-content-subjects. He describes this framework as follows:

> *1. **Building relations**. Advertising discourse embodies an ideological representation of the relationship between the producer/advertiser of the product being advertised, and the audience that facilitates the main ideological 'work'.*
> *2. **Building images**. Advertisements get their audiences to draw upon ideological elements in their members' resources (MR) in order to establish an 'image' for the product being advertised.*
> *3. **Building the consumer.** Advertisements use 'images' which audiences 'help' them to generate for products as vehicles, construct subject positions for 'consumers' as members of consumption communities. This…is the major ideological work of advertising (167).*

The term 'Members' Resources' or MR is used by Fairclough to include what "people have in their heads and draw upon when they produce or interpret texts – including their knowledge of language, representations of the natural and social world they inhabit, values, beliefs, assumptions and so on" (24). This includes both negative and positive experiences they have had with ADHD symptoms and prescription drugs, as well as values specific to American higher education and young adult life. Based on this, the viewers then position themselves to the featured object (prescription stimulants or ADHD management resource) in order to participate in a particular desirable (and in this case, empowered and responsible) lifestyle that Fairclough refers to as a "consumption communities."

Using Fairclough's model, I examine how these various forms of DTC advertising work ideologically to present moralized exchanges between the drug companies and consumers (building relations), the perceived function of prescription stimulants in the context of ADHD management (building images) and the intersecting ideologies of health, empowerment, and responsibility that produce the ideal ADHD sufferer (building the consumer). Ultimately, the goal of this chapter is to show how these DTC campaigns have redefined what it means to be an empowered, yet responsible, prescription stimulant consumer in this evolving marketing landscape.

In the following sections, I present four case examples that highlight moments in which Shire strategically situated themselves against concerns over irresponsibly promoting unsafe, unfair, or ineffective products to their consumers and rationalized their marketing practices as acts of social responsibility. These cases include (1) The "Own It" Initiative - a set of contests and commercials aimed at adults who believed they outgrew their ADHD (2) The "U do the Rest" Campaign - a set of contests and resources for adults to use in combination with stimulant treatment (3) The Michael Yasick ADHD College Scholarship - a financial award sponsored by Shire for students with ADHD that includes ADHD coaching services and (4) CPAMM - a coalition of medical and educational professionals, funded by Shire, who are addressing the issue of prescription stimulant misuse.

### *3.2.1 The Own It Initiative: Responsibility as Taking Ownership*

In his historical analysis of Adult ADHD, Conrad (2004) notes that one of the primary functions of DTC advertising is to raise awareness for medicalized conditions. While Shire continues to profit from new diagnoses and subsequent prescriptions, they have also begun targeting adults who were once diagnosed with an attention disorder but have since discontinued their treatment. This can occur for several reasons, including: a rejection of their childhood diagnosis; a rejection of ADHD as a legitimate illness; a belief that they outgrew the condition; feeling stigmatized because of their diagnosis; a fear of side effects from or dependency on prescription stimulants. As Dumit (2012:76) explains, "Marketers do not like stigma because they fear it will inhibit self-recognition of patient status and therefore reduce prescription demand. They call these stigmatized diseases, 'diseases of denial', implying that individual psychology is at the heart of the marketing problem."

In order to address these concerns and recapture this demographic, Shire launched the "Own It Initiative" in 2011, a series of advertisements that reframed ADHD acceptance and management as a fundamental responsibility of becoming an adult. In a press release from 2011, they explain,

> Adam Levine, lead singer of Maroon 5, and Shire today announced the launch of 'The Own It Project'. The Own It Project is designed to encourage adults who are taking responsibility for their ADHD – and owning it – to motivate others to do the same by entering their story for a chance to become the next Own It spokesperson… Prize package options for the contest include sessions with an ADHD coach. The winner also will receive an autographed guitar as a personal gift from Adam Levine… The leaders of patient advocacy groups CHADD and ADDA have released the following joint statement in support of The Own It Project: 'It's so important for people with ADHD to hear from their peers and share experiences. "The Own It Project" does just that – and we support the project as one that encourages the ADHD community to support itself.'

The rhetoric in this ad campaign was powerful because it not only acknowledged the stigma of being labeled as ADHD, but also encouraged patients to embrace, embody, and promote the diagnosis. It attempted to create a sense of biosociality among potential consumers by reminding them that they belong to an ADHD community, whether they like it or not. In other words, the responsible consumer should not just accept their diagnosis, but "own it" and incorporate as a part of their individual and group identity. Moreover, they are willing to team up with the pharmaceutical industry in order to motivate others to get re-assessed by their doctors now that they are adults. By soliciting patients through the Own It Project, Shire was also able to collect original narratives about consumer experiences with ADHD and treatment, to which they now own the rights. In return, the consumer was rewarded with commercial prizes, like an autographed guitar, or treatment-oriented prizes, such as access to alternative forms of ADHD management, like coaching. Given the potential apprehension of their target consumers around stimulant medication, Shire strategically placed focus on accepting the diagnosis before introducing their drug, Vyvanse, through subsequent marketing.

Shire eventually released a series of commercials for the “Own It” Initiative, which aired between 2012-2014. One of which featured the winner of the contest, a graduate student named “Megan M.” who undergoes a transformation in her academic performance and social circumstances once she finally accepts her ADHD diagnosis. At the end of each commercial, viewers were encouraged to visit "ownyouradhd.com" to find out more about ADHD and potential treatment options. The website was divided into three sections, each of which uses a particular marketing strategy to entice viewers to become diagnosed and seek treatment. The first section is titled, “We Own Our ADHD. Hear Our Stories”. It links the viewer to the “Own It” DTCA commercials featuring Megan M., as well as celebrity personalities, like musician Adam Levine and athlete Shane Vicotorino, who are generally considered successful adults, owning their ADHD. This campaign drew on the use of celebrity to increase awareness and to illustrate the potential social benefits of overcoming one’s ADHD. The Own It Initiative featured celebrities who many young adults would be familiar with and might aspire to be. Moreover, it was insinuated that the decision to treat ADHD was the reason why they have become successful in their particular field. This implies that if the viewer also “owns their ADHD,” they too could achieve the same level of professional success.

Once the viewer has overcome the concerns of ADHD-related stigmas and has become open to the possibilities of success that treating the condition might allow, they were then primed for self-diagnosis. The second section of the website featured an “Adult ADHD Screening Test.” The questions are rated on a Likert-type scale of 5 choices: never, rarely, sometimes, often, very often. It included questions such as “How often do you have problems remembering appointments or obligations?” and “When you have a task that requires a lot of thought, how often do you avoid or delay getting started?” If the user scored between 0-3, the system prompts

a generic response that indicated that “ADHD is Unlikely”. If the user scored between 4-6, the system indicated that “ADHD may be likely”. It further explained that although the quiz score does not indicate a real diagnosis, it is likely that others with the same score did eventually receive a diagnosis and treatment. In her study of DTC advertising for Premenstrual Dysphoric Disorder (PMDD). Ebling (2011) explains that these types of checklists are now a staple of most prescription drug websites. They serve to “universalize and personalize the bodily experience of symptoms and translate that experience into a need for treatment and action by the patient” (831).

Now that the viewer has been convinced that “ADHD may be likely,” they may have questions about the details of the condition and what to do next to address this newly recognized problem. Accordingly, the third section of the website was titled “Get Answers to your questions about ADHD.” It features a series of dropdown menus structured around four questions: “(1) Is ADHD a real condition? (2) Can ADHD be managed? (3) How is ADHD diagnosed? (4) Are there tips that may help?” After a brief answer reifying the likelihood of diagnosis and necessity of treatment, the viewer was prompted to click on a “learn more” tab which took them directly to “www.adhdandyou.com.” This is an informational website hosted on Shire’s primary website to inform potential consumers about ADHD and its treatments. It features a page called “Getting to know your ADHD team” and includes information on coaching, cognitive behavioral therapy, and medications. The significance of this page is that both Shire and its products are framed as part of a larger ADHD management plan that is supported by these other treatment modalities. Given the growing popularity of ADHD coaching and new forms of behavioral therapy, it is in Shires best interest to leverage their support in presenting a more palatable model of treatment for their target consumer base - especially those who are still skeptical or concerned about

prescription stimulant use.

### *3.2.2 The U Do the Rest Campaign: Teaching Responsibility*

As ADHD patients continue to deal with the stigmas and challenges associated with prescription stimulant use, Shire has also reimagined the ideal relationship between consumers and the drug itself. This is due in large part to public commentary and published research on the in/efficacy of ADHD medications to increase performance. One of the most common critiques is that stimulants give their user an unfair advantage in competitive fields such as higher education, professional athletics, and the workplace (Firger 2014). Thus, ADHD patients face accusations of being called cheaters who did not rightfully earn the successes they achieved while on their medication (i.e. the magic bullet it too magical). Ironically, another common critique is that stimulant medication alone is not effective enough to give the user the desired performance enhancing effects (i.e. the magic bullet is not quite magical enough) (Hamilton 2010). Some studies even suggest that the feelings of success related to the consumption of stimulants can be attributed to the placebo effect (Looby and Earliwine 2011). In one case, the drug is perceived as being too powerful, and in the other, not powerful enough.

Shire addressed both these concerns when they developed the "U Do the Rest" campaign, which shifts the responsibility and rewards of successful ADHD management from the medication back onto the consumer. Between 2013-2014, Shire featured a number of advertisements on the Vyvanse website with a variation of the tag line "Vyvanse manages my ADHD. I do the Rest." The ads linked to "UDoTheRest.com," which welcomed users with a statement that reads, "What's the rest? All the stuff you do for yourself. This site is filled with specially selected apps, articles, tips, and more to help with the rest." Like the "Own it"

Initiative, the U Do the rest campaign focused very little on the efficacy of Shire's pharmaceutical products and instead attempted to train the patient on how to be an empowered, responsible and engaged medical consumer.

The viewer was introduced to a curated set of industry manufactured materials and collections of outside resources that promote a particular view of ADHD – one that is simultaneously neurological (because they still want to sell you their drug) but also individual, in that everyone experiences the condition differently. Moreover, they asserted that these are challenges specific to ADHD and that learning to cope with them is ultimately the responsibility of the consumer. For example, each section of the website offered infographics, copy written by Shire, and step by step tutorials on everything from "How to organize your closet" to "How to prepare for class" to "How to prepare for a job interview". These topics are especially relevant to young adults and especially college students who were looking to increase their academic performance and prepare for an unstable job market. As a result, the "U Do the Rest" campaign continued to promote the role of the pharmaceutical industry as an "educator" who empowers their consumer with valuable information and resources to help manage their condition.

In 2014, the "U Do the Rest" campaign featured a national contest called "Organize your Stuff", which offered a number of prizes to "adults who want help organizing their space and reducing clutter." Entrants were asked to submit a photo and description of a space they wanted help organizing and the challenges holding them back. The grand prize winner would receive up to $2500 worth of prizes, including a gift card to The Container Store, a tablet with pre-loaded organization apps, and a consultation with a professional organizer. A press release from Shire in 2014 explained,

> "Shire today announced the winners of the Organize Your Stuff contest, which was designed to help adults organize their space and reduce clutter. Sydney Bloom, 28, from

> Charlotte North Carolina was chosen as the grand prize winner after submitting a picture of her craft room and the reason she needed help organizing it… To help Sydney achieve her organizational goals, Monica Friel, president and founder of Chaos to Order, a respected professional organizing service, designed and implemented an individualized organization plan... 'The success of the contest demonstrates a real need for the resources Shire provides through UDotheRest.com' said Perry Sternberg, Head of the Neuroscience Business Unit at Shire. 'As leaders in the ADHD space, Shire understands the challenges individuals with ADHD may face" (Shire 2014).

The before and after photos from the organizing session were featured on the blog "From Chaos to Order". The fact that the before picture was not that dramatically chaotic suggests that even the mildest ADHD challenges can benefit from the help of an industry professional. It also is important to note that Shire did not sponsor a makeover (akin to the magic bullet model of ADHD treatment). Instead, they sent an expert organizer to teach Sydney how to successfully manage the symptoms of her ADHD (akin to the ADHD team management approach). At the same time, prescription stimulants remain an important, implicit, yet understated part of this management model. We can see this when we go back to the U do the Rest website and zoom out to see that the initially hidden bottom half of every page does in fact feature information about Vyvanse. Thus, even the structure of the website itself promoted a particular view of the responsible prescription stimulant user – one who must literally build her own personalized ADHD management plan on top of a necessary and supportive pharmaceutical foundation.

Although securing brand loyalty has always been a priority for the industry, the U Do the Rest campaign shows how Shire has moved away from simply showcasing the superiority of their drugs, to promoting a sense of shared responsibility with their consumers and allied ADHD service providers. Shire holds up their end of the relationship by providing new and improved pharmaceutical treatments, access to ADHD experts and resources, and incentives to empower the consumer to own and face their ADHD challenges. Thus, if the consumer was successful, it was a team victory – if not, it was a failure on the part of the consumer, not the pharmaceutical

company that went above and beyond their role to produce safe and effective drugs.

### *3.2.3 The ADHD College Scholarship: Rewarding Responsibility*

While UdoTheRest.com offers some helpful tips for academic success, Shire had also created a set of supplementary materials to secure brand loyalty among the college demographic. Specifically, they set out to show that their company knows exactly what it takes to achieve a successful college experience, from obtaining admission into the right institution, to finding a job after graduation, and everything in between. For example, the website "ADHD & You" featured a set of resources intended to help prospective college students and their parents prepare for the daunting process of applying for college. One of these guides is titled "6 Steps to College" and featured thirteen pages of checklists and resources that promise to simplify the college search process. Another guide, titled "The College Testing Guide" offered similar advice on the specifics of college admissions exams, such as the SAT and ACT. Information included in the guide ranges from how to choose an exam, to how to study for an exam, to how to prepare for the actual test day. For example, one page of the guide suggested that a week before the exam, parents should encourage their child to "chill out" and practice driving the route to the exam. These resources insinuate that the successful college experience starts with parents who are willing to do whatever it takes to ensure that their ADHD student gets the help they need, including medication. This follows the same logic of the U Do the Rest campaign in that parents cannot expect stimulants alone to get their kids into a good school – but luckily, Shire is there to help them along the way.

These resources were also linked to one of Shire's most innovative marketing campaigns for college students – "The Michael Yasick Scholarship" program, first established in 2007.

Scholarships are available in the U.S. and Canada and include a $1,500-2,000 monetary award and a pre-paid year of weekly ADHD coaching from The Edge Foundation ($4,400 value). Students are eligible for the scholarship if they (1) have been formally diagnosed with ADHD, (2) are currently accepted or enrolled in an undergraduate program at an accredited university (not a trade/technical/ vocational school), and (3) are under the care of a licensed healthcare professional for their ADHD. Since its inception, the program has provided over 250 scholarships and continues to offer 50 scholarships per year. According to the press kit posted to their website:

> The ADHD Scholarship by Shire is named in memory of Michael Yasick, a senior executive at Shire whose vision made the Scholarship possible. Mike envisioned the Shire ADHD Scholarship as a way to recognize brave individuals with ADHD who work hard to overcome the challenges of the condition and to help them continue their educational pursuits.

The creation of this scholarship program acted to secure Shire's role as supporters of access to higher education. Because ADHD has become an academically-centered condition, it is beneficial for Shire to build relationships with students and their parents – in this case through financial and other non-pharmaceutical resources. The scholarship program also allows Shire to collect demographic data and testimonials from students who submit applications and essays for the contest, which Shire can use at their own discretion. According to the website, "The Scholarship Sponsor may use the Application in any manner and in any medium or form, whether now known or not currently known, throughout the world in perpetuity without compensation, permission, or notification to the applicant or any third party." This allows Shire complete freedom to solidify the value and success of their scholarship program by promoting the experience of former recipients. Names of all winners and their institutional affiliations are listed on the website. The press kit also features testimonials from students who have received

the award and how it has helped them succeed in college. For example,

> "I'm grateful to Shire for investing in my education and believing in me. Receiving this honor instills me with confidence." – Mallory Hansen, West Virginia University
>
> "The Shire ADHD Scholarship served to reaffirm the hard work I've done to get to where I am now in college. With the Edge coaching, I've been able to work with someone who fully understands the issues unique to those with ADHD." – Tom Kline, Oswego State University
>
> "As a freshman, I was unprepared for the demands of college. My ADHD coaching experience equipped me with the life skills necessary to adjust and succeed!" – Jacqueline Martin, Tuskegee University

In these testimonials, ADHD is presented as a barrier to academic success. It is not something that defines a student, but is an external challenge that can be managed by medication and coaching. The responsible consumer is presented as a student who is pursuing formalized higher education and seeking help for their ADHD through multiple avenues. Shire frames this pursuit as not just an act of responsibility, but one of bravery.

The notion of battling one's condition in order to beat the odds is a powerful metaphor in which Shire, Vyvanse, and the Edge Foundation fight side-by-side. Although the sheer cost of college is also part of the battle for most students, it is important to note that these scholarships are not dispersed according to financial need. Rather, they are seeking students who represent the prominent demographic of their target consumer base and actually have a chance at succeeding in college (regardless of financial need). Moreover, they are expected to do more than simply earn good grades. This expectation is articulated in the requirements for the scholarship application essay:

> The Personal Essay will be scored according to the applicant's story (how he or she faced challenges in living with ADHD and met them) and insight about the applicant (interests, hobbies, community work, and career aspirations), in consideration of what it means to be brave and the Shire values of BRAVE—Bold, Resilient, Accountable, Visionary, and Ethical.

Thus, students are expected to not just be "BRAVE" but also articulate how they overcame their specific challenges in a language that is in line with Shire's company values. The rhetoric in this scholarship suggests that students are responsible for more than just good grades, but also a balanced social life, extracurricular activities and community service. In this way, Shire is not simply producing students who can achieve these goals with their help – rather, they are choosing to reward students who are already able to demonstrate their success so that they can serve as evidence of how well Shire's products and affiliated service providers work together.

The alliance between Shire and The Edge foundation serves a particular function in constructing the responsible prescription drug user. It is a way for Shire to promote their support of complementary treatment modalities (e.g. education and coaching) via their relationship with The Edge Foundation. As a result, The Edge Foundation also gets a platform to promote ADHD awareness and the efficacy and necessity of their services to students. The responsible consumer is one that not only proactively seeks financial assistance from Shire, but appreciates the value and necessity of these services to their academic success. This point is illustrated in a news report from Global News, Canada, which highlights the experience of Zach Erickson, a 2014 winner of the Shire's ADHD Scholarship Program in Canada.

> **Reporter**: "Assignments, studying and exams. It's a lot of pressure for any student. But add in Attention Deficit and Hyperactivity Disorder and it can feel unbearable."
> **Erickson**: "I'm just an idiot, or I must be lazy, or I am just irresponsible."
> **Reporter**: "Zach Erickson was diagnosed with ADHD during his third year of university and it hasn't been an easy road."
> **Erickson**: "It's something that you can very easily feel sorry for yourself for."
> **Reporter**: "He's now working on his last year of a degree in Neuroscience. The high pressure year has become bearable after being selected for the Shire ADHD Scholarship."
> **Erickson**: "Working with my coach has just been developing strategies and habits to stay organized and stay on top of everything and just kind of basically be able to achieve the goals that I have set for myself."
> **ADHD expert**: "We find that many students that enter post-secondary with ADHD who don't have a combination set up and don't have someone to work with on this very often fail out first or second year."

**Reporter**: "Erickson receives an hour of coaching each week over the phone. He says not only is it making a difference with his education, but his everyday life."
**Erickson**: "It's good to have the cash but the coaching is life changing. Coaching is good for one year but then being able to take what I've learned and apply it will be huge."
**Reporter**: "But in order for students to access help, the first step is for students to acknowledge the disorder. One that thousands of Canadians deal with every day without a diagnosis."
**ADHD expert**: "Its one of the most common health conditions, so we are looking at almost 5% of children and 4% of adults and that's the most conservative number."
**Erickson**: "Acknowledging that you have problem with something isn't the same as using it as an excuse and it's not the same as calling yourself as less than."

Testimonials from the ADHD scholarship winner, the ADHD expert and the reporter herself serve as powerful tools in Shire's marketing armory. Each become a convincing mouthpiece for the company without ever mentioning prescription stimulants - in return, they are able to meet their own objectives of raising ADHD awareness, fighting stigma, and promoting coaching as an effective management strategy. However, the fact that the ADHD expert refers to a "combination" management plan subtly re-asserts the framework that drugs must be a part of the equation - but the responsibility to maximize their effects through coaching (made possible through engagement with the pharmaceutical industry) and perseverance is ultimately the responsibility of the contest winner. In this case, that is someone who is already in the final year of a neuroscience degree and can serve as a convincing spokesperson for Shire's efforts in improving academic performance among college students.

### *3.2.4 CPAMM: Delegating Responsibility*

In this chapter, I have described at length how Shire's marketing campaigns construct a vision of productive, empowering and responsible ADHD management – and the function of stimulants within that vision. I have also discussed how Shire is putting the responsibility of productive ADHD management and prescription drug use back into the hands of the consumer.

This strategy has been effective in redefining and re-delegating responsibility over preventing the irresponsible use of stimulant medications. With the increase in criticism over the medical, social and psychological dangers of prescription stimulants, Shire had no choice but to respond to allegations of irresponsible drug production and marketing.

When Vyvanse was first released in 2007, Shire claimed that the drug had a low likelihood of being abused because of its long acting nature as a pro-drug, unlike other stimulants, which had instant chemical effects (citation). However, a recent google search of the term "Vyvanse abuse" turns up almost 400,000 hits, suggesting that Shire's original claim was pre-mature if not completely fabricated. Today, Shire has removed all materials with the original claim that Vyvanse is not habit-forming, and replaced them with clear warnings regarding its high potential for misuse and abuse. For example, when logging into vyvanse.com the viewer is prompted with a warning before being able to access the main website. The language gives the impression that the drug is abused by some people who are already predisposed to addictive tendencies, such as alcoholism and street drugs. Telling the consumer to essentially hide their medications suggests that Shire is not accusing them of irresponsible use; rather, they are responsible for guarding their medication from *others* who might abuse it. This rhetoric is powerful because it puts the pharmaceutical industry and the consumer on the same side against the immoral, irresponsible drug user.

The Vyvanse website also features a 5-page guide titled "Proper Use of Prescription Stimulant Medication" which lays out the responsibility of the consumer to prevent "improper stimulant use." They follow the FDA's definition and describe misuse as using the medication in a way other than the way a doctor intended e.g. "Taking an extra pill of your own prescription because you think you need it" or "taking a friend's stimulant for your own use". They define

abuse as taking a medication to get high or see how it makes you feel. They also describe diversion as anyone using a medication that does not have their name on the prescription bottle, including "giving your medication to a friend or taking medication from a sibling." The brochure instructs patients to ask their doctor for instructions on what to do if they find themselves in a situation where they do not understand how to properly take their medication or for help preventing the misuse and abuse of stimulants among their loved ones. Shire ends the guide with the following statement:

> Working Together to Ensure Proper Stimulant Use: We at Shire are dedicated to working with healthcare professionals and patients to help ensure the proper use of stimulant medications. We are committed to creating materials to help educate and promote the appropriate use of stimulant medications.

The guide is linked to a larger project initiated by Shire in 2014, titled "The Coalition to Prevent ADHD Medication Misuse" (CPAMM). The project website features research and resources from a number of organizations invested in facilitating appropriate prescription stimulant use. This includes patient advocacy groups like CHADD and ADDA, as well as the American Academy of Family Physicians, and Student Affairs Administrators in Higher Education (NASPA). At the heart of these efforts is drawing a clear distinction between sanctioned responsible stimulant use, and the irresponsible use of stimulants among non-prescribed users. According to the press release for the project,

> Shire opposes the misuse, abuse and diversion of ADHD prescription stimulant medication and is committed to being a part of a solution to help prevent nonmedical use while preserving access to these important medications for those with a legitimate medical need. Shire recognizes that to create change we need collaborative solutions, which is why we've brought together this team of diverse and experienced experts and advocates (Gwen Fisher, Senior Director of Corporate Communications for Shire).

Although the project is presented as a collaborative effort, it is important to note that "Shire is the sole funder of CPAMM [and] other partner organizations do not provide financial

contributions to CPAMM." Thus, although these other organizations support the stated mission of CPAMM, Shire ultimately controls the content and direction of the coalition. This is particularly important to consider when assessing CPAMM's aim to "be a trusted source of information on the issue of ADHD prescription medication misuse, abuse and diversion – with a primary focus on college students." Interestingly, at the time of this writing, the website only highlights three research articles as well as the results of only one Harris poll survey conducted on behalf of CPAMM. Ultimately, there is no way to know exactly who curated and approved the data presented on this page or what their intentions were.

The highlights of the Harris Poll survey were featured in a series of 1-3 minute videos on Shire's YouTube Channel. In one video, we are addressed by Gwen Fisher, Senior Director of Corporate Communications for Shire. She opens with a long comment about Shire's commitment to putting their consumer first and how the misuse of ADHD medications harms patients more than anyone else. She passionately explains that, "Ultimately we [Shire] believe that when people who don't need ADHD stimulants take them, they trivialize a real psychiatric disorder and take medicines away from people who really need them." This statement is significant because it pulls attention away from the inherent addictive qualities of the drug and the responsibility of the pharmaceutical company that produces them, while also reaffirming that their legally prescribed consumers still deserve access. However, when describing the troubling statistics from the Harris Poll survey, her tone becomes more relaxed as she refers to the data as insightful rather than alarming. The juxtaposition of her conviction towards protecting the consumer, and being apathetic about the people who illegally use the drug suggest their primary concern protecting their consumers' rights to access medications rather than taking responsibility for the larger problem.

Upon watching these videos, it is difficult to tell who the intended audience would be. Despite their claim that this website is a vital resource for prescription stimulant misuse, it is unlikely that a college student would ever stumble upon CPAMM's website or Shire's YouTube Channel. Rather, it seems the entire purpose of this campaign is for Shire to officially condemn the misuse of their products and protect the rights of consumer, the legal stimulant user. If someone is concerned about what Shire is doing about this issue, Shire can point them to the website. The message presented to the viewer clearly indicates that the responsibility of preventing irresponsible stimulant use should be shared with the consumer, medical professionals and university administrators. By teaming up with these organizations, they are able to leverage their social capital and position themselves as a responsible drug company that facilitates responsible drug use. It is also worth mentioning that taking a stand against illegal stimulant use serves an understated benefit of gaining more legal consumers who will seek diagnoses and purchase their products legally. Given that many of the messages presented within these materials refers to diverting medications to family and friends, it is not unlikely that a consumer will encourage a loved one to obtain their own legal prescription. Doing so may make everyone feel like they are doing their part to be a responsible stimulant user who also facilitates the responsible use of others.

## 3.3 DISCUSSION

Conrad and Potter (2005) note that in the late 1990s and early 2000s, the stimulant marketing landscape was heavily influenced by ideologies and processes related to the "shifting engines of medicalization" or biomedicalization. Attention disorders, once reserved for misbehaving children, were reformulated by the Diagnostic and Statistical Manual (DSM),

advocacy groups, and drug marketers to accommodate the under-performing adults these children grew into. The emergence of DTC advertising provided a platform to present Adderall as a safe and effective means of liberation from the tyranny of Ritalin, a drug criticized as a form of medical social control wielded by the medical profession (Conrad 1975). As a lifestyle drug, Adderall catered to consumers who wanted to quickly, safely, and effectively fulfill their biomedical and social potentials. In this framework, ADHD diagnoses presented an opportunity to access these drugs and the transformations they promised.

My research suggests that in the last decade, the DTC stimulant marketing landscape has evolved significantly in response to pharmaceuticalization, resulting in social moment of moral breakdown for the American public. Mass increases in drugs sales coupled with media coverage of medical and social dangers of stimulants has lead the public to question the intentions of the pharmaceutical industry and the medical professionals who push their products on patients. The prevalence of drugs like Adderall that were once touted as a way to return the power of healing to patients now represented the infiltration of the pharmaceutical industry into the most intimate spheres of American life. Markets for non-medical ADHD treatment emerged and appealed to those consumers who were growing weary of the disempowering effects of prescription stimulants on their lives and society as a whole. Together, these factors contributed to an ongoing struggle between the pharmaceutical industry and its consumers to properly define ADHD and regulate the responsible use of prescription stimulants. In the following section, I discuss how Shire morally positioned themselves, their products, and their consumers in relation to this social moment of moral breakdown.

### *3.3.1 Practices: From Selling Sickness to Supporting ADHD Management*

My research provides examples of how Shire has engaged in new forms of DTC marketing that enabled them to actively cultivate the needs of the evolving access-oriented consumer while also quelling the criticisms of the injury-oriented consumers (Abraham 2010). To do so, they constructed a relationship where producer and consumer inform and support each other in the united fight to manage ADHD. They hold a shared commitment to this responsibility, which requires both parties to play their part in making sure stimulants are in fact being consumed, but in a responsible way. It seems that one of Shire's goal's in these campaigns was to shed the image of being a corporate drug pusher who is only interested in profits, becoming, instead, an expert ADHD advocate who empowers and protects its consumers. Shire accomplished this by assuming a number of dynamic roles through their DTC drug marketing campaigns.

In the "Own It" Initiative, we see Shire play the part of a pharmaceutical parent, or guardian, using tough love to convince their consumer that they need to own their condition and take their medication whether they like it or not. They used celebrities such as Adam Levine almost like "big brother" figures or mentors who are teaching consumers that it is okay to admit you need help - because once you do, the possibilities are endless. As a result, Shire is presented as helping the consumer make the tough choices and offering a hand to help them fight the struggles of ADHD. Ultimately, Shire is teaching its consumers how they should feel about ADHD and how to act accordingly.

In the "U Do the Rest" campaign, Shire built on their role as an ADHD expert, but one who will be there to help you manage your condition even after they have taken your money. The creation of websites, contests and other resources suggests that they understand the struggle

of ADHD and can offer you an entire management plan that goes beyond selling you stimulant medication. By doing so, they set themselves apart in the prescription stimulant market by teaming up with other ADHD experts and offering a whole suite of resources and financial incentives to keep your loyalty. We also see this in Shire's collection of college-specific resources and access to information about stimulant misuse. As a result, consumers and parents adopt Shire's view of ADHD as well their view of college life and expectations of academic performance.

Finally, Shire assumed the role of protector, especially when it came to providing ADHD scholarships and taking a stand against the misuse of prescription stimulants. In the first case, Shire helps students with the financial burdens of pursuing higher educations and giving parents insider information on how to beat the complicated and often overwhelming college admissions process. With CPAMM, Shire brought together the collective power of their many allies to protect their patients against the harms caused by prescription stimulant abusers. This included the potential stigmas or pressures legal consumers might feel with consuming or diverting their medications. Shire made it clear that empowering their consumers (through resources, financial prizes, etc.) is their number one priority and, in return, they expect the consumer to fulfill their role in continuing to take their medication responsibly.

### *3.3.2 Objects: From Lifestyle Drugs to Pharmaceutical Foundations*

The expiration of Adderall's patent in 2008 presented Shire with an opportunity to repair the producer-consumer relationship and set themselves apart from generic brands now flooding the market. They accomplished this by repackaging ADHD treatment as a team-based experience and the function of prescription stimulants as its foundation. In these campaigns, Vyvanse is

being promoted as a foundational drug that places the agency over the drug and illness experiences back into the hands of the consumer. This is a departure from previous conceptualizations of stimulants as a form of medical social control wielded by doctors (Conrad 1975) and, more recently, as a magic bullet enhancement drug vended by drug companies to increase performance (Conrad 2000). I argue that in both these paradigms, stimulants embody the ultimate power to control or transform an individual's mind, body, and social subjectivities. This is problematic for the consumer because a loss of agency, or dependency on the drug, may result in medical side effects, social stigma and possible addiction, making it less desirable to take the drug in the first place. It also calls into question the loyalties and motives of the pharmaceutical industry and physicians involved in the promotion and prescription of these powerful substances. Thus, if Adderall embodied the unrealistic and glorified pharmaceutical transformation – perfect grades, perfect relationships, perfect health, as described by Singh (2006) – Vyvanse embodied a more realistic and believable pharmaceutical experience. It is a drug that is powerful enough to address the neurochemical limitations of ADHD, yet not so powerful that it compromises the moral subjectivity of its user by fully controlling or transforming them.

Shire also offset the concerns over the misappropriation of stimulants by reframing Vyvanse and the like as a part of a larger, comprehensive ADHD management plan. Doing so dilutes the perceived power or control of the drug over the consumer and redistributes it among a number of treatments, such as behavior modification, therapy, coaching, and even the consumer himself. Accordingly, Shire allied with several private medical markets to promote this new treatment framework. In particular, this alliance benefited Shire because it replaced the heavily criticized relationship between the pharmaceutical companies and prescription providers (IOM

2009). In many ways, ADHD specialists (researchers, therapists, coaches, educators, advocates) are more effective as spokespersons than private doctors because they are key contributors in the construction of ADHD in popular discourse. They often work directly with the public, raising awareness for the condition and potential treatments through local events, social media, websites and other promotional venues. They are not limited to the same legal measures and public scrutiny as the pharmaceutical industry when it comes to advertising and other forms of claims-making. Moreover, the goods and services they provide are often perceived to be a safer alternative to pharmacological treatments to ADHD, thus making them seem more cognizant of the needs and expectations of the modern medical consumer.

However, in light of their growing partnership with the pharmaceutical industry, treatments like coaching and behavioral modification therapy are not framed as alternatives but rather complementary to pharmacological treatments. My research suggests that private treatment providers may be enticed into alliances with Shire because it gives them the funding and venues to promote their services to large groups of consumers (via educational conferences, research funding, paid spokesmanships, etc.) They can return the favor by endorsing a neurobiological model of ADHD where prescription stimulants become the chemical foundation on which these other therapeutic modalities can take effect. Thus, I argue that presenting drugs like Adderall as part of a larger system of ADHD management does not necessarily take away their power as transformative magic bullets. In fact, it can multiply it by drawing on the influence of these complementary treatment modalities and the social capital of the individuals that promote them.

### *3.3.3 Subjects: From Medical Consumers to Pharmaceutical Delegates*

Adderall emerged in the late 1990s in relation to the invention of what Applbaum (2006) terms the medical consumer, a neoliberal subject who empowers themselves through calculated pharmaceutical consumptions. However, changes in the last decade has reframed this pharmaceutical subject as a target of irresponsible pharmaceutical advertising, relying on drugs that ultimately marked them as cheaters or addicts. My research shows how Vyvanse has emerged in relation to the invention of what I term as the "pharmaceutical delegate," a moralized subject who shares responsibility over ensuring responsible stimulant use with the pharmaceutical industry. The pharmaceutical delegate is depicted in these campaigns as someone who is both empowered by and responsible about prescription stimulant use. As in previous ads, they are depicted as someone who does not let ADHD get in their way of success and actively seeks professional and pharmaceutical help. Throughout these campaigns, Shire features individuals who are highly functioning and educated adults - like Megan M. the graduate student from the "Own It" contest and the dozens of winners of the Michael Yasick ADHD scholarship prize. This illustrates that anyone, even those who are academically successful, could meet the criteria for ADHD and benefit from the resources and medications provided by Shire.

Unlike previous advertisements, these campaigns depict the pharmaceutical delegate as someone who does not just own their ADHD, but also embraces it and promotes the diagnosis to others. Sharing quality testimonials through contest entries and scholarship prizes becomes a fundamental part of fulfilling the role of this responsible and engaged consumer. For example, in the ADHD scholarship campaign, consumers are rewarded if they are brave, or rather, if they can convince Shire that they ascribe to the same definition of bravery that is promoted on the company's website. Moreover, they are already successful in school and have a well-rounded

background in extracurricular activities and community engagement. The ideal consumer is one who will not only take their medication to manage their ADHD, but use it to push themselves to the next level of success. They are willing to "do the rest" so that all the of the benefits of the medication are attributed to their hard work and the quality of Shire's product - whereas any failures are due to the consumer not going the extra mile.

Finally, the pharmaceutical delegate is someone who cares about his or her family and friends and wants to prevent them from using Adderall illegally. They take the initiative to properly safeguard their prescription and take full responsibility if someone else illicitly uses their medication. The ideal consumer is someone who will seek information about misuse directly from the pharmaceutical company because they want to be informed by the source. They will encourage anyone in their life who uses medications illegally to seek professional care. This may help the person address an addiction problem, but it could also create an opportunity to seek legal access by obtaining their own prescription. Finally, the pharmaceutical delegate is someone who will only use the medication as prescribed, but if they do not, they understand that it is their responsibility to work with a medical professional in dealing with the consequences of their misuse. They appreciate the information the pharmaceutical industry has provided and will act accordingly to share that message with others and use it to create a personalized management plan with their doctors.

## 3.4 CONCLUSION

In this chapter, I provided evidence to investigate the ongoing struggle between the pharmaceutical industry and its consumers to properly define ADHD and regulate the responsible use of prescription stimulants. I examine this struggle as a social moment of moral

breakdown associated with the biomedicalization and pharmaceuticalization of performance in American culture. I take this as a departure from previous conceptualizations of the neoliberal informed medical consumer who feels empowered through pharmaceutical marketing (Applbaum 2006). As Singh (2006) points out, DTC advertising of Adderall in the early 2000s focused on the idealized and instantaneous transformation it afforded. This perspective both appealed and contributed to medical neoliberalism at the turn of the century as described by Fisher and Ronald (2008), by putting the control over health back in the hands of the consumer rather than the authority of medical professionals. My findings suggest that Shire still relies heavily on traditional tactics of creating and perpetuating disease categories by personalizing risks, motivating diagnoses and creating branded compliance (Dumit 2011). However, they have situated these tactics within a rhetoric of *responsibility* alongside *empowerment*.

These case examples suggest that Shire has teamed up with other ADHD experts to create new forms of moralized and engaged consumerism founded on the goal of responsible stimulants consumption. In the process, the symbolic meaning of stimulants has been reformulated as an empowerment drug rather than a controversial performance enhancer or form of medical social control. They have also constructed what appears to be a clear distinction between responsible and irresponsible stimulant use based on legal and sanctioned access as determined by collaborations between patients and their doctors. As a result, Shire has delegated both the benefits and burdens of the drug back to the consumer and the medical professionals who are charged with prescribing and monitoring their use. I argue that by doing so, consumers are now given the responsibility to diligently consume stimulant medications while also promoting the responsible use of others.

In the following chapter, I consider how these moral discourses are transmitted and

transformed as prescription stimulants are materialized in the context of ADHD diagnosis and treatment. I examine the experiences of health service providers and professional ADHD experts who are tasked with defining and distinguishing students who are eligible for access to treatment and ensuring that prescription stimulants are used responsibly. It also speaks to their positionality in regards to the pharmaceutical industry and how it influences their perceptions of prescription stimulants and their relationships with ADHD college students.

## CHAPTER 4: TREATMENT

This chapter considers how moral ideologies are filtered from the DTC prescription stimulant marketing landscape and absorbed in the modern treatment landscape to inform definitions of responsible stimulant use in the college environment. It builds on anthropological literature that describes the expert patient, a neoliberal subject who empowers themselves by actively pursuing medical treatment. I examine the potential for diagnosis, treatment and accommodation of ADHD to trigger moments of moral breakdown where both doctors and patients deploy a number of strategies to maintain agency over the exchange. This includes strategies that range from to rigorous testing, to pharmaceutical detox, to malingering, to doctor shopping. Accordingly, it becomes the responsibility of the patient to actively pursue access to stimulants and consume them responsibly.

I build on this literature and consider how the stimulant treatment of ADHD has evolved in respect to trends in pharmaceuticalization over the last decade. Increases in diagnostic rates and the prevalence of illicit stimulant use have raised public concerns over the intentions and actions of health service providers who over-facilitate or deny access to ADHD services. I use media reports to provide key insights into public discourse surrounding this social moment of moral breakdown and highlight the ethical dilemmas faced by health service providers. I situate these dilemmas within the evolving ADHD treatment landscape described in Chapter 2 and illustrate how certain factors such as evolving diagnostic criteria for adult ADHD, lack of confirmatory testing, and competing treatment modalities have reshaped the doctor-patient relationship.

My goal in this chapter is to explore how health service providers at American State University have positioned themselves, their services, and their patients in relation to both social and personal moments of moral breakdown within the modern treatment landscape. To

accomplish this, I engaged in informal interactions with a variety of experts that engage with U.S. college students across a number of social settings. This included participation in two ADHD conferences sponsored by Shire Pharmaceuticals; two academic disabilities conferences; four group meetings with the American State counseling program; and a series of ADHD coach training classes. I present six case examples that highlight moments from these interactions in which health service providers and ADHD experts positioned themselves in response to concerns around ADHD treatment and framed their decisions to promote or discourage stimulant use as acts of social responsibility. The case examples are organized around three overlapping contexts in which health service providers lay claims to authority over the responsible treatment of the condition: medical expertise, cultural expertise, and educational expertise. I present my analyses of these case examples around the practices-subjects-objects framework to systematically map the moral discourses that surround and are produced through the modern diagnosis, treatment and accommodation of ADHD. I conclude the chapter with a discussion of how this analysis informs conceptions and expectations of pharmaceutical morality and subjectivity among US college students.

## 4.1 MORAL BREAKDOWN: PUSHING DRUGS OR DENYING TREATMENT

Despite the fact that students with ADHD are less likely than their peers to graduate from high school and attend college, it is estimated that approximately 2-9% of the U.S. college population is diagnosed with the condition (Dupal et al. 2009). Studies indicate that these individuals make up 25% of college students receiving university disabilities services and this number is on the rise (Dupal et al. 2009). For advocates of the condition, the increase in ADHD students attending college signals a growing need for services and accommodations to help these

individuals achieve a successful college experience (Hinshaw 2014). At the same time, the rise in students attempting to access ADHD treatments has raised significant public concerns over the legitimacy of this disorder and its implications of increasing the availability of stimulant medications on campus. As a result, campus health providers and administrators are faced with the dilemma of potentially facilitating the increased availability of stimulants on campus or failing to accommodate the health needs of their students.

Media commentaries on these concerns offer key insights into how Americans are responding to the increase of ADHD diagnoses and stimulant use on college campuses as a social moment of moral breakdown. For example, on April 20 2013, New York Times reporter Alan Schwartz published another installment in his series of critiques on ADHD and stimulant culture in the United States. It was titled "Attention-Deficit Drugs Face New Campus Rules" and focused on the detrimental impacts illicit Adderall use was having on those students who needed the drug for medical purposes. He began the piece describing the difficulty a student named Lisa had trying to obtain a prescription for Adderall from the student health center at California State University, Fresno. According to the article, Lisa “endured over two months of testing” for ADHD and was only given a prescription after signing a contract agreeing not to share her medication with anyone else. In addition to contracts, Fresno State also does not allow early refills to replace lost or stolen medication and reserves the right to administer urine tests should a university clinician suspect stimulant misuse. All students receiving prescription for ADHD treatments through the university are also required to see a Fresno State therapist for one hour each month to ensure proper use. Campus counselor Dr. Daniel Little explained, “It’s not just taking a pill every day… It’s about learning coping skills.”

Schwartz quoted a Fresno State official who state that these measures were a response to

the “disquieting surge of students requesting A.D.H.D. diagnoses — along with news media reports of stimulant abuse and questionable diagnostic practices nationwide.” Catherine Felix, the director of Health and Psychological services was also quoted saying that the university no longer makes diagnoses, largely because of the substantial time required “to do it right.” This sentiment also stemmed from the number of legal cases over the last decade of parents who have sued the University health centers for malpractice after their children were prescribed stimulants after only one appointment. Today, Fresno state is one of several institutions including North Carolina State, Georgia Tech and Penn State, who also said they could no longer handle the volume of ADHD diagnosis requests and were, as one health director put it, “getting out of the ADHD business.” Schwarz stated that these policies are ADHD-specific and tend not to apply to other psychiatric conditions. He quoted Ruth Hughes, chief executive director of CHADD, who said that such rules create “a culture of fear and stigma,” around ADHD and that if students need to sign a contract to obtain stimulants, they should have to do so for other controlled substances, such as painkillers.

Schwartz suggests that because of these new rules, many students are encouraged to see their private family doctors to seek out a diagnosis. After obtaining official documentation outside the university, they can then conveniently have the student health center fill their prescriptions. According to the article, diagnosis “typically involves hours of neuropsychological testing and conversations with parents and teachers to assess impairment and other possible explanations.” Students must either comply with these rules or fill their prescriptions elsewhere and bring them back to campus.

Despite these restrictions, Adderall is still widely available and students like Lisa continue to be solicited for their medications by fellow students. Critics like Hughes argue that

"If a university is very concerned about stimulant abuse, I would think the worst thing they could do is to relinquish this responsibility to unknown community practitioners… Non-prescribed use of stimulant medications on campus is a serious problem that can't just be punted to someone else outside the school grounds." Schwarz also quoted several students who supported Hughes statement and bragged that any university efforts to prevent illicit Adderall use would be futile.

In the article, Schwarz questioned the logic of putting students through such strict policies to obtain their medications. He quoted one university health official who admitted "We get complaints that you're making it hard to get treatment…there's some truth to that… [but] the counterweight is these prescriptions can be abused at a high rate, and we're not willing to be a part of that and end up with kids sick or dead." While Fresno State is working on cutting off the Adderall supply on campuses, other Universities like Duke have targeted the illegal users through rules that incorporate "the unauthorized use of prescription medication to enhance academic performance" as a category of academic dishonesty. At the same time, Schwarz quoted one Vanderbilt student who laughs at the policy and states "I don't think they're doing enough to stop people like me."

These concerns outlined in Schwarz's critical commentary are part of a growing tension among ADHD service providers, campus administration, and college students around the fair assessment, treatment and accommodations of ADHD. It has emerged as the result of a number of factors that shape this new treatment landscape, such as evolving diagnostic criteria for adult ADHD, a lack in confirmatory testing, increase in prescription stimulant demands and competing treatment modalities for the condition. In this chapter, I examine how ADHD services providers at American State University have positioned themselves in order to navigate this morally convoluted environment. Specifically, I ask, how is responsible stimulant use defined and

facilitated by the ADHD experts and patients through the diagnosis, treatment, and management? How do these interactions influence and embody shifting expectations around the responsibility of US college students to facilitate and participate in responsible stimulant use? In the following sections, I explore these questions and investigate how service providers at my field site frame ADHD treatment, the function of stimulants, and the role of the responsible patient in relation to these social and personal moments of moral breakdown.

## 4.2 CASE EXAMPLES

To better understand this landscape, I interacted with ADHD experts across a number of social and professional settings. Initially I did not set out to interview these individuals, rather I wanted to observe how expert discourses about ADHD and stimulants were being constructed and disseminated to patients at educational events. This included participation in two ADHD conferences sponsored by Shire Pharmaceuticals and two Disabilities Services in Higher Education conferences. It was after these public presentations that I interacted with these experts one-on-one and built rapport, asking more in-depth, informal questions pertaining to my research. Additionally, I attended four private group meetings with various health and disabilities services programs at American State which were followed by group and individual discussions about the proper management of ADHD students. I also attended a number of ADHD coach training classes while in the field. I had learned about the program during my participation at one of the ADHD conferences and applied for a fellowship to complete the training for a discounted price. This experience provided an intimate perspective on the training these experts receive on ADHD and prescription stimulants, and how they are expected to interact and market themselves to potential clients. As a result of these diverse experiences, I gained a relatively broad scope of

the evolving ADHD treatment landscape.

These interactions reveal that the treatment of ADHD on college campuses has become a deeply moralized negotiation of health, empowerment, and responsibility by which social and biomedical subjectivities are fashioned. The significance of these transactions is bolstered by the fact that the demand for ADHD diagnosis, treatment, and accommodations have become a normal part of the college experience for many students. So much so that American State had to open an ADHD testing center to accommodate the needs of these students, while also maintaining a sense of responsibility over the medical, social, and academic well-being of the entire student body. Often, these objectives conflicted with each other as ADHD experts struggled to provide treatment to those who needed it, while also preventing access to those who would use it irresponsibly. This problem was compounded by the fact that each expert worked within the same setting yet had different definitions of what promoting responsible use and preventing irresponsible use meant.

The notion of being an "expert" service provider was understood and expressed by my informants through a number of personal and professional discourses. While some pointed towards their professional training and certifications, others felt their years of experience or natural intuition meant that they were best able to distinguish those who had ADHD and those who did not. Others pointed towards their personal experience with the condition and claimed that there was no way a non-ADHD person could know what the condition looked like or felt like. However, most of these experts relied on a combination of these forms of evidence to construct their expert subjectivity and rationalize their authority in managing ADHD. At the heart of these arguments was how these experts positioned themselves around prescription stimulants as healing medications and/or dangerous substances. While none of the experts I

spoke with outright objected to the use of prescription stimulants in public, they each seemed to express a clear view of how these objects either contributed to or detracted from their ability to successfully treat ADHD.

The experts I spoke with drew on a combination of medical, social and academic logics to ultimately make their decision on whether or not to facilitate the diagnosis, treatment or accommodations of ADHD. While each claimed to follow a strict protocol to make these decisions, at least three of the experts I spoke with admitted to treating a client even though they "probably didn't have ADHD." For example, Dr. Edwards, a private psychiatrist told me that he had a college student/patient whom he knew was buying Adderall illegally from his friends to increase his academic performance. He explained that he was worried that the student would get in trouble with the law or start to abuse the medication so it was in his best interest to give him a prescription so that he could "at least supervise his use."

Another expert, Tom, an ADHD coach, told me about one of his clients who likely also did not have the condition but was still benefiting from his services. When I asked him if his client knew he probably did not have ADHD, Tom told me that in his opinion, "it does not matter what you call it, if he needs the label to finally feel brave enough to seek help, what is the problem?" On the other hand, Betty, a woman who worked within the disabilities services center at American State told me that she was skeptical of many of the students who came in with evidence for ADHD. However, she still provided them with accommodations because she could not disprove their diagnosis. In contrast, the rest of the professionals I interacted with vehemently claimed to only diagnose/treat/accommodate those students who "needed it." It is these distinctions that would both socially and subjectively set them apart from "irresponsible" ADHD experts like Dr. Edwards, Tom and Betty.

In the following sections, I present six case examples of professionals who represent the various forms of expertise I encountered within the ADHD treatment landscape. This includes an ADHD advocate, an ADHD coach, a private medical doctor, a university psychologist, an academic program coordinator and a university disabilities specialist. While each professional shared in the concerns listed above, the ways in which they strategically positioned themselves in the treatment landscape and around prescription drugs varied notably. Each constructed a persona which served to ethically rationalize their decisions to support or deny ADHD treatment, and illustrates the complex value systems they constructed out of necessity. By coupling data from public professional presentations and more intimate interactions, the following cases show how expert's moralized self-constructions compared to their lived experiences as ADHD treatment providers.

### *4.2.1 ADHD Advocate: Responsibility to Optimize Management*

In October of 2014, I attended the 14th Annual Calvin Scott Memorial ADHD conference (pseudonym) at a small community college close to my primary field site. I had read about it in a local newspaper and saw it as an opportunity to see firsthand how knowledge about the disorder was constructed and distributed at these educational events. I was especially enticed by the discounted registration price for students, and intended to speak with individuals about their interest in ADHD research. When I arrived that morning, I was impressed by the turn out. Clusters of eager parents, therapists, teachers and students were lined up at the registration table, filling out name tags, gathering pamphlets and filling up on complimentary coffee. Once I had wrestled my way through the crowd, I took my seat in the main auditorium and began thumbing through the lofty welcome packet. It was filled with information one might expect from

conference organizers: a schedule for the day, biographies of each presenter, and speaker evaluation forms. There was also a dozen or so brightly colored advertisements for local ADHD services, including self-help books, neurofeedback therapy, productivity coaching, and information for teachers hoping to earn continuing education credits (CECs) from their participation in the conference.

After a few minutes, the lights started to dim and the master of ceremony took the stage. Behind her, the projector powered up to illuminate the dark room. Two large logos of equal size filled the screen. On the left side, written in muted letters inside a gold medallion was the name of the conference. Next to it, in bright blue letters was the logo for Shire Pharmaceuticals. The text read "14th Annual Calvin Scott AD/HD Conference is supported by Shire: to be as brave as the people we help." Beneath was a statement explaining, "This educational activity is supported by an independent medical education grant from Shire." The audience sat silently for a moment, carefully reading the words on the screen, as the master of ceremony took the microphone and declared, "Welcome to the 14th Annual Calvin Scott ADHD Conference! Thank you so much for being here today! And a special thanks to our friends at Shire for making this amazing event possible!" The audience erupted into applause.

After a brief explanation of the history of the conference and some highlights of the events to come, she introduced the keynote speaker, Monica Evans. Ms. Evans was touted as a "best-selling author, speaker, classroom teacher, school psychologist, mental health counselor, local and state level mental health administrator, lobbyist and executive director of a statewide mental health advocacy organization, and national mental health consultant on children's issues. Perhaps, more importantly, she is also the mother of two grown sons and a daughter with ADHD." Ms. Evans took the stage and began her slide show presentation titled "ADHD and

Executive Functioning," which promised to be a neurological exploration into the condition. However, she started her slide show with an image of what appeared to be her extended family of parents, siblings, children, and grandchildren dressed in all white in front of their home. She turned to the audience and announced proudly, "Moms, dads, I know what you are going through. This is my family and every single person in this photo has been diagnosed with ADHD." I looked around the room to see if others shared in my visceral skepticism over her statement and was surprised to see quite a different reaction - sympathy. Ms. Evans continued with a personal story about her son Adam who had a hard time concentrating in school as a young boy. She recounted a moment when she sent him to get a pen from the home office and she found him "staring at the dog drinking water" in the kitchen five minutes later. She took this to be a critical sign and eventually had him tested and diagnosed with ADHD.

Over the next hour, Ms. Evans moved into the neurobiological origins and effects of ADHD on executive functioning. She cited a number of scientific studies which indicated that individuals with the condition are actually three years behind in emotional and psychological development and that it is not their fault they are not performing to their full potential. She used the phrase "brain chemistry" to describe the complex neurobiological functions responsible for this deficit and argues that medication works for 75-90% of those with the condition. She also informed the audience that the condition is genetic and encouraged parents to get themselves tested for the condition if they related to any of the adult symptoms she has listed.

Ms. Evans then proceeded to show the audience a fifteen-minute clip from a video that she had produced with her son Adam, who had since graduated from college, on being a student with ADHD. The clip showed a series of interviews with students and ADHD experts who explained the necessity of stimulant medication to treating the condition. One student explained that before

she took the medication, she would get to the bottom of the stairs of her apartment and forget why she went downstairs in the first place. A doctor on the film explained that these challenges are "unnecessary" because "we have medicines that treat the dopamine receptors and slow down the chemicals" so people can stay focused on their goals. After the clip, Ms. Evans reiterated to the audience that ADHD is not an excuse for poor performance, it is a neurobiological explanation for it. She at one point compared trying to deal with ADHD without medication to "tying to tie your shoes with one hand tied behind your back. You could do with, but why not just untie your hand?" She then reiterated that while medicines help with focus, but what one does with that focus is up to the individual. Ms. Evans also told the audience that if they or their child take medication and people around them notice an increase in their performance, they should just take the compliment and not mention the medication because "it is you that is doing the real work" and that the medicine just helps to "focus the chemistry in your brain so it works better."

During the last ten minutes of her presentation, the tone changed as Ms. Evans started to promote her business and the products she has developed to help parents and ADHD adults. She showed us her website with a series of videos on ADHD that one can purchase for $35-$50, as well as a giant poster of an iceberg that shows the hidden symptoms and costs of ADHD most people do not know about. She finished the talk by inviting her husband up on stage to show their united front against ADHD and then announced that they would be raffling off one of her best selling books on the topic. She told the audience to check under their seat to locate the lucky winner - it was a mother of two children who was delighted to win the prize. By the end of the presentation, the audience seemed primed to experience the rest of the conference.

### *4.2.2 ADHD Coach: Responsibility to Personalize Management*

During my participation in the ADHD conference, I had learned about a coaching certification program that would be offered the following spring. The certification was for general life coaching but offered a specialization in ADHD coaching for those who were willing to pay for the extra credits. When I found out they were offering fellowships to obtain the certification at a discounted price, I signed up to hoping to gain an insider perspective into the evolving emergent market of ADHD coaching for college students.

The class was run via teleconference and was mediated by one of the foremost ADHD experts in the field, Dr. Alexander Marin. Not surprisingly, we were required to purchase his book as our primary text for the course. Like many specialization courses, this one was only offered four times a year and as a result, filled up relatively quickly. In fact, the interest was so high that he decided to accept double the students (and double the funds) and break the class into Tuesday and Wednesday groups to accommodate everyone. The course was set up around a series of modules that focused on a particular dimension of having ADHD and/or how to market one's ADHD coaching business. Each class started with a roll call and about 20 minutes of lecture from Dr. Marin, in which he would talk about the day's topic through reference to research and personal anecdotes from his own clientele. The next 20 minutes were dedicated to discussing a prepared case study from a fellow student that he would send out to the class ahead of time. These were based on a real challenge they were facing with a client. This was possible because at least 40% of the class were practicing ADHD coaches without any official certification because it is not required by law to be certified. The final ten minutes were spent asking Dr. Marin lingering questions we had about the lecture, the case study or just picking his brain on how to deal with our own ADHD challenges.

During the first class, Dr. Marin made it clear to everyone that coaching was much different from therapy or consulting. It was not our responsibility to "fix" our clients, but instead, empower them by using a positive psychology or strength's based approach. He explained, "As coaches, we do not treat the disorder, we help them manage their lives, increase self awareness and help them research their goals. We still need to consider that they have this disorder while we are coaching them." This perspective was critical to setting the ideal relationship between the coach and the client – one that is both empowering and personalized.

Dr. Marin then moved into a historical overview of what he refers to as "The Great ADHD Debate," between two camps of ADHD experts, most notably Dr. Ned Hallowell and Dr. Russell Barkley. He explained that Hallowell and company believed that ADHD should not be considered a disorder because it is disempowering to the client. They encourage coaches to see their clients as empowered individuals who happen to interact with the world in a different way, and as a result may face some obstacles. Alternatively, Barkley and company believed that coaches should absolutely approach ADHD as a legitimate disorder that deserved special attention. They argue that without the official label, clients will not have the leverage to request or receive special accommodations or access to medications. This would prevent them from being successful in their personal and professional lives. Dr. Marin discussed the pros and cons of each side and ultimately advised the class that the best approach is to have a "realistic optimism" about the condition so that our clients feel good about receiving the treatment they might need.

Interestingly, stimulants only came up in passing during class when students described the background of their case study clients and any potential medications they were on. However, about midway through the course, Dr. Marin presented a module called "The Neurobiology of

ADHD" which included a primer on ADHD medications. He began by going over a series of simplified diagrams of the prefrontal cortex of brain that we could use to explain the science of the condition to our clients. He then switched to a number of cartoons that illustrated how this neurobiology translated into behaviors - this included a screenshot of the famous cartoon "ADHD dog" from the Disney movie "Up" that is easily distracted by a passing squirrel. The students in the class were amused and many of them said they have used that example when describing ADHD to their friends and family. Dr. Marin's ultimate point was that it was our job to use these visuals to show our clients that there was a neurological explanation for their challenges.

With about 10 minutes of lecture time remaining, Dr. Marin finally approached the topic of ADHD medications. He explained that 50-70% of ADHD clients also exhibit symptoms of co-existing conditions, such as oppositional defiance disorder, anxiety, depression, bipolar disorder, or some type of learning disability. As a result, medication would be necessary for many of our clients, but only as part of a larger comprehensive treatment plan. This included coaching to encourage a productive environment, a time management plan, and other ADHD-specific structures that would help clients manage their ADHD symptoms. He cited a lecture from last year's CHADD conference that was presented by behavior psychologist that compared the benefits of medication against coaching with two groups of ADHD patients. According to this study, after the first year, the group on medication outperformed the group who only received coaching. However, after the first year, each subsequent year the group who received coaching continued to surpass the performance of those who were treated with medication alone. This meant that although we were to acknowledge the value of medications for our clients, it was only in the context of a holistic treatment plan centered on ADHD coaching. Dr. Marin explained it

was our responsibility to make sure our clients understood that medication should never replace coaching entirely.

The final ten minutes of the lecture was dedicated to a hyper-condensed overview of the various medications that have been prescribed to treat ADHD over the last fifty years. This included the chemical names and brand names of the drugs, as well as a quick evaluation of what he thought about the drug. For example, he told us that "no one really uses Ritalin anymore because of the embarrassment factor" and that "Focalin is great because it's half the power of Ritalin with the same effectiveness." He also explained that a number of non-stimulant medications such as Strattera which were once thought to be effective really are not because "it takes a while to build up in your system." However, as a result, such medications are less likely to be abused. Dr. Marin contended that stimulants like Adderall and Vyvanse were the most common and effective and, as a result, we should make sure our clients consider those as alternatives to less effective forms of medications. When he asked the class if we had any questions, a few asked him to compare the benefits of one drug over another. Dr. Marin quickly responded with a ranking, placing Vyvanse at the top. It was rare that the students ever questioned his authority on this or other ADHD related matters and it was likely that many took his word at face value.

According to Dr. Marin, it was part of the coach's responsibility to make sure we helped our clients become advocates for their own health. He explained that it was common for patients to not remember to take their medications, are not on high enough dosages, or experience serious side effects - yet fail to communicate these concerns to their doctor. Thus, it was our responsibility to help them manage their medications to maximize their benefits while avoiding the potential negative side effects. This included strategies such as role playing with our clients

we were would pretend to be the physician, or help them learn what kinds of resources are available at school or in the workplace. Ultimately, medication management should become a part of the coach's purview because our clients may not know if and when to ask questions or seek help when treating their ADHD. Throughout this training, I could not help but wonder how many of my classmates would feel that this 20-minute lecture provided enough knowledge for them to successfully and safely advise their patients on something as potentially serious as medication management.

### *4.2.3 Private Medical Doctor: Responsibility to Optimize Treatment*

It was the first break out session of the Calvin Scott Memorial ADHD conference and I was sitting in a well-equipped, stadium style lecture hall ready to listen to the next presentation, "ADHD: Finding Effective Medication Therapy for Children and Adults." The presenter was Dr. Jason Phillips, a Harvard trained M.D./Ph.D. in his late thirties who owns a local private practice. He wore an expensive suit and spoke with an ivy league confidence as he started the presentation with a slide outlining two disclosures: "I have no significant financial interest or other relationship with the manufacturers of the products discussed in my presentation" and "Data from personal research was funded by institutional funds from the Pediatric Psychopharmacology Unit at Massachusetts General Hospital." In other words, he was an unbiased expert that we could trust.

Dr. Phillips began the presentation with an overview of the prevalence of ADHD in the United States. He explained to the audience that although nearly nine million people in the U.S. likely have the condition and "as many as 8 million adults with ADHD are <u>not</u> receiving pharmacologic treatment." Dr. Phillips then presented a number of slides illustrating the

consequences of untreated adult ADHD, which included lower income levels, inability to complete high school or college, potential for drug abuse, car accidents, incarceration, and becoming divorced. He also had a slide emphasizing the likelihood of these consequence which included warnings such as, "without treatment, you are four times more likely to contract a sexually transmitted disease."

Dr. Philips moved on to defining ADHD as a highly heritable, life long, neurobiological condition, thus, "when you diagnose ADHD in a child, you always look for it in the parent." He spent a significant amount of time explaining how childhood symptoms of inattention, hyperactivity and/or impulsivity manifest differently in adults and that this is recognizable by a good doctor. Many adults, he explained, think their symptoms are caused by other psychiatric disorders like anxiety, depression or even learning disorders, which challenges diagnoses. However, ADHD often appears as comorbidities with other psychiatric conditions such as anxiety, depression, or learning disorders, so it is important to test for ADHD if you suffer from any of these other conditions. Dr. Phillips also explained that many adults do not experience severe symptoms because they compensate by choosing a job or spouse that helps them cope with their ADHD without even realizing it. However, he emphasized that medication can inevitably help improve the symptoms of ADHD and should be considered as potential course of treatment.

Next, Dr. Phillips provided into an in-depth overview of the various types of stimulant and nonstimulant treatments that are available on the market, as well as some figures on their proven efficacy. After the overview, he turned to the audience and said, "even though the sponsors of this conference probably want me to tell you that their drugs are the best, the truth is that all classes of stimulant work well." Thus, the important thing was to get on the medication, no

matter what brand. Dr. Phillips then explained that while the FDA provided dosing guidelines based on height and weight (~68mg/100lbs), it was important to work with your doctor to optimize the drug's effects. He used the quote "start low, but don't go slow" to emphasize the importance of regular increases in dosage and working with a doctor to monitor the progress. He showed a slide titled "Goals of ADHD Therapy" which had a chart with an ascending line, a slight drop, and a then another quick ascension off the screen. The words underneath read "Treat the core impairments. Don't stop at just partial symptom improvement. Aim for the normative range." Dr. Phillips explained that many doctors stop increasing treatment before "a patient's target symptoms continue to improve without side effects."

Lastly, Dr. Phillips introduced the results from his own clinical study in which he administered more than double the suggested FDA limit and found acceptable tolerance, blood pressure levels, and no indication of chemical toxicity. As long as the patient can tolerate the side effects of the medications, he did not see any reason to discontinue the treatment. He concluded his presentation by reminding the audience that medication should always be the "first line of therapy" and that "medications are not without risk, but those risks can be managed."

### *4.2.4 University Psychologist: Responsibility to Personalize Treatment*

I first met Dr. Nicholson when I attended his talk at a statewide Disabilities in Higher Education Conference hosted at American State University in 2012. The title of his presentation was "ADHD Crises: An Interdisciplinary Approach to Supporting Students with Academic Performance Concerns." It was the result of a collaborative effort between Student Counseling Services (SCS), the Student Health Center (SHC), the Disabilities Resources Center (DSC) and the Center for Psychiatry at American State.

The first slide of the presentation was titled "A scene from scholarly pursuits" and featured a cartoon of a student sitting at his desk, distracted by all of the minutia in his room. Dr. Nicholson told the audience that attention issues are a part of the college experience for many students but that does not always indicate ADHD. This was especially important to consider when understanding why the number of students requesting diagnoses for the condition has increased dramatically over the last eight years. Before 2008, he explained, the Student Health Center was bombarded with what they called "ADHD crises" – desperate students looking for a doctor's note to explain a late paper or poor score on an exam. Because they were not equipped to handle this volume, students were diagnosed and prescribed medications without proper assessments. The head of the psychiatry department contacted Dr. Nicholson, who had over fifteen years of assessment experience before he joined American State, and asked if he could start a structured ADHD testing clinic to provide referrals. He agreed, and with the joint efforts of various campus units that dealt with ADHD students, they developed a system to properly test, treat and accommodate ADHD students. In the first year, only 28% of students tested for ADHD received a diagnosis, 60% were diagnosed with another psychiatric condition, and 12% were within the normal range. He explained that it was the responsibility of university health personnel to distinguish the difference between real medical issues and college students placing unreasonable academic expectations upon themselves.

Over the next 24 months, Dr. Nicholson and I became well acquainted and talked often about the challenges of diagnosing and treating college students with ADHD. During one of our early conversations, he described the assessment process. This included an initial intake conversation; followed by a recommendation for a full assessment (two days of testing which cost around $1000 to complete); an evaluation of personal histories from the student and close

family members; and, finally, an informing session where he would review the results of the testing. If the student tested positive for ADHD, he would write a referral to the Student Health Center, at which point they could seek pharmaceutical treatment. He told me that during the initial intake, he could usually tell if a student's attention issues were normal, indicative of ADHD or due to another underlying factor.

Sometimes, he explained, students would admit to him that they have taken a friend's Adderall and it "worked" for them. Although he knew that this alone was not "grounds for a positive diagnosis," it is hard to convince a student of this fact. He said, "when I have to tell them that in my professional opinion they don't have ADHD, and that their lack of focus is normal or worse, that it is due to depression or bipolar, they get visibly upset... it's like they don't want to deal with the real problem, they just want the Adderall." Although he might try to save them the $1000 testing fee, sometimes a student was adamant that they needed the testing and he would go along with it. He felt that it would allow him to work with the student to really get to the heart of the problem and in most cases, which some students really appreciate. I asked him if he felt that students ever tried to cheat on the assessments and fake ADHD. He laughed and told me "of course, but we have ways to detect for malingering. Of course I can't tell you what those are. They are trade secrets!"

In a recent conversation with Dr. Nicholson, he told to me that the number of students requesting assessments at the university had dropped significantly in the last year or so. When I asked him why he thought this had happened, he told me that it is because students have caught on that he does not just hand out ADHD referrals and are probably going to other doctors to obtain legal access to Adderall. He explained that most primary care physicians are unable to perform rigorous assessments on their patients and, as a result, give out strong medications to

people who may not have ADHD or may need treatment for a different psychiatric condition. This is different from the approach he takes, which he explains as “diagnosis by exclusion of all other explanations.” This is especially the case when students do not have a history of ADHD symptoms from childhood, or are only concerned with academic performance issues. He told me that if and when he does diagnose the condition, he makes sure to thoroughly explore all of the treatment options with his patients, of which medication is only one possibility. Although it is ultimately up to the patient and the prescribing physician or psychiatrist to determine the course of treatment, he feels that it is his responsibility to prepare them for that conversation. He uses the phrase "pills don’t teach skills" as a mantra to remind students that yes, drugs can help, but not in all cases, and never on their own.

#### *4.2.5 Academic Support Program: Responsibility to Optimize Accommodations*

Following lunch at the ADHD conference, I headed to the next session, “How to Succeed in College with ADHD.” Unlike the other sessions, which took place in auditoriums and conference rooms, this session was held in a regular classroom where the audience sat at desks like real students. I took my seat between two middle-aged white women and introduced myself as a graduate student interested in learning about ADHD. The woman on my right told us that she was at the conference because she recently fostered two African American boys with ADHD who were about to enter high school and she wanted to learn more about the condition. The woman on my left told us that she also had a son in high school and was considering getting him tested for the condition because he was having a hard time in school. Out of the corner of my eye, I watched the room fill up to the point where one of the moderators had to bring in extra chairs. This would be a popular session, especially for parents. Sitting on the panel at the front of

the room were three graduating students from the community college: a while female name Emma, a Hispanic female named Gabby, and a white male named Zach. Joining them were the mothers of all three students, as well as the of the director for Project BRAVE, a program at the community college which provided academic and technological support for students with ADHD. The program was funded by a grant from Shire Pharmaceuticals and is only eligible to students who have a verified diagnosis and make it through a rigorous selection process, much like the Michael Gold's ADHD College Scholarship Program.

The Project BRAVE director, Elsa Adams, began by introducing the students and the wide range of accomplishments they achieved while being a part of Project BRAVE. These included improvements in their GPA, running for student government, and acceptance into four year institutions. Ms. Adams then asked a prepared set of questions about their experience in Project BRAVE and how they were able to become successful ADHD college students. The first question asked, "What is the biggest difference between high school and college?" Zach immediately responded, "You need to actually take responsibility for yourself." He went on to describe how unstructured college is because you cannot just hop on the school bus and have your teacher remind you what is due all the time. Emma and Gabby nodded in agreement and Emma said "if you don't show up or do the work, you are basically wasting your parent's money." Zach also explained that in college you also have a lot of freedom, you can smoke on campus or drink so it is the student's' responsibility to make sure they do not "go crazy with the freedom." Ms. Adams jumped in and explained that this conflict between responsibility and freedom is especially difficult for students with ADHD because they do not have the skills to organize their life.

"What helped you to finally be successful?" was the second question Ms. Adams asked.

Zach chimed in again and said “learning how to get organized, manage time, basically learn how to be a student.” He went on to describe how before Project BRAVE he did not have the motivation to do well in school because it felt too hard. Ms. Adams interrupted his story and asked “Zach, can tell the audience about the other big change you made that really helped you?” Zach paused for a moment and racked his mind. “Do you mean the smart pen?” he said holding up the pen in this hand which allowed him to digitize his class notes. Ms. Adams replied, “No, the other thing that you started taking that really helped you get your school work in line.” Zach looked confused but then it hit him. “Oh yeah! I started taking medication again!” Ms. Adams looked pleased and asked Zach to tell the audience about his experience. Zach explained that when he was first diagnosed with ADHD in middle school, his doctors had put him on Ritalin and it made him “feel like a zombie.” He lost his appetite and as soon as he was eighteen, he stopped taking the medication, even though his parents wanted him to continue. It was not until last year, after his classmates told him about their positive experiences with a new medication, that he considered taking it again. He turned to the audience and explained, “even though medication didn’t work for me before, that doesn’t mean that it can’t work for me now that I am an adult. Now I actually want to do well in school. I actually love learning.” The woman sitting next to me with the son in high school raised her hand and asked Zach “What’s the name of the medication you are using?” Another parent said out loud “yeah, is it Adderall?” Zach replied “no, it's called Vyvanse.” Another parent asked “How do you spell it?” I looked around the roomalmost every person was writing down the letters as Ms. Adams spelled it out. “V-Y-V-A-N-S-E.”

### *4.2.6 Disabilities Services Provider: Responsibility to Personalize Accommodations*

It was a late afternoon in the spring of 2014 when I sat down meet with Francesca Riley, one of the staff at the Disabilities Services Center (DSC) at American State University. We were introduced via email by Dr. Nicholson after I had attended the Disabilities Services Conference the preceding fall where they had jointly presented the "ADHD Crises" talk. When we sat down, she told me that the best way to really know how services work are to walk me through the entire process from start to finish. Over the next hour, we pretended that I was a student who had come in for ADHD accommodations and it was Ms. Riley's job to determine whether or not I would be eligible for the services. Throughout the mock intake, Ms. Riley shared with with me a number of anecdotes that began to reveal the underlying complexity of what at first seemed to be a relatively transparent process.

Ms. Riley began by pulling up the DSC homepage on her computer and told me that the first step to receiving accommodations is to make a formal request to meet with a services officer. To do this, a student must login to the website with their university ID and create a profile that included detailed contact information and some general notes about their disability. We logged in and were prompted with a checklist of options, one of which was "Learning Disability (includes ADHD)". Once I submitted the electronic form, it automatically generated a request for a "confidential needs assessment" with a disabilities services officer. Ms. Riley explained that before they created the online profile system, they spent the majority of their time dealing with students who would call in or stop by the office to request accommodations because they believed they had a disability. In many cases, these students did not have documentation of a diagnosis, or would fail to follow up, making it difficult to keep track of their information. She told me "students come in and they think that is all they need to do. But no. I don't even know

you. I need documentation. They need an assessment." Ms. Riley told me that now that they have the electronic system, they take every opportunity to advertise the website during workshops for students so that they take the responsibility to initiate the process.

She then told me that once the student registers with the website, the DSC then starts a file on the student and sets up the needs assessment meeting. Students are asked to provide formal evidence of their condition during the meeting, but she told me that many students fail to comply because they either do not understand what that means or simply do not have any documentation. Ms. Riley told me that this is one thing she wishes she could change about the system - to require students to submit evidence before the meeting. That way, she could "weed out" those students who do not have a documented disability before spending an entire meeting deciding on potential accommodations that they do not even qualify for. She told me this was especially true for ADHD because students would often come to DSC to receive accommodations for the condition before they were even officially diagnosed because they were sure they had the condition. When this would happen, she often told them "we are all a little ADHD sometimes. ADHD is a spectrum and you need an assessment to know if it's bad enough that you need accommodations."

I asked Ms. Riley to describe the kind of evidence she expected from a student and she told me that at minimum, she wanted to see a clear diagnosis written on official letterhead from a licensed medical professional. However, this was rarely what students would provide. In fact, Ms. Riley told me that one of the hardest parts of her job was deciphering the range of evidence that students brought in. She complained that a lot of doctors were vague in their diagnoses and "don't want to put their jobs on the line" so she ends up having to sort through "twenty pages of gibberish" and only to find out they didn't give a diagnosis. She recounted one story in particular

that highlighted his frustration.

> "One time I called a secretary [at a doctor's office] because there was no diagnosis. It was vague language all the way through. And I called her and said 'You know I need a diagnosis.' And she laughed and said 'Yeah, we call that fluff.' And I said 'What?' And she said "We call that fluff. I mean, they pay over a thousand dollars to get this so we want to give them something that makes them feel like they're getting something for their money.' Can you believe that?"

Other forms of ADHD evidence that students have brought into DSC include empty prescription bottles for various stimulants and non-stimulant medications; packets of full page brain scans (without any clear diagnosis); self-assessments from the internet; and even notes from their parents. To deal with these discrepancies, students were now required to have a licensed medical professional fill out a standardized form provided by DSC in order to qualify for accommodations. Even then, she would have to look through the paperwork with a critical eye to determine the qualifications of the doctor and whether or not they did a thorough job with their diagnosis. She explained that a psychiatrist or a neurologist was more convincing to her than a regular M.D. because they knew how to do a proper assessment.

If Ms. Riley was still unsure about a student's ADHD status she almost always suggests that they go, see Dr. Nicholson to receive a formal assessment. That way she could feel good about providing an accommodation because she knew the student was thoroughly evaluated. This was especially true for students who were diagnosed as children and have been on stimulant medication for a long time because their testing was outdated and "they aren't the same people they were ten years ago." At the same time, Ms. Riley also referred to several doctors who work within the student health care system and the surrounding area who were notoriously bad at conducting assessments and filling out documentation. When she would see these names on student's records, she would take extra care to make sure everything checked out before providing accommodations paperwork.

I asked Ms. Riley if the DSC kept track of medication or whether or not they used that as evidence that a student qualified for accommodations. She explained that they do make a notation if a student volunteered the information or if they are having problems with the medication. She told me that she has had a number of students who do not respond well to Adderall and that she told them that everyone responds differently so they should not feel pressured to take what others are taking. I asked her if their decision to use or not use medications in anyway affected their ability to receive accommodations. She told me, "if they decide to stop taking it, I'm not going to change their accommodations. If anything, it might mean that they need more accommodations."

Lastly, I asked Ms. Riley how she though professors felt about having to provide accommodations to ADHD students and she told me that every once in awhile she would have to deal with a professor who did not understand the rules. She recounted one incident with a professor who was fed up with the number of students who were asking for special test venues because of their ADHD. She told me "the guy was just a total obnoxious jerk, and you know, and he would yell and scream and carry on, and she just wanted to say, 'Look buddy. Put a lid on it. Bring it down a little.'" Although these professors are the outliers, Ms. Riley's told me that this is why they try to make sure the accommodations are supported by DSC, as well as a medical professional. This is one of the reasons she becomes frustrated when students fail to follow up with proper documentation. She told me, "I would hope that they follow through. Because then I'm putting in a lot of time. So, if they don't follow through at that point, it's kind of a waste of my time."

## 4.3 DISCUSSION

Conrad and Potter (2005) describe the influence of medicalization processes and ideologies in the early 2000s has reshaped the dynamics of the doctor-patient relationship. Although doctors remained gatekeepers for medical treatment, their roles had become more subordinate as diagnoses were driven by pharmaceutical industry interests and demands from the expert patient (Fox et al. 2006). The internet, advocacy outreach and other forms of communication-diffused knowledge about adult ADHD and the potential benefits of Adderall in improving performance in adults. As a lifestyle drug, Adderall catered to consumers who wanted to quickly, safely, and effectively fulfill their biomedical and social potentials. In this framework, ADHD diagnoses presented an opportunity to access these drugs and the transformations they promised.

My research suggests that, in the last decade, the ADHD treatment landscape has evolved significantly in response to pharmaceuticalization, triggering social and personal moments of moral breakdown for health service providers at American State University. DSM definitions for Adult ADHD continued to evolve throughout the late 2000s and early 2010s, which both expanded and obscured criteria for diagnosis. Moreover, it morphed ADHD into a simultaneously psychiatric, neurobiological, and behavioral problem, creating opportunities for new forms of expertise to become engaged with and emerge from these newly expanded/refined diagnostic categories. Increases in ADHD students requiring accommodations, along with media coverage of dangers of stimulants, lead the public to question the intentions of the medical professionals who facilitate or deny treatment. Together, these factors contributed to an ongoing struggle between medical professionals and their patients to properly define ADHD and regulate the responsible use of prescription stimulants. In the following sections, I discuss how health service providers and ADHD experts in my study morally positioned themselves, their products,

and their consumers in relation to these moments of moral breakdown.

### *4.3.1. Practices: Generalized Treatment to Optimized/Personalized Management*

The ADHD treatment landscape has become increasingly complex and experts are now engaging with patients in multiple settings and through a number of interactions, including various forms of diagnosis, treatment, and accommodations. This complexity is due to the multiple and highly compartmentalized ADHD treatment modalities that are currently operational across the modern American university. These interactions were heavily influenced by the paradoxical concerns that ADHD experts face when treating clients in a university setting. On one hand, they were danger of making it too difficult for students who need ADHD treatment and accommodations to receive it - (e.g. failing to facilitate responsible stimulant use). On the other, they were in danger of making it too easy for students to receive treatment and accommodations for ADHD when they do not really need it (e.g. failing to prevent irresponsible stimulant use). This resulted in a number of personal moments of moral breakdown in which they had to decide which students truly required and deserved treatment.

One way ADHD experts in my study recovered from these moments of moral breakdown was by establishing and re-asserting their authority over the treatment process. However, the forms of evidence they use to support this authority varied greatly within and across treatment modalities. For some, authority was established through earning professional credentials, such as a formal coaching certification, an Ivy League medical degree or holding a high ranking title within a professional organization, like CHADD. For others, authority was established through professional experience, such as published books or videos, original research articles, and the number of assessments you have completed in the last fifteen years. For others, it was more

about personal experience, such as Ms. Evan's positionality as the mother of three children with ADHD or experiencing the condition yourself, as was the case with many of my coaches in training.

Authority could also come from the ability to disperse financial and academic resources, such as ADHD-based scholarships, technology, academic tutoring and other forms of accommodations, as illustrated by Project BRAVE. It was further established by using scientific jargon and referring to recent research in the field that shows you thoroughly understand the condition, but can translate it to your patients, as was the case with each expert to various degrees. Finally, authority can be established by how hard you work to responsibly treat your patients, either by giving them access to as many pharmaceutical, medical, and academic ADHD resources as possible - or taking the time to find out if they even qualify for these resources in the first place.

Another strategy that experts in my study used to deal with moral breakdowns was to critique the practice of other ADHD service providers within and across various treatment modalities. We saw this in the way both university psychologist Dr. Nicholson and DSC officer Ms. Riley critique the poor diagnostic practices of private doctors. For them, proper assessment was the first and most crucial step to ensuring that only those students who truly have the condition are receiving the treatment and accommodations they need. This was most evident in Ms. Riley's critique of the "fluff" she receives from doctors who fail to properly debrief patients after assessments and allow them to leave the office without clarifying if they have a diagnosis or not. In contrast, Dr. Phillips critiqued those doctors who did not do everything in their power to ensure diagnosis and maximize treatment. For him, ADHD was a major debilitating condition that can significantly ruin a person's life if not treated properly. Dr. Marin also took a critical

view of doctors when he described the responsibility of coaches to teach their clients how to talk to their prescribers about their experience with stimulants. This is because he was skeptical that doctors would have the time, interest or knowledge about their ADHD patients to properly monitor their treatment.

In order to publicly assert their authority, these experts engaged in public forums in an attempt to shape the discourse about ADHD and present themselves as responsible treatment providers. The public interactions these experts had with potential clients was in many ways filtered through messages already established in the direct-to-consumer (DTC) prescription stimulant marketing landscape. All the participants in my study agreed with the pharmaceutical industry in that it was ultimately their responsibility to properly diagnose, treat and accommodate their clients. However, their standards of evaluation varied greatly and the more formalized they attempted to make these criteria, the more convoluted the process became - especially when they tried to communicate this with patients. We saw this in how Dr. Phillips presents over 75 slides with charts and graphs to indicate the legitimacy of his methods - especially when it seems like he is putting his patients at risk. Dr. Nicholson also relied on what he considers rigorous assessment methods, a combination of standardized psychological testing, patient history, self reporting and his own intuition as a veteran assessment expert. The fact that he spent between 1-3 hours with a patient debriefing them on the whole process signals the complexity of his evaluation and his investment in making sure the right people get the right diagnosis.

At the same time, patients may be unwilling or unable to understand this language and are more drawn to explanations provided by cultural experts like Monica Evans or other expert patients, like the students from the Project BRAVE panel. These experts presented ADHD in tangible terms which clients would easily digest and relate to. Ms. Evans was especially effective

in drawing connections with her audience through the use of multimedia mediums, like documentaries, books and posters that humanize the condition. Project BRAVE took it a step further and showed parents and other students what was possible to achieve through their treatment modality by providing living, breathing examples. Finally, instability caused by these multiple models came to full view when students who self-identified as ADHD came to DSC to meet with Ms. Riley for accommodations. Her struggle to make sense of all the conflicting forms of evidence they provide, and her attempts at standardization, highlight the growing instability of these issues. Although she was not a scientist or a medical professional, her assessment of ADHD was critical in shaping the treatment experience for many ADHD students at American State University. She only became an "expert" out of necessity due to the fact that ADHD was now qualified as a learning disorder. This put her in a powerful position to decide what counts as ADHD, and thus merits special accommodations, and what does not.

### *4.3.2 Objects: From Enhancement or Lifestyle Drug to Cure or Foundation or Option*

During the treatment phase, prescription stimulants materialized and became tangible objects with real individual effects on patients. They were the reason why many people entered into exchanges with ADHD experts in the first place - to seek out or find out if they could benefit from these powerful medications. As a result, these ADHD experts must also present themselves as stimulant experts - even when they do not have the power to prescribe the drugs themselves. This also is why these experts face accusations under/over-facilitating stimulant use, because ADHD is so inherently tied to access to Adderall. Thus, the way they orient themselves and their practices around the drug is extremely important in establishing themselves as responsible treatment providers.

The ADHD experts in my study fell roughly into three camps regarding their thoughts on the functions of stimulant medication: stimulants as the cure, as the foundation, and as one of many options. Medical professionals largely regard drugs like Adderall as the primary treatment for ADHD because, in part, stimulants have been used to treat the condition for over forty years. As pharmaceutical science creates "new and improved" versions of these drugs, like Vyvanse, it is not surprising that experts like Dr. Phillips want to maximize the benefits of the drug. His studies that tested 2-3 times the FDA recommended dosage show how much value and trust he invested in stimulant medications. Dr. Phillips saw the function of medications not just to treat the symptoms of ADHD but to maximize the success of the patient. The only cap to this potential was any significant side effects that the patient was unwilling to deal with. Moreover, because it is seen as a lifelong, heritable, genetic condition, his job as a stimulant monitor never ends.

While all the doctors I spoke with recognized the potential benefits of stimulant medication, some started to reframe it as "the first line of treatment" for ADHD, rather than an overarching cure. This is due in part to the shift towards a neurobiological model of ADHD where stimulants are understood by their chemical effects and ability to regulate the dopamine uptake in the brain. At the same time, many experts, like Monica Evans and the directors of Project BRAVE, would argue that they are just a first, yet necessary step. During her presentation, Ms. Evans compared trying to deal with ADHD without medication to "trying to tie your shoes with one hand tied behind your back - you could do with, but why not just untie your hand?" In this metaphor, the user still needs to learn to tie their shoe, but medication makes it more possible. Similarly, Dr. Marin saw Adderall as one part of a more comprehensive treatment plan that included coaching and behavioral therapy. While he acknowledged the value of the drug, he also saw the potential issues that came from improper diagnosis and prescription. As a

result, he encouraged his coaching students to become experts on the medication to help empower the clients to be responsible users. At the same time, his definition of expertise is questionable, as he spent only a few minutes providing an overview of the drugs to the class - which begs the questions of how powerful he thought these drugs might be and whether or not it was a good idea to tell non-experts that it was their responsibility to help their clients manage their medication.

Finally, there were those experts who believe that stimulants can work, but not for everyone, and never on their own. This was certainly the case for Dr. Nicholson, who told me that Adderall was one of many options he presents to his clients. Although he himself cannot prescribe the drug, he had become an expert on its effects and the science around it because he was the last gatekeeper before the student took the referral to their prescribing doctor. Because he recognized the propensity for students to reach for the quick fix instead of working through the root cause of their problem and personalizing a treatment plan, he took it upon himself to thoroughly educate them. Ms. Riley also saw Adderall as one of many options, as well as the choice of the student. However, she clearly believed the substance has an effect because she explained that if a student decides to stop taking their medication, it is likely she would have to increase their accommodations.

### *4.3.3 Subjects: From Expert Patient to Pharmaceutical Client*

Adderall emerged in the late 1990s in relation to the invention of the informed expert patient, a neoliberal subject who takes responsibility for their health care and empowers themselves by actively pursuing medical treatment (Henwood et al. 2003). However, changes in the last decade has reframed this pharmaceutical subject as a victim of irresponsible and unfair

diagnoses, treatment, and accommodations, relying on drugs that ultimately marked them as cheaters or addicts. My research illustrates how ADHD experts in my study have responded to this social moment of moral breakdown to create what I term as the "pharmaceutical client," a moralized subject who shares responsibility over responsible stimulant use with a variety of health care providers. This occurs by interacting with and informing patients through a number of public and private exchanges, including public presentations, professional training, and private treatments. While there are some key differences in these interactions, there are also some crucial qualities which they all expect from their clients. First and foremost, the pharmaceutical client is willing to take initiative to seek out treatment. This initiative can take many forms, such as attending an ADHD conference; completing a complimentary session with an ADHD coach; purchasing a book or DVD about the condition; or filling out a form that registers them with disabilities services. While clients are expected make the first contact, they must also be willing to listen to the expertise of the service provider.

For Dr. Phillips, the responsible client was someone who accepts their ADHD diagnosis as the barrier to success and happiness in their life. He was also someone who trusts in biomedicine and believes in the power of stimulants to remove these barriers. More importantly, they were willing to do whatever it takes to conquer their ADHD and maximize their potential until they cannot handle the side effects of the drugs. He also expected his clients to keep him in the loop so he can closely monitor the efficacy of the stimulants. Thus, although he was the drug expert, the responsible patient made sure to keep up their end of the deal by checking in regularly and being honest with him about whether or not they could handle more medication.

Monica Evans also expected her clients to accept ADHD as a real condition before she reached them. In fact, when I sat next to her during lunch at the conference and asked her if she

had heard the argument that "ADHD is a socially constructed condition" she literally dropped her fork, looked at me and said "never! And anyone who says that is clearly an idiot!" Ms. Evans founded her career in CHADD around establishing the legitimacy of this disorder and as a result, interacts with a tight community of other experts and patients who share the same view. Her ideal client was someone who had the same convictions about the condition and would do whatever it took to fight for their rights as a person with a neurobiological disorder. At the same time, she also expected her clients to adopt her philosophy (or brand) of ADHD and support her cause by purchasing her merchandise and sharing it with others.

Dr. Nicholson also expected his clients to respect his years of experience and actively participate in the diagnosis process. However, he did not expect his clients to come in already knowing they have ADHD and ready to take medications. Instead, his ideal client was someone who was honest about their struggles and was willing to go down a guided journey to find the root cause and a personalized solution. He was particularly weary of students who tried to fake ADHD - although he did not blame them, he blamed the pro-stimulant environment they were embedded in. Instead he hoped to be the one to help this client realize the "real issue" and accept it, even if it was something they did not want to be labeled with, such as depression or PTSD. Because he dedicated so much time and effort into the assessment process, Dr. Nicholson hoped that his patients would appreciate his care and take his advice seriously as they moved on with or without a referral for ADHD.

Coaches in my study like Dr. Marin took a more co-active approach and focused on empowering their patients instead of applying their expertise to their condition. He also expected that his client would reach out to him if they needed help and were willing to go through the long and extensive process of ADHD coaching. At the same time, he did not see his clients as innately

understanding how to balance the coaching/behavioral therapy side of treatment with the sometimes necessary medication. Similarly, the directors of Project Brave also expected their potential clients - in this case, the audience members made up of parents and students - to recognize the importance of both medical and nonmedical interventions. While Dr. Marin did not want his clients to focus only on stimulants, Ms. Adams did not want parents to only rely on tutoring and other support services to be successful in school. Thus, for both of them, the responsible client someone who took the initiative to build their own personalized treatment program - but with the guidance of a knowledgeable ADHD expert.

## 4.4 CONCLUSION

In this chapter, I provided evidence of an ongoing struggle between the ADHD experts and their clients in properly diagnosing the condition and regulating the responsible use of prescription stimulants at American State University. I argued that this represents a key moment of moral breakdown associated with the biomedicalization and pharmaceuticalization of performance in American college culture. I take this a departure from previous conceptualizations of the neoliberal expert patient who feels empowered by actively pursuing medical treatment (Fox et al. 2005). This perspective both appealed and contributed to concurrent patients' rights movements and the establishment of advocacy groups like CHADD at the turn of the century by putting the control of health back into the hands of the consumer rather than the authority of medical professionals (Conrad and Potter 2005). My findings resonated with Oldani's (2014) descriptions of high prescribers, such as Dr. Phillips, and pharmaceutically conscious doctors, like Dr. Nicholson, but also considers the influence of pharmaceuticalization on the emergence and practices of new forms of professional ADHD expertise.

The case examples presented show how these health professionals are not only relying on neoliberal logics of consumerized healthcare but also creating new forms of moralized pharmaceutical subjectivity in response to this breakdown. Specifically, these experts relied on their positionality to stimulants as as un/safe, un/fair and in/effective treatments as a way to assert their authority over these exchanges and present themselves as responsible service providers. This included flexible criteria on how ADHD is defined, evaluated, treated, monitored and accommodated. Yet with each exchange, the symbolic meaning of stimulants as medication became unstable as both experts and clients unsuccessfully attempted to standardize fair qualifications for, and access to, ADHD services. As a result, ADHD clients must strategically assert their congruent identities as patient, consumer and/or student in order to navigate these multiple contexts and rationalize their desire for ADHD services. I argue that by doing so, both ADHD clients and experts are able to respond to these moments of moral breakdown, and maintain a perceived sense of responsibility to consume stimulants while also promoting the responsible stimulant use of others.

In the following chapter, I examine how these moral discourses are transmitted and transformed as prescription stimulants are dispersed to college students and circulated to their peers. I describe the experiences of college patients, turned Adderall dealers who are tasked with responsibly consuming prescription stimulants while maintaining responsibility over the responsible drug use of others. It also speaks to their positionality in regards to health services providers and how this influences dealer perceptions of prescription stimulants and their relationships with drug seekers. Moreover, it offers context for how illicit Adderall users interpret their experiences once they have gained access to these drugs.

## CHAPTER 5: CIRCULATION

This chapter considers how moral ideologies are filtered from the ADHD treatment landscape and absorbed in to college environment to inform definitions of responsible stimulant use among Adderall Dealers. It builds on anthropological literature that describes the experiences of the drug seeker, a subject who is driven by the desire to get high and is in danger of becoming disempowered by a dependency on drugs. I also draw on studies from the health and social sciences that look specifically at the illicit Adderall market on campuses, most of which focus on the exchange from the perspective of the drug seeker. While this research underscores the normalization of dealing/seeking Adderall on college campuses, little is known about the intentions and experiences of those who supply these valued commodities. As a result, it is unclear if and how responsibility over the responsible use of prescription stimulants is negotiated and asserted between these actors.

Building on this literature, I consider how the circulation of prescription stimulants has evolved in respect to trends in pharmaceuticalization in the last decade. Increases in the prevalence of illicit Adderall use among college students has raised public concerns over the intentions and actions of drug dealers who irresponsibly distribute stimulants to their peers. I use media reports to provide key insights into public discourse surrounding this social moment of moral breakdown and highlight the ethical dilemmas faced by students who are legally medicated for ADHD. I situate these dilemmas within the evolving Adderall trade on campus described in Chapter 2 and illustrate how certain factors such as the perceived impunity of dealing, the demand for stimulants, and the controversial nature of the drugs they deal have shaped the prescription stimulant dealer-seeker relationship.

My goal in this chapter is to explore how Adderall dealers at American State have positioned themselves, their medications, and drug seekers in relation to both social and personal moments of moral breakdown within campus stimulant landscape. To accomplish this, I conducted interviews and observations with eleven students who are legally medicated for ADHD and documented their experiences within the stimulant economy on campus. I present three in-depth case examples that highlight moments in which ADHD students strategically resisted from/participated in the Adderall market on campus and framed their decisions as acts of social responsibility. These case examples are based on three key informants who illustrate the broad spectrum of moral logics Adderall dealers draw upon when rationalizing their decisions. I present my analyses of these case examples around relations-objects-subjects to systematically map the moral discourses that surround, and are produced through, the circulation of prescription stimulants. I conclude the chapter with a discussion of how this analysis informs conceptions and expectations of pharmaceutical morality and subjectivity in the U.S.

## 5.1 MORAL BREAKDOWN: FAILING FRIENDS OR DEALING DRUGS

Studies of illicit stimulant use on college campuses indicate a prevalence rate of up to 43% within some college populations (Advokat et al. 2008). Many attribute this to the growing availability of these drugs from fellow students who have legal prescriptions (DeSantis 2005). According to research from McCabe et. al (2006), nearly 54% of ADHD students have been approached for their medication by fellow peers. Garnier et al. (2010) reports that nearly 62% of students admit to willfully distributing their prescription ADHD medication. The growing prevalence in the circulation of prescription stimulants has raised serious concerns around the safety, legality and ethics of this drug behavior. These commentaries typically focus on the

experiences of the Adderall user, who actively seeks out medications from their peers in order to increase academic performance. As a result, little is known about the students who are legally medicated for ADHD and supply these drugs in the first place.

However, there are a few key instances in the last decade in which Adderall dealers have become the center of discussion. This was the case on December 10, 2010, when five students at Colombia University were arrested for selling $11,000 worth of drugs, including marijuana, cocaine, ecstasy, and Adderall. It was the result of a five-month undercover police investigation known as "Operation Ivy League." One of these students was Stephen Perez, a Gates Millennium Scholar, who was the only student charged with selling his prescription ADHD medication to peers. After pleading guilty, Perez served 300 hours of community service and was subsequently expelled from the university. His story was one of the most publicized instances of a college student with ADHD who found themselves in the position of becoming a prescription drug dealer.

Media reports on this story offer insights into public discourse surrounding this moment of moral breakdown and the highlight the ethical dilemmas faced by students like Perez, who are legally medicated for ADHD. For example, in a primetime interview with reporter Kate Snow, Perez shares his story: a young boy growing up in a poor family, dedicated to the dream of one day attending prestigious Colombia University. He described the sacrifices he made in high school and continued to make in college in order to maintain the high level of performance needed to be successful at such a competitive school. One of his strategies was to use Adderall, which he became dependent on. In the interview, he recounts how easy it was to obtain his own prescription from the student health center, filling out a few forms, and even admitting to doctors that he had used the drug illegally with positive results. Perez blames everyone but himself for

this situation, including the health center, administration and the academic culture of the university. He holds on to the belief that in the end, he was only trying to help his fellow students.

While Snow's interview paints Perez as a good student caught in a bad situation, media accounts of this event have varied. Alternative news website Gawker ran an article titled "Accused Colombia Frat Boy Drug Dealer Threw 'Da Sickest Party'", underscoring a different, less responsible side to Perez. In the story and associated images, he is portrayed as someone more interested in drinking alcohol, smoking weed, and meeting women than managing his academic responsibilities. During his trial, Perez's lawyer wrote a letter to the court admitting that although he had joined a fraternity, worked a campus job, and was involved in various student groups, he also began smoking marijuana daily, a habit he financed by selling the Adderall he had been prescribed. Although it is impossible to know his true motives, it is clear that, for Perez, having a prescription for Adderall served a number of academic and social functions beyond treating his diagnosed ADHD.

Perez is not representative of all ADHD college students but his sentiments highlight several key elements of being in college with a legal prescription for Adderall. In some ways, his narrative mirrors that of a street drug dealer in that access to prescription stimulants can be seen as a form of social capital and an avenue for financial gain. But unlike most illicit drug use, consumption of prescription stimulants is believed to have a productive function by most college students. Thus, the distribution of one's medication is often framed by both drug dealers and seekers as an act of generosity, or even social responsibility, rather than a straightforward financial transaction. Perez's story also calls into question the legitimacy of ADHD diagnoses and the increasingly complex task of serving ADHD students in an environment where their

medications have become valued commodities. Finally, the fact that Perez was the only student arrested for selling Adderall, and was also the only one to receive this level of media attention is telling about the way the public views the distribution of prescription stimulant versus illicit street drugs. Perez suggests that illicit circulation of stimulants has become so normalized on college campuses, that fearing legal implications was laughable. Moreover, if anyone was to blame, he claims it was the professors who assigned unreasonable workloads, the doctors who prescribed him the medications, and the police who were ignorant to the culture of normalized stimulant use in the university.

The concerns raised by Operation Ivy League are part of a growing public debate over the intentions and actions of drug dealers who irresponsibly distribute stimulants to their peers. It has emerged as the result of a number of factors that shape this evolving Adderall market on campus, such as the perceived impunity of dealing, the demand for stimulants, and the controversial nature of the drugs. In this chapter, I examine how Adderall dealers have positioned themselves in order to navigate this morally convoluted environment. Specifically, I ask, how is responsible stimulant use defined and facilitated by the Adderall dealers and seekers at American State University through the willful circulation of prescription stimulants? How do these interactions influence and embody shifting expectations around the responsibility to facilitate and participate in responsible stimulant use among my participants? In the following sections, I address these questions and examine how Adderall dealers at my field site frame the drug deal, the function of stimulants, and the role of the responsible Adderall seeker in relation to these social and personal moments of moral breakdown.

## 5.2 CASE EXAMPLES

I conducted 24 months of interviews and participant observations with 11 students who were legally medicated for ADHD and documented their experiences resisting and participating in the stimulant economy on campus. During the interview phase, students were asked questions about their ideologies and experiences as they related to medical factors (ADHD, Adderall, pharmaceuticals, doctors); social factors (family, peer groups, socialization, drinking/drug use); and academic factors (transitions into college, college culture, study habits, grades). Each interview lasted between 2-4 hours and was tape recorded and transcribed. Interviews were coded via NVIVO based on these three primary contexts and then with sub-codes related to emergent themes from the data.

During the interview, I built rapport with these students and touched base with each of them at multiple times over the next twelve months. Many of them contacted me to share updates and invited me to social events, study groups, and doctors' appointments where prescription stimulants were openly discussed and sometimes distributed. During these encounters, I witnessed moments where students were approached by their peers for ADHD medication, both in person and after the fact via social media. I also accompanied several informants when they were actively delivering or distributing their drugs to other students. It became clear to me that no two drug deals were the same. Some were pre-planned drop-offs/pick-ups, where others happened organically during study groups because someone had an extra Adderall they were willing to share. It is impossible to tell how exactly my presence affected these encounters.

I illustrate how the circulation of Adderall at American State has a deeply moralized negotiation of health, empowerment, and responsibility for my participants, by which new biomedical and social subjectivities are fashioned. The significance of these transactions is

bolstered by the fact that participation in this drug economy is not only normalized, but has become an expected part of the college experience for many of these students. So much so that simply having a prescription for ADHD medications means you must either actively resist or ethically rationalize your position as potential drug dealer, sometimes at great cost. Of the eleven students I interviewed, nine admitted to having distributed their medication to peers and family members while two actively resisted such requests. Of these two, one had their medication stolen multiple times by friends of roommates and eventually discontinued filling her prescription. The other ended up in rehab several months later because of a subsequent addiction to her own medication, which was the primary reason she was unwilling to share her supply in the first place.

The prospect of being a drug dealer in college was understood and acknowledged in various degrees by my informants. Some find it so detestable that they cut ties with friends who approach them for the drug, or hide their ADHD diagnosis altogether to avoid such requests. Others saw the identity as an opportunity for both economic and social gain, as well as a means to help fellow students manage their medical and/or academic struggles. Most students fell somewhere in between, struggling to maintain agency over each potential drug exchange, while convincing themselves that their actions are noble, or at the very least, socially acceptable.

The dealers I interviewed drew on a combination economic, social, and medical logics to ultimately make their decisions on whether or not to sell their drug. Alex, an undeclared sophomore, was the only informant I interviewed who seemed to fit the traditional drug dealer stereotype. He had a legal prescription for Adderall, which he sold along with a number of street drugs, such as marijuana and molly. For him, Adderall was no different than the other commodities he peddled, and he mostly sold to students (many he did not know) who would use

the drug for recreational purposes. His perception of impunity seemed the highest, as I remember him pulling out a Spiderman lunchbox from his backpack during our interview, to reveal a collection of small baggies filled with pills, weed and other drug-related items. Despite his confidence (or maybe because of it), Alex was eventually arrested for dealing Molly and ended up dropping out of American State within few months of the initial interview. In contrast, the rest of the informants in my study only ever distributed their prescription Adderall, sometimes for free and only to known peers who "needed it". It is these distinctions that would both socially and psychologically set them apart from “irresponsible” drug dealers like Alex.

In the following sections, I present three case studies from drug dealers whom I spent a considerable amount of time with for this study. While each expressed the desire to both serve and protect the Adderall seeker, the way they strategically position themselves in the stimulant market varies greatly. These positions served to ethically rationalize their participation in this controversial practice and illustrated the complex value systems they created out of necessity. By coupling interviews and participant observations, the following cases show students’ moralized self-constructions compared to their lived experiences as students, friends, patients, and drug dealers.

### *5.2.1 Becca: Responsibility as Reliability*

It was a month before final exams week and I was sitting in the campus food court with Becca, a sophomore in sociology. I had texted her that morning to meet for lunch so I could talk with her about the Adderall shortage that was supposedly panicking the nation that spring. As we sat down with our trays, Becca began to describe her two-week quest to track down a pharmacy that could fill her prescription. After six failed attempts, she finally found one an hour away that

could accommodate her. She recounted her frustrating experience waiting in line behind a dozen people, worrying that they would run out of Adderall before it was her turn. Needless to say she was relieved when she finally came back to campus, stimulants in hand. We spent the rest of lunch talking about the various people Becca needed to contact now that she had her prescription refilled. First on her list was Jeremy, a student whom she met at Battle of the Bands the year before. He was a bassist in a featured band and had caught Becca's attention because of his good looks and musical ability. She told me that she "hooked up" with Jeremy that night only to find out he had a girlfriend a few weeks later. She laughs and told me that now the three of them are friends and that she sells them both Adderall on a regular basis. Another customer was Rita, a student in her history class who, according to Becca, knows every DJ and break dancer at American State. Becca heard Rita telling another student before class how her "addy hookup" fell through. Becca offered to "hook her up" and explained to me that Rita was so grateful - "she acted like I saved her life!"

As we were finishing up our lunch, Becca spotted her friend Jack standing with a group of athletes across the cafeteria and waved him over. I had met Jack before at a soccer party that I attended earlier that semester with Becca. Back then, she did not really know him that well. Since that party, she had been flirting with Jack via text but the extent of their relationship was unclear to me at that point. Jack slowly made his way through the crowd and over to our table. She smiled, playfully tugged on his shirt and announced: "Guess what? I just got my script. 90 days. So tell your boys." Immediately, a smile spread across Jack's face as he sat down and put his arm around her and exclaimed: "Are you serious? This is why I love you." Becca giggled and replied, "I'll remember you said that".

During our initial interview several months earlier, Becca had little experience selling

Adderall but openly embraced the idea of being a "drug dealer" because it made her feel like a "badass". She contrasts this glorified persona to her pre-college identity which was an inexperienced "prude" who did not have any friends - or fun. She told me,

> **"**Throughout my life I've always struggled with acceptance. And I've been grappling with that my entire life and especially through middle and high school because I was like an outcast and I wasn't cool and all that stuff and I didn't have a lot of friends. And so I've always struggled with that especially like with physical image and just being accepted. I have a need to be liked and I've been working on that… The weird thing is that I resented my parents for putting me on meds so young. That's probably a big part of why I felt like an outcast, like a delinquent or something."

Becca's claimed that her insecurities growing up were rooted in her initial ADHD diagnosis which occurred when she was just six-year-old. Although she does not remember exactly how she was tested, she recalls being in a room filled with toys while her parents and doctors talked about how they thought that something must be wrong with her. She was eventually prescribed Ritalin and remained on the drug for only six months before she was switched to Wellbutrin, an anti-depressant. In many ways, Becca blames her lack of social skills on being medicated from such an early age. She told me about her difficulty connecting with people, especially during high school when popularity started to become more important to her. She told me how the "cool kids" in school were known for their promiscuity and recreational drug use, something that she never considered taking part in until she got to college. When I asked her what changed between high school and college, she told me,

> **"**I guess you could say I grew up? I used to be extremely naive. Well, on the one hand I didn't know things. On the other hand, I disagreed with a lot of drug use and stuff. Like now I smoke weed and sometimes I drink alcohol and I take Adderall and I sell it and I'm not a virgin anymore. I used to be incredibly naïve and that would come from not being in the popular crowd because it was socially acceptable for them to do everything."

The fact that Becca seamlessly weaves her Adderall dealing in with drinking and losing her virginity suggests that for her, it is part of a larger social transformation into adulthood. Taking

this stance helps to rationalize her decision to experiment with risky behaviors that she knows could pose serious medical and legal consequences. Although Becca had heard about students in high school taking Ritalin recreationally, it was not until she was at American State that she realized how valuable of a commodity prescription stimulants had become. She had tried Adderall once during her freshman year after she received it from a friend with a prescription and thought it really helped her focus. She decided that she wanted to see her psychiatrist and try to get her own supply. She told me that although she wanted Adderall, they prescribed her Strattera, a non-stimulant ADHD treatment. According to Becca, prescribing Strattera was a strategy to prevent students from gaining access to Adderall because they know a lot of people abuse it.

After using the drug for a few weeks to mask suspicion, Becca told me that she eventually convinced her psychiatrist to switch her to Adderall because she felt it would work better. Her doctor agreed, and for the first time Becca found herself in the position of having extra medication laying around. It was at that point that she first considered selling her medication to make some extra money. Since Becca knew little about how to sell drugs, she gave her bottle to a friend who sold marijuana and claimed he would be able to find buyers. Becca told me that after almost two months of dodging her calls, she realized that he had ripped her off and either could not find buyers or had sold the medication and kept the profit for himself. She told me that after that incident, she knew if she wanted to make money off of her medication, she needed to handle it herself. She had witnessed other students sell Adderall and felt like she now had a better understanding of how the drug economy worked on campus.

After a few weeks on Adderall, Becca realized that she did not need to take it regularly in order to complete her academic work. Once again, she found herself with a surplus of

medication, this time a name brand pill that everyone would want. Becca told me she really "owned" the drug dealer persona and pushed hard to sell her medication every chance she got because she had a surplus of over 100 pills that had accumulated over the course of one semester. I asked her why she did not just return the unused drugs to her psychiatrist and/or ask for a reduced dosage and she told me that she had not even considered that before. At the time, she claims that her decision to sell them was strictly pragmatic and that she would only sell it to people she knew. When I asked her if she felt like she would be pressured to sell her Adderall once people knew about her prescription, she told me, "No. It's usually people that know that I take it or that I have a prescription. I broadcast it pretty widely so I'm like hey, if you ever need Adderall, I have some."

Becca seems to construct herself as a reliable drug dealer who is there to provide her friends with a commodity that she knew was in high demand. Because she is networked with other students who regularly use the drug, she saw her surplus medication as a way to solidify those friendships and build new ones. When she talks about her clients, she does so with a positive inflection and excitement in her voice. For example, she told me, how she shares her Adderall with her roommate who does not have a prescription, **"**My roommate takes it like a few times and I'm like totally cool with giving her the pills because she's my roommate and I love her to death." Later during my participant observations with Becca, I would come to realize how Becca depended on the affections of her clients just as much as they depended on her for her medication. This fact became clear when Becca's surplus eventually ran out and she was put in a position where all of her handwork networking and building friendships might become compromised.

Although Becca sells her medication regularly to people who do not have ADHD, she does

not approve of students who fake having the condition in order to obtain and sell Adderall to others, especially those who "brag about it". It seems that for Becca, having ADHD meant that her access to Adderall was somehow more legitimate than for others who only got a prescription to sell it. Because it was rightfully her medication, she should be able to do what she wants with it, and that includes selling it to other students. She also feels like students have the right to buy Adderall if they want to even if it is illegal because it comes with the territory of being a college student. She told me how students, including herself, brag about the benefits of the drug. She told me,

> "Yeah…um…I've done it [bragged about it]. I took Adderall yesterday and I cleaned my entire room. Like, um, a victory…not a victory, that's a wrong word. Like a success type thing. Like, I cleaned my entire room! I'm very proud of myself right now. Yeah or like I finished a 30-page paper because I took Adderall…so yeah."

Although Becca uses Adderall because she believes she has ADHD, she also acknowledges that it can be a powerful performance enhancer for students without the diagnosis - a fact that does not seem to bother her. If anything, it helps her to feel connected to her peers because they are using the same drugs and experiencing the same sense of productivity and success. Framing Adderall as a productive commodity also helps to rationalize her decision to continue selling drugs to her friends in the first place, as though she is granting them access to its powers. This is a significant departure from her narrative of feeling like an outcast in grade school because of her medication, and ultimately illustrates the role Adderall plays in constructing Becca's identity as peer, patient and drug dealer.

It seems that for Becca, the demand for Adderall in college is a large factor in fashioning her own identity as a student with ADHD. It has transformed the way she views her diagnosis as a mark of delinquency, to an opportunity to gain the social status she so desperately wanted. Like many students who were diagnosed with attention disorders as a child, Becca described her

struggle with understanding and accepting her diagnosis, as well as her need for the medication. However, as she entered into the college environment, where Adderall use was not only normalized, but glamorized, she acquired a new lens to understand her relationship to her medication. Becca rationalizes her behavior by contextualizing it as part of the modern college experience, where students are expected to mature and grow up, while at the same time, experiment with drugs and rebel against the system. In other words, experimenting is in fact a part of Becca's responsibility as an emergent adult in the college context.

Becca seems to willingly assume the drug dealer identity and constructs her moral agency around the ability to reliably provide Adderall to her friends. The more time I spent with Becca, the more I realized that the majority of her social relationships in college were somehow connected to her role as a dependable Adderall provider. In this way, Adderall tied directly to her social value as a friend, roommate, classmate, sexual partner, and a drug dealer. The strength and basis of these ties are brought to light when Becca is faced losing the trust of her network during the Adderall shortage. It is only when she is able to finally refill her prescription that Becca seems to be able to uphold her responsibility to her clients, and maintain their trust, that her agency is restored.

### *5.2.2 Mark: Responsibility as Liability*

I was sitting outside on the steps leading up to the campus library around 9pm during finals week with Mark, a junior in economics. He had texted me earlier that night to meet up so he could show me all of the messages he received from fellow students looking for Adderall that week: *"Hey can I come over tonight?", "Can I get some Adderall?"," I hate to ask you but do you have any Adderall left?", "Did you get your script this month?", "Addy?", "You studying*

*tonight?"* There were 16 messages in total, each soliciting Mark for Adderall in both overt and subtle ways. I asked Mark how he felt about the influx of attention he was receiving and he rolled his eyes. He explained that he thought it was pathetic how desperate students were and was amused that they thought they could actually get him to just sell off his own medication. He also expressed frustration because many of the people who texted him were not even supposed to know that he had a prescription for ADHD medications, let alone assume that he would be willing to share.

A few minutes into our conversation, a young man named Stephen emerged from the library and offered us a cigarette. He sat down and chatted for a few minutes, asking us about exams and venting about his own unreasonable finals schedule: two papers, an oral presentation, and a calculus final. After about ten minutes of small talk, Stephen leaned in toward Mark and asked if he could borrow some Adderall to finish the paper he was struggling with. Mark looked down at the ground and told him that he was sorry but he did not have any on him. Stephen asked if he could stop by his dorm later that night and offered to pay Mark ten dollars for a 10mg tablet. Mark hesitated for a moment but ultimately gave in. He told Stephen that he did not want his money as long promised not to tell anyone where he had got the Adderall from. Stephen enthusiastically agreed and gave Mark and I a hug before heading back into the library. As Stephen walked away, Mark turned towards me and said, "so now you see what I am dealing with?"

During our initial interview, Mark told me that he was not openly interested in selling his Adderall. In fact, when he got his prescription for the drug his freshman year, he tried his best to completely avoid the pressure of becoming a drug dealer by hiding his diagnosis. He explains,

> "Nobody knew I had Adderall except my roommate for as long as I could possibly keep it that way. Because when I first got it, I had this weird moral thing about giving it to other

> people or selling it. I just felt weird about it, like 'I don't want to be a drug dealer' type of attitude about it. Plus, I need them. I actually have ADHD."

Mark was first diagnosed with ADHD in the 8th grade when he learned about the condition in a high school preparation class called "Freshman Focus". Prior to the class, he had a particular image of students who were on ADHD medications in middle school. He described them as "truant" and having an "I don't give a fuck" attitude about their grades or respecting their parents and teachers. According to Mark, these students did not have the proper intentions with the drug for it to work. Alternatively, his initiative to seek treatment was a direct reflection of his desire to become a responsible student and do well in school. Mark's mother took him to his pediatrician and he explained the issues he was having in school. After asking a few questions, and with no formal testing, Mark walked out the door with a prescription for Strattera, which he had not heard of before. Although he was hoping for Adderall because that is the drug he was familiar with, he decided to give this drug a try.

Over the next three months, Mark felt as though his academic performance improved significantly. At the same time, he also experienced severe side effects from the medication, such as nausea and vomiting, which counteracted any positive effects of the drug. Mark decided to stop taking Strattera and continued through high school without any further use of prescription drugs. As he reflects on that time in his life, he believes his improved grades were a result of the neurological effects the drug but also his decision to finally take his school work seriously. Although he felt like he could have gone back to his doctor and asked him for a different medication, he decided that he could get through high school on his own and did not want to risk experiencing any more side effects. It was not until his freshman year at American State that he considered taking ADHD medication again when he started hearing about students taking Adderall illicitly as an academic performance enhancer. Mark told me that he decided to go

through a family doctor since he heard it was easier than going through the student health center. He told me that the first time he took Adderall, he was shocked by the strength of the medication and how "shaky" he felt when taking it.

As Mark embarked on this new journey to understand how to handle his powerful new medication, he was also faced with the pressure to sell his medication, especially once his roommate found out. Once it became public knowledge, he started being approached more often for the drug, which began to make him question the basis of his social relationships. He told me,

> "It's funny because there's two approaches. There's the 'I want Adderall approach,' and the I'm gonna hang out awkwardly and not say anything for twenty minutes and have a weird side conversation, while the whole time I'm just wondering if you are hanging around for Adderall… I had no problem telling these people to piss off."

Mark elaborated on his frustration with drug seekers who feel entitled to ask for his medication. On the one hand, he is turned off by individuals who outright ask him to sell his Adderall because it makes him feel like he is being treated like a drug dealer. On the other hand, he feels angry when certain people "waste his time" pretending to be his friend or care about his life when ultimately they are just trying to get his medication. As a result, Mark held a particularly negative view of the types of people who would approach him for Adderall, especially the ones that would brag about snorting Adderall or using it to party. For Mark, these boastful narratives of irresponsible Adderall use, likened to the consumption of street drugs like methamphetamine or cocaine, only increased his weariness of sharing his medication. While it is unlikely that this description fits every student who has approached him for Adderall, generalizing this group of people as irresponsible drug users helps Mark solidify his own moral higher ground.

While he shows general disdain for these individuals, his sentiments also indicate a level of concern over the fact that these students were unaware of the potential dangers associated with

Adderall use. Given his own negative experiences with the drug, even under the supervision of a medical professional, he was concerned how this might affect him as the one supplying the drugs. He told me he is especially concerned when people ask him for multiple pills at a time. He told me,

> "Am I gonna get in trouble if this kid is found in a ditch somewhere after he took 4 Adderall?" People don't realize that odd things go into prescription pills. Things that you may or may not be allergic to that you have no idea about! Like things that only your doctor knows. Like if I give you this amphetamine and you're allergic to it and swallow a whole bunch of them, I'm gonna be the one who's held responsible."

Despite Mark's confidence in his ability to resist selling his Adderall to these irresponsible, uninformed drug seekers, he clearly does distribute his medication, as evidenced by his exchange with Stephen. During the interview I asked him how he decides when it is okay to share his pills. He laughed and told me:

> **"**[Mark's] Moral Criteria, that's what you have to meet. I dunno, it's weird, I have like a moral compass…What if you use it to party, and you end up dead in a ditch or something? You know, the whole responsibility thing…People don't realize the power of it."

Mark frames his hesitation to sell his medication as a feeling of responsibility over the health of his peers. He assumes that if a seeker requests what he considers to be an excessive amount of Adderall from someone they do not know well, they must be inexperienced or simply irresponsible. At the same time, Mark is also concerned with maintaining agency over the transaction itself. In particular, he expresses the discomfort that comes with accepting money from peers and the social implications it brings. He told me that one of the main reasons he gives the pills away for free is because he can justify only giving 1-2, versus selling more pills for a reasonable sum of money. He told me that doing so "feels like a transaction or drug deal or whatever… Like it would never get to that point, where like I am a legit drug dealer".

At the same time, Mark admitted that he does accept money from people when it makes

him feel comfortable. He told me that there is “no rhyme or reason to it” and that “Because like if I’m giving it to you, I’m gonna make the transaction comfortable for me and whether that include money or no money, that’s my decision.” Mark’s desire to maintain agency over the drug exchange is particularly evident when he described being approached by someone who he feels pressured to sell to.

> "They’ll come up to you and say like ‘can I get two pills, I’ll give you 5 bucks each’ - okay, whatever. Or they’ll ask me rather, so if I actually have them pay, I’ll say like 3 bucks each, so they’ll give me the money. And then he’ll be like, ‘ah man, my friend has it too, I should have gotten it from him because he has 30’s and you only have 10’s’ and I’m just like [in an aggravated voice] ‘Then don’t come to me!’ Like don’t come to me and then complain about it. Like I don’t care about selling to you at all."

Mark’s story indicates an internal struggle over how to rationalize his distribution of medication, especially when he ultimately does not want to. In this scenario, he gave into the pressure to sell his medication and rationalizes it by not charging the full offered amount (e.g. taking $3 instead of the offered $5 per pill). For Mark, this proved that he was not in it for the money, rather, he was just trying to be a nice guy. However, when the drug seeker questions the value of his medication and argues for a better price or threatens to go buy Adderall from another dealer, Mark became defensive. For him, these bargaining techniques implied that the seeker saw him as a drug dealer trying to make money, rather than a friend looking out for their best interest. He reasserted his agency by reminding himself that these seekers are only interested getting the best deal for their money, rather than making an informed decision to safely increase their academic performance.

Like many prescription holders, Mark found himself faced with the moral dilemma of how to hold onto his medication, which he felt he needed, without alienating his peers who are experiencing similar academic struggles. To cope with this, he constructed a narrative of a moral self who can resist the social pressures to sell to irresponsible, uninformed drug seekers. Mark

believed that his morality precedes his use and distribution of Adderall - this allowed him to justify his actions as ethical because otherwise he would not do it.

His moral compass was based on his desires to be a responsible student, his experience with ADHD medications and the fact that he recognizes and respects the power of these drugs. In contrast, he likened the typical Adderall seekers to a recreational drug user rather than someone who would use the drug responsibly and for noble purposes. At the same time, Mark was also struggling to understand his own use of Adderall as he described the simultaneously enhancing and detrimental effects. His negative experience with Strattera and the fact that he had little control over the powerful effects of Adderall, played a strong role in the way he understood his hesitation in distributing his medications. By assuming the moral authority to determine who is responsible enough to access his medication, he also asserted his own morally appropriate use of the drug.

Mark was not an experienced drug dealer, nor was he outwardly interested in making money off his prescription medication. While he held on to the image of the upstanding friend who is only looking out for his peers, he also felt as though he is constantly being taken advantage of by his friends. This was articulated in his desires to feel comfortable during the drug exchange. Once again, by believing that his morality precedes his distribution of the drug, he relied on his intuition as a guide as to who to sell to and whether or not to charge them for the transaction. For him, this was the ultimate distinction between his practice and those of a traditional, immoral drug dealer. Yet his contradictory actions signaled a struggle to understand his own morality as he constantly re-evaluated these criteria with each situation.

### *5.2.3 Abby: Responsibility as Authority*

It was 6:15PM on a mid-November evening and I was driving through the south end of campus with Abby, a senior in pre-medicine at American State University. We pulled up to a duplex in a student neighborhood and walked up the snowy sidewalk to ring the doorbell. We were greeted by three large but friendly German Shepherds, kept at bay by Jessica, a freshman in Biology whom we were scheduled to meet with. We took off our shoes, wet from the snow outside, and made our way to the living room. The three of us sat on a large, second hand sectional sofa and chatted for a few minutes about the weather, boyfriends and school before the conversation turned towards Adderall. The "consultation," as Abby called it, was about to start. She began, "So, let's get into it. I know that you have never tried Adderall before. Can you tell me what you know about it?" Jessica shifted in her chair and replied "Well, I know it's supposed to help you like focus".

Over the next two and a half hours, we sipped on coffee as Abby ran through her complete consultation agenda. It included an emotional narrative of her lifelong struggles with ADHD, an in-depth medical explanation of the condition and the effects of prescription stimulants, and a full battery of behavioral questions for Jessica. This included a history of previous prescription drug use, study habits, sleeping patterns and a number of other factors which ultimately determined whether or not she could properly benefit from Adderall. Once she had confirmed her eligibility, Abby pulled out a small Ziploc snack-size bag with one tiny blue 10mg tablet of Adderall IR and told Jessica, "I want you to split this and take half tomorrow morning and half on Friday. Don't take the whole thing. Call me on Saturday and we can figure out if it is helping or not". Jessica agreed. We sat for a few more minutes, playing with the dogs and laughing at the infomercial on TV for "pajama jeans" as Jessica fiddled with the bag in her hands. We followed

her to the kitchen to put our coffee mugs in the sink, hugged her goodbye and left.

When I first interviewed Abby several months earlier, she had clear idea of who the typical Adderall dealer was and refused to put herself in that category. She described them as "ridiculous", "irresponsible" and "uneducated" about ADHD the drugs that they were selling. For example, she told me how some students would openly advertise their Adderall as a "study aid" on "AllAmericanState.Com," an online classifieds forum for students. I asked her to describe the advertisements and she told me,

> "People are like [sarcastically] 'oooh do you want study pills?'… These kids can't spell it either! It's 'A-D-D-R-O-L' and I know what you're trying to say but you obviously don't know what's going on… Why the hell would you word it that way? I'm like 'study pills', seriously? And I almost want to e-mail them and be like who the hell are you? First of all, if you're going to sell it or buy it know what you're talking about, spell it the right way."

Throughout the interview, Abby constructed herself as someone who was much more informed and responsible about the drug than these other dealers she references. She credits this knowledge to her therapist, her expertise as a pre-med student, and her self-initiated research on the topic. Abby told me that most students who end up selling their drugs receive them from a doctor who give them prescriptions without properly diagnosing them. When I asked her why she thought that happens, she told me that she believes doctors "just want to give you the meds" without properly testing for the condition – which is why the condition is over diagnosed. Abby told me that testing can be expensive but it is worth it to know that the science supported her diagnosis, and as a result she had "no fear that the drugs [prescribed to her] will work and are safe."

Abby described her own experience getting tested for ADHD by her family therapist at the age of 19, a year before she transferred to American State University from community college. The testing was her therapist's idea and she was initially skeptical of the whole thing because she

did not have any academic performance issues. She recounts the tedious day-long testing process, much of which she saw as "random" and unnecessary to explaining her condition. After three months of waiting, she was shocked to find out that she tested positive for diagnosis, but as her therapist began describing the symptoms, and eventually revealed her own struggles with ADHD, Abby felt like it finally clicked for her. Moreover, her therapist's willingness to divulge her own diagnosis convinced Abby that she really could trust her to know what was best in the situation. Abby worked with her therapist to determine the appropriate dosage of medication to manage her ADHD symptoms. Over the next year, she was prescribed 80mg of Vyvanse and two 10mg Adderall tablets daily, which she was instructed to consume in the evenings to extend the effects. However, after experimenting with her medications, she determined that she did not have to take Adderall daily – only on days she forgot to take her Vyvanse in the morning. As a result, she had a surplus of her Adderall at the end of each month and the possibility of sharing her drugs was now on the table.

Although Abby did not sell her Vyvanse, she told me that she eventually did become comfortable with the idea of selling her Adderall under certain circumstances. She finally sold it for the first time to a longtime friend named Jennifer who she knew had used ADHD medications in the past. One day while studying, Jennifer and Abby had a long conversation about the possibility of selling her Adderall. She ultimately determined it was the ideal scenario because she had extra medication and an opportunity to make a few extra dollars for household expenses. Moreover, she seemed to have the ideal client – a friend who probably had ADHD and would likely take the drug responsibly. Although Abby sounded confident reflecting on her decision to sell her Adderall, she told me that a few months later, she felt like Jennifer was only coming around to seek the drug and that it was "getting annoying." While Abby ultimately

decided that Jennifer deserved her medication, it is clear that the way her clients approach her is an important consideration and one that ultimately shapes her self-understanding as a responsible and respectable dealer. Abby mentioned on several occasions her desire to maintain agency over not only who would receive the drugs, but when, how often and how much. For example, she told me that although she believes her friend has ADHD, she does not give her enough to take it on a daily basis for several reasons. She told me,

> "I made it clear like if I am going to sell this to your or give it to you, this is what I expect. Knowing that I'm liable and you can't challenge what I say. So I'm not doctor even though I don't prescribe this and if you really want this and this is how you feel and I trust you, then you have to show me the same respect and acknowledge what I'm saying. So she's very good about it."

As more and more people found out about Abby's Adderall supply and approached her for the drug, she became increasingly adamant about her expectations of her clients. Her biggest fear was that they were trying to trick her in order to obtain the drug for recreational purposes and, as a result, would end up getting hurt. One of the primary ways she determined a potential client's intentions was by how they would approach her for the drug. She told me that she is more likely to give it to a person who shows hesitation asking about the drug, than someone who outright asks for me. She explained that it is because they "have a concern for their well-being whereas the people who just walk up and ask it's like do you want to ask me without caring what I'm giving or selling or why I'm selling." When I asked her why that was important, she told me that a person who does not care about their own health is not some she would trust with her Adderall. She explained,

> "It's the whole responsibility aspect where I feel responsible if anything happens to you and if you are irresponsible and immature, why would I want to make myself responsible for that? Buying is so much less dramatic I guess. Selling is like you're responsible if they overdose, like you've killed them."

For Abby, responsibility should be shared between the buyer and the seller and is

negotiated through an exchange where where both parties acknowledge and respect the legal and medical risks of illicit Adderall use. This is the key difference between the way she sells Adderall and they way she views the rest of the stimulant economy. Abby contextualizes this frustration with irresponsible buyer and dealers when she told me a story about a girl in her biology class who had some questions about trying Adderall for the first time. As they were sitting in the lecture hall talking about ADHD after class, another student named Angela interrupted and offered to sell her Adderall at a better price. Abby told me it felt like she was "a prostitute on a corner and if you walked up and tried to get a guy and make money off him, you're crossing a boundary." When Abby told Angela she was being disrespectful, Angela retorted by claiming she needed the money more than Abby, and therefore she should be able to put a bid in for her client. Abby's frustration in this situation highlights the key differences she sees between herself and the typical Adderall dealer. The analogy of Angela as the prostitute literally pressuring the "virgin" drug user is especially telling about the way Abby constructs her own moral subjectivity. While Angela is more concerned about who is entitled to the sale, Abby is worried about how this exchange affected her client, making her the more trustworthy party.

Abby told me that after this experience, she realized that there was a time and place to negotiate the drug deal, one which required privacy, honesty and mutual respect. This negotiation or initial conversation is what Abby refers to as "the consultation". She told me that whenever someone asks her for Adderall, she told them that she will only consider it if they are willing to sit down and talk with her about it first. Abby told me that at this point, the majority of the people who approach her usually back off, which in itself is a powerful "weeding out" process. She told me, "I'm responsible for selling to you so if you're not comfortable sitting down with me, then you're not worth my time." I asked her if she is concerned that they will go

and purchase the drug from a less responsible dealer. She responded that it is none of her business what they want to do. She would rather spend her energy investing in a few clients who she knew she could help responsibly.

After a consultation, Abby also sets up a system to follow up with her clients. She told me that it is usually less structured after the first few weeks because she feels like her clients have enough experience to manage their drug experience. At the same time, she admits that there is always a risk when it comes to taking powerful prescription stimulants. I asked Abby if she could minimize that risk by encouraging her patients to seek professional help for their condition. She told me that no matter where the drug comes from there is always a risk and, "This is why I'm very specific to who I sell to because it concerns me that I'm liable and I think that anybody who sells should know that they're liable and if they don't they're an idiot."

She further explained all of the possible side effects of taking Adderall, as well as lesser known facts, that could impact the efficacy of the drug, like consuming it with orange juice. She told me,

> "It took me years to find out all this stuff over time as I'm taking this. [My doctors] didn't tell me all this up front. So it's more of me doing studies of other people too and I'm like okay this is what it is and this is what it does and you can do instead of this… I mean understanding what it is and doing more studies like this just opens up a world of knowledge I don't think that understanding is there.

Thus, although Abby believed that doctors should play a role in educating patients and supervising their ADHD management, she feels that there is always an inherent risk with drugs no matter where they come from. Moreover, she suggested that doctors rarely do a thorough job informing their patients, unlike Abby who had years of research and experience with her medication and could share that knowledge with her clients. In this way, Abby's pharmaceutical expertise became the foundation to her identity as a responsible drug dealer.

As a pre-med student, and a person with ADHD, Abby morally rationalized her approach to selling her medication through a rhetoric of both authority and responsibility. She loathed how the drugs was being sold by "clueless" prescription holders, as well as legally by indifferent doctors who charged unreasonable prices and never followed up with their patients. As she continued to address requests for the drug, these concerns evolved into ethical criteria and eventually a comprehensive consultation protocol for treating and monitoring students whom she believed suffered from ADHD. During the consultation, Abby shared her own experience with the condition as a way to build trust with her clients. At the same time, she was also critical of the length and style of traditional diagnoses. For that reason, Abby crafted a new agenda for her consultations, which she felt gets more to the heart of the matter without all of the extraneous components that would be taxing on someone with ADHD.

The consultation was ultimately a way for Abby to determine who has access to her medication. It served both as a way to diagnose her friends, but also to set up the ground rules and expectations for the drug exchange. Formalizing the process made Abby feel more like she was providing a service for her friends, who in fact need the help, rather than someone making money off selling drugs. At the same time, Abby was pragmatic about her decision to sell her medicines - the prescription costs money, she has bills to pay and she is not charging an obscene amount. She also referenced other dealers, like Angela, who claimed she did not need the money as much as they do, yet she does not see it as a matter of financial need. Ultimately, she seemed to understand Adderall dealing as a private agreement between two people where both parties' goals are aligned.

Abby was also concerned with the responsibility that came with selling her medication.

She often referenced other Adderall dealers who did not understand how serious and complicated the distribution of Adderall could be. Because she knew so much about ADHD and the drug itself through research and personal experience, she felt she had more of an authority to sell her medication. At the same time, she was highly selective about the types of people she offered her services to, and even the format and location of the consultation, in order to maintain agency over the drug experience. Although she went to other people's homes, she as the one running the show. Abby's relationship with her therapist was also a key contributor to how interacted with these potential clients by sharing her own experience. It played a large role in how she understood herself as a person with ADHD and, eventually, how she constructs her identity as a responsible drug dealer.

## 5.3 DISCUSSION

The biomedicalization of childhood and Adult ADHD in the late 1990s and early 2000s contributed to an increase in the number of students entering college who are legally medicated for the diagnosis. Although there is limited data on the dynamics of the prescription drug dealer-seeker relationship (Incardi 2009), the increased availability has had significant effects on the perceived value, safety, and social acceptability of sharing and consumer these medications (Quintero 2006).

My research suggests that the illicit Adderall market on campus can triggered a series of moral breakdown for students who are legally medicated for the condition. The breakdown is facilitated by the perceived impunity of dealing, the demand for stimulants, and the controversial nature of the drugs they deal. These factors have significantly shaped the values and experiences of college students who are legally medicated for ADHD and inform their experiences when

encountering Adderall seekers. These factors also directly set the prescription stimulant market apart from other drug markets and, as a result, shapes how these students perceive themselves as empowered, yet responsible, drug distributors. Moreover, these factors influence how students evaluate the legitimacy of requests from Adderall seekers as looking to get high, self-medicate, improve studies, or some hybridized combination of these uses. Together, these factors contribute to an ongoing struggle between Adderall dealers and seekers to properly define the responsible, or at the very least acceptable, use of prescription stimulants. In the following sections, I discuss how Adderall dealers at American State University have morally positioned themselves, their products, and their consumers in response to these social and personal moments of moral breakdown.

### *5.4.1 Practices: From Dealing Drugs to Governing Health and Performance*

The drug dealer-drug seeker relationships presented in my case studies were based on intersecting social, academic and medical logics that served a number of purposes. For Becca, the drug deal symbolized her investment in her friendships and her friend's dependence on her as a reliable and responsible friend who could supply them with Adderall. Her decision to sell served to increase her social capital and self-worth within her growing networks. Because the drug is such a foundational part of Becca's identity as patient, student, and peer, it is hard to distinguish which of her relationships were founded on and facilitated by her access to Adderall. We see this when Becca panicked over her inability to supply Adderall during the shortage and it becomes clear to her that she may not be able to hold up her end of the relationship. Despite the obvious drawbacks to this, Becca is not concerned, but rather comforted by the fact that as long as she does have access to Adderall, her relationships will remain intact.

For Mark, the occasional drug deal was in the context of helping out a friend in need, rather than a formal transaction for social or financial gain – motivations he attaches to the "drug dealer" identity. Mark was not particularly interested in selling his Adderall because he did not want to be liable for any potential side effects his buyers might experience. He would rationalize his decision to do so by only selling to those whom he considered to be responsible users. This category, for Mark, included people who would only use Adderall for academic purposes and never for recreation. He saw recreational users as irresponsible and likely to underestimate the power of the drug. Avoiding liability was his primary objective. However, we nonetheless see Mark succumb to the pressures of diverting his medication even when he did not feel comfortable. Mark grew agitated by these continual advancements and begins to question many of his social relationships and interactions with friends and roommates. Even when not asking directly, he became almost paranoid, assuming that all they want is his medication.

Abby also expressed her frustration with peers who asked her outright for the drug, viewing this behavior as a sign of irresponsibility and disrespect. For Abby, the drug deal was an honest exchange where both parties' intentions and expectations are aligned and there is a mutual respect between them. To accomplish this, Abby eventually developed a comprehensive protocol, which she calls the consultation. The name itself served to distance her relationships from the traditional dealer-seeker exchange and reframe it as a professional service. Furthermore, this re-framing of the drug-deal signaled her desire to maintain agency over the exchange. Although Abby saw it as a method of determining who has ADHD, it ultimately became a strategy for her to justify whom she feels comfortable selling to.

### *5.4.2 Objects: From Illicit Drugs to Social Benefits and Burdens*

By reframing Adderall as a valuable commodity to which she has privileged access, Becca was able to concurrently reframe her identity as a vulnerable patient, to an empowered drug dealer. Adderall became a tool in her evolution from immature "prude" to mature "badass" during her college years. She came to perceive the effects of the drug as a performance enhancer rather than a mere medication. This perception allowed her to feel empowered by her use and connected to the experiences of her non-ADHD friends, who use the drug for the same reason. In this sense, Adderall became foundational not only to her social relationships, but also her identity as a normal college student. Her productive view of the drug also helped her rationalize her unregulated distribution among friend and acquaintances. Her only apprehension about the drug was the social stigma she felt when she was younger. Now that this stigma was eliminated in the college context, Becca saw no reason not to use her medication to help her new friends.

For Mark, Adderall went from being a potential performance enhancer to a social burden. It is unclear whether Mark ever truly believed he had ADHD or if that even mattered in his decision to take the drug. What did matter for Mark was the intention and respect he, and others had, for the drug. Stories about the truant high school kids who did not use it to apply themselves and the college students who would use it to party only reaffirmed his belief that not everyone deserved access to the drug. For Mark, Adderall was only for those who would use it safely and in appropriate academic situations. The dangers of Adderall were also a strong consideration as he struggled to manage the strength and side effects of ADHD medications at various points in his life. Sizing up a potential buyer's ability to respect and handle the strength of the drug was a strong consideration when determining who he would sell it to. Yet with each pressured exchange, Mark began to view the drug as more of a social burden than a benefit.

For Abby, Adderall has and always will be a medication that is only for people who fit her criteria for ADHD. Although she was apprehensive about her own drug use at first, her rapid increase in dosage and the positive effects in her social and academic life made her feel like she made the right decision. Moreover, her extensive experience gave her a sense of expertise over manipulating and harnessing the power of stimulants to manage the symptoms of ADHD. Like Mark, Abby also recognized the potential dangers of stimulants, which is why she spent so much time educating others about the drug before she sold them. As a result, Adderall also served as a tool for her to help others until they could be formally helped through sanctioned medical channels.

### *5.4.3 Subjects: Dealers/Seekers to Pharmaceutical Benefactors/Beneficiaries*

Although each individual had a unique construction of the drug dealer identity, there are three themes that emerged across all three case studies in various forms. First is the desire to feel respected by the potential drug seeker, whether it is by approaching them in an appropriate way, or not at all, and showing gratitude for the transaction. Mark and Abby both viewed distributing Adderall to the wrong person as a potential liability and want to be appreciated for the risk they are taking. For Mark, this was especially important because he did not have the surplus that both Abby and Becca had – thus making his Adderall more valuable. For Becca, being a drug dealer was about gaining respect by selling to the people she really wants to incorporate into her social network – especially those who she saw as being popular or holding some social status. She justified her role by reminding herself that she was only selling to friends who needed her help.

Another theme that emerged was the desire to assert one's authority over the drug deal. This feeling of authority came from a number of sources. For all three, it started with the legal

access to the drug. We saw this in the way Becca justifies her right to distribute Adderall because it is her medication and she can do what she wants with it. This emerged also in how Mark constructed himself as understanding the importance of drug intentionality and being more cognizant of the potential negative effects because of his past experiences. Abby based her authority on her personal experiences as well as her close relationship with responsible medical professionals and her pre-med background. In all three cases, a failure to recognize their authority or expertise became a sign that the seeker was not worthy of the drug.

Finally, all three incorporated some explicit dimension of morality into their drug dealer identity. Mark claimed to use an informal moral compass to guide his decisions, implying that he is fundamentally a good, responsible person who will make good choices. Abby on the other hand, developed a more formalized protocol based on her view of what the diagnostic process should be. Becca also used her moral judgment when she claimed only to sell to her friends who needed her help, a fact that sets her apart from the irresponsible, albeit glamorized, drug dealer who was only out to make money. However, throughout participant observations, it became clear that the inconsistencies in applying these strategies serve more to rationalize morally ambiguous decisions after the fact, than make them in the first place. We especially see this when Mark gave into the pressure to sell, Abby continued to sell to Jennifer despite her hesitations, and Becca realized that she may lose her friends if she is unable to refill her prescription.

## 5.4 CONCLUSION

In this chapter, I have illustrated that there is an ongoing struggle among college students to make sense of and maintain agency over the chemical and symbolic transformation that comes from consuming Adderall. I argue that this represents a key moment of moral breakdown

associated with the biomedicalization and pharmaceuticalization of performance in American college culture. I take this as a departure from traditional conceptions of the illicit drug dealer and who are driven by purely economic interests or the desire to get high (Tunnell 1993).

I used a combination of ethnographic vignettes and interview data to show how these students move away from purely neoliberal logics of financial gain to create new forms of moralized pharmaceutical subjectivity in response to this breakdown. They rely on their positionality to stimulants as effective, coveted, but potentially dangerous medications as a way to assert their agency over these exchanges and present themselves as responsible drug beneficiaries. This includes flexible criteria on who knows about your Adderall supply, who to give it to, how it is used, what it is used for, how much to give at once, if and how much to charge for it, and how you should monitor someone's use. Yet with each exchange, the symbolic meaning of stimulants as medications becomes unstable as students struggle to determine which seekers are worthy of their valued commodities. As a result, Adderall dealers must strategically assert their identities as patient, student, or friend in order to navigate theses morally ambiguous exchanges and rationalize their decisions to conserve/distribute these powerful drugs. I argue that by doing so, ADHD students are in my study were able to respond to this moment of moral breakdown as they attempted to maintain their perceived sense of responsibility over the responsible drug use of others.

In the following chapter, I examine how these moral discourses are transmitted and transformed as prescription stimulants are illicitly consumed. I describe the experiences of college students who are tasked with defining and distinguishing responsible drug behaviors and maintaining a sense of moral agency over the drug experience. It also speaks to their

positionality to Adderall dealers and medical service providers and how it influences their perceptions of responsible stimulant use.

## CHAPTER 6: CONSUMPTION

This chapter looks at how moral ideologies around responsible stimulant use from the market, treatment and circulation landscapes circumscribe and shape the consumer experience. It builds on anthropological work that describes the experiences of the strategic drug user, a neoliberal subject who empowers themselves through the strategic consumption of pharmaceuticals. Here, consumption is a means for both medical and social transformation, defined by the intentions of the user, the context in which the use occurs, and the symbolic meaning of the drug itself. I also draw on studies from the health and social sciences that look specifically at the self-reported motivations and behaviors of college students who consume Adderall without a prescription. While this literature provides key demographic information about this drug behavior, it largely describes illicit Adderall use as a form of performance enhancement. As a result, it fails to account for the multiple and often contradictory moral logics which students use to understand and express their controversial behaviors as constitutive of responsible stimulant use.

Building on this literature, I consider how the illicit consumption of prescription stimulants among college students has evolved in respect to pharmaceuticalization in the last decade. Increases in the prevalence of this behavior has raised public concerns over the intentions and actions of these illicit users. I use media reports to provide key insights into public discourse surrounding this social moment of moral breakdown and highlight the ethical dilemmas faced by college students who have illegal access to prescription stimulants. I situate these dilemmas within the university stimulant culture and illustrate how certain factors, such as the experimental ethos of college culture, the increasing normalization of illicit Adderall use, and

the simultaneously productive/destructive nature of the drug itself, have influenced the consumption experience.

My goal in this chapter is to understand how students at American State have positioned themselves and stimulants in relation to both social and personal moments of moral breakdown within the campus stimulant landscape. To accomplish this, I conducted twenty-four months of interviews and participant observations with 45 college students, documenting their experiences resisting and participating in Adderall use on campus. I present six case studies that highlight moments in which students interpreted a positive or negative drug experience and subsequently developed strategies to make themselves feel like responsible drug users. I present my analyses of these case examples around the practices-subjects-objects framework to systematically map the moral discourses that surround and are produced through the modern consumption of prescription stimulants. I conclude the chapter with a discussion of how this analysis informs conceptions and expectations of pharmaceutical morality and subjectivity in the US.

## 6.1 MORAL BREAKDOWN: MINIMIZING COSTS OR MAXIMIZING BENEFITS

The increase in illicit prescription stimulant use on college campuses has gained the attention of scholars across various fields in the health and social sciences. Many of these studies implicitly describe these behaviors through neoliberal logics, framing Adderall use as an intentional and calculated decision to increase academic performance (Loe et al. 2006). Some have even gone so far as to endorse the availability of these drugs to the healthy as a means to improve human capacities on a larger scale (Greely et al. 2008). At the same time, the increased normalization of this behavior has raised public concern over the implications of this behavior on issues of merit and success in the university setting. As a result, college students with access to

stimulants are faced with the dilemma of failing to meet performance expectations or facing the health, legal, ethical, and chemical consequences that come with consuming stimulants.

Media reports offer insights into public discourse surrounding this moment of moral breakdown and the highlight the ethical dilemmas faced by American college students. For example, the issue was highlighted on April 25, 2010 during a segment of the news program "60 minutes" titled "Boosting Brain Power." During the opening sequence, reporter Katie Couric asked viewers, "If there were a drug that would make you smarter, would you take it?" The morally ambiguous undertone of her question set the stage for the rest of the segment, which centered on a focus group of eight white college students at the University of Kentucky. She opened the conversation by asking students "how common is it to see friends poppin' pills during finals?" to which the group responded, "it's the norm." Her informal conversation with these young people about "pill poppin'" was spliced with commentary from medical and social science researchers - a framing technique that showcased the dissonance between the medical and ethical concerns of experts and casual attitude of college students who were witness to, if not active participants in, this controversial drug behavior.

Throughout the segment, Couric uses the term "self-medication" to describe the illicit stimulant use, but not in reference to the treatment of self-diagnosed ADHD. In fact, she made a point to show the audience a neural image which suggests that "Ritalin works in a healthy brain the same way that it does in a brain of someone with an attention disorder." Rather, her use of the term "self-medication" was meant to frame illicit Adderall use as a strategy to overcome the academic pressures of college life. In doing this, it seems as though Couric was encouraging the audience to remove stimulants from the auspices of medication and place them squarely in the realm of performance enhancement. From there, the conversation focused exclusively on the

medical and ethical implications of using Adderall as a "brain booster." Couric interviewed the director of the National Institutes on Drug Abuse (NIDA), Nora Volkaw, who warned viewers against the addictive and psychosis-inducing properties of stimulants. However, Professor of Communications at Kentucky, Alan DeSantis, who has conducted numerous studies of this drug behavior, argued that students do not view it as a risky drug and compare its effects to a "stiff cup of coffee." He explained that this is because students have friends who have been on the medication legally for over a decade without issue and thus see no harm in their own occasional use of the drug.

With the safety of the drug being apparently of no concern to students, Couric turned towards the efficacy of stimulant use in her interview with psychologist and researcher Martha Farrah. She interviewed a number of subjects from Farah's study on the effects of 20mg of Adderall versus placebo on healthy individuals completing cognitively-oriented tasks. Farrah concluded that although Adderall can increase alertness, it may also hurt performance in people by suppressing creativity or giving them "tunnel vision", thus missing more effective methods to solve problems. Alternatively, featured commentary from students in a focus group suggests that students do see a marked improvement in their ability to focus on tasks and "make the grade." DeSantis further supported these claims and explained that according to his research, 90% of college students who used the drug believed it increased their final marks by at least 1-2 letter grades.

Couric rounded out her segment by interviewing an Economics Professor at Harvard who openly admitted to using Adderall throughout college and during his career to help finish his latest book. His professional success and willingness to talk about his illicit drug use presents Adderall as a de-stigmatized method to improve performance within the academy. Couric

finished the segment by asking the focus group how they would feel if Adderall was available to anyone without a prescription. One student responded, "I guess the question is, 'how do you feel about it morally,' and our general consensus is that most people are okay with it."

The issues outlined in the 60 Minutes news segments highlight the growing tensions among students around the responsible use of prescription stimulants. It has emerged as the result of a number of factors that shape this new stimulant culture, such as the increasing normalization of illicit Adderall use, and the simultaneously productive/destructive nature of the drug itself. In this chapter, I examine how illicit Adderall users have positioned themselves in order to navigate this morally convoluted environment. Specifically, I ask how is responsible stimulant use defined and facilitated by college students at American State University through the consumption of prescription stimulants? How do these practices influence and embody shifting expectations around the responsibility to avoid/participate in stimulant use? In the following sections, I address these questions and examine how the college students in my study framed their behaviors, the function of stimulants, and their subjectivities in relation to these social and personal moments of moral breakdown.

## 6.2 CASE STUDIES

The data in the chapter is based on 24 months of interviews and participant observations with 45 students at American State University and their experiences resisting/participating in illicit Adderall use. During the interview phase, students were asked questions about their ideologies and experiences as they related to *medical factors* (ADHD, Adderall, pharmaceuticals, doctors); *social factors* (family, peer groups, socialization, drinking/drug use); and *academic factors* (transitions into college, college culture, study habits, grades). Each interview lasted

between 2-4 hours and was tape recorded and transcribed. Interviews were coded via NVIVO around these three primary contexts and then with sub-codes related to emergent themes from the data.

During the interview, I built rapport with these students and touched base with each of them multiple times over the next twelve months. Many of them contacted me to share updates and invited me to social events, study groups and private residences where prescription stimulants were openly discussed, sought after and sometimes consumed. I also witnessed these conversations and behaviors during my day-to-day life at American State University in public spaces such as the library, coffee shops, classrooms, the cafeteria and other locations where students frequented. At first, I was surprised to hear students talk about it so openly, so much so that when I would talk about it with my research assistants or colleagues, I would say the "A-word" with a hushed voice. However, I soon realized that Adderall talk among students is as normalized as discussing any experimental college behavior, like drinking, smoking weed, or having sex. They would talk about doing it; who else was doing it; how to do it correctly; where to get it from; why it is a good idea; and occasionally, why it is a bad idea. However, comparing public perceptions to what I observed when students experiment with the drug in private, suggests that the glamorization of Adderall as a "magic bullet" study drug did not tell the whole story.

In this chapter, I show how the illicit use of Adderall by students American State can become a deeply moralized negotiation of health, empowerment, and responsibility, by which new biomedical and social subjectivities are fashioned. The significance of practice is bolstered by the fact that experimenting with Adderall is not only normalized, but has become an expected part of the college experience for many of these students. This means that students rarely needed

a reason beyond innocent curiosity or justifiable desperation as a motivation to try the drug in the first place. However, the normalization of "trying Adderall" is not without its complexity, a fact that I realized when I started the interview process and found that students had vastly different definitions of what constituted an Adderall user.

Of the 45 students I interviewed, 23 were initially identified as "non-prescription users", 11 as "prescription users" and 11 as as "non-users". Yet during the interview process, I found that some "non-prescription users" used to have prescriptions for the drug but had since chose to purchase it illegally for a variety of reasons. I also found that some "prescription users" started as "non-prescription users" but subsequently received a diagnosis for ADHD. There were also a number of "non-users" who admitted to using Adderall once or twice a long time ago, but considered themselves "non-users" because they do not consider themselves Adderall users. I began to rethink the stability of these categories - what exactly was I trying to compare by using them: Who had a prescription at exactly the moment I interviewed them? How recently they had consumed Adderall and whether or not that single incident now permanently labeled them as a user? As I listened to their stories I realized that these labels were in fact an obstacle to capturing the complex logics they used not only to decide whether or not to "try Adderall" but how they eventually interpreted their behavior as ir/responsible drug use. In response, I reorganized my demographic breakdown to account for any use, past or present to provide some indication of their experience and how it influenced these perspectives (see Chapter 1 for demographic information).

The students I interviewed drew on a combination of economic, social, and medical logics to make sense of and maintain agency over the chemical and symbolic transformation that comes from consuming Adderall. This includes rules about where they access their medications;

modes of consumption; and what types of academic work are both logically and ethically appropriate for pharmaceutical interventions. Yet with each swallowed pill, the symbolic meaning of stimulants as self-medication, enhancement and/or recreation becomes unstable as students struggle to justify their controversial behaviors. As a result, students must constantly re-assert boundaries between their moral selves and the potentially immoral pharmaceutical practices in which they engage. I argue that through the negotiation of boundaries these students are able to rationalize their behaviors as a form of responsible, albeit illicit, drug use.

In the following sections, I present six case examples from drug users with whom I became well acquainted during this study. While each participant at some point made the decision to "try Adderall" or eventually use it without a prescription, the way they strategically position themselves as responsible drug users varies greatly. Each constructed persona serves to ethically rationalize their participation in this controversial practice, and illustrates the complex value systems they created out of necessity. By coupling interviews and participant observations, the following cases show how students' moralized self-constructions compare to their lived experiences as students, friends, patients, and drug users.

### *6.2.1 Shannon: Responsibility as Seeking Health Care*

It was the beginning of spring semester and I was sitting at the kitchen table with Shannon, a freshman in biology. She had asked me to come with her to her mother's house for "moral support" when she decided to tell her that she wanted to get tested for ADHD. After almost an hour of chatting about school and family, Shannon finally mustered up the courage to bring up the issue at hand. She began, "Mom, you know that I really care about school, right? Like I am really trying my best." Her mother looked concerned as she nodded her head. "I know.

Your grades were really great last semester. What are you trying to tell me?" she asked. Shannon replied "Well, I think I have ADHD." Shannon began telling her mother how she had been taking Adderall without a prescription for about three months and that she had never felt more focused. She was worried that her mother would be angry with her for using the drugs illegally but to her surprise, she seemed relatively calm. Shannon's mother listened carefully and began to ask questions about where she got the drugs and if there were any side effects. Shannon assured her it was from a trusted friend and that Adderall was completely safe, especially for people who needed it like her. Shannon's mother began talking about her own issues with focus and wondered if she too had ADHD. We spent the next half hour gathered around Shannon's smartphone, googling videos about the condition and the effects of Adderall on the brain. She then told Shannon, "Well, I am glad you told me about this but I don't think you should be taking someone else's medication. Let's talk with the doctor and decide what to do from there." A month later, both Shannon and her mother obtained legal prescriptions for Vyvanse and began to take the medication on a daily basis.

When I first interviewed Shannon, she was struggling to decide if the increased focus she felt with Adderall was evidence that it was just a "study aid" or if it was evidence that she had ADHD. Like many of the informants in my study, she had tried the drug for the first time during finals week the night before a big paper was due. Shannon had never used any other drugs, street or prescription, for "moral reasons" so she had no point of comparison when it came to evaluating the physiological effects of Adderall. However, the fact that she did not experience any negative side effects lead her to feel more and more comfortable with using the drug on a regular basis. After using it weekly for over a semester, she told me that she started to feel guilty about the improvement in her grades and wondered if she was somehow "cheating the system".

She had never considered the possibility of having ADHD before her first experience with Adderall because she was never "hyperactive" or had problems paying attention in class. However, now that she knew that the drug was "working" for her, she did some research on ADHD and felt like she might meet the criteria.

Following this research into ADHD, Shannon told me that she asked her friends what they thought and they believed that she probably did not have this disorder. However, she said they encouraged her to try to obtain a script so she could contribute to their supply. After some thought, she decided that the best course of action was to be tested for ADHD so she could come clean to her parents about her Adderall use and take the drug the "responsible way". After she obtained a legal prescription, I asked Shannon if she would share her Adderall, like her friends assumed, and she told me that she did not think of Adderall as a study aid anymore, but a medication. As a result, Shannon felt like she had more of a right to take the drug than her friends because she actually has ADHD, as evidenced by her doctor's official diagnosis of both herself and her mother.

### *6.2.2 Peter: Responsibility as Engaging in Self Care*

It was the Tuesday after spring break and I was walking into a coffee shop off campus to meet with Peter, a sophomore in history. We were supposed to meet that afternoon so he could tell me about his appointment with his family doctor to talk about getting a legal prescription for Adderall. I took my seat and we talked about what we did over break and his plans for the semester. After about 20 minutes of waiting for him to bring it up, I finally asked him what happened at his doctor's appointment. He leaned back in his chair and told me that he thought about it for a while but ultimately decided not to go through with setting up the appointment

because “it wasn’t worth the hassle”. When I asked him what he means, Peter reminded me that the only reason he wanted to go to the doctor in the first place was to get a regular supply of Adderall so he would not have to keep bothering his friends for it. However, after he found out how much it would cost to get the testing done and fill a prescription without using his parent’s insurance, he realized it would be much cheaper to just buy the substance illegally.

I asked Peter if he still thought he had ADHD. He told me that he knows he does but it is not as severe as other people so he could manage with obtaining Adderall from his friends on an “as needed basis”. I asked him if he would feel confident in telling other people that he did in fact have ADHD without an official diagnosis. Peter laughed and told me, “like I need to pay some doctor to convince me I have ADHD?” He told me several stories about students he had heard of who have the diagnosis but faked it to get a prescription for Adderall. He told me these stories made him doubt the legitimacy of the diagnostic process and as a result, helped him rationalize his decision to not get tested.

During our initial interview, Peter told me that he knew he had ADHD for as long as he could remember because his grades were always up and down and he could not concentrate in classes. When a few of his friends started receiving diagnoses for the condition in high school, he had brought up the idea with his parents. He told me that they did not believe in ADHD and thought Peter was just using it as an excuse for his poor academic performance. Over the next four years, he struggled in school but never tried Adderall because he was afraid his parents would be upset with him, and did not think it was worth the consequences. Once he was in college, however, Peter found that a lot of people were using Adderall without a prescription and he was curious as to what it would do for him.

Peter tried Adderall for the first time before an exam and felt "laser-focused" on the questions. He used it again a couple of days later to study for a different exam and experienced a heightened sense of confidence as he moved through the materials. He began buying the drug regularly from his roommate and used it a couple of times a week to work on assignments or pay attention in his lectures. He saw his grades significantly improve.

Peter explained that after feeling the positive effects of Adderall, he felt both frustrated and vindicated. Frustrated that he clearly had ADHD and his parents and teachers had failed him by not taking his concerns about the possibility of the condition seriously. He felt vindicated that he no longer needed their permission to finally address the one thing that was standing between him and a successful academic experience. However, because Peter knew how his parents would feel, he decided to keep it a secret from them and seek out a prescription on his own, which he was able to do as an adult. When the costs of the diagnosis and the drugs itself became a barrier to Peter's plan, he turned to his ability to self-diagnose, in spite of the adults in his life, as evidence that he knows what is best for himself. In this case, it meant using Adderall without a prescription to treat his undiagnosed ADHD.

### *6.2.3 Erica: Responsibility as Avoiding Dependency*

I was attending class at a local yoga studio when I saw one of my informants, Erica, a senior in physiology, take the instructor's place at the front of the room. I had met her almost 12 months earlier when I did my initial interviews but had subsequently lost touch with her when she stopped returning my emails and text messages. She spotted me during class and gave me a gentle squeeze on the back to let me know that she recognized me. After the session, she came over and apologized for "falling off the face of the earth" but promised me that I would forgive

her once I knew the whole story. We decided to grab some coffee next door which is when Erica told me that she had been in rehab for almost six months because of her addiction to Adderall.

I listened carefully as she described her battle with the drug, which she began taking illegally her freshman year before she eventually obtained a legal prescription. It was during her time in rehab that she took up yoga and later became a certified instructor so she could support herself when she returned to school. She told me that although she had heard of "Adderall abuse", she never thought she would be "one of those people". I asked her to tell me what that means and she described the feeling of not being able to get out bed in the morning without first taking the drug, and the withdrawals she experienced when she tried to quit on her own. I asked her how she thought it was possible to become addicted to her own medication, and she asserted, "doctors don't really understand how dangerous these drugs are." She compared Adderall to the street drug Methamphetamine and reminds me that they are just "one methyl-group apart." She asks me if I have "tried it yet" and I shake my head. She looks relieved and told me, "Good! Never ever take that shit, Taz. It's not worth it. Just stay away from it no matter how good it sounds. Even if you think it's gonna help, it is not worth it."

When I first interviewed Erica, she had already begun questioning her constant use of the drug and told me that, "it was more trouble that it was worth." Like many students, she had taken Adderall for the first time during finals week her freshman year to find that the drug "worked" for her. At first, she would only use it for high-stakes assignments, like exams and term papers. Eventually, however, she used it to clean, work out, or just feel more "social" at parties. She interpreted her constant desire to use the drug as evidence of undiagnosed ADHD, not an addiction problem. Other friends were using Adderall daily with a prescription so she felt it only made sense to become diagnosed herself. After going through a formal assessment, Erica

received a legal prescription from her family doctor at the beginning of her sophomore year. She told me that her doctor never talked with her about the potential to abuse the drug and even encouraged her to take an extra pill if she "really needed it that day." Eventually, she needed an extra pill every day, which became an issue because her friends would ask her for her medicine but she did not have any left for herself, let alone to share.

At the end of this first interview, Erica told me that she was considering not refilling her prescription because she did not like the way it makes her feel anymore, but was torn because she did not want her grades to drop either. She was especially concerned when her pills were stolen from her apartment during a house party and she was too embarrassed to ask her doctor for a refill so she just bought the drug illegally for the rest of the month. I asked Erica if she felt like she could talk to her doctor or her parents about what was happening and she said that she does not want them to freak out and think that "she is a drug addict or something" and that she can handle it on her own. During that time, she still viewed Adderall as a medication, rather than an illicit substance. Although she knew it was similar to Meth, she told me the comparison did not really register with her because it legally came from a doctor.

### *6.2.4 Jenna: Responsibility as Managing Dependency*

It was a Tuesday night at the beginning of spring semester and I was sitting on the couch with Jenna, a senior in economics. We were at her apartment and Jenna was going through her course syllabi with me, trying to figure out how much Adderall she would need to get through the semester. Because she considered herself an "Adderall expert", Jenna was able to tell me exactly when she though she might need Adderall and exactly how many milligrams is needed to complete each assignment. She pointed to a reflection paper for an elective philosophy course

and told me “that is only worth like 1% of my grade so I don’t need any Adderall for that”. It is not until she comes to the high-stakes assignments, like her economics final, which would take "at least a twenty, ten to study and ten for the exam." She told me that although she feels like she needs Adderall to help her get through finals, she did not like how she felt when she overloaded her system with the drug in just a couple of days. Jenna looked at her planner and counts back three weeks from the end of the semester and put a star next to Sunday with a green gel pen. She told me, “this is when I will buy my Adderall for finals. Ten-5s [mg], ten-10s [mg] and five-20s [mg].” She explained that in order to avoid getting sick, she started taking the 5mg tablets every other day, then the 10mg tablets every day and then the 20mg pills as needed for her finals. She also made sure to buy a couple ounces of weed for the end of the semester to help “cancel out the speediness” of Adderall and help her get to sleep at night so she can resume her studies the next day. Jenna also told me that she never uses Adderall to write the final draft of a paper, because every time she does, it turns out to be “complete rambling bullshit”. For that reason, she will write a rough draft of her history paper two weeks before the deadline when she is starting on the 5mg tablets, and just needs the “motivation to get started.” Once she has a draft, Jenna will edit the paper during one of her off days before she moves onto the 10-mg tablets.

During our initial interview, Jenna told me that she was diagnosed with ADHD by her family doctor her senior year of high school and took Adderall every day through her freshman year at American State. However, she eventually felt like she was becoming dependent on the drug to get anything done, not just school work, but cleaning, exercising and socializing. I asked her if there was a moment when the realization hit her and she told me, "When I lost more than twenty pounds in just a couple months, that’s when I knew it had gone too far". Jenna had stopped filling her prescription her junior year and decided to quit cold turkey without her

parents finding out. She told me that they would freak out if they knew she was not taking her medication anymore. However, quitting was much harder than she thought it would be and she experienced severe withdrawal symptoms which caused her to almost drop out of school at the beginning of her sophomore year. She told me that although she could have refilled her prescription, she no longer trusted herself with sixty-ninety pills at once. She decided that the best course of action was to start buying Adderall illegally from her friends as a way to regulate her use. Because she felt somewhat embarrassed to ask for more than a couple of pills at a time from any one person, the awkwardness itself is a good regulation system. Jenna also told me that now that she has been regulating her own use for over two years, she had become somewhat of an expert on how to best use Adderall to maximize its benefits and minimize its side effects. I asked her if she felt like her existing ADHD diagnosis made her feel like she has a right to buy the drugs illegally. She told me that that she felt more responsible doing it this way.

### *6.2.5 Megan: Responsibility as Maintaining Integrity*

It was the Monday of finals week and I was studying with Megan, a sophomore in chemistry. We sprawled out in one of the study rooms in the dorms with four of her classmates from her organic chemistry class who were also preparing for the final exam tomorrow. Megan had been up since 6:00AM because she had picked up an extra shift working at the university coffee shop at the library to earn some extra money to save up for a study abroad program next spring. Although she had unlimited access to coffee, it was clear by the redness of her eyes and the continuous and contagious yawning that Megan was fading fast. By 11:00PM, the group still had three chapters to review for the exam and Megan told the group that she might have to call it a night so she can some sleep before the test. Eric, a young man in her study group offered to

share one of his Adderall with her if she wanted to keep studying, assuming she would accept. Megan looked at me and said jokingly “I’ll only take one if Taz does.” I smiled and told her “nice try." Everyone at the table laughed. Eric also laughed, but again he extends the offer again. Megan smiled sincerely and replied “Thanks buddy, but I got this.” We stay for another hour before Megan and I left and I drove her back to her apartment across campus. In the car, I asked her how she felt about what happened and she told me that she appreciated his offer but she did not feel like she needed it. I asked her if she felt weird taking the Adderall with me being there, but she reassures me, and replies “I know you wouldn’t judge me Taz, but really, I just didn’t need it.” She continued to tell me that people like Eric should not feel bad about taking Adderall since they needed it but she has learned that for her, it is just unnecessary.

Although she did not use it that night, Megan admitted to me during our initial interview that she had indeed tried Adderall before. In fact, the drug was offered to her by Eric during a study session last semester, much like the one we had attended together that evening. She described the situation as one of desperation. She was always a good student but was having a hard time finding time to study because her parents were having financial troubles and she had to pick up another part time job on campus. The pressure of a full course load and demanding work schedule was beginning to take its toll as Megan struggled to stay awake in class, let alone prepare for final exams. She had seen Eric become “super-focused” after taking an Adderall before class or when studying for exams throughout the semester. So when he offered it to her that night, she “had a moment of weakness” and thought “well let us just see what happens.” I asked Megan if she thought Adderall was a performance enhancer and she told me that it definitely kept her awake but she was not sure if it actually improved her exam scores. I asked her if she felt like it was cheating to take the drug and she told me “well, not really cheating

because it didn't actually help me retain any information. At least I don't think it did? So I would say no."

Megan went on to tell me that her parents would be really disappointed in her if they knew she had used the drug because she does not need Adderall to be a good student - just more discipline. I asked her if she thinks it is cheating when other students use it and she says, "I don't know, probably not because they really might need it." Megan told me that she believed that any advantage they achieve on the test would be outweighed by the fact that they would not remember it down the road. And if they did, it is probably because they had ADHD and legitimately needed the drug.

### *6.2.6 Justin: Responsibility as Taking Initiative*

It was the Sunday before finals week and I was hanging out in the kitchen with Justin, Max, and Eddie, all juniors at American State who were also roommates. I sat at the table and watched the three rummage around the kitchen assembling the ingredients to make an impressive meal of pancakes, eggs, hash browns and sausage. As they began cooking, each told me about his finals week schedule. Justin told me "three exams and a twenty-page paper, but I am done by Thursday." Max chimed in, "I got you beat. I have four exams, and one is on Friday morning. At 8:00AM!" The three cringed together at the thought. Eddie told me that he lucked out because he only had two papers to write and both were due on Friday, but he had not even started the research on them yet. Although they were laughing, I could feel the nervous energy fill the room as we sit down to finally eat our unusually large breakfast. The rest of the conversation turned towards plans for summer break and the "debauchery" that will ensue once the three of them are finally free. It would start off with a party at their house on Friday night to help them recover

from the “PTSD” from finals week. As the three finished their meals, Eddie pulled out two baggies with four 30mg pills each and hands them out to his friends. He also pulled out a single pill from of his prescription bottle for himself and sets it on the table. They each take a pill, and raised them - much like toasting a glass of champagne - and say loudly in unison, "Fuck you, finals!" before swallowing them. We cleaned up the kitchen, and headed to the student union.

I had interviewed Justin earlier that semester which is when he first described to me the finals week ritual that his roommates had created to foster solidarity before "entering into battle". The three had been friends since their freshman year of college when they lived in the dorms together. That was when Eddie first shared his Adderall with Justin and Max, which according to Justin, would be the act that laid the foundation to their friendship for the next four years.

Justin told me that before coming to know Max and Eddie, Justin was an “average student” who had ambitions of doing something great with his life but never quite had the motivation or initiative to get started. As a result, his grades were just good enough to get into American State, but within a semester, he was on academic probation for failing almost every class. Justin told me that he never really took school seriously and was used to disappointing his parents. But when the reality of his probation sunk in and he knew he would have to explain this to his parents, he became severely depressed. When Max found out about Justin’s problem, he offered him an Adderall that he had received from Eddie and told Justin that it was the only way to make it through finals week. Justin had drunk and smoked marijuana before but had never tried Adderall or any other prescription drug. He decided to give it a try and told me that it turned him into a “study machine” and that it definitely improved his grades. At the same time, he recounts moments where he did not use Adderall “the right way” and ended up cleaning his room or “creeping on Facebook for eleven hours” instead of studying. He also found that if he did not

drink enough water or eat before he took the drug, he would lose his appetite. After three or four days straight, the effects would be unbearable, which is a big part of why the three of them developed the "breakfast before battle" ritual in the first place. When I asked Justin if he feels guilty for using Adderall or what his parents think of his drug use, he told me, "My parents don't know that I use Adderall. But if they did, they wouldn't be mad. They would be proud of me for taking initiative and doing better in school."

## 6.3 DISCUSSION

Some medical anthropologists have argued that the increasing availability of pharmaceuticals through both sanctioned and illicit channels has generated a sense of agency among Americans who feel they could benefit from these technologies for both medical and nonmedical purposes (Vuckovic and Nichter 1997; Petryna and Kleinman 2006; Tone and Watkins 2007). This process requires an increase in self-surveillance by the user and the belief that pharmaceuticals could quickly and effectively improve medical and social circumstances (Clarke et al. 2006). In particular, the increase in drug marketing, flexibility of ADHD diagnoses, and the pressures of college life encouraged young people to seek out legal prescriptions for stimulants (Conrad 2005). At the same time, Abraham (2010) notes that biomedicalization theory alone is not sufficient in explaining the growth in the prevalence in ADHD diagnoses; we must also take into consideration the expanding power of drugs in American society. This is especially true in the context of illicit stimulant use, which has in some cases become entirely disassociated with the original disorder and, in other cases, has become even more entangled with it (often preceding and encouraging the diagnosis). In this framework, the illicit consumption of Adderall

presents an opportunity to improve health and/or cognitive performance issues that serve as obstacles to academic success.

My research suggests that the increased availability of stimulants at American State can trigger a series of moral breakdowns for students with access to these drugs. The increased prevalence and publicized normalization of this illicit drug behavior has lead the public to question the intentions and actions of students who seek out and consume these medications. Medications that were promoted by the pharmaceutical industry and health care providers as having the power to improve mental health and social performance are now the source of the moral dilemmas that are associated with pharmaceuticalization. The strategic drug user had become a victim to irresponsible advertising, diagnoses, and a culture that promoted performance over health. This, coupled with the experimental ethos of college life and the normalization of this drug behavior have lead to an ongoing struggle among students in properly rationalizing their participation in this contentious drug behavior. In the following sections, I discuss how these illicit Adderall users have morally positioned themselves in response to this moment of moral breakdown.

### *6.3.1 Practices: From Transformation to Experimental Practice*

My research illustrates how college students have attempted to empower themselves through the use of prescription stimulants while attempting to avoid or lessen the myriad medical and social side effects. Although each origin story is unique, all of the users from these case examples initially used the drug to improve their academic performance. However, the way they interpreted and rationalized this improvement varied from managing symptoms of ADHD, to pushing past their natural limits, to reaching their full potential, to coping with the struggles of

finals week, to gaining the motivation to do the work. This is because these students draw on a variety of complex moral logics to interpret the negative/positive chemical and symbolic transformations they experienced through their consumption of Adderall. As a result, each had a unique understanding of what constituted responsible or irresponsible Adderall use, and developed strategies to mitigate the medical and social side effects of the drug. This included rules about when and where they accessed their medications; modes of consumption; and what types of academic work are both logically and ethically appropriate for pharmaceutical interventions. However, these rules changed over time as students continued their experimentation with Adderall while attempting to maintain a sense of agency over the drug transformation.

For Shannon, responsible Adderall use meant seeking a legal prescription through a licensed medical professional. Although she was treating what she interpreted as the possible symptoms of undiagnosed ADHD without a prescription, she felt guilty about hiding her drug use from her parents. Similarly, Peter interpreted his improvement on Adderall as a sign of ADHD, and although he considered the benefits of obtaining a prescription, he did not think it was worth the money or the effort. Moreover, he was skeptical that a medical professional would even diagnose him properly, and felt that he could better manage his ADHD on his own as needed, even if it meant taking Adderall illegally. While both students articulated their illicit use of Adderall as self-medication, their personal interpretations of the drug transformation were informed by existing and evolving beliefs about ADHD, the role of doctors, and the ethics of consuming a drug in secret/illegally to improve their grades.

Others held legal prescriptions, yet interpreted the drug transformation as a possible sign of addiction or abuse. Although she was diagnosed with ADHD, Jenna felt like she knew more

about the drug and its potential side effects than her doctors and did not trust herself with so many pills at once. For her, responsible drug use meant regulating the frequency and purpose of her consumption, even if it meant buying the drug illegally from friends rather than filling her own legal prescription. On the flip side, Erica sought a diagnosis for ADHD after taking Adderall illegally on occasion - only to become addicted once she had a legal prescription. For her, there is no such thing as responsible Adderall use because the drug is simply too dangerous. While both Jenna and Erica participated in legal and illegal Adderall use and were concerned with the potential for misuse and abuse, they each developed individual strategies to maintain agency over the drug experience, by controlling it or avoiding it completely. These examples are particularly hard to classify within existing frameworks because their relationship to Adderall changed so dramatically since their initial consumption. It also illustrates the problems with labeling users at any given period of time based on their motivations alone because both students are still motivated to do well in school. However, the role of Adderall and their responsibility in the actual drug experience is directly influenced by their interpretation of the transformation that occurred when partaking, both immediately and over time.

For Megan, responsible Adderall use meant only using the drug if you really needed it. Although she admits she first used the drug in a desperate attempt to complete academic work, she eventually convinced herself that it did not actually improve her performance, although it might for other people who were not as disciplined as her or had ADHD. Although she was able to complete the assignment, she does not credit Adderall with that accomplishment - for her the transformation was ineffective. Her interpretation of a failed transformation helped her to rationalize her decision to never take the drug again. This interpretation further excuses her from taking the drug in the first place because if it did not work, it is not cheating. Alternatively, Justin

saw Adderall use as the only way to cope with the demands of finals week, which was a large part of his responsibility as a college student. For him, the transformation was essential to his academic success, as evidenced by his improved grades. Thus the act of taking Adderall was one of fulfilled academic responsibility. Moreover, it was at the foundation of an elaborate ritual that was both socially acceptable and empowering.

### *6.3.2 Objects: From Magic Bullets to Moral Meanings*

While these students used a variety of labels to describe Adderall, such as “medicine", "study aid", "drug”, or “addy”, the word itself was not a consistent reflection of how they believed it functioned or transformed them. In fact, students would often use these terms interchangeably depending on who they were with. For example, Justin and his friends called the drug “blast”, which was a term only his inner circle knew. On several occasions I heard them say things like “are you blasting right now?” or “let me get some blast” as a way to talk about their drug use in front of others without being questioned or put in a position where they would feel pressured to share their drugs. However, most people just called the drug “Adderall” - even when it was Vyvanse. This is because, as a word, “Adderall” holds symbolic meaning within popular culture. It is a catch all for its multiple perceived functions and effects. This flexible cultural symbol is tangled with the individual experiences which give the drug a complex meaning that is perhaps impossible to capture with the medication/enhancement/recreation framework. As my case examples illustrate, Adderall does not only move between these boundaries, it blasts them apart. The user is then left to piece together what they think the drug means to them with each swallowed pill.

Before Shannon took Adderall, she saw it as a popular study drug that could help her focus and improve her performance. It was only once she started feeling guilty about her continued use that she considered the possibility of having ADHD. Her exploration of the condition and motivation to fit into the flexible category is a key example of self diagnosis via drug efficacy. It is impossible to know whether she really believed she had the condition or if it was just an interpretation that allowed her to maintain a moral sense of self. Moreover, by viewing it as a medication, she could now seek out a diagnosis and prescription that would allow her daily access to the drug without feeling like she was cheating the system or breaking the law. It also meant she no longer had to lie to her parents.

Peter, who claimed he always believed he had ADHD, took Adderall for the first time as a study drug and and immediately interpreted its positive effects as validation of his self-diagnosed condition. Unlike Shannon, he does not see Adderall as a daily necessity, but rather a medication that should be used as needed. Although this may indicate a view of ADHD that is temporary or not as severe, it could also just be a perspective he constructed to deal with the fact that he could not afford to gain regular, sanctioned access through a doctor. Instead, he was willing to re-adjust his values and continue to purchase it illegally from his friends.

While Shannon and Peter seemed to have a sense over the chemical transformation that Adderall provides, Jenna, Erica and Justin were more aware of their necessary participation in the consumption process. Jenna believed she could harness the power of Adderall through calculated consumptions in which she only uses the drug to do the tasks necessary and nothing else. This management allowed her to feel like she is in control and not succumbing to the temptation to use the drug for irresponsible purposes. Justin also creates a ritual around the consumption process in order to avoid the physiological side effects of dehydration and loss of

appetite. For him, however, the consumption process is at its core a social experience - partaking with his friends makes him feel like they are all participating in a rite of passage and suffering in solidarity. This acted to curb any social stigma that might arise from their illicit use of the drug. Of the three, Erica is the weariest of the power of Adderall and decides that it is impossible to control the drug experience. Although it started as a legal medication, it quickly became an addictive substance - something she recognized when the adults in her life did not. She saw it as a dangerous drug whose benefits as a medication or enhancer was outweighed by the costs of consumption. As a result, the only way for her to control the experience was to avoid it altogether.

Adderall also had a motivational function for all three in that they used it to drive themselves to do academic, and sometimes non-academic, work. Justin saw this as the primary purpose of the drug because it motivated him to get his work done, despite his grueling finals week schedule. However, Jenna only wanted motivation for appropriate academic tasks and nothing else, which is why she had to be so calculated about her use. Finally, Erica also found herself using it to "get out of bed in the morning" and did not want to rely on the chemical motivation.

### *6.3.3 Subjects: From Strategic Users to Pharmaceutical Interpreters*

My study illustrate how these students relied on a number of moral logics to not only make decisions about their consumption, but to rationalize their behaviors as a form of responsible, albeit illicit, drug use. In particular, they relied on social and individual experimentation to determine if and how they could benefit from the drug and whether or not they were willing to deal with the social and medical side effects. My case examples suggest that

these decisions were not based purely on neoliberal goals of performance enhancement, but also included moral judgments to articulate their pharmaceutical choices. In particular, the students in my study continuously re-asserted boundaries between their moral selves and the potentially immoral pharmaceutical practices in which they were engaged.

Megan constructed a self that does not need the transformation that Adderall provided, marking herself as a responsible and perhaps moral person. She does not see herself as a cheater, but as someone who tried the drug once with positive intentions and made the responsible decision to never do it again. She is a responsible student because she works really hard for her grades and cares about retaining the information. As she does not want to disappoint her parents by taking drugs illegally, she may also consider herself a responsible daughter.

Similarly, Peter assumed responsibility by constructing a self that selectively needs the transformation that Adderall provided. He does not see himself as a bad student, but someone who needs medication to manage his ADHD symptoms from time to time. He does not rely on doctors or his parents to take care of his health needs, taking responsibility for his own needs. He cares about improving his performance, even if it means taking drugs illegally – delineating himself as a responsible student.

Constructing a self that selectively needs and controls the transformation Adderall provided, Jenna does not see herself as an ADHD patient or drug user, but rather as an Adderall expert who knows how to use the drug responsibly. She is a responsible patient because she recognizes the power of Adderall even when her parents and doctors do not. As she systematically plans out her use and knows exactly how to use it to maximize its positive effects while minimizing its negative ones, she is also a responsible student.

Similar to Megan, Erica identifies as someone who does not need, and actively avoids the transformation Adderall provided. She does not see herself as an ADHD patient or a drug addict, but rather a victim of the drug. In recognizing the negative effects of the drug even when her parents and doctors did not, she is acting responsible for her own health. She identifies as a good student because she recognized her misuse and sacrificed her good grades so she could take care of herself and go to rehab. She is also repairing her mind and body through Yoga and using the money to put herself through school. In warning others about the dangers of Adderall, Erica exercises responsibility in acting as a good and wise friend.

Justin does not see himself as a lazy or stupid student, but someone who is doing what it takes to get through finals week, assuming responsibility by constructing a self who wants to control the transformation Adderall can provide. He takes the initiative to receive good grades, even if it is at the expense of his health. His use is responsible because he tries to take care of the physiological side effects by eating breakfast and drinking water. He participates in an Adderall ritual with his roommates, which creates a sense of solidarity, as well as a system of accountability, reiterating the responsibility of his actions and marking him as a good, supportive friend.

Shannon does not see herself as a cheater or drug user, just someone who needs the medication to manage her ADHD symptoms – fully accepting the transformation Adderall can provide. As she chooses to treat her condition the right way by seeing a doctor first, she can separate herself from the category of irresponsible Adderall users. She acts as a responsible student because she is working hard to improve her grades and Adderall is a part of her success strategy. Choosing to be honest with her mother and encouraging her to also seek treatment for her undiagnosed ADHD marks her as a responsible and good daughter.

## 6.4 CONCLUSION

In this chapter, I provided evidence of an ongoing struggle within these college students to make sense of, and maintain agency over, the chemical and symbolic transformation that comes from consuming Adderall. I examined this as a key moment of moral breakdown associated with the biomedicalization and pharmaceuticalization of performance in American college culture. I take this moment of breakdown as a departure from previous neoliberal conceptualizations of of pharmaceutical subjectivity in which individuals feel empowered by increased pharmaceutical consumption (Fox et al. 2005). Instead, I consider the range of moral subjectivities and experiences that emerge from access to pharmaceuticals in the modern college environment.

I used a combination of ethnographic vignettes and interview data to show how these students use both neoliberal and moral logics to justify their stimulant use. In the process, they create new forms of moralized pharmaceutical subjectivity that addresses these social and personal moments of moral breakdown. Specifically, they relied on their interpretations and create strategies to mitigate the medical and social side effects of the drug. This included rules about where they access their medications; modes of consumption; and what types of academic work are both logically and ethically appropriate for pharmaceutical interventions. Yet with each swallowed pill, the symbolic meaning of stimulants as self-medication, enhancement and/or recreation became completely unstable as students struggled to justify their controversial behaviors. As a result, students must constantly re-assert boundaries between their moral selves and the potentially immoral pharmaceutical practices in which they engage. I argue that by doing so, these students are able to rationalize their behaviors as a form of “responsible”, albeit illicit, drug use.

# CHAPTER 7: CONCLUSION

In this dissertation, I presented an anthropological account of how some US college students are constructing and managing their moral subjectivities through engagements with prescription stimulants. I used a combination of ethnographic methods to explicate the moral logics students used to address dilemmas that came with seeking, circulating and consuming these drugs within a college setting. These methods included formal and informal interactions with students and health services providers at my field site who were, to various degrees, tied to the Adderall economy on campus. I presented analyses of several direct-to-consumer (DTC) drug marketing campaigns and news media reports to illustrate the ways in which moral discourses can be diffused through peripheral economic, medical, and academic landscapes to inform the user experience. This included messages around the safety, fairness, legality, and efficacy of these drugs, which in combination contributed to diverse definitions of "responsible" stimulant use in the university setting.

I based my analyses of this data around Zigon's (2007) concept of "moral breakdowns" to anthropologically illustrate if and how students acknowledged these ethical concerns during their engagements with stimulants. Specifically, I examined at how students experienced Adderall use as an unreflective moral choice to manage academic performance, or one that could trigger personal moments of moral breakdown. By combining interviews with participant observations, I was able to witness these moments firsthand as students were made to reflect on their pharmaceutical experiences - either for the first time during the interview, or in their day to day lives as students, patients, dealers, seekers and users. I provided case examples to illustrate these moments and the various moral strategies students used to work through these dilemmas in order to continue operating productively and unreflectively in a pharmaceuticalized environment.

Together, my findings suggest that engagements with prescription stimulants have become a fundamental part of how numerous students construct themselves and are constructed by others as healthy, empowered, and responsible individuals. This is because under the process of pharmaceuticalization, the marketing, treatment, circulation, and consumption of these drugs has become part of daily life for many Americans. This is especially true in the context of college life, where participating in experimental and risky behaviors, such as drug use, is a fundamental part of the cultural ethos for many students. At the same time, this normalization has come under scrutiny in light of scholarly and media reports, which portray stimulants as potentially dangerous, illegal, unethical, unproductive substances that can cause more harm than good. As a result, individuals in my study were, at various moments, pulled from their unreflective moral states and forced to address concerns over facilitating, failing to prevent, or participating in irresponsible stimulant use.

The multi-method approach employed in this study provided the means to observe students' lived experiences along Adderall against the imagined life of prescription stimulants that were described during initial student interviews. I compared this imagined life with conceptions of Adderall use that are commonly presented by the media, pharmaceutical advertisers, and the health service providers with whom I interacted at American State University. I discuss how drug promoters/providers developed criteria to define responsible Adderall use to rationalize their decisions to facilitate or deny college students access. In Chapter 3, I provided examples of how companies like Shire Pharmaceuticals strategically protected their interests by supporting what appeared to be a clear delineation between responsible and irresponsible stimulant use in the college environment. These distinctions were based on endorsing legal and sanctioned access to stimulants, as determined by informed collaborations

between patients and their doctors. This strategy served to delegate both the benefits and burdens of the drug back to the consumer and the medical professionals who are charged with prescribing and monitoring their use.

In subsequent chapters, I illustrated how these imaginary boundaries between responsible stimulant use became increasingly flexible as Adderall begins its material life and travels through contexts of treatment, circulation and, eventually consumption. In Chapter 2, I situated this flexibility within the contentious history of stimulants and attention disorders in the twentieth and twenty-first centuries, as well as evolving modern economic, medical and academic environments in which these drugs currently operate. It is this flexible quality of Adderall as a medication, enhancement, and recreational drug which makes it seem so empowering in the college environment. This flexibility enabled both the users and providers in my study to mold its symbolic meaning into a form that would compliment or enhance their moral sense of self, and help them rationalize their pharmaceutical practices.

Significantly, my research also illustrated how this empowering flexibility can lead to instability as students were forced to adjust their definitions of responsible Adderall use to account for the various social and medical implications that accompanied access to these drugs. This includes complex concerns over medical non-compliance, malingering, social stigma, drug dealing, academic dishonesty, and addiction. The strategies informants developed to preclude and respond to these moments of moral breakdown, and the multiple functions of Adderall within these rationales, were documented by my multi-method approach. As a result, my research provides ethnographic evidence to better understand how students are managing the simultaneously productive and destructive aspects of prescription stimulant use.

I argue that my articulation of the flexible versus unstable boundaries between Adderall as a medication/enhancement/recreational drug is a key contribution to the project of pharmaceutical anthropology. My framework extends beyond describing boundaries between good and bad drug behaviors, and instead seeks to capture the moral ambiguity these boundaries represent. Moreover, it offers a way to articulate the benefits and costs of this ambiguity to the provider/users who engage with these powerful drugs. The notion of flexibility versus instability speaks directly to Whyte et al.'s (2002:15) argument that although pharmaceuticals may seem to empower their user, "control can lead to being controlled" by the drug through addiction, or by drug providers through processes of medicalization. Using prescription stimulants as a case study, my research highlights the moral dimensions of this slippery slope and provides ethnographic data to show how this can occur. Moreover, it describes the strategies some US college students have developed in order to maintain a sense of moral agency over their Adderall experience.

## 7.1 PHARMACEUTICALIZATION

The case examples presented in this dissertation were limited to those key informants who actively avoided, circulated or consumed prescription stimulants. My goal was to illustrate how their engagements with Adderall figured into their day to day lives at American State University as well as their moral sense of self. In many ways, their experiences embodied Dumit and Greenslits' (2006) description of pharmaceuticalization as an all encompassing force where students unreflectively reach for prescription stimulants to manage their ethical identities. This was evidenced by the normalization of Adderall on campus and the fact that many of the students I interviewed told me they had never seriously considered the ethical implications of the

behavior. In these cases, it was the interview itself which triggered a moral breakdown and forced the student to work through the potential dilemma and explain to me why they felt their behaviors aligned with their moral sense of self.

At the same time, there were also students in my study who discontinued their Adderall use because they no longer saw it as a productive or ethical choice for them. These decisions were usually preceded by a moment of moral breakdown in which they had to reconcile the various implications that came from their use of the drug. Together, these positive and negative accounts supported Abraham's (2010) description of the *access-oriented* versus *injury-oriented* consumer who could consciously accept or reject pharmaceuticalization. However, I found that while some of my informants developed moral boundaries around their own Adderall use, they rarely passed judgments on peers who continued to use the drug. This is likely due to the fact that students are socialized to be accepting of each other's individual choices, especially around risky behaviors like illicit drug use in the college environment.

The students in my study seemed to be, for the most part, operating unreflectively in an environment where prescription stimulant use is a normal and sometimes expected part of the college experience. However, I found that these periods of unreflective morality were punctuated with moments of breakdown in which students, for a variety of reasons, had to stop and consider how their drug behavior was compromising their moral sense of self. Sometimes, these moments were reconciled as flukes, or a single poor decision on the part of the user. Often these moments were used to inform new consumption or circulation strategies - including the decision to cease their drug use. A few students in my study experienced a traumatic moral breakdown when they realized that their Adderall use had transitioned from a form of ADHD or performance management to addiction. In these situations, students felt a complete loss of moral agency over

the drug experience. In one instance, a student used this experience to warn others about the dangers of Adderall use, and contribute to what Abraham (2010) refers to as "de-pharmaceuticalization" in the university setting.

In each of these cases, students regained their sense of moral agency by adjusting their own behaviors or expectations to better fit their pharmaceuticalized surroundings. In other words, when Adderall's empowering flexibility turned into instability, students themselves became unstable, which triggered the moral breakdown. To recover, they learned to become flexible subjects either by adjusting their definitions of morality or by adjusting the way they interacted with the drug to meet their moral expectations. Throughout this dissertation, I have provided detailed ethnographic examples of how this transpired in various contexts: marketing, treatment, circulation and consumption. In the following sections, I describe some of the patterns that emerged when analyzing data from within and across these contexts and how they contribute to and better understanding of pharmaceutical morality in the U.S.

## 7.2 MORAL PHARMACEUTICAL PRACTICES

My dissertation contributes to an understanding of pharmaceutical morality by considering the role of drug promoters or providers in constructing and managing the moral boundaries around prescription stimulants. These individuals are responsible for determining which students should have access to Adderall and what constitutes responsible use in contexts of DTC drug advertisements, the diagnosis treatment and accommodations of ADHD, and illegal drug deals between students. However, due to the increasing complexity of the economic, medical, and academic landscapes in which these providers operate, I argue that these individuals are also faced with concerns over managing the flexibility/instability of prescription

stimulants in the college environment. In particular, the evolving definitions of ADHD and the emergence of multiple, competing modalities of ADHD treatment has increased the flexibility and subsequent instability of Adderall as a legitimate medication. Moreover, the demand for stimulants in the college environment for potentially immoral purposes lead many of the drug providers in my study to create or adjust strategies to preclude or respond to the moral breakdowns that came from marketing, prescribing, and dealing ADHD medications at American State.

Although these providers had diverse definitions of responsible Adderall use, I found that they often employed similar strategies when morally framing their interactions with drug seekers. The most common of which was establishing a sense of authority over the pharmaceutical practice through claims of expertise. During DTC drug marketing and ADHD treatment, this predominantly referred to formal credentials such as coaching certifications or medical degrees. It also included professional experience such as original research, number of publications, years of assessment work, or high ranking positions within professional organizations. As Adderall moved through treatment and into circulation and consumption stages, I found more stakeholders making claims to informal expertise. This included reference to personal experience such as suffering from ADHD, having family or close friends with the condition, or personal experiences with prescription stimulants. In particular, many of the student dealers I interviewed referred to personal research and experimentation with Adderall, which they believed made them more suitable to facilitate the drug use of their fellow students than some doctors with formal training.

The Adderall/ADHD experts in my study translated their claims to expertise into a variety of structured protocols which served to justify why they held the power to decide who

ultimately has access to prescription stimulants. I provided examples of the generic self-assessments and ADHD resources that Shire manufactured to establish their expertise on ADHD. I also showed how some health service providers also use multiple assessments to diagnose ADHD and determine who has access to not only stimulants, but academic resources. Even the student drug dealers in my study had some form of protocol or disqualifying criteria which they would refer to when rationalizing why one peer deserved their medication over another.

At the same time, I found that at every level these criteria were, in themselves, highly modifiable and in the end, left open to interpretation. Sometimes, this flexibility served to increase access to prescription stimulants. This was especially true for the generalized quizzes and resource materials featured on Shire's website, with the implicit aim of increasing self-diagnosis among consumers. This was also the case for many of the health service providers and dealers in my study who believed they were helping students by facilitating access to Adderall to either treat ADHD and/or improve their academic performance. Other times, the belief that an expert should grant final approval was actually a safeguard against the instability of these assessments and the fact that students can potentially manipulate the results or work around the qualifying criteria. As a result, the doctors, disabilities services providers and even drug dealers in my study were able to justify denying students access to ADHD treatments and services if they did not feel as though the student would use it responsibly.

### 7.3 MORAL PHARMACEUTICAL OBJECTS

I also mapped the fluid symbolic meaning of Adderall within specific transactions and across contexts. I presented ethnographic evidence to highlight the drug's capacity, through the processes of pharmaceuticalization, to produce and mediate moral subjectivities. My intention

was to uncover and explore the tensions between agency and dependency that Whyte et al. (2002) argue are inherent to many instances of pharmaceutical use. I conceptualize this tension as the shift between the flexibility and instability of Adderall's symbolic meaning. I provided a limited genealogy of this flexibility in Chapter 2 and described how the cultural meaning of Adderall is directly shaped by shifting paradigms of medicalization and biomedicalization at the turn of the century. As definitions for Adult ADHD continued to evolve throughout the late 2000s and early 2010s, it both expanded and obscured criteria for diagnosis. Moreover, it morphed ADHD into a simultaneously psychiatric, neurobiological, and behavioral problem, creating opportunities for new forms of expertise to become engaged with and emerge from these newly expanded/refined diagnostic categories.

My research showed how increasing the qualifiers that are placed around responsible drug use, the more ambiguous the definition becomes. I found that many of the students in my study used this ambiguity to their advantage by either identifying with ADHD (e.g. *I probably have ADHD anyway*) or using it to reject the category altogether (e.g. *ADHD isn't real, so Adderall isn't really a medication*) in order to rationalize their illicit behaviors. Thus, it appears that the flexibility of stimulants is what gives users a sense of both moral agency and neoliberal agency to be able to access the drug and apply its power as needed. This flexibility is also what made Adderall a logical resolution to other moments of moral breakdown associated with college life. This includes dealing with the pressures of improving academic performance, paying for college, treating mental illness, preserving academic integrity, and maintaining social relationships.

At the same time, my informants rarely described Adderall as a magic bullet that could, without influence or consequence, solve their social or medical problems. For some, Adderall

was a tool that could be used as part of a larger plan to increase mental health, cognitive function, and/or academic performance. For others, Adderall was a tool that came with social and medical side effects that needed to be strategically managed. This includes flexible criteria on who knows about the Adderall, who to give it to, where to get it from, how it is used, what it is used for, how much to give/take at once, etc. Yet, my study illustrates how students constantly adjusted these rules in order to constrain Adderall within their perceived moral boundaries of medication/enhancement/recreation. I articulate this as the movement from categorical flexibility, where users perceive control over the drug experience – to categorical instability, where users must adjust their behavior and definitions of responsible stimulant use to maintain a sense of moral agency over the drug experience.

### 7.4 MORAL PHARMACEUTICAL SUBJECTS

A third contribution to the study of pharmaceutical morality made by this dissertation was in examining the various ways in which Adderall users interpreted their pharmaceutical experiences in relation to their moral subjectivities. In each data chapter of this dissertation, I analyzed how the participants in my study described what they believed to be the ideal moral consumer, patient, drug seeker and user. Each of these moral subjectivities represented a variable combination of social contexts, relationships, practices, and value systems. They also entailed a diverse set of moral considerations and breakdowns, each stemming from an increased availability of prescription stimulants in the college environment. My research illustrated how students relied on both neoliberal and moral logics to rationalize their desires to seek out, circulate and consume Adderall. However, these logics were not consistent and were often conflated to the point where it was difficult to tell whether their decisions were pre-mediated or

rationalized after the fact. However, by combining interviews with participant observations, I was able to identify the congruencies and dissonances between how my informants described themselves during interviews—as healthy, empowered and responsible individuals—and their lived experiences as students, friends, patients, drug dealers and drug users.

One of the key findings from this study is that moral subjectivity was intimately linked to students' ability to maintain agency over the drug experience by maximizing the benefit and/or minimizing the harms. This was a skill that could be developed overtime through supervised experimentation with a medical professional. In some cases, this meant working with a doctor who would be willing to explore treatment options which may or may not include Adderall. In other cases, this meant working with a doctor who would adjust or increase their dosage to make sure they were achieving the maximum desired effects of the drug.

Agency was also maintained by the students in my study through ongoing, unsupervised experimentation with the stimulants. This refers to the independent practice of consuming Adderall with or without a prescription, reflecting on the positive or negative experience, and adjusting accordingly. In many cases, these adjustments highlighted the range of conflicting moral logics students relied on to justify their pharmaceutical choices. For example, I found that some illicit Adderall users engaged in optimization strategies which included stockpiling and seeking out high dose pills. In some cases, these illicit users would decide to seek out a prescription in order to justify their illicit behaviors while at the same time, gaining regular access to the drug. I also found that some illicit Adderall users would engage in personalization strategies which included only consuming certain brands or dosages obtained from dealers they trusted. Some students rejected the suggestion that obtaining their own prescription or

discontinuing a previous prescription in favor of illicit use because it would limit their temptations to consume Adderall more often than needed.

It is important to note that these experiments were not always premeditated calculations, rather, they are a constant feedback loop of moral breakdowns that students use to inform their future pharmaceutical choices. As I mentioned earlier, some students claimed that they never really thought about their strategies before their participation in my research. When I asked them to explain their behaviors to me, it forced them to work through the potential moral concerns my questions triggered. Documenting how students responded to these questions during the interview and acted on them in day-to-day situations was key to understanding how students dealt with the double-edged nature of these drugs. As discussed, students in my study did not fit Abraham's (2010) dichotomy of *access-oriented* versus *injury-oriented* drug consumers. Instead, I found that most students were either ambivalent or respectful about the power of Adderall. This approach allowed students to cope with the temptations of Adderall use without compromising their moral subjectivities.

## 7.5 TOWARDS AN ANTHROPOLOGY OF PHARMACEUTICAL MORALITY

As prescription stimulants become an increasingly normalized yet controversial fixture in the college environment, it is important to contextualize the origins and implications of this trend across multiple domains and levels of pharmaceutical experience. This is because no single theory or account of pharmaceutical consumption is enough to understand the wide-reaching influence of these powerful cultural objects. As commodities, stimulants produce and mediate a range of economic relationships between consumers, political regulatory bodies, and multinational corporations. As treatments for Attention Deficit/Hyperactivity Disorder (ADHD),

they embody the healing power of biomedicine to transform impaired bodies into healthy, industrious citizens. As illicit substances, they carry implicit medical and social side effects including the potential for heart attacks, psychosis, addiction, and stigma. As cognitive enhancers, they stretch the imagination of what is possible to accomplish with the medically upgraded brain.

Like any prescription drug, Adderall is not inherently good or bad, yet its complex chemical and cultural functions have made it incredibly contentious, especially within the university setting. In this dissertation, I illustrated the flexible quality of prescription stimulants and how it can reflect and reshapes moral expectations and experiences of health, empowerment, and responsibility among U.S. college students. I accomplished this by tying together theories of pharmaceuticalization and morality and grounding these abstract concepts through authentic ethnographic accounts of Adderall use in multiple forms and across multiple contexts. I argue that when considered collectively, these moments contribute to a more thorough understanding of the ways in which pharmaceutical morality is challenged, negotiated and constructed across the social life of Adderall at American State University.

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