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Authenticity, Values, and Context in Mental Disorder: The Case of Children With ADHD

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AUTHENTICITY, VALUES, AND CONTEXT IN MENTAL DISORDER: *The Case of Children With ADHD*

ILINA SINGH

KEYWORDS: ADHD, authenticity, stimulants, children, self-control, moral agency

ERLER AND HOPE'S insightful article underlines the significance of authenticity to the experience of mental disorder; in particular of anorexia nervosa and bi-polar disorder, but also of depression and attention deficit/hyperactivity disorder (ADHD). Their analysis draws on personal accounts and empirical evidence to illustrate a range of ways in which psychiatric diagnoses and treatments interact with self-understanding and the negotiation of personal identity. because these concepts—'self-understanding' and 'personal identity'—are both meaningful and vague, particularly when trying to get a handle on 'authenticity'—another difficult concept—the authors usefully tie the empirical data to the experience of different 'mindsets' that represent a 'substantial inner conflict' often associated with psychiatric diagnosis (Erler and Hope 2014). From this perspective, a person's struggle with authenticity is related to wanting to resolve the conflict and to achieve 'psychological unity and stability.' After an extended analysis of different contemporary writers' views of authenticity, the authors claim the 'true self' account of authenticity (which they link primarily to Charles Taylor) to be the account that most accurately maps on to psychiatric patients' struggles to discover an authentic self.

In this commentary, I extend Erler and Hope's analysis in two ways: first, I consider their 'true self' account of authenticity in relation to young people's experiences of mental disorder diagnosis and treatment—specifically ADHD and stimulant drugs; and second, I consider briefly authenticity in the context of clinical practice.

In families of children with ADHD, something of the 'inner conflict' described by Erler and Hope in adult psychiatric patients is represented in parents of child patients; it is especially visible in parents' dilemmas around stimulant drug dosing. Parents of children taking stimulant medication as treatment for ADHD spontaneously deploy authenticity in reasoning about, and in justifying, dosing decisions (Singh 2005). Their reasoning about the relationship between authenticity and medication is inconsistent, however: on the weekend, withholding medication allows a child to be 'free to be who he really is'; during the week, providing medication allows a child to 'know who he really is—a successful learner.' Parents use re-

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ductionist accounts to advocate on behalf of their children for school resources and services; they say, for example" 'He doesn't have a behavioral problem; it's his brain." It may seem as though these parents 'know' the real child and view ADHD as alien and inauthentic. In practice, however, parents' responses to ADHD children's behaviors indicate a far more ambiguous conceptualization of the relationship of the child's diagnosis to his 'true self' and to the child's responsibility for his behavior (Singh 2004).

Parents' dilemmas inevitably inform ADHD children's own concerns about the relationship between stimulant drug treatment and authenticity, but in younger children (ages 9 to 14) at least, authenticity is not a primary mode of understanding the relationship between stimulant drug treatment and the self. This is in part due to the fact that, at this stage of development, children's sense of self is still deeply relational and embodied. In interviews, children did not engage well with an abstracted discussion of 'the real self' and tended to contest accounts that suggested they were somehow less authentic or inauthentic when taking medication. Yet authenticity emerges as significant in children's embodied experiences of self, most clearly when they experience bad side effects of medication. Here even young children, whose self-concept is just emerging, will say, "I don't feel myself" in describing side effects (Singh 2013a). Another important way in which a concern about authenticity expresses itself is in children's experiences of ADHD symptoms. In some cases of highly aggressive children with ADHD, a sense of the 'true self' is bound up with very negative self-attributions ('inside I must be evil'; Singh 2007). More commonly, children report experiences of self-alienation when describing a lack of ability to reason and to make good decisions in face of a negative stimulus, such as a bullying taunt on the playground. Repeated experiences of such self-alienation ("I just lose control of myself, and then I don't know anymore what happened later—what did I do?") can cause suffering. In these cases, stimulant medication is viewed as helping to restore a positive sense of self through a greater ability to pause, reason and act; this reduces the experience of being, "not me; like not knowing what I was doing or why I was doing it."

Interviews with children suggest that the struggles over authenticity depicted by Erler and Hope, Karp, and others in adult psychiatric patients map only partially onto children's experiences. Children are unlikely to have a developed a sense of urgency around a 'true self' (although they have intuitions about an authentic self and, in the case of side effects, they recognize when the self has been violated); nor do they have the mature cognitive capacities to engage in the level of psychological dissection and analysis that Erler and Hope show in adult patients. Elsewhere, I have suggested that children's struggles with self-control, and their moral concerns about doing the right thing, represent a formative and valuable preoccupation with moral agency (Singh 2011, 2013a, 2013b). Here, it seems important to note that a developmental account of authenticity needs to acknowledge the significance of an emerging sense of moral agency to capacities for both self-creation and self-discovery. Moral dimensions of behavior emerge in a social context (Walker 2009), and this interplay between behavioral acts and environmental responses to those acts informs children's sense of their moral capacities as well as the appraisal of their character. We might say that children simultaneously discover and create a concept of the 'real me' via a freedom to choose how to act.

As Erler and Hope explain, our freedom to act in ways that are true to ourselves is, of course, significantly constrained by social pressures and by biological limitations. Social pressures are especially important for the self-development of children diagnosed with ADHD, and are likely to contribute cumulatively to the nature and degree of their inner conflict as adolescents and adults. The extent to which children see the symptoms of ADHD as part of their core characteristics ('part of who I am') varies considerably depending on, for example, the severity and kind of symptoms; the views of parents, teachers and peers; and children's ages. Moreover, children's expressed sense of self can reflect efforts to negotiate a confusing set of social messages about the relationship of mental disorder to self: You are different. Everyone is different. Difference is good. Difference is natural. Difference should not matter. Difference should be celebrated.

Stigma is another barrier to a child's ability to freely choose whether or not to announce her diagnosis to the world or to keep it a secret. A child's environment makes a big difference to what level of disclosure feels possible. In our interviews with children with ADHD, we found that when children view their dysfunctional behavior in terms of a duty to 'do well'—that is, to perform and achieve academically, they are more likely to keep their diagnosis a secret (as are their parents and their teachers). Medication helps these children 'pass' as 'normal' to a certain extent, and this inevitably has an impact on a child's capacity to integrate ADHD as part of a healthy sense of self over time. These impacts may be positive and negative: medication may have prudential uses with respect to authenticity (recall the parents who want their children to know themselves as 'successful'); however, such use of medication may reduce simultaneously a child's ability to discover her 'true self' insofar as that self is bound up with the symptoms of ADHD. On the other hand, if ADHD is viewed as objectively separate from the true self, as Erler and Hope suggest at one point, then taking medication may reduce the fog hanging over the true self—and thereby enable discovery of the authentic self.

So how should a parent or a clinician think about the 'true self' in relation to ADHD in children, and how should a child who has concerns about authenticity be helped to think about it? Although I absolutely agree that authenticity is a relevant concept in mental disorder, and I have seen its relevance in ADHD diagnosis and treatment decisions, I have not yet seen a way to resolving the tensions around the question, 'what is the authentic self?' without returning to a consideration of values and context. For example, 'passing' is not nearly as common in an environment where ADHD behaviors are viewed in terms of a duty to 'be good' (and where the duty to 'do well' is a secondary or distant concern). In such an environment, authenticity tends to be more a moral concern (following Taylor) than a prudential concern. For example, when children are asked to consider a radical intervention (in the form of a whole or part brain transplant) that may eradicate their ADHD symptoms, those children who view ADHD in the context of a duty to 'be good' are more likely than the other group to reject any brain intervention. Their reasons reveal a deep moral concern with self-acceptance and social embeddedness, which structures the duty to behave well: children reason that the brain intervention would disconnect them from their families and from their friends, from their communities and personal history. Therefore, choosing such an intervention would constitute a profound loss of self, which, when weighed against the burden of ADHD symptoms, is not just unjustified but, for many of these children, simply 'wrong.' Here we see again that, in children, 'authenticity' is often wrapped around a concern with moral agency; or in this case we might more accurately say with moral citizenship—that is, with a concern about right and meaningful participation in the historical networks and social relations that have given children life and a sense of identity and purpose. (This is one of the many reasons why an ADHD intervention that acts only on the individual child and does not address contributing factors in a child's environment is rarely sufficient to make a long-term, positive change).

Given the rich scope of their article, Erler and Hope are unable to spend much time on how authenticity should or could be used in clinical practice. This would be an important follow-up paper to their article. If there is a moral duty to be authentic, and if this duty sometimes comes into conflict with what is easier or better to do, then authenticity demands a great deal of any person with a psychiatric disorder, but especially of a young child and his parents. In my view, clinical practice can help children address current and potential authenticity-related inner conflict (Singh 2013a). Our research suggests that young children can recognize, experience, and express moral concerns with their behavior, with adult support. Introducing discussion of these concerns into clinical care and treatment decision-making before adolescence will pave the way for discussions about self, mental disorder and treatment, if those preoccupations emerge in adolescence (as they so often do).

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